1972

# Adolescents perceive their psychotherapy: a unique approach towards understanding the therapist-adolescent patient interaction

Jerome Harris Meyer
*Yale University*

# ADOLESCENTS PERCEIVE THEIR PSYCHOTHERAPY: A UNIQUE APPROACH TOWARDS UNDERSTANDING THE THERAPIST-ADOLESCENT PATIENT INTERACTION

JEROME HARRIS MEYER

1972

Permission for photocopying or microfilming of "Adolescents Perceive Their Psychotherapy"

(TITLE OF THESIS)

for the purpose of individual scholarly consultation or reference is hereby granted by the author. This permission is not to be interpreted as affecting publication of this work or otherwise placing it in the public domain, and the author reserves all rights of ownership guaranteed under common law protection of unpublished manuscripts.

Jerome H. Meyer

Signature of Author

May 18, 1972

Date

# ADOLESCENTS PERCEIVE THEIR PSYCHOTHERAPY:

# A UNIQUE APPROACH TOWARDS UNDERSTANDING THE THERAPIST - ADOLESCENT PATIENT INTERACTION

Jerome Harris Meyer

Yale University
School of Medicine
Class of 1972

"We grisly old sykos who have done our unsmiling
bit on 'alices, when they were yung and easily freudened"

---Finnegans Wake

* * * * * * * * * * *

In memory of two teachers who helped guide the way through medical school:

Seymour L. Lustman, MD

E. Richard Weinerman, MD

A good teacher does not teach;
He allows his students to learn.

# ADOLESCENCE, CULTURE AND PSYCHOTHERAPY

## --a foreword

A diachronic view of any one moment in a man's life would reveal that the determinants of his aspirations, pains and behavior are not solely biological and evolutionary as would, perhaps, be the case for a lower, more stable species, but are dynamically related to the symbologies of a culture which he creates and by which he is created. Human adolescence can be viewed as the time of biological maturity where man the animal is capable of meeting his physical needs and of reproducing his species but where man the purveyor of symbols is still struggling for integration into the human community. Not only can human adolescence be understood as a process of acculturation where the values and priorities of civilization are assimilated, where the Eriksonian ego-identity is established, but the phenomenon of adolescence is a direct expression of the culture itself; the struggles of a culture are the struggles of its adolescents.

Much has been written on the nature of adolescence and there has been a great deal of thinking recently on the role that psychotherapy plays in society. Psychotherapy as a research tool attempting to answer the questions "What is man?" and "How is man?" as well as psychotherapy as a societal tool attempting to treat man's affective behavior has a vast interface with adolescence. Adolescence is the unique period of life where the striving for individual definition - the "what" and the "how" - confronts the established cultural norms. We need look no further than to our arts and to our politics to see nonacculturated

youth serving as both the testing ground and the prime mover for cultural change. Quite simply, it is the young who have not yet invested themselves in the tenets of the established who are revolutionaries and who can raise questions about society which the older, more integrated members have forgotten.

And what of psychotherapy? Psychotherapy in the probing, analytic model is particularly difficult with adolescents in light of the fact that this is a time of inherent change, where new roles are tried on, modified and abandoned daily. On the other hand, it would be myopic to view psychotherapy as only an instrument of society which aids the process of cultural adaptation, although some writers feel this to be the case. In both childhood and maturity there is a sense of stability: there is a clear formulation of what a child should be like, how he should behave; likewise, there is a clear code, culturally determined, of the ground rules for appropriate behavior for an older, responsible member of society. In the age of adolescence, alone, is deviance somewhat of a norm rather than an aberration - it is the stuff of romance and adventure, of sanctioned irresponsibility. The psychotherapy of adolescence is without the landmarks basic to the treatment of other age groups.

