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DIFFICULTIES IN THE ESTABLISHMENT OF PSYCHOTHERAPEUTIC RELATIONSHIPS WITH ADOLESCENTS

BY

WILLIAM HAMILTON AYRES

A thesis submitted in partial fulfillment of the requirements for the degree of

DOCTOR OF MEDICINE

at the

UNIVERSITY OF WISCONSIN

1956

INTRODUCTION

The goal of this paper is primarily to present brief summaries of five case histories of children age 13 through 16, in the period of adolescence, who were seen for varying lengths of time in psychotherapy. The primary attention is to be focused on the nature of the relationships that it was possible to achieve and the difficulties encountered in these patient-therapist relationships.

As a background for the presentations of these case histories, some mention will be made of the concepts of adolescence and problems of adolescent psychotherapy that have contributed to the orientation of the therapist. There has been an immense amount of material that has been written in regards to the complexities of the adolescent process and the attendent difficulties in initating psychotherapeutic relationships with children in this particular developmental period. It is not within the scope of this paper to attempt a thorough review of this literature. The discussion will be restricted to mention of those concepts advanced by some of the workers in this field toward attempting an understanding of adolescence as it is related to the therapeutic situation. The first part of the paper will thus be devoted to the nature of the adoles-

cent process, the therapeutic approach to the adolescent and the difficulties frequently encountered within this approach, while the second part will be devoted to the presentation and discussion of case summaries. Hopefully in this way the problems encountered will have some meaning in relation to the total concept of the process of psychotherapy.

CHAPTER I

THE NATURE OF THE ADOLESCENT PROCESS

A great deal has been written on the mores and subcultures that constitute adolescent society and there has been much documentation of the observable emotional reactions and expressed beliefs of the adolescent. As well, there have been attempts at the analysis of the structure of the peer group and parent-child interrelations that are active at this age. All of these are important in the understanding of what occurs at the time of adolescence. Through these as well as through information gained through psychotherapeutic experience it appears that there is a basic problem. This is the fact that at this time the individual is required to relinquish his first love objects within the family and to replace them with others outside of this circle. (1) This transition is necessary and of paramount importance if the adolescent is to achieve psycho-social maturity.

At the time of puberty there is a tremendous reinforcement or development of the sexual drives and with this a resultant alteration and disruption of the established character structure. The individual by the conclusion of his prepubertal years has usually learned how to be a successful child. In most instances, he has achieved an ego structure that will adequately handle the libidinal

drives and thus allow him to live satisfactorily within the social structure to which he is exposed. However, at the time of puberty, there occurs a marked influx of libido, a relative strengthening of the basic drives within him. This requires a compensatory alteration of the ego structure to be able to again establish a satisfactory adjustment within himself and in respect to the society in which he lives. (2) Because of the incest taboo it is necessary that this alteration of the ego structure include the establishment of love objects outside of the family structure as recipients of this surge of libidinal energy. This restitution of the ego with the redirection of basic drives is essentially the final product of the adolescent process. The changing reality demands and the necessity of learning new patterns of behavior results in the requirement of a considerable length of time in our culture.

The immediate reaction at the onset of the pubertal period seems to be that the adolescent fears the quantity rather than the quality of his instinctual demands. He finds the safest policy to be simply to counter more urgent desires with more stringent prohibitions, typically leaving no loopholes for substitutive gratifications. This asceticism of puberty must be interpreted then,

not as a series of repressive activities, but rather as denial. It is a manifestation of the innate hostility between the ego and the instincts which is indescriminate, primary and primitive. (3) Thus, under the conditions of puberty, the ego behaves as if it were in danger of extinction and falls back upon primitive defenses which originated in the earliest struggle of the individual to preserve and maintain the boundaries of the emerging self. (4) The asceticism, or denial and rejection of the libidinal forces, becomes directed toward the immediate family grouping. This occurs because the family circle represents the love objects that are desired but forbidden and a self-determined isolation and estrangement from the family results. The superego, which had been primarily derived from the parental figures, concomitantly becomes involved in these rejective processes through a primitive generalization from the primary love objects. (5,6) Consequently the process of emancipation overreaches its developmental utility. Not only does it turn the adolescent against the existing and actual controlling relationships but also against the internalized controls which are derived from them. His demand for freedom thus becomes a denial of vulnerability which he feels consciously or unconsciously. (7)

In the interim, before the resolution of this problem, the individual relies on primitive defenses, one of the most important of which appears to be that of identification. The transient identifications which characterize even normal adolescents appears to be a constant flight from disillusionment and a constant quest for certainty and denial of vulnerability. (8) These identifications are not object relations at all, in the sense in which we usually use the term, but are identifications of the most primitive kind, attempted projections of the self such as we meet in early infantile development. (9) In this light it becomes clear that these identifications are a narcissistic process. (10) That the pervading orientation of the adolescent is one of narcissism is a point very seldom disputed. (11,12,13) In the course of a successful restitution of the ego structure in adolescence, there occurs a change from this narcissism to the capability of forming significant object relationships in the peer group that eventually constitutes the basis of mature "love". (14) This awareness of the importance, quality and interdependence of two human beings with a consensual valuation of each other's personal worth, in contradistinction to narcissistic dependence on the love object, is a new product of the successful

adolescent personality reorganization. (15,16)

A related phenomenon and one that appears to be another aspect of the same restitution process is the "individualism" of adolescence. This is the need to experience the self as a separate entity apart from the parents and distinct from emotional dependence. (17) The attempt to delineate the self in the face of experiencing partial disintegration of the ego structure has been described by E. H. Erickson:

> "Decisions and choices, and most of all, successes in any direction bring to the fore conflicting identifications and immediately threaten to narrow down the inventory of further tentative choices.. (At the same time) any marked avoidance of choices leads to a sense of outer isolation and to an inner vacuum which is wide open for old libidinal objects and with this for bewilderingly conscious incestuous feelings....Thus adolescent regression is an attempt to postpone and to avoid, as it were, a psychosocial foreclosure....As the young individual seeks at least tentative forms of intimacy he is apt to experience a peculiar strain, as if such engagement demanded from him a fusion with others which would amount to a loss of identity, and therefore, required a caution in committment....Where experimental surrender fails, as it often must from its very intensity and absoluteness, the young individual recoils to a position of strenuous introspection and self testing which can lead him into a paralyzing borderline state....This state consists of a painfully heightened sense of isolation; a disintegration of the sense of inner continuity and sameness, a sense of overall ashamedness; an inability to derive a sense of accomplishment from any kind of activity; a feeling that life is happening to the in-

> dividual, rather than being lived by his initiative, and finally a basic mistrust. This loss of a sense of identity usually leads to a scornful and snobbish hostility a snobbism which is based on the pride of having achieved a semblance of nothingness. At any rate, many a late adolescent, if faced with continuing diffusion (of identity) would rather be nobody or somebody bad, or indeed, dead - and this totally and by free choice - then be not-quite somebody. Their strange air of sado-masochistic satisfaction....their self-deprecation and their willingness to "let the ego die" harbors a devastating sincerity". (18)

This is a description of the devastation of the self-image that occurs when the adolescent rejects his original familial love objects and his identity as an integral dependent subjegate of the family unit and is, however, unable to establish object relations subsequently to provide him with validation of his worth as a separate individual.

Although this type of experience of which Erickson speaks is probably a fairly constant occurrence in the pubertal period, we see only a small percentage of adolescents that are unable to cope adequetely with this problem. The historical data on markedly disturbed adolescents seems to indicate that there is no sharp change in the quality of their behavior. Rather there is an intensification of pre-existing problems for which the child has devised defenses. The sharp rise in the incidence of emotional problems during the pubertal years is due to the fact

that the child has been unable to muster any additional reserves. There is regression to earlier levels of gratification in order to prevent the seeking of gratification at a more advanced, but far more disturbing and dangerous level and this is a defense which is designed to stall for time while the ego attempts to reconstitute itself. (19)

In considering the adolescent with significent emotional problems, we find that there were initial problems of earlier life. It is these that later make the establishment of object relations and a sense of identity so difficult to achieve in adolescence. This may often be the discovery by the child that manifesting the need for tenderness toward the potent figures around him leads frequently to his being made anxious, to being rebuffed or more broadly to being emotionally hurt. Thus, the perceived need for tenderness brings a foresight of anxiety and encourages a reciprocal pattern of rejection of the desired object. (20) It is this process of the patterning of rejection that Sullivan speaks of as leading to "the basic malevolent attitude". (21) The case of rebellion in an adolescent is almost always, then, a reaction provoked by the genuine rebellion of the parents against the child's needs for affection or in other words the

attitude of basic nonacceptance of the child. (22) This of course solidifies the necessity for a strong narcissism in the child.

Due to the emergence of these primitive narcissistic defensive attitudes in adolescence, many workers feel the disturbed adolescent resembles the psychotic. (23,24,25,26) In all cases of adolescent behavior deviation that are serious enough to require the services of the trained psychiatrist a pseudo-psychotic core will be found that gives rise to and maintains defenses in the form of the symptoms of maladjustment or a typical behavior. It is termed pseudo-psychotic because that except in a circumscribed area of deviant behavior and thought, the adolescent's thinking usually appears to lie within normal limits. (27)

In summary it appears that the problem of adolescence is the rejection of the original love objects and the establishment of strong object relationships outside of the family. In doing this the rejection may include the internalized controls and a confusion of self-identity may arise. Primitive narcissistic defenses, often resembling those of the psychotic patient are used in an attempt to redefine the self-image. The failure to accomplish this restitution process may frequently be traced to patterns of previous parental rejection. Thus

the failure to establish healthy object relationships with the initial love objects makes it difficult later in adolescence to establish emotionally satisfying object relationships within the peer group.

