Psychoanalytically informed psychotherapy for adolescents

INTRODUCTION

Most clinicians practicing psychotherapy with adolescents today, though not trained psychoanalysts, are practicing in a tradition derived from clinical psychoanalysis. Psychoanalysis refers to psychological treatment based on assumptions about largely unconscious, frequently conflicted, multilayered personal ways of organizing and reacting to experience that allow us to understand and explain thoughts, feelings and actions that would otherwise seem illogical. Despite being unconscious, conflicted or multilayered, such personal patterns and motivations are, in principle, considered to be knowable to the individual through the guided, self-reflective process which is the essence of the psychoanalytic method, and changeable in the context of a relationship dedicated to the patient’s emotional development.

Although there is no consensus among clinicians about how to define psychoanalytically informed treatment of adolescents, most would agree that this work seeks to engage, develop and transform internalized meaning structures (established patterns of organizing experience and reacting to the world) via dyadic, affect-laden interaction, both verbal and nonverbal. The clinician attempts to:

- implement his understanding of the relationship between the present and the developmental past in treatment;
- facilitate the adolescent’s developmental progress; and (sometimes);
- engage the younger in the self-reflective process that illuminates the relationship between the present and the past.¹

¹Therapeutic engagement that does not include immediate reflective awareness may nonetheless be discovered later in life to have significantly transformed meaning structures (see Maron 1992b, 1997).

I define psychoanalytically informed psychotherapy by its goal of inner transformation and by the degree to which the resources of the dyad are marshaled to meet that goal, rather than by its conventions and technical precepts of frequency, duration, use of the couch, activity level of the therapist or the development and resolution of a transference neurosis.

THE CENTRALITY OF UNDERSTANDING ADOLESCENT DEVELOPMENT

The psychotherapeutic task with adolescents is to effect change in a still-developing, not yet fully formed personality, though one that may already contain residua of faulty development. One must remediate psychological liabilities while simultaneously recognizing the normal developmental tasks of adolescence and fostering further psychological maturation (see also Tyson 1998). Psychoanalytically Informed psychotherapy, because it is sensitive to the developmental process, is uniquely qualified to address pathological character formations, and to effect changes in the sense of self. It can alter internalized relationships and defensive styles that would otherwise warp further personality development and restrict healthy growth. While adolescents in the throes of psychological reorganization, transformation and growth may manifest affective and behavioral extremes, the matuational thrust often provides a readiness to form new relationships and take in new experiences that can significantly aid the therapeutic process.

To understand developmental indications for psychotherapy, the practitioner needs to acquire an understanding of the adolescent developmental phase. For treatment purposes, differences among the various psychoanalytic theories of adolescent development are less
important than the goal of absorbing the 'developmental' or 'epigenetic' point of view. This view holds that development consists of a series of unfolding stages in which the 'personality' continually faces new challenges through which higher-order psychological formations may emerge. Past problems are brought forward to the present and may complicate further development, though there are simultaneously renewed opportunities to rework old issues.

The developmentalist asks himself, 'What current problems is the adolescent trying to solve?' 'What previous struggles have helped and hindered him?', and 'What new experiences can resolve old problems and facilitate further growth?' The continuous construction model that is revolutionizing the psychoanalytic understanding of development, psychopathology, and treatment (Zeannah et al. 1989) holds that the individual is exquisitely sensitive to the context within which growth takes place. The developmentally attuned pioneers of psychoanalytically informed work with adolescents must have understood this, for the premise provides the rationale for the participatory stance that characterizes successful work with adolescents. The dyad formed by the therapist and patient constitutes an adjunctive developmental opportunity for adolescents.

A BACKGROUND CONTROVERSY

The plethora of arguments regarding where to draw the boundary between psychoanalysis and psychoanalytic psychotherapy for adults is reflected in controversies amongst psychoanalysts treating adolescents. Some (Chused 1988) would hold that unless the adolescent's conflicts, repressed infantile wishes and fantasies, intensify, concentrate and resolve (in the transference) in relation to the analyst, the process is not psychoanalysis. Many others believe that the distinction between psychoanalysis and psychoanalytically informed psychotherapy with adolescents is rapidly disappearing (Marohn 1997). Rather than draw a boundary between these modalities which can suggest a continuum of efficacy or inefficacy, I include psychoanalysis for adolescents within the broader category of psychoanalytically informed psychotherapy. Whether or not specific psychoanalytic methodology (e.g., the fostering of a transference neurosis, the analysis of transference, the resolution of a transference neurosis) is linked to developmentally defined psychotherapeutic action is a question to be resolved by research of the sort begun only recently (Fonagy and Target 1994; Target and Fonagy 1994).²

² With adults, research has not borne out the expected linkage between psychoanalytic methodology and therapeutic action (Wallenstein 1988).

