Textbook of Psychotherapy in Psychiatric Practice

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19. Psychotherapy with adolescents

P. Wilson

'Who are *you*?' said the Caterpillar.
This was not an encouraging opening for a conversation. Alice replied, rather shyly, 'I – I hardly know, Sir, just at present – at least I know who I *was* when I got up this morning, but I think I must have changed several times since then.'
'What do you mean by that?' said the Caterpillar, sternly. 'Explain yourself!'.
'I can't explain *myself*, I'm afraid, Sir,' said Alice, 'because I'm not myself, you see.'
'I don't see,' said the Caterpillar.
'I'm afraid I can't put it more clearly,' Alice replied, very politely, 'for I can't understand it myself, to begin with; and being so many different sizes in a day is very confusing.'
'It isn't,' said the Caterpillar.
'Well, perhaps you haven't found it so yet,' said Alice; 'but when you have to turn into a chrysalis – you will some day, you know – and then after that into a butterfly, I should think you'll feel it a little queer, won't you?'
(Lewis Carroll *Alice's Adventures in Wonderland*)

INTRODUCTION

Adolescence is well known as a time of major growth and change. It is by definition transitional: it is 'The Age Between' (Miller 1983) – an unsettled position both Beyond and yet Not Yet. It is neither one thing nor the other. Childhood has passed; adulthood, yet to happen. Past certainty, however false, has faded; adult sureness, however illusory, has yet to be acquired. The adolescent wants to be cared for as a child and respected as an adult. Like Alice, the adolescent 'changes several times' and has 'so many different sizes in a day'. It is a very indeterminate and contradictory state of affairs. The adolescent is confused, the adult perplexed. So too the psychotherapist.

Winnicott, in inimitable form, summed up the problem. He introduced the image of the 'doldrums' to describe the state of adolescence:

'A few years in which the individual has no way out except to wait and to do this without awareness of what is going on. In this phase the child does not know whether he or she is homosexual, heterosexual or narcissistic.

There is no established identity and no certain way of life that shapes the future and makes sense of graduating exams. There is not yet a capacity to identify with parent figures without loss of personal identity.' (Winnicott 1966b)

Much of the essence of adolescence is captured in this statement – not least its unclear identity, its curious state of awareness and fear of submission. What is conveyed is a time of waiting, an inevitable ennui, in which things might or might not happen. But the notion of the doldrums, oceanic, equatorial, 'where calm and baffling winds prevail', is apposite. Adolescence is a time of unpredictability. It is not surprising that Winnicott concludes: 'There is only one cure for adolescence and this is the passage of time and the passing on of the adolescent into the adult state.... We hold on, playing for time, instead of offering distractions and cures' (Winnicott 1966b).

Faced with the weight of this sigh, it is tempting to conclude that adolescents are inherently untreatable, best kept out of sight until adult and recognisable. There is, indeed, little doubt that many psychotherapists steer a wide berth, or at best keep a tight ration of adolescent patients on their caseloads – preferring the greater stability and conformity of the motivated and self-observant adult, or the relatively greater compliance and charm of the younger child. In brief, neither the child nor the adult, regardless of individual idiosyncrasy, presents such ambiguity or ambivalence as does the adolescent.

It is, nevertheless, clear that adolescence is a critical phase of development, in which fundamental solutions are found and decisions made affecting the future life of the individual. It is a unique period of life, in which childhood experience is reawakened in an especially powerful way by the impact of puberty. 'The individual recapitulates and expands in the second decennium of life, the development he passed through during the first five years' (Freud 1905c). The possibility arises in adolescence of reviewing and rearranging past experience in the light of present and future requirements. By virtue of being a time of change and reformulation, adolescence is a potentially optimal time for intervention.

It is also a time of considerable energy and remarkable cognitive development. This may not necessarily lead to clarity of understanding or vision, but it nevertheless augments the adolescent's inherent curiosity and fascination in himself and others. Most adolescents spend hours in private preoccupation – about their bodies, families, friendships, achievements and fantasies. All of this is new and intense, frequently bewildering and potentially overwhelming. Most cope well enough by themselves with their friends. Others, however warily and uncertainly, need and seek adult help.

Thus, despite forebodings and undoubted difficulties, there is much in the maturing adolescent – in terms of capacity and motivation – that can be brought into the service of making good use of psychotherapy.

Adolescent development

Adolescence is fundamentally concerned with the negotiation of two specific developmental tasks. The first has to do with adjusting to the impact of puberty and the changing body (Laufer M 1968). This is primary, and involves the adolescent's preoccupation with questions of control, adequacy, mutuality in relationships and sexual orientation. The second concerns the problem of separation and individuation (Blos 1967) – the adolescent struggling to differentiate himself from those upon whom he has implicitly depended as a child, and to establish a degree of autonomy and self-resource, sufficient to accept the dependance of others as an adult. The two tasks are interrelated, each essentially referring to the growing capacity and readiness of the individual to take responsibility for his body and self.

There is undoubted excitement in this development. And yet always there is the prospect of failure, the fear of the unknown, the peril of disintegration and loss of control. Throughout, there is an essential narcissistic concern with coherence, identity and value. Much depends on the extent to which the adolescent can keep hold of a realistic and positive sense of himself, and achieve a degree of self-assurance and integration of the disparate parts of his personality.

The fears of adolescence and the confusions that surround them cannot be minimised. There is, above all, a brooding sense of increasing unbridled power and of limitless destructive possibility. There is also increasing disquiet in the shifting relationships within the family. Childhood assumptions of care and protection no longer stand so firm. The adolescent perceives his parents in new and more critical ways and becomes more acutely aware that he is on his own. The internal and external demand for self-reliance, though exhilarating, is daunting. Friends and groups clearly play a crucial part – but again there is here no certain comfort or panacea. Issues of identity, of sexuality and intimacy and of belonging become highlighted in this group context. The adolescent may well be part of the group, but frequently he feels very different, oddly exceptional and uncomfortably isolated.The adolescent thus lives in an internal world of considerable apprehension, with major questions about whether he will ever 'make it' in the broadest sense of the term. There can be no immediate solutions, and the adolescent is left in limbo, as it were, awaiting adulthood for the answers. Adolescence is, in more ways than one, the 'meantime'.

It can be of little surprise that, in response to so much anxiety and uncertainty, there should be a significant force within the adolescent to retreat in behaviour and fantasy to the actual or illusory comforts of childhood. There are few adolescents who do not yearn at times to be Peter Pan. Indeed it is this regressive pull back, counterpointing so

dramatically with its opposite, that accounts for much of the exasperating inconsistency and variable maturity of so many adolescents.

The capacity and freedom to regress is clearly an essential part of growth – to replenish and draw on past experience in order to move forward. At the same time, regression can also draw the adolescent towards the sheer rawness of childhood experience, and effectively undermine his striving for control and coherence. However benign or favourable childhood once was, the revival of intense infantile feelings – of greed, rage, possessiveness, fears of annihilation, of loss of love and approval – can be very disturbing. This regressive force, though necessary in the process of integration, also threatens the capacity to integrate. The more vulnerable adolescent is caught in a quite desperate tangle – both wanting to escape from the demands of growing up, and yet terrified, excited and confused by the return of childhood experience.