CHAPTER II

THE APPROACH TO THE ADOLESCENT

Having some conception of the processes of the adolescent period of development and of what the disruption of this period may constitute, it is now possible to formulate what approach to the adolescent would be most valuable in assisting the disturbed adolescent to achieve an adequate adjustment. In the past, the therapeutic results in the age group have been eminently unsatisfactory in response to the attempts of therapy, be they endeavors to "graft" patterns of behavior into the adolescent personality structure (28) or the application of the classical psychoanalytic techniques. (29)

Because of these discouraging results in the past, there has been a tendency to turn away from direct psychotherapeutic relationships with adolescents and a number of auxiliary devices have been advanced for the purpose of coping with these problems. Emphasis has been placed rather on practical help with environmental manipulation (30) or on various group techniques (31) or actual group therapy. (32,33,34,35,36) Gitelson feels that this appears to be an inclination to keep the patient at therapeutic arm's length. Although such techniques may have a place in particular cases, they more likely express a defensive maneuver of the

therapist himself, either because of his participation in the adolescent patient's resurgent primitive anxiety or because of a threat to his own emotional economy. (37)

In contradistinction to the therapists who prefer to maintain considerable distance with their adolescent patients, there are also therapists such as K. R. Eissler who provides considerable emotional gratifications for his patients in the adolescent group. He attempts to provide his adolescent patients with situations of surprise to retain their interest in therapy, he assures his female patients that they are charming and attractive and finds it necessary at some time to give each of his male patients money. Additionally, he makes himself available to these patients, extending considerable personal effort in extricating them from practical life situations where they are in difficulty. He admits that this requires considerable acumen and energy as he attempts to maintain an omnipotent position in the face of whatever his patients may devise to prove otherwise. This leads at times to the brink of dissolution of the relationship. Usually the patient later in therapy finds it difficult to proceed into a more practical therapeutic relationship because the patient is unwilling to relinquish the profuse gratifications previously provided by his

therapist. This necessitates a change of therapist.(38) Other therapists have also found the maintainence of unequivocal control and the security in their position as therapists important. (39,40)

This then, raises the question as to the necessity of attempting to maintain this appearance of omnipotence that not only causes difficulty later in therapy, but which also puts heavy demands on the therapist. Not only does this raise the question of the necessity of omnipotence but also the advisability of it in terms of the therapeutic relationship and what the objects of therapy might be. In the clarification of what Eissler feels to be the dynamics of the advantage of maintaining the appearance of omnipotence he suggests that the acceptance of the therapist's omnipotence by the patient is a conversion of primary omnipotence of the patient to secondary omnipotence, likening this to the conversion of primary narcissism to secondary narcissism. The dynamics become even clearer when he further stresses not only the acceptance of the omnipotence of the therapist, but also the conviction of the patient "that the analyst will never be tempted to use his quasi supernatural forces for the patient's displeasure in spite of all provocations to which the patient may expose him." (41) It would seem apparent that this interpersonal

faith is the important factor in the relationship. This constitutes an experience for the patient of feeling secure and satisfied, while at the same time being in a position that is easily perceived as one in which there is great vulnerability to being emotionally hurt. The acceptance of emotional vulnerability with the conviction that there exists no reason for anxiety is merely another way of describing the successful achievement of the formation of meaningful object relationships. (42)

If this supposition is correct, then the deliberate attempts at omnipotence by the therapist is not only unnecessary but may make it even more difficult for the adolescent to achieve a comfortable and effective therapeutic relationship. (43,44) Instead of attempting omnipotence, it would be advantageous to be quite simply human, open, unmysterious and not too clever while being interested in whatever the patient brings to the therapeutic situation; being as completely divorced from omnipotence as is conceivably practicable within the limits of preventing the patient from hurting himself or others. In this way we achieve two objectives. The first of these objectives is the demonstration to the patient that the therapist is not the authority from which he seeks independence but rather someone who stands with him.

In this way the therapist prevents a repetition with the child of the situation with the parents that initially led to the conflict. (45) This becomes especially important in the case of the child who has generalized his conflict to include society as a whole. (46) The therapist's alignment must be unequivocably with the ego structure of the patient and not with the superego or its perceived equivalents.

The second major objective achieved within the atmosphere established by negation of the idea of the omnipotent therapist is that the threatened ego of the patient is given some measure of control in this new and strange interpersonal situation. This is an assurance that the patient will be an active, not a passive partner in the process of psychotherapy. (47,48) This is exceedingly important as the child in puberty is often terrified by his failure to find his own solutions to his problems. This is in terms of the effect of failure on his self-concepts and the previously mentioned experience of ego structure inadequacy. In fact, to allow the ego structure of the adolescent patient to maintain as much control as is possible, we should reverse the analytic rule as suggested by Aichhorn so that the patient may feel that he need not tell the therapist anything that he does not

wish to. (49)

It is well known that formal psychoanalysis has long been considered not applicable to the adolescent. One reason that is advanced for the inability of the adolescent to profit from this type of therapy is his apparent inability to form a transference neurosis. This is a consequence of the basic narcissism, the difficulty in forming object relationships and usually the persistence of the original love objects in reality. (50,51) Another reason that the customary psychoanalytic techniques seems to be ineffective in these cases, is that it is a form of expressive insight therapy which relies on a relatively intact ego essential for the integration of the expressed material. Thus these techniques are more suitable for neurotic problems than for conditions where the ego structure is weak and relatively disorganized as in psychoses (52) and in adolescence. This lack of the benefits of verbalized insight, and thus the decreased importance of facts is extended by Allen to the statement: "If one is interested in content there will be less feeling, if one deals with feeling there will be less content and more therapy, the content is used as a defense against feeling." (53) In this same matter Anna Freud also stresses the mechanism of intellectualization as a defense and the

tendency of adolescents to discuss their difficulties intellectually without the apparent insight being incorporated into their total personality adjustment. (54)

Therefore in the therapy of the adolescent there is an emphasis on the relationship of the therapist with his patient. The therapist's participation in the development of therapy rests more on an affective level than on an ideational one. (55,56) The therapist should respect and recognize the importance of the patient's struggle with the incongruity of the verbal and affective levels and extending a human warmth and friendliness which does not engulf the child. (57) The psychotherapeutic effort must then create a situation where the patient is in a relatively non-structured relationship in terms of verbal interaction. (58) Thus, he is allowed to explore himself and come to accept himself for what he is and in this way to establish his identity. (59)

Much of this approach to the patient is found in the "nondirective" orientation of Rogers who, in stating what he feels to be the function of the therapist, writes that it is "to assume, in so far as he is able, the internal frame of reference of the client, to perceive the client himself as he is seen by himself, to lay aside all perceptions

from the external frame of reference while doing so, and to communicate something of this empathic understanding to the patient." (60) This empathic process by the therapist is also described by Gitelson as "the sensitive perception of another person's state of emotional structure and balance on the basis of awareness of one's own. Empathy is interpersonal and requires the vehicle of common language, both verbal and nonverbal, if it is to carry over to the other person....(It is in this way that) the therapist must succeed in making and maintaining what is substantially a narcissistic contact." (61)

To achieve a successful therapeutic relationship in the case of the adolescent behavior disorders one must empathically enter the affective narcissism of the patient. (62,63) In this respect the initial establishment of the relationship becomes a problem very similar to that of entering the narcissistic structure of the psychotic. This is true both in regard to the frequent lack of motivation and in regard to the barrier of the primary narcissism. The seeking of therapeutic help in adolescence is the result not of the patient's own feelings in the matter. Usually therapy arises at the instigation of the parents from whom he is seeking to free himself (64) or at the insistence of a parent surrogate such as a school or law en-

forcement agency. It is for this reason that the "nondirective" approach of Rogers is often not applicable in the initial contacts with relatively nonverbal adolescents where a neutral position on the part of the therapist is construed by the patient as a passive rejection. (65) In the instance of the adolescent as with the psychotic, the awaiting of a spontaneous participative gesture from the patient is likely to develop into a situation of indefinite therapeutic stasis. (66)

Substantially then, this amounts to the assumption of a participative responsibility on the part of the therapist for the purpose of establishing empathic contact with the patient. It is in this way that the therapist must compensate for a psychic lack in the patient, the inability to readily form object relations. (67,68,69)

The therapist's tactics in assuming initiative become a prime technical consideration. The use of intellectualistic, interpretive or direct advisory maneuvers or the attempts to gain access to the patient through diagnostic insight into the illness generally lead to consistent failure. (70,71,72) However, a variety of means can be used in an attempt to establish contact so long as they allow the therapist to be accepted by the child into his autistic world: silent participation, acceptance of all

mannerisms, even imitations of the patient's words and gestures when appropriate. In fact, any attitude is advantageous which, without threatening the child's precarious security of his locked isolation, may impart to him the feeling that his behavior is understood and accepted. (73) Any suitable means that seems to put the therapist with the patient so that the patient has some experience of togetherness in contrast to aloneness, is efficacious in this problem. (74) Of course, the therapist's techniques are most effective in this active participative approach to the patient when forthright and honest and not artificially created. If this is successful the therapeutic situation then becomes "a constant and continuous mutually and reciprocally influencing human situation. The patient then having the right, the privilege and the responsibility to wander in his own wilderness in his own way, the therapist's task being to convey his being with the patient, available and alert for clues as to where the patient is." (76) Thomas Hora in describing such a relationship states:

> "The kind of growth process that ensues is possible only if the relationship between therapist and the patient is such that a true, completely undefensive reciprocal partnership exists at all times... providing the patient with the invaluable experience of participating in a joint venture of growing in and through inter-

> action. The experience of togetherness and reciprocity is one of the most valuable factors in the therapist's difficult task of relieving his patient from his emotional isolation; it goes beyond countertransference. This means a form of relatedness where all channels of communication are open resulting in the experience of being totally understood in turn leading to an integration of the disorganized psychic functioning in such a way that the affective processes in patient and therapist become synchronized which makes it possible for the hitherto isolated and diffuse personality of the patient to interact with other human beings as a complete organism, in harmony with itself." (77)

In this way the patient learns that his hostile and aggressive defenses as well as the weak core of his more positive identity can be accepted. This should occur without the patient's identity being devoured by the therapist or having the therapist allow himself to be manipulated to the point that his own identity is devoured by that of the patient. (78)

Nearly all those who write on the direct psychotherapy of the adolescent stress the importance of a strong emotionally dependent relationship but it appears instead that the therapeutic situation needs to be dependable rather than dependent. By this, we mean that instead of establishing a relationship to the therapist of dependency as to a parent substitute, it is better if the patient regards his therapist as a dependable ally. The treatment of the adolescent cannot be directed

toward a more benign reexperience of his past, on the contrary, treatment must provide the adolescent with a new emotional experience. Treatment may fail thus not because it is dynamically inaccurate, but because it is emotionally inadequate. (79) This emotional adequacy is not achieved through gratification of the patient's needs but rather through the form of mutual intimacy, respect and understanding.

CHAPTER III

DIFFICULTIES IN ADOLESCENT PSYCHOTHERAPY

Having formulated an approach to the adolescent and the general object of psychotherapy it is now possible to examine some of the difficulties that are frequently encountered. Of course, the difficulties entailed in the formation of any psychotherapeutic relationship are present in the approach to the adolescent. No attempt will be made to delineate them in this paper. However, there are certain difficulties, not entirely unique to the problems of dealing with the adolescent, but often more prominent in this particular field. It will be these that we will mention. These difficulties appear to lie roughly in three fields, those derived from within the structure of the patient's personality, obstructions primarily engendered by the enviroment and finally and usually most important are those difficulties derived from the therapist's own personality structure.

