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Application of Theoretical Underpinnings: A Differential Approach to Practice with Adolescents

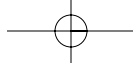
The previous three chapters have introduced the practitioner to the fundamental theories necessary in order to have a comprehensive understanding of the adolescent client and her family, as well as to the formulation assessment and engagement principles that can help him establish a therapeutic relationship with her. This chapter will discuss the major theories that are utilized in working with most clients. It will also enable the clinician to determine, based upon the nature of the case, which approach is most likely to be successful. This is a daunting task for any clinician, but a necessary one if he is to help the teenager.

There is no universal approach that fits all clinical situations. Some are more appropriate than others to a particular case. Very few highly experienced practitioners use a particular theoretical approach exclusively. Most clinicians practice what might be called *informed eclecticism*. As the clinician develops his theoretical and applied template for practice, he incorporates a variety of theoretical approaches and techniques (Beutler, 1999; Franklin & Jordan, 2003; Roth & Fonagy, 1996). The choice of clinical style depends upon what has worked. This is a pragmatic choice, based upon years of trial and error. There are many theories and approaches to clinical practice (Hubble, Duncan, & Miller, 1999). The following discussion is a basic review of the five basic approaches along with clinical case examples to illustrate them.

COGNITIVE BEHAVIORAL THERAPY (CBT)

Cognitive behavioral theory/therapy (CBT) is a theoretical approach to practice that includes cognitive and behavior theory in a relatively short-term, structured format. Each of these theories can stand on its own merits and





has been used by clinicians in working with a variety of clients including adolescents for many years. They have recently been combined into what might be described as a problem-solving or task-centered approach. CBT has become the buzzword for this type of clinical work. Cognitive theory is an approach to practice that emphasizes thinking as the primary factor in a client's behavior and emotions. Some of the early contributors to this theory included Alfred Adler, one of Sigmund Freud's disciples; Albert Ellis, who developed rational emotive therapy in the 1950s and 1960s; and Aron Beck.

Cognitive theory and therapy holds that people are influenced in their actions by their inherent beliefs about the world and themselves. Some of these beliefs may be conscious, but many are not. Human problems come from operating on faulty or irrational beliefs. The role of CBT is to recognize and challenge those irrational beliefs, thereby changing negative or destructive behavior.

At the core of cognitive theory is the notion that all thought, including values and assumptions about the world, is layered in the mind in what are referred to as *schemas*. Schemas are developed throughout life but most especially in childhood and adolescence. The hierarchy of schemas runs from the most fundamental values and beliefs about life (unconscious in nature) to simple, everyday notions about all human actions, for example, it is wrong to run a stop sign, or it is bad to lie. Assumptions about life and the subsequent behaviors that result from them direct all of our actions. Problems result when we have irrational beliefs, ideas, and values that contribute to troublesome behaviors in life. It is the goal of the clinician in cognitive therapy to help the client identify the thoughts and beliefs that are getting in the way of healthy living and direct new thinking that will lead to a change in behavior and a happier life (Adler, 1963; Beck, 1976; Dobson, 2000; Ellis, 1973; Kendall, 2000).

Behavior theory posits that all human actions are the result of what we have learned or been conditioned to do. Some of its major theorists are Ivan Pavlov, B. F. Skinner, and Albert Bandura. When our actions are reinforced by either reward or punishment in a repetitive and consistent manner, those behaviors become the basis of our functioning in life. Bandura's social learning theory is a good example of these ideas. According to Bandura and other behaviorists, a child is conditioned to behave in certain ways through rewards, punishments, and observation of significant others in the world. Dysfunction, according to behavior theory, comes from learned behaviors. Domestic violence can be explained from a social learning perspective as the development and ongoing use of dysfunctional learned behaviors in intimate relationships with others. The child learns and is conditioned to use violent behavior throughout life. When he becomes involved in an intimate relationship with a partner, violence is one of the learned and conditioned behaviors that is used to handle conflict or anxiety (Bandura, 1977; Pavlov, 1927; Skinner, 1953). The focus of treatment from a behavioral therapy standpoint is to identify the dysfunctional behaviors and



help the client to learn new, more adaptive and healthy approaches to the same situation. There are a variety of techniques that behavior therapists use in working with their clients. The main thrust, however, is to eliminate negative or destructive behaviors by substituting new behaviors that are reinforced inside and outside the therapy. This can be accomplished, for example, through role plays in the counseling sessions and homework between sessions.

CBT is a therapeutic approach that combines the elements of both cognitive and behavior theory. Recognizing that thoughts and behaviors are intimately connected, CBT addresses both in a highly structured therapeutic model. There are many varieties of CBT. Albert Ellis's rational emotive behavior therapy (REBT) is one of the most recognized CBT approaches. Ellis utilizes the A B C D E approach to CBT. *A* stands for activating events or adversities, in other words, the presenting problems. *B* is for irrational beliefs, the distorted thoughts and ideas that have contributed to *A* and help to sustain them. *C* represents the consequences of both *A* and *B*. *D* involves the process of exploring and disputing the faulty or self-destructive beliefs. *E* stands for the effective new emotions, behaviors, and philosophies that help alter *C*. REBT and CBT are highly structured approaches that carefully identify, track, and modify the thoughts and behaviors of the client. The focus is on the here and now. There is very little exploration of underlying feelings or history except that which relates directly to the presenting problem. CBT has been a highly effective therapeutic approach for many types of problems and is strongly encouraged by managed care companies because of its relatively short duration and quick problem resolution (Ellis, 1973).