Clearly, these internal developmental issues take place in the context of the 'adolescent family' (Berkowitz 1979; Shapiro 1978). Current and past parental attitudes and family dynamics are crucial to the facilitation of the adolescent's development. Adolescents carry within them, from childhood, parental values and expectations and, in addition, face ongoing parental responses to their growing autonomy. The ease with which the adolescent can achieve separation and individuation depends on the parents' ability to relinquish their implicit parental control and revise their assumptions and requirements of their child as a growing adult. As the adolescent increasingly differentiates himself, so the parents have to face difficult feelings of loss, disappointment and envy. They also have to confront their own sexuality and marriage, as their children develop adult bodies and enter into sexual relationships.

The 'adolescent family' is notoriously in a state of turbulence, and it is not surprising that, in many families, tolerance of the adolescent's curious and variable state, with its inevitable secrecy, rebellion and ingratitude is severely strained. In the more vulnerable family, the adolescent may well find his moves towards independence restricted and opposed; or construed as proof of his badness with convenient grounds for scapegoating. Optimally, an adolescent needs relative stability around him in order to find his own bearings; families and parents who are immersed in their own disturbance do little to foster healthy adolescent development.

Adolescent disturbance

Given that there is inevitable anxiety and inherent vulnerability in the state of adolescence itself, the question is often raised as to what can be considered 'normal', and what 'disturbed' development. Most adolescents, after all, are likely to act at various times in impulsive, shocking, even dangerous ways. There can be no conventional pathway to adulthood. In appreciation of this, Anna Freud wrote:

> 'In general, the adolescent upset and its manifestations are not predictable... Adolescence by definition is an interruption of peaceful growth. The adolescent manifestations come close to symptom formation of the neurotic, the psychotic or dissocial order and verge almost imperceptibly into borderline states and initial, frustrated or fully fledged forms of almost all mental illness.' (Freud A 1958).

There is an undoubted difficulty in gauging what is within the range of normality and what falls within the category of established disturbance. At what point, for example, does adolescent risk-taking and recklessness (for example, staying out late, in dubious company, where delinquent activity and drug taking are prevalent) become a significant manifestation of pathological self-destructiveness?

There are no precise guidelines. Perhaps the most distinguishing mark of adolescent disturbance, however, is the element of *compulsivity* – that is, where adolescents are engaged persistently and repeatedly, as if driven from within, in extreme forms of self-destructive behaviour, invariably against their better judgement. These are adolescents who have fundamentally failed adequately to negotiate the developmental tasks. They are unable to draw stimulus from the tensions of their life, and cannot find ways of mastering anxiety in the service of creativity. Their development is essentially restricted by internal preoccupations and conflict, and by lack of family support and encouragement. They are overwhelmed by demands made upon them, both internally and externally. They are especially frightened of being alone, and have limited capacity to tolerate depression. Equally, in relationships, they are frightened of losing their precarious sense of identity or of being dominated, humiliated or rendered useless. They find relationships confusing and have difficulty in tolerating their disappointments and the frustration of their need for closeness. The power of their emotions, of their aggressive and sexual feelings and desires is particularly terrifying to them.

These young people have invariably experienced various extreme forms of trauma and deprivation in their childhood. They have not grown up in an atmosphere of order and cohesion, and have frequently been overlooked or abused. It is not surprising that they lack any sure internal sense of structure or of organisation. By virtue of their past environmental circumstances, they have not been equipped with the means of controlling impulse, testing reality or developing any sense of value in themselves or in others. They are especially vulnerable to the anxiety engendered in adolescence by the revival of past disturbing childhood experiences.

The disturbance in these adolescents can be understood in terms of *unmanageable anxiety*, *poor ego capacity* and *inadequate defensive responses*. Much of their behaviour and symptomatology can be seen as a kind of panic reaction, a blind defensive flinch to avoid feeling left, forgotten or attacked. Their delinquency is often an attempt to avoid the experience of loss or emptiness by grabbing supplies felt to have been withheld. It can

also represent an attempt to avert fears of submission or helplessness by exerting false dominance over others. Their self-harming is frequently a desperate measure to avoid mental anguish, by substituting physical pain. Their promiscuity is not uncommonly a way of pre-empting abandonment through seductive control and active leaving.

Other adolescents, with less severe but nevertheless disturbing experiences in their background, may respond to the complexities of relationships and emerging independence by retreating into social isolation (often retaining firm but ambivalent links to their parents), in an insulated dream world or in obsessive bodily preoccupation. The anorexic girl is clearly in hiding from the sensations and implications of her growing sexual body. The under-achieving, drug-abusing boy, is often in retreat from the power of his destructive and sexual fantasies and the feared consequences of his triumphs or successes. In many of these cases, the picture is not so much of limited ego capacity to control impulse, as of *excessive conscience* and *omnipotent ideals*. These necessarily derive from severe standards, prohibitions and pressures to achieve, internalised in childhood. They continue to exert impossible demands in adolescence, leaving the young person unable to tolerate imperfection of any sort and thus unable to play, make mistakes or enjoy ordinary relationships.

PSYCHOANALYTIC PSYCHOTHERAPY WITH ADOLESCENTS

Whether or not psychoanalysis is to be recommended for adolescents is a debateable issue. Certainly, there is much in the nature and complexity of adolescent disturbance that requires firm containment and detailed attention and understanding. There are many psychoanalysts who believe that only through the re-experiencing of earlier trauma in the transference, can there be any true possibility of enabling the adolescent to achieve a satisfactory degree of integration. The Laufers (1989), for example, forcefully argue for the necessity of psychoanalysis as a treatment of choice for certain severely disturbed adolescents who have undergone an adolescent breakdown: 'Not to undertake psychoanalytic treatment of such vulnerable adolescents is a chance lost and... would leave them open to more severe and crippling pathology in early adulthood.'

Such intensive psychoanalytic treatment, however, should not be undertaken without very careful consideration of the capacities of adolescents to make use of it and the abilities of psychoanalysts to conduct it. For such treatment to be effective, it requires above all the commitment and experience of trained psychoanalysts. These, of course, are in short supply and, in the ordinary course of events in ordinary psychiatric settings, psychoanalysis is not practicable and should not be attempted. There is also the question of whether or not psychoanalysis is in any case, suitable. Many adolescents are unready to make such a major commitment, and are frightened by the intensity of the psychoanalytic

relationship. The psychoanalytic re-awakening of the past fits, as it were, too closely to the adolescent's internal processes of recapitulation of the past. The adolescent is wary of his precarious controls and bids for independence being undermined. The very containment and continuity that psychoanalysis fundamentally provides may in fact be counter-productive – its embrace only serving to consolidate and prolong dependency, in substitution for the parental relationship, at a time when progressive processes of detachment need to be under way.

There is undoubtedly considerable tension inherent in the relationship between the psychoanalytic pursuit and the spirit of adolescence and its disturbance. The challenge of psychotherapy with adolescents is to find ways, at any given time, of resolving this tension (Wilson 1986).