DOING THE WORK

Indications for psychoanalysis and psychoanalytic psychotherapy in adolescence

In 1905, Freud's case report of his adolescent patient Dora included evidence of his own frustration with the treatment. It has been widely recognized that there are great difficulties in conducting a classical psychoanalysis with adolescents. Usually, adolescents simply will not cooperate. (For a fresh approach to engaging adolescents in psychoanalysis, see Lament 1997.) In 1958, Anna Freud commented on the regretfully small number of such reports in the literature, and reports of successful, traditional psychoanalyses with adolescents are still few in number. Galatzer-Levy (1985) provided an extensive case report on the psychoanalysis of an adolescent boy, conducted without modification. He believes that Anna Freud's traditional selection criteria still apply and that psychoanalysis remains the treatment of choice for 'neurotic' adolescents; that is, those inhibited and constricted on the basis of psychological conflict who, otherwise, have good psychological endowment.

Many well-trained psychoanalysts, however, would not undertake formal psychoanalysis with an adolescent unless it was an extreme case of delayed development. Goldberg (1978), a self-psychoanalyst, was the first to reserve psychoanalysis in adolescence for conditions which required the total reorganization of the self. Levy-Warren (1996), a contemporary Freudian, has also prescribed psychoanalysis proper rather than psychoanalytic psychotherapy for cases in which development has come to a complete halt. For her, this 'heroic' indication warrants the frequency, intensity, and duration of a full psychoanalysis.

Contemporary psychoanalysts treating adolescents more typically speak of 'psychotherapy,' and use that term to refer to the way in which they apply psychoanalytic theories of development, pathology and cure to their adolescent patients (Esman 1990; Levy-Warren 1996). Psychoanalytically informed psychotherapy is indicated when there is some interference with the developmental process. Adolescence is a good time to institute psychotherapy, as deficits in development sometimes can be corrected and often the developmental process can be facilitated. Such an indication for psychotherapy is exemplified by Marohn's work with delinquent adolescents (Marohn 1992a). According to Marohn, 'Violent adolescents have little awareness of an inner psychological world, cannot name affects or differentiate one from another, and often confuse thought, feeling, and deed. In psychodynamic treatment, adolescents are helped to experience affect as a part of themselves and to develop the capacity to manage affect and use it as a basis
for communication and self-understanding.' (Marohn 1992a, p. 622).

Psychoanalytic psychotherapy has been prescribed for the entire gamut of psychopathological difficulties. Esman (1985) suggests psychoanalytically oriented psychotherapy for virtually all symptoms and behavioral difficulties, whether stemming from internal conflict, deficit, or external circumstances, and excludes only psychotic, frankly addicted, and sociopathic youngsters. Marohn (1992a) does not exclude sociopathic character disorders. Like Aichhorn (1925), Marohn based his judgment on his assessment of the adolescent's potential capacity to form a transference bond; sociopathic characters are considered treatable if they have a history of having admired someone or someone. While some forms of psychopathology have important constitutional roots, even the expression of biological tendencies is affected by psychological context. The concrete pattern of experience which results from the interaction of these factors (Escalona 1965) can be modified or transformed in a new psychological context. That context is psychoanalytically informed psychotherapy.

Structuring the treatment

Issues about the structuring of the treatment need to be dealt with especially thoughtfully for each adolescent case. Together, the therapist and patient will form a new psychological system, one that is charged with effecting psychological change within the patient. The therapist must therefore be as mindful as possible as to what each of his communications - in both action and speech - will mean to the patient. Elements that seem routine to the therapist are likely to be experienced by the new patient as communicating something of the therapist's personality, his attitude towards the patient, and the possibilities inherent in the new process. Later, patient and therapist will examine the meanings made of words, actions, etc. A renewed appreciation that the patient will ascribe meaning to every aspect of the set-up can help the therapist begin to engage his young patient and attempt to avoid behaviors that scuttle the treatment before it is off the ground.

