

Paweł Glita

**ADOLESCENT PATIENT AND HIS THERAPIST IN THE FAMILY CONTEXT  
– A PSYCHODYNAMIC APPROACH**

Private practice

**psychodynamic adolescent psychotherapy  
compliance with parents  
transference and countertransference**

**Summary:** The goal of the author is to propose a psychodynamic model of understanding the transference and counter-transference phenomena, which take place in the triangle patient – individual therapist – patient’s parents. By analyzing examples of destructive patterns of interaction appearing in the context of the psychotherapy of adolescents, the author tries to show how those patterns are unconsciously activated by the participants of such situations, in what way they be the consequence of their psychopathology or problems and what influence they can have on the process of treatment. The main goal of the article is to help the therapists to efficiently deal with the intense counter-transference emotions and to use such responses to produce an even deeper diagnosis of the patient. The author discusses also the issues of the possibility and limitations of the formula of coexistence of the individual psychodynamic psychotherapy of the adolescent patient and a systemic family therapy. The issue of the influence of therapist definition of his own role on the ability to prevent destructive results of the processes taking place within the transference – counter-transference triangle.

**I. Introduction**

When asked about the greatest difficulty in their job, adolescent therapists not uncommonly respond that it is cooperation with parents. The answer disguises many difficult experiences, such as lack of alliance needed for the adolescent patient’s good, inadequate expectations of the therapist, questioning his authority in the patient’s eyes through subtle or overt devaluation, dragging the patient away from the therapy at pivotal moments, torpedoing positive changes, and many more. Problems encountered in cooperation with parents instigate a range of therapist’s emotional reactions, starting from a sense of helplessness to aggressive attitude towards parents. Helplessness results from the fact that he cannot refer to parents in purely therapeutic terms; after all, it is an adolescent who is the patient, not his parents. The therapist may display aggression by getting into ‘diagnosing’ psychopathology in parents rather than in the patient himself. At times, accumulated emotions of that sort lead the therapist to perceive parents as enemies of the therapy and nurture escalating dislike for each other, which can lead the therapy to fiasco or involve the adolescent patient in the conflict of loyalty between parents and the therapist. The therapist’s primary threat is the loss of therapeutic

neutrality, understood as an ability to maintain equal emotional and cognitive distance from different sides of the conflict, both intrapsychic and interpersonal.

However, although most of the therapists may have gone through difficult cooperation with parents, it must be noted that in some way they give as good as they get. What I mean here does not pertain only to behind-the-scenes abreactions or cutting remarks, but also certain disapproval exposed in theoretical discourse. It is an already known phenomenon, both in various trends of psychotherapy, as well as in psychiatry, which has occurred in the work with schizophrenic patients, for instance. It is also present in Frieda Fromm-Reichmann's concept of "Schizophrenogenic Mother" and an early version of the "double bind theory" [1], which seeks causes of schizophrenia in the family. In addition, it also appears in psychogenic theories of childhood autism whereby the disorder is seen as a consequence of the premature attachment disorder [2]. Explicit or implicit criticism of the patient's (not only adolescent) parents came also from the doctors or psychotherapists who were exceptionally devoted to their patients (such as Bettelheim), and was manifested in blaming parents for their children's psychopathology. From today's perspective, it can be seen as a consequence of mindless embracing of various psychoanalytic theories which underlined the importance of early parent-child relationship (mother) at the expense of biological and constitutional factors. However, when analysed as a therapeutic process within the psychoanalytic framework, the dislike for the patient's parents most often results from unconscious and uncritical identification with the patient's part that suffers, gets angry, devalues parents, and idealises the therapist. Therefore, it is experienced by those therapists whose patients use, as part of their psychopathology, the mechanism of splitting for fixation and regression related purposes. I think it is a crucial phenomenon and will discuss it in depth later in the article.

The article aims at putting forward a model for understanding intricacies in the therapist-patient-parents relationship, which would reduce the risk of the adolescent patient's therapy failure as a consequence of getting entangled in an unfavourable triangle emotional interaction, simultaneously helping the therapist to stay neutral. These relationship-related phenomena and their understanding will be described in psychoanalytic terms. In particular, the article will make references to a psychoanalytic theory of the psyche, as well as to Katarzyna Schier's theory of the transference and counter-transference triangle [3] with an attempt to elaborate on them by referring to concordant and complementary counter-transference reactions proposed by Racker [4], and then developed by Kernberg, among others [5].

My opinion, which holds that the model suggested may not only reduce potentially destructive aspects, but also use them constructively in the course of the adolescent's therapy, should not be considered an instant remedy to the difficulties emerging in the therapist-patient-parents relationship.