Of critical issue in the psychoanalytic psychotherapy of adolescents is the interest and preparedness of the psychotherapist to adapt technique and expectations to the particular developmental state of affairs that characterises this period of life. At a practical level, this invariably means offering a less intensive psychotherapeutic experience – usually once or twice weekly. It also involves a certain realism on the part of the psychotherapist with regard to the aims of psychotherapy. Young people seek help because they are unable to work, study or form or sustain satisfying relationships. Others are troubled because they are caught in some obsessive compulsive preoccupation or activity. They are fundamentally seeking symptomatic relief, and it is important in the psychotherapy of adolescents to hold this as a legitimate aim – not simply to relieve immediate difficulties and distress, but more substantially to enable young people to get back onto the path of normal development, so that, for example, they can actually begin to enjoy study or find that they can hold a job down or that they have found the courage to join a group. At a more urgent level, the aim of therapy may be to help and support a young person through a crisis, and prevent or forestall extreme behaviour that could disrupt family life or endanger their own lives.

In approaching the adolescent, the psychotherapist has to be prepared to encounter certain resistances that are specific to adolescence and derive essentially from the adolescent's immaturity and conflict in relation to his dependency. Clearly there are differences according to the age and developmental level of individual adolescents (Esman 1985). Older adolescents, by virtue of their greater independence and more developed capacity for self-observation, tend to show a greater readiness to make use of psychotherapy than do young adolescents. The characteristics that apply in early adolescence, however, pervade most of the adolescent period in varying degrees. What is at issue is a developmental, rather than an individual or pathological, problem. This concerns both the adolescent's attitude to, and capacity to make use of, psychotherapy.

Anna Freud (1958) has succinctly clarified the nature of the adolescent's resistance to psychotherapy, in terms of characteristic

defences against dependency on his parents. In his struggle to detach and separate from his parents, the adolescent turns his investment and energy towards activities and people outside the home. He withdraws within himself, away from his parents; additionally, he reverses affect, turning loving childhood passive feelings into their opposites – the essence of rebellion. In psychotherapy, the psychotherapist is experienced in one way or another as a parent, and the same defences are redeployed. The adolescent, in order to avoid being dominated by the therapist/parent (James 1964) averts his gaze and keeps on guard against the psychotherapist's concern and potential control.

The adolescent, in short, is mistrustful of adults – he is suspicious that they will take over or control or misunderstand. He has a need to keep himself to himself. Privacy is essential, and the keeping of secrets often vital. Telling the truth is not always possible. The adolescent needs his own time to experience and find out things – and he has to do things which adults and parents would ordain not good for him.

It is crucial that the psychotherapist appreciates this state of affairs – and does not punish or fight against it. It is essential, too, that the psychotherapist gives the adolescent time and space to encounter and secure his own impressions and experience before being expected to give account of them publicly. Many of these experiences and feelings are baffling to the adolescent, difficult to articulate and in many respects embarrassing and frightening. Some concern sexual and bodily preoccupations, and are couched in shame, guilt and uncertainty. Some involve ideas and fantasies that are unexpectedly intense, frightening and best not mentioned. Others concern observations and impressions of family and parental life which the adolescent may feel unable, out of loyalty, to disclose outside the family.

The psychotherapist thus needs to be sensitive to and respectful of the adolescent's caution in approaching psychotherapy. He needs, too, to be tolerant of the adolescent's difficulty in making use of help. The adolescent's capacity for, for example, self-observation is relatively limited, still in the process of formation. Young adolescents in particular have difficulty in containing anxiety, and are more prone to relieve tension through action rather than thought. Their excitement is in the doing of things in the here and now, rather than in reflection. Moreover, their typical defences tend to be more rigid and concrete than in the older adolescent. They are inclined to dissociate themselves from their mental distress, and project and put responsibility elsewhere. And, of course, often they simply do not have the words to formulate or express what is on their minds.

Therapeutic setting

The primary task of a psychotherapist is to ensure conditions of work that facilitate communication, and enable both psychotherapist and patient to observe and think about what is happening within and between them.

The concept of a therapeutic setting refers to everything that forms the background in which psychotherapy takes place. At a basic level, it refers to the actual *place* and physical surroundings. In terms of procedure, it is built on an agreed set of *ground rules*. Particularly with children and adolescents, it exists in the context of the *family*. Ultimately, it is determined by the *presence* of the psychotherapist – his orientation and personal style and, in relation to the adolescent, his specific counter-transference and general attitude.

Place

The importance of providing a place which is pleasant and comfortable, and which ensures privacy and safety cannot be emphasised enough. Such a provision serves as a fundamental communication – far better than any words can convey – to the adolescent that he is worthwhile and respected. This is frequently overlooked, especially in services for adolescents, who are mistakenly seen as bejeaned and dishevelled and not warranting such attention to detail. It is important, too, that the waiting room is welcoming and not bare, and that receptionists are friendly, without being intrusive. Care should also be given to the size and arrangement of the therapy rooms. They should not be too large or imposing, nor too small and enclosing; and where possible, they should not be cluttered with desk top paraphernalia or diverting pictures (such as of the psychotherapist's family). Where psychotherapy takes place in institutions or in hospital wards, care should be taken to locate psychotherapy rooms separate from the everyday hurly-burly, and sufficiently distant not to excite curiosity or envy from other patients.

Ground rules

The ground rules laid down by the psychotherapist in the beginning sessions set the tone and define the boundaries of the therapeutic setting. Adolescents, at first, are often not at all sure what they are doing with a psychotherapist, and even less clear what is expected of them. Hill puts this quite directly: 'It is only too easy to assume that the adolescent understands the ground rules ... that he is supposed to volunteer suitable information, refrain from prying into the psychotherapist's private life and recognise this sort of confidential conversation as treatment' (Hill 1989).

It is important, therefore, that the psychotherapist is as straightforward as possible about what he understands of the adolescent's problem, and how he thinks psychotherapy can be of help. This, of course, is not always possible to convey nor easy for the adolescent to hear in the inevitable tension and confusion of early meetings. Nevertheless, the psychotherapist

should endeavour to make a statement, at some point during the course of the first session or so, that registers something of his position and understanding.

Case study 19.1 Jim, a 17-year-old: the chance to talk

The following statement includes some of the major points that need to be covered. This was made towards the end of the first session with a 17-year-old boy who had been urged by his mother to see someone in an outpatient setting. For illustration purposes, this statement is written as if given without interruption. This, of course, was not the case in actuality.

'What I understand so far is that you have been feeling miserable for some time. You are bored at school and, although you say that exams don't matter, you think you are a failure and you're feeling hopeless about the future. You tell me you feel bad about your mother – because you have let her down. In fact, you are here because of her. She wanted you to get some help and she fixed it here with me. I wonder what you think about that? Not much, maybe. I think you think it is all a bit pointless and you cannot see what on earth I can do for you.

Well, right now, nor do I. I hardly know you. My guess is that you are feeling that you are not worth much and that you are frightened of what is going to happen to you. I also think you're very dissatisfied and angry about something. If I am to be of any help, I am going to need some more time to get to know you. And you are going to have to decide whether you think it's worth coming here.

I would like to help you – but you have to know now that I have no magic. I have no tricks or quick cures. The best I can do is to offer you the chance to talk over what's on your mind; about what is happening and has happened in your life. It would be good too, to find out what you want to do. At the moment it's all a bit of a mystery. We may be able to make some sense of it – and you may begin to feel you can do things differently or do some things that you want to do that you think you cannot do. A lot is up to you – whether you really want to change anything. You cannot possible know right now how talking can help – you will just have to give it a try.