CASE EXAMPLE

How would a clinician utilize CBT in working with an adolescent client? The following is a good case example. Kitty is a fifteen-year-old girl who was brought to therapy because of her mother's concerns about her depression. Kitty comes from an intact nuclear family (mother, father, and brother). They live in a middle-class suburban community. From the onset of therapy Kitty has been cooperative in sessions. Although she was not self-referred, Kitty is agreeable to therapy. She was in therapy once before but had a bad experience. According to Kitty, her therapist was overly paternalistic, condescending, and violated her confidentiality by telling her parents what she talked about in sessions. I assured Kitty that I would do my best to respect and honor her privacy within the bounds of ethical requirements. Everything she discussed in therapy with the exception of self-destructive behaviors would remain confidential. I realized that Kitty's parents would want to know the general progress of therapy, but Kitty and I would discuss what specific information I would share with her parents. Kitty agreed that she was somewhat depressed but was not exactly sure why or what to do about it. She was a somewhat withdrawn, shy girl, irrespective of any depression she might be



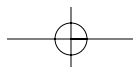
experiencing. Kitty could be described as an introvert. She had friends and was somewhat social, but spent much of her time alone reading science fiction/fantasy novels and working on computer graphic art. Shortly after she began to see me, Kitty decided that she wanted to work on losing weight. She believed that much of her sadness was related to her size, and that losing weight might help remedy the situation. From my standpoint Kitty was somewhat overweight but resembled her mother in stature. I believed that Kitty's weight was related to her eating habits and possible depression but also part of her inherited constitution. I did, however, agree to help Kitty work on this self-identified weight problem.

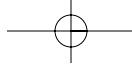
In addition to spending all therapy sessions discussing Kitty's week, we also began to focus directly on her weight loss program. We began to explore together Kitty's beliefs and ideas about weight, exercise, and the extent to which she wanted to incorporate a weight loss philosophy into her value system. These ideas were not presented or discussed in these words but in a language that had developed between the two of us over a period of time and that Kitty was comfortable with. Another very important part of this plan was to help Kitty decide how she would like to approach losing weight. Kitty decided that she would like to use running as her exercise and weight loss program. Every week Kitty and I would review her weekly running schedule as well as her weight loss. Kitty was anxious about using the scale, believing that the incremental weight loss she might experience week to week would be a deterrent to her overall goal. Instead, Kitty measured her weight loss by how her clothes fit. This was a useful and nonthreatening way for her to stay committed to the goal. In addition to this structured weight loss regimen, Kitty and I continued to discuss other key emotional and relationship factors in her therapy. The CBT-like structure served as part of the foundation of Kitty's overall approach to her life problems.

This case example helps to illustrate the use of a form of CBT with a client who is struggling not only with her weight but also with her self-esteem and perhaps a mild form of depression. Utilizing the modified CBT approach, Kitty is able to work on a specific identified problem area while still engaging in other therapeutic discussion that can also be useful. A more rigid CBT approach with Kitty might have been alienating and perhaps seemed too stilted. Given her earlier bad therapeutic encounter with another therapist, it seemed important to establish a strong, trusting, non-judgmental therapeutic relationship in order to form the basis for effective work. My flexibility in utilizing a modified form of CBT allowed Kitty to engage in it without feeling uncomfortable. In fact she truly owned it.

FAMILY SYSTEMS THEORY

Human beings are social animals and need other people in order to survive emotionally. All people have grown up in some sort of family structure. Living in a family helps to shape one's values, ideas, and behavior throughout

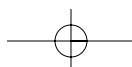
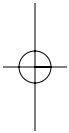




life. Family systems theory as well as family therapy models are other important clinical avenues for working with adolescents. Some teenagers can benefit from family therapy much more than individual work. In addition, much of the work done with adolescents in general is often a combination of individual and family work. The unique and delicate combination of these two approaches is crucial to successful work with adolescents of all ages.

Family therapy models and approaches developed in the late 1950s and early 1960s utilizing basic systems theory. The unique contribution of family therapy was the emphasis on examining the entire family system and its impact on the individual. In general, family systems approaches focus on the here and now. The concepts and techniques of family therapy aim toward an understanding of the entire system: its functions, structure, content, and process, and how to successfully intervene in order to alleviate identified problems within the family. Problems from a family systems standpoint are a function and symptom of systemic issues, not individual dynamics. This approach is an important and useful lens through which to understand the adolescent.

In order to understand family therapy it is useful to discuss some of the major concepts of the approach. A *system* is a group of interrelated people who function together in common purpose. There are many types of systems in life, including the classroom, the workplace, the peer group, and especially the family. All systems have *boundaries*. Boundaries are the artificial and subjective barriers that dictate structure and function within the system, in this case the family. Boundaries range from completely open or chaotic to completely closed or enmeshed. Both extremes are usually considered to be dysfunctional. All families should be understood *contextually*. In other words, each family has its own unique culture that has developed over time. What is functional for one family may be dysfunctional for another. The concept of boundaries can help the clinician understand communication, discipline, roles, rules, and values, as well as how interactive the family is within the community. An example of an extremely open or chaotic family might be one in which adolescents have no curfew. They can come home whenever they want, even if they have school the next day. Parents in this example may believe that teenagers should define their own structure. Of course this type of chaos is probably not good for the adolescent struggling to find her own limits and identity. Ultimately either the police or state child welfare system would probably intervene with this family to help create greater structure and security for the teen. An extremely closed family system could be one in which the adolescent is home schooled and not allowed to interact in any way with the outside world, even to watch television. The parents' intention might be to insulate and protect their child from what they perceive as a dangerous society, but such restriction does not allow the teenager to negotiate the necessary skills to interact and succeed in life outside the family. Both of these examples demonstrate the dangers of extremity in the ongoing development of a family system's boundaries.



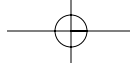


Within all family systems there are also *subsystems*. Subsystems are smaller systems within the family that carry out important functions for the entire family system. Subsystems have implicit rules and roles that dictate their function. In an intact nuclear family, for example, the parents are actually two subsystems. The first is the parental subsystem, which manages the parenting function for the children within the family. The other subsystem is the marital subsystem. The parents are also a subsystem that provides emotional, intellectual, and sexual gratification to its members through their own intimacy. The natural boundary of this subsystem seems self-explanatory. Some topics and activities should be contained within the parental subsystem and not shared with children. Sexual activity between parents is a good and probably universal example of a parental subsystem taboo or boundary. Four- or five-year-old children should not be allowed to hear their parents discussing their sexual relationship, let alone witness them having sex. This is an example of a clear breach in family boundaries.

