The Adolescent

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Abstract

In this article I attempt to address some core questions about psychoanalytic psychotherapy for adolescents. Is adolescent turmoil inevitable? Some think it is, and generate their understanding from psychoanalytic investigation in the therapeutic relationship. Others disagree, and base their argument on psychological research. Why is it that different conclusions are reached, and what do each mean by adolescent turmoil? In this context, what are the implications of psychotherapy in the adolescent period, and what factors need to be considered in deciding on psychotherapy? Finally, what might adolescent psychotherapy look like?

Is Adolescent Turmoil Inevitable?

Psychoanalytic theory describes adolescence as a period of transition that involves inherent struggle and turmoil (Blos, 1978; Freud, 1958). There are physical changes, change in the parental relationship and cognitive changes. Physical change brings about an increase in sexual and aggressive drive at a time when ego strength is not yet sufficient. Adolescence thus includes a struggle between new emerging desires and phantasies of the id, and the repressive forces of the ego (Freud, 1958; Jureidini, 1991; Klein, 1922). A change in relating to parents also occurs. Preadolescent sexual instinct is predominantly autoerotic, but that of adolescence is in new sexual objects outside the family. This necessitates disengaging from external and internal parents, a process of dramatic change that entails rejecting parental ego support, and accepting a degree of ego weakness (Blos, 1978; Freud, 1958; Freud, 1905).

There are also cognitive changes in adolescence, involving a move towards formal operational thinking, which can cause discomfort and anxiety. This rapid development in cognitive ability can overwhelm an adolescent, and coping may include denial and eliciting strong reactions from adults (Jureidini, 1991). Adolescence involves reworking early frustrations and fixations, meeting threatening phantasies head on, and is a period of psychic restructuring and secondary individuation (Klein, 1922; Blos, 1978). All in all the period of change is described as a stressful time. Some even go as far as saying that not experiencing some sort of turmoil could signify a delay in development and should be taken seriously (Freud, 1958). On the other hand psychological research describes adolescence as an adaptive phase of growth characterised by integrational harmony and emotional stability, without disabling crisis. Turmoil is seen as the exception not the rule (Weiner, 1992).

Why are there such differences of opinion? Perhaps different methods are used to study the adolescent group, and what is gained is understood through different

theoretical eyes? In general, psychological research seems to focus on what is expressed, including thoughts, feelings and symptoms; in other words, on what is more or less conscious or preconscious. In comparison, psychoanalytic theory investigates deeper strata of the mind, and looks to the unconscious to explain adolescent processes. While research is gathered from the general population, psychoanalytic findings are often based on those who are unwell, rather than the norm. Research may be based on surveying attitudes. As adolescents are in a stage where they are particularly vulnerable to anxiety about normality, acknowledging that something is wrong could significantly threaten narcissistic omnipotence, and asking about turmoil could see an adolescent reporting that there is nothing wrong with them. This attitude can be seen in normative adolescent reluctance to seek help, and in a rationalising attitude that problems experienced are simply the fault of school, parents, friends and their changing body. Adolescents avoid being seen as different and are strongly influenced by their peer group, which could translate into a reluctance to share difficulties or in normalising them (Laufer, 1975).

Perhaps a central issue in understanding the debate is the definition of turmoil. Psychoanalytic investigation is based on seeing turmoil, and the associated discomfort and anxiety, as part of normal development. It acknowledges that only a minority experience neurosis or psychosis because of an existing vulnerability in the psychic structure, and that this makes dealing with adolescent tasks difficult (Blos, 1978; Freud, 1958; Klein, 1922; Martin, 1963). In comparison, some research seems to define turmoil in a more pathological light (Weiner, 1992). The definition of turmoil varies so it is understandable why it appears that different conclusions are reached. But each approach makes valid contributions and yields relevant findings. Perhaps a theory is needed to account for and explain the validity of both psychological and psychoanalytic approaches?

