CHAPTER 3

the therapeutic alliance with the adolescent

THE CONCEPT OF THE THERAPEUTIC ALLIANCE

Almost every form of serious psychotherapy requires that there be a therapeutic alliance or a working alliance between the therapist and the client. This is true of psychoanalysis and psychoanalytic psychotherapy (where the concept of the therapeutic alliance originated), as well as interpersonal psychotherapy, cognitive therapy, behavior therapy, hypnosis, client-centered therapy, transactional analysis, paradoxical therapy, family therapy, and group therapy. Furthermore, a therapeutic alliance is present in most uses of psychopharmacology. The therapeutic alliance refers to the collaboration between the therapist and the client, in which the therapist and the conscious, observing ego of the client work together on his or her problems. There is a pact between the therapist and the observing portion of the client’s ego aimed at an honest and uncritical examination of the client’s inner experience. The psychotherapist allies himself with the healthier, more reality-oriented aspect of the patient’s ego for the purpose of observing the maladaptive, neurotically defended, and conflicted portions of the personality.

There are some forms of treatment—which most practitioners would not consider psychotherapy—for which a therapeutic alliance is not necessary. For instance: a therapist might devise a behavior modification program for a teenager who has no interest in having his behavior modified; a practitioner might arrange involuntary hospitalization for a younger who currently has no observing ego to work with; a psychiatrist might administer psychotropic medication to a patient who is out of touch with reality. The talking therapies, however, require that there is a part of the client that wants to change. Of course,
many teenagers may desperately want to change some aspect of themselves, but are not the least bit interested in revealing that desire to parents, friends, therapists, or anybody else.

Early psychoanalysts identified the need to develop and utilize a conscious, cooperative portion of the patient's personality as an observing ally during the storms of transference feelings that appear during analysis. In Freud's 1912 paper, "The Dynamics of Transference," he pointed out that, paradoxically, transference is both the force that binds the patient to therapy and encourages cooperation, as well as the major resistance to analysis. In his book on analytic technique, Greenson (1967) emphasized the importance of this relationship with the therapist, which he preferred to call the "working alliance." Friedman (1969) reviewed the concept of the therapeutic alliance.

In working with adolescent clients, the first and most important step is the creation and strengthening of the therapeutic alliance. One of the major obstacles in developing a therapeutic alliance with an adolescent is the youngster's fear of dependency, which is most marked in the early adolescent. In fact, a major reason that the therapeutic alliance with the adolescent is fragile is that the therapist is trying to help the youngster see that he needs help despite the teenager's natural reluctance to collaborate with adults.

There are several specific techniques that the therapist may use during the early stage of therapy to encourage the formation of a therapeutic alliance (Meeks, 1997).

1. The key element in developing an alliance is the therapist's ability to respond empathically to the adolescent's resistance to the very process of therapy and to respond to manifestations of negative transference as they appear in the therapy meetings. The adolescent may not come right out and tell the therapist what he thinks about these lousy appointments, but may present his concerns in a disguised or displaced manner. For example, a 13-year-old boy gave his new therapist advice on how a person should approach an unfamiliar dog. The boy said that the person should not try to pet the dog on the head initially, since the dog may perceive that as a threatening gesture; but the person should put out his hand so
the dog can sniff it. The therapist agreed that the boy had a good plan for how to get acquainted with unfamiliar animals.

2. *It is important to accept without question the positive feelings that the youngster may have toward the therapeutic process.* This positive transference—although unrealistic—may help the adolescent get through the initial meetings and until he develops a more solid alliance with the therapist.

3. *The therapist should recognize and respond empathically to the adolescent's pain.* It is usually best to do this in an understated manner ("Gee, that was a rough time for you.") since teenagers are turned off by therapists who are "mushy" or infantilizing.

4. *The therapist can teach the youngster how to start the work of therapy.* There will be opportunities for the therapist to praise behaviors that indicate that the adolescent client is catching on to how the therapeutic alliance works. For instance, the youngster will open up a little about his concerns regarding family issues, friends, or some other significant topic. This is a chance for the therapist to comment in a positive manner ("It helps me understand your situation at home, when you told me what happened between you and your Dad.") and reinforce the youngster's tentative use of therapy.

WILL THE REAL OBSERVING EGO PLEASE STAND UP?

In adolescents, the capacity for self-scrutiny is something of a paradox. At times, the adolescent seems completely immersed in self-observation. Ruminative preoccupation with inner feelings, interminable musings over real or imagined inadequacies, and detached experimentation with new feelings states and altered states of consciousness all appear to signal the emergence of a capacity to stand aside and observe one's own psychological structure and functioning. This capacity is demonstrably unstable, however, and the adolescent also expends great effort in denying his impulses, affects, and needs. Often, this tendency to disavow his inner life is reinforced by an explosive tendency to act, rather than to think or feel.

A primary reason for this unstable state of affairs is the adoles-
cent's conflict with his conscience. The emerging capacity for self-observation can flower only as the harsh and unrelenting superego of early adolescence is gradually modified toward a more flexible and humane code of conduct. When the capacity for noncritical self-observation appears, many adolescent patients seem virtually to "cure themselves" with relative rapidity.

It should be emphasized that the primary function of the therapeutic alliance with the adolescent is to assist the youngster in understanding the link between his feelings and his behavior in the present. The adolescent's anxiety about the future and his fear of regression contraindicate extensive focusing on the genetic determinants of his behavior. Early developmental defects and severe fixations cannot be worked through during early adolescence because the necessary degree of regression would threaten the progressive thrust of the developmental period. Brief regressive episodes appear spontaneously and account for the fluctuating transference of adolescent patients. However, only the older adolescent can tolerate the careful study of these ego states. The therapist must usually focus his efforts on helping the adolescent to recover from regressions. As a rule, adolescents respond to a correct and appropriate interpretation by a progressive developmental leap forward rather than by further regression and exploration of genetics. If the therapist tries to interfere with this tendency by encouraging the development of a regressive transference, many adolescents will bolt from therapy. The conscious, rational alliance must be emphasized, not the irrational, infantile bonds to the therapist.