Communication is also a key concept in family therapy. The way a family and its subsystems communicate is a diagnostic indicator for how the family as a whole functions. Once again, there are explicit and implicit rules regarding not only what can be discussed in a family but also the way it can be discussed. Sex is a good example of this. An extremely open family system may have no clear limits about how graphically sex is discussed. This could be a serious problem for young children as well as adolescents. An extremely closed family system may have the implicit rule that sex is never discussed, not even by the parental subsystem in the privacy of the bedroom. This too can cause problems. How do children learn about sex, values, behavior, and so on if they are not addressed in some way within the family? The communicative style of each family system can shed important light on the diagnostic picture of the adolescent client within it.

The manner in which the family members interact with each other is also an important feature of family therapy. Individual family members may engage in *coalitions* with other family members in an attempt to deal with family stress and conflict. These coalitions can cause problems when they jeopardize family functioning or interfere with the healthy and optimal functioning within family subsystems. A mother and son who form a coalition against an alcoholic father are an example of this. If a mother talks only with her son about the father's drinking, it circumvents the possibility for future work within the marital subsystem regarding this problem. It also develops an unnatural alliance which could interfere in the parental subsystem. Mom may be much more likely to favor the son in arguments with the father about discipline, rules, and privileges. Careful assessment of family dynamics and structure is a very important element of the diagnostic and ongoing work with the teenager.

Circular causality is another key concept in family therapy. A change in one part of a system can affect the entire family. Nowhere is there a better



example of this than when a child becomes an adolescent. Rules, roles, communication, subsystems, and so on are all affected by this one shift in the family.

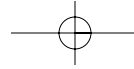
Family systems theory also examines the family's functioning in terms of the *family life cycle*. For those families that decide to have and raise children, the family life cycle is a helpful paradigm in understanding family functioning within specific stages or times periods of family life. From the beginnings of family formation through coupling, to the initial stages of raising infants, and the final adjustment to an empty nest, the family is pushed through a number of unique challenges and life tasks. Adolescence is considered one of the major family life stages. Particularly in adolescence, the family structure and function change in order to adapt to the dramatic shift in the adolescent's personality and behavior. The once compliant and cooperative little boy now becomes the defiant and oppositional teenager. Communication may become very different. Rules and roles that were not of much concern in childhood now become extremely important to family survival. Even the way the adolescent relates to his parents may dramatically shift, necessitating an adjustment in the parental and marital subsystem. In fact, many families begin to experience problems in the marital/couple subsystem as a result of a child's entering adolescence and the subsequent shift in family dynamics.

Of course there are many different types of families, from many diverse backgrounds and situations. The next chapter is devoted to this topic. Divorce, single parenting, blended families, stepfamilies, racial, cultural, and spiritual factors as well as numerous other situations affect the development and functioning of all families.

There are many different types of family therapy approaches. Bowenian family therapy, structural and strategic models, contextual family therapy, narrative/solution-focused approaches, and even object relations models are excellent vehicles for successful work with adolescents and their families. Each of these approaches has its own unique set of concepts and techniques, but all of them operate on the same fundamental systemic principles discussed above (McGoldrick, Giordano, & Garcia-Preto, 2006; Nichols & Schwartz, 2006).

CASE EXAMPLE

A case example will help to demonstrate the application of family therapy principles in working with adolescents. Bill and Brian are fourteen-year-old identical twins who were referred to therapy as a result of being caught breaking into their high school computer system. These two very intelligent and perhaps gifted boys are what one might consider computer geeks. They saw a challenge in attempting to break into the high school computer system and did not really think or feel that their actions were serious in nature.



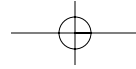
The high school suspended the boys from school and future use of any type of computers on school grounds for the remainder of the year. The twins were also restricted from computer use at their mother's home.

Bill and Brian come from a divorced family. Their parents have been divorced for several years. The boys live with their mother but spend their weekends with their biological father. Mom and Dad both agree that the boys could benefit from therapy, but they are not very consistent in their parenting approaches to the twins. Dad appears to be a bit looser in his expectations of the boys. As an example, Mom has restricted the twins' use of computers at home, whether for schoolwork or recreation, but Dad allows them to use the computers when they stay with him. The boys have not shared this fact with their mother, however, and neither has their father. The onset of adolescence for Bill and Brian, combined with the recent divorce, has obviously contributed to their problem.

Bill and Brian are both vehemently opposed to therapy. Bill is a bit more open to trying it, but Brian does not see the point. Brian has said, "We admitted we did something wrong. That should be the end of it. Why do we have to talk about it?" Both Mom and Dad feel that their boys could benefit from therapy that would help them express their emotions to a greater extent, as well as be more respectful and cooperative with adults. The twins appear to be very oppositional, arrogant, and even a bit entitled in their personal styles. Much of this takes the form of their superior air regarding their intellectual ability and computer expertise. Needless to say, both of the boys are a challenge to engage in therapy. I decided to work with each of them individually, as well as do some family work because of the nature of Mom's and Dad's concerns regarding authority issues with the boys. In other words, there are major problems not only at school but also home and in the community in general.

My individual work with the twins was from a psychodynamic perspective, which will be discussed later in this chapter. Family work, however, was crucial to addressing the problems with these boys as well. In addition to weekly individual sessions with each of the twins, Mom and her two boys would meet with me for family therapy once a month. These sessions focused on helping Mom develop firm and consistent limits and structure with the twins, as well as improving family communication. The content of most family sessions initially addressed the twins' concerns about having their computer privileges revoked. Both Brian and Bill complained continuously that the punishment was not fair, as well as asking when they would get to use their computers again. Although Bill was a bit more respectful in his tone with Mom, Brian continued to insult her and raise his voice, as well as threaten to and actually leave the room. Brian's behavior seemed reminiscent of a three-year-old's temper tantrums. The twins were really a handful to deal with in session.