To assume that all adolescents experience turmoil and that turmoil is pathological, could lead to difficulty in identifying those in real need of therapeutic help and signifies a risk of a self-fulfilling prophecy. On the other hand, some abnormality may be characteristic of this stage, and formal assessment should not take place too quickly. This does not mean that assessment and intervention may not be necessary, as turmoil that is in excess of normal adolescent functioning can significantly affect future emotional wellbeing and may compromise the psyche (Bronstein & Flanders, 1998). Psychotherapy may be of assistance in locating early frustration and fixation and removing obstacles to ongoing development. A successful therapy outcome means freedom to resume individual development (Slaff, 1979).

There are some differences regarding the type of therapy that is suitable in adolescence. Some call attention to the relative weakness of the ego during this stage, and adolescent reluctance to engage in therapy, and believe adolescents should treat themselves and find their own solutions to difficulties. Others believe therapy should only deal with preconscious and conscious material, with the aim of strengthening the ego through suggestion and support (Anthony, 1974). Yet others

support in-depth psychoanalytic work, and describe the aim as discovering the cause of the problem and bringing this into consciousness, which assists in adjusting the demands of the conscious and unconscious (Klein, 1922). In recent evidence-based research psychodynamic therapy has been shown to be of at least equal value to other popular therapies like cognitive behaviour therapy. However, what has also been found is that while approaches like the latter have positive effects which decay over time, gains from psychodynamic processes not only endure, but increase with time (Shedler, 2010).

I believe that most adolescents go through some sort of change and turmoil, and that most do so without harm. Some experience great difficulty, and even pathology, and are in need of help. It seems that the line between being psychologically healthy and unwell is less easy to define in adolescence. It is the latter group that is in need of assistance, and even psychotherapy. I believe that adolescence can be a good time for psychoanalytic psychotherapy because it is defined by the personality structure not being stable. It is a time of regression, progression, reworking of early conflict, introspection and awareness of internal conflict. But, such therapy may not always be the answer, and may even be contra-indicated in some circumstances.

Psychotherapy or Not Psychotherapy, that is the Question

In the following section I look more closely at such issues and how to assess an adolescent's suitability for psychotherapy. It is divided into three parts. The first focuses on the adolescent's external reality or environment, the second on factors of the adolescent and the third on examples of where psychotherapy is contraindicated.

The psychological health of the adolescent is dependent on the balance between body needs, drives, and the demands of the external reality. The symptoms presented in assessment represent poor solutions and compromises in attempts to defend against anxiety. Defence mechanisms are activated, and in some cases result in symptoms and maladaptive behaviour (Freud, 1966). The described balance can be disturbed by internal processes, normal development or harsh demands of the external reality. It is for this reason that psychotherapy will not be fruitful unless the objective threatening aspect of the external reality is reduced. It is only once this has occurred that greater adaptation and balance is possible between the individual and the environment, which results in a reduction of symptoms (Freud, 1965).

A number of areas need to be considered when assessing the environment of an adolescent for psychotherapy. A suitable psychotherapist needs to be available (Connor and Fischer, 1997), and the length of treatment needs to be considered. The longer the therapy the more resources are needed from both the institution that offers the psychotherapy, and from the parents. In the health system of today cost effective treatment is important. Parents, carers or the adolescent need to have transport resources to attend therapy on a regular basis. The environmental

expectations of the outcome of therapy are also important. This expectation may differ from the adolescent expectation and may not necessarily be reality based and could hinder healing, as well as pressurise the assessor to adopt an inappropriate treatment plan (Dyke, 1987). For example, an adolescent could be referred for emotional and behaviour problems, but during the assessment process it is revealed that custody issues, parental divorce or drug and alcohol abuse by one or both parents are affecting the situation. In such an instance where the adolescent environment is not stable, psychotherapy may not be the answer. Rather, intervention could be aimed at stabilising the environment, and perhaps reassessing for psychotherapy at a later stage.

The external reality includes not only society, but also the family. This necessitates asking some of the following questions: Is the adolescent's family in harmony with their environment, and how does this affect the adolescent (Simmons, 1987)? For example, an adolescent of a family that has recently immigrated can be expected to have cultural adjustment difficulties, and psychotherapy may not necessarily be indicated. The adolescent does not live in isolation, but in a family system that is affected by the environment. It is therefore necessary to assess the relationship between the young person, their family and the environment in order to decide if the adolescent needs psychotherapy or if intervention should involve the external reality, including the family and school. It is necessary to ask specific questions to untangle the complicated relationship between the young person and the external reality.