It is obvious that these relationships involve therapeutic situations, where everyone is helpless and no one, regardless of the therapeutic approach, knows how to proceed. For instance, it is a situation, where significant discrepancies arise on understanding the meaning of a good change, especially in case of separation. As another example can serve the patient's negligence by the environment which does not call for the intervention of state authorities as yet, but largely reduces possibilities of the therapy.

Analysing the cooperation with the adolescent patient's family within the context of individual psychodynamic psychotherapy, I would like to refer to opportunities and limitations of running two therapeutic processes simultaneously in two different orientations: individual psychodynamic psychotherapy of the adolescent and systemic family therapy. I am aiming here to present possible advantages, limitations, and risks related to such a situation.

## **II. Is it possible to specify optimal degree of parental presence (absence) during the adolescent individual therapy?**

Therapists working with adolescents hold very different opinions about the optimal degree of parental presence in the adolescent individual therapy, depending on their preferred way of thinking. Their attitudes range from the belief that, bar from the preliminary stage, parents should be excluded altogether from the therapy (some psychoanalytic trends, starting from Freud's and Klein's) to the stance according to which the adolescent therapy should always, if possible, involve regular presence of patient's parents [3].

Psychoanalysis-oriented therapists also agree that adolescent psychotherapy is always embedded in the family context. Therefore, family representation inferred from the thought content provided by the patient and unconsciously reconstructed in a therapeutic relationship will be the primary reference for psychodynamic and psychoanalytic therapists. From such a point of view, the problem arises as to whether, in addition to dealing with a conscious and unconscious representation of the family in the adolescent's mind, the real presence of the family is beneficial or not.

The trends implying that the contract, under which parent's presence would be limited or none, could be a solution in this respect does not seem convincing to me. It is easy to understand the source of such an approach— the strong parental presence often complicates transference and counter-transference processes, whereas their absence helps maintain a clearer overview of the patient's psychopathology and processes taking place in the therapeutic relationship. However, even the most conservative therapists in this respect have to take legal circumstances, such as a consent to therapy, into consideration. Moreover, such understanding of the family context necessitates, or at least advocates, entering into a therapeutic alliance with parents and setting up preliminary objectives of the therapy. These would include, for instance, concretising parents' expectations or agreeing on the

applicability of the word 'pathological' under specific circumstances. However, some therapists may decide not to get parents involved at this stage already. Cultural and legal conditions of the contact with parents also include issues related to therapy frames, such as therapy confidentiality and exceptions to its rules (risk to human health and life), fees, cancellation of sessions, and others. In yet more general terms, they entail the necessity of taking into consideration the patient's real conditions, as well as the influence of the real parental objects with whom his relationship is based on childlike dependence. This in turn becomes especially important in the therapy of younger adolescents.

In the context of psychoanalysis, a psychogenic symptom is primarily understood as specific and inadequate adaptation to the pressure from contradictory internal (e.g. derivatives of drives) and external factors, including family ones. The symptom whose primary gain consists in avoidance of suffering can at times get reinforced by the family who unconsciously strengthens its secondary gain. It is commonly observed that an adolescent begins to change pathological mechanisms and object-relationship patterns, but at the price of alienation or the conflict with the family environment he was "adapted" to (and vice versa). Shifting from the acting-out behaviour (e.g. by using the body) to verbalisation of an affect can end with the parents' ears exposed to difficult things, previously "acted out". At such moments, the active therapist, who practices convincing psychoeducation, can have the beneficial impact on the permanent therapeutic change. In the same vein, parents' general understanding of the background of problems experienced by the adolescents whose psychopathology consists in the most difficult forms of resistance, can turn them into the therapist's allies. It is common in the case of phobia, panic disorder, eating disorders (libido adhesiveness) or character disorders (characterological resistance), which are rare at adolescence. Yet another form of parental help can be needed in the case of adolescents whose psychopathology is largely determined by some defects, or who are brought up in extremely harsh environment.

Even though parental presence causes aforementioned difficulties, I think that banning parents from contacting the therapist and refusing them any feedback is a too costly solution. Many parents simply cannot stand such frames of the therapy. Also, with such frames upheld, patients are subjected to strict selection.

However, I also cannot agree with the contrasting opinion, whose advocates sometimes claim that the majority of the problems discussed may not even arise if from the very beginning the adolescent therapy considers as necessary some form of the therapy for family members. In my opinion, it is not that obvious, especially in the case when parents send the child for therapy, but do not want to undertake any work themselves. Then, we are facing the dilemma whether to take up the therapy if parents do not support it or do harm to the adolescent patient. Should we then reject the individual

child therapy? In many cases, usually when the family does not retain secondary gains from the symptom, it seems unnecessary.