I should also say that what we talk about here is private and confidential. There is no reason why you should believe that – it's a matter of trust. All I can say is that I shall not talk or communicate with anybody about you without your consent. Similarly, if I hear about you from other people, I shall do my best to let you know what I know. This is the only way we can work.

Having said that, I have to tell you that your mother did in fact telephone me before the session. She wanted me to know that you are taking a lot of drugs. She also said you are not getting up until the middle of the afternoon. You are missing a lot of school and you treat her like a doormat. She said she cannot make you out any more and you are throwing your life away. It sounded as if you are driving her crazy.

You haven't said much about all that so far today. I suppose you'd prefer not to think about it. The only reason I've raised it is because it was what your mother told me – you need to know what I know. She has quite a lot to say, doesn't she? It sounds as if she could do with some help – but my job is not to be her right hand man. I am here for you. But let me say just one thing about what I think, before we go any further. It may be that your mother has got it all wrong about the drugs – but if there is any truth to what she says, then I have just four words 'Drugs are Bad News'. I cannot stop you taking them. I won't be your nanny but I can tell you straight to cut them out. They are not going to help you or me to help you.

I suggest that we meet for another six sessions until Easter – each week for an hour each time. We can see at the end of that time where we have got to. It may be that you will think enough has been done by that time. Or it may be that you will want to carry on and find out more about yourself –in which case we can arrange that.

So, see you next week.'

A statement such as this contains a number of important messages. It puts into words what the psychotherapist understands of the adolescent's problem and of the anxiety that lies behind it. It clarifies the reason for meeting, the concern of the mother and the role of the psychotherapist. It emphasises the importance of talking and of trust, and pays respect to the adolescent's independence. The statement also indicates a readiness to help but not a promise of cure; it conveys a sense of authority and expectation but not of excessive omnipotence. Finally, it conveys with some force the psychotherapist's concern (hence the unequivocal statement on drugs) – but also leaves open whether or not the adolescent chooses to commit himself to change and to psychotherapy.

One aspect that is not included in this statement concerns the behaviour of the adolescent in therapy sessions. Clearly, standards of acceptable behaviour will vary from one psychotherapist to another and in different settings. An adolescent unit or a therapeutic community may be prepared to allow more aggressive behaviour than can an individual psychotherapist in an outpatient setting. In individual psychotherapy, it is essential that the psychotherapist is clear within himself what he can and cannot tolerate. In one way or another, it is important to convey to the adolescent that there are limits to what is permissable – for example, that the patient is not to damage property or to attack the psychotherapist. Laying down these ground rules is often difficult in initial meetings without arousing unnecessary alarm or seeming overly combative. With the majority of adolescents, this is not necessary. However, there are some adolescents whom the psychotherapist may believe to have poor impulse control or be unclear about boundaries, in which case it is important that he be explicit from the outset.

Finally, it is important that the psychotherapist expects the adolescent to attend sessions punctually and regularly. The psychotherapist, paradoxically, may well anticipate that the adolescent will forget or miss

sessions or be late – but he should never expect it. He should let the adolescent know that he cares about this boundary of time as much as any other, and be as clear and unequivocal about the time of ending sessions as of beginning them.

The family

Psychotherapy with adolescents always takes place in the context of the adolescent's relationship to his parents or caretakers. It is important that consideration is given to how and where the parents are placed in relationship to the adolescent's psychotherapy. With older adolescents, this is generally not a major issue since, by and large, they seek and receive psychotherapy in their own right. With younger patients, however, who are more dependent on their parents, the position is quite different. In most cases, parental consent to and sanction of psychotherapy for their children is necessary. Without this, there is little hope of success – the parents effectively sabotaging the adolescent's attendance and the adolescent feeling unable to make a commitment out of loyalty to his parents.

In principle, where there are parents who feel responsible or concerned, they should be seen by the psychotherapist at some point in the initial stages of psychotherapy. This may include parents of older adolescents if they have been influential in one way or another in persuading the adolescent to seek help. Some adolescents, of course, are suspicious of the psychotherapist's contact with their parents, and feel that their own space and privacy are being invaded. Older adolescents may not agree to any such contact, and this simply has to be respected. Others, however, particularly younger adolescents, often feel reassured that their parents and psychotherapist are in contact with each other – relieved that the psychotherapist has bothered to see their parents and that there is a sense of shared concern around them. Whereas there is some danger of the parents exerting pressure on the psychotherapist to exact compliance from the adolescent to meet their requirements, there is general overall advantage in having the opportunity to assess the adolescent in the context of his family and, indeed, to have actual sight of the parents and vice-versa.

In general, with young adolescents, it is most useful in the first instance to see them together with their parents or families, and then, if need be, to move onto individual psychotherapy. The parents may subsequently be seen periodically for review or in the event of crisis. If they have significant problems in their own right, they should be referred for help elsewhere. With older adolescents, it is more advisable to insist on offering the adolescent individual interviews in the first instance, to be followed, if necessary, with interviews with the parents – either together with or separately from the adolescent, according to the adolescent's preference.

The older adolescent is more concerned to establish his own separateness and individuality, and it is generally inadvisable for the psychotherapist to have on-going contact with the parents. Clearly, again, if the parents are very concerned about developments, or in the event of a crisis, it should be agreed that they have some right of access to the psychotherapist.

Confidentiality is inevitably a major issue in these various arrangements with parents and family. Clearly, the basic principle of confidentiality should be upheld, and parents encouraged to respect their adolescent's privacy in psychotherapy. Where confidentiality is likely to be threatened – for example, arising out of parental discussions, telephone calls – the psychotherapist can do no more than try to be as open as possible with the adolescent about what has been said. It is often helpful, where the psychotherapist has arranged to meet the parents during the course of the therapy, to ask the adolescent what he would like and not like to have discussed. The adolescent ultimately has to trust that the psychotherapist will honour the agreement that has been made.

There may arise situations in which the psychotherapist judges it necessary to inform parents and others who are responsible for the adolescent of intentions, for example, to commit suicide. The therapist may have to act in this way without the adolescent's consent – but always with his or her knowledge (Wilson 1986).

The psychotherapist

Ultimately, the general tone and atmosphere of the therapeutic setting will be determined by the personality and style of the psychotherapist – for it is he who provides the place, lays out the ground rules and makes the arrangements with the parents. The question of who the psychotherapist is and what he brings to the situation is crucial.

In general, it is to be hoped that the psychotherapist is someone who carries within him a level of personal authority and integrity that enables him to deal with anxiety and confusion without losing control or the ability to listen. Similarly, it is to be hoped that the psychotherapist brings to the therapeutic situation a high degree of self-awareness and a reasonably coherent conceptual framework that can serve to regulate and structure his feelings, perceptions and thoughts – in the interest of offering some clarity to the patient.

These general characteristics are essential to all psychotherapists, but perhaps more so in relationship to adolescents who, above all else, need to have a sense of being contained within clear boundaries and who are quick to sense weakness, prevarication and dishonesty in others.