The most obvious difficulty encountered as a function of the patient is inherent in the process of adolescence itself, the aformentioned basic narcissism. This inability to form interpersonal relationships readily and the hostility that is a product of the patient's anticipated rejection in many instances, may reveal itself, as an all per-

vasive mockery if not overtly. Whatever way it may be manifest, it very often results in the necessity of having to deal with a defiant individual. (80) The negativism of puberty, too, is a primitive defense against the danger of surrender, a danger of merging with the object and losing in this way the personal self-identity. Negativism in this way serves to remind the individual of his existence and capability of action apart from outside influences. Thus, the patient fears that the therapist may carelessly or deliberately destroy the weak core of the patient's identity and impose himself instead, if the patient were to reveal himself to the therapist. (81) This concept becomes of particular importance because of the frequently fantasied image of the therapist as an omnipotent being who might utilize his power unscrupulously to gain control over his patients. (82) Therefore, it appears that the resistances within the individual can be grouped into two basic groups, the negative and hostile feelings in anticipation of rejection and the fear of the consequences of the establishment of a positive relationship with another human being. The actual patterns of behavior are expressions of these two concomitantly but we will attempt to discuss them separately, in certain aspects at least, while bearing in mind that the expression of negative

feelings effects an interpersonal distance that allays the fears of the consequences of a more intimate relationship.

Negative feelings are directed at the therapist not only as a result of anticipated rejection by the therapist as a person, but also as a diffuse rejection of all that represents society. This applies especially to the adult faction that is representative of the parental figures either directly as an authority figure or indirectly in that the parents are often instrumental in arranging the child's introduction to therapy. Thus, to the patient it appears, many times, that the therapist has been hired by the parents to "find out things." (83) If the child is successful in sabotaging the efforts of the therapist, he achieves revenge against the unwanted intervention of the parents or a social agency and more broadly against the influencing pressures that he fantasies are robbing him of his individuality and preventing his achievement of emancipation. (84)

The expression of negative feelings toward the therapist as described by Alexander and Pope are often varied and complex. Besides overt verbal or motor agression directed toward the therapist or the psychotherapeutic situation, disguised hostility appears as silence, sleepiness, coquettishness, attempts at manipulation, tenseness,

rigidity, subjective feelings of discomfort apparent to the therapist or as the appearance of somatic complaints. There may also be displacement of the hostility to elements of the environment representing the therapist or the therapy situation. If the hostility be repressed it may appear in the form of internalized, self-directed criticism, as doubts that the therapy will be of value or that therapy represents merely humiliation and a needless encroachment on privacy. This is often expressed in such a way to the therapist that its design is to mobilize guilt feelings in the therapist. (85)

Of these reactions, one encountered much more frequently in adolescents than in children or adults, is long periods of silence. These silences result in a paucity of material for the therapist to work with. (86,87) Puberty is the age of secrecy and this has usually been indirectly reinforced in the case of the emotional disorders of adolescence by the parental figures. One of Aichhorn's patients succinctly stated: "At home they always said that if I'd talk nothing bad would happen to me but when I did it was always much worse. So I quit talking."(88)

However, not all silence represents resistance but may simply be a means of preverbal communication. (89,90) In this respect it can become invaluable to the therapist in establishing a "per-

sonal language" with his patient. When silence is recognized as a significent element of communication and not regarded simply as an obstruction, the aim of psychotherapeutic interviews becomes more clearly one of mutual understanding rather than mere acquisition of detailed histories. (91) Later we will mention specifically how silence may appear as a function of the fear of a positive relationship.

Positive feelings of the patient emerge as more of a problem as the therapist is able to accept and resolve the negative expressions of his patient while maintaining the conviction that a more positive identity exists. (92) The fear of a positive relationship as a loss of identity, as already mentioned, is one of the most important factors but another related feeling may become evident. Not only is the patient afraid that he may be "devoured" by the therapist but in turn, he is afraid that he will find the therapist weak and able to be manipulated. (93) In this way he would destroy his identification of his therapist with his ego ideal of a strong, relatively independent individual and fail to find practical limits to aid him in reality testing and delineation of his own ego boundaries. It is thus important that the therapist neither gain control of the patient nor allow his patient

to manipulate him.

Feelings of shame on the part of the patient become intensified as the adolescent's positive feelings toward the therapist increase. As the realization develops that the therapist understands and perceives him for his real self, the patient may not yet commensurately appreciate that the therapist also accepts him with equal respect. Thus, shame, the desire that the world, and especially the therapist, not notice his exposure, may result in a temporary retraction from the therapist. This retraction occurs as a result of beginning to care increasingly what the therapist may think of him while fearing his more real self will not be acceptable.

Conversely the patient may feel the rewards of acceptance without feeling that the therapist understands or perceives his real identity. This disparity may result in attempts to maintain the relationship while still preserving a defensive facade. Intellectualism is cleverly employed in this way by the adolescent (94) even to the point of apparently "working through" tranference neuroses while only manipulating the therapist to an egocentric end. (95)

With increasing feelings of acceptance the

adolescent may also experience periods of paralyzing silences. These are not from shame alone but also result from fears that he might blurt out forbidden words or thoughts that would reveal him to the therapist and to himself. (96) The alienation of parts of the psychic structure, the alterred body image, the disturbance of the reality sense, the masturbatory conflicts, all contribute in puberty to terrible speculations regarding sanity. (97) There is fear not only that the therapist will discover that he, the patient, is insane but that he will confirm his own fears. With this fear of revealment, there may also be fears of the emergence of homosexual feelings toward the therapist if the therapist is of the same sex as the patient (98) with all of the attendent difficulty then in resolving this with his self conception and his convictions on the meanings of perversions.

The environmental factors may also contribute a portion to the resistances to therapy. The peer group and its subculture is of paramount importance in adolescence. (99) This must be considered both from the standpoint that the child fears the discovery by his peers that he is seeing a psychiatrist and that the child, if associated with an adolescent gang is often strongly identified with it. (100)

If the adolescent has achieved some emancipation from his parents the gang represents a welcome shelter, a transition phase from the dependence of the parental home to the eventual state of mature interpersonal interdependence. In accepting this temporary structure he utilizes the group code as a substitute superego to replace the elements of his superego discarded in the rejection of parental behavior codes. (101,102) A consequence of this is that the gang superego for the protection of its existence includes the classification of adults as dangerous to the integrity of the gang and consequently of each member. (103) The adolescent does not readily forsake this security of the group, tenuous as it may be, for the prospects of reinstating the old sense of failure in a dubious relationship with even a well intentioned adult. (104)

The other significant environmental influence is the parental relationship to the child. In many instances the parents offer either open approval of delinquent acting-out behavior or more commonly indirect encouragement. The basic reason for this indirect sanctioning of deviant behavior of the child is the vicarious gratification experienced by the parental figures of their own forbidden impulses. Thus, the superego defects of the child frequently reflect similar defects in the parents.(105,106,107)

When this parental approval remains unconscious in the parents' personality structure, it may result in a demand for punishment of their child's indiscretions as a projection of their own feelings of guilt and need for punishment. This demand for punishment is compounded if the parents are themselves basically narcissistic and react to the adolescent's behavior difficulties as rejection and hostility directed toward them. (108) The establishment of an understanding intimate relationship with a therapist then becomes quite opposed to the punishment that they had envisioned and attempts to sabotage the relationship may become evident.

The parental obstructionistic tactics in the cases of schizophrenic adolescents are even more apparent. Here the possesive quality of parental love makes the establishment by the child of an emotional relationship with a therapist even more threatening to the pafents own emotional economy than in the cases of other adolescent behavior disorders. Because the schizophrenic child is the vehicle of the parents own needs, any therapeutic progress represents a serious threat, the loss of the child as a source of need gratification for the parents. (109,110) Additionally, many of these parents are exquisitely sensitive to the approval

of others and religiously school their schizophrenic children in techniques of "covering up" and "making a good showing". (111) The attempts to disrupt the relationship usually are exerted through parental attitudes and verbalizations to the patient. They may extend at times to harassing the therapist or to attempts to prevent the child from keeping appointments and other more direct interferences with the course of therapy.

Some of the difficulties inherent in the adolescent patient and the influence of his environment are of considerable importance. However, the most important factors, and the ones that are often neglected, are the difficulties that arise from the therapist's own personality structure. Countertransference accounts for a large percentage of mistakes and failures in psychiatric treatment.(112,113) This is particularly true where so many therapeutic attempts with delinquents are doomed to failure by the therapist's own resistance. (114) In a society which stresses conformity, the pressure within the therapist toward having his adolescent patient "adjust" and "succeed" is probably very strong and it may be more difficult for him to refrain from imposing his philosophy and hopes on his adolescent patient than on his adult ones. (115)

There is a tendency on the part of the inex-

perienced therapist in some instances to react to the adolescent child, especially the schizophrenic patient, with sympathy instead of empathy, usually feeling "all the child needs is mothering". (116) This may well lead to a tendency to protect the child and seriously endangers the therapist to manipulation by the patient. (117,118) This excessive identification with the adolescent is often on the basis of a juvenile fixation or sexual overinvolvement by the therapist and leads to therapeutic failure. (119) This emotional attachment may be a sadomasochistic one that after only a short time the therapist finds some means to terminate disadvantageously to the patient. Such termination is achieved usually by a covert alienation from his patient, well disguised by rationalizations. (120) On the other hand, the patient-therapist relationship may be a very emotionally satisfying one for the therapist. This may result in strengthening the patient's defenses initially by the therapist's attempts to force himself on his patient. If a relationship is established, the therapist may be reluctant to have the patient terminate therapy. As a counterpart to newly developing abilities to form significent object relations, there is usually a great readiness on the part of the adolescent to give up his therapist. (121) The reticence of the

therapist to recognize this point is obviously detrimental to his patient. It is not the function of the therapist to love his patients, in fact, it is well to recall that in dealing with adolescents that hate is not overcome by love but having no more reason for existence it will disappear. (122)

In contradistinction to the excessive positive countertransference there is the negative countertransference. This most commonly manifests itself as a bland, amiable therapist playing an essentially emotionally sterile intellectual game of interpretations and expressed insight. (123,124) With a therapist such as this the uncooperative, often silent patient, providing little material with which to work intellectually, creates a certain technical unease, a kind of therapeutic anxiety where the therapist tries "to make much out of little." (125) It is this sort of difficulty which leads to expressions such as "There can be no relationship without the more alive and responsible evidences of self which are involved in the expression of feeling."(126) It is in such instances that the therapist, discouraged and anticipating failure projects the threat of his own failure onto the patient. (127)

The first test of the therapist then is found in his capacity to tolerate distrust without recourse to reciprocation of hostility, self defensive

seduction or sympathy determined identification.(128) As in the treatment of psychotics, the therapist in the case of the adolescent must have such a degree of inner security, that he is able to function independently, whether he is loved by the patient or not. (129) He must be able to fully accept the patient who lies and deceives him and retain the conviction that he would rather be deceived than be basically mistrustful of his patients. (130) In short then, the therapist must recognize the patient's unequivocal right to react to him in any possible way and be able to accept this, respecting lies and deception as the defense mechanism that they represent. This is not by any means restricted to adolescent therapy but the adolescent, because of his demobilized psychic structure, bombarded by anxiety, and emotionally self-centered puts the psychic integrity of the therapist to its severest test. (131)

