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Clinical Social Work With Adolescents

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INDIVIDUAL TREATMENT

Psychotherapy

The term *psychotherapy* was used by Freud, and the theory and techniques of individual psychotherapy have been enriched by the use of classical and newer psychoanalytic theories of mental functioning and psychopathology. These theories reflect the evolving conceptions of psychoanalytic foci: drive theory, ego psychology, object relations theory, self psychology, and attachment theory and the amplifications, modifications, and extensions of all these theory bases that are informed by inclusion of data that are, in turn, derived from infant research, neurobiology, and communication theory; a contemporary philosophy of science; and the intersubjective interplay between the two differently organized subjective worlds of clinician and client.

Alexander (1953) reminds us that psychotherapy is older than psychoanalysis and, while originally the traditional domain of psychiatry, is now shared with other clinicians, notably social workers, psychologists, and psychoanalysts:

While it is customary to divide individual psychotherapeutic procedures into two categories, the

supportive and *insight-oriented* psychotherapies, it must be borne in mind that supportive measures are knowingly or inadvertently used in all forms of psychotherapy; and conversely, some degree of insight is rarely absent from any sound psychotherapeutic approach. (p. 270)

Intensive Insight-Oriented Individual Therapy and Supportive Individual Therapy

The literature on technique and choice of interventions addresses two broad classifications: (1) supportive psychotherapy and (2) insight-oriented psychotherapy. Intensive uncovering, insight-oriented individual treatment seeks to increase the ego's capacity to tolerate emotionally conflictual situations that are partially or completely repressed. These situations commonly originate in early childhood, and their later reverberations are precipitated by subsequent actual life situations and relationships. The principal therapeutic tool is the transference. Transference occurs when the client relives early personal relationships in the treatment because old patterns and reactions are transferred, or displaced, onto the therapist and then repeated through the

regression that is commonly characteristic in intensive, uncovering therapy. In contrast, supportive individual treatment is indicated as follows:

Whenever the functional impairment of the ego is of temporary nature caused by acute emotional stress. In such cases the therapeutic task consists, first of all, in gratifying dependent needs during the stress situation, thus reducing anxiety. Another important therapeutic device consists of reducing emotional stress by giving the client an opportunity for emotional abreaction. (Alexander, 1953, p. 281)

Commonly, support involves a review and examination of the client's stress situation and offering advice and clarification to assist in judgment and clearer assessment of stressors. If the continual involvement in external life situations proves beyond a client's coping capacities, environment manipulation might well be required.

Supportive treatment goals include the improvement of ego functions to promote better adaptation to the inner and outer worlds, the provision of symptom reduction and relief, and overt behavioral change without attempts to modify the personality or greatly reduce unconscious conflict. Repression can be maintained because the therapy focuses on preconscious and conscious elements of mental life.

It is always the ego in its various functions that is supported in psychodynamically-oriented individual supportive therapy. Support can be accomplished directly by focusing on problematic ego functions, or indirectly, by decreasing the pressure or strain on the ego from drives, superego prohibitions and external reality. (Rockland, 1989, p. 8)

The concept of adaptation is crucial in supportive therapy. Some authors base recovery on the empowerment of the client and the creation of new connections (Herman, 1992; Kardiner & Spiegel, 1947; Saleebey, 2000; Symonds, 1982), whereby there is a re-formation of faculties such as the capacities for trust, autonomy, initiative, competence, identity, and intimacy (Erikson, 1963).

In general, supportive techniques—those that primarily stabilize, maintain, and soothe—attempt to keep current functioning optimal and prevent regression. These techniques include universalization, whereby clients are helped to feel that their responses, emotionally, are typically what others would feel under similar circumstances, thus sharing a similarity to the rest of humankind rather than feeling isolated or disconnected. Other interventions include subtle suggestion, offering advice, posing alternative constructions, and exploring the psychosocial surround. The focus in all these supportive measures is on understanding and dealing with current feelings and exploring interpersonal relationships with family, friends, and authority figures. Effectively operationalized, these supportive procedures enable the client to keep an “even keel,” both strengthening mature defenses that possess adaptive value and lessening the use of primitive mechanisms that tend to be self-defeating in the long run. Supportive techniques have been described as *here-and-now* interventions that attempt to reduce distortions of self experience, promote reality-oriented appraisals of others' behaviors, and minimize all good/all bad concrete thinking. Encouragement to go on and the instillation of confidence (hope) that therapy will be of benefit, albeit with hard-won rewards, also have their place in the supportive treatment arsenal.

By comparison, the goals of insight-directed intensive psychotherapy are more ambitious than in the case of supportive treatment. In intensive therapy, the clinician attempts to help the client achieve greater self-awareness and some degree of underlying personality change. The immediate relief of symptoms is secondary and should not be used as a guideline to consider termination of therapy. The goal is to make the underlying conflict conscious, thereby permanently staving off later or subsequent symptom formation or symptom substitution. Insight-oriented procedures focus on the interior mental and emotional life of the client and deal with representations of internalized experience that reside primarily in the unconscious. The techniques of uncovering, insight-oriented psychotherapy bring

unconscious and preconscious focus into consciousness; this includes conscious comprehension of drives and drive derivatives, as well as the preconscious and unconscious superego and ego functions, especially the ego's defenses.

The distinction between supportive and insight-oriented psychotherapy can be blurred, and while differences between the two approaches abound, so do their points of intersection. For example, it would be unimaginable that a successful, 2-year-long insight-oriented psychotherapy would fail to include preparatory work with supportive procedures to foster the development of a therapeutic alliance. Generally, the frequency of appointments—twice a week versus once a week—is one recognized criterion of distinction. Individual supportive treatment is a mode of therapy focused less on unconscious intrapsychic conflicts and generally more on interpersonal and environmental conflicts. It is a therapeutic intervention in which less regression is encouraged than in insight-oriented uncovering treatment. The focus on the here-and-now, rather than on early infantile conflicts, generally dictates that the clinician assume a more active stance than the nongratifying, nondirective neutral clinician, providing uncovering, insight-oriented treatment.

“Neutral” means that the therapist does not take sides in the client's inner conflicts or try to direct the client's life decisions. . . . The . . . neutral stance is an ideal to be striven for, never perfectly attained. (Herman, 1992, p. 135)

In supportive treatment, the clinician's stance of neutrality is less than in insight-oriented therapy. In the context of a frequently needed, reflective, educative, advising therapeutic role, active support is provided. Basic character change is not a goal; rather, supportive treatment aims to increase the client's capacity for reality testing, strengthen object relations, and loosen fixations. With these aims in mind, supportive individual treatment is always an element of adolescent psychotherapy. Supportive individual treatment is the most appropriate intervention for many adolescents and other clients living amid

considerable chaos; in some situations, outreach; collaborative contacts with family members, teachers, and others; and even environmental manipulations are necessary, in conjunction with direct work with the client. Generally, supportive treatment is of shorter duration than uncovering, insight-directed psychotherapy. The therapist who is providing supportive treatment will comment and reflect on apparent behavior patterns, reactions, and relationships, leaving some areas deliberately untouched and unexplored, so as not to assault needed defenses.

Insight-oriented, uncovering individual treatment is the optimal intervention for clients suffering from internal conflict—conflict unrelated to environmentally generated chaos and traumata. The conflict, commonly originating in the past, is not accessible to conscious awareness and problem-solving efforts. The client's problems are intrapsychic; if interpersonal conflicts or academic or work problems are apparent and are to be treated by analytic uncovering techniques, they must be transformed into intrapsychic problems. At this level, insight-oriented procedures are probably an element of the vast majority of all long-term adolescent psychotherapies. Complaints about interpersonal, intrafamilial, and work-related difficulties are common presenting problems. These stresses must be due to circumscribed basic intrapsychic conflicts, in contrast to those caused by constitutional or environmental failures. This method of therapy is best suited for suffering individuals who nevertheless possess a fairly intact psychic structure. Clients who present basic ego weakness or deficits commonly manifest poor frustration tolerance, poor impulse control, a meager capacity for drive modulation, inadequate self/other distinctions, inadequate reality testing, impaired object relations, and defects in regulating affects, all of which interfere with a capacity to develop transference and contain acting out. Such individuals who have suffered greater injury are best treated in supportive individual therapy, in contrast to the more intact client, who possesses the ego strength to tolerate and profit from uncovering treatment through more complete working through of basic conflicts. Generally, working through

evolves out of reenactment in the transference of repetitive object choices and comprehension of the repetition compulsion (repeated self-injurious behaviors), via insight and introspection.

Treatment technique in insight-oriented therapy is predicated on abstinence—absence of advice and active support. In a climate of empathic attunement, the principal tool is interpretation, reflection, and demonstration of the connection of the early traumas with the current presenting problems. The hallmark of an insight-oriented approach to the client's conflicts is the use of interpretation. Through interpretation, the client has the same mental representation in two separate regions of the mind in two different forms: (1) the conscious memory of the therapist's words and (2) the unconscious memory, in symbolic or condensed form, of an experience, event, thought, attitude, wish, fear, or feeling. The closer the repressed content is to consciousness, rather the ease with which it may be moved to the preconscious and beyond the repression barrier and censor to consciousness, the less likely it will be subject to resistance and returned to the dynamic unconscious: However, to have listened to something and to have experienced it are psychologically two different processes, even though the described content is the same (Freud, 1912). Over time, interpretations provide connections: (a) from the present to the past and to represented inner experience and (b) from the unconscious to the preconscious-conscious systems. Interpretive activity, fostering insight and increased client self-observation, is contingent on the therapist's capacity for empathy and the ability to regress with the client's clinical material through an attitude of "evenly suspended attention" (Freud, 1912). The bipersonal, relational field—a therapist-client mutually "shared unconscious" (Lyons-Ruth, 1999)—is the forum that permits the clinician to come to some kind of understanding based on deduction, induction, or an intuitive hunch via a clinically valid, subjective fact (Ogden, 1994), which he then shares with his client.

Interpretations are not dogmatic statements of indubitable truth. They are, rather, phrased tentatively and speculatively as if asking for a response from the client to a question. As such, they are always imprecise and seek to reveal or uncover a new, hidden meaning. The thrust of interpretive work conveys to the adolescent that experiences have meanings, that what is experienced as outside is represented on the inside, and that the external world of reality is connected to the internal world through constructions of these personal meanings. A useful guideline for beginning an insight-oriented strategy is to start, first, with interpretations of the behaviors and motivations of significant others as they affect the client and, second, with interpretations of the adolescent's affects as they spontaneously emerge in treatment, feelings that often reside outside conscious awareness. At a later stage after the relationship has deepened, through the emergence of the therapeutic alliance, interpretations of defense are appropriate, working with such defenses rather than confronting them directly. As the therapist comes to know the client better, developing a working model of the mind of the adolescent in interaction with his own subjective self, the clinician may operate on the basis of "conjecture" (Brenner, 1982), which then becomes the working hypothesis as to the nature of many earlier conflicts emanating from misalliances, absences, inconsistencies, trauma, or failures of parental support or empathy. This later agenda would include interpretations aimed at addressing early developmental arrests and clarifying complex affect states, and related characterological and interpersonal styles of relating, that are ingrained, repetitive, and maladaptive. As uncovering, insight-oriented treatment progresses, the adolescent relives the psychodynamic past in the present, organizes a more integrated narrative of his autozoetic history,¹ and develops new capacities for "mindsight" into self and others (Allen, Fonagy, & Bateman, 2008; Fonagy, Gergely, Jurist, & Target, 2002; Schore, 2003; Siegel, 1999).