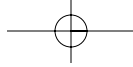
Through careful and patient discussions with Mom and her twins in family work, the boys began to see that Mom was in charge, not them. The



family sessions were used to clarify and restate Mom's concerns about her boys and exactly what kind of behavior and communication was acceptable in the family. Communication had completely broken down, and in many ways the twins were out of control. Their offense at school might have been considered symptomatic of their inability to control their impulses as well as a sense of entitlement. Family sessions focused on confronting the twins' inappropriate language and behavior as well as giving them some clear and concrete examples and expectations for their behavior. Initially this family work was extremely tedious. Virtually every minute of the sessions was filled with complaining, crying, and challenging of Mom. It became my role to help empower Mom to be firm, clear, and consistent in not only communicating with her boys but also not allowing them to talk to her in an abusive manner. Over time, Bill and Brian began to see that they could no longer manipulate their mother as they had previously, and that in order for them to have any type of privileges in their lives, they would have to begin to be more respectful and cooperative in their language and behavior. This type of family intervention was a useful way to firm up the boundaries of the family as well as help Mom reestablish her role as an authority figure. It also was a necessary adjunctive piece to the ongoing individual work with both twins. Individual work alone with the boys could not have been successful if some type of family work was not done in conjunction with it. This case example illustrates that many types of adolescent problems are not only individual but also family oriented in nature. Successful work entails the unique and carefully constructed combination of both family and individual theory and technique.

PSYCHODYNAMIC/ATTACHMENT/RELATIONAL THEORIES

A number of psychodynamic, attachment, and relational theories were addressed in chapter 1. They will be revisited now as viable and necessary therapeutic approaches with many types of adolescents. Object relations theory, self psychology, and relational approaches are especially salient forms of intrapsychic intervention because of their focus on the inner emotional development of the self of the adolescent, the adolescent's ability to achieve object constancy, and the inevitable mutual interactions in the clinical relationship. Object relations theory posits that the infant/toddler gradually internalizes a consistent and reliable emotional image of the primary care-taker(s) that can then be utilized in times of stress, anxiety, and tension to self-soothe. Peter Blos, who was also mentioned earlier, theorized that adolescents revisit the separation/individuation task in a different manner. Whereas the task in childhood is to separate self from other, the task in adolescence is to separate self from family. The process has essentially the same intensity and the same result, emotional independence. It is not surprising, then, that although adolescents are more than ten years older than the toddler challenged with initial separation tasks, their behavior is often remarkably similar to the toddler's. For example, many teens alternate intensely and

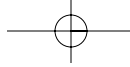


unpredictably between states of dependence and independence in many relationships, but particularly with their primary caretaker(s). This ambivalence is similar to the way in which a toddler demands to have her needs for dependency and independence responded to immediately. Combined with this need in adolescence, however, are the teen's budding self-esteem, identity formation, and sophisticated cognitive approach to the world. This complex behavior can be purposeful, oppositional, and defiant at times but more often is unconscious and troubling to the adolescent. It becomes the therapist's task to help adolescents struggling with these issues to be comfortable with their identity, build their self-esteem, and modulate their emotions.

Object relations theory would suggest that it is the task of the clinician working with a teenager to first develop a *holding environment*, a physical and emotional space within the therapeutic relationship in which the adolescent can feel safe enough to be herself and spontaneously express her thoughts and emotions. Only then can the teenager recognize herself as a separate individual in much the same way the toddler achieves a degree of emotional separation through the consistent and reliable way in which the primary caretaker(s) allows him to be both dependent and independent according to his needs. In therapy with the adolescent, this is achieved through conversation. Of course, this process is quite variable depending on the teenager, her presenting concern, her earlier success at separation/individuation, and a myriad of other factors. But for some adolescents, some form of object relations or relationship therapy is essential to the successful completion of this task.

Self psychology, another form of psychodynamic treatment, can also be an invaluable approach to working with teens. As mentioned earlier, self psychology examines the inner emotional development of the self through the incorporation of what Kohut called self-objects. All human beings have an intrinsic emotional need for the three types of self-objects: mirroring, idealizing/merging, and twinship. These are the emotional equivalent of the need for food and oxygen. The need is much greater for a child but continues regardless of age.

In adolescence, the teenager has ideally been able to establish a relatively cohesive self, as self psychology would call it. That means that in early childhood the teenager was able to get enough of her self-object needs for mirroring and idealizing/merging met so as to develop the ability to meet her own emotional needs. Through repetitive and consistent mirroring or validation of her talents and abilities, and through idealizing and emotionally merging with important emotional caretakers in life, the small child was also able to gain a sense of security about herself. The development of these self-objects is very rudimentary in childhood, however. They must continue to be nourished in adolescence, in the same way that teenagers need more physical nourishment than adults. The adolescent who has not had his self-object needs met sufficiently in childhood will be emotionally hungry for



them. This deficit may be expressed through a variety of dysfunctional behaviors including social isolation, depression, acting out, and drug use. It becomes the task of the therapist to provide a therapeutic milieu in which such a teenager's self-object needs can be met.

The third self-object need, twinship, is especially important during adolescence. Teenagers need to have others in their lives who are similar to themselves. They are striving to become emotionally independent from their primary caretaker(s) and family, and yet they still have dependency needs. This is a paradoxical dilemma that can be helped through the use of twinship self-objects. If the teenager struggling with insecurity, anxiety, depression, and isolation can connect with another who shares her concerns, she does not feel so alone. Adolescents' need for the peer group is a twinship self-object need. The peer group enables the teenager to be separate from family while still meeting his emotional needs for mirroring, merging/idealizing, and twinship. The peer group is not the only way in which self-object needs are met, however. Older people, especially trustworthy adults, can also serve that purpose. The therapist working with an adolescent with self-object deficits can be instrumental in helping her overcome her problems.

Mitchell's relational concepts help integrate and expand some of the contributions from object relations and self psychology theories. The ongoing and inevitable mutual contributions from the personalities of both the clinician and the adolescent are influential in the therapeutic process. The therapist's ongoing awareness and use of his own professional self enhances the adolescent's ability to understand and grow in the context of such a relationship. Appropriate identification and use of self can be a key factor in helping the adolescent (Mitchell, 1988; Stolorow, 1992).