Fromm Reichmann (Principles of Intensive Psychotherapy) sees the therapist as inextricably bound in the values of society himself. The therapist helps to bring about the "self-actualization" of the patient keeping in abeyance his own relegious, philosophical and political viewpoints, yet he cannot divorce himself from culture entirely; just as the patient cannot be treated in a vacuum, ignoring his socio-biological-psychological stage of development, the therapist, also, is bound by his culture:

"[illegible] and [illegible] the authoritarian

"security and inner independence of the authoritarian values attributed to the conventional requirements of our culture are indespensable for the therapist who wants to guide his patients successfully towards finding out about the degree of cultural adjustment which is adequate for their personal needs." (p.33)

We must identify some of the problems inherent in the situation where an adolescent arrives at a confrontation with a psychotherapist. The adolescent, by definition in a state of flux between acceptance and rejection of societal values, compounded by an immediate crisis either affective or situational, interacts with an older individual, the therapist, who is at once an agent of society and a human being struggling for an objective reality in the interpersonal situation. In all probability there is no one ideal stance for the psychotherapists of adolescents to take. The variables in the relationship are too numerous. Adolescence is by nature a time where the capacities for intamicy are tested and realized - how does this mesh with the psychotherapeutic relationship? How does the therapist serve as an agent of cultural adaptation? How does he understand and treat the needs of his young patients? And, finally, how does the psychotherapist reconcile his own resolution of his adolescent conflicts and the choices he has made which have given him accreditation as an adult member and representative of society with the dreams and turmoils of his adolescent patient?

# PREFACE

"There are no purely objective data in psychiatry, and there are no valid subjective data, because the material becomes scientifically useable only in the shape of a complex resultant - inference."

---Harry Stack Sullivan

There is a joke in which a 2,000 year-old psychiatrist reminisces about one of his patients who was obsessed with tearing paper. The patient sought psychiatric help after years of agony from continuously ripping paper into tiny shreds and pieces. The 2,000 year-old psychiatrist, questioned as to what he did for his client, replied, "I said to him, 'don't tear paper.'" The humor of this story lies in the psychiatrist's all too simple response. It stands against years of psychotherapy shrouded in subtleties, mystery, countless systems and analyses. Today the literature on the psychotherapeutic relationship is insurmountable. What justification can there be for another study, ephemeral and incomplete, on this relationship, even for a study dealing with the subgroup of adolescent outpatients in individual psychotherapy?

To answer my question I shall have to share with you in this preface (is not a preface, after all, a justification) some of the history of the origins of this project. Last year I began working with the Panel on Adolescence of the Psychiatric Utilization Review and Evaluation Project in which the Connecticut Mental Health Center participated. Dr. Leonard Zegans, chairman of the panel, suggested that I could fulfill

both my desire to learn more about the psychotherapy of adolescents and my requirement for the Yale Medical School thesis by conducting a follow-up study on a sample of adolescents treated during the past year in outpatient individual psychotherapy at the C.M.H.C. After several discussions and a quick look at the literature, we decided that the best approach would be to conduct and tape-record a rather subjective interview with a sample of adolescents who had terminated their therapy at our facility. We were excited that there had been no reported studies which allowed ex-outpatients to speak quite freely of their experiences in psychotherapy. Supported by a National Institute of Mental Health summer fellowship for medical students, I began to plan and structure this project.

While my appetite to speak with these younger people, many of them near my own age, was appropriately whetted, the difficulties of collecting and presenting meaningful data grew increasingly apparent. How could I collect <u>objective</u> data? At first I thought that it would be meaningful to correlate the adolescent's impression of the success of his therapy with that of the therapist. However, if the therapist felt that therapy helped his patient and the patient felt that it did not, whose opinion is relevant? How could I arrive at a touchstone for determining what therapy was really like? There could be no objectivity in assessing change - there are no controls and, furthermore, the mood of the interviewee and his reactions to my personality could markedly alter his responses.

As my review of the literature and thinking progressed, the notion of <u>objectivity</u> became remote. The adolescents I planned to study came for help with varied complaints; there

was a wide range in the number of therapy sessions, and the credentials of their therapists ranged from graduate students in clinical psychology and social workers to experienced psychiatrists. Besides, I learned little from the published literature, burdened by the medical model of research, which attempted to reap statistical data from the ancient tradition of counselling man's soul.