Social work authors in the tradition of a psychodynamic approach to psychotherapy include

¹*Autozoetic consciousness* may be defined as the capacity of the individual to relive experiences in his or her past, resulting in a subjective sense of familiarity or knowing.

Woods and Hollis (2000), whose research and writings have informed clinical social work practice for half a century. While offering an initial typology that separated sustainment from insight-oriented procedures, the clinicians' repertoire of clarification, explorations of the psychosocial surround, and interpretation was expanded to include person-situation reflection, dynamic reflection, and developmental reflection. A later analogue study using the Woods and Hollis typology of interventions found that an uncovering, interpretive psychotherapeutic approach was preferred by clinicians in the treatment of clients diagnosed as neurotic, whereas clients with borderline personality organization were more likely to improve with supportive treatment (Lucente, 1980).

Some clinicians tend to minimize the significance of genetic interpretations, believing that they divert attention from the immediacy of transference feelings. In many instances, "pushing the present back into the past, can serve as a defense for the analyst against painful countertransference feelings" (Giovacchini, 1987, p. 253). In sum, the degree of needed abstinence or emotional holding and support the client is provided is determined by the original assessment, which emphasizes ego functions and the nature of transference manifestations.

A careful diagnostic assessment and appraisal of the patient's strengths, life circumstances, psychological mindedness, and intrapsychic structure determine which level of intervention is appropriate. A misappraisal may have serious consequences if too much regression is encouraged and the patient becomes overwhelmed and despairing, feeling that hopes for "cures" have been betrayed. (Mishne, 1993, p. 89)

Dewald (1964) reflects on complications when clinicians confuse methods, goals, and the readiness of clients to handle material that is unconscious, and he cites massive inappropriate regression, therapeutic stalemates, and severe, dangerous acting out when abstinence and insight-uncovering approaches are misapplied to clients who need more active direction and support. The importance of a skilled assessment cannot be overemphasized.

Assessment

The evaluation and diagnostic label is not meant as a pejorative depreciation or stigmatizing effort. Diagnoses, rather, are shorthand descriptions of presenting problem(s) and symptoms, underlying character structure, physical state, and nature of milieu and environmental stressors. Diagnosis should offer information about the strengths and weaknesses of the client and family, thereby providing guidelines for optimal treatment planning. The distinction between evaluation and treatment is not merely a semantic one. A basic confusion is introduced when initial contacts are regarded as "treatment" before any insight is gained about the structure, nature, and history of the problem. Clients cannot genuinely engage in contracting and mutual goal setting before they have a better understanding of their presenting problems and the reasons they have been offered a particular therapeutic modality. They need to comprehend the nature of the prescribed therapy, including an estimate of the time and cost involved:

Beginning treatment before formulating a diagnosis is analogous to prescribing antibiotics indiscriminately for any undiagnosed physical disease. There are various modalities of ongoing intervention, but few agencies and clinics provide the full range. Without a diagnostic assessment, clients may simply be forced into whatever modality a given agency offers, with no differentiation of case need. The reality that an agency cannot be all things to all people, and rather should, on appropriate occasions, refer clients elsewhere, underscores the need for assessment as a separate and distinct phase. (Mishne, 1983, p. 27)

Anna Freud (1962) believed that the diagnostic approach provides data to determine a decision for or against treatment, the choice of therapeutic model, and treatment aims and goals, based on distinguishing transitory from permanent pathology:

Accordingly, it becomes the diagnostician's task to ascertain where a given child stands on the developmental scale, whether his position is age-adequate, retarded or precocious, and in what respect; and

to what extent the observable internal and external circumstances and existent symptoms are interfering with the possibilities of future growth. (pp. 149–150)

In determining what holds individuals back, consideration must be given to fixation and regression. In situations of fixation, there remains a potential in psychic development for residuals of earlier phases to acquire and retain cathexes, strong “charges” of psychic energy. Arrests or fixations of development occur in instinctual, superego, and ego organization, and this causes various degrees of persistence of primitive, often childlike ways of thinking, reasoning, and relating to people to attempt to derive satisfaction or retain an old sense of danger and fear (Freud, 1965). In addition to insufficiently understood constitutional reasons for fixation, there are early experiences in which the child’s developing immature ego was overwhelmed by stress. These traumatic experiences, such as parent loss, separations, and critical illness, usually involve an unfortunate combination of excessive frustration and excessive gratification. (A bereaved young mother, suffering from her spouse’s untimely death, allows their 3-year-old son to sleep with her; thus, the child suffers the pain and frustration due to the loss of the father and excessive gratification from inordinate closeness and overstimulation from the mother.) With disturbances of development and conflict over current functioning, regression to earlier behavior and functioning occurs. (Thus, the boy, arrested and too tied to his mother, may seek overindulgence and inappropriate closeness with her when facing adolescent stressors.)

Regression presents itself in two forms: libidinal and ego regression. Libidinal regression is a retreat to an earlier phase of psychosexual organization, especially of the infantile period. Such a retreat or falling back occurs when a predetermined maturation step presents the individual with difficulty that he or she is unable to master. A simple example of libidinal regression is evident at instances of serious emotional stress; for example, a 12-year-old child resumes thumb sucking, a habit previously abandoned. In ego

regression, the mind may revert to modes of functioning typical of an earlier period of life. The concept of regression is intimately related to the hypothesis that in the course of attaining adulthood, an individual passes through a series of epigenetic phases, each with a phase-appropriate mental organization. The makeup of each such organization is inferred from the way instinctual drives discharge, ego functions operate, and the conscience and ideals guide. Under stress or trouble with successful management of age-appropriate maturational stages, there is disruption of mental functioning, and regression occurs. A college senior who was achieving well in school fears graduation and career choices and regresses into earlier dysfunctional patterns and poor academic performance, the original presenting problems that necessitated therapy. Despite enormous therapeutic and academic gains for 3 years, the demands of adult life after college pose a threat sufficient to cause substantial regression.

Psychological testing may be another assessment tool but generally is not a standard diagnostic procedure. However, academic problems, developmental delay, and suspicions of learning disabilities may be better understood by means of intelligence and projective testing. An appraisal of an adolescent’s physical condition is essential during the assessment process, and this may or may not require the attention of physicians for a physical or neurological exam, or both, when organic pathology is suspected. Concerns about child abuse and substance abuse commonly require assessment efforts by psychologically and medically trained clinicians. When assessment is positive for abuse or neglect, reporting via mandated reporter acts to the appropriate state departments of children and family services is always indicated.

Throughout the evaluation processes, it is crucial to note how parents and adolescents share material. The importance is far beyond factual data, such as the child’s developmental history, accounts of illness and separation, or the adolescent’s articulation of presenting problems. The child and the parent’s emotional attitudes, feelings, and style of relating to each other and to the clinician are often more telling

than hard data and facts. The clinician must be alert to affects of depression, anger, anxiety, aloofness, and indifference. Do the members of the family present apathy, anger, helplessness, enthusiasm, or empathy? Parental style, the nature of parenting provided, and parental motivation are probably key prognostic issues that serve as guidelines for the ongoing planning for therapy (Mishne, 1983).

The process of the assessment phase involves listening, exploration, and efforts to begin to form an alliance with family members. Clinicians must be alert to becoming overidentified with the teenager or the parents, becoming infected by parental anxieties, or feeling pressed to provide premature advice and recommendations before the depth and true nature of the presenting problems are understood. The process of the diagnostic study stresses the importance of observation and verbal communication in therapeutic work, diminishes any aura of mystery or magic about such procedures, and enables the parents and the adolescent to feel actively involved and to focus their attention on the work ahead. Often, an assessment affords relief for parents' guilt and anxiety as they secure help for their child and themselves. In collecting information, the diagnostician must recognize and respect parental resistance or the adolescent's resistance. Parents may object to a necessary school inquiry, questions about their marriage, and explicit expectation that they remain actively involved on behalf of their child. Adolescents may and often do displace any and all problems onto their parents or teachers, feel stigmatized about needing help, and thereby oppose any idea of ongoing contact. If there is no working through of the parents' and adolescent's resistance, it frequently increases, resulting in a disinclination to complete the assessment phase or to begin treatment. In many situations, strong parental resistance offers a clear diagnostic message of where treatment interventions should begin—with them. In other situations, a child's resistance reflects parental uncertainty, covert resistance, or ineffective parenting; that is, the parent is afraid or otherwise unable to set limits and expectations. A young child cannot be permitted to make decisions about the need for

treatment, and in some instances, this may be equally true for the adolescent client. Ideally, the adolescent is allowed considerable input into the decision to seek help. This is obviously not the case, however, when the teenager is a nonvoluntary client, perhaps referred by the juvenile court, school, or some other such agency of power.

It is unrealistic for a clinician to expect resistances and defenses such as denial or projection to be surrendered quickly or easily. Parents and adolescents may project all difficulties onto teachers and the school; time is needed for them to arrive at a more realistic understanding of the legitimate reasons for insistent referrals by school personnel. Teenagers are not allowed autonomy regarding attendance at school or with regard to medical or dental needs. Similarly, they are often not able to make wise decisions regarding psychotherapy contact. In such situations, where the clinician faces intense resistances, ambivalence, or parental ineffectiveness, it is wise to remain firm and patient, clarifying the situation rather than allying with the regressive infantile stance of the parents or teenager or identifying with parents' covert rejection and helplessness. Firm limits, outreach, and persistence often constitute a form of caring that overwhelmed parents have not been able to provide their child. When the referral is nonvoluntary, the clinician is well-advised to inform the adolescent about expectations and reality and take a therapeutic stance that will not permit collusion; for example, if the teenager misses appointments, this reality will not be kept in confidence and withheld from parents, the school, the juvenile court, the probation department, or other relevant authority (Mishne, 1986).