Some therapists solve the problem of parents' contribution to therapy by striking up a clear contract which obliges them to various forms of co-participation, such as regular consultations at the time when the therapist is entering into contact with the adolescent. If parents do not consent to such a solution and the adolescent is not in acute condition, the therapy does not commence [6]. It is a clear course of action, yet doubts arise with regard to its validity in benign forms of psychopathology and the potential risk of discarding the essential in an attempt to get rid only of what is undesired. Undeniably, the contract with the parent, made to uphold the frames of therapy, is a good practice. However, what is also needed includes psychoeducation on the possible course the therapy can take, instances of resistance, abreactions, or the time needed for improvement. Cooperation is absolutely essential in the case of antisocial disorders; it is necessary that the therapist have a realistic overview of the patient's functioning outside of therapy and be able to estimate how deeply seated are his antisocial tendencies in order not to fall under the illusion of improvement.

In all probability, there are no definite answers to the question why therapists opt for a given form of therapy and not some other. Perhaps one should seek answers not so much in substantive indications, but rather in therapists' personalities, the record of therapeutic training, and relationships with their model figures. As a psychodynamic therapist, I believe that for the majority of disorders, individual therapy gives a unique opportunity to establish a therapeutic bond which other forms, including group therapy, cannot offer. They are different and complementary to each other, yet many therapists still consider the individual therapy as primary treatment, nurturing an intimate relationship which can bring about most deep-seated changes. It is of special importance in the treatment of adolescent patients with inappropriately developing personalities or personality disorders established in early life, that is where alterations to intrapsychic structures are essential to make permanent changes [5].

The opinion I would like to present and justify in this article falls in between the two aforementioned points of view. Having experienced various difficulties during my work with parents, and seeing how repetitive in nature they are by supervising other therapists, I was seeking some theory to help me grow some distance from these phenomena. Browsing the professional literature for the information on this subject, I came across a theory developed by Polish researcher Katarzyna Schier, whereby emotional phenomena in the therapist-parents-patient relationship can be captured under the term of a transference-counter-transference triangle. The term suggests it is a good idea to refer, from the very beginning, to the relationship with the patient and family in terms of transference and counter-transference, yet with consideration for the fact that in the adolescent therapy these relationships are not dyadic in nature, but triangle, and sometimes, if parents differ from each other, quadrangle. The

therapist's emotions with regard to parents can be the result of their contribution to the relationship, as well as an expression of his usually unconscious identification with the picture of parents as created by the child in one-to-one contact. Patient's emotions to the therapist, in turn, can be the result of his transference projection, as well as of the relationship the therapist maintains with parents. Therapist's counter-transference emotions to the patient can derive both from the reaction to the patient's transference and his unconscious identification with parents. These phenomena can occur within each arm of the triangle [3]. Yet, so long as the theory seemed to me very valuable and useful for clinical purposes, it left me unsatisfied. My sense of the theory's insufficiency stems from the belief that it still could be expanded to show why and how (based on what mechanisms) these phenomena apply to specific clinical situations, or why and under what circumstances they have destructive impact on the adolescent's therapy. At this point the question arises as to what action the therapist can undertake when he sees a given scenario being played out. In my deliberations to follow I will attempt to develop Katarzyna Schier's theory with the abovementioned aspects.

Let us analyse several characteristic phenomena taking place within given "arms" of the triangle to help recognise destructive types of interactions that are played out. Usually, such recognition spontaneously alters the therapist's attitude, which does not mean that the change must be reflected in any specific action.

### **III. Emotional dynamics within the transference–counter-transference triangle**

Types of interactions will be grouped by the "triangle" member from whom comes the transference impulse.

#### **1. Patient-therapist relationship:**

a) The therapist identifies himself with the sense of harm and injustice did by a hostile, deserting or neglectful parent, and begins to respond to the adolescent's regressive needs in order to become a "perfect parent". He is starting to experience himself countertransferentially as someone who could be a better (perfect and omnipotent) parent than real parents, and thus unconsciously begins to act aggressive and compete with them. Parents, in turn, may at times feel it and respond emotionally, turning against the therapy through non-verbal and indirect signals to the child ("It's raining today, maybe you will not go to therapy today?" or "Is this whole therapy of any use to you?", among others). Such a collusion with the patient satisfies the therapist's narcissistic needs, whereas the patient feels he stays in touch with a perfect object, someone who "finally understands him". At times, the therapist-patient relationship can abound in very positive feelings, whereas the patient's external relationships worsen. Parents tend to be blamed for all evil, both by the patient, and his therapist. Sometimes this can assume extreme forms of countertransferential acting-out on the therapist's side consisting in unjustified threats of family court issued against parents or over-interpreting as violence any family

conflicts the patient is involved in. This is a common scenario in the case of patients who try to resist adolescent depression by means of various mechanisms, ranging from regression to splitting and idealisation. Believing in an ideal object helps them relieve developmental sadness stemming from disappointment with parents, failed relationships with peers, and loss of images of a safe world.