Besides the feelings of rejection and hurt that a therapist may feel when the patient seemingly makes it impossible for him to help, (132,133) a therapist may experience the feelings of fear engendered by the shock of sudden exposure to crude, primitive and unbridled expressions and acts of a libidinal and aggressive nature. The fear that is felt, usually unconsciously, seems to be related to

the stimulation in the therapist of unconscious problems similar to those of the patient. Infantile aggression will almost invariably bring forth feelings of a similar nature in the therapist either openly or in a disguished form. (134,135) The therapist may then react with abandonment of the patient, usually under the guise of various rationalizations or he may become involved in a therapeutic situation where he struggles with determination so that the patient will not beat him down, unaware that in this way he loses sight of the therapy problem involved. (136)

In many instances, identification with the delinquent seems to harbor more danger than the corresponding process with the schizophrenic child simply because the former's psychopathology concerns recently acquired functions in which the therapist is more likely to have difficulties of his own. Adolescents frequently require us to identify by empathy with their open aggression, their stealing, lying and deception. In order to understand the adolescent, one must temporarily relinquish one's own moral standards. Since these are a recent acquisition, the treatment situation becomes a greater danger to the therapist with the deliquent adolescent than with the more seriously ill schizophrenic patient. (137)

CHAPTER IV

CASE SUMMARIES

Five case summaries will be briefly presented with attention being primarily directed toward the psychotherapeutic relationships. The author, who acted as therapist in these cases, had had no formal training prior to his experience with these patients. However, he was, at all times, under the supervision of trained therapists. The observations and conclusions are, for the most part, subjective ones of the author and reflections of the insight that he was able to obtain in the course of tutorial sessions with the supervising therapists. In an attempt to gain some objective view of the course of therapy, the author recorded the interviews in the first two cases with which he worked. These were the cases of M. B. and N. H., the recording being accomplished with a tape recorder with full knowledge of the patients. The recorded interviews were reviewed by the therapist and some of them were presented to the supervisors for discussion and criticism.

CASE I M. B. a thirteen year old girl

M. B. was seen for a total of twenty two formally arranged interviews over a period of eight weeks. All of these but one were tape recorded. In addition to the formal appointments, there

were many casual, informal contacts on the ward at the Wisconsin Diagnostic Center in Madison, Wisconsin, where this girl was a patient for this time. One follow-up interview, about six months after the termination of therapy, was held at the Wisconsin Child Center in Sparta, Wisconsin to which M. B. had been transferred from the Wisconsin Diagnostic Center. For this case the therapist was supervised by Dr. William F. Fey of the Department of Psychiatry, University of Wisconsin School of Medicine and Dr. Robert O'Connor of the Wisconsin Diagnostic Center.

This chunky, thirteen year old girl is generally sloppy and her short hair, usually worn with bangs, is frequently uncombed. Her features are not unpleasant but are often sullen, defiant or screwed up demonstratively into a sneer or teasing coquettishness. Most people, including some professional personal, were quick to react toward her with ill concealed hostility and she was referred to by her peers as an "obnoxious brat".

M. B. came to the attention of the Juvenile Court because of a recurrent problem of running away from home and poor school performance. Eventually M. B. refused to return home and her mother concurred with her in this decision, feeling that she could no longer control her daughter. At this

time, she was referred to the Wisconsin Diagnostic Center by the Juvenile Court for psychiatric evaluation and recommendation of placement.

The father of M.B., twenty one years the senior of her mother, deserted his wife during her pregnancy and she apparently attempted suicide at that time. Shortly after the birth of M. B. however, her parents reunited. This man subsequently spent little time with his family, travelling extensively and is known to have been a fur thief and bigamist. A sister of the patient was born when she was four years old. Shortly after this the father discontinued his sporadic visits home, deserting the family entirely. M. B. has not seen her father since this time and is bewildered as to why he deserted her. The patient's mother has schooled M. B. in hostility toward her father and has apparently displaced some of her own hatred for her husband to the patient. As a result of this M. B. looks on her father as wicked and feels that because of this she must be "bad" in some way herself. She often fantasies visiting her father's other wives and children about the country.

Initially M. B. was unable to verbalize anything but open hatred for her mother, recounting many stories of physical abuse at her hands. However by the termination of the relationship, she

was able to state that she was much the same as her mother, being unhappy, sarcastic, afraid of people, trusting few people and being liked by few people. Until M. B. was nine years old the family, after the desertion of the father, lived either by themselves or with the patient's maternal grandmother, the mother working throughout her married life to support the family. When M. B. was nine years of age, the patient feels that her mother changed dramatically. Prior to this time her mother had, to M.B.'s knowledge, remained faithful to her first husband. At this point however, the family moved into the farm home of a man who will be referred to as a stepfather. There apparently was never a legal marriage, a fact of which the patient is fully aware.

With these developments, M. B. found it necessary to vie for the attention of her mother. Her younger sister became the open favorite of her mother and stepfather and the patient's attention getting behavior resulted in many severe beatings. The stepfather is reported to be a rather passive man who spends many hours playing with M. B.'s younger sister. The patient is jealous and has futilely attempted to be likable to this man being deeply hurt that he did not care enough for her to adopt her. The patient's younger sister is apparently adept at blaming her own misdeanenors on M. B.

Two boys, aged two and four years, have been born to her mother and stepfather and she has found that these two boys were the only members of the family who would accept her and she is very fond of them.

T hroughout her school history she has performed adequately acedemically. She has had few friends, was a "tomboy" and "daredevil" and caused concern to the teachers through her attention getting behavior. More recently she has come to the attention of the teachers for telling sexually tinged stories. She did not chose to discuss her sexual interests with the therapist until the follow-up interview. At that time she discussed her awkwardness with boys and her desire to be able to have a boyfriend without having feelings of shame.

The course of the twenty-two interviews could only be described as consistently unpredictable and at times almost tumultous. There was variation from a marked push of speech and flight of ideas to long periods of silence, the patient appearing in abject despair. Only occasionally, and these times in the later interviews, was any semblance of a discussion of a single topic possible. The great majority of the time, there was marked distractability, the patient rarely sitting,rather pacing the room continuously, handling and examining whatever objects were available. She spent a consider-

able time at the window, ignoring the therapist, calling out to anyone that she recognized and involving them in prolonged conversations whenever possible. Rather long periods of direct teasing and open hostility were common, the therapist being deluged at times with persistent personal questions and accusations. She alo presented a fantastic array of somatic complaints and challenged the therapist's medical abilities when she found that she was unsuccessful in obtaining sympathy in this manner. The majority of the material that she chose to talk about revolved about the hospital activities and ward routines.

The most constant object of her open hostility was the tape recorder. M. B. frequently manipulated the microphone and would finger the revolving spools of tape, never actually stopping them, however. She frequently used her masterful teasing technique in this connection: "I would tell you why I'm so mad at you but the recorder in on." The therapist was careful not to allow himself to be baited into these "don't you wish you know what I know" games. It is interesting to note that the patient never utilized periods of casual ward contact to talk of any of the material that she stated was withheld because of the tape recorder. Because of uncontrollable circumstances, one interview was held without the tape

recorder and this was one of the most unproductive and unsatisfactory interviews of the series. It seems plausible to surmise that the tape recorder was used by the patient as an object for aggression displaced from the therapist, her pretense at withholding material being an attempt to manipulate the therapist. As an interesting corallary the therapist, in response to his own anxiety, turned off the recorder near the close of the seventh interview after M. B. had expressed considerable hostility toward it. As soon as this had occurred, the patient became anxious, very hyperactive, likened the therapist to her stepfather and insisted the therapist was angry with her. Perhaps she recognized the turning off of the recorder as a seductive move which intensified her fear of a more intimate relationship. One difficulty that the recorder did accentuate was that of feelings of shame on the part of the patient. These were prominent throughout the entire course of therapy.

The first two interviews were devoted to feelings of persecution, open hostility toward her family and a sarcastically flavored self depreciation. The next five interviews were either spent in almost total silence or contained long periods of silence. During the silences her affect was one of depression and at times she would bury her head

in her hands and cry. The therapist made no attempt to interrupt any of these silences. In the last of these hours, the seventh hour, the patient began to demand that the therapist not look at her and that the recorder be turned off. It was at this point that the therapist did indeed turn off the recorder as already mentioned. The recorder was reintroduced at the time of the next interview. The early objections of the patient to the tape recorder seemed to revolve about her feelings of shame ("I don't want a million and one persons listening to me.") as did her demands that the therapist not look at her. Her verbal attacks on the recorder persisted, and in fact increased, up to the conclusion of therapy. The quality of the objections changed however. The recorder later was described as a confusing, hard to understand object that made her dizzy, and of which she was afraid. By the tenth hour, she had begun to liken her feelings of being "dizzy" to her fear of water and inability to swim. For these reasons she wished that she could smash it. Here possibly was a displacement of her fear of the developing positive relationship with the therapist.

With the twelfth hour, there began an acceptance of the developing positive relationship. She protested that the room seemed different: "I know I'm gone now. I've tried to pretend everything's

all right but I can't keep it up. I'm so unhappy I could die, just a chicken with it's head cut off, that's me! I know I'm crazy, go ahead and say it." And thus began sporadic reference to her fear of insanity and the fear that she would never improve but only get worse. Near the close of this same hour, she began to speak of her feelings for her real father and her fear that people would take advantage of her if she were to trust them. During this hour she began to evidence unsteadiness on her feet, that culminated three interviews later, in a total collapse on the floor. This fall on her back appeared to be without objective cause. She very seriously announced "I always laugh instead of cry but I'm glad you're not laughing." With this dramatic episode she seemed to summarize her willingness to trust the therapist.

In the next hour, M. B. began to show her first positive feelings for the therapist. Characteristically this was as dramatic as the previous hostility. She said that the therapist was the father that she had never had, that she worried what he might think of her, that she wanted to run her fingers through his hair and began to find excuses to touch him as she walked about the room. However, her evasiveness and distractibility remained and the teasing increased. She spoke now of her worthlessmess and

insisted that she would run away. Just prior to the eighteenth interview M. B. did make an attempt to run away though she stopped and waited when it appeared that she might actually get away. That same night she participated in attempts at property destruction with the other patients on the ward. She was ashamed to face the therapist the following day and when he indicated neither approval nor disapproval she demanded punishment from him: "Now you know what I'm really like."

In the remainder of the interviews, she began to speak of her identification with her mother, her dejection that her stepfather did not seem to like her and feelings about her father. She stated openly that her somatic complaints were affected to gain attention. On one occasion she remarked "I used to worry that I was crazy, now I know I'm not. I'd die if you were a paychiatrist and could figure me out. This way I wonder about you just as you do about me, even steven."

The patient was reluctant to go to the Wisconsin Child Center at Sparta, Wisconsin. However, she made a fairly good initial adjustment and began to do well in school. At the time of the follow up interview, six months after the termination of the interviews, the patient immediately began to speak of her problems. She was able to relax and talk

of her feelings even more easily than any time during the course of therapy. She talked extensively of the correspondence with her mother that she had recently resumed, of her interest in boys. She spoke of dreams involving the therapist, making reference to her conviction, when depressed, that at least the therapist, if no one else, cared what became of her.