STRENGTHENING THE EGO IDEAL

Blos (1962) described the adolescent's use of a special friendship to accelerate the development of the ego ideal. The special attachment is made to a friend of the same sex, usually somewhat older. An important aspect of this attachment is that the older person displays some essential traits that are lacking or that the young adolescent feels are lacking in himself. These
traits are then idealized to provide the missing perfection of the self so that narcissistic balance is partially restored. This relationship is later internalized as a stabilizing but also liberalizing introject. The friend's values are gradually abstracted and detached from their origin and come to exist completely in their own right in the adolescent's mind. In the process of developing a therapeutic alliance with the adolescent patient, the therapist may find that he has become the youngster's "special friend" in the sense described above. Even when this does not happen, the therapist's permission to discover and relate to an older friend of this kind may be one of the most important gains in therapy

**FOSTERING THE THERAPEUTIC ALLIANCE**

Since the alliance is of central importance yet is often difficult to achieve even with the neurotic adolescent, the techniques and problems associated with this phase of therapy are discussed in some detail. This becomes even more crucial in brief psychotherapy.

The basic technique of establishing the therapeutic alliance is the timely interpretation of affect and defense. This process can be restated as helping the adolescent to recognize that his behavior is motivated by inner feeling states. Early in the therapeutic situation, these feeling states are commonly impatience, frustration, feelings of helplessness, and a sense of narcissistic impairment over the need to consult a psychotherapist. Some of the typical early defenses against these painful affects include rebelliousness; passive compliance; timidity; disdainful, condescending attitudes toward the therapist; and cool, aloof intellectualizing. Recognizing these defenses and the feeling states that they disguise is the first order of business in psychotherapy. This may be overlooked when the adolescent's primary defense is passive compliance. These adolescents appear to be "good" patients, eager to get right to work on their problems. The therapist should not be deceived into confusing this frightened obsequiousness with a true therapeutic alliance.

More often, the adolescent therapist must proceed to the clari-
fication of the connection between feeling and action by means of a difficult way station, namely, through interrupting the adolescent’s propensity to act in order to avoid feeling. When the therapist challenges this pattern, he is quickly cast in the role of a critical parent, a superego figure. It is a difficult but crucial undertaking to convince the adolescent that “Why did you do that?” is a neutral question, rather than a statement of moral disapproval.

SAVING NO THE EGO WAY

Adolescent acting up and acting out must be limited by the therapist. The only rational basis for the authority to direct behavior proceeds from the therapist’s knowledge of the conditions required for effective therapy. In short, the adolescent is told that his behavior is none of the therapist’s business except that some actions interfere with the therapeutic process and these must be controlled or therapy will not proceed properly. Often, it is also possible to demonstrate that acting out disrupts the youngster’s psychological harmony or threatens to harm him. The therapist tries to convey his wish that the adolescent win the developmental war while keeping it clear that it is the youngster’s battle and that the therapist cannot fight it for him. This position is more convincing to the adolescent when it becomes apparent that the therapist has the same benevolent, inquiring attitude toward all symptomatic behavior, whether it is “wrong” or not.

Sarah, a 15-year-old in psychotherapy because of promiscuity and poor academic performance, was openly skeptical of the therapist’s assertion that his disapproval of this promiscuous behavior was not based on moral indignation. She jeered at the assertion that there were reasons behind her behavior that she did not understand and which could not be explained by her statement that she was “hyper-sexed.” She continued to believe that the therapist was “another square” with “hang-ups about sex” who was trying in typical blue-nose fashion to interfere with her fun.

After some positive transference had developed, the girl
began to study secretly. Eventually, she brought an excellent report card to a psychotherapy session as a seductive gift to the therapist and as proof of her value. She was at first offended, and then amazed that the therapist did not praise her "good" behavior. Instead, the therapist noted that she did not seem to be enjoying the grades and that this suggested she had worked hard because she felt for some reason that it was expected of her. She talked for a few moments about her motives for improving her academic performance, then said, "You know, I've been telling you what a sex expert I am. Actually, the only reason I was willing to come see you in the first place is that I have never enjoyed sex. Not once. I love the idea of sex, but in practice it's lousy for me. Yet I practice and practice and practice. I know that sounds crazy."

The therapist agreed that this must be a puzzling state of affairs and suggested that he and the patient try to understand it together.

The adolescent is exquisitely sensitive to any manipulative control that threatens his tenuous sense of autonomy. Unless the therapist maintains his neutral, sympathetic but inquiring attitude toward all the adolescent's behavior, he cannot convince the adolescent that his goal is to foster understanding, not to dominate the patient through psychological warfare.

"DON'T KNOCK YOURSELF"

The therapist should be quick to point out tendencies toward judgmental and self-critical attitudes in the adolescent. The adolescent should be encouraged to look for the sources of his behavior, attitudes, and affective states, rather than call himself names. The goal of therapy is to increase self-understanding and inner psychological strength and flexibility, not to suppress annoying behavior. Often, the demonstration of therapeutic neutrality and of the motivational origins of behavior can be made effectively through the office interaction with the patient.

A 16-year-old boy started his first three therapy sessions
by slouching in his chair and lighting a cigarette. The therapist's inquiry about the meaning of the behavior made him angry. "You mean I can't even smoke in this crummy office?"