A different and more subtle therapist-patient relationship is established when the therapist and patient share mutual idealisation with simultaneous disregard for the parent, who reacts not so much with aggression, but rather with relief at the partial discharge from parenthood. At times, in the case of parents with child care problems, this can even turn into a certain form of abandonment. Under such circumstances, idealisation is not subject to interpretation, and the therapy, at times based purely on such a positive (?) bond, is run undisturbed by parents. The bond upholds an illusion that a long-wanted object (therapist), who finally satisfied dependency and idealisation-related needs, was found at last. Usually, the meaning of therapist's words is of no importance; what matters instead is the very fact of him speaking. Such a relationship seems to take on the form of defence against developmental mourning and depressive moods, both from the patient and therapist's side. However, there are some circumstances in which it is worth considering whether such a form of relationship is not all we may offer to the adolescent patient at a given time.

The moment we see such a relationship develops, we face the dilemma of how to react. This problem was mentioned in the discussion concerning treatment of narcissism suggested by Kohut and Kernberg [7]. Their theories contained contradictory (or different) understandings of idealisation. According to Kohut, idealisation can be construed as activation of frustration-driven developmental needs for having the parental object to admire and be proud of. Sensible and reserved acknowledgment of idealisation is considered a positive phenomenon. According to Kernberg, idealisation is primarily a form of defence against the aggressive side of the self and/or relationships with other people which bring detrimental effects. It is because the mechanism establishes an artificial and incomplete relationship, which prevents from the integration of its positive and negative aspects in the real life. Deliberations on whether we deal with two kinds of idealisation in this case, or on how to differentiate between them, and what therapeutic strategy should be applied, are crucial for the adolescent therapy, but go beyond the scope of this article. Yet, it is worth noting that none of the theories hold that considering idealisation as "the truth" about the therapist, either consciously or unconsciously, is a positive phenomenon.

b) The adolescent patient projects his unconscious needs of childhood dependency and idealises the therapist who, in turn, reacts in an overprotective manner by relieving the patient of developmental tasks (e.g. contacts parents too often and holds conversations on behalf of the patient, while this should be his own developmental achievement). This practice shares some similarity with the former one, yet

it is of a subtler nature and is commonly adopted in treatment of developmental disorders in adolescence.

c) In response to antisocial, arrogant, boundary-crossing, and disparaging behaviour of the adolescent, the therapist begins to understand more parents' problem than the patient's (e.g. his behaviour as a form of defence against depression). Such a pattern of behaviour stems from the phenomenon contradictory to the one described in point b). In this case, the analyst is in complementary countertransference identification with the patient, and concordant countertransference identification with his parents. As a consequence, the therapist usually loses empathy for the suffering side of the patient's self and turns to treating him unnecessarily as a juvenile psychopath or narcissist, relying, in his harsh diagnosis, on one's own unconscious emotional reactions. If such an attitude persists, the therapist comes to an understanding with parents who also feel understood by the therapist. Consequently, they may quote his words at home and induce the therapist to a specific child-raising alliance against the child. The patient can sense it and starts to perceive the therapist as a representation of his parents' criticism, which usually builds distrust and evokes aggression to the analyst. More prone to such identification are those therapists who are parents themselves and struggle with behaviour issues with their own children.

## 2) Therapist-parents relationship

a) Another example pertains to all cases, where the therapist, due to having his own adolescent problems only partially disentangled, excessively identifies himself with the adolescent patient and unconsciously projects specific intentions and attitudes onto parents. For instance, if the analyst runs a hidden dialogue with social norms, then he considers them as overcritical and limiting patient's natural separative tendencies, simultaneously remaining blind to their vengeful or aggressive personalities. Prone to such identifications are usually young therapists, fresh graduates, who account for a large group running youth therapies. If analysed in terms of Erik Erikson's concepts of the developmental tasks and crisis, they seem to be in almost the same stage of life as their patients. They lack their own parental experiences, which shows in reduced empathy for parents' concerns. Parents, in turn, perceive such therapists as immature; they are negatively predisposed to them, which often provokes an attack on the relationship with the patient.