Many of the studies in the psychoanalytic tradition, addressed to the question of psychotherapy of adolescents, were exciting and beneficial in that they dealt with the notion of psychic change and implications for technique. Authors such as David Rapaport, Kennith Colby, Escalona, Benjamin and Glover, to name only a few, spoke of the possibilities of collecting meaningful data from the experiences of therapy, in particular long-term, intensive psychotherapy. The data here, however, what Sullivan referred to as "inference from a complex resultant" was inaccessable to a follow-up interview. The studies were authored by the therapists themselves.

I found myself in the interesting position of being able to meet with adolescent ex-outpatients, having the permission and encouragement of the Connecticut Mental Health Center for credibility and support, and having free range to structure as informal and informative an interview as I wished. I could be a once-removed "participant observer". A compromise proposal for conducting my research was reached. Although I would have access to the patient's charts and the therapist's impressions of their problems and course of treatment, I chose to seek only two selected areas of information: the adolescent's chief complaint upon seeking help and the number of therapy sessions for which he was seen.

In order to glean some "reportable" information (initially, it is admitted, to satisfy my MD thesis requirement), I devised a research protocol. It was to be called:"Adolescents Perceive their Psychotherapy". I had hoped to categorize the nature of the adolescent-therapist relationship and correlate this relationship with the success of the therapeutic endeavor and, perhaps more importantly, to discover which of these relationships was particular to adolescents. I divided therapeutic possibilities into two large groupings. These were "change-oriented therapy" and "supportive therapy". There were fourteen sub-headings under these two groupings. Now I would have some data! Not only would I have a chance to see which therapists were practicing what kinds of therapy, but I would also have a new and clear exegesis of the psychotherapy of adolescents. (see Appendix A for this proposal)

Today I view my assumptions in this proposal as nothing short of fantastic. I need not elaborate that there is no simple nor elaborate method for determining the nature of a psychotherapeutic interaction, especially multiple interactions between assorted patients and therapists which, more often than not, ignore the exploration of the transference neurosis in the analytic model or transference in general as espoused in the intensive psychotherapeutic model of Fromm-Reichmann. I conducted barely one interview where I felt at ease assigning my impression of the patient-therapist interaction to one of the models which I had proposed. Being taught that a valid set of controls is the backbone of a scientific study, this project being a "medical school thesis", I had planned to ask others to listen to some of the tapes of the interviews and

categorize the nature of the relationship which occurred between my subject and his therapist. Some of these controls undoubtedly would be experienced professionals.

I became aware that I was contriving a research paper. While this work would "add to the literature" in the very least by sitting on a shelf in the sub-basement of the Yale Library System, I felt dishonest both to those who would read such research and to myself for purporting to conduct it.

Amidst this dilemma of understanding what constitutes research, I realized that the only real data available to me was that the tape-recordings of the interviews were an exact replication of the language which my subjects had used. I also had available some decent demographical statistics on the population which I sampled. While momentarily hesitating to ponder the known and unknown selection factors which determined whom I was able to speak with for my study, versus the adolescent outpatient population of C.M.H.C. seen in individual psychotherapy from January to July, 1971, I realized that I had an abundance of meaningful and useful information to report.

In their own words, the adolescents whom I interviewed were describing their various experiences in psychotherapy... what they liked about it and what they didn't like, what in the therapy and their therapist's approach they felt had helped them and the manner in which they interpreted it had helped them. There was no need for me to forge a synthesized and interpretive report on how adolescents feel about psychotherapy and the psychotherapeutic relationship. Indeed, I did not have to interpret whether they felt therapy had helped them or not,

for they all spoke clearly and directly to this point. My "data" existed in the taped interviews, from which we could all make inferences about the psychotherapy of adolescents.

This paper is sub-titled "A Unique Approach". Critics may point out that my methodology does not give an accurate picture of the nature of the adolescent patient-therapist interaction. They would argue that certain distortions in the adolescent's perceptions of his psychotherapy have taken place and that his impressions have been colored by the passing of time and reactions to the transference situation. My answer to this objection is that any attempt to remove or compensate for these distortions is an inevitable addition of further distortions.