"I didn't say there was a rule against it. I just have noticed that you never talk about smoking, yet you light up the moment you hit that chair."

"So what?"

"So we're here to understand why you do the things you do."

"Because I want to, okay?"

"Well, if you want to go through a session standing on your head and playing a harmonica, I guess that's okay, but I'd probably ask you why you wanted to."

The boy grinned, and then asked carefully, "Are you going to tell my parents I smoke here?"

"We can talk about that in a minute, but I wonder why you're doing something here that you know your parents disapprove of."

The boy hung his head. "Yeah. I know I shouldn't smoke. It would kill my parents if they knew. I don't know why I'm always bad."

"I don't think it's going to help to criticize yourself. Let's try to understand what's really going on here."

"Well, I kinda wanted to see what you'd say about the smoking."

The smoking represented an attempt to corrupt the therapist by implicating him as an accessory in a forbidden behavior. Without a persistent effort to expose the reasons behind the smoking, the therapist would have been either maneuvered into a compromised position or forced into an arbitrary prohibition. In either case, no therapeutic alliance could develop. Later, when the therapist was calmly able to confront the boy with his tendency to manipulate people, the boy said, "Yeah, I like to have my way with them, I guess."

The therapist did not pick up on the sexual implications in the wording, but commented, "I'm sure there are reasons why
you can’t trust people enough to be honest with them. That’s one of the things we might try to understand."

Eventually, the boy was able to talk easily about what he called his “crook tendencies,” both in terms of their disadvantage to him and the situations in which they appeared. The capacity to observe himself in action and in feelings was finally achieved.

TOWARD TRUE FREEDOM

The youngster discussed above was finally able to realize that “just wanting” to perform certain actions was actually the end result of many forces within himself. This recognition is extremely important in the treatment of the adolescent. The startling realization that his freedom of choice is being sabotaged by unknown inner forces greatly strengthens the adolescent’s motivation for therapy. The young person’s wish for freedom and autonomy will then be a support to the therapeutic effort to change rebellion into true freedom and self-direction rather than merely to substitute slavish submission to instinctual drives for earlier submission to the parents.

Several psychological forces within the adolescent interfere with his acceptance of this liberating insight. The typical narcissistic, omnipotent defensive conformation of adolescence, reinforced by the preoccupation with formal operations and the omnipotence of thought, is severely threatened by the idea of unconscious motivation. The adolescent feels a desperate need to see himself as absolute master of his fate. The idea that he is not infinitely malleable but must adapt himself to his own instinctual drives, his own conscience, and external social demands is offensive and frightening. The flip side of total control is total helplessness. When the bubble of his omnipotence is punctured, the adolescent tends to feel completely vulnerable and pitifully weak. The therapist must be extremely supportive and sometimes quite forceful to convince the adolescent that ignoring a fire in the basement or merely trying to “think it away” is an excellent way to get burned. The therapeutic support consists of helping the adolescent to see that his real abili-
ties to devise methods of putting out the fire or confining it to safe areas are much greater than he thought. In short, the therapist supports the adolescent’s ego skills to discourage his reliance on magic omnipotence.

'TIS AN ILL WIND—

It is important not to drift into a pattern of only observing and studying pathological and maladaptive behaviors within the therapeutic alliance. A fair and objective evaluation of the adolescent will always reveal areas of strength and competence, often unrecognized by the patient. These must be included in any total observation of psychological functioning. This is also true of the adaptive value of ego defenses. For example, a distrust of appearances may result in interpersonal touchiness in the adolescent, but it also characterizes the personality of many successful social and scientific innovators. If the adolescent is to learn to trust the objectivity and honesty of the therapist, he must have the opportunity to see the therapist patiently look at all sides of every question. This strengthens the client’s faith in the therapist’s position of friendly neutrality. It is a demonstration of the therapist’s wish to avoid intruding and his determination to provide the adolescent with as much information as possible so that the youngster is better prepared to reach his own decisions.

ADOLESCENT ATTITUDES TOWARD A THERAPEUTIC ALLIANCE

The wishes and fears with which adolescents face the beginning of therapy have very little congruence with the goals of the therapist. Consciously, the adolescent is fearful of becoming embroiled in another dependency relationship, whereas unconsciously he hopes and fears to find in the therapist the gratification of various irrational and childish wishes. Because of these emotional currents, the adolescent typically utilizes various techniques to avoid the establishment of a therapeutic alliance. He may project negative attributes onto the therapist or externalize
his difficulties and invite the therapist to criticize or reject him. Other adolescents attempt to convert the therapeutic situation into a friendly parent-child relationship in which they will be advised and assisted. Others are overwhelmed by massive superego pressure and can only condemn themselves and beg for mercy.

UNHOLY ALLIANCES

The distortions of the therapeutic relationship just described can usually be managed by the patient application of the principles previously enumerated. However, Keith (1968) described in a timeless paper another group of resistances that he appropriately designated as "unholy alliances." These must be recognized and avoided in order to achieve a usable therapeutic alliance. Keith classified these structurally as unholy alliances (1) with the id, (2) with pathological ego defenses, and (3) with the superego.

Id Alliances and the Swinging Therapist

All of the unholy alliances are dangers with the adolescent patient. Id alliances are especially seductive, since the therapist is often eager to appear more understanding, tolerant, and "hip" than the other adults whom the adolescent criticizes. The therapist who finds himself discussing specifics of sexual behavior, techniques of outwitting parents, or the absurdity of official authority early in therapy may well suspect that he has been drawn into an unholy alliance with the id or with id derivatives. The result of such an alliance is the weakening of the adolescent's controls and an upsurge in impulsive acting-out behavior. The lack of a true alliance may be demonstrated through overt hostility that the adolescent soon directs toward the therapist, probably with the unconscious goal of inviting external control. It is of crucial importance to avoid this alliance with the adolescent because of his tenuous controls and his resultant fear of his strong feelings and impulses. Because of these fears of loss of
control, many adolescents will react to an id alliance with intense anxiety that leads to defensiveness, silence, and attempts to avoid the entire therapy process. The therapist is viewed as an actual threat, a tempter who is encouraging them to lose control of themselves and give rein to the worst aspects of their nature.