THE INITIAL CONTACT

Often, the first contact is on the telephone with someone other than the adolescent. Adolescents are frequently sent to treatment. If the parent has phoned, the therapist should ask whether the adolescent knows about the contact and whether the adolescent, too, wishes to speak to the prospective therapist. Even if the answer to one or the other question is negative, the therapist has begun to communicate (to the parent, and possibly the adolescent) that in his mind the adolescent is not reducible to what others say about him.

In clinic settings or in private practice, the first practical question the therapist must face is whether to meet the adolescent first or the parent. Levy-Warren (1996) counsels that early adolescents often expect their parents to meet with the therapist first, while late adolescents frequently require that the therapist meet with them and often wish to exclude their parents from treatment altogether. Godenne's (1995) method (see also Chapter 6.1), which specifically excludes accounts other than the adolescent's own until after the initial contact has been made, may facilitate the alliance with the adolescent. The point is central to all psychoanalytic theories - all behavior has meaning; adolescents process and react to the meaning they make of all the therapist's behaviors.

COMMUNICATING WITH PARENTS

It must be remembered that some alliance with the parents is virtually always necessary. Sometimes practitioners incorrectly interpret a 'psychoanalytic' stance to mean that no contact should occur with anyone other than the adolescent. Parents make the treatment possible through their support. Whether or not they pay for treatment, parents usually help to arrange their adolescent's life so that treatment can occur, for example, by transporting the teenager or by arranging for lessons and family and school schedules to accommodate the treatment. A failure to respect the parents' concern for their child may lead to treatments that end suddenly and prematurely, as parents may then sabotage the work. There are treatments that fail when parents either cannot tolerate feelings of competition or cannot understand the need for treatment after symptomatic improvement has occurred. Parents may then pressure adolescents to end treatment in subtle and not-so-subtle ways. Adversive, if occasional, parent guidance sessions are useful in helping parents to understand the unfolding of the therapist's treatment plan. Additionally, an approach that acknowledges parents is usually reassuring to teenagers, though their reservations must be elicited, understood, and sometimes heeded. Whatever the state of their Strivings for independence, most adolescents deeply feel some unreadiness for being entirely autonomous.

THE EVALUATION PHASE

Parents and adolescents should be told that the therapist will require several initial sessions to meet with each (in a sequence determined by one's best judgment about what might be tolerable) to develop some sense of what is going on and what might be the best way to address the situation. Not only is it clinically prudent to evaluate each youngster, but this communicates the therapist's interest in understanding the adolescent in depth. While some therapists believe they can assess an adolescent and his family in two single sessions, more time is often desirable. It is wise to suggest that outcomes other
than a plan for individual treatment may be recommended. Aside from the possibility of referring the parents to individual, couple treatment, or family therapy, the clinician's assessment of parental functioning—and particularly the parents' capacity to understand the adolescent—will be crucial in determining the form of contact appropriate in each case. Possibilities other than minimal contact may be indicated, from continuing contact to ensure support of the treatment, to the use of the parents to modify the environment, to the possibility of working with the parents in an ongoing manner to identify and ameliorate the effect of difficulties regularly encountered by the adolescent (Rosenbaum 1994). We sometimes forget that Anna Freud (1958, 1968) counseled that working with parents of adolescents is sometimes very useful.

The first several visits are a crucial time in which direct emotional contact must be established with the adolescent and, if possible, also with the parents (Blos 1962; Meeks 1971). It is important to be able to speak comfortably and naturally with adolescents. The therapist's capacity to listen empathically, think developmentally, and speak affecting must all come to the fore in the first several sessions. Ways must be found to frame the adolescent's issues which are honest and novel, and which allow for hope about a good resolution to the issues not previously considered by the adolescent. The therapist's creativity plays an important role. Consider Levy-Warren's comment (1996): 'Sometimes the only way an adolescent who feels forced into treatment will be able to engage in it is if the therapist suggests that it might be worth the adolescent's while to discuss what it is like to live with parents who demand that the adolescent be in treatment.' (Levy-Warren 1996, pp. 162–163).