Can the family collaborate in agreeing on a treatment plan or is there a possibility of it being hindered by, for example, their own mental health? Furthermore, how does that which hinders this process affect the adolescent and how is it envisaged that the process of psychotherapy will impact on this (Simmons, 1987)? It will be of benefit, if resources allow, to work with the adolescent and family concurrently. In the absence of this, community support may be necessary. At times a family may need or expect one of its members to be sick. For example, if an adolescent has emotional problems the parents may occupy themselves with this so that they do not need to look as closely at their own difficulties (Simmons, 1987). An adolescent's problem could also be influenced by family expectations. For example, it may be expected that the adolescent will be similar to his or her father or brother who has a criminal history.

Part of the normal process at the start of therapy is experiencing an exaggeration of symptoms at times. This means that we have to ask questions about the parents' ability to contain their own anxiety and that of their adolescent child. You would not want the therapy to result in the family falling apart, or in the family's resistance significantly affecting the adolescent's therapy. You would also not want the family to terminate the therapy process prematurely (McDonald, 1965). When assessing an adolescent for psychotherapy it is important to consider to what extent the parents' experience of their own childhood influences their relationship with their child. Maybe it is not the adolescent that is in need of therapy (Fraiberg,

Adelson and Shapiro, 1975; Lyons-Ruth and Zeanah, 1993). Finally, the parents need to understand the problem and collaborate in the treatment plan, for example by providing a reliable setting for work with their child. The therapeutic process will flow more smoothly if everyone is on board and doing their part; this may include the parents, the school and others who are significantly involved with the young person (Rustin, 1982).

There are also a number of factors of the young person that influence saying 'yes' to adolescent psychotherapy. First, the general health of the adolescent needs to be assessed. Perhaps the problem is of organic origin and the adolescent needs physical or neurological assessment and intervention (Broder and Hood, 1983). The quality of the adolescent's object relations should also be considered, as a certain basic object relating ability is necessary for successful therapeutic intervention. Is the adolescent able to have meaningful relationships, and will he or she be able to experience identification with the therapist? Can the therapist be used in the transference (McDonald, 1965; Meeks, 1971)? In extreme cases the quality of an adolescent's early relationships is not sufficient to exploit the transference (Winnicott, 1949).

The severity of the problem is also important. Is the disturbance transitory, as in normal development? If so, psychotherapy may not necessarily be indicated. Alternately, is the adolescent at risk of developing more serious concerns at a later stage of development if therapy does not take place (Laufer, 1965; Simmons, 1987)? It is of benefit that the adolescent wants to change, has insight into the problem, and is able to sufficiently communicate the problem through speech. If psychotherapy is the treatment of choice, how the client may get along with the therapist needs to be considered. For example, the adolescent may have a rejecting, punitive father and may refuse to attend therapy with a male therapist. Other cultural and social factors may also contribute to such a situation. It should also be considered how the therapist will be affected by the client and to what extent countertransference will be bearable and therapeutic. For example, it may not be in a client's best interest to explore their sexual abuse with a therapist who has been affected by sexual abuse and has not sufficiently resolved this.

There are some instances where psychotherapy is contraindicated. It has been found that psychotherapy can be relatively ineffective in treating adolescents with severe pathology (Reisman, 1973). Psychotherapy is also not indicated for adolescents who have experienced recent trauma, including loss of a parent or sexual abuse. In such cases therapy can be experienced as traumatic, and should be considered only after the adolescent has worked through the trauma. Phantasies can only be safely explored once the adolescent perceives his or her reality as safe (Dyke, 1987; Jernberg, 1979).