A very basic requirement of any psychotherapist is the capacity and readiness to be receptive. In practical terms, this simply means that the psychotherapist ensures that he has time and space to see and hear his patients – that he can ensure regular times of meeting and that he can be

present in the session without undue preoccupation elsewhere or intrusions of telephones or bleeps. In emotional terms, it means a relative freedom from intrusive irrational feelings and prejudices. In relation to the adolescent, it is important that the psychotherapist is alert to the influence of his counter-transference, as well as positive in his attitude towards young people in general.

Counter-transference. Counter-transference refers to the wide range of irrational feelings and thoughts, expectations and attitudes that are evoked, largely unconsciously, in the psychotherapist in response to the presence of the patient (Money-Kyrle 1956, Moehler 1977). Continuous situations arise in psychotherapy in which the psychotherapist feels at different times helpless, stupid, powerful, persecuted, humiliated, rejected, desired, seduced, punitive and so on. These feelings may well mirror the way in which the patient has felt as a child and/or how he has experienced his parents.

The psychotherapist is thus forced back into areas of his own personal vulnerability. The danger arises of the psychotherapist, by force of the patient's transference, being drawn into ways of reacting that are excessive and unhelpful to the therapeutic needs of the patient. Thus, the past can all too easily repeat itself in the therapeutic situation, to no avail and without understanding. The therapist finds himself reacting, in effect, in the same way as the parents – and the possibility of reflection and of change is lost. All that happens, in accordance with the dictates of transference, is further repetition.

Counter-transference can present more of a major problem in the psychotherapy of adolescents than in that of children or adults. Adolescents' emotions are often very powerful and poorly defended against. Moreover, they bring into the therapeutic situation experiences and attitudes revived and re-enacted both from the past and from current family relationships. If the therapist is to be open to the disturbance within the adolescent, it is inevitable that he will feel the pressure of many of these confusing feelings. What is crucial is that this is monitored and not blindly acted upon. In so many subtle and indirect ways, counter-transference reactions can disturb the sense of stability and of continuity that is the foundation of the therapeutic setting, and is so important to the adolescent patient. Interpretations can easily be made, for example, not so much to improve understanding as to control or excite or punish the adolescent patient.

It is essential that adequate supervision and/or consultation is provided as part of the overall therapeutic setting – to help the psychotherapist clarify, amongst other things, what feelings belong to the adolescent and what belong to him as an individual.

Attitude to adolescents. Beyond the specific feelings of the psychotherapist's counter-transference to an individual adolescent, there reside in all psychotherapists certain fundamental attitudes towards the state of adolescence itself. These relate to the psychotherapist's own experiences of adolescence and to his current predicament as an adult. Psychotherapists have all, of course, been through their own adolescence. Some have been rebellious, others compliant. Some have experienced breakdown, others have enjoyed success. Some remember their adolescence with anguish and hostility towards their parents and authority, whilst others look back with affection and a sense of fun and achievement. As a result, some psychotherapists are excited by the lives of their adolescent patients, and tend to be permissive in their judgements. Others look upon their adolescent patients with alarm and envy, and are inclined to control or even rebuke them in their quest for independence. These feelings are additionally compounded by others related to the psychotherapist's current life as an adult; for example, they may be burdened with family responsibilities, and so resent the adolescent's greater freedom and irresponsibility.

These diverse elements shape the psychotherapist's attitude towards young people in general, and influence his approach to the uniquely transitional and tentative state of the adolescent patient. If left unacknowledged and uncontained, they can easily impede the psychotherapist's capacity to tolerate the adolescent's unpredictability with patience, sympathy and forbearing. Above all, the psychotherapist has to be sensitive enough to appreciate the adolescent's equivocal relationship to dependency, and to hold the balance between respecting the adult and caring for the child in the adolescent. The psychotherapist has, on the one hand, to trust the adolescent's pursuit of independence, allowing space for the adolescent to find his own way and make his own mistakes; on the other hand, the psychotherapist has to be alert to adolescent self-destructive and impulsive tendencies, and be ready to intervene, keep on asking questions, and to set boundaries when needed.

The psychotherapist's task is difficult and fundamentally relies upon his enjoyment and respect of the adolescent state. Without this, he will be unable to be sufficiently flexible or adaptive to make sense of the inherent contradictions in his adolescent patient.

The working alliance

The most difficult task of all in the psychotherapy of adolescents is to establish a working alliance. Much of the art and skill of the psychotherapist resides in the process of forging, often against the odds, a relationship in which the adolescent becomes interested both in understanding his difficulties and in the possibility of change, and in which a spirit of cooperation and enquiry prevails. Many adolescents, despite a potential to be helped, are lost through a failure on the part of the psychotherapist to establish such an alliance – whether it be because of the psychotherapist's inept introductions, inappropriate expectations or

sheer inability to understand and respect the adolescent's inherent equivocation. The adolescent usually enters into therapy in a confused and ambivalent state. He is mistrustful, frightened and frequently in resistance to those who have suggested he come to therapy in the first place. There is much that he wants to keep to himself. He knows that he is troubled and that there is something wrong, but he prefers to disown his problem and put blame elsewhere. At the same time, he is curious about himself and about the possibility of help. There is often an overwhelming wish to be understood and to find someone who can magically offer salvation or certitude. There is in most adolescents a readiness for new experience and possibility.

The overriding initial therapeutic task is for the psychotherapist to appreciate this ambivalence, and to find ways of exciting the young person's curiosity about himself and of engaging with that part of the adolescent that is worried about his normality or adequacy. The extent to which this can be achieved depends as much on the attitude of the psychotherapist as on any particular technique or procedure. There is usually a certain element of urgency in the beginning sessions of psychotherapy with an adolescent, for the adolescent is half ready to leave unless reassured by the psychotherapist's manner and level of understanding. The adolescent needs to feel that the psychotherapist is taking him seriously and can grasp the gist of what is worrying him, without knowing too much about him or trying to take him over.

The psychotherapist has to adopt an essentially paradoxical position – conveying, as it were, both interest and disinterest. On the one hand, the psychotherapist needs to be active and positive in expressing concern about the adolescent – inviting dialogue and conversation, and generally trying to capture the adolescent's imagination. On the other hand, he has to be careful not to be too forceful – he must hold back, keep things open and not press the adolescent for commitment. Miller (1983) has argued that, with certain adolescents, it is sometimes necessary to take on a certain larger-than-life, omnipotent manner – answering their request for somebody to take command and prevent them from engaging in further self-destructive behaviour, such as suicide or different forms of delinquency, that could preclude any further help. It is clear, however, that the adolescent also needs to be reminded that the psychotherapist is not omnipotent and cannot bring about magical change, for such an approach inevitably brings its own disenchantments and arouses intolerable anxieties of domination. The opposite position is well described by Anthony (1975) who suggests a 'preparatory course of inaction' in the early phases of treatment, in which the psychotherapist exercises a 'negative capability' to allow for the adolescent's ambiguities before any therapeutic commitment is decided.