During the early part of the assessment process, and especially in the evaluation of the early-phase adolescent, parents may require assistance in preparing their adolescent for the diagnostic study, and at the conclusion, children as well as parents need a follow-up or "informing interview." This is necessary to communicate the diagnosis and recommendations, to cope with any anxiety and resistances, and to motivate family members to act on the recommendations. Sharing findings and recommendations

requires skill and sensitivity on the part of the clinician. Parents and adolescents should receive the clinician's explanation of the conflicts confronting the child and where and why the child seems stuck developmentally. The significance of the adolescent's conflict and its potential impact on the teenager's long-range development and future adjustment must be estimated. Recommendations and findings need to be presented simply and clearly, minus the jargon of the profession. Parents, adolescent, and clinician frequently need time and several appointments to consider the emotional significance of the recommendations. Professionals often lose sight of the impact of therapy on a child and her parents, minimizing the investment of time and energy and the effect on the family (Mishne, 1983). In cases involving adolescents, there are a number of situations where a therapist surmises that although a child presents some problems, the child's problems serve as an entree for parents with either marital or individual problems. A recommendation for marital or individual treatment of the parent may indeed be the outcome, accompanied by no recommendation of any therapy for the teenager. There are instances where an adolescent who is not seen directly benefits greatly by improvement of the family milieu or by improvements in parents, through the provision of parent guidance or individual therapy to a parent.

For the older adolescent, especially for those who self-refer, a briefer evaluation process that relies less on parental inputs and more on the details generated in individual interviews may be possible. The axes of the expanded *Psychodynamic Diagnostic Manual* (PDM Task Force, 2006), which incorporate findings from neurobiology and the attachment research literature; the six areas of inquiry that reflect the biopsychosocial point of view (Meeks & Bernet, 2001); and other systems of assessment, for example, Brandell (2004), all offer plans for the orderly collection of the data necessary for treatment planning.

The model most frequently used for the diagnosis of conditions in adolescence is the one developed by Meeks and Bernet (2001). The six arenas for assessment are framed with questions the diagnostician seeks to answer. The first involves the role of the

constitution—the extent to which psychopathology may be related to biochemistry or an inherited familial pattern. Examples include the symptoms of an underlying bipolar disorder, learning disabilities or minimal brain dysfunction, attention deficit disorders, and schizophrenic illness.

The second arena for investigation relates to the question “What is the highest level of psychological development the adolescent has achieved?” This question seeks to establish fixation points or serious arrests in developmental stages to which the adolescent regresses when experiencing pressure related to a maturationally timed crisis. A careful historical look, backward in time, may establish unmastered tasks from the oral, anal, or phallic phases; trauma, for instance, in the processes of attachment or separation-individuation; or a clear miscarriage of transmuting internalizations of selfobject needs in developing a cohesive self.

The third arena attempts to formulate the most characteristic interpersonal style of relating in the adolescent's object relations with others. For instance, is he or she primarily narcissistic, manipulative, withdrawing, shy, dependent, rebellious, paranoid, or inappropriately intrusive?

Meeks and Bernet's fourth arena asks the question “Why does the adolescent appear to be disturbed now?” It may be that the current symptomatology in reality reflects long-standing conflict that has heretofore eluded diagnosis. A 16-year-old suffering serious abandonment trauma at the age of 2, evidencing varying degrees of an anaclitic depression that has waxed and waned for 10 years, only now presents with a crisis of suicidal ideation subsequent to a breakup with a romantic partner who had served as a secure holding environment.

The fifth question has to do with the extent to which the adolescent displays a sense of being distressed or conflicted: “Are the symptoms of dysfunction experienced as ego alien or ego syntonic?” If they are of the former valence, the potential client will be more motivated to accept a recommendation for treatment based on a hope for relief, for instance, from the painful affects of anxiety, depression, or guilt. If the symptoms are of the latter valence, considerable pressure from the

family may be necessary to deal with the initial resistance to treatment.

The sixth and final question asks, "If the adolescent accepts the treatment recommendation, to what extent will the family be able to accept it and the implications for supporting the changes the adolescent will be making in his or her life?"

Incorporating all the above six elements of the Meeks and Bernet assessment profile, a recent contribution to the literature frames four additional questions, expanding and modifying the original schedule (McKenzie, 2008). First, are the adolescent's defenses primarily mature or immature, adaptive and sublimatory or maladaptive with projection, acting out, or denial everywhere in evidence? Second, what is the nature of the family system? Third, are there significant areas of diversity (ethnicity, race, spirituality, oppression, socioeconomic status [SES], or cultural beliefs) that permeate the psychosocial surround? The last has to do with the availability and nature of the resources, both internal and external, that speak to the adolescent's resilience or vulnerability to stress.

Another equally viable approach to assessment of the adolescent client is Brandell's psychodynamic model (2004), which lists eight distinct components covering the regulatory personality structures, for example, ego functions, affects, and the self system, as well as specific areas of competence and effectance. Irrespective of the diagnostic system chosen to guide this aspect of the initial phase past referral, however, the pivotal issue is that the assessment model should be inclusive, comprehensive, and multifaceted in the organization of data involving observation, clarification, and the use of nomenclature (American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision [DSM-IV-TR], 2000), the underlying principle being that in a psychodynamic formulation of conflicts, most symptoms of psychological dysfunction are profoundly overdetermined in their etiology and expression rather than being unitary or static.

The informing interview should generally be done with the adolescent alone, after the interview

with the parents. In general, the approach used with the parents is also appropriate for the adolescent. The clinician should share with the teenager the assessment observations, impressions, and recommendations and should help the adolescent deal with anxiety and resistance. The recommendations should be presented as logically fitting with the presenting problems and in age-appropriate language. Adolescents should always be seen for a follow-up interview. Often, children want to know about their parents' reactions and responses, which frequently can be shared openly. However, if the parents have been very resistive to the recommendations, the clinician must not reveal all, since it is not useful to create dissension between adolescent and parent(s). When the clinician and parents differ, this fact can be recognized with the teenager while careful attention and respect is given to the parents' opinions.

The Recommendation for Individual Treatment

The criteria for determining indications and contraindications for individual or family or group therapy are many and varied. There are a number of fundamental theoretical struggles in the clinical field, and in some cases, decisions are made on the basis of clinician bias, philosophy, orientation, and training. Some clinicians, trained in several methods of intervention, are more open to issues of diagnosis and considerations of criteria for determining the optimal modality. Offer and Vanderstoep (1975) reflect on the conflicts regarding treatment recommendations and cite the psychoanalytic and systems analysis perspectives. The psychoanalytically oriented practitioner considers several interventions, in contrast to family systems analysts, who generally believe "that the question of indications and contraindications is a 'non-question'" (p. 145). The psychoanalytically oriented practitioner uses a nosological classification and views individuals and families from a psychodynamic point of view; according to this view, certain problems are suitable for treatment by family therapy, and others are not. Systems analysts in the field of family therapy make

no distinctions and strongly object to considerations of indication and contraindication; some believe that assessment is merely a device to deal with the therapist's anxiety and advocate an action-oriented point of view. Such a view leads therapists to engage in rearranging the family system, since the unit of attention is not the individual but the family system itself.

A psychoanalytic perspective and affirmation of a diagnostic process requires distinctions and cautions regarding indications and contraindications. The presence of severe psychotic-like depression; severe masochistic character pathology; hardcore psychopathology, child abuse, and/or domestic violence; perversion; criminality; a firm decision for divorce; or unyielding prejudice against family or group therapy points to a clear recommendation for individual treatment. Similarly, highly narcissistic individuals who lack empathy and are fixated in struggles regarding self-esteem or self-regard are inappropriate candidates for group therapy. Adolescents with deficient controls generally cannot be effectively treated in group or family therapy. Suggestive clients who are easily led become stimulated to excessive acting out in group treatment (Heacock, 1966). Ginott (1961) enumerates several other criteria to exclude specific children and teenagers from group therapy, among them, those experiencing intense sibling rivalry who require one-to-one attention; sociopathic adolescents who present shallowness, cruelty, persistent stealing, intense selfishness, impulsivity, or lack of empathy; those with accelerated drive expressions; highly sexualized or extremely aggressive children; children eroticized due to their exposure to perverse sexual activities or as the result of sexual victimization; and children traumatized by overt catastrophes. All such adolescents need supportive individualized treatment.

In sum, individualized insight-oriented therapy is optimal for teenagers with discrete areas of internal conflict, a strong basic ego structure, psychological mindedness, and a capacity for insight. More damaged adolescents who suffer from constitutional, perceptual, and cognitive deficits or whose families present severe pathology need active and supportive

treatment. Supportive treatment is appropriate for severely disturbed adolescents who present habit disorders in eating, discipline, and sleeping, related to a lack of appropriate parental direction or environmental structure, limits, and boundaries. Some adolescents with adequate personality development can be helped by a brief course of supportive treatment following trauma due to surgery, divorce, or death of a parent. In supportive work, attention should be focused on the present, with efforts toward improving rational control, diminishing anxiety and depression, and reinforcing secondary ego processes. Adolescents who are considered "less than neurotic," with diagnoses of borderline or narcissistic personality organization, often can be engaged only by individual supportive interventions; sometimes they can move into a more uncovering, insight-oriented treatment.

The Treatment Relationship

Individual treatment can be behavioral, supportive, uncovering, reconstructive, or interpretive and reflective. Mistakes, failures to assess the client properly, or the inflexible provision of one modality or form of treatment to all clients can cause a teenager to become more disturbed. Some clinics offer short-term treatment exclusively; others provide only individual treatment and in cases of adolescent clients omit necessary family work with parents; still others provide only a family or group form of intervention. Too frequently, slogans, panaceas, agency bias, or dictates from third parties via insurance companies control practice, with the result that there is little demonstrated respect for the individual. The burgeoning managed care industry has dramatically affected the provision of treatment services to adolescents and their families over the course of the past 15 years. Currently, more than 50% of the population is enrolled in these organizations, where case management practices restrict both the independence and decision making of clinicians who treat and the right of free choice among clients to select their own therapists. Being an unregulated industry means the obvious: There are no uniform

standards or procedures that govern the relationship with treatment providers relative to reimbursement schedules, length of treatment and its frequency, and expected treatment outcomes. A recent study of a randomly drawn sample of National Association for Social Worker (NASW) professionals found that the majority of respondents reported pressure from managed care organizations (MCOs) to alter their original diagnoses and shorten the recommended course of treatment at the behest of utilization reviewers (Bennett, Naylor, Perri, Shirilla, & Kilbane, 2008). Concerns about lowering their fees abounded as did ethical dilemmas relative to client confidentiality and the inherent problems with a system that contains cost at the expense of providing service to those in need.