Psychotherapy is also largely ineffective as a treatment of psychopathic adolescents. In such a case therapy can only be effective if the young person is pre-adolescent, if the parents are agreeable with not accepting the delinquent

behaviour, and if they are prepared to work at their own problems. Unfortunately, parents of delinquent children all too often have resistance. Caution should also be exercised in choosing treatment options for adolescents who are emotionally fragile. Such adolescents may react with anxiety and panic to structured or directed psychotherapy. It may be preferable to refer such adolescents for non-directive work, where they can experience feeling safe and able to influence others (Jernberg, 1979).

Therefore, when deciding on saying 'yes' to psychotherapy, a question is being asked about treatment. As psychotherapy is often but one of many treatment options, the first area that needs to be explored in agreeing to psychotherapy might include, "*What* treatment, by *whom*, is most effective for *this* individual with *that* specific problem, under *which* set of circumstances?" (Paul, 1967, p. 111).

What adolescent therapy might look like

I have chosen a young man, who for reasons of anonymity I have called Chad, as an example of a psychoanalytic therapy process with an adolescent. At the time of Chad's referral for psychotherapy I worked at a family support organisation that deals with children and adolescents with behavioural and emotional problems. We accepted referrals for psychotherapy only from the local child and adolescent psychiatric service. This included those who had been diagnosed with moderate mental health difficulty or who were at risk of developing personality disorder. My therapy with Chad, which took place in our playroom, was accompanied by work with Chad's Mother that took place with one of our social workers. The aim of the latter was to support Chad's family while he was in therapy, and work on parenting issues relevant to the referral question. Chad had already gone through a formal process of psychiatric assessment and review, so I did not replicate this. However, I did meet with his mother for a couple of sessions before starting therapy for purposes of my own history taking, and to gain a more specific understanding of the relevant phantasies, anxieties and general family interaction patterns.

Chad presented as a 13 year-old boy of high average intellectual ability. He had been diagnosed with Attention-Deficit Hyperactivity Disorder (ADHD) and Oppositional Defiant Disorder (ODD). He had also been diagnosed with a congenital eye condition, called Cone-Rod Dystrophy, which meant that he had progressively lost his sight. Chad first starting speaking at the age of eleven months and his mother reports that he was toilet trained by twelve months. At twelve months he also suffered from severe asthma and showed motor clumsiness. By the time he was three he had become quite clingy, and this was described as becoming worse with age. He was first recognised as having degenerative vision problems at the age of five. The origin and prognosis of this condition was not clear, and had caused much confusion for the family and Chad. At the age of five Chad was also first prescribed stimulant medication. His start at school was troublesome, and saw him described as challenging, competitive, aggressive and controlling. He had trouble making friends. By the age of seven Chad had developed a fascination with fire lighting and spoke about burning down houses. He did not allow such

phantasies to be challenged. Chad threatened to kill himself, his parents and others. On one occasion he ran after his sister threatening her with a hammer, and also got into a severe fight with a boy that landed the boy in hospital. By age nine his behaviour had got worse and his parents made arrangements to send him to a specialised school for the blind, very far away from home. But, Chad was expelled at the point of one of numerous oppositional episodes requiring calling out the police to secure the school. He was referred for therapy soon after returning home.

Chad's parents could be described as competitive. In particular, his father was significantly occupied by and well known in the sporting world. Chad's mother described a strained marital relationship influenced by her husband being uninvolved in family life, and his having engaged in an extra-marital relationship. At the time of entering therapy Chad made use of a walking cane and read Braille. However, he completely denied not being able to see, and would become angry if mention was made of this, to the point of becoming aggressive. I met with Chad once a week, over a period of a year, in total for about 40 sessions.

Before starting the therapy process I generated hypotheses about presenting symptoms, anxieties and defences, based on the information I had gathered. During the actual therapy process these were continually tested for confirmation, and revised. My first hypothesis concerned how Chad being blind affected his parent's relationship, and conversely how their estrangement further increased his anxiety, something he had difficulty tolerating in the first instance. It seemed that the parents did not provide sufficient containment for their children or for themselves for that matter. I wondered how the family members were feeding off each other's anxiety, and how their anxiety gathered momentum.