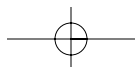
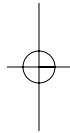
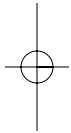
CASE EXAMPLE

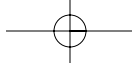
The following case example illustrates the use of self psychology in working with adolescents. Bill and Brian, the twins who were mentioned earlier in regard to family systems theory, are also a good example of teenagers who can be helped through the use of a psychodynamic clinical approach. Bill's and Brian's obnoxious and entitled behavior could be interpreted as a reaction to their underlying insecurity as well as emotional immaturity. It is certainly true that both Bill and Brian, like most adolescents, are struggling with their own narcissism as they develop their identities. A certain degree of self-centeredness is absolutely normal for most adolescents. However, the twins' extreme arrogance, entitlement, and rudeness reek of narcissistic insecurity. Most people who have been diagnosed with so-called narcissistic personality disorder or even traits of this diagnostic category are easy to spot and remarkably easy to understand once you recognize that their obnoxious behavior is a result of their underlying insecurity. I am always fascinated by any person who feels the need to brag about her accomplishments and put



on superior airs with her peers. If that person were truly comfortable with her sense of self and identity, why would she feel so compelled to convince everyone else of her greatness? Usually humility comes with confidence, because one's sense of identity is secure within oneself. The extent to which such people signal to the world their knowledge, skills, and accomplishments can be a diagnostic indicator of how empty and insecure they really are inside. Such is the case with Bill and Brian.

I decided, and their parents agreed, that the best approach would be a combination of family therapy and separate individual work for each twin. In order to help Bill and especially Brian modify their obnoxious and in some ways self-destructive interactions with others, I decided to use self psychology to bolster their self-esteem and fill their self-object deficits. Both Bill and Brian were initially hesitant to allow me to form any type of relationship with them. The first few individual meetings with both of them felt very awkward as I tried to engage with them and develop a common language and ground in which to work. Bill was fairly civil to me in sessions, answering questions in a perfunctory fashion but not providing much detail or elaboration about anything. Brian was outright rude and indignant that *he* had to come to therapy. I decided to go with this issue as a starting point for both of them. We would work on trying to help each of them individually become more of what their parents would like them to be. This topic did not hold their attention for very long, and we soon had to move on to other conversation in order to help them progress. I discovered quite innocently in conversation with each of them that they both would open up if we talked about computers, the Internet, programming, and so on . . . DUH! Why didn't I recognize earlier that this vehicle would be most conducive to safe conversation? I learned quickly that the best way to encourage both Bill and Brian to communicate in sessions was for them to be regarded as the experts and me as the student. If I made any statements that could be construed as flaunting my own knowledge of computers (remember, I love computer games), the twins would respond with their usual arrogance and entitlement. The focus of interaction must be entirely on them. Anything else might be interpreted as a threat or as an unempathic response. I implicitly and explicitly understood that my responses to their conversations regarding these areas needed to mirror them. I was genuinely positive about their comprehensive knowledge and computer expertise. I praised their enthusiasm, creativity, and specialness in a genuine and sincere manner. Bill responded to this approach by discussing at length the Web sites he was creating and his plan to develop a new form of online telephone communication. These ideas were actually very creative and compelling, and I had no difficulty mirroring Bill's accomplishments. When I mentioned to Bill that he could probably make a fortune once he developed his new communication system, he emphatically stated, "No, I would distribute the program for free online!" Bill went on to talk about how unethical (my word) he thought it would be to selfishly make





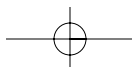
money on something the whole world should get for free. Over time this personal ideal served as an obvious transition to helping Bill recognize the disparity between his own values and the incident at school when he and his brother broke into the security system. Bill came to recognize through careful and consistent mirroring from his therapist that he truly was special, which helped him have sincere regret for his actions at school.

Brian was a different story. From the onset of therapy, Brian insisted that he was very different from his brother and did not want to be compared to him in any way. This is often the case with twins. Developing a separate identity in adolescence can be a more complex process when there is another who not only looks like you but possesses your genetics in virtually every way. It appeared that Brian's self-object needs, especially for mirroring, were much greater than his brother's. This was why Brian was more obnoxious, entitled, and rude with just about everyone, especially authority figures. I had to develop a different approach to help Brian meet his self-object needs. With Brian, I resorted to discussing my gaming computer. I learned very quickly that if I sounded too knowledgeable, Brian would respond with his usual condescending discussion aimed at letting me know how much he knew and I didn't. I decided to engage Brian in a discussion about what type of computer would be the best. What kind of hard drive should one purchase, video card, sound card, DVD drive, and so on. I related and responded to Brian as my expert computer consultant. Brian initially seemed to balk at this approach, even though it was sincere. Over time, however, he began to enjoy coming to therapy because it made him feel good. He too was being mirrored. The intensity of the mirroring in sessions was much greater than any relationship in his life and served to repair his self-object deficits from a self psychology viewpoint. Brian gradually began to be more pleasant, first in sessions, but eventually with his parents, teachers, and peers.

This case vignette is a good example of how a clinician can utilize psychodynamic theory in working with adolescents. Some teenagers need this type of approach because of their difficulties in developing a secure inner life. CBT or more surface-oriented approaches are not as helpful with this kind of issue. Psychodynamic theories and techniques specifically address these more underlying dynamics.

NARRATIVE AND SOLUTION-FOCUSED APPROACHES

It may seem odd to discuss narrative and solution-focused therapy in the same section, but both approaches have a great deal in common. Narrative and solution-focused models developed in the 1980s and are steeped in postmodern and constructivist philosophy. Simply put, both of these therapeutic models espouse the notion that reality is not absolute or objective but is created by all human beings (De Shazer & Berg, 1997; Monk et al., 1997;



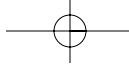


White & Epston, 1990). Life and experience are contextual. Even two children of similar ages raised in the same family (the twins mentioned above) could have entirely different views of their world based upon how they internalized their experience. Narrative and solution-focused approaches help clients attend primarily to the present. While narrative therapy helps the client tell his story in-depth, it also aims at helping him deconstruct and reconstruct a new narrative that helps him function better in life. Solution-focused approaches as well promote the philosophy that clients (or *consumers*, as they are often referred to in solution-focused work) are their own best experts in solving their problems. The therapeutic work enables the consumer to develop her own solutions to her problems in a relatively short-term cognitive approach. Each of these clinical models has specific techniques that help the client examine her present problem and develop new ways to approach or understand it without delving into the past or gaining insight into early life experiences. Both approaches externalize the problem. The problem is the problem, not the client.