This pitfall can be avoided by remembering that it is unwise to interpret or discuss aggressive or sexual material until the distinction between thought and action is clearly established and the adolescent understands that the therapist’s encouragement of free expression includes only thoughts and feelings. Only a comfortable recognition that the therapist is opposed to impulsive and unwise action can create a proper atmosphere for the open expression of strong feelings and lead to a true therapeutic alliance. To fantasize that one is omnipotent is a dangerous luxury. It is a game of pretense that the therapist must not play even temporarily. Stated differently, the adolescent can never be seduced into a therapeutic alliance, and the therapist who attempts to deal with his uncomfortable patient in this way is likely to end up with an unworkable and unholy alliance with the id.

A 15-year-old girl was referred for psychotherapy after her parents learned that she and her boyfriend were having sexual intercourse regularly. In early sessions, she admitted that she was promiscuous and eagerly volunteered specific information on her sexual fantasies and adventures in seduction. The therapist ignored her racy stories and merely commented repeatedly on the absence of affect in her friendships as well as her cool and distant way of relating to him. Her titillation gradually ceased and she began to describe her feelings of contempt for all her sexual partners and eventually her wish to outsmart the therapist and show him up as “another dumb, horny male.”

Over a period of time, it was possible to create a friendly and honest therapeutic alliance that allowed a moderately successful exploration of the girl’s serious character problems that had prevented her from forming close emotional
ties. Therapeutic results were first apparent when she began to develop satisfying friendships with girls for the first time since early childhood.

Alliances with Pathological Ego Defenses

The primary pathological ego defense that may be utilized in an unholy alliance by the adolescent is intellectualization. The intelligent, psychologically minded adolescent, often well read in popular psychology (or even Freud, Erikson, Fromm, etc.) can discuss fascinating insights for hours on end while remaining totally untouched by therapy. The defense may even be actively used to act out competitive and demeaning attitudes toward the therapist under the guise of enthusiastic cooperation. If the therapist, relieved that he does not have to struggle with one of those belligerent, uncooperative adolescents, joins in an alliance with this defense, a therapeutic alliance will not appear. Instead, therapy will deteriorate into sterile, philosophical discussions gradually producing feelings of boredom and despair in both therapist and patient.

There is a place in the therapy of the adolescent for ideological discussion and even for the defense of intellectualization. However, it is important first to establish a therapeutic alliance strong enough to allow the experiencing and reporting of affect. This can only be accomplished by refraining from extensive discussion of conceptual content early in therapy when affective contact has not been established with the adolescent. The intellectualizing patient should be asked to define all jargon such as "hostility," "ambivalent," "erotic," "incestuous," "really meaningful," "I-Thou relationship," and the like. He is asked what he means by those words and asked to tie them to concrete experiences and his feelings during his involvement in those real-life interactions. The therapist, of course, avoids any technical terms, using instead emotionally laden, everyday words such as "mad," "angry," "burned up," "sexual," and even slang sexual phrases if these do not seem unduly seductive with the specific patient.
Generalities are discouraged and specifics are sought. The goal, of course, is to bring real emotion into the session. When affect does appear, either in the description of events outside the psychotherapy session or in direct relationship to the therapist, this is encouraged by a demonstration of interest and acceptance.

An 18-year-old college freshman was seen for psychiatric evaluation when he became psychotic following the ingestion of LSD. Even after the brief overt psychosis cleared, he remained rather grandiose, preoccupied with cosmic issues of good and evil. Psychotherapy with limited goals appeared feasible despite the fragility of the personality structure.

Initially, the general philosophic structure and preoccupation were accepted, although not encouraged. The therapist occasionally interjected the observation that personal feelings were important and seemed absent from the patient’s thinking. The patient’s objection that he intended to rise above his feelings was received with friendly skepticism. The extremely intelligent young man was reminded of historical examples in which philosophical systems were distorted by the personality quirks of their innovators. At the same time, the patient’s infrequent references to “human weaknesses” in himself were applauded as evidence of his desire to know himself and thereby avoid the blind errors of other ideologists. Gradually, a capacity for self-observation was developed, although the therapist had to continually disavow the patient’s attempt to cast him in role of maharsha.

The conviction that people did not rise above their feelings was constantly reiterated and was demonstrated to the patient in his own behavior whenever possible. The therapist himself continually insisted that his only area of competence was in understanding emotions and that this skill was the result of special training, rather than any supernatural power or mysterious talent. Gradually, the patient was able to admit that much of his aloof, mystical superiority cov-
ered anxiety and feelings of inferiority and that philosophical detachment was often his way of dealing with feelings of frustration and helplessness.

Greater caution was necessary in approaching the intense anger that he covered with a fervent pacifism and masochistic turnings of the other cheek. Only after repeatedly showing him evidence of his capacity to have strong feelings without acting on them was it possible to comment directly on his anger. The intensity of his fear of losing control of his aggressive impulses was illustrated by his delusional projection of a “conspiracy of evil” that he felt was trying to make him “homicidally insane” during his initial psychotic episode.