My second hypothesis concerned Chad being an adolescent in the process of secondary individuation and psychic restructuring. I wondered if he had difficulty in the withdrawal of libidinal cathexis and disengagement from external and early identification with internalised objects (Blos, 1978; Freud, 1958). His progressive loss of sight would mean needing to be more dependent on his mother. This had manifested throughout his development as clinginess, and may have delayed development.

My third hypothesis concerned the affects of the libido being directed towards the body. This investment in the body would raise more anxiety than it would in normal circumstances, as Chad's body had in reality failed him. The extent of his anxiety and the persecutory nature of this were to a large extent dependant on the developmental stage at which his sight had first started to deteriorate. Early frustration, anxieties and phantasies could result in a persecutory superego and a division between the real ego and ego ideal. I wondered to what extent his oppositional behaviour related to an excessively harsh superego. This harshness could also have resulted in negative narcissism and vulnerability to depression (Holmes, 2001; Klein, 1963).

My fourth hypothesis concerned Chad's phantasy about burning down houses, and his denial of being blind. His escaping into a world of omnipotent phantasy could be a defence. To what extent did this result in poor reality testing and deficient ego functioning? I was concerned that he had already had problems with his aggressive drive during latency, a period of relative calm under normal circumstances. What would happen during adolescence, a period of elevation of aggressive and sexual drive (Freud, 1905; Freud, 1958)?

In summary, I thought that Chad was delayed in his developmental line, as the result of a significant stressor and inappropriate resolution and fixation in the early stages. At the time of initiating therapy Chad had difficulty tolerating and facing these anxieties and phantasies, as well as those applicable to the adolescent stage. I doubted that he could navigate his way through adolescence without the help of psychotherapy.

The first time I met Chad was at our initial psychotherapy appointment. His mother made the introductions. Chad was a tall, slim boy, with short brown hair and a smattering of freckles on his face. He seemed confident and sure of himself, and interacted in a friendly manner, with a good sense of humour. His clothing was appropriate, but perhaps not as fashionable as that of some boys. It was only when I spoke directly to him that I could tell he was blind. Chad did not speak about his friends, school, wanting independence or any other topics that adolescents usually speak about. Instead, he told me about his extraordinary abilities, including his superior ability to hear things. He asked if I was jealous of this ability. In general, our interaction was not what I had expected. His behaviour was more that of a child in the Oedipal stage. It was surprising how quickly this transference was re-enacted and how clear it was to identify.

Therapy continued to develop along lines that are not typical of adolescent therapy. Chad preferred communicating through the use of toys, and projecting into these his extensive and rich phantasy world. This was a unique process. His unconscious seemed to have easy access to the conscious mind. They appeared to be unusually fused, perhaps the result of failed repression.

There were a number of therapeutic themes and a variety of processes that we worked through. An initial one concerned his wish and phantasy of being a vampire. As a vampire he could fly, was very quick in his movements and had great powers. I was also aware of how vampires live in the dark, like Chad. He often referred to the sharp teeth he had, a weapon of the oral sadistic and oral cannibalistic stage (Klein, 1963). I thought this was where the fixation had likely occurred. Maybe this was due to his severe asthma and his deterioration in eyesight, both evidencing a failing body. The fixation occurred at a stage when sadism becomes active and reaches its height. In normal circumstances this is threatening to the ego (Klein, 1927 & 1933). For Chad this may have been further complicated as the ego, with its introjected psychic representation of the body, is first of all a body ego (Brenner, 1973). Chad's difficulty with breathing and taking

life into himself would, in this case, be an experience of an increase in threatening stimuli. As this occurred at a stage of incomplete development it would be more likely to have a traumatic effect. In order to escape this Chad may have treated the stimuli as if they were originating from the outside (Freud, 1920; Freud, 1966).

The consequence of this early projection taking place at the same time as introjection, was two-fold. First, the threatening qualities would be identified as belonging to the external object. Second, the persecutory object would come to reside inside self (Klein, 1933). Chad likely felt that he was being assaulted from both the outside and the inside by persecutory part objects, which may have resulted in him turning away from the reality principle during this period of infancy, towards the pleasure principle and the omnipotence of phantasy. In doing so he could deny the external reality and his vulnerability to it. Chad experienced the external world as a blind bat. But in his phantasy this blind bat went through a metamorphosis into an all-powerful vampire, who could suck the life force out of others. This meant that he would no longer have to be afraid of not being able to take life into himself, as he had been in infancy.