The genuine nature of the problems and, in many instances, severely rationed care lead to a “revolving door” effect, with client needs remaining unmet and crises unresolved, with clients continually returning for needed ongoing attention. The treatment process and the nature of the treatment recommended (supportive or insight oriented) are nevertheless regulated to varying degrees by these outside forces today. Even more insidious is the subtle effect of MCO policies on the relationship between clinicians and their administrators in agency-based practice. Pressured to conform by abbreviating treatment, young clinicians are encouraged to focus on alleviating overt behaviors, concretizing symptom formation at the expense of developing a therapeutic relationship. This is true in both private and agency-based practice and thus cannot be ignored. These outside forces, in dictating the length of the care provided, determine in fact whether an actual therapeutic relationship can or cannot be established.

The Therapeutic Alliance

In a genuine treatment process (one that is not merely an extended diagnostic evaluation concluding with directions for overt behavior change), the therapeutic alliance is the single most important element in the treatment relationship. The literature on psychotherapy outcomes, studied and researched for

decades, has consistently demonstrated that establishing and maintaining the therapeutic alliance in the treatment relationship correlates significantly with client improvement (Lawson & Brossart, 2003). Studies of the therapeutic alliance as a process (e.g., Frieswyk, Allen, & Colson, 1986) related to outcome (Luborsky et al., 1980) and as a scaled, measurable research variable (Marziali, Marmar, & Krupnick, 1981) pointed to two more recent, evidentiary meta-analytic research studies that have confirmed the therapeutic alliance as central to the effectiveness of practice (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000).

The therapeutic alliance is seen as emanating out of the client’s “conscious or unconscious wish to cooperate and his readiness to accept the therapist’s aid in overcoming intense difficulties and resistances” (Sandler, Kennedy, & Tyson, 1980, p. 45). While the alliance in child psychotherapy arises out of the wish for pleasure in the treatment situation, the alliance for the adolescent involves a genuine comprehension of problems and the need to deal with them. The alliance is not an end unto itself but rather a means to an end, a way of facilitating the treatment process. According to Basch (1980), it is based on a new and corrective relationship, “a fund of trust” (p. 133), that adolescent client and therapist mutually share with one another. Alongside this rapport and positive feeling the adolescent develops for the therapist, the alliance is also based on an accurate appraisal of a need for understanding and for gratification in being understood. Adolescent clients will look to therapy for relief only if they have the capacity for self-observation and some awareness that there are significant problems.

The therapeutic alliance is the larger, subsuming context of psychotherapy that encompasses the treatment relationship: what is transferred as well as “real,” the working-through process in the middle phase, and the decision to eventually terminate. As the alliance goes, so goes every aspect of the psychotherapy. The alliance emerges gradually as the therapist becomes a “good-enough object,” an “auxiliary ego,” in a supportive holding environment where the client’s capacity for self-observation

and reflection increases in consonance with the clinician's ongoing encouragement and timely interpretation of the adolescent's feelings underlying behavior. These emotional states, for instance, of impatience, frustration, sadness, helplessness, shame, and embarrassment, and the categorical affects (Tomkins, 1962, 1963), many of which frequently operate out of conscious awareness, are observable in facial displays, body language, and posture or can be inferred, as coded, in the manifest language used to describe experience. These interventions that target emotions are employed because of the adolescent's tendency to act in order to avoid awareness of feelings. This interpretive pattern of therapeutic activity serves to connect thoughts, attitudes, emotions, and behavior in the client's present life situation.

Not all teenagers have sufficient inner ego structure for self-observation and self-awareness. Severely disturbed clients may not regard their symptoms as painful, projecting blame onto parents or experiencing their self-injurious behaviors as ego syntonic. In the absence of feelings of guilt, anguish, or anxiety in the adolescent, it is the parents and other concerned adults who suffer and worry, and they must insist on the teenager's involvement in treatment. In such cases, the parents usually make the initial alliance, which then supports and sustains the treatment.

Most adolescents simply will not relate to a distant authority figure, who keeps his client "at the end of a 10-foot pole." Therefore, the effective engagement of the client in this early stage of therapy will be modeled on the therapist as a special guide, an older adult friend, or a favorite aunt or uncle. This "experience-near" form of relating in the therapeutic alliance, which may include timely and appropriate clinician self-disclosures, permits the adolescent client to begin a controlled regression to the pathogenetic nuclei of internalized conflicts (Blos, 1970), the residues of unmastered developmental tasks from which the current symptoms emanate. The development of the alliance can be gauged by the adolescent's increased capacity for self-observation and by the therapist's subjectively felt experience of relief that the treatment effort has

finally begun to be shouldered by the client as well as himself.

The developing alliance witnesses an increase in the young client's capacity for self-observation, which will become the basis for a successful working through of conflicts. In this regard, being thoughtfully self-analytical and reflective begins to resemble the adult's capacity for reality testing and advanced reasoning based on formal operational thought (Piaget, 1950). At the other extreme, there are also elements of the child therapy situation, where play vehicles support the simple enjoyment of hobbies, games, crafts, and sports. For the young adolescent, especially, board games, the easel and chalkboard, or Nerf basketball may occupy a significant portion of the 55-minute hour. To the extent that the treatment relationship affords some partial gratification of drives and the release of pleasurable feelings, this aspect of the alliance supports the mature sublimation of libidinal and aggressive strivings. At still another level, the adolescent's "experiencing ego," coupled with the normative immersion in teen peer culture activities, literally mandates initiation into new social roles with concomitant expectations for performance and mastery in myriad new forums—team and solo sports and membership in extramural school clubs and social networks, for example, the debate team, theater and the performing arts, band and orchestra, or the pom-pom squad. All four of these dimensions involve self-expression and agency as the adolescent contributes to the therapeutic alliance with a sharing of his or her subjective world and its multiple personal meanings. In this fashion, these four dimensions—the reality ego, the pleasure ego, the observing ego, and the experiencing ego—represent the structural/functional elements that promote and strengthen the adolescent's contributions to the alliance and reciprocally interact with the clinician's timely interventions, that is, a mix of insight-oriented and supportive procedures. The outcome of a successful engagement with the adolescent client in building the therapeutic alliance is a beginning identification with the therapist and a strengthening of the adolescent's ego ideal (Lucente, 1986).

Case Illustration

Fifteen-year-old Abby was referred to me² by her parents on discharge from a psychiatric inpatient service after a 3-day period of observation for depression with suicidal ideation. I had treated her mother 20 years earlier and followed her as an outpatient in long-term insight-oriented psychotherapy spanning a period of 3 years, which also included an individual brief treatment of her husband and some marital therapy. Initial sessions with Abby included her thoughts on the similarity of her current symptoms of depression with her mother's past history and her decision to enter outpatient treatment with her mother's former therapist. In these regards, she freely volunteered that I might see her in stereotypical fashion as merely a replica of her mother and that I might miss her uniqueness and individuality. While thoughtful and intelligent, she was clearly subdued and conveyed little pleasure in her daily routine, which had previously included active, joyous participation on the high school volleyball team. In addition to elaborating on her current interests, activities with peers, and childhood experiences, she slowly began to hint at the depth of her anger, "lurking just beneath the surface," which attached to the three crucial recent events in her life that had contributed to her suicidality: (1) the change in her previously close relationship with her father, (2) a breakup with a close female friend and peer who had betrayed her trust, and (3) her mother's attempts to "smother" her. During this time, I experienced Abby as hesitant to acknowledge and disclose these emerging preconscious feelings of frustration and angry impatience. I also noted her defensive avoidance and nonresponse to any of my positive comments on her achievements, talents, and resiliencies. I sensed that the potential for a therapeutic alliance was hanging in the balance or, worse, that it might actually be lost. Feeling at odds with my own self-created pressure to engage, I began to struggle in session to maintain an "evenly suspended attention" to Abby's material. Finally, she described in detail an altercation with her mother later in the week after our session. Her mother had "smothered me once again," demanding that she accompany her to the wake and funeral of one of her college friends, a woman whom Abby barely knew. At the same time, Abby pointed out that her newfound friends had planned a sleepover slumber party for that very same Friday, that the event had been on the family calendar for more than 2 weeks, and that the Saturday events included mall shopping, a movie, and a light afternoon restaurant meal. Struggling with the intensity of her mother's insistence that she meet her mother's needs at the expense of her own, and noting her own escalating argumentativeness and disrespect, Abby said that a picture of my face had suddenly flashed through her mind as she wondered what I would do if I were in this situation and in her shoes. In a split second, she had become more focused and more caring toward the hurt in her mother's voice as she offered a solution to their dilemma. She would attend the wake that Friday afternoon and evening with her mother but would be dropped off at her friend's house in time for the get-together and evening sleepover. In the morning, she agreed to check in with her mother before setting out for the mall and movie later in the day.

Our "shared two-person unconscious" (Lucente, 2008; Lyons-Ruth, 1999; Stern, 1983) actually contained unconscious elements, represented in each of our memory systems, of Abby's mother as my client and as her parent. With some reflection, I came to understand, through Abby's vivid description of the argument with her mother—of being pressured to perform as a parent's dutiful daughter and "smothered"—that I had unwittingly re-created the very same dynamics based on my own un verbalized high expectations of her performance as my client. In subsequent sessions over the next few weeks, I noticed myself becoming increasingly more comfortable and less preoccupied with plans to make the alliance happen. My further reflections on Abby's selfobject deficits aided me in tracing them to my understanding of her mothering, through my working model of her mother's mind,

(Continued)

²Abby was treated by Dr. Lucente.

(Continued)

as the source of these problems. This self-correcting, mentalizing review of Abby's mother—as lacking mirroring and idealizing functions—was followed by an increase in Abby's self-observing and reflective functioning, as evidenced by her report of the following dream, which I interpreted, silently to myself, as a significant, tacit statement that she had accepted me as her therapist and that I was no longer her mother's.

"I am alone in this large, white three-story house with many rooms on each floor and a picture of someone with white hair in one of the third-floor bedrooms. There is scaffolding on one of the exterior walls as if a work crew is making much needed repairs, and I am trying hard to use the scaffolding to look into the rooms from the outside, but I am having trouble climbing to the next level."

Abby's associations to her dream are (a) that her "dream house" is a very different house from the modern, split-level one in which she currently resides; (b) that the man in the picture with the white hair seems to resemble her grandfather, who died a year ago and with whom she had been extremely close throughout her childhood; (c) that variations on this same dream have been recurrent for the past 2 years of her life, since entering adolescence; and (d) that this is the first time she has been outside the house and the first time scaffolding has been part of the manifest content.