b) Yet another example refers to the case where the therapist and patient share common difficult experiences, which leads the therapist to believe, usually wrongly, that he understands adolescent's problems particularly well. These may include both very clear experiences like parents' divorce, and subtler ones like rejection by the cold, narcissist mother or passive and withdrawn father. Common experiences give grounds for strong identification with the adolescent. If done consciously, such a practise rarely brings a positive impact on the therapeutical process. Empathy and identification

processes, strengthened by commonality of experience between people living in the same culture, lay foundation for every bond, therapeutic bonds notwithstanding. When unconscious and related to pathological areas, they turn disadvantageous. The therapist's unconscious identification with the adolescent patient may lead the analyst to unwittingly suggest his patient such ways of handling difficult situations that he himself finds effective or that have worked out for him. The in-depth analysis of such relationships usually produces surprising findings. At times, experiences are not as similar as the therapist finds them. His assumption can be based on the patient's idealisation and therapist's projection of his own past experiences on the adolescent. Recommended solutions may not always prove constructive, either. This stems from the fact that under such circumstances therapists tend to reject psychotherapeutic theories in favour of emotional intimacy with the patient, which usually means working according to one's own private "theory".

c) The therapist's fear of recognising (counterresistance) parents' pathology and their aggression, of one's own aggression and anger with them and, consequently – wrong recognition of the child's circumstances and course of treatment, are also detrimental to the therapy. Such a scenario usually takes place in the relationship between the young, diffident therapist and confident parents who impress him or are, in his opinion, more life experienced. Therefore, it happens when the therapist makes patient's parents the object of unconscious idealising transference, often in concurrence with hidden devaluation of himself. If the therapist perceives parents in this way, he may have the tendency for putting pressure on the adolescent to make changes faster or even for meting out emotional punishment. This obviously leads to complications in the relationship with the patient.

### 3) Parents-therapist relationship:

a) For most parents, coming to the therapist strikes at the narcissistic side of their personalities. It proves they did not cope with their children's upbringing, are not competent enough to educate them or of little worth as parents. They have a tendency for taking on total responsibility for the child's problems, and unconsciously provoking the therapist to judge them, reasoning backward, and encouraging him to treat them like patients who need help. In response, the therapist enters into an unnecessary quasi-therapeutic relationship with parents and undertakes previously agreed psychotherapeutic interventions on them. In return, this may spark off various transference reactions from parents, ranging from growing dependence, through heightened idealistic expectations and pressure, to a sense of abuse and aggressive break-up. Under such circumstances, the patient is left aside or the therapist's understanding of his problems is significantly disturbed by countertransference processes within therapist-parents relationship.

At this point it should be noted that some degree of firmness and a capacity for setting out conditions for parents in order to enable the child's development and therapy (e.g. a condition under which a 13-

year old patient does not sleep with his mother in one bed) are beneficial for patients. In exceptional circumstances, consideration can be given to whether parent(s) should be advised to undertake therapy themselves as a condition for the child treatment. Equally disadvantageous seems shunning (out of fear) from any interventions with regard to parents, such as simple clarification, even if it could facilitate therapeutic relationship with the patient. The most reasonable stance to take in this respect is to understand (diagnose) parents' problems and maintain an air of authority over them, but work using psychoeducation and one's own justified therapeutic ideas.

In order for the therapist to feel comfortable with his interventions on parents, it is essential to indicate a general criterion differentiating between therapy and psychoeducation. The therapist seems to cross the boundary of psychoeducation the moment he starts to direct his interventions to parents' unconscious affects and mechanisms, moving beyond overall entanglement of psychological dependencies in the patient's family considered essential for his good. If parents invoke therapeutic interventions or, in the therapist's view, need therapy (individual, family or couples therapy), he should suggest it. A usually well-received comment goes like: "You are asking me a lot of questions it would be possible to respond if I could relate to your own problems and personal experiences. If I did, that would be an abuse since we have not agreed that. And yet another thing – it would hinder my role of a therapist for your daughter/son. However, on the whole, it is good when parents are in therapeutic or psychoeducational relationship with another therapist, concurrently with the child's therapy. This is what I would like to suggest". The therapist may at times face the dilemma of whether this should be only a "suggestion" or rather a condition for the therapy with the child.

In my opinion, there is no room here for the reasonable "third" work method, the one between psychoeducation and parental psychotherapy, as Schier suggested [3]. Careful psychoeducation is not a quasi-lecture for parents, but a sketch of family affairs, hence a form of transmission which moves and induces changes in their attitude to the child and therapy. The therapist clarifies their behaviours and emotions, but refrains from interpreting unconscious motives standing behind these behaviours at home and destructive transference. If he does not stop at this point, the analyst reinforces transference–counter-transference processes only to get entangled himself. I believe that the therapist's emotional capacities have a limit, beyond which it is impossible to stay neutral (e.g. in case of very frequent contact with parents).

b) Parents' adverse, usually narcissistic-natured reactions, such as silent and hostile withdrawal, denying any influence over the child, or refusal to cooperate (e.g. in case of referral for therapy issued by national institutions), and then a demanding attitude, therapy devaluation and therapists altogether. The therapist's counter-transference response may vary, too. Entering into an overt or hidden sadomasochistic relationship (based on who-dominates-whom dependency) is here the greatest threat.