The psychotherapist has to live with the paradox that the adolescent wants and does not want to be treated as a child; that he wants and does not want to have his problems taken care of. The psychotherapist in turn finds himself having to be both active and omnipotent, and laid back and laissez faire. The unifying factor has to reside in the psychotherapist's tolerance of the essentially contradictory nature of adolescent. The psychotherapist *holds* the opposites, and thereby prevents psychotherapy ending prematurely, either because the adolescent is unimpressed or bored, or because he is overwhelmed and frightened.

In the example which follows, an account is given of the fifth session with the 17-year-old adolescent introduced earlier. In this session, the adolescent and therapist were still occupied in forming some kind of working alliance. It was all very much at a delicate and uncertain stage. He was clearly drawn by the prospect of the therapist's interest and attention, and yet he was frightened and resistant. Much of how he behaved in the session was typical of adolescent resistance, but clearly it also reflected significant transference currents to do with his fear of humilitation and rejection. The account gives some indication of the therapist's attempt to play both lightly and seriously with the adolescent's assertion of independence, whilst at the same time engaging with the part of him that was lost and very troubled by the intensity and confusion of his feelings. The therapist was all the time trying – both explicitly and through his attitude and behaviour – to convey what psychotherapy was and could be about.

Case study 19.1 (contd) 'I don't talk about problems to anyone'

In this session, the main question was whether or not Jim could be bothered with psychotherapy. After all, he maintained, there was little wrong with him. There was nothing unusual in being miserable – everyone was. As for school, well, exams were irrelevant. There was no point in learning all that stuff – the teachers could not teach and what they did was boring. He could learn better by himself. He had better things to do.

The therapist said he was glad about that. What were they? At first, Jim said he had not come here to talk about 'pleasure'. The therapist said they could talk about anything that mattered to him. He then talked at length about his fascination with radio, hi-fi and TV. He spent hours working on them. He reckoned that within a year or so, he would have built a completely new and unique system. He would then market this and become rich.

The therapist listened, showed interest and asked questions. For a while Jim was animated. He enjoyed impressing me. The therapist said he had an image of a kind of super DJ – Jim at the top, super controls and flashing lights, turning the world in and on. He was amazed. How did I know? That was exactly it. He already did a few gigs. It was great. He felt like a king, they would get better and better.

Suddenly, he said that the therapist was taking the piss. 'You probably like Mozart and opera and all that junk. You're a phoney – just egging me on. You don't care at all – you just say all this because you're paid'. The

therapist said, 'Pow – what's all that about? One minute we're talking about what interests you, the next minute you are more or less kicking me out'. For a while he went on about how all 'you psychiatrists' are all alike – clever, devious, just in it for themselves. And anyway, talking was a waste of time. 'I don't talk about problems to anybody – I'm not giving my secrets away. I have all the understanding I need, thank you very much.'

The therapist said that right now he felt at the end of a very strong radio transmission that was saying loud and clear 'Keep Off', to put it mildly. If that is what he really meant, then of course he would. He was not there to frog march him into anything. If what he was telling him was that he really believed that he had no particular problem, that he was fully occupied and that he understood enough of what he needed to know then clearly there was no point in being there at all. Jim said the only reason he was there was to keep his mother quiet. The therapist asked whether she was quiet, and he said he did not know, he did not care. 'If you don't care, why are you bothering to keep her quiet?' He laughed and said: 'Because I can't stop her nagging – she's always putting her big nose in my business. She's always barging into my room. Why doesn't she keep out? She doesn't care anyway. Whatever I do she puts it down. And anyway, she's out half the time with her bloke. I hate her – she's a whore'.

He was suddenly close to tears and for a moment looked furious at the therapist. They sat in silence. The therapist said he knew there was a bit of Jim that would rather not be there. But at the same time, he knew things were not right and he was telling him. He was not upset for nothing – clearly there was a lot that was difficult in his relationship with his mother and no doubt he had a lot of feeling about her bloke – not to mention his father. The gist of it all, the therapist said, seems to be that Jim felt badly let down – by his parents, by adults, by psychiatrists. Nobody can be depended on. No wonder, he said, he was giving him the business earlier on – no way would he trust him yet.

Jim listened but appeared not to be immediately receptive. He reasserted that he knew the therapist didn't care. 'Nobody does'. There was no point in talking about it; 'There is nothing to talk about'. He insisted that he was quite able to take care of himself. The therapist said that no doubt he was right – at 17 he was going to have to take more care of himself. Maybe he didn't like that – it could leave him feeling very alone. He immediately assured the therapist that he liked his own company best, he didn't need anyone else – anyway he had his radios and hi-fi. He was quick then to warn the therapist off 'analysing' anything about his radio. The therapist said once again that Jim was on the alert – wary that the therapist would put him down or dismiss what was important to him.

The therapist made it quite clear that, however Jim saw him, he was not there to diminish him. Nor was he there to deceive him, or to extract his secrets. He was there to help him sort out something that was clearly troubling his mind, and that was getting in the way of what he wanted to do. The therapist added, rather forcibly, that he was not too convinced that Jim could take care of himself yet, and told him that he had not forgotten about the drugs, even though he had not mentioned it. the therapist also disagreed that Jim 'had nothing to talk about'.

As the session ended, Jim grumbled about how difficult it was to travel there. The therapist simply said, 'I hope to see you next week'. He said, 'Do you want to see me?'. The therapist said, 'Yes'. His response was 'Perfectly understandable – it's your job'. The therapist said something like 'It ain't going to be easy to convince you otherwise. How about you – do you want to see me?' He smiled and reminded the therapist about 'my mother's nose'. The therapist said 'Let's talk about it'. He said 'OK – have a good weekend'.

Therapeutic process

Once a working alliance is more or less established – it can never be taken for granted – psychotherapy can take on a life of its own. A therapeutic process is set in motion in which all the various elements of a therapeutic interaction become active in one way or another. In psychotherapy with adults, the predominant activity revolves around the patient verbally bringing experiences and memories to the therapist for thought and understanding. This generally proceeds in an orderly fashion, in which the psychotherapist can retain a degree of distance and objectivity and focus his interest primarily on interpreting the unconscious meaning of what is being said in relation to the transference.

With some adolescents, particularly late adolescents, this model of practice is also possible; and if it is not, it remains a reference point to which to aspire or return. With many adolescents, however, it is rare that psychotherapy can take place in such a straightforward or settled fashion. Most cannot be relied on to talk freely or honestly in a sustained spirit of introspection. Many have difficulty in expressing themselves in words. Their mood and sense of themselves is often extremely variable, they have difficulty just sitting, and they remain typically resistant, as adolescents, to the scrutiny and dependency implicit in psychotherapy.

Throughout treatment, as in establishing a working alliance, the psychotherapist has to maintain a flexible attitude (Steinberg 1987). Much more so than with the adult, the psychotherapist has to take responsibility for attracting and holding the adolescent in therapy, especially at times of resistance and disillusionment. He has to be more prepared to be adaptable. Winnicott's (1971) simple definition of psychotherapy – 'Psychotherapy has to do with two people playing together' – rings especially true in work with adolescents. The psychotherapist has to be ready to be playful in response to the changeable nature of the adolescent – and to do so seriously and with humour.