Central to the success of solution-focused therapy is the use of the “miracle question.” Early on in therapy the client is asked to imagine that when he goes to sleep that night a miracle will happen and his problem will be solved. What would that look like? How would things be different? The client is engaged in a problem-solving venture that helps them create his own solutions to life’s problems. From that intervention, the therapist (sometimes referred to as *facilitator* or *guide*) works together with the client to construct concrete and specific ways in which he can change his life.

Narrative approaches are a bit more abstract and obscure in technique, but the philosophy is the same. Help the client to tell her story, deconstruct her narrative to help externalize the problem, and reconstruct a new narrative that is more positive, empowering, and constructive for the client’s present situation. Again the client is the expert, and the therapist’s role is to help her find and construct a new narrative through gaining a different perspective on her situation. This approach as well is very cognitive in nature. Narrative therapists will often ask their clients to journal about their thoughts and situations. This very practical and pragmatic approach can serve as a basis for further examination and reconstruction later in therapy.

What is useful about both of these postmodern approaches in working with adolescents? First, they do not place great emphasis on delving into the past or on extensive insight in that area. Adolescents tend to avoid lengthy discussion or exploration of their past. That is because they are moving toward autonomy and emotional independence from their primary caretakers. Discussion of these issues serves only to stir up dependency feelings or memories, or even conflicts. Fortunately, many teenagers seem to conveniently forget these things, probably a form of repression that serves to foster their growth toward autonomy. Postmodern approaches such as narrative and solution-focused models do not require the teenager to go much



beneath the surface. In addition, these models treat the adolescent as the expert. These approaches are also typically short in duration, which makes them attractive to school counselors and social workers as well as short-term community-based settings.

CASE EXAMPLE

The following is a case example utilizing a narrative approach in working with adolescents. Clyde and Carol were another set of twins who came to see me for therapy several years ago. They were outstanding high school students, who ended up being numbers 1 and 2, respectively, in their high school class. Their parents referred them to me because they felt that Clyde and Carol needed to develop better social skills in order to be more successful in their future college careers. Both Clyde and Carol were extremely compliant in therapy, doing their best to honor their parents' wishes. They were each very enjoyable to see in therapy but seemed like miniature adults in their interactions. They also came across as very intellectualized in their conversations. Clyde was the most extreme in this regard, and even though I knew he was only seventeen when I started to see him, he acted like a thirty-year-old. I saw Clyde and Carol throughout their junior and senior years of high school and right up until they left for college in the fall. They both made good progress in learning to express their emotions, and we worked a great deal on helping them prepare for college life. I did not see either of them during their freshman academic year but received a call from the parents early the next summer. Clyde was experiencing tremendous anxiety and depression and wanted to resume therapy with me to help him with these concerns.

As Clyde began his second round of therapy with me, I realized that he certainly had grown emotionally. He had gotten all As in his freshman year and had also received awards for his academic prowess. Naturally these accomplishments were not the problem. Clyde was troubled by racing and intrusive thoughts about life in general and his future. He had taken a summer job in the human resources department of a company that was in the process of severe downsizing. Clyde had become troubled by watching his fellow employees (most of whom were already out of college) struggle with an uncertain future. His racing and intrusive thoughts were about the uncertainty of life. What was he really doing? What would his future be? What was he working toward? Was any of this worth it? These and many more questions intruded into Clyde's mind continuously. Clyde was in an existential crisis. Considering his age, now nineteen, this was in fact a fairly normal part of young adult identity formation. For Clyde, however, a wonderfully talented young man, this was new territory. All his life, the future had been certain. Everything he did was planned by his parents and aimed toward giving him a successful life. But Clyde now felt that things were



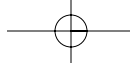
amiss. Something didn't fit anymore. He wasn't so sure that he would be safe or even that he knew who or what he wanted to be. He knew that he would be all right academically and that he most likely would get a very prestigious professional position. Clyde didn't mean to be arrogant, like the other twins mentioned above; he was just comfortable with the facts about his potential future. What Clyde did worry about was everything else. As he went through his freshman year getting straight As, he was initially happy but eventually felt a sense of emptiness about himself. He realized that his academic accomplishments were only a part of life. He also realized that his ideals (or even life narrative?) were changing, and he didn't know what he believed anymore. This became the thrust of our work together.

Utilizing a narrative approach, I helped Clyde discuss in depth his recollection of his past view of himself and how that view no longer seemed tenable for him. Therapy sessions throughout the summer focused on helping Clyde see that the anxiety, depression, and uncertain feelings he was experiencing were a problem outside of himself and not (as he imagined) a flaw in himself. He began to recognize that his developing identity included this process of uncertainty and that he was in fact the master of it. As he was able to normalize the thoughts and feelings that persecuted him initially, Clyde became able to relax and approach his life with a new story or narrative about himself. This new Clyde narrative was much more complex and abstract than the one of a few short years ago, but reconstruction of it helped him own it and feel much more comfortable with his life as he approached his sophomore year at college.

This case example, although admittedly focusing on an older adolescent, is a remarkable example of how a postmodernistic or constructivist approach to practice can be a very helpful model with many teens. If adolescents are able to externalize many of their troublesome problems and brainstorm about them with an objective, supportive, and nonjudgmental therapist, they may be able to solve them. Narrative and solution-focused models can be a refreshing, creative, and expedient approach to problem solving for many teenagers.