This patient almost consistently presented a petulent and coquettish facade, sneering, pouting and teasing in alternation. The most difficult single factor for the therapist was the persistent and insistent questions and accusations, all of which were of a personal nature. The patient was not motivated for therapy at the onset of the interviews. Despite the above mentioned difficulties however, it appears that the patient was able to utilize this opportunity to form a psychotherapeutic relationship.

CASE II N. H. a fifteen year old boy

N. H. was seen for a total of thirty-one interviews over a period of eleven weeks. As with CaseI all of the interviews were tape recorded with the patient's full knowledge. These thirty-one structured interviews were conducted during the time that the patient was at Mendota State Hospital,

Madison, Wisconsin. However, previous to these interviews, the therapist had had casual contacts with the patient while he was at the Wisconsin Diagnostic Center. During the course of the thirty-one interviews, the therapist was supervised by Dr. William F. Fey of the Department of Psychiatry, University of Wisconsin School of Medicine and Dr. V. Terrell Davis, then Clinical Director of the Wisconsin Diagnostic Center but presently Director of Mental Health for the State of New Jersey.

This fifteen year old boy, though well developed, is not as physically solid and muscular as many boys of his age, rather retaining certain childlike qualities. He is, however, well proportioned with pleasant features, superficially friendly and cooperative, soft voiced and attentive. At the Diagnostic Center he showed occasional bursts of generalized overactivity and inappropriate anger of an impulsive and rather undirected nature.

N. H. came to the attention of the Juvenille Court for stealing. Three unsuccessful foster home placements were attempted before the patient was sentenced to the Waukesha School for Boys for car theft. Almost immediately he became a management problem because of overt homosexual activity and he was transferred to the Wisconsin Diagnostic Center for psychiatric evaluation. It was concluded

that, although this boy was not psychotic, the most desirable available disposition was a transfer to Mendota State Hospital.

The father and mother of N. H. separated at the time of his birth and he was immediately placed with his maternal grandmother, a woman who had had three illegitimate children. His mother was never interested in his care and at the age of three he was placed with a children's agency. At this point his father prevailed upon his own married sister to adopt him. Following this, his father joined the armed services, later deserted and at the present time is in the Minnesota State Penitentiary.

The adoptive parents both held factory jobs so that the majority of the day he was always cared for by a neighbor woman. This was the case throughout his childhood. The neighbor woman who cared for him reportedly was neither affectionate nor understanding and cared for him solely because of the monetery remuneration that she received. His adoptive parents showed little interest in his welfare and as they had little modesty, they frequently went about the house nude. As N. H. slept in their bedroom until he was twelve years old, he frequently observed them in sexual intercourse, his parents making no attempts to conceal sexual acts from him.

N. H. was always an unhappy child who had few

friends. He had been free of overtly delinquent behavior until age ten. It was about this time that while going through some of his parents belongings he discovered that he had been adopted. He recalls this discovery as a catastrophic shock and he cried for long periods in despair. His parents attempted to deny his adoptive status but after a month's period of persistent questioning, they conceded that it was true.

From this time on, he was hostile and resentful toward his parents. At school, he became antagonistic and rebellious and was an agitating influence in the classroom. He would return from school with the property of other students - a fact to which his parents paid little attention. Soon after this, he began to steal bicycles and money and came to the attention of the state agencies. He was removed from his three attempted foster home placements because of lying, stealing and in one instance for taking sexual liberties with a twelve year old girl.

In the thirty-one interviews the patient generally did not chose to talk of his problems but talked evasively of hospital activities - only occasionally introducing his own feelings, and these in a fleeting fashion. His attitude varied from quiet, deep dejection, through irritated bore-

dom to the more common insolent flippancy. This often became so intense that whatever the therapist said was categorically denied, even if it be a repetition of the patient's own words. Except on rare occasions, during the entire thirty-one interviews, it was impossible for him to accept any reflection that he was uncomfortable, regardless how distraught he might be. In like fashion any reflection that he wondered about something was met with; "Oh, I never give that a thought." In this way he attempted to appear as a detached, emotionless person, insulated from the problems of life. The only emotion that he would at all commonly admit to was that someone had made him "mad." Such an admission was always followed with elaborate descriptions of how that person had suffered before his unleashed anger.

The patient almost always came late and left early, armed with trivial excuses. On two occasions he failed to keep his appointments. N. H. was allowed as complete control of the interview situation as was possible. No objection was made to his coming late or leaving early and all of his defensive evasiveness and denial of his problems were permitted unchallanged. This was done as the therapist felt that these were important defenses and that if he were able to gain sufficient ego strength

in the course of therapy he would be able spontaneously to rearrange his defenses.

There were three dramatic exceptions to his usual affect and behavior, the eighth, the sixteenth and the twenty-fourth interviews. The initial three interviews were of a sarcastic, whining, complaining nature with expressions of feelings of persecution and requests for personal favors. In the next four interviews, periods of pensive and dejected silence began to appear. These silences would at times extend up to twenty or thirty minutes and very little subject matter was discussed during these hours. At the close of each session, the patient would ask if the therapist was intending to come to the next scheduled interview. The culmination of this was the first of his three exceptional interviews, an active eighth hour. The patient began by voicing his expectations for the future in glowing terms. This however, soon faded into expressions of feelings of uncertainty and the necessity to fight. The latter was expressed in almost desperate terms and he concluded with references to his feelings of inadequacy: "Even if you lose, you got to fight or the whole world walks on you. But I ain't strong, I'm weaker than a mouse, I have to try to get by on cleverness."

It was following this eighth interview that

N. H. developed the habit of coming late and leaving early. This persisted until the termination of therapy. The seven succeeding interviews, often as short as twenty minutes, were tense, distant, and highly evasive, no other feeling of any kind being apparent. In the last of these, N. H. stated that he felt somewhat obligated to talk but that he didn't have anything to say and was bored with silence whenever this occurred. The therapist assured him that this feeling was understandable and acceptable and that he was not obligated to come at all. The next interview was again a meaningful one. We will see this occur again even more dramatically in Case IV - the effects of a restatement of the noncompulsory nature of the interviews on a tense and distant patient.

The sixteenth interview was, as the eighth, filled with steady verbalizations, the patient relaxed and appearing depressed. Previous to this time, he had often stated that all that he wanted was to return to his parents. This hour he spoke of many past experiences, of his car theft, of his enjoyment of farm work. This led to a spontaneous suggestion on his part that perhaps it would be a mistake for him to go home, that he might do better on a farm.

After failing to keep the next appointment

there again ensued seven tense, distant and evasive interviews. There appeared complaints that the doctors were ignoring him and he was thinking of running away but had not yet attempted it. In retrospect it appears that the therapist did not perceive these as requests for more active participative gestures on his part. Perhaps, if the therapist had more directly attempted to assist the patient to deal with his problems, this stasis might not have ensued. On the other hand, this therapist-patient distance may have been necessary in assuring the patient that the therapist was available though did not intend to assert his position nor seduce the patient into a closer relationship. Thus, more active moves on the part of the therapist might have made it necessary for N. H. to retract from the relationship altogether.

However, the conclusion of the second appearance of a seven interview stasis, the therapist, in response to his own dissatisfaction and discouragement, began to more actively pursue the patient's feelings. Again, as in the eighth and sixteenth hours, the twenty-fourth hour was one of relaxed dejection and steady verbalization. N. H. stated that he wanted to join an actively antisocial adolescent gang when he was released. If he didn't he would feel that he was a "nobody": "Grownups

never understand things like that. If I don't go back home and prove that I'm not chicken anymore they'll be laughing at me the rest of my life." This stream of verbalization was however suddenly interrupted and an intense silence followed. From this silence he suddenly blurted, "Why didn't I keep my damn mouth shut! I've been locked up three lousy years, now I've fixed my only chance to go free." With this he left the office.

The final seven interviews were turbulent ones, filled with uneasiness and hostility on the part of the patient. There was considerable "forgetting" of appointment times or remarks such as: " I can just stay a few minutes, they're waiting for me to come and play cards on the porch." Interspersed with this increase in his resistance there were also brief moments when he chose to reveal some of his intense feelings. Such statements were voiced as: "I try to be good around here but nobody pays a damn bit of attention. That's the way it always is, you may as well do as you damn please. " "I don't give a s--- about anything else, I just want to get out. Ever since I was thirteen, I've been locked up in some f------ place. Never could do nothing. One damn lousy football game I've been to! Only time you're free is when you run away, then

they get you." "People here, people there, people anyplace I been to, they don't give a s--- about me. It's terrible to know that nobody give a good God damn what the hell happens to you."

At one point the patient in a hostile tone announced that his doctor had told him that as soon as the therapist terminated the interviews (because of having to leave the city) a social worker would be assigned to him to work out plans for his discharge. This announcement was effective in mobilizing the therapist's feelings of discouragement. Feeling guilty over apparently prolonging a relationship that was so unsatisfactory to the patient, The therapist immediately offered N. H. termination of the interviews. This apparently took N. H. somewhat off guard and with the only warmth that he had ever shown toward the therapist in the thirty-one interviews said: "No. If it weren't for you I'd be here much longer, you're the only person that ever tried to help." With this he immediately changed the subject.

In the next to last interview he announced that he had decided that he wouldn't go home. Instead he had told his social worker that he thought that he had better stay in the hospital several more months and that then he would like to try another farm foster home.

The last interview was typical of the previous ones. Near the end of the interview he began to tell of an experience of having fallen through a hole in the ice over a lake. He felt that he didn't know which way to swim; he found an air pocket, "but I didn't have brains enough to breathe from it. Somehow, by accident, I found the hole and my friends pulled me out. I was lucky they grabbed me, I was ticketed to be a goner." He dwelt on this incident for some time, repeating and elaborating on the details. Whether this was related to his feelings concerning the interviews, there is no way to ascertain. This was followed immediately by his final parting from the therapist, so characteristic of N. H. "Well I have to go to the movies now, I'll be seeing you. Oh wait, this is the last time isn't it? (pause) Yeah I guess so. When will you be back? (no pause) Oh well, so long, gotta rush."

This was a difficult patient for the therapist and his occasions of discouragement at times may have been apparent to the patient. Only on the occasion that N. H. reassured the therapist about his interest in continuing the relationship was it overtly apparent that the patient reacted to the therapist's discouragement. What deleterious effect this discouragement may have had at other times could of course not be measured. As this was the

second attempt of the therapist, he may have been less discouraged than might be expected however. He had little expectation of achieving psychotherapeutic progress and had had no experience with cooperative patients at this point. Interestingly, the tape recorder which was a focus of so much comment in the case of M. B. was never openly a cause of difficulty.