Since adolescents place such importance on logical thought and ideological speculation, it would be a gross technical error to dismiss their intellectual efforts in therapy as useless and unacceptable resistances. Instead, one accepts intellectualization but does not support it. The therapist continues to point out that feelings are also important. A patient and persistent effort is made to bring affect into the therapy hours without making a direct critical attack on the defense of intellectualization. The therapist does not ally himself with the pathological ego defense, but neither does he try to force the adolescent to abandon it before he is ready. In behavioral terms, the therapist positively reinforces affective expressions and attempts to extinguish intellectualization by failure to reinforce that behavior.

To a lesser extent, adolescents may attempt to draw the therapist into alliances with other pathological ego defenses, especially denial and reaction formation. In these instances, the therapist maintains his neutrality and encourages greater objectivity without directly assaulting essential defenses. In the emergency states that appear during adolescence, many pathological defenses will be utilized by adolescent patients. The wise therapist approaches them with respect and caution, but it is rarely necessary for the therapist to give his stamp of approval to distortions of inner or outer reality.
THE THERAPEUTIC ALLIANCE

The Unholy Alliance with the Superego

It is almost impossible to avoid completely an unholy alliance with the superego in adolescent psychotherapy. It is natural for the adolescent to maneuver to externalize his conscience. This developmental characteristic will be brought into the adolescent's relationship with his therapist, since it is universally present in the adolescent's interactions with all significant adults. This propensity is commonly expressed by the strategy of acting up provocatively to seduce important adults into meting out sadistic punishment. The therapist, as an important environmental figure, must be constantly alert to the danger of being drawn into this kind of relationship with the adolescent patient. The unavoidable technical requirement to limit defensive acting out automatically places the therapist in a precarious position from which he can all too easily slide into a superego alliance.

A 13-year-old boy's easygoing amiability was successfully interpreted as a resistance against his inner feelings. The boy's father was an angry, harsh, competitive man who frequently struck the youngster whenever he challenged any of the father's rules or statements. The youngster was able to discuss some of his anger in a session during which he was able to recognize that his excessive deference and compliance toward the therapist was a defensive continuation of a pattern that he utilized with his father to cover his inner feelings of rage.

In the next session, however, he was silent and sullen. Near the end of the session, he suddenly stated that he was "going" and headed for the door.

The therapist, rather surprised, tried to keep him in the room, and a mild shoving contest developed. The therapist recognized his error and was not surprised to encounter a very negative youngster in the next session.

He discussed the boy's need to "pick a fight" and indicated his interest in understanding how the boy felt about remaining in the office. The youngster was congratulated
on the honesty he was demonstrating in his relationship with the therapist and was assured that his anger could be discussed.

Of course, the adolescent does need to externalize superego issues in order to find ways to modify his harsh conscience while using the external agent as a temporary protection against the unwise expression of impulse. The adolescent therapist can expect to be used in this way and can be helpful by tolerating some distortion of his intentions. An almost daily example occurs around the question of continuing therapy during difficult periods. Some version of the following conversation is a periodic commonplace during the therapy of many adolescents.

Adolescent (in anger): I never did need to come here. I sure as hell don't need you, and I'm not coming back in here for any more of these silly talks.

Therapist: That's not too surprising. We both know you have a tendency to run away from things when they make you too nervous, but you're strong enough to stay and talk about your feelings.

Adolescent: Why should I sit through this? Do I have to come back?

Therapist: You know that you need therapy. That's not the question. What are you really up to with all this quitting talk?

Adolescent: Okay, I'll be here next week. I should have known you wouldn't let me quit.

Therapist: Why do I have to stop you from doing something that wouldn't be good for you?

Adolescent: Aw, forget it. I'm not going to quit your precious therapy.

Therapist: Sorry, I can't forget it. Just not quitting won't cut it. We need to look at how you're trying to set me up.

Adolescent: God! Even my parents aren't this hard to get along with.

Therapist: Maybe they're mainly interested in how you behave—what you do. I'm interested in why you do things and how you feel. Sometimes it's easier to do what you
think I want than to look at your feelings. The only reason that it's any of my business whether you quit or not is that it would interfere with your therapy.

Adolescent: Very funny! But you did say that I need to stay in therapy. You are telling me what to do!

Therapist (laughs): Yeah. Simon Legree rides again.

Adolescent: Aha! You admit it!

On it goes as the adolescent forces the therapist into a superego role. Still, the therapist must resist the temptation to criticize the adolescent for his provocation, to threaten him, or otherwise behave in a punitive way. This does not mean that the therapist avoids superego issues. Later, we consider the methods of dealing with material in this area in a way that encourages emotional growth.

The immediate point is that only the observing ego is a dependable ally in therapy with the adolescent. Even when a superego alliance produces a diminution of acting-out behavior, there is little true gain in maturation. The surface improvement tends to be ephemeral in most cases. In other instances, it is maintained through an ascetic constriction of personality that chokes off spontaneity and the capacity for pleasure—a terrible price to pay for superficial socialization. There has been no gain in independence and autonomous control in either case.

RECOGNIZING THE ALLIANCE

If the therapist is able to avoid unholy alliances and to respond with appropriate empathy, tact, and precision to the adolescent's defensive operations, evidence of a therapeutic alliance begins to appear. It is important to recognize and acknowledge this important new skill in the adolescent without implying a paternalistic endorsement of "good" behavior. Perhaps, the most meaningful acceptance of the alliance is a comment that merely recognizes its value in the therapeutic process. Its value is purely "instrumental." It is a tool that permits more effective therapeutic work.

In order to credit the adolescent with his discovery, however,
it is necessary to recognize its appearance. The alliance may show itself in various forms, depending on the style and personality of the adolescent patient. One recognizes its presence primarily through a subtle change in the tone of the sessions. The atmosphere is somehow no longer totally adversarial. The therapist recognizes intuitively that he can relax somewhat, since his patient has at least become interested in observing and understanding the frightened, wary, guarded, and devious styles of relating that have characterized him in earlier sessions. In short, the therapist no longer feels that he is working totally alone in opposing the patient’s resistances.