Evans (1982) has addressed the significance of play in adolescent life and in psychotherapy. He sees many aspects of adolescent behaviour as a form of play, in which the adolescent enacts various roles that actively express different aspects of himself and of his relationship to others. This role-playing is only partly under the adolescent's conscious control, and is

essentially a transitional phenomenon as the adolescent 'works out a new identity'. In psychotherapy sessions, for example, the adolescent may present himself at times as a defiant, insolent layabout who does not care about anything; or as a helpless, hopeless, ingenue who does not know what to do next; or as a sharp, smooth operator who knows all the answers; and so on. These are not simply superficial postures, but substantial modes of communication – dramatised no doubt in order to feel the more real and to see the more clearly. The psychotherapist must be ready to receive them as such and to react accordingly.

Similarly, Eissler (1958) has recognised how variably adolescents can present themselves and how, in effect, each presentation requires different responses from the psychotherapist. His view is that in adolescence psychopathology is in a state of flux, and the adolescent manifests many different clinical conditions and levels of ego capacity. Because of this:

> 'we encounter technical problems specific to puberty. In many instances, psychopathology switches from one form to another, sometimes in the course of weeks or months but also from one day to another and even within the same psychoanalytic hour. The symptoms manifested by such patients may be neurotic at one time and almost psychotic at another. Then sudden acts of delinquency may occur only to be followed by a phase of perverted sexually activity... the frequency of symptomatic changes manifested by many adolescent patients makes it evident that no one technique can fulfil the requirements for the treatment of adolescents.' (Eissler 1958)

It is clear that, faced with such a variable picture, the psychotherapist cannot sustain the classical analytic position of neutrality. In Eissler's (1958) terms the psychotherapist needs to be in a constant state of alertness and adaptation, seeking always the correct timing of a change in technique to meet the adolescents varying clinical manifestations. He gives a hypothetical illustration in which at times the psychotherapist is predominantly: interpretive in relation to the neurotic aspect of the adolescent; limit setting and authoritative in relationship to the delinquent; gratifying and reassuring in relation to the acute schizophrenic; and actively anxiety arousing and conflict generating in relation to the perverse.

Evans (1982) sees the role of the psychotherapist as 'a transitional object, a substitute authority who is only partially real and with whom the adolescent can "play" through the assumption of temporary roles in relationship to the therapist'. Implicit in his view is the psychotherapist's preparedness to participate in this play – both standing, as it were, for reality and boundary, and also reacting to the adolescent's role-play, by adopting corresponding roles. This is a complex process, which borders [illegible]ely and dangerously on the psychotherapist becoming embroiled in [illegible] the adolescent's transference re-enactments. Evans makes it

clear that the therapist must 'simultaneously' be 'able to stand back and observe what is happening'.

Important in this emphasis on the psychotherapist's conduct and manner is the idea that the psychotherapist conveys meaning not only through his words, but through the way he behaves. Osorio (1977) has recognised how adolescents 'express themselves through a language of action', and suggests that the psychotherapist needs to respond in a corresponding way to the symbolic meaning of the adolescent's behaviour. He refers to the concept of 'behavioural interpretation' – the psychotherapist communicating to the adolescent through posture, gesture or manner. Such behaviour is based on and fashioned by the psychotherapist's understanding; it serves to highlight this understanding in action, in counter-response to that of the adolescent. For many adolescents, this can carry far greater weight than words alone. If, for example, an adolescent is dismissive of the psychotherapist, and provocative in his sessions, what he may be primarily expressing is his fear of humiliation and yet need for some boundary and care. If the psychotherapist is able to remain calm, be firm and show humour, he is in effect conveying an awareness of this adolescent's concern. The psychotherapist is not trying to make the adolescent feel 'better' through some form of corrective emotional experience; what he is doing is 'answering', through his way of being, the adolescent's call for understanding.

It would be misleading, however, to suggest that verbal communications are of no significance, for, clearly, within the context of the therapeutic relationship there is ample opportunity and much need for thoughts and ideas to be shared and understood. Much of the work with adolescents is spent in helping the adolescent find words for his feelings and ways of thinking that help him make sense of his relationship and difficulties. Often, the psychotherapist has to be quite active, asking questions if need be to keep things going, offering ideas and perspectives to stimulate and clarify thinking, and at times, where necessary, putting quite openly and honestly his views of the adolescent's behaviour (for example, with regard to drug or alcohol abuse, or attempted suicide). In many respects, this level of activity, which is often quite concrete and down-to-earth, has an educational function, appealing to the adolescent's developing cognitive capacities and growing interest in himself (McAdam 1986).

The focus of this kind of work is close to the adolescent's conscious awareness. It is more about clarifying reality than interpreting what the adolescent is unaware of. Interpretation, in the sense of elucidating unconscious processes particularly in relationship to the transference, refers to a different level of psychotherapeutic activity. This, clearly, is at the heart of all psychodynamic psychotherapy, and undoubtedly plays an important part in psychotherapy with adolescents. It must be remembered, however, that such interpretations are often experienced by adolescents as invasive and controlling. They are strenuously resisted and

frequently misconstrued. The danger is that they can so easily be merely complied with or defied, rather than received and assimilated with interest. It is important for the psychotherapist not to be carried away with interpretative zeal nor, indeed, with the belief that verbal understanding alone is effective (Wilson & Hersov 1985). Interpretations need to be given clearly, in the language of the adolescent, and with good evidence. The adolescent must understand how the psychotherapist arrives at his perceptions and must always be allowed room for disagreement and manoeuvre. The effectiveness of interpretations depends as much on their timing as on their accuracy and the way the psychotherapist conveys them. Interpretations can so easily be used by the psychotherapist, out of his negative counter-transference, as tools of control and censure, rather than as levers for self-discovery, and may awaken the adolescent's dread of passive surrender (Balint 1959, Khan 1974, Stewart 1989).

For transference to be an effective therapeutic tool, it is essential that the patient has the capacity to sustain a split between what Greenson (1978) has called 'the experiencing, subjective, irrational ego' and the 'reasonable, observing, analysing ego'. This is fundamental; the patient has to be able to experience the psychotherapist both as a transference object and as an actual psychotherapist. Intense feelings, revived from the past, need to be allowed to emerge whilst contact with the reality of the therapeutic situation is securely held. Without this capacity, transference can be an overwhelming and confusing experience. Many disturbed adolescents do not possess this capacity, nor do they have adequate impulse control, capacity for reality testing or the ability to differentiate between self and object. Their hold over themselves is precarious, and they frequently fail to appreciate the metaphorical nature of transference. They see the psychotherapist as more or less real, and cannot make sense of transference interpretations. They frequently become frustrated and angry that the psychotherapist does not directly fulfil their needs and desires. For some adolescents, the therapeutic relationship and the transference that evolves can be an excrutiating tease.

Case study 19.1 (contd) Understood and withstood

The following account gives some impression of the process of once-weekly psychotherapy over a period of a year with the 17-year-old mentioned earlier. This continued to carry much of the tension present from the beginning, and there was similarly little sense of reliability or predictability. A working alliance was, however, achieved so that, despite his various attacks on the therapist and on understanding, Jim did hold on to an agreement to meet regularly and persist with the concerns that he initially brought.

During the initial six months of psychotherapy, he showed much of the defensiveness and arrogance that had characterised his earlier sessions. His moods were variable. At times he could be light-hearted and ready to share

feelings with the therapist. At other times, without any apparent reason, he could be extremely morose, fraught and critical.