Here is an opportunity to read some of the language in which ex-patients describe their feelings about and impressions of an experience in the "talking cure". Afterwards we will be free to make some assumptions and, perhaps, to learn. At this point we have some evidence, hearsay at best, that at least one psychotherapist told one patient, "Don't tear paper."

I express my thanks to Eileen Goodhue who directs the record room of the C.M.H.C., to Mike Levine and his staff for their help in finding my population among the thousands of "change of status" cards which came through their office and for teaching me how to program the demographical data. Florence Ficocelli, Dr. Zegans' secretary, has been of inestimable help and comfort to me in arranging my interviews, taking messages, procuring supplies, giving me coffee, cigarettes, warmth and quick appointments with Dr. Zegans. Of course, it is Dr. Leonard Zegans, my advisor, who has given me the most

help on this thesis. His friendly suggestions, encouragement and intellect are always available. Thanks also, Roz, for waiting.

It is the twenty-five adolescents, however, who really deserve the thanks for this paper; it belongs to them. Their willingness to share some of their impressions with me and concern about psychotherapy make this paper possible.

## INTRODUCTION

Twenty-five adolescents who had been seen at the Connecticut Mental Health Center as outpatients in individual psychotherapy between January and July, 1971 were interviewed after termination. In an attempt to unravel the nature of short-term individual psychotherapy and its application for younger patients, these adolescents shared some impressions of their experiences in psychotherapy in a relatively unstructured interview.

We know that the period of life called adolescence is delimited by the modalities of culture, biology, geography and time. It has been termed as that part of an individual's life where "a relatively strong id confronts a relatively weak ego" (A. Freud, 1936); where "the realization of the finality of the end of childhood, of the binding nature of commitments, of the definite limitation of individual existence itself... creates a sense of urgency, fear and panic" (Blos); or as a time that's "just plain hard" (Rouslin). Still others view adolescence as an extension of social irresponsibility coincident with biological maturation. The Panel on Adloescence of the Connecticut Mental Health Center has defined adolescence as that time of life between the ages of thirteen and twenty-one.* This definition, based upon chronological age is the clearest, if not the universally agreed upon description of what comprises adolescence and will be the definition employed in this paper.

It will not serve our purposes to reach any definition of

---

*Although the C.M.H.C. defines adolescence from thirteen to twenty-one, this study covers the ages of fifteen thru twenty-one.

adolescence other than a chronological one. We are interested only in the vicissitudes of this group's needs and responses to the experience of short-term psychotherapy. Only after listening to the subjects' responses can we make inferences as to how psychotherapy may have met their psychosocial needs, what they felt their psychotherapeutic needs were, and how they imagined these needs were met.

The focus is the patient-therapist interaction in a setting of individual psychotherapy on a once-a-week basis in a community mental health center. Their therapists were psychiatrists, psychologists, social workers and students. While we can hardly consider the issues of psychological change, disposition, or systems of psychotherapy, we have a unique opportunity to listen to adolescents' language communicating their feelings about their therapists and the conceptualizations of their experiences.

It is unfortunate that these twenty-five adolescents cannot be known as the individuals which they are. Their histories, psychic identities, and the life experiences which brought them to psychotherapy must remain somewhat of a mystery. The literature to date on the psychotherapy of adolescents has dealt with its populations either in a markedly statistical fashion, shedding no light on its subjects as living, thinking, albeit troubled individuals (such papers as Rosen, et.al., Beatty, Haskell, et.al., Goldberg, et.al., and Nehama), or has presented longitudinal studies of a few select adolescents (see Miller, Rogers, Daniels and the bulk of the psychoanalytical studies). The apology and novelty of this study is that the population is large and is represented in its own language.

In listening to what they have to say, it is not surprising that the overwhelming majority of those contacted to participate were eager to share their experiences with an interested, third-person professional.