My understanding of Abby's dream begins with the white house as a metaphoric image of her evolving adolescent identity information. (1) The rooms, some of which she already knows, as well as the new ones that she will eventually decorate in conformance with her individuality, symbolize her many "me selves" (Erikson, 1968), as the various components of her identity representations. (2) Her initial feelings of excitement, turning to worries and trepidations of the unknown, suggest the ambivalence that is endemic to the adolescent stage as a passage to self-knowledge and a revised narrative. (3) That she is "alone" implies its opposite, that is, there is a "work" crew of valued others—consisting of her therapist and a father whose hair is prematurely white, linked to the picture of her paternal grandfather, an internalized object of identification who occupies one of the rooms in her white house—all of whom serve the purpose of guides, assisting her "in putting her house in order." (4) Starting at the ground floor, with the scaffolding at the foundation, signifies the vertical complexity of the structure of the building as well as her psyche and points to a hierarchy of functions from id to ego, from unconscious to conscious mentation, and from one epigenetic stage to the next. Furthermore, starting with her foundation indicates a willingness to regress in the service of a therapy contract. Finally, that she is for the very first time "on the outside looking in and finding it hard going" attests to her willingness to self-observe and reflect on the psychological interior of her edifice. The themes in this single dream pointed to the foci of treatment for the next year: character formation, identity, and a second separation-individuation.

Transference

In his early considerations of transference, Freud (1912, 1915, 1916–1917) stated that all people unconsciously displace and transfer the libidinal aspects of their primary object relationships to current object relationships. The term *transference*, derived from adult psychoanalytic therapy, refers to

the views and relations the client presents about significant early-childhood objects: parents, siblings, and significant caretakers. Transference phenomena are expressed in the client's current perceptions, thoughts, fantasies, feelings, attitudes, and behavior with regard to the therapist (Sandler et al., 1980). In the classic sense, transference phenomena involve

the reliving of the client's psychodynamic past—internalized, conflictual relationship experiences—in the current and present object relationship with the therapist. It is these repressed wishes and fears that continue to shape the client's expectations of the therapist, as well as his behavior toward him and his perceptions of him, as a replica of primary objects from the past. Not infrequently, unconscious wishes and fears return with a change from passive to active. For example, there may be an active and conscious wish for closeness and intimacy and an equally active but more powerful unconscious fear that were this closeness to occur, rejection would surely follow—wearing a “chip on the shoulder,” out of conscious awareness, almost guarantees that the stated goal will never be attained by rejecting an intimate relationship before it has a chance to develop.

Self psychology posits different transference phenomena for clients with structural deficits, who suffer faulty self-esteem, and who are incapable of making clear self/other distinctions. They develop a “selfobject transference,” which must be distinguished from the classic definition and understanding of transference. Selfobject transferences are not displacement phenomena but rather a use of the therapist to provide a missing part of the self for the client. Because adolescents typically continue to reside with their significant early objects, they generally do not displace feelings, defenses, and perceptions from their past in the classic model of the repetition compulsion. More generally, they demonstrate what have been called *transference subtypes*: (a) where there is an extension of or a defensive displacement from the current relationship with the primary objects or (b) where past experiences, that is, conflicts involving drive, wishes, and defense, are revived as a consequence of clinical work and are displaced onto the therapist in the manifest or latent preconscious imagery (Sandler et al., 1980, pp. 78–104).

Another transference phenomenon commonly demonstrated by children and adolescents is that of externalization in the transference. Children and adolescents often do battle with their environments

and use the therapist to represent a part of their personality structure. During the adolescent upheaval, externalization and projections are common defenses with which the teenager wards off inner conflict; the superego function is relegated to outside authority figures whom the teenager defies but also invites to control or punish him for disobedience and defiance (Furman, 1980):

However, the externalization not only changes an inner battle into an outer one, it also supplants a very hard inner threat into a usually milder punishment from the outside. The visible misbehavior is seen as less of a violation than the inner forbidden activity or wish, for example, masturbatory activity or sexual or aggressive feelings toward forbidden objects. (p. 271)

In addition to these subtypes of transference manifested by adolescents and children, many have noted specific types of adolescent transference patterns related to the adolescent's habitual style of relating. These patterns can tax or disrupt the therapeutic alliance and also obstruct ego growth, thus requiring identification and active management (Meeks & Bernet, 2001). Meeks has noted four patterns: (1) the erotic transference, (2) the omnipotent transference, (3) the negative transference, and (4) the superego transference—the therapist as superego. Management of these varied transference phenomena includes acceptance of the adolescent's feelings, avoidance of counterattack, and a firm refusal to accept unrealistic blame and excessive criticism. As the adolescent is helped to explore and comprehend his or her anger, the empathic therapist tries to reflect a recognition of how things appear and to feel from the client's perspective. The therapist does not try to force his or her views on clients, but

neither does he attempt to avoid his responsibility as an adult to offer his ethical conclusion. . . . Such openness in discussions also encourages the adolescent to think about his own assumptions and to use his own powers of logic to the best possible advantage. (Meeks & Bernet, 2001, p. 135)

Self psychology views these transference patterns more as narcissistic transference, common in

adolescence, which is a time of heightened narcissism and self-regard. Idealization and de-idealization of the therapist are common, and Goldberg (1972) recommends that the therapist not confront but

accept the narcissistic disorder of the adolescent client as existing alongside a relative paucity of object love and not try to change narcissistic investment into object love. Treatment consists of a gradual undermining of the grandiosity and exhibitionism of the client as well as a diminution of his search for unattainable ideals. (p. 5)

In all, the therapy focuses on recognition and acceptance of the adolescent's narcissism in a nonjudgmental fashion, using the transference to demonstrate the use of the clinician as a regulator and modulator of self-esteem.

Transference phenomena can be particularly intense in individual psychotherapy. In group and family therapy, there can be considerable dilution or diminution because of the presence of other family or group members. When others are present, clients commonly conceal more private feelings, hopes, and fantasies. Some adolescents, struggling for age-appropriate self-presentation, tend to be less open in the presence of others about any productions in treatment in the realm of play, poetry, or painting; they may be similarly disinclined to reveal feelings of anger, omnipotence, grandiosity, or dependency longings. Such feelings are generally most easily shared by adolescents in the privacy of individual psychotherapy.

Countertransference

Countertransference, like *transference*, is an overused term that commonly covers any and all feelings and reactions from the therapist in response to the client. In fact, there are varied and conflicting definitions that reflect differing perspectives regarding the legitimate domain of this term. Dewald (1964), for example, states that countertransference arises not out of a client's behavior alone but from unconscious and preconscious forces within the

therapist that cause the therapist to react to the client in ways that are inappropriate to the current reality of the therapeutic relationship. Such unrealistic, unprovoked reactions are viewed as displacements from significant early relationships with the therapist's siblings and parents. Giovacchini (1985a) differs with this formulation and offers a broader definition:

I believe countertransference is ubiquitous; it is found in every analytic interaction in the same way transference is. Everything a therapist or a client thinks, feels or does can be viewed as being on a hierarchal spectrum, one end dominated by unconscious, primary process elements, and the other end dominated by reality-oriented, secondary process factors. When a client directs his feelings toward the therapist, the primary process elements of the spectrum represent transference, and in a similar fashion that part of the analyst's responses that stems primarily from the more primitive levels of his psyche can be viewed as countertransference. (p. 450)

Some clinicians make distinctions along Giovacchini's spectrum, designating reality-oriented factors as counterreactions and those that emanate out of unconscious primary-process variables as countertransference. Marcus (1980) defined countertransference as a reaction to a specific client, to the client's transference response, or to other components of the client's material. When used defensively, it can interrupt or disrupt the therapist's analyzing function because it "activates a developmental residue and creates or revives unconscious conflict, anxiety and defensiveness" (Marcus, 1980, p. 286). When not used defensively, it can be a valuable diagnostic tool and an effective treatment response in which a clinician is led to reflect and undertake a frank examination of his or her aroused feelings in order to avoid or resolve various therapeutic impasses or stalemates.

There are appropriate and all but universal countertransferences or counterreactions (according to one's definition of therapists' responses) to specific clients—those who are very impulsive, acting out,

highly narcissistic, extremely aggressive, unmotivated and resistive, or suicidal. Such adolescents arouse understandable anxiety, fears, and frustration in all therapists. Furthermore, there is a wide variation in the client-therapist fit. One cannot work with equal effectiveness with all of one's clients.

Rather than viewing treatability only in terms of the client's limitations, it is more realistic to consider the patient/therapist relationship as the axis that determines treatability. A patient may not be treatable by a particular therapist, but that does not make that patient untreatable. (Giovacchini, 1985a, p. 450)

Some adolescent clients provoke anger, rejection, and hostile demands for compliance; others cause therapists, like parents, to feel anxious, overwhelmed and helpless, or ashamed and professionally mortified. Clients who are productive and promising may please and gratify the therapist, who unconsciously uses the client as a narcissistic extension, as a source of pride and praise. Signs of countertransference problems are the therapist's lateness, boredom, overinvolvement, fear, anger, mistakes about scheduling, and so on. The therapist must be self-observing and self-aware and seek appropriate sources of help and support to minimize the potentially negative impact such countertransference reactions may otherwise have. Supervision, consultation, and personal treatment help the therapist stay in touch with and control his or her unconscious and preconscious early conflicts and properly modulate conscious behaviors and responses. The goal is to provide a safe holding environment, one that is characterized by restraint, appropriate containment of drive expression, attunement, an absence of nihilistic pessimism, and a continuous sense of concern and compassion, based on the clinician's ability to remember the adolescent's history. This enables the therapist to see that earlier injuries and pain have in fact produced unpleasant defenses such as denial, projection, and externalization.

Empathy is crucial in all treatment relationships. Kohut, the founder of self psychology, included it as

a central concept in his seminal psychoanalytic papers on psychoanalytic therapy. In 1975, Kohut pronounced psychoanalysis as the science of empathy par excellence. Earlier, Kohut discussed introspection as the process of self-observation of the inner world of fantasies, feelings, and wishes and empathy as the process in which others were similarly understood. He used the phrase *vicarious introspection* to denote that through empathy one observes vicariously the inner world of another. Empathy is a central concept in self psychology, and Kohut (1971, 1978a, 1984) conceived of it as curative in the treatment process. He called it "a value neutral method of observation attuned to the inner life of man" (1984, p. 395).