CHECKPOINTS FOR THE ALLIANCE

This general "feel" for the situation can be checked against some behavioral specifics that usually attest to the development of an alliance.

1. *The client expresses an interest in introspection.* For example, the youngster occasionally says, "I'm not sure I know why I did that," or "I think I understand why I got so upset," or "Can you understand what I really was upset about?" In other words, the client demonstrates a tendency to reflect on his affective experience, or at least a willingness to allow the therapist to suggest an underlying motivation for an intense feeling state. This is particularly meaningful if the affective experience in question directly involves the therapist, as "I think the reason your comment made me so angry is—-"

2. *A switch from threatening actions to discussing thoughts and exploring their origins.* Instead of "I'm not coming back here," a change to "When you say things like that, I get so angry at you I feel like quitting."

3. *Paradoxically, the development of the therapeutic alliance may also be indicated by a more tolerant attitude toward episodes of loss of impulse control.* These episodes are discussed with moderation and objectivity, rather than withheld, bragged on, or criticized with an air of self-loathing. The attitude is not merely intellectualization, however, since the accompanying affects are not
isolated but are discussed. The adolescent can say, “I lost a battle, but overall I feel I’m winning the war.”

4. A recognition and discussion of affects appearing during the session. The patient is able to comment, “I don’t know why, but this discussion makes me very nervous.”

5. A recognition and acceptance of ambivalence as an internal reality. No longer “My parents treat me like a baby,” but rather, “Sometimes I want to grow up, but at other times it scares me to death.”

6. A reflective, curious response to appropriate confrontations and interpretations rather than a defensive, critical reaction.

All of these attitudes may appear as isolated occurrences without signaling the arrival of a therapeutic alliance. They represent merely some specific behaviors that may serve as checkpoints for verification of the general air of cooperation described above. Without the overall sense that the therapist has been accepted as a working partner, these behaviors mean nothing.

MAINTAINING THE ALLIANCE

The therapeutic alliance is a delicate structure that is constantly threatened by the anxiety that results from its operations. The successful functioning of the alliance leads repeatedly to upsurges of aggression and erotic feelings that are threatening to the working coalition, especially since these feelings frequently become directed toward the therapist. The adolescent, with his constant search for real objects, has great difficulty in understanding the meaning and nature of transference. We discuss the overall management of transference in adolescent psychotherapy in the next chapter. It is mentioned in this context merely to note that it is a major force acting against the maintenance of the therapeutic alliance.

The fluctuations that characterize ego functioning during adolescence are themselves a threat to the steady maintenance of a therapeutic alliance. During periods of marked regression, the rational therapeutic alliance may be scuttled along with
other reality-oriented ego functions. The adolescent therapist must be flexible and adapt himself to the startling changes in level of functioning and defensive patterning that the adolescent shows from one session to the next. The adolescent patient himself often does not view these "moods" as changeable reflections of aspects of the self. He tends to see each new ego state as the way he "really" feels and the way life "really" is. The therapist must try to utilize the therapeutic alliance to assist his patient in accepting his complexity and variability. It has been suggested that when the adolescent seems to ask "Who am I?" the therapist can often be most helpful by replying, "Many people. It depends on circumstances inside you and conditions around you." The therapist assists the adolescent to maintain a sense of "wholeness" and personal continuity despite rapid and puzzling changes in mood and attitude.

EXTERNAL THREATS TO THE ALLIANCE

In addition to internal dangers, the alliance may also be threatened by external events. Parents may unknowingly or consciously sabotage the alliance for a variety of motives. Possessive parents may be threatened by the affectionate tie between the therapist and the child. Controlling, hostile parents may view the therapist as an agent of their control and convey this image to their youngster. Other parents may actually be threatened by the improvement they observe in the adolescent if these changes interfere with family patterns that are important to neurotic stability. Some ideas regarding the management of these problems are presented in chapter 8, dealing with the parents of the adolescent patient.

Other external occurrences may produce such intense affects that the adolescent is forced to erect rigid defenses that cannot be explored for a period of time. These occurrences may be the illness or death of an important person in the adolescent's world or an overwhelming defeat or disappointment in the adolescent's personal struggle for competence and acceptance. During
these periods, the adolescent needs to withdraw and mourn. The therapist must recognize the legitimacy of this need and accept a role of passivity and empathic sharing until the adolescent is prepared to work again. More active intervention during such a period may permanently impair the therapeutic relationship. These instances do permit the therapist to observe the adolescent's style of dealing with loss. When the mourning process goes awry or is avoided by the adolescent, the therapist may act to encourage the appropriate expression of grief and the constructive adaptation to loss. However, when the adolescent's grief and mourning are appropriate, the therapist should remain unobtrusive and grant the necessary time for the work to be completed.

WHAT TO DO UNTIL THE ALLIANCE COMES—AND WHEN IT DOES NOT

The therapeutic alliance may simply never materialize. This can result from the failure to respond accurately or effectively to early defenses or affects in a particular patient. In these instances of therapeutic error, an open discussion of the problem may permit a new start. If this is not possible, transferring the patient to a different therapist may be considered. Before carrying out transfer, however, it is worthwhile for the therapist to examine his decision closely to be sure his plan does not merely represent a rejection of the adolescent based on countertransference. Even when this proves to be the case, a transfer may still be in order. However, the therapist and the adolescent will benefit if the real reason for the transfer is recognized and discussed.