NEUROSCIENCE

The theory of neuroscience, mentioned in the first chapter, is a cutting-edge adjunctive aspect of the therapeutic process of all the theories already discussed in this chapter. Neuroscience is the study of the brain and how it functions. Central to the discussion of clinical work with adolescents are the ways in which neural pathways develop in the brain and help the young teenager manage her thoughts, feelings, and behavior. The infant's and young child's brain develops through repetitive experiences of the cognitive, emotional, and experiential variety. The more functional, repetitive, and adaptive early life experiences are, the more solidified they become in the



network of the brain. This network is somewhat analogous to hard wiring. The more stable and secure the neural pathway has become, the more it might symbolically resemble a very strong, secure, and physically solid electrical wire. If the experience is repetitive, adaptive, but primarily cognitive in nature, the wiring may be strong but not very large. The more complex the early experiences—that is, cognitive, emotional, experiential, and so on—the larger and more secure the pathway. For example, an infant begins to develop the ability to self-soothe through the internalization of experiences it has with its primary caretaker(s). This internalization can be represented physically and chemically in the brain by the concept of neural pathways. If the infant is fed reliably and consistently but without any emotional qualities to it (loving look by the caretaker, stroking the infant's head), the neural pathway related to initial self-soothing may be limited to physical properties only. If that experience is rich in emotion, verbal interaction (cognitive), and experience, the wiring will be not only strong but complex and solidified. On the other hand, if that initial feeding experience is neglectful or even physically abusive, the infant internalizes an entirely different type of pathway that if repeated could contribute to self-destructive types of self-soothing. Whatever the young infant has experienced early on can have dramatic implications throughout life because it is internalized in the neural pathways of the brain.

There are three very important concepts from neuroscience that are worth addressing here. One is *neural plasticity*. Although neural pathways in the brain are solidified very early in life, modification or rerouting of the neural pathways is always a possibility. The person who has suffered a stroke often must learn how to walk and talk all over again. This process of developing new pathways is what neural plasticity helps to explain. It is a rerouting of existing pathways through new experience.

Neurogenesis is another crucial concept. Until recently, it was thought in many neuroscience circles that human beings develop a finite number of neurons in their brain. Neurons are the cells that are used to transmit chemical and electrical signals that tell us how to think, feel, and so on. It was assumed that the individual acquired his or her total number of neurons by the early twenties. Recent studies have demonstrated, however, that in some circumstances, human beings may be able to grow new neurons even later in life. This is an exciting discovery because of its implications for neuroscience and clinical work.

The final concept to be discussed is the notion of critical or *sensitive periods* of brain development. There appears to be a timetable in the development of the brain. Certain growth needs to happen by a certain time or it may not happen at all or be severely hampered. For example, if an infant is severely sexually abused it may become so traumatized that brain development is inhibited and its ability to manage emotions in life is severely compromised. Sensitive periods are a relative concept, varying somewhat



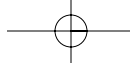
depending on the individual's neurological makeup, but they are important for diagnosis, assessment, and intervention planning with adolescents (Cozolino, 2002; Siegel, 1999).

The implications of these concepts are crucial to clinical work with not only teenagers but people of all ages. The field of neuroscience helps clinicians understand that when they are providing therapeutic services to adolescents, they are affecting their brains. Ongoing repetitive clinical work is a concentrated therapeutic laboratory in which new pathways can be developed that lead to healthier functioning in life. Even short-term types of therapies can bring about this type of change in the brain. This is a remarkable discovery. For many years clinical work has been considered more of an art than a pure science. Neuroscience helps to explain the physical changes that can result from a well-informed clinical approach. What is interesting about this process is that it does not seem to matter which type of therapy approach is used. What matters is that it is the right approach for the right situation. Cognitive, behavioral, psychodynamic, family, narrative, solution-focused, client-centered, Gestalt, and many other forms of treatment can modify the neural networks of the brain according to neuroscience.

CASE APPLICATIONS

A brief application of this knowledge to several of the cases above helps to demonstrate this point. The CBT-like approach utilized with Kitty focused on the repetitive discussion and behavioral activity of exercise to help her lose weight. This focused and structured process helped Kitty develop new neural pathways that influenced not only her daily physical routine but also her thoughts and emotions. Without realizing it, Kitty was reprogramming her brain to think, feel, and act differently. Brian was helped to feel better about himself through the use of self psychology. The mirroring that Brian experienced over time became internalized as a new or modified neural pathway to help him develop greater self-esteem. My decision to focus exclusively on his low self-concept and attempt to modify it using mirroring self-object techniques can be understood much more fully utilizing the concepts articulated by neuroscience. Clyde's existential dilemma was treated from a narrative perspective. Narrative therapy is primarily cognitive in nature, but it also influences the client's emotions and feelings about his story. As Clyde was able to deconstruct and externalize the problem and reconstruct a new narrative, he was also altering the neural structure of his brain. The repetitive rewriting process, done in an empathic, nonjudgmental laboratory, enabled Clyde to modify the neural networks in his brain and add a more sophisticated cognitive/emotional aspect to his thinking.

These brief vignettes help to illustrate the ways in which neuroscience would explain brain growth through clinical intervention. Medication can sometimes accomplish the same thing. This information is an important and

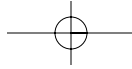


useful lens for the clinician working with adolescents. If the therapist understands what areas of the client's brain functioning may need modification, she can carefully construct therapeutic interventions that will be most successful.

INFORMED ECLECTICISM OR INTEGRATIVE PRACTICE

Now that many different types of theories for working with adolescents have been addressed, how does one know which one to use and in what ways? It is rare that a clinician uses only one theory or approach with any type of client. In fact many therapists would say that they operate under the concept of *informed eclecticism*. This means that they use a variety of theoretical ideas and techniques to help them think about and intervene with their clients. The clinical practice template mentioned above houses the clinician's repertoire of theory, empirical knowledge/experience, and technique. It operates automatically in the mind of the experienced clinician. But what does this actually look like in real life?