One of the things that I struggled with in the therapy process related to my countertransference feeling of being frustrated by my own tendency of continuously needing to escape into my own phantasy world. Many times, I felt as though the reality and our interactions were too slippery to hold onto. I continually had to battle with myself to bring my attention back into the room, to our interaction. This was partly resolved in supervision, where I came to understand these feelings as the result of projective identification. I had identified with Chad's frustration and his difficulty in choosing and maintaining the external objective reality. Therefore, I was able to see projective identification, not only as a defence, but as an object relation and a means of communication (Ivey, 1990). I also struggled to understand the complex transference, the part object that was being identified with, and what identity I assumed in his phantasy (Casement, 1985).

In any one session I was invested with different identifications of part objects. I could be the original pre-Oedipal castrating mother who had removed faeces, which were perceived as part of self during this stage of infancy (Klein, 1928). I think this related to Chad's phantasy of his mother having filed down his teeth, which he spoke about in therapy. I also soon assumed the identity of the castrating Oedipal father, who was threatening and experienced as a rival. I believe that because of my wish to understand him, we were able to progress in therapy, and in doing so I became a good-enough object that allowed Chad to resolve some of his early frustrations. In turn, this ushered in the more appropriate developmental period of adolescence.

Chad's working through the many anxieties relating to early object relations resulted in a toning down of his libidinal cathexis, which freed him to seek and pursue love interests outside the family. In therapy he started speaking about male friends at school and his experiences with consecutive girlfriends. His mother

confirmed that he actually had started to engage in such experiences. In therapy Chad started presenting with anxieties relating to sexuality. The de-cathexis of his early love objects not only resulted in his directing his libidinal energy towards other objects, but also in it becoming attached to his own body. This gave rise to his viewing his body as a source of potential danger. In reality his eyesight had indeed failed him. In phantasy he imagined passing on terrible diseases to sexual partners, and spoke of this in therapy. His guilt resulted in him moving from one girlfriend to the next in his real social interactions, albeit that such interactions were defined by innocent non-physical contact. Unfortunately, I did not have the opportunity to see the resolution of such anxieties, as my moving to another city resulted in termination of the therapy process. But, on a positive note there was no longer a significant delay in his developmental line. He had resolved some of the pathogenic origin of his excessive anxiety, which had manifested in the triad symptoms of inattention, impulsivity and hyperactivity.

As a result of constitutional factors, his body failing him and insufficient parental responsiveness, Chad failed to master the early developmental stages. This failure complicated each successive stage of development, which became increasingly distorted and delayed. In this context it is understandable why he needed to play rather than converse in therapy. I believe this is also the reason why he presented with neurotic phantasies about monsters, derivative of the oral and anal stages. In therapy he was developmentally delayed rather than emotionally regressed, which would be a more normal part of pre-adolescence. For these reasons, I believed that the exploration of psychodynamic issues, rather than the remediation of the neurophysiological or cognitive problems was appropriate (Smith, 1986). At the end of the therapy process Chad was functioning well, both at home and at school. He had successfully stopped his stimulant medication. In therapy I had become a whole object that existed in reality, an object that was both satisfying and frustrating.

Conclusion

In conclusion, the question of whether or not to accept an adolescent for psychotherapy is not an easy one. This process requires bearing in mind many aspects that could influence the success or failure of therapy. I have tried to outline some main points in this regard. I hope I have also illustrated that while psychotherapy may be of benefit to some adolescents, in certain circumstances, it could also be contraindicated in others. If nothing else, I hope that I was able to convey that while we spend much time assessing the mental health of the adolescent, we should be careful not to short-change the process of assessing for psychotherapy, especially in light of inevitable restrictions of resources. If therapy is an option, I think it is important to make sure that the adolescent will be able to maintain a therapeutic relationship and be able to benefit from the process.

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