The problems are somewhat different when the patient was simply never a candidate for outpatient psychotherapy. No matter how carefully the diagnostic process is conducted, some errors will occur. When this is recognized, one must present the problem and the new recommendations to the patient and his family without undue embarrassment or apology. This situation is discussed further in the chapter on termination.
WHY DOES THE ADOLESCENT STRIVE FOR THE ALLIANCE?

After surveying all these problems, one might wonder why the therapeutic alliance ever survives the vicissitudes that it meets. These negative forces we have just enumerated are countered by two positive effects that tend to balance them. The first of these is the sense of freedom and release that usually results from increased self-awareness. The adolescent is motivated to persevere because of the sense of mastery that accompanies therapeutic gains. This rational advantage is bolstered by the adolescent’s pleasure in the identification with the therapist. The frequency with which adolescent patients develop the ambition to be a psychotherapist reveals both the identification and, at least very often, the defensive fear of passively losing identity unless they turn passive into active and “go the therapist one better.” In our opinion, this defense should not be challenged. Instead, the adolescent should be permitted to regard himself as a junior partner and eventual peer so long as he does not use his psychological insight destructively toward himself or others. After all, when the therapeutic alliance is functioning properly the adolescent is literally functioning as his own therapist much of the time. Even when the adolescent uses his newfound skill destructively, the perversity of such a practice can be interpreted without attacking the identification.

Sarah, the 15-year-old girl with the symptom of promiscuity described earlier, had many preoedipal problems with her mother. In the middle course of therapy, she had developed considerable expertise in observing and interpreting her behavior and feelings. During this time, she related an interchange with her mother. The mother saw the patient’s kittens, already quite large, nursing the mother cat. She reacted with anger and disgust that such large kittens “would not leave their mother alone.” Sarah interpreted her mother’s disapproval of libidinal pleasure and associated to her mother’s negative statements about sexuality. She then told of accusing her mother of being chronically unhappy because of neurotic self-denial (a correct interpretation, by
the way). She told the mother she really should see a psychiatrist. The mother became quite angry and criticized Sarah for needing psychiatric help, since that revealed her lack of “true Christianity.”

Sarah was initially indignant at her mother’s reaction “when I was only trying to help her.” The therapist noted he had been unable to detect much sympathy or understanding in Sarah’s comments. Could it be that Sarah was angry and critical of her mother, simply using her insight as a more effective weapon of attack?

Sarah was able to accept the interpretation and turn to an exploration of the origins of her overreaction to her mother’s attitudes toward the cat. She eventually recognized her identification with the aggressively demanding kittens and her guilt because her mother acceded to her wishes but then induced guilt through an air of sadness and martyrdom.

Later in therapy, she came to a sympathetic and affectionate understanding of her mother. She was able to support and encourage the mother to find community activities in which the mother’s dependency needs could be met comfortably and without shame or disgust.

EVIDENCES OF A FAILING ALLIANCE

The recognition that the therapeutic alliance has collapsed usually comes from the same intuitive grasp of the total therapy situation that was mentioned as the best evidence of the presence of the alliance. One senses a new tendency toward opposition, not so much toward the therapist but toward the work of therapy. Again, the therapist senses that he is struggling alone in his efforts to utilize the therapeutic session to aid the process of self-understanding. The adolescent is no longer manning one of the oars, and the therapist must row the boat upstream without assistance.

There are isolated events or checkpoints that help to confirm the overall impression:
1. An absence of any evidence of self-observation and exploration. The adolescent is again immersed in experience and shows little interest either in understanding his role in creating his personal emotional experiences or in dealing effectively with these experiences.

2. Subtle or gross actions directed toward the therapist that are dismissed as unimportant even when they are noted. Examples would include coming late, missing sessions, interrupting the therapist, frequently misunderstanding the therapist's words, and other manifestations of hostility, but also bringing gifts, praising the therapist, and other seductive behaviors.

3. The reappearance of defensive attitudes that were previously interpreted, understood, and discarded. Again, this is accompanied by a bland disregard of the implications of the behavior.

4. A return of manipulative behavior and attitudes toward the therapist. Stated differently, there is a return to neurotic interpersonal interaction with the therapist expressed in action rather than verbalized for exploration.

REESTABLISHING THE ALLIANCE

If the therapist identifies a disruption of the therapeutic alliance, he can then work to repair it. The therapist should recognize that no other work will be useful until the alliance has been reestablished. No matter how much inherent interest the content of the sessions may hold, the therapist should utilize only that portion of the material that may help to rebuild the therapeutic alliance. In the absence of a working alliance, the therapist's intervention will be ineffective or even antitherapeutic.

How, then, can the therapist reestablish the alliance? The first step is the identification of the cause of the disruption. As mentioned above, the most common sources of disruption are the anxiety and uncomfortable affects released through the activity of the therapeutic alliance itself. One very honest 13-year-old, confronted with her resistance, stated the problem succinctly: "The trouble with looking at yourself is that it doesn't feel good."
Of course, this is the very stuff of which therapy is made. The therapist should accept the inevitable fact that properly conducted psychotherapy produces pain and all people try to avoid pain. The adolescent patient has every right to complain about this and to expect his therapist to sympathize. Mankind has always chafed under the painful demands of reality. Surely, we can be sympathetic and supportive when the adolescent frets at these nettles. Of course, the therapist’s sympathy is directed at helping the adolescent to bear this realistic fact of life, not toward shielding him from it.

When confronted with a break in the therapeutic alliance, the therapist needs tactfully to acknowledge with his patient the change in their relationship. Often, the therapist will have to explain to the adolescent that his change is not viewed as “goofing off,” obstinacy, or rebelliousness. The distinction between resisting the therapist and resisting the therapeutic process often needs extensive clarification if the adolescent is to learn how to observe this interaction objectively and without feeling criticized by the therapist. It is essential to help the adolescent to understand that his interactions with the therapist will be treated in the same objective, curious, nonjudgmental way with which the therapist responds to his other affective experiences.