The process of communicating findings and recommendations to adolescents and parents is an art unto itself. Care must be taken to balance frankness with respect for self-esteem. Real psychological issues must be addressed in jargon-free terms that connect to the adolescent's experience. The treatment arrangement that follows will be a function of the therapist's evaluation and the quality of engagement that has developed with the adolescent and family. Similarly, the frequency of sessions will reflect the clinician's diagnostic judgment, the parent's financial circumstances, and the adolescent's other obligations. While many people today need to be educated to the value of two- to three-times-a-week sessions, the impact of this on the adolescent and the family needs also to be considered. It is useful to remind everyone that initial arrangements are provisional and may require alteration. At this early time, arrangements must be made to protect an on-going treatment—who pays for the sessions, how much, how the bill is transmitted, and under what circumstances there is a charge for missed sessions. All of these arrangements are fraught with meaning, which the therapist must monitor (see Levy-Warren 1996, pp. 137–165).

CONFIDENTIALITY

Therapists should, naturally, be alert for opportunities to address issues of confidentiality. Adolescents often allude to beliefs that the parents would be angry or distressed by something the adolescent has just told the therapist, whether thought or deed. The adolescent can then be told that everything which occurs in sessions stays in sessions, that parents would be informed only if the therapist were to become convinced that the adolescent's safety was in danger. Some adolescents will want to explore examples, and this should be encouraged. Exploration will reveal the distinction in the therapist's mind between fantasy and action, and between experimentation with risky behavior and commitment to self-destruction. Such clarity in an adult is a source of comfort to virtually all adolescents. Parents, too, must be informed of these clinical boundaries. It is actually more common for issues of confidentiality to be nettlesome with parents than with adolescents, as parents frequently feel threatened by the recognition that a stranger has privileged access to their child from which they are excluded.

DURATION OF TREATMENT

How long should treatment last, and how does it end? Treatment in adolescence is often unorthodox. Useful treatment can sometimes be quite brief (Staff 1995; Golombok and Kerenblum 1995). Nonetheless, psychoanalytically informed psychotherapy with adolescents typically implies long-term treatment, perhaps one year or longer. Indeed, careful research on the outcome of psychoanalysis and psychoanalytically oriented psychotherapy has demonstrated that a longer duration of treatment is correlated with more successful outcomes for adolescents (Target and Fonagy 1994).

While the therapist holds certain developmental goals, the adolescent frequently links treatment to external circumstances (i.e., 'Until I graduate'; see Novick 1976). When therapists are caught off-guard by an adolescent who announces a precipitous end to treatment, it must be remembered that the adolescent's psychological organization is in a state of flux. A teenager may not be able to articulate why treatment should end. He or she may need to put into action the gains made. Dulit's presentation, 'In and out of treatment – An okay thing' (Dulit 1982), was perennially popular on the adolescent psychotherapy circuit. Episodic treatment is more common with adolescents than with adults. In any case, it is important to remember that the gains of treatment may not become apparent for many years. The impact of treatment and the relationship with the therapist may not be articulated during the course of therapy and sometimes may only be discerned retrospectively (Marohn 1992b, 1997).
Technical aspects of the actual interaction

What happens in the room? The work has long been recognized as challenging (Freud 1958), both because adolescents are often difficult to engage and because working with them is thought to arouse and engage the therapist’s own unresolved adolescent issues. While doing psychoanalytic psychotherapy with adolescents is different than working with adults, developing competence with adolescents is excellent preparation for general psychotherapeutic work (especially with more difficult patients).

Analyst–patient interaction is less formulaic, more creative, and more active than in adult treatments. While child treatment is sometimes quite physically active, adolescent treatment may be quite emotionally stimulating. To put it mildly, adolescents often use words incisively to express themselves and to explore the psychological world of the therapist. Therapists need to be comfortable being more responsive to their adolescent patients than they may have learned to be with adult patients. More casual conversational style does not lead to countertransference abuses if the therapist understands that this setting, even more than the standard adult setting, requires that the therapist reliably develop access to wide and deep self-knowledge. It is crucial that the therapist come to know his own vulnerabilities and that he be familiar with the affective and behavioral signs which signal that these vulnerabilities are being evoked. When the therapist is sufficiently aware of his vulnerabilities (Doctors 1996), he can decenter from defensive patterns of psychological involvement and resituate himself so as to be useful to the adolescent in the psychological field. The mature analyst may be playful and utilize humor to engage the patient, to change the pace of the dialogue, to promote self-reflection, and to engage the patient’s latent capacities for relatedness (Schimel 1992).