It can assume the form of the aforementioned quasi-therapy, manifesting therapist's anger, his attempt to dominate parents and force them to submission. Giving up the use of therapeutic varieties, coming into conflict with parents or making aggressive comments ("It is you who are to blame for his symptoms"), usually applied as defences against being undermined, can be another possible reaction. The influence of such a relationship on the patient can vary, too. First and foremost, it can strengthen the therapist's identification with this side of the patient which rebels against parents. In such circumstances, recognition of his aggression-related problems is altogether overlooked. What can also occur is the emotional repression of parental rights, which in some cases induces the therapist to undertake unnecessary actions in the external world, e.g. bring the case to family court or invoke various community interventions. (Surely I do not refer here to instances of real violence or abuse with regard to which such interventions are fully legitimised).

The reactions discussed in the above point comprise one of the groups most difficult to handle. The therapy under such emotions often proves impossible. Identification of the source of parents' antisocial tendencies and their reinforcement is an overriding objective at this point. The therapist's strong counter-transference identification can lead him to interpret parents' aggression as an expression of their psychopathy, not as a defence against narcissist anxiety or threat. At times, even a simple gesture, showing parents that we are not going to question their parental competencies, calm things down.

c) With the development of the therapeutic relationship, parents' way of its experiencing can change; for instance, they can be unconsciously jealous of their child's intimacy with the therapist and consider therapy effects as detrimental. For instance, a mother displaying symbiotic tendencies will consider her so-far inhibited son's self-reliance and behaviours like scrimmaging as his deterioration. In extreme cases, the therapist can be perceived as someone to "rescue" the child from. He, in turn, can make an attempt to destroy his work, attack the bond, or belittle parents in return.

d) Lastly, there are all non-defensive, "primary", and aggressive reactions of the parents who have various overt borderline personality disorders and send the child to therapy for the reasons other than its treatment. Usually in such cases therapy is impossible. These are the most difficult circumstances due to the fact that they bring about the strongest counter-transference reaction and biggest helplessness, too. The majority of possible counter-transference reactions have already been described above and they include, for instance, strong identification with the child, sadomasochistic impulses, and fear of venting one's anger on parents. In the case of strong emotions and insufficient therapist training, it is more likely that the therapist will abreact the counter-transference.

I realise this general overview of possible scenarios may frustrate therapists in need of exact suggestions on how to cope with aggressive parents. However, firstly – there is usually not much that can be done, secondly – this would require a detailed description of the issues related to defining

frames of the therapy for patients with aggressive parents [8], and lastly – every such case must be discussed under supervision in a therapeutic team.

It can be generally stated that the ease of experiencing an array of counter-transference emotions in the relationship with parents and recognising their potentially pathological character can have a very positive impact on the child's therapy. It is due to the fact that counter-transference projection onto parents is an invaluable source of information on the patient's feelings that he himself may be denying (e.g. what is the source of his, conscious or not, aggression, and to what degree it is justified). It is a general and very important piece of diagnostic information about the patient's emotional circumstances and the impact they may have on his way of experiencing emotions.

I have mentioned that application of this theory may help to avoid destruction in the therapist-patient-parents relationship. Yet, are we able to specify what relationship with parents we are striving for and what relationship with them is beneficial for the adolescent's therapy? It can be generally stated that we aim at such a relationship with parents whereby they are our allies with whom we share, despite different understandings of given circumstances, common care for the child's good. Therefore, the alliance between adults must prevail over competition and narcissist issues.

The use of the suggested model may seem extremely difficult, whereas the number of possible complications in a triangle relationship – huge. However, if we look closely at given examples, it turns out that all of them illustrate concordant and complementary counter-transference reactions described by Racker [4]. Kernberg's additional contribution [5] to this subject consisted in evidencing in a detailed manner that these identifications do not need to refer to other people whatsoever, but to certain aspects of their personalities, the more so if their psychopathology is based on mechanisms of dissociation and splitting. The specific nature of psychodynamic psychotherapy for the youth consists in the fact that the therapist can identify such reactions both in the relationship with the adolescent patient, and the parent. In the first relationship, such reactions can be used for therapeutic purposes, while in the second one, the therapist can incorporate his internal observations into psychoeducation, but also use them to refrain from any action getting him entangled in destructive plays. He can also initiate specific actions in the external world. The adolescent therapist's exposure to the pressure of getting entangled in the patient's external world is definitely greater than adult therapists', especially when one has to deal with externalising disorders, and parents' presence prevents the therapist from staying neutral.