Clearly empathy is a critical ingredient in countertransference, and accurate empathy is composed of affective and cognitive components (Kohut, 1978b). Empathy is not used to satisfy or gratify client needs, nor is it the same as sympathy or support. "Rather, empathy informs the individual as to what is needed or yearned for by the other" (Lynch, 1991, p. 16). Ornstein (1978) notes that Kohut summarized his understanding of empathy with the following propositions:

- (1) Empathy, the recognition of the self in the other, is an indispensable tool of observation without which vast areas of human life, including man's behavior in the social field, remains unintelligible.
- (2) Empathy, the expansion of the self to include the other, constitutes a powerful psychological bond between individuals which, more perhaps than love, the expression and sublimation of the sexual drive, counteracts man's destructiveness against his fellows; and
- (3) Empathy, the accepting, confirming and understanding human echo evoked by the self, is a cherished nutriment without which human life as we know it and cherish it could not be sustained. (p. 84)

In the context of the treatment relationship using a self psychology perspective, efforts by the therapist must evoke efforts at empathic immersion, to gain understanding of each client's demands, hopes, fears, ambitions, and symptomatic

behavior. “The theory of self psychology removes the focus from the client’s faulty functioning in favor of learning to understand the underlying structure responsible for the faulty functioning” (Basch, 1980, p. 409). Interpretations are offered following the achievement of understanding, to assist in structure building, that is, “compensatory structures where development was earlier interrupted and thwarted by traumatic empathic failure” (Basch, 1980, p. 404). While better cognition and insight might occur, a goal of treatment is to open a path of empathy between self and selfobject and deepen the client’s capacity for self-acceptance. A further treatment goal is the development of a cohesive self, through a process Kohut called *transmuting internalization*. Transmuting internalization occurs incrementally as clients develop capacities to self-soothe, self-regulate, increase self-regard, and mirror and “to accept the hurts that are caused by failures of optimal responses by important others” (Solomon, 1991, p. 132). Kohut (1984) viewed treatment as a corrective emotional experience, and it is generally agreed that the expanded theoretical constructs of self psychology, as a model of deficits versus conflicts, have been particularly useful in consideration of countertransference and for working with the more fragile populations. It is especially productive in clinical work with adolescents.

The Real Relationship

Alexander (1963) was one of the first to challenge the concept of analytic neutrality. He stated emphatically that the analyst’s values are subtly learned by the client through verbal and nonverbal communications and by the experience of genuineness, warmth, and respect in a corrective emotional experience with a real person. Empathic warmth and active participation in the treatment process, include the judicious use of self-disclosure, particularly in work with adolescent clients who clearly respond to their therapist’s gender, age, appearance, style, humor, and other characteristics. While psychoanalysis is an intensive, in-depth process of

uncovering that requires the client to lie on a couch, in psychotherapy, the emphasis is primarily on the here-and-now and the manifestations of transference, which may or may not be addressed in any depth. Thus, the real relationship may well dominate over the transference relationship.

The approach of self psychology, based on Kohut’s expanded views of empathy, is predicated on the therapist’s greater emotional availability and spontaneity, resulting in a “generally calmer and friendlier atmosphere.” In individual psychotherapy with adolescents, support, reflections, enhancement of self-esteem, education, and guidance in a talkative and responsive interchange are more frequent interventions than interpretations of the transference or of defenses, or the elaboration of fantasies and unconscious primary-process material, as is the case in analysis.

THE MIDDLE PHASE OF TREATMENT

Resistance, Working Through, Intersubjectivity, and Psychoneurobiology

The beginning phase of treatment consists of assessment, selection of appropriate intervention, initial engagement, and contracting, which it is hoped would culminate in the development of a working alliance that is based on the growing treatment relationship between the adolescent client and the therapist. Resistance, commonly dealt with in the middle phase of treatment, is defined as any obstruction that evolves in the process of treatment and in the treatment relationship. Character resistances are present from the beginning of treatment and can be distinguished from the opposition that arises in the course of therapy. Such opposition arises because internal conflict is defended, and there is always some degree of resistance to removing these defenses. Dewald (1964) noted that resistances emerge during the treatment process at varying levels of consciousness. They are caused by the client’s fear of change or gratification arising from regressive infantile drives, early patterns, or infantile relationships, and the need to maintain

repression of the unconscious conflicts that produce anxiety and guilt. A complete lack of defenses and resistance is an ominous sign, suggesting a lack of psychic structure, possible decompensation, or a propensity for merger and indiscriminate compliance. It is important to understand why, what, and how the client is avoiding. Therefore, resistances and defenses should not be assaulted with confrontational or intellectualized reflections and interpretations.

Anna Freud (1958, 1978) discussed the inability or unwillingness of children and adolescents to maintain a stable therapeutic alliance, tolerate frustrations, and translate feelings into words rather than actions. There is a “type of juvenile patient who does not allow anxiety to find expression in thought or words but constantly negates it” (Sandler et al., 1980, p. 58). Adolescents often demonstrate resistance before and during the course of therapy because of their wish for autonomy and their fear that the therapist—the agent of the parents—will attempt to transform them in accord with the parents’ needs and not the adolescent’s preferences. Silences, broken appointments, tardiness, action rather than verbalization, passive-aggressive behavior, impatience, boredom, and resentment are standard adolescent manifestations of resistance.

Defenses are commonly used in the service of resistance. *Defense* is a term used to describe struggles of the ego, unconsciously employed, to protect the self from perceived danger. The threat of recognition or conscious awareness of repressed wishes or impulses causes anxiety and guilt and must be avoided. Assessment and diagnosis determine whether the defenses demonstrated are age adequate, primitive, or precocious and whether they prove to be effective in binding impulses and anxiety to promote coping and adaptation. The defenses employed shape the individual’s personality and style of coping with reality. Some clients’ defenses are ineffectual and create secondary interference with reality functioning and consequent disequilibrium, for example, denial, projection, and acting out. Others reflect more adaptive, mature accommodations to external reality and internal ego structure, for example, sublimation and

undoing. Splitting defenses become more object bound as the adolescent undergoes a second separation-individuation. More adaptive projective identification mechanisms—where part self and part object representations, and their associated affects, are projected onto others to replicate unresolved conflicts with introjects—eventually replace primitive splitting. Interpersonal reenactments frequently involve role reversals with aggressive, affirming, or rejecting part selves and bad part objects.

The defenses must be recognized, understood, and accepted as the client’s needed protection against anxiety. Many adolescent clients are often objectionable, assaultive, draining, and provocative, yet despite this reality, a nonpunitive therapeutic stance must be maintained. The discussion of countertransference and counterreactions suggested ways to maintain therapeutic calm, objectivity, and ongoing commitment to the adolescent client.

Working Through

The term *working through* was originally used by Freud to describe the continuing application of analytic work to overcome resistances that persisted after interpretation of repressed instinctual impulses. The goal of working through is to make insight effective in order to bring about significant and lasting change. When longer-term therapy is possible, it can strengthen the working-through process, after the client’s attainment of earlier treatment gains (e.g., mastery of reality, the enactment of age-appropriate life roles and tasks). Introspection and insight are linked with working through, which occurs when the client’s ego identifies with the therapist, so that the client may share in the therapist’s understanding and take part in the therapeutic effort.

Adolescent efforts are not typically directed toward understanding the past because of their intense preoccupation with current real difficulties and apprehensions about the future. It is usually not until late adolescence that young clients internalize the analyzing, observing, and reflecting function of their therapists, and they begin to acquire and retain

an understanding of the genesis of their difficulties. Many teenagers who are provided treatment may require additional therapy later in adulthood, when more genuine working through is possible.

It is critical to bear in mind that even insight has limitations. Self-understanding produces neither magical change nor relief. Working through and resolution of both internalized and externalized conflicts require considerable time and repeated encounters with and recognition of newly learned truths. Many clinicians believe that “sufficient working through has taken place when the [young client] has moved to the next level of development and established himself there” (Sandler et al., 1980, p. 184). This progression would involve an alteration of balance among the defenses, neutralization of resistances, formation of new identifications, reconstruction of the ego ideal (Campbell, 1981), and more adaptive character traits.

INTERSUBJECTIVITY AND PSYCHONEUROBIOLOGY

The paradigm shift that has been emergent for the past decade and a half in contemporary psychoanalytic thought is now complete. Informed by psychoneurobiology research, this new model, with its overarching umbrella of intersubjectivity, is a synergistic blend that includes attachment (e.g., Bowlby, 1969; Main & Solomon, 1986; Sander, 2002) and object relations theory (e.g., Mahler, Pine, & Bergman, 1975; Winnicott, 1951, 1956, 1960), relational and narrative approaches, constructivism, and the traditional theories, for example, drive and ego psychology, self psychology, and systems theory. This paradigm shift has dramatic implications both for the conduct of psychotherapy, especially with adolescents, and for understanding change processes, choice of interventions, and expected treatment outcomes.

The clinical relationship provides an “experience-near” opportunity for the adolescent to understand and regulate emotions. Primary emotional experience (Brown, 1993), the foundation of and precursor to a more advanced and expanded awareness of

feeling states and their self-management, emerges as an initial capacity from internalizations of intersubjective episodes in the early holding environment (Winnicott, 1960, 1967) and is represented in neural networks, that is, it is encoded as implicit memories in the affect centers—the limbic system, the amygdala, and the prefrontal orbital cerebral cortex—in the right hemisphere of the asymmetric and bilateral human brain (Schore, 1994, 2003; Siegel, 1999, 2007). These early experiences of intersubjectivity and affect sharing, for example, “feeling felt,” serve as a substrate for all later close relationships, including the dialogue in treatment between therapist and client as the two subjective selves mutually interact with one another (Attwood & Stolorow, 1999). When empathically mirrored, the infant self evolves with structure, cohesion, and stability. However, where misalliances, attunement ruptures, and other empathic failures have occurred in the holding environment, the adolescent’s therapy must be directed toward their repair in the working-through, middle phase of treatment. Because the adolescent phase revisits separation-individuation for the second time, a psychotherapeutic focus on maintaining the alliance throughout this middle phase almost ensures that areas of arrest will be addressed and reworked. Treatment in the middle phase focuses on developing mindsight (Siegel, 1999, 2007), affect regulation (Allen et al., 2008; Fonagy et al., 2002; Schore, 1994, 2003), and understanding the adolescent’s current relationships in the context of peers and the primary objects of childhood. The mentalizing strategy, as operationalized interventions, starts with the clinician’s attitude of active curiosity about the workings of the adolescent mind, as well as his own, and encouragement to explore the working model of the minds of others (Allen et al., 2008; Fonagy et al., 2002). Techniques include the use of metaphorical thought and analogies, exploring fantasies and engaging in the playful, “let’s pretend mode” to develop a capacity for safely exploring the more complex emotions, motivations, thoughts, and impulses of self and others. Maintaining an “evenly suspended attention” (Freud, 1912) to the adolescent’s productions is essential in a mentalizing therapy

because the clinician's default mode, for knowing the minds of others, is egocentric, that is, his or her own. Allen et al. (2008) recommend that the clinicians "quarantine" their own affects as much as possible to ensure that they do not discover in the client only what they expected to find anyway. In this fashion, quarantining one's own affects serves to self-correct the tendency to assume that we know the emotional lives of others solely on the basis of our own feelings.