Even though I discussed my clinical work above as discrete types of theory and intervention, I was lying! In fact, I always utilize informed eclecticism in my clinical approach. I can't help it; it is now an automatic part of my clinical self. The cases discussed above all lend themselves to multiple theoretical understanding and intervention. They all can benefit from a mixture of technique, as long as it is informed and not random. Kitty is a good example. Had I insisted on a purely traditional CBT approach with her, Kitty probably would have felt controlled. Kitty is a teenager, she needs her autonomy in order to develop a sense of self, and she had just experienced a mistrustful relationship with a previous therapist. The CBT-like aspects of the case enabled Kitty and me to construct a reasonable plan that would help her lose weight at her own pace, but in addition our sessions focused on her emotional life and contained elements of narrative, and even family systems theory as we discussed her relationships with her father and mother. When working with the twins, Brian and Bill, I consciously utilized family systems theory to help strengthen the loose parental boundaries, but my family interventions were always influenced or tainted by a psychodynamic understanding of the boys' low self-esteem. Conversely, as I worked with Brian and Bill individually, I also kept in mind their family dynamics and how my interventions would also address problems in the family in addition to helping the boys feel better about themselves. I used primarily narrative therapy with Clyde, but I could have easily attempted to view him through a psychodynamic or even CBT lens. Although our discussions were very abstract and the sessions clearly had a client-centered, nondirective feel, there were many times I encouraged Clyde to try different approaches to his daily tasks. So my approach was not purely narrative but directive and reminiscent of CBT. To remain in a rigid and inflexible approach when the client clearly needs something else is not helpful. It is incumbent upon the



clinician working with teenagers especially to develop a flexible and eclectically informed approach to practice.

BASIS OF PRACTICE

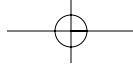
All of the practice approaches mentioned above developed from an intuitive knowledge base. Clinicians had a commonsense notion that they could be helpful in both understanding and working with clients. These same models entered into the realm of practice wisdom as clinicians began to validate their professional experiences of clients through their ongoing successes in therapeutic practice. Theoretical knowledge helped to further enhance the intuitive and practice wisdom of many of these approaches by formulating theoretical hypotheses that helped predict what would happen with clients and guide the therapeutic process (Krill, 1990).

The debate has been raging for years on which approach to practice is most successful as evidenced by the studies that have been performed. The evidence seems clearly to indicate that the therapeutic relationship is one common and necessary factor for successful treatment regardless of the approach (Prochaska & Norcross, 2003). However, there seems to be varying degrees of agreement regarding the success of specific clinical theories and methods.

This controversy is highly political and would take the length of this text to address. There are some therapeutic approaches that lend themselves better to research because the concepts within them are easier to operationalize and measure (Heineman, 1981). For example, it is much easier to measure a stimulus-response form of treatment, like behavioral therapy, than it is to measure narrative, psychodynamic, or even family therapy models. The more complex the method, the more difficult to accurately operationalize the concepts for measurement; one is never quite sure that what is being measured has been adequately defined to be measured. Thus, research on therapeutic models is controversial and can be quite complicated.

James O. Prochaska and John C. Norcross's text *Systems of Psychotherapy* (2003) does a tremendous job in exploring a wide range of clinical approaches, including the ones mentioned in this chapter. According to their comprehensive examination, there are varying degrees of success and validated knowledge for most of them. Thomas O'Hare's recent book *Evidenced-Based Practices for Social Workers* (2005) is a good reference guide to the systematic study of some of the recent literature on research with practice interventions. Evidenced-based research tends to focus primarily on the validity of intervention and is not strongly tied to theoretical knowledge (but see Roseborough, 2006).

Research into clinical practice will continue to be a rich source of validated knowledge for the practitioner working with adolescents. I encourage the reader to balance this type of validated knowledge with his own intuition, practice wisdom, and theoretical training.



SUMMARY

This chapter has presented the clinician with a variety of fundamental theories that are essential to working with adolescents. CBT, family systems theory, psychodynamic approaches, and narrative/solution-focused models are key to enhancing the development of the clinician's theoretical template. Neuroscience dramatically enriches the practitioner's understanding of the effectiveness of all of these approaches. The case examples helped to demonstrate not only the utility of each theory but also the need to practice from a stance of informed eclecticism. Research in the area of practice models tends generally to acknowledge the relative validity of a variety of clinical approaches. The difficulty with such models is to determine the extent to which they capture the phenomena being studied. The reader is encouraged to continue to pursue his search for intuitive knowledge, practice wisdom, theoretical knowledge, and validated clinical studies. All are important sources for the seasoned clinician working with adolescents.

RECOMMENDED RESOURCES

Readings

- Judith S. Beck, *Cognitive Therapy* (New York: Guilford Press, 1995). This book is a user-friendly source for CBT concepts and techniques.
- Louis Cozolino, *The Neuroscience of Psychotherapy* (New York: W. W. Norton, 2002). This is an excellent source for understanding neuroscience concepts and their relationship to and utility for practice.
- Miriam Elson, *Self Psychology in Clinical Social Work* (New York: Norton, 1986). Miriam Elson worked extensively with Heinz Kohut, who developed self psychology. Her book presents his concepts with clarity and compassion.
- Eda G. Goldstein, *Object Relations Theory and Self Psychology in Social Work Practice* (New York: Free Press, 2001). This classic work comprehensively covers object relations and self psychology with depth, clarity and utility.
- Stephen A. Mitchell, *Relational Concepts in Psychoanalysis: An Integration* (Cambridge MA: Harvard University Press, 1988). This classic book on relational theory does a solid job of presenting the inherent complexity of the concepts.
- Gerald Monk, John Winslade, Kathie Crocket, & David Epston, eds., *Narrative Therapy in Practice: The Archaeology of Hope* (San Francisco: Jossey-Bass, 1997). This is a good review of narrative therapy.
- Thomas O'Hare, *Evidence-Based Practices for Social Workers* (Chicago: Lyceum Books, 2005). This text is a thorough review of the evidence-based literature.

Internet

<http://www.integrativetherapy.com/index.php> This Web site provides good information on the process of theoretical integration in psychotherapy.