The above remarks also point out what should be additionally incorporated into the training program of the adolescent therapist. Training workshops during which a trainee therapist holds a

preliminary consultation with the patient showing problems similar to the therapist's at his age are invaluable in this respect.

#### **IV. Cooperation with family therapists**

I would like to share some reflections on a common model of the two concurrent therapies: systemic family therapy and the child's individual psychodynamic therapy in order to show its possibilities and limitations.

The psychoanalytic perspective considers it a priority to turn to the patient's inner world by clarifying, confronting, interpreting, and upholding a relationship that fosters internalisation of positive aspects of the object. From this point of view, the family psychotherapy appears, along with drug therapy and various community interventions, one of the ways to exert an impact on the patient's external reality, that is an attempt to change the inner world by an extra modification of some element from the external world, or an alteration of the external element only (to protect the patient, for instance).

From this perspective, family, couples or parent's individual therapy can often prove beneficial for the patient's individual therapy. Some psychoanalytical and psychodynamic circles negate this opinion or even read it out as a sign of disloyalty and only partial identification with one's own paradigm. As it is easy to guess, I do not agree with this statement. Despite these voices to the contrary, it should be noted that thoughts on combining actions targeted at both external, and internal sides of the patient, including the family's involvement, have been present, though to a small extent, throughout the development of psychoanalytical thought. The beginning was marked by Little Hans' therapy to be followed by the model of psychotherapy for children and adolescents construed by Anna Freud [8], Winnicott's works, and a contemporary model of the therapy for adolescents and adults with personality disorders conceived by Otto Kernberg and associates [8]. In spite of getting involved in various forms of cooperation with the family, all these therapists remained prominent psychoanalysts who gave priority to the patient's inner world.

In my opinion, reaching for various interventions directed to the patient's external reality is driven by the therapist's awareness of the limitations of his method with regard to specific mental disorders and diseases. An in-depth individual therapy may sometimes lead the therapist to think he has great influence on the patient's inner world at the price of paying no attention to etiological factors other than psychogenic. A hidden feeling of omnipotence and absolutisation of one's own method can appear as side-effects of such an approach. Meanwhile, there has been no empirical evidence hinting at the possibility of curing schizophrenia-related or affective disorder solely with psychotherapy, with no drug therapy. Yet, there are numerous studies proving that the best results in such cases are achieved

by combining interventions focusing both on the world of the patient experience and his external reality [e.g. 11]. From the perspective of the individual psychodynamic therapist, a referral for family therapy can be an abreaction to helplessness, but can also result from the therapist's recognition of the limitations of his method, regardless of the subjective level of intimacy with the patient. Apart from limitations of the biological nature, there come into play certain forms of inherent personality resistance (which happens rarely in adolescent therapy), in the case of which family support can be useful. Another limitation is posed by the phenomenon called adhesiveness of libido based on the perpetuation of some destructive forms of giving vent to sexual and aggressive drives, which is common in addictions, perversions, and eating disorders. Yet, individual adolescent therapists refer for family therapy most often because of various deficits, either in the patient or his environment. An illustration of such circumstances can be the case of a mental disease, where psychoeducation or family therapy can be beneficial so long as it serves as an auxiliary ego when some of the patient's functions are disturbed (examination of the reality, rational thinking, taking care of oneself in social, financial and other terms). Yet another such a situation would be the case where the family environment of the adolescent patient is unable to take care of him. Deficient parents usually reject such a recommendation; if they have not cared about the child so far, they will not change under the influence of therapy. However, if the family therapy does start, adolescent therapist's and family therapist's visions may also differ. At times, the adolescent therapist expects, not always directly and adequately, someone (e.g. family therapist) will assume the role of the "overparent" of the patient's own parents in order to support and teach them how to fulfil protective function with regard to their own child. Therefore, he more or less consciously advocates the scenario where the family therapist takes on the role typical for the structural family therapy approach. Meanwhile nowadays, it is a rarely held view, sparking a lot of controversy among family therapists due to the skewed character of the therapeutic relationship, understood as a subtle form of inadmissible authoritarianism.