It appears that the major difficulty was the patient's fear of developing a positive relationship. Whether this was connected with a fear of a homosexual transference is not apparent but no overt evidence exists in this area except its possibility because of the patient's previous homosexual history. If the patient had been in the community, faced with more immediate practical problems, he might have developed more anxiety that could have been instrumental in motivating him more strongly to explore his difficulties. Subjectively, the therapist feels that a psychotherapeutic situation existed, tenuous and unsatisfactory as it may have been. Whether progress could have been achieved, whether the relationship could have been maintained is problematical. The patient's ability to reject his parental home and seek the more realistic farm placement seems to reflect an increase in ego strength. What part the hospital, the therapist,

the parents, the other patients and this boy's own restitutive capabilities may have contributed can only be speculation.

CASE III J. M. a sixteen year old boy

J. M. was seen for a total of eighteen interviews, as an outpatient, over the course of nine weeks. The therapist was supervised at this time by Dr. Harold F. Borenz of the Wisconsin Diagnostic Center. The patient was under the jurisdiction of the Stevens Point District of the Division of Children and Youth, Department of Public Welfare, State of Wisconsin.

This sixteen year old boy is well developed, muscular and generally large for his age. He has curly hair and a swaggering gait, his features being mobile, readily refledting his emotions. On first encounter he bore an air of flippancy and defiance that might easily be construed as self confidence.

The patient came to the attention of the Juvenile Court early in 1954 after threatening the "town character" with a knife and engaging in several street fights. Subsequently there were two instances of public petty theivery of articles that the patient did not actually need. For example, one of these was the theft of two packs of

cigarettes from a parked car when he had cigarettes in his pocket.

J. M.'s father is autocratic, demanding unquestioning obedience, with severe punishment the result of any challenge to his authority. This man has a second grade education and from his early childhood has worked vigorously, being unable to tolerate idleness in himself or in others. He has always been unable to acknowledge any success on the part of J.M., quick to discourage and depreciate any of his son's attempts at accomplishments, apparently seeing his son as a dangerous, competetive figure. This man has never enjoyed his children, will be glad when they have left home and in the meantime is distrustful of them, frequently checking on their whereabouts when they are away from home. J. M. has received many beatings in the past from his father but has never struck his father at any time. He feels guilty about his strong desires to do so. J. M. has always sought to have his father like him and be proud of him, but he now avoids contact with him, as he feels that even friendly gestures on his part are misinterpreted by his father as hostility. J. M. is fully aware of his ambivalence toward his father and was able to associate his desire to fight older, stronger men, who would invariably subdue him, with his desire to fight his

father. On the other hand he wishes that he were closer to his father and is disappointed that his father never attempted to help him as he had hoped he would when he was in trouble.

J. M. 's mother is a meek woman who married the only boyfriend she ever had. She has always felt unsure and offers the fact that she has shown little affection toward her two oldest children but resents their lack of dependency on her. She attempts to get him to confide in her when he is upset but if he does she belittles his problems. J. M. has found that it is better not to talk at all, many days going by without any words being exchanged between he and his parents. His mother has arranged to collect large proportions of his wages to spend as she wishes on herself and blames the patient for her large medical bills due to her "nerves". These result, she claims, from J. M.'s arguments with his father. At one point in the interviews J. M. said while sobbing brokenheartedly: " I want Ma and Dad to love me so badly but I know they've never cared about me. Nothing I ever did made them happy. If I only knew what they wanted God knows I'd do it or die trying."

From the age of five to ten years J. M. spent his summers on the farm of a childless aunt and uncle. This arrangement supposedly arose quite

spontaneously one Sunday when the family was visiting the farm. He vividly recalls his father asking him if he would like to stay on the farm and his reply: "I'm not scared to, I'll stay." He feels that this was the start of his trouble, that he deserted his family. He remembers wishing that he could stay on the farm all year, regretfully returning home in the fall and not caring whether his parents visited him in the summer. The summer that he was eleven however, his aunt and uncle quarrelled continously, his uncle drank excessively and there are some indications that he had a disturbing sexual experience, He asked his parents to take him home at this time and he has rarely visited the farm since.

J. M. has an older sister, age eighteen, who married, left home, and rarely visits the parental home. At age sixteen she was on probation for a year after stealing from her employer. During the course of therapy, the patient's attitudes toward his sister changed from one of condemnation to one of emvying her successful emancipation from their parents. He now shares many of her views concerning parental attempts at overcontrol. A sister one year younger than J. M. is reportedly "boy crazy". Near the end of the eighteen interviews, the patient began to express his embarrassment that she, though younger, was virtually engaged, when he had never

had a date. A younger brother, age ten, is openly favored by the mother. J. M. feels envious of his favored position but also recognizes that he will have even greater difficulty in achieving emancipation. This ten year old boy has already come to the attention of the school authorities for stealing from his classmates.

J. M. was a defiant, unhappy child with very few friends. The winter following his return from the farm of his aunt and uncle he sufferred from nausea, severe headaches, "fainting spells", most of which occurred in church. J. M. always did well in school until high school. He failed the first year of high school and while repeating it, he decided to quit six weeks before the final exams. He regrets this decision and wishes that his parents had cared enough to insist that he continue. His poor school performance he relates to being angry "twenty-four hours a day" with loss of interest in everything. He had few friends when attending school and since quitting school engages in no activities whatsoever with his peer group, his few interests being to hunt and fish alone or spend hours alone in his room listening to the radio. The majority of his time is spent working at his several jobs.

J. M. joined the Marines at the close of ther-

apy and he had considerable conscious ambivalence over this decision. He joined the service to escape his home, to prove to his father that he could be a success and to find a situation "where they are willing to enforce the rules for your own good, treat you fairly but don't let you get away with doing the wrong thing." J. M. was convinced that he was going to be very homesick but felt the family, as long as they received his allotment checks, would not miss him.

J. M. is very concerned about his bodily integrity, remarking often on his strength and toughness. In the course of therapy he began to mention his feelings of inadequacy, especially when in the presence of girls. Eventually, he began to speak of the fact that he was often mistaken for a girl in photographs and concluded: "I guess I'm a boy whether I like it or not and I can't change it." This confusion of sexual identification reflected itself in his never having had a date and a troublesome masturbatory problem with elements of fetishism. During the latter part of therapy he began to correspond with a girl despite considerable fear and anxiety over this enterprise.

From the initial interview J. M. was able to use the therapeutic hours to a remarkable degree. At no time did it become necessary to question the

patient except to clarify statements or feelings that he was expressing. All subjects were introduced spontaneously by the patient himself and the great majority of the insightful remarks stemmed directly from the patient, the therapist assuming practically none of the responsibility for the progress of the interviews. The patient was open in the expression of his feelings, stating in the very first interview that he felt that he needed someone with whom he could talk and he was wondering if the therapist could be trusted. He then immediately launched into his feelings of ambivalence toward his parents.

Over the course of the first ten hours, the subject matter revolved primarily around his past and present difficulties with his parents. As early as the fourth interview he was able to release a torrent of emotion concerning his feelings, his need for love and his feelings of rejection by his parents. Shortly after this, he stated that he was regaining the appetite that he had lost a year and one half previously and was feeling better able to be around other people without feeling he was being laughed at behind his back. In the next four hours he turned his attention away from past events to a more careful scrutiny of his present feelings.

He began to show amazing insight. For example, when discussing an automobile accident in which he had just been involved, he began to describe other accidents that he had had only to stop suddenly to say; "Why most of those were my own damn fault, as if I was just asking to get hurt, like when I pick fights with some of the big guys in town. Sometimes, I feel that all I really need is someone to beat the tar out of me for all of the things that I've done." The last four interviews were devoted to his fears about entering the Marines, his feelings of inadequacy as a man and his difficulties in the sexual sphere.

So in the course of the nine weeks, J. M. showed a progression from the discussion of his past to that of his present difficulties. At the termination of the relationship, the patient spent considerable time in discussing his feelings about the experience. At one point he said; "When I first began I felt I had to come and talk but somewhere I began to want to come. At least I could blow off here if nowhere else. It seems that I used to be mad all of the time for the past two years and I kept doing things because I was mad and people kept trying to stop me because they were mad. I don't remember what it was but you must have given me some advice because I'm not mad anymore. Oh I

still get mad now and then but not as often or as bad. I don't know if I need help anymore or not but I'm not going to think about it because there won't be any around."

Except for the inability of J. M. to express hostility toward the therapist this was a highly satisfactory relationship. If there were difficulties in establishing the psychotherapeutic relationship, the therapist is unaware of them.

CASE IV E. M. a fifteen year old boy

E. M. was seen for a total of eighteen outpatient interview sessions over the course of nine weeks. During this time the therapist was supervised by Dr. Harold F. Borenz of the Wisconsin Diagnostic Center, Madison, Wisconsin and Dr. William Heywood of the Marshfield Clinic, Marshfield, Wisconsin. Throughout this period the patient was under the jurisdiction of the Stevens Point District of the Division of Children and Youth, Department of Public Welfare, State of Wisconsin. The patient had come to the attention of that agency because of a single episode in October 1954 when, in the company of two other boys, he had participated in puncturing bicycle tires and stealing bicycle parts in the school yard.

This fifteen year old boy is slender, well

proportioned and well developed though somewhat effeminate in appearance. He moves stiffly and somewhat awkwardly in a very self conscious, rigidly controlled fashion. He shows marked flattening of affect with very few spontaneous facial expressions. His expression was usually an assumed one of thoughtfulness and obediant resignation.

E. M. was born as the third child of frugal, rigid, socially reserved parents. His father is a small, quiet man who rarely speaks or joins in activities, even within the family group, his only interests being hunting and fishing. E. M. rarely speaks with his father, is frightened of him and although he has never been struck is afraid of bodily injury whenever his father becomes angered. This man has always disparaged any of his son's accomplishments. Except for a carefully calculated amount of money that allows E. M. to attend the movies once a week, he gives the patient no money, feeling that he should be earning his own money. However, when E. M. requested permission to obtain a paper route he refused on the grounds that he didn't want any member of his family to be out "in all kinds of weather". This man has refused to cooperate with the social agencies, interpreting their intervention as an invasion on his family's

privacy.

E.M. is closer to his mother than to his father and the few problems that he confides to anyone are confided to her. All requests within the family are directed to her. Whenever a request is to be refused however, she frequently refers the child to his father. The mother is the chief disciplinarian, never using corporal punishment, but apparently being liberal with verbal abuse. The patient recalls quite warmly that his mother would read to him as a child. As late as age fourteen, she would read his school reading assignments to him in lieu of his attempting them himself. She has been diligent in protecting him from physical harm, disapproving of sports and being selective in the boys that she allows E. M. to have as friends. Her reaction to her son's difficulty with the law was; "How could he have done such a thing to me." She has persisted to the present in the feeling that she will never be able to forgive him, instituting extreme measures to keep his difficulty secret, even from her own mother who resides with the family. She immediately curtailed the patient's liberties for more than a year. He was required to come directly home from school, associate with no members of his peer group at any time and was allowed out in the evening only one night per week. That night, he was allowed to attend the movies

with his mother or his sister. She deemed this regime as fair punishment for what E. M. had done to her.