Interpretation, the sine qua non of classical psychoanalysis, is also used in adolescent work. Technically, clarifications and confrontations are more often utilized than genetic interpretations, which seek to link current psychic events to their infantile origins. The therapist tends to stay closer to the level of consciously available experience. The adolescent therapist helps the adolescent to become more self-reflective, to recognize patterns of affectivity and to become aware of how he or she organizes experience and reacts to experience. Though genetic reconstruction may occur, therapist interventions are primarily directed at expanding the adolescent’s psychological repertoire, freeing him or her from self-restricting defensive patterns, and helping the adolescent develop a sense of conviction about subjective experience. How the therapist listens, understands, and responds is at least as important as the content of what is interpreted (Kalogerakis 1997).

While psychoanalysis originated with the discovery of unconscious impulses and motivations, we have come to understand that the patterning of experience may also be unconscious (Stolorow and Atwood 1992). Becoming aware of and transforming patterns of attachment and relationship is a crucial mode by which psychotherapy in adolescence can alter the developmental course. Being in relationship to a benevolent therapist who routinely comments on the mental state of both patient and analyst can enhance self-reflective capacities in adolescents (Fonagy et al. 1995). The development of reflective mental processes is increasingly recognized as an element in the individual’s capacity to form secure relationships and to shape and guide a successful life course.

The analysis of the transference, a crucial locus of therapeutic illumination in work with adults, tends to take on a different valence in psychoanalytic psychotherapy with adolescents. The definition of transference as organizing activity (Stolorow and Lachmann 1984/85) is useful in adolescent work, as it directs attention to the patient’s typical ways of being, without insisting that the adolescent focus routinily and specifically on feelings about the therapist. Certainly there are times when the clinician senses that feelings about the therapist must be attended to before other matters can proceed. However, understanding that transference will manifest itself in a host of psychological productions allows the therapist of adolescents to avoid the rigid, doctrinaire stance that could easily compromise the therapeutic alliance.

Being with the adolescent: the new relationship

The relationship between patient and therapist is probably the crucial component of the therapeutic action of the therapy. The characteristics that underlie the primary attachment relationship, namely emotional availability, dependability, empathic attunement, sensitivity to developmental needs, and provision of comfort and security, are also prerequisites of the therapeutic relationship (Peterfreund 1983, as cited in Zeannah et al. 1989). The combination of the relational perspective (Mitchell 1988) gaining ground in psychoanalysis, and the growing understanding of the implications of infant research for the treatment process (Lachmann and Beebe 1996) is directing our attention to the context in which development, pathology, and cure occur. The real relationship in psychotherapy and psychoanalysis is increasingly recognized as a most powerful element in the transformation of relationship pathology (Zeannah et al. 1989).

Some of the papers written by senior psychoanalysts about being with adolescent patients are amongst the most humane, evocative papers in the annals of psychoanalysis (Anthony 1975; Schimel 1992; Marohn 1992b; Kalogerakis 1997). I take this to be a reflection of Marohn’s idea (1992b, 1997) that doing the work contributes to the development of a ‘psychotherapeutic self’ and, more
broadly, to the maturation of the analyst's personality. With experience, adolescent therapists come to recognize the powerful impact of one's personhood on the patient's experience (Marohn 1997, p. 291) and to respect and rely on the process. Describing the way in which patient and therapist may come to share earlier impressions of one another (Anthony 1975), as if sharing photos from a family album, warmly evoked the radically inter-subjective nature of the adolescent treatment process. Interestingly, the process of lending oneself wholeheartedly to understanding and enhancing the development of an adolescent often expands and deepens one's acceptance and understanding of one's own development. Anthony's (1975) reminder that psychotherapy is a mutual voyage of discovery and neither therapist nor patient should be too certain how it is all going to turn out (Anthony 1975, p. 342) seems a fitting way to epitomize the adolescent psychoanalytic psychotherapy adventure.

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