From the individual therapist's point of view, cooperation with family therapists is also beneficial when both forms complement each other in terms of going through primary and secondary gain derived from the symptom (it is also the area where these two approaches diverge from each other most). If my understanding is correct, from the perspective of systems psychology, a symptom arises in the identified patient in relation to his covert usability for the system. For instance, depressive disorders developed in an eighteen-year-old or anorexia in a seventeen-year-old can make for coping with separation anxiety of parents and the adolescent, making them focused together on themselves and strengthening mutual involvement in their own life. From the psychoanalytical perspective, such an approach to the problem describes well what is called a secondary gain derived from the symptom. The symptom gets reinforced by various benefits provided by the environment. Yet, classical

psychoanalysis sees the function of the symptom differently; a primary gain<sup>1</sup> is essential for its appearance. Although the symptom is the source of suffering, it protects against the greater one, driven by admitting into consciousness affects, defences, or representations that constitute unacceptable and unconscious aspects of the self (through super-ego or out of fear of real consequences). Simultaneously, the symptom is a compromise-formation because it protects against admitting forbidden content into consciousness on the one hand, but also partially expresses and satisfies it on the other [10]. The form it will take depends on the defences used; for instance, in neuroses, they will include those related to repression, whereas in borderline disorders – to splitting [7]. The depressive symptoms in an eighteen-year-old may be interpreted as a compromise solution to the unconscious conflict between repressed developmental separation tendencies or anger with parents (e.g. for control) and a desire to avoid the risk of losing their love (separation anxiety), coming to the end of the relationship with them altogether (depressive anxiety), or an overwhelming sense of guilt (superego anxiety). Depressive moods may be a partial and passive expression of aggression directed to parents. Only such symptoms can get secondary reinforcement and become established by benefits coming from the environment. It is one of the reasons why psychodynamic therapists are sceptical of the possibility of treating chronic personality disorders without an intensive analysis of the unconscious defences, splitting, or patterns of experiencing in the relationship with the object. Meanwhile, from this point of view, the systemic therapy comes in as an adequate therapeutic response to all sorts of family and developmental crises or reactive disorders, but also supports the individual therapy in removing secondary gains derived from the symptom<sup>2</sup>. It seems that in the adolescent therapy the cooperation can be based precisely on the complementary working through primary and secondary gain from the symptom.

However, some risk appears here as well. Using an array of theoretical assumptions and construing the picture based on numerous clinical experiences, therapists can come up with contradictory explanations of the adolescent patient's psychopathology, as a result of which the patient will be subject to contradictory therapeutic interventions. It does not happen very often, though occasionally it does, especially when therapists are entrapped in different and unconscious identifications projected on various parties of the family conflict, that is when they do not realise the loss of therapeutic neutrality. Differences between therapeutic identifications will delineate the boundary of agreement between therapists, but they may also establish a kind of illusionary agreement for the sake of cooperation. In my opinion, a more favourable solution here is to acknowledge differences by both

---

<sup>1</sup>Developed by Freud, it is one of the most prominent and still valid achievements.

<sup>2</sup> I am not sure if systemic therapists would agree. The analysis described above is rather a risky interpretation of only one therapeutic paradigm (systemic) in relation to another one (psychoanalytic). Hence, it is methodologically controversial.

sides and accept the fact that cooperation is impossible. From the point of view of the psychodynamic therapist, the number of problems arising on defining causes of disorders and understanding the therapeutic process falls when the family therapy is held from the psychoanalytic perspective.

### References

1. Barbaro B, red. Schizofrenia w rodzinie. Kraków: Wydawnictwo UJ; 1999.
2. Bettelheim B. Uciekinierzy z życia. Leczenie dzieci zaburzonych emocjonalnie. Warszawa: Wydawnictwo Akademickie Dialog; 2004.
3. Schier K. Terapia psychoanalityczna dzieci i młodzieży: przeniesienie. Warszawa: Pracownia Testów Psychologicznych; 2000.
4. Racker H. Transference and countertransference. London: Karnac Books; 1988.
5. Kernberg OF. Object relations theory and clinical psychoanalysis. New York: Jason Aronson; 1976.
6. Harris M, Bick E. The child psychotherapist and the patient's family. W: Williams MH, red. The Tavistock model: Papers on child development and psychoanalytic training by Martha Harris and Esther Bick. London: Karnac; 2011, s. 251–272.
7. Kernberg OF. Borderline conditions and pathological narcissism. New York: Jason Aronson; 1975.
8. Yeomans F, Clarkin JF, Kernberg OF. Psychoterapia skoncentrowana na przeniesieniu w leczeniu zaburzeń osobowości borderline. Podręcznik kliniczny. Kraków: Polskie Towarzystwo Psychoterapii Psychodynamicznej; 2015
9. Edgecumb R. Anna Freud. Gdańsk: GWP; 2007.
10. Freud Z. „Ja” i „To”. W: Freud Z. Psychologia nieświadomości. Warszawa: Wydawnictwo KR; 2009.
11. Alanen Y. Schizofrenia. Jej przyczyny i leczenie dostosowane do potrzeb. Warszawa: Instytut Psychiatrii i Neurologii; 2000.

address: glita@poczta.onet.pl