A review of the literature emphasizes the uniqueness of this approach towards understanding and evaluating the nature of out-patient psychotherapy. In the extensive writings in this area there are many fine studies which attempt an exegesis of short-term psychotherapy and the needs of younger patients, yet no one has presented an open-ended interview with younger patients and listened to their responses. Basler, in his book Psychotherapy of the Adolescent, Wolberg (Short Term Psychotherapy), and Zuker (Problems of Psychotherapy) study the problems of psychotherapy with younger patients from the perspective of the therapist. Inferences are drawn from clinical observations made in the course of treatment.

There are three studies which take a serious look at the subject of psychotherapy retrospectively and attempt to evaluate the success of therapy. All three of these works, however, differ radically in their methodology from my study. Strupp, Fox and Lessler (Patients View Their Psychotherapy) study an older population of 44 patients who were seen in therapy for an average of 166 interviews. Their method of follow-up consisted of mailing a questionaire to their subjects (with a significantly poor response rate). While their work sheds light on the nature of the patient-therapist interactions, there is an imposed lack of freedom in having the patients respond to a questionaire and no mention is made of the particular needs

of younger patients.

Koegler and Brill (Treatment of Psychiatric Outpatients) present an extensive, controlled study of psychiatric outpatients. Theirs is a three-year review involving 300 patients and 44 psychiatrists. The sample is divided into three groups: "normal therapy", "brief psychotherapy with drugs" and "no therapy at all". The method of evaluating change is the M.M.P.I. They are interested only in measuring change in the patient and not is exploring the therapeutic relationship. Although the study is thorough, there is little freedom for creative response by the subjects.

McLaughlin (Long-term Results of Psychiatric Out-patient Treatment) presents a longitudinal review of several cases which had failed in all types of psychiatric care over an extended period of time. Case reports from the core of the study; there is no attempt to assess the ex-patient's impressions of his therapy.

One of the best studies of the psychiatric treatment of adolescents is Holmes' The Adolescent in Psychotherapy. Holmes focuses on those characteristics of adolescent patients which are unique and offers advice on their treatment. There is much material which attempts to analyse the adolescent patient-therapist interaction, yet no consideration is taken of the adolescent patient's responses to therapy as seen by the adolescent himself.

The methodology of previous studies, an attempt to produce objectivity, has severely limited the breadth and depth of the subject's freedom of response. Whether employing questionaires

or longitudinal individual case histories, to create an "objective" reportable product, something is lost. There is no finality in interpersonal psychiatry. It is an ongoing, ever-changing modality which thrives upon new questions rather than solutions. Perhaps the questions have been raised by the wrong people for too long - the practitioners themselves, who in an attempt to answer their own queries ultimately end on a plane of theoretics leaving their patients and his impressions behind. There is no opportunity for creative feedback from the subjects themselves. In this study, it is the open-ended interviews, an evolving methodology that permits the ex-patients free range for expressing their own views and asking their own questions, which makes it useful and justifiable.

## DEMOGRAPHICAL INFORMATION*

The Connecticut Mental Health Center, a "joint venture between Yale University and the State of Connecticut" is a community mental health center serving the greater New Haven area. Both out-patient and in-patient services are available. Demographic data is collected at intake for all patients seen at the center, regardless of their disposition (i.e., if someone walks in for one evaluation and is not seen again, he is considered to be an "admission"). From July 1, 1970 thru June 30, 1971, there were 3,705 admissions. These can be broken down into 2,460 first admissions and 1,245 re-admissions. In total, 1,152 of the admissions were between the ages of 15 - 21 (birthdates from 1/1/49 to 1/1/56).

To gain a clear picture of the representability of the sample studied in this project, we must be aware that the computer was programmed only with the admitting disposition for these adolescents. See table one.

Some of the adolescents who were placed under the initial category of "evaluation" later joined the nine patients who were placed immediately in "brief treatment and individual psychotherapy". Many of these 660 were not referred to individual psychotherapy at all, some of them being placed in group psychotherapy, some referred to other agencies, the drug-dependency unit, or eventually placed in in-patient services.