E. M. feels guilty that he "let down" his mother and is uncertain as to how his mother feels toward him, perceiving that he is the object of considerable hostility. He suppresses his anger toward his mother, fearing massive retaliation and handling his anger by retreat to his room and fantasy life.

E. M. has always envied an older brother's accomplishments who has now married and lives away from home. The patient has a sister one year older than he who still resides in the parental home. He has never been close to either of his siblings though during childhood the children of this family always played together, rarely with other children. The patient can recall no time when any other children have been in his home, feeling that they would not be welcomed by his parents. In fact visitors of any kind are infrequent, even close relatives rarely visiting the home.

For the past eleven years E. M. has spent summers, or parts of them, on a farm of an uncle and aunt who have several children of their own. He has enjoyed these summer periods, finding his aunt a warm, understanding person and his uncle a man

who has shown interest in teaching him skills such as driving a car and other endeavors that his parents have never allowed him. Interfamily discord has now disrupted these summer visits.

E. M. has dreaded to get up each morning, has always been frightened of his peers and has been the object of teasing since he can recall. He has made very few friends and feels that no one likes him. Despite an I.Q. of 97 he has done poorly in school, frequently being grouped with slow learners. However, he plans to finish high school at his mother's insistence. The patient's jobs have been restricted to mowing lawns for friends and he states that he is much too frightened to ask for employment in any store or filling station. His eventual ambition is to get a job, any kind of job. This ambition has a desperate quality connected with it suggesting that he fears no one would ever employ him.

The subject of sex has been a rigid taboo at home and all that he knows of sexual matters is what he has overheard in school, never daring though to join any group discussing sexual matters. The patient's interests are autistic ones for the most part; building model airplanes, listening to the radio or daydreaming of being a cowboy in the "old

West" riding a white stallion and engaging in "six-gun" battles. He spends his time at home in his room, emerging only to eat meals.

The progress of the eighteen interviews was generally from material of a definitely factual nature to a discussion of his feelings and from a discussion of the peripheral aresa of his environment to more intimate material such as interpersonal family relations and his fantasy life. Throughout the course of the eighteen hours, the patient arrived punctually, being careful not to sit or arise until invited to do so. Except for a very few times in the last few interviews, he never spoke unless asked a direct question. At no time was he able to respond to a question as broadly stated as; "Tell me about your sister." or "What sort of things do you like to do?" Almost all responses were short, incomplete, often "yes" or "no" or "sometimes", never expanding his answers, providing only as few words as possible within the rigid framework of the question. Any question that he chose not to answer was dealt with by entirely ignoring it or initially appearing thoughtful, only to drift off into a blank detachment.

The first two interviews the patient responded only to very factual questions such as his place of birth or grade in school. He remained immobile and

silent when any question involving feeling or opinion, either of himself or others, was directed to him. In the third through the eighth hour, he became even more withdrawn and for long periods would not respond in any way, responding to five or ten questions per hour. The few innocuous questions that he did chose to answer were responded to with one or two word answers. These answere would invariably come after a period of silence so long, that they almost seemed to represent carefully calculated moves, as in a game of chess. The therapist misconstrued the silences in the third through sixth hours as similar to the early silences in CaseI, that of M. B., the thirteen year old girl. The therapist thought that they represented a recognition by the patient of the acceptamce of his nonverbal nature by the therapist. However, as E. M. began to show irritation and boredom during the silemces it became apparent that this was clearly an insulating and hostile mechanism. Because of these difficulties, card playing was introduced and the ninth hour was spent satisfactorily in this way. The succedding hour E. M. mutely declined to play and returned to a defensive, withdrawn position. It was learned later that E. M.'s mother would, after each interview, ask for a detailed resume of what had occurred.

When she learned that an hour had been used in card playing she had become openly derisive. At the conclusion of this unproductive, silent hour, the therapist again restated the voluntary nature of the opportunity to see the therapist. He remarked on the obvious distance which separated he and E. M. up to this point. In rather definite terms it was stated that this distance was entirely understandable and acceptable, if the patient felt that it were necessary, the therapist being glad to continue the interviews. However, it was stated that E. M. most definitely should not return for the next appointment unless he cared to come.

E. M. returned and the next four interviews showed a dramatic change. The patient began to introduce tangible feelings and the previously slow, very thoughtful selection of answers was replaced by a rapid and spontaneous response to questions. A reversal thus occurred so that at this point only five or ten questions now would go unanswered. The fifteenth interview was used to explain to the patient that he would, sometime in the indefinite future, be requested to have an interview with the field psychiatrist of the Division of Children and Youth. This would be for further evaluation and determination of future plans. He was presented with the option of telling his parents himself of

the proposed interview or having the social worker inform them. He chose to tell them himself and then was able to express considerable hostility toward the therapist with a defiant, sullen affect quite different from the flattened affect previously seen. Acceptance of this anger was expressed to the patient and the remaining three interviews showed an even greater expression of feelings than previously.

This patient seems to demonstrate graphically the difficulty in working with a patient that is not motivated for psychotherapy. The total lack of any spontaneous verbal or affectual responses placed the total responsibility for the establishment of a relationship on the therapist. Although in the nine weeks that the patient saw the therapost, no motivation was overtly apparent, it does not seem to preclude the possibility of motivation developing later in the relationship if it had been possible to continue the interviews. The influence of the almost omnipotent mother figure in this boy's life can not be underestimated. Though her interference was only clearly seen in the failure of the medium of card playing, it would seem safe to assume that her influence was leveled against the total idea of psychotherapy from the beginning.

Despite the manifest difficulties that this

patient had in being able to verbalize his feelings to the therapist, he was able to divulge such secrets as parts of his vivid fantasy world, his terror of his father, his anger toward his mother and his feelings of inadequacy within his peer group. It is uncertain what the effects were of the therapist's discouragement that eventuated in a virtual invitation to discontinue therapy with the tenth hour. However, the immediate improvement might indicate that the patient had experienced sufficient narcissistic gratification that he wished to maintain the relationship. The other possiblity is that it was sufficient reassurance that the therapist was willing to allow the patient as much control as possible and did not intend to force himself on his patient. Perhaps the knowledge that the therapeutic encounter was limited to nine weeks could have contributed to the willingness of the patient to attempt communication in the later sessions as he was well aware that, because of the short time remaining, there was little danger of an intense relationship developing.

CASE V T. M. a thirteen year old boy

In contrast to the first four cases, which were primarily adjustment reactions of adolescence, this boy demonstrated a psychotic, schizophrenic

process. T. M. was seen in psychotherapy for roughly 170 hours over a period of ten weeks. During the first four weeks, while he was a patient at Rochester Municipal Hospital, Rochester, New York, he was seen approximately three to four hours per day. The remainder of the hours were at two hours per day, six days per week, while he was a patient at the Rochester State Hospital, Rochester, New York. Throughout this time the therapist was supervised by Dr. Myrtle L. Pleune of the Department of Psychiatry, University of Rochester School of Medicine and Dentistry.

This thirteen year old boy is of slight build, stooped posture, uncombed hair and walks with a self conscious, somewhat shuffling gait. On initial contact, the front of his clothes were stained with food and he would drool apparently without noticing. His facial expression was vapid with an inappropriate grimace, his speech halting, fragmented, yet consistently coherent. There was no gross disociative element and there were no apparent hallucinations. He appeared frightened at all times and constantly displayed stereotyped, tic-like movements. These movements involved bringing his hands to his face, rubbing his eyes or sticking his fingers into his ears, nose or mouth. His fingers were held closely together and used as a single unit in most cases.

T. M.'s father lives a rigid, unaffectionate life as a man who is tyrant of his family and frightened of the rest of the world. He prefers to live with as little contact with people as possible, requiring his wife to anser the door and the phone. He is germ conscious, never eating or drinking anything away from his home. He has frequent uncontrollable temper tantrums and states openly that he has always felt that T. M. was a wedge between he and his wife: "I can hardly stand to have him around he disgusts me so." He has threatened to run him down in the car so that the patient was afraid to cross the street for several months. Nonetheless T. M. expresses many positive feelings toward his father.

The patient's mother is a tense, unhappy woman who has always regreted marrying her husband. She has always been terrified that she would "do the wrong thing" in rearing her two boys and has tried to rear them following the advice of books, newspaper articles and friends, applying each idea rigidly only to disgard it in favor of then another idea. She speaks of her life as being the patient and has been overprotective and overcontrolling throughout his life. A little more than a year ago the patient began to develop secondary sex characteristics but his mother discouraged his attempts

at modesty and at one time when he was in the bath-tub she hugged him, kissed him and remarking on his sexual development said; "Oh darling how wonderful. You were my baby, but now you will be a man." At the present a recurrent comment about her son's illness is; "He doesn't seem to realize anymore how much he hurts me." She feels persecuted by people and has accused the therapist of having staff personal dress as patients to approach her to "test" her, as well as other such bizarre ideas.

T. M. has one brother, age eight, toward whom the father has always shown much open affection and to whom the patient is always compared unfavorably. This brother still sucks his thumb. With this thumb sucking as an inciting factor the patient has had outbursts of overt aggression against this sibling.

The home has always been discordant and filled with angry feelings between the parents. T. M. was no particular behavior problem during childhood except for many attention getting devices that he employed followint the birth of his sibling. The patient has always dreaded school, being terrified of associating with his peers and has had few friends. He has been the constant object of teasing and has always fled from other children. T. M.'s mother has exhorted the neighborhood children to include T. M. in their games to no avail. Within the last

year, and especially since entering high school, the patient has had several uncontrollable aggressive outbursts against children who were teasing him. Despite these difficulties, T. M. has always maintained an excellent acedemic standing.

Psychological testing revealed failure of reality testing, autistic perception with a regressive trend and marked withdrawal from human contacts. In the contacts that the therapist had with this boy, he was always verbal, silence being no problem. The patient stated later that for the first twenty to thirty hours he dreaded to see the therapist and hated to talk with him. And during this time the patient did appear frightened, maintaining his stereiotyped movements and handled his genitals through his clothing much of the time. Initially the content of his spontaneous talk was displaced from himself. He discussed in detail many incidents of violence and death. In the first fifty hours he described, in elaborate detail, about sixty or seventy deaths. These were deaths of friends and relatives or those described in newspaper accounts. In detail he described the life and behavior of the family cats and he elaborated on constructed magical number systems that were to predict when he would die. The mother of this boy, during the entire course of therapy, told the patient to talk only of pleasant

things, to put up a good front and to be sure to tell her everything that he told the therapist.

In the twentieth through the fortieth hours the same general subjects were pursued and a fascination and fear of fire appeared. He began to relate more of his fantasy material and included autistic, symbolic gestures, a few of which he explained to the therapist. His facially focused tic-like movements became displaced to the pelvic region and became much less frequent. Between the fortieth and the sixtieth hours the patient began to relax considerably, the frozen smile would at times disappear, being replaced by dejedtion. The content of his verbalizations shifted to focus on his parents, their hostile behavior toward him and finally to his own feelings. These feelings included fears that his parents were ashamed of him, that they thought he was crazy and didn't want him. He had felt worthless and inept throughout his life. At about this same time, the patient's mother became particularly disturbed. She accused the therapist of trying to analyze her and of placing microphones in the room so that he could listen when she talked with her son.