In his better moods, he enjoyed talking about his achievements and his cleverness in the world of radio and hi-fi. It was clear that he felt at ease, safe within this knowledge. His purpose in talking about it to the therapist – apart from diverting him from more troubling matters – was to capture his interest and admiration. He demanded the therapist's audience – who for the most part played along, implicitly acknowledging Jim's need for control and time in which to preserve distance from him. The therapist was particularly struck at such times by Jim's narcissistic vulnerability, his fear of humiliation and denigration. The therapist was concerned not to prematurely challenge this for fear of producing some form of forced compliance or, indeed, outright rejection of psychotherapy. His going along with the role assigned to him was not so much a collusive giving in to Jim's imperious demands, as a form of behavioural communication of acceptance and respect for his vulnerability. Occasionally, when feeling less threatened, Jim was able to extend his interest beyond his own self-preoccupation and show interest in the therapist as somebody separate from him and with whom he could learn rather than impress. At such times, they shared interest in the connection between Jim's technology and the therapist's music, and moved on to some reflection on various songs and their lyrics that bordered on his own feelings.

There were sessions, however, in which Jim seemed full of fury and malice. He was blatantly contemptuous and quick to contradict and denigrate anything the therapist might say. In all this, his overriding complaint was that the therapist didn't listen, that he was prejudiced and only interested in himself, and disdainful of anything Jim might think important. He was at times almost beside himself with rage, tearful with clenched fists. The therapist was filled with a kind of impotent fury. In so many ways, Jim seemed hell-bent on provoking a powerful explosion or the therapist's rejection of him.

What mattered above all else for the therapist in this situation was to hold on to some understanding for himself of what was happening, based on Jim's evident feelings and those engendered within the therapist himself. In brief, what made sense to him was that Jim was reliving some earlier painful fight, intensified in puberty, with his mother, whom he perceived as both overwhelmingly controlling and seductive. This transference situation needed to be managed, held within bounds and not further complicated with words. As far as possible, the therapist drew from his understanding some sense of Jim's fear of abandonment and explosive denigration, and managed to behave in a relatively calm, firm and unprovoked manner. Of course at times Jim caught the therapist's exasperation and anger, and almost seemed relieved that he had touched him in this way as well as remorseful that he had hurt him. But for the most part, the therapist tried to meet Jim's anxiety with a behaviour that reflected and conveyed appreciation of this anxiety. At a fundamental level, the therapist survived his attacks. Jim felt both understood and withstood.

During the first six months of psychotherapy, there was a great deal of variability both in Jim's moods and, indeed, in the therapist's responses.

As is so often the case in work with adolescents, a turning point was reached when he felt reassured, out of his testing, of the therapist's implicit understanding of him and capacity to hold some limit. The last six months settled, with periodic eruptions, to a level of psychotherapeutic work that was more orderly and reflective. He became more ready to acknowledge his sense of failure and futility in ever being able to 'get somewhere'. He could also see his loneliness as a reflection of his inability to 'get on with anybody' – he quickly felt sensitive to any possibility of being stood up or criticised. His acceptance of such vulnerability within himself contrasted with the way he had dominated in earlier sessions. He and the therapist were able to draw on some of their memories of how it had been between them and began to make some sense of what mattered to him in his family life. It became increasingly clear how very divided he was in his feelings towards his mother – both very attached, almost obsessively jealous of her boyfriends, and very angry both at her betrayal and the way in which she had ridiculed and frightened him as a child.

The therapist was able to make sense of his moods, his drug-taking and failure at school, in terms of this anger which found so many ways of effectively thwarting and punishing his mother. His life, it seemed, was set to refuse to comply with her wishes – or indeed those of anybody with power. It has been seen how this had found expression in his attitude towards the therapist – he too had felt frustrated and ridiculed, as both Jim and, no doubt, his mother had in various ways. Putting this into words in the form of an interpretation had meaning, and was of use to Jim because of the inescapable evidence provided by what had happened between them in the therapeutic relationship.

Psychotherapy ended after a year, when he moved away to start working. Clearly, there was much that was left incomplete. The understanding that he had gained needed consolidation and there were many other areas, not least his sexuality, and feelings for his father, that had not been adequately covered. Enough, however, had been done to enable Jim to become unstuck, less held back in his revenge against his mother. He was less miserable and less reliant on drugs. He was planning to study again. He found himself better able to tolerate other people without fear of humiliation or of disappointment. He was beginning to allow himself to join the mainstream of normal development, albeit with much idiosyncrasy left intact.

SUMMARY

Throughout this chapter, the main question has been about the possibility, or otherwise, of creating a relationship out of very different interests: on the one side, psychoanalytic therapy with its essential scrutiny and call for reflection; on the other, adolescence, with its essential privacy and preference for action. Both tug away or against each other, and for the two to come together each has to be prepared for at least some partial

inversion of what they stand for. The adolescent, by dint of his disturbance, agrees to come to therapy and thereby compromises his independence. The psychotherapist in turn agrees to be flexible and foregoes something of his 'adult' discipline.

Effective psychotherapy with adolescents is a question not so much of specific technique or accurate interpretation as of the development and maintenance of a therapeutic attitude which is sensitive to and respectful of the adolescent state. The psychotherapist has to understand and contend with a mass of contradictions that exist at the centre of the adolescent predicament – sometimes an adult, sometimes a child and always neither. The adolescent needs to find his own way and not be called too much to account; yet he needs attention, guidance and someone to care about him. He does not want to be understood; and yet he does. He wants licence; and yet he needs boundaries.

In response, the psychotherapist's position has to be inevitably and likewise contradictory. At one and the same time, the psychotherapist needs to be ready to be flexible, to play roles and change posture – and yet remain essentially a firm and reliable presence. He has to retain faith in the usefulness of words and yet remind himself that much of what he does non-verbally is crucial. He has at times to be active and involved, sometimes even larger than life and directorial – and yet never lose his fundamental capacity to listen and observe, and tolerate the adolescent's confusion, failure to respond and, at times, sheer silence. Winnicott (1966) suggested that adolescents 'eschew psychoanalytic treatment, though they are interested in psychoanalytic theories' because their 'preservation of personal isolation is part of the search for identity'. Of importance here is Winnicott's concern with the development of the core of true self, uncompromised or intruded upon by the external world. In adolescence, this core self is in a state of delicate and partial formation, and requires both protection and leaving be. Phillips (1988), in his account of Winnicott's work, summarises succinctly the contradiction that characterises so much of psychotherapy of adolescents: 'The paradox that he [Winnicott] had begun to formulate was that the infant – like the adolescent... – was an isolate who needed the object, above all, to protect the privacy of his isolation'.

FURTHER READING

Evans J 1982 Adolescent and pre-adolescent psychiatry. Academic Press, London

Laufer M, Laufer E 1989 Developmental breakdown and psychoanalytic treatment in adolescence. Yale University Press, London

Miller D 1983 The age between: adolescence and therapy. Jason Aronson, London

Wilson P, Hersov L 1985 Individual and group therapy. In: Rutter M, Hersov L (eds) Child and adolescent psychiatry, 2nd edn. Blackwell, Oxford