Tammy, an attractive 17-year-old girl, requested psychotherapy one night in the midst of a family row over her poor school performance. She told her therapist that her real reason for wishing to be in therapy was a feeling that life was passing her by and that she was unable to form close friendships that were meaningful to her. Over the first few psychotherapy sessions, Tammy formed a warm relationship with the therapist and utilized her capacities for introspection with some success in understanding her relationship to her hard-working, intense, and somewhat driven mother. She was able to recognize that her poor academic record reflected both a repudiation of her mother’s anxious way of life and a fear of competing with the mother.

Throughout this time, she periodically complained that she did not seem to be popular. Although she first blamed
this unpopularity on her moral standards, which she felt were higher than those of most of the girls at her school, she gradually recognized that she was somehow “turning off” the boys who showed an initial interest in her. As this became a focus in therapy, the therapist commented on the fact that Tammy did not seem to take her femininity seriously and seemed in many respects to treat relationships between boys and girls as though they were a game that did not involve any intense feelings. Tammy’s response at the time was to distort the comment somewhat and to state defensively that she has engaged in some necking and that she was not afraid of sexuality.

However, in the next interview Tammy was visibly anxious and found it difficult to talk. She fidgeted in her chair and regularly pulled at her skirt. She tended to avoid the therapist’s direct gaze and frequently blushed whenever she would try to speak. After a few minutes of this, she was able to become somewhat comfortable, but seemed to be talking at a very superficial level and showing none of her characteristic curiosity about her own feelings, thoughts, and behaviors.

When the therapist commented that it seemed Tammy had lost a good deal of interest in exploring her feelings, Tammy felt that she was being criticized. After the therapist clarified that this was not the case and suggested that feelings about therapy and the therapist could be openly discussed, Tammy was able to say that she was feeling somewhat annoyed with the therapist when she left the previous session and was aware that she was quite upset. She stated further that she could not remember the topic of discussion from her previous session and volunteered that this was unusual for her, since as a rule it was quite easy to remember her sessions. The therapist supported her honesty in this and encouraged her to continue talking about any reactions that she might have had toward the therapist.

Initially, she spoke with some timidity, but gradually this
diminished as Tammy began to complain that the therapist was "finding problems" that she did not know she had. Because of this, she could not be sure whether therapy was helping her or making her worse. She noted that generally she enjoyed a good mood most of the time but that she has been rather depressed for the entire past week. At this point, the therapist reminded her that he had commented that she sometimes treated life as a game and refused to take it seriously and suggested that perhaps she found this necessary because of some tendency toward depression, which she was attempting to avoid. The therapist supported her honesty in facing up to some of these sad feelings and wondered with her which course of action held the greatest promise in the long run.

“Well, if you can stand a blubbering idiot, I guess I can weep my way through it. I suppose I’ve known this all along myself,” Tammy replied.

It seemed that Tammy’s discomfort was related to sexual feelings toward the therapist that were activated by his direct recognition of Tammy’s femininity. However, in the absence of a therapeutic alliance strong enough to deal with this kind of material, the appropriate response was in the direction of dealing with the uncomfortable affects stirred by the therapy process in the interest of reestablishing a therapeutic alliance. The techniques of management of sexual transference in adolescents are discussed in the next chapter.

If the disruption of the alliance arises from some unfortunate event in the adolescent’s life, a period of unobtrusive and undemanding support will need to precede any attempt to reestablish a therapeutic alliance. As mentioned above, the therapist must allow the adolescent to take the initiative in indicating an interest in continuing the exploratory work of the treatment unless the grief reaction itself is seriously distorted. More likely than not, the adolescent will indicate his readiness to go back to work by complaining, “We don’t seem to be getting much done in here lately!” The complaining adolescent may be quite sur-
prised to see his therapist, somewhat worried during the mourning period, suddenly smile and say, "Man, I can't tell you how relieved I am to hear you say that! Let's get with it."

Parental sabotage of the alliance must be recognized and differentiated from stresses arising from the therapy itself. Often, parental interference is signaled by comments that disavow previous areas of conflict with the parents. The adolescent, on the contrary, reports "therapeutic sessions" with the parents and may imply that they can help him more than the therapist. Especially if such periods coincide with or follow anxious phone calls from the parents, the suspicion of parental sabotage is justified. These problems are discussed more fully in a later chapter, but it is well to recognize that the problem cannot be handled unilaterally with the adolescent patient once it has reached this level. The parents themselves must be helped either through a collaborative therapist or directly by family conferences.

THE ALLIANCE IN PERSPECTIVE

The therapeutic alliance is not only essential to any psychotherapy; it coincides with an important developmental task of the adolescent period—the emergence of the observing ego. Therefore, the development and maintenance of a therapeutic alliance with the adolescent patient assume a double importance. We have explored some of the particular problems and pitfalls in establishing a therapeutic alliance during this phase of psychosexual development. We have also tried to point out that the maintenance of the alliance is inextricably linked to various other aspects of therapy, especially the transference tendencies of the adolescent and the problems of the adolescent's parents. The capacity to establish a therapeutic alliance is an essential skill for the therapist of the adolescent.

At this time therapists are struggling to treat increasing numbers of adolescents whose problems make it extremely difficult for them to develop a classical therapeutic alliance. Because of severe defects in their sense of self they cannot even grasp the
concept of growing through honest self-scrutiny and often cannot understand the therapist's role as a separate and helpful human being. In the next chapter we will try to understand the subjective experience of these youngsters and to explore techniques for helping them.