In the sixtieth through the eightieth hours the patient's anxiety showed a quite sudden increase and the masturbatory activity which had always been

present became much more marked. The stereotyped movements and drooling which had entirely disappeared by this time did not however reappear. He felt that the tablets of chlorpromazine that he was taking were settling in his heart, that it would burst and he would bleed to death. He later decided that they were settling in his genitals and that they would be injured in some way, complaining that his genitals ached and itched at this time. He experienced dreams of being placed in a watery casket by a strange man and of being chased in a barn by a woman with a knife. Thoughts of electroconvulsive therapy terrified him and he likened the unconscious state following shock treatment to the time that he had a tonsillectomy at age five, shortly after his brother's birth. At that time he had wondered what the doctors would cut out and in like fashion he felt that during shock treatment the doctors would probably cut his eyes out "for seeing things that I shouldn't have." Concomitant with this display of heightened anxiety he began to attempt to detain the therapist when he was leaving and showed other positive feelings toward him. He spoke more openly of his fears and told of his recent problem of enuresis and his feelings of shame surrounding it. He related also that when he heard his mother's voice when she was out of sight, he was afraid that she

was only some kind of robot or dummy and not a real person at all.

In the period of fifteen to twenty hours preceding T. M.'s transfer to the Rochester State Hospital, he was able to discuss his feelings about this move. These were mainly feelings such as; "I'm glad that the awful truth is finally out, I couldn't keep going on day after day as I was. At least something is happening, maybe things will change now!" He also began to tentatively advance some anger toward the therapist, expressing the feeling that the therapist had tricked him. At this point the parents approached the therapist to see if perhaps their blood types might indicate that he was not their child but that an exchange had occurred in the hospital nursery.

During the first thirty hours at the state hospital T. M. became more relaxed and the fantasy material and autistic gestures that had been so prominent began to disappear. Instead of his fantasies the patient talked of current hospital activities and his difficulties in adjustment. More and more he was able to express anger toward the therapist because of his placement in the state hospital.

Between the one hundred and twentieth and one hundred and fiftieth hours the patient spoke of

some of his serious worries. These revolved about masturbation, nocturnal emission, his physical weakness, and worry over whether he would ever be able to learn how to be a man. He began to make his first overt friendly gestures toward other people. The first of these was a frightened, but determined and successful effort at offering a cookie to one of his fellow patients. In discussing his parents during this time he expressed more and more positive feelings toward his father and became more hostile toward his mother. He referred to her as a trickster and shrew and began to show resentment at some of her attempts to run his life. He was angry at her for telling his brother and neighbors that he was away visiting friends. The only reason that he felt that she wanted him to return home was to make a good appearance to the neighbors and the school.

From this point to the one hundred and seventieth hour he began to identify strongly with another patient of about his own age. This other boy is not overtly psychotic and is able to express his hostility toward the hospital and the other patients. In this light T. M. began to reevaluate his disease process for himself and concluded; "You know I've changed, this is a turning point for me. I don't

have all of those nervous movements like I used to and it's sort of fun to make conversation with the other people here. I still notice that I smile sometimes when I'm really sad but not as often. I've decided that I would rather be bad than crazy. I'm scared to be bad though. I dreamed that to be bad meant death, that people would come with knives and cut me up and kill me." In this regard the patient actually turned on the fire hose in the occupational therapy shop and announced that he did it "because I felt like it." Afterwards however, he told the nurse that he had seen snow out the window where there was none. "I didn't really see snow but I thought it would be better if she thought that I was sick." By this time he was able to differentiate and accept teasing, anger and inappropriate psychotic verbalizations of the other patients. He was even able to cry before the therapist in the one hundred and seventieth hour when talking of being homesick, the first intense affectual response he had ever shown.

On the other hand however, T. M. was still very timid, finding it impossible as yet to resist any demand made upon him unless extremely inappropriate. Anger has been expressed to no one except the therapist as far as can be ascertained. The patient has been aware since the eightieth hour

that the interviews would be terminated at the one hundred and eighty fifth hour. Since the one hundred and sixtieth hour he has begun to find it more difficult to express hostility toward the therapist, has once more begun to speak of his fear of death and is using magical number systems to attempt to predict the date of his death. He states that nothing has ever gone right in his life and he is afraid that it won't change now. Feelings of persecution and fantasy material are again appearing, though not at all prominently.

The therapist has at all times allowed T. M. to talk of whatever subject matter he chose and at no time did the therapist interpret any symbolic material to the patient. He answered few questions and those on occasions when it was apparent that T. M. was unable to do his own reality testing in an area of interpersonal relationships with other patients or ward personel. During the latter part of the therapy, part of the time was spent in teaching the patient to play pool so that he could participate in this game on the ward. During these sessions it was necessary to set firm limits to prevent the patient from striking objects with the pool cue or bouncing the pool balls on the floor. Nonetheless T. M. was able to learn the fundamentals of pool and has begun to play with the other patients

on the ward. It was only at this time that his impulsive behavior presented a management problem.

The major difficulty in therapy was the interference of the mother. During the total course of therapy she exhorted her son to withhold all material of any family discord, of misbehavior, and of thoughts that weren't acceptable within her rigid limits. She has told him on several ocassions that the only reason that he is in the state hospital and the reason that he has not been released is his insistence on telling the therapist things that she has forbidden him to talk of. At the time of T. M.'s transfer to the state hospital she gave him a list of five things that he must do if he was ever to return home. These were: (1) Tell the therapist only of good deeds and happy feelings. (2) When observed by attendents and nurses, always pretend to be happy and cheerful. (3) Socialize with the other patients. (4) Always be neat and clean and be careful not to get food on your clothes. (5) Always do whatever the personel asks but don't let other patients tell you what to do.

Besides the influence of the mother, there were two other factors that made therapy difficult. One of these was the amount of time that it was necessary to devote to this patient. The second was the therapist's irritation at times with the

dependency of the patient. The latter factor may have been advantageous in preventing even more dependency than the patient developed in the relationship as it was. In one of the later hours the patient said: "Oh I guess it's no use to ask you that question, all you'll say is, 'Maybe you can answer that yourself.'" There was, then, the constant expectancy of the therapist that T. M. could do the great majority of his own reality testing and, if left to his own resources, could manage without the therapist's intervention. Whether or not this retarded or accelerated the initial phases of therapy can not be determined. Whether the patient will again return to a more overtly psychotic symtomatology after the termination of the interviews can not be determined. It is the feeling of the therapist that, even if this does occur, as it very well may, the patient has gained some ego strength and hopefully will be better able to respond to later opportunities for therapy if they arise.

CHAPTER V

SUMMARY

Five case summaries have been briefly presented along with comments on some of the aspects of the relationships as the therapist was able to perceive them. In review these five cases were those of:

(I) M. B., a thirteen year old girl who recurrently ran away from home after the introduction of an unaffectionate stepfather into her family unit. She was coquettish, evasive and distractable but was able to relate fairly well in the course of the therapist's contacts with her.

(II) N. H., a fifteen year old adopted boy whose stealing and homosexual activity drew attention to his unsatisfied needs. He was, except for three interviews, insolent and distant within the patient-therapist relationship.

(III) J. M., a sixteen year old boy with rigid, neurotic parents. His arrogance and fighting brought him into difficulty at home and in the community. He utilized the relationship well and developed considerable spontaneous insight.

(IV) E. M., a fifteen year old boy, severely withdrawn from both his parents and his peers. He was unable to take amy responsibility in the relationship but was able to express some of his feelings in the presence of the therapist.

(V) T. M., a thirteen year old schizophrenic boy who was able eventually to relate quite well. In the course of 170 hours, he became fairly spontaneous in the presence of the therapist and began to make friendly gestures toward other people.

The most difficult of these five patients, for the therapist, were N. H. and E. M. They were apparently unmotivated initially and probably because of their fears surrounding the development of a positive relationship they found it difficult to effectively utilize the psychotherapeutic opportunity. E. M. was an outpatient and it was so arranged that N.H. came to the interviews on his own initiative. N. H. was able, in this way, to come late and leave early so as to regulate the amount of contact with the therapist that he was able to tolerate. However, E. M. punctually attended the interviews, probably from fear of deviating from what he felt was expected of him. Only on rare occasion were these two patients able to make affectual responses in the psychotherapeutic setting. Similarly T. M. found it difficult to make affectual responses because of his schizophrenic process but was, on the other hand, well motivated for therapy after only a short initial period. Overt hostility was expressed consistently only by M. B. and N. H. This was always in a well

controlled manner and never presented a problem. At no time was gross acting out a major difficulty in these cases.

The environmental difficulties that were encountered were minimal except in the cases of E. M. and T. M. In both of these cases the mothers attempted to interfere with the patient-therapist relationship. In both instances the pattern of withdrawal of these boys from interpersonal contact had been actively encouraged by the mothers. As most strikingly seen with T. M., these mothers encouraged their sons to participate only superficially in psychotherapy.

None of the adolescents were involved in any peer group gangs and in fact, all of them had been essentially friendless, lonely children. This was true even though M. B., N. H. and J. M. had been active in their peer groups as agitators, encouraging their fellow students at school to rebellious acts.

The most significent areas of difficulties probably lay in the reactions of the therapist. It is, of course, impossible for the therapist to evaluate his own unconscious processes and very difficult even to assess the effects of his conscious feelings. The therapist was unaware himself of any inappropriate amount of positive couhter-

transference. The only feelings of any intensity that were apparent to him were those of discouragement in the cases of N. H. and E. M. In both instances he expressed this overtly at one point by a restatement of his perception of the patient-therpist relationship and invited the patient to discontinue the interviews. In both instances the patients declined the invitations and then allowed their feelings to become more apparent in the relationship.

The therapist's irritation at the failure of E. M. and T. M. to assume more responsibility was expressed more diffusely and the effects are thus more difficult to evaluate. As both of these patients had previously been subjected to overprotection and possessiveness by their mothers, the therapist's irritation may have been some assurance that this pattern would not be repeated.

In these five cases there is thus a variation in the success of the therapist in attempting to establish psychotherapeutic relationships. The therapist has attempted at all times to provide relationship, rather than insight psychotherapy. In this respect the two fundamental principles that have been most prominent in the basic orientation of the therapist are: (1) Rigid interpersonal honesty: "We never fool ourselves or anyone else about

the truth of ourselves." (138) and (2) "Neither the therapist nor patient need live up to the standards of a superman's perfection. Striving in human alliance, although not providing any absolute security elicits the courage to transcend the anxieties of loneliness, powerlessness and vulnerability."(139)

FOOTNOTES

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Approved William S. Fay

Date 6 June 1956