Schore, D. J. Siegel, Fonagy, and numerous recent theorists, for example, J. P. Siegel (2007), Brown (2008), and Barth (2008), have identified the significance of internalized, unmetabolized, raw affect states (Kernberg, 1985)—the result of alliance ruptures, misattunements, and mirroring failures in early object relations—that become the basis for defensive splitting and projective identification mechanisms as the prototype mode for all close future attachments. An intersubjective, affect-regulating treatment approach naturally activates these projective identification processes in therapy, signifying a reciprocal invitation from one unconscious mind to another to engage in a shared state of affect attunement (Schore, 2003). As the clinician and client pair at this level of the unconscious affect engagement, the synchronous matching of the two right brain hemispheres of client and therapist permits a transfer of accurately mirrored emotions that modifies what had been previously encoded, in implicit memory, as misattuned (Lyons-Ruth, 1999; Trevarthen, 1996). Mentalizing interventions with these projective identification mechanisms in the middle phase of therapy alter the manner in which self and object images, and the attendant affect states, are represented. In this manner, therapeutic empathy detoxifies raw affects, which are reinternalized by the client in a more benign, metabolized, and deaggressivized representational form (Ogden, 1986, 1994).

TERMINATION

The topic of termination has received relatively scant attention in the clinical literature. Some believe

this is due to the fact that the concluding phase of treatment produces the greatest amount of stress and difficulty. Related transference reactions, counterreactions, and countertransference problems, though common, have received little attention as a consequence. How the therapeutic process is brought to a conclusion may in fact be the most important aspect of the entire treatment process, solidifying gains or, if unsuccessful, weakening and undoing the therapeutic work. Ferenczi (1927/1955) was the first to focus specifically on the concluding phase of treatment and noted that completion is attainable "only if unlimited time is at one's disposal" (p. 82). The next significant examination was Freud's (1937/1950) seminal paper, titled "Analysis Terminable and Interminable," in which he offered guidelines and criteria for concluding analytic work. He emphasized relief of the client's suffering, the conquering of anxieties and inhibitions, and the therapist's conviction that treatment be successful enough to ensure against relapse and repetition of the client's symptoms and pathology. He emphasized sufficient intrapsychic structural change to permit optimal functioning.

Under optimal conditions, when individual psychotherapy has been of sufficient duration to effect a meaningful treatment relationship and corrective emotional experience, the termination phase is of utmost significance. It entails loss and separation, emancipation and growth, and it always reactivates earlier losses and separations that the client has endured. Ideally, the client will conclude treatment feeling strengthened and fortified by the experience of mastering the current loss. Termination can offer an opportunity to rework and modify earlier separation problems; it can evoke panic and rage, guilt and grief, or a sense of accomplishment and mastery.

The classic criteria for termination generally exclude decisions based solely on symptom relief; rather, there is an emphasis on movement beyond points of arrest or fixation and demonstration of the capability to handle ongoing and predictable future developmental and environmental problems. Psychotherapy, in contrast to psychoanalysis, focuses primarily on the here-and-now and on the

interaction and interpersonal relationship of client and clinician. Less attention is given to early conflicts, and instead, the focus is on the capacity for reality testing; stronger, more age-appropriate object relationships; and loosened fixations. Particularly with children and adolescents, the young person's failure to develop progressively (or damage that interferes with such growth) is the most significant feature in undermining future mental health (A. Freud, 1962).

Dewald (1964) suggested that for clients treated in insight therapy, indications for termination are some structural change in the personality, the lessening or elimination of symptoms, or evidence of improved capacity to tolerate specific symptoms and conflicts. Other indicators are improvements in relationships, work life, academics, and, more generally, self-awareness and self-control. For those seen in supportive therapy, indications for appropriate termination would be reduction of symptoms, better management of drive expression, improved self-esteem, and cessation of the prior regressive pull. Decisions about termination may be determined by external factors, such as change of locale of the family or the therapist, change of jobs, or conclusion of an internship for a clinician who has been in training.

Clients' reactions to termination are many and varied. With some, conflicts intensify during the conclusion of therapy due to resistance to facing old losses, sadness, and grief. Mourning is often masked by a facade of anger and denial, which may break down, revealing intense grief, sadness, and anxiety. Some clients try to stave off the date of scheduled termination with denial, regression, and resumption of old symptoms.

Countertransference dilemmas are frequent during this phase of treatment. A therapist's overly intense attachment, dislike of a client, therapeutic overambition, or overidentification will interfere with an effective termination. Therapist and client are both affected by the termination phase, the reasons for conclusion of treatment, and the nature of the therapeutic gains achieved and maintained. The real relationship is usually more evident at the conclusion of treatment, since termination connotes a

separation between two individuals whose relationship has been in the nature of a collaboration on a precious enterprise (Hurn, 1971). This real relationship must have professional parameters in accord with the prior treatment relationship.

Clinical social work has a long and storied history with research that examines the effectiveness of practice—both long-term and brief—with all its myriad service delivery systems, populations, and intervention methods. Significant controversy still exists over the merits of long-term as opposed to short-term treatment (Reid & Shyne, 1968). The most recent literature on these two broad classifications confirms the “practice wisdom” that long-term, dynamically informed therapies are needed to address complex dysfunctions; further, they produce better results, that is, client improvements, than short-term treatment. Long-term treatment will benefit clients whose multifaceted depressions and chronic symptoms of anxiety (*DSM-IV-TR*, 2000, Axis I) are comorbid with character pathology (*DSM-IV-TR*, 2000, Axis II) and who, therefore, possess serious potential for more than just mild dysfunction relative to social, familial, and occupational responsibilities (Fonagy, Roth, & Higget, 2005; Gabbard, Gunderson, & Fonagy, 2002). Leichsenring and Rabung (2008) subjected this hypothesis to rigorous computer analysis. They compared the outcomes of treatments that were defined as long-term, psychodynamically oriented, and relationship-based with brief treatments using cognitive behavioral therapy (CBT), family therapy, crisis management, supportive “psychiatric treatment as usual,” or dialectical behavior therapy (DBT). They located 23 such studies in the literature from 1960 to 2007 that conformed to their rigorous inclusion criteria, for example, random assignment of clients to the experimental and comparison conditions and/or clinical observation/measurement packages with multiple instruments for collecting data and statistical analysis at Times 1 and 2. The long-term treatments were self-defined as psychodynamic (e.g., attachment oriented, ego psychology, or self psychology) and of at least 50 weeks' duration, and interventions comprised a mix of insight-oriented and supportive procedures. Of the more

than 1,300 clients (adolescents and young adults) treated in these 23 studies and subsequently subjected to meta-analytic review, fully 96% were better off at the end of their long-term treatments compared with the control clients receiving short-term therapy. Finally, of the 23 outcome research reports that were subjected to this critical review, those adolescent and young adult clients with borderline personality organization receiving mentalization-based, long-term treatment (Bateman & Fonagy, 2001) had the second highest improvement scores of all. In sum, from the above evidence-based literature, it can be reasonably inferred that mentalizing-based, longer-term psychotherapy would be appropriate for many clinical populations of adolescents. This would include those with depression, anxiety, and other symptoms reflecting a broad range of potential character dysfunctions, because it is in this stage of development that adolescents normatively begin to demonstrate greater maturity in their self-reflective and affect-regulating functions.

LATE ADOLESCENCE

Late adolescence is viewed as a stage of consolidation and stabilization. We anticipate and expect clarity and purposeful actions, productivity, constancy of emotions, stable self-esteem, and more mature functioning. Narcissism has lessened, and there is a greater tolerance for frustration, compromise, and delay. In his seminal work on adolescence, Blos (1962) noted that the adolescent strives for

1. a highly idiosyncratic and stable arrangement of ego functions and interests,
2. an extension of the conflict-free sphere of the ego (secondary autonomy),
3. an irreversible sexual position (identity constancy), and
4. the stabilization of mental apparatuses. (p. 129)

Anna Freud (1958) described the five central issues of adolescence as (1) impulses—acceptance versus

rebellion, (2) love versus hate of parents, (3) revolt versus dependency, (4) idealism versus narcissism, and (5) generosity versus narcissism. Finally, being “on the way to consolidating” identity for the late-stage adolescent (Lucente, 1996, 2008) involves the following: (a) an adultomorphic body image rooted in one’s core gender as unambiguously male or female (Stoller, 1968); (b) mature psychosexual drive organization, that is, genitality and a sexuality that expresses itself via arousal for a preferred erotic object (Erikson, 1959; Freud, 1905, 1923, 1924); (c) autonomous, independent functioning, that is, a second separation-individuation with capacities for object and self-constancy; (d) moral reasoning using hypothetico-deductive thought and internalized ego ideals (Gilligan, 1982; Kohlberg, 1976); (e) an evolved, superordinate ego-superego system that organizes the various components of the personality (Blanck & Blanck, 1974, 1986); and (f) a maturing capacity for affect regulation and related processes, for example, autooiesis, mindsight, and empathy (Allen et al., 2008; Fonagy et al., 2002; Schore, 2003; Siegel, 1999).

Current social realities and the enhanced awareness of the length of time involved in pre-adult personality consolidation, plus adolescents’ extended financial dependency and their lengthier academic preparation, have expanded our concept of adolescence and the coextensive mastery of age-appropriate tasks beyond the teenage and even college years. This expanded perspective of adolescence, including Erikson’s concept of “moratorium” (a time for continued education, contemplation, role experimentation, or work or travel), has redefined the adolescent stage of life in contemporary Western society.

Beth, an Older Adolescent³

Based on this expanded contemporary view of adolescence, Beth, a 21-year-old college graduate from an upper-middle-class, midwestern Jewish family, may be viewed as an older adolescent. She had not resolved what Anna Freud (1958) noted as the five central issues of adolescence described earlier.

³Beth was treated by the late Dr. Mishne.

Beth was referred for treatment by her father's previous therapist, following her father's request. She agreed with her father's concerns and seemed motivated for therapy at the onset of contact. She expressed an immediate sense of relief to "be doing something positive now" and was clearly pleased by the natural fit between herself and this clinician (Dr. Mishne). Beth had just moved into the city following college graduation. She was employed at her first job in the fashion industry and, subsidized by her father, resided in a comfortable semiluxury apartment that she shared with a roommate. She presented as a wholesome and very attractive young woman, with athletic interests and abilities. She described a wide circle of friends from college to whom she was devoted. Much of her time and energy involved friends and shared activities, such as health club daily workouts, jogging, rollerblading, skiing, charity fund-raisers, group gatherings, group summer and ski houses, and going to dinner and clubs with these friends. Beth was devoted to her family and communicated with them constantly, which involved daily calls with her father at his office, frequent evening calls to Dad and his second wife, as well as calls to her older sister and stormy weekly conversations with her mother.

A combative and conflictual relationship with her mother was a major presenting problem. Weight management and control of her eating was also of real concern. Beth acknowledged a long-standing reading disability, struggles with some academic work, and well-concealed poor self-esteem, secondary to her history of academic problems. This made her uncertain about whether to pursue graduate studies in business, an area of interest and one in which she had achieved notable mastery, given her competence with figures and numbers. Because of her reading disability, Beth shamefully revealed that she was completely unable to engage in many intellectual pursuits and could not even peruse the newspaper by herself at home. She knew that she was an attractive and engaging young person but often felt empty and too eager to keep "busy busy" to distract herself.

Beth dated these feelings back to elementary school. Her academic difficulties surfaced in the fourth grade, at the time of her parents' divorce. Both Beth and her sister were provided psychotherapy as children, and Beth took responsibility to have clinical reports and summaries of her childhood treatment forwarded to me. Following an assessment, she committed herself to biweekly individual psychotherapy, which her father agreed to underwrite. She wanted to work on the problems she had with her mother, weight management, her history of romantic problems with boyfriends, and feeling better about herself. She easily entered into a treatment contract and soon developed a therapeutic alliance.

The process of treatment was a mix—initially supportive, then, insight-oriented psychotherapy, as Beth became less concerned about her present circumstances and future and could reflect on her earlier experiences and observe their later reverberations. Beth was able to move from a posture of rage, disregard, and contempt for her mother to a position whereby she felt and demonstrated greater empathy and compassion for her mother and for herself. As her controls improved, there was a decided improvement in her transactions with her mother and diminution of the long-standing guilt that had always followed her explosions and rebelliousness. Beth's mother, who was self-employed, was described as a warm and intelligent woman who was very attractive despite her being grossly overweight. She was overly dependent on her own parents and seemed to be stuck in self-defeating patterns that had prevented her from remarrying or becoming romantically connected with a genuinely available partner since her divorce.

Beth's anger and shame about her mother's life appeared to be a natural outcome of her mother's long-term involvement with a married man and her inability to sever this connection. Beth's mother was unable to break off this relationship despite her supposed personal aspirations and years of promises to Beth that she would do so. Beth's greater enjoyment of time with her father and stepmother generated eternal conflicts between Beth and her mother. It also gave rise to demands and accusations from her mother, followed by Beth's explosive verbal abuse,

and finally Beth's reactive guilt. As she reflected on the long-standing nature of their conflict, Beth came to recognize her lack of complete and genuine separation-individuation from her mother; furthermore, she seemed to mirror her mother in weight management problems and in her unwise romantic choices of boyfriends who did not treat her well.

The manifest transference was one of idealization, with the therapist being perceived as the all-good, empathic idealized maternal object. The corresponding counterreaction or countertransference (Marcus, 1980) can be best described as a positive maternal one, with the therapist taking care and attention not to impose her personal values or goals (e.g., enrollment in graduate school) on Beth. Using a self psychology perspective, interpretations were offered to assist in structure building. In addition to better cognition and insight, the goals of Beth's treatment involved the opening of pathways of empathy between Beth and her mother and the deepening of Beth's capacity for self-acceptance and empathy for herself and her mother. A further objective was the development of greater self-cohesion, which evolved through transmuting internalization, that is, the internal changes that occur as clients develop a "capacity to accept the hurts that are caused by failures of optimal responses by important others" (Solomon, 1991, p. 132).

After 2 years of therapy, Beth appeared to demonstrate a significant degree of working through. As a consequence, it seemed unlikely that she would regress to the earlier mother-daughter rageful battles or food management difficulties. Out of identification with the therapist and the therapeutic work, she made substantial gains. She became less impulsive and less erratic with food management, resolved her feelings of love versus hate for her mother, was more realistic and less worshipful of her father, and assumed greater responsibility for her finances. She was able to increase her earnings and savings, was more independent of her father (save for therapy bills), and was idealistic and generous about giving, emotionally, to all in her family, as well as her friends. She made additional gains in romantic relationships, and although she was not involved in an exclusive attachment, she enjoyed far better relationships with boyfriends of late.

Termination was decided on by Beth, based on her feeling strengthened and fortified by the treatment experience. She felt ready "to graduate" because of the elimination of symptoms and presenting problems, and improvements in her relationships, work performance, self-esteem, and self-control. The real relationship was more evident during the planned termination phase, with Beth's commenting on the closeness and support she felt she had received. She indicated comfort at the thought that she could and would return at any point if she found it necessary. Beth appeared to have resolved the tasks of late adolescence at the conclusion of therapy. Accordingly, no objections or questions were raised about her decision, since it is crucial to effect an appropriate letting go of adolescent clients based on the therapist's surrender of omnipotent hopes of safeguarding the adolescent client against future dangers, life's vicissitudes, and regression. One must allow the adolescent the opportunity to take the chance of independent passage (Ekstein, 1983).

REFLECTIONS ON THE TREATMENT PROCESS

Work with Beth was supportive and empathic, and the self psychology perspective was employed. In a warm and friendly ambience, the therapist permitted and encouraged emotional availability and spontaneity, and the treatment process focused on

techniques of understanding, explanations, and interpretations of Beth's demands, hopes, ambitions, struggles, and symptomatic behaviors. Beth's lack of separation and individuation from her mother was viewed not from the perspective of oedipal anxiety or fears of oedipal victory but rather as the effects of disintegration anxiety, mild learning disability, and

the mortification inherent in the lack of early mastery of academics. Beth's aggression and adhesive negative attachment to her mother were redefined, not ignored, and the therapist, through interpretive linkages and genetic reflection, enabled Beth to understand her bond of anger as the result of her shame over her mother's overweight, poor self-control, and long involvement with a married man. Interpretations, when offered, focused on Beth's low self-esteem and embarrassment about herself and her mother rather than her overadmiration and idealization of her father, the more competent and effective parent. There was no focus on Beth's faulty functioning but rather an effort to understand the underlying structure responsible for the faulty functioning. By providing "experience-near" explanations of Beth's self-experiences, she was aided in developing self-soothing techniques and understanding more accurately her retaliatory responses to her mother's repeated traumatizing empathic failures. The self psychology approach avoided critical confrontation with Beth's evasions, demands, and excitability; the therapist's reflections instead focused on providing the origins and explanations of her actions and behavior.

The goal of enhancement of Beth's self-perceptions was achieved, as evident in her growing capacity to empathize with herself and her mother and better understand the shortcomings in their selfobject bond. She demonstrated insight into her mother's relationship with Beth's maternal grandparents and was thereby able to experience greater tolerance and compassion toward her mother. Additional educational interventions addressed her learning disability and its short-term and long-term effects on her self-esteem. Greater understanding enabled Beth to exert better self-control and tone down her affective exchanges with her mother and her boyfriends. In addition, she began to consider the possibility of graduate school courses. She also demonstrated improved performance at her job, evident from the promotions and increased responsibility given to her.

In the transference, Beth idealized the therapist as the good mother who is consistently patient, calm,

and empathic. Through identification and transmuting internalization, Beth felt less frantic or overwhelmed and increasingly could engage in well-modulated and controlled deliberations and problem solving. With better self-control and self-understanding, she was also able to surrender her "tough" demeanor, which she came to understand as her defensive facade in disagreements. When disappointed by her mother or a boyfriend, Beth learned to relate in a more benign and less reactive manner; imperfections and small slights from others now could be experienced as manageable. With better self/other distinctions, learned in treatment, Beth felt less provoked and personally diminished by the inconsiderate behavior of others. She came to see herself and the other more realistically and, with this enhanced self-acceptance, was better able to accept her "imperfect" mother and the shortcomings of her friends. Beth's mother was able to respond positively to Beth's improved mode of relating to her, and this was vividly demonstrated when Beth required surgery. Beth's mother as well as her father came to be with her, and her mother functioned in a considerate parental fashion, with a noticeable absence of the explosive arguments, accusations, and childish demands that Beth's mother typically made of her.

Beth's treatment was initially supportive and then shifted to an insight-oriented focus. Beth seemed to benefit and grow from the curative effect of the "correctional emotional experience" (Kohut, 1984, p. 78). The improvements seemingly evolved out of a therapeutic dialogue that provided understanding and explanations of what went wrong in Beth's early childhood and throughout her adolescence.

CONCLUSION

Adolescents are generally recognized as one of the most difficult age-groups to treat. Some clinicians and researchers do not believe that adolescents can actually engage in and maintain a therapeutic alliance. Others believe that only short-term periods of therapy are possible, with adolescents coming for help periodically when stress becomes overwhelming. A number of writers recommend the setting of

only moderate goals, specifically to increase the ego's tolerance for conflicts and to improve reality testing. Since teenagers attempt to disengage from their parents, many resist any dependent relationship with an adult parental figure. The decathexis from parental love objects often results in impoverishment of the ego because of the pain and mourning associated with the loss of the close and loving parent-child ties. This mourning process may leave little ego energy for attachment to an individual therapist. Frequently encountered treatment obstacles in work with adolescent clients have consisted of a lowered threshold for frustration, a preference for action rather than verbalization of feelings, and new weaknesses and immaturities of ego structure. Because of adolescent narcissistic withdrawal, many teenagers have little if any libidinal energy available with which to explore their past or relate in the present. Because of all these realities and the specific vulnerabilities of adolescents, supportive, empathic treatment is the best beginning intervention. Insight-oriented psychotherapy may later be possible if the alliance is positive and when the teenager is motivated to seek greater self-understanding and mastery of age-appropriate tasks.

The adolescent therapist is cautioned regarding the use of confrontation to avoid the possibility of regressive fragmentation. Many adolescents are not candidates for group or family therapy, because of the stressors in the family or because some are unable to empathize with peers or tolerate public self-exposure due to their shaky self-esteem or self-regard. Group and family interventions can be threatening to many adolescents who are very sensitive to criticism and self-conscious with peers. Individual psychotherapy is appropriate for the widest range of adolescents: the severely disturbed, the teenager in a traumatic home situation, or one who presents a habit disorder, ego deficits, or developmental disability.

Specialization in adolescent therapy can begin only during formal clinical education. Adolescents present special demands; their communications are frequently unclear, and they are reticent, resistance prone, and rebellious, with a propensity for action

rather than words and the sharing of feelings. Work with this population requires lengthy, ongoing training, experience, and supervision.

In addition, to be able to do intensive psychotherapy with adolescents, aspiring therapists, regardless of discipline, may require some personal treatment in order to develop a therapeutic, objective, empathic response that both embodies self-awareness and self-observation and controls against regression and countertransference acting out with adolescent clients. We may or may not have encountered, struggled with, or lived through the identical pain and stresses that our clients experience, but as adolescents, we once all engaged in the same developmental struggles for autonomy, separation, and individuation. We have also suffered the same fears of narcissistic injury and failure as our teenage clients. We once encountered with alarm, anxiety, and excitement our first love, erotic arousal, and sexual and emotional intimacy. Thus, clinical work with adolescents strikes continuous, responsive chords in all therapists in a unique, though stressful manner, which must be recognized and contained.

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