*Much of the following information was compiled in the office of statistical analysis of the C.M.H.C. relying upon a "Crosstabs" computer.

table one

Admitting disposition of all adolescents seen in fiscal year 1971:

| evaluation | brief treatment and individual psychotherapy | inpatient and anomalies* |
|---|---|---|
| 660 | 9 | 483 |

total = 1,152

*This group includes both inpatients, "unknowns" and those adolescents referred to the drug-dependency unit, either as inpatients or outpatients. None of my sample was drawn from these groups.

Many were only evaluated and not placed in further treatment. It must be remembered that the data on the further disposition of the 660 adolescents was not available for computer analysis at the time of this study.

There are two steps towards understanding the demography of the sample studied. First, the computer makes available demographical information on the entire population of all adolescents seen for evaluation and outpatient treatment at the Connecticut Mental Health Center during the fiscal year of the study. Secondly, through the elaboration of the method in which the sample was chosen for this project, an accurate impression of the representability of the sample can be gained.

The total population of adolescents initially placed in the categories of "evaluation" or "brief treatment and individual psychotherapy" in the fiscal year 1971 (n=669) can be broken down according to sex, ethnic group, marital status and religion (tables two thru five)*

*The last time period for which programmed data is available on social class was the period of 1/1/70 thru 1/1/71. The data for the 666 adolescents who registered at C.M.H.C. during this period is as follows:

Class I = 5.7%
Class II = 6.9%
Class III = 18.6%
Class IV = 37.8%
Class V = 30.9%

(see Hollingshead and Redlich, Social Class and Mental Illness)

table two

Sex of population of adolescents with admitting disposition to "evaluation" or "brief treatment and individual psychotherapy" from 7/1/70 thru 6/30/71 at C.M.H.C.

| | number | percentage |
|---|---|---|
| male | 287 | 43.0 |
| female | 382 | 57.0 |
| total | 669 | 100.0 |

note - Of the admissions to C.M.H.C. in this period for all ages, there were 1,735 males and 1970 females. The information contained in tables two thru five is recorded in the lobby of C.M.H.C. prior to being seen by a professional staff member.

table three

Ethnic groups of population of adolescents with admitting disposition to "evaluation" or "brief treatment and individual psychotherapy" from 7/1/70 - 6/30/71 at C.M.H.C.

| | number | percentage |
|---|---|---|
| Caucasian | 555 | 83.0 |
| Negro | 84 | 12.5 |
| American Indian | 0 | 0.0 |
| Puerto Rican | 9 | 1.5 |
| Oriental | 1 | 0.02 |
| Info. missing | 17 | 2.5 |
| Other | 3 | 0.48 |
| Total | 669 | 100.0 |

table four

Marital status of population of adolescents with admitting disposition to "evaluation" or "brief treatment and individual psychotherapy" from 7/1/70 - 6/30/71 at C.M.H.C.

| | number | percentage |
|---|---|---|
| never married | 562 | 84.0 |
| married | 71 | 10.6 |
| separated | 27 | 4.1 |
| divorced/annulled | 3 | 0.4 |
| widowed | 0 | 0.0 |
| info. missing | 6 | 0.9 |
| total | 669 | 100.0 |

table five

Religion of population of adolescents with admitting disposition to "evaluation" or "brief treatment and individual psychotherapy" from 7/1/70 - 6/30/71 at C.M.H.C.

| | number | percentage |
|---|---|---|
| Protestant | 141 | 21.1 |
| Roman Catholic | 305 | 45.6 |
| Jewish | 67 | 10.0 |
| none | 96 | 14.4 |
| unknown | 9 | 1.3 |
| other | 51 | 7.6 |
| total | 669 | 100.0 |

## SELECTION OF 25 SUBJECTS

Details of the methodology of subject selection can be worthwhile from several viewpoints. An appreciation can be had not only of the intricacies of the mechanics of research, but of how easy it becomes to overlook the fact that clinical research deals with real people in a real community. Some of the variables in this system of selection include the accuracy of record keeping, the availability of patient's charts, the postal system, the telephone system, and individual responses to receiving a letter and a phone call from a stranger.

The "pyramid of selection" is outlined in table six, yet it is necessary to detail and clarify the selection process.

The criteria for being considered as a subject in this study were that the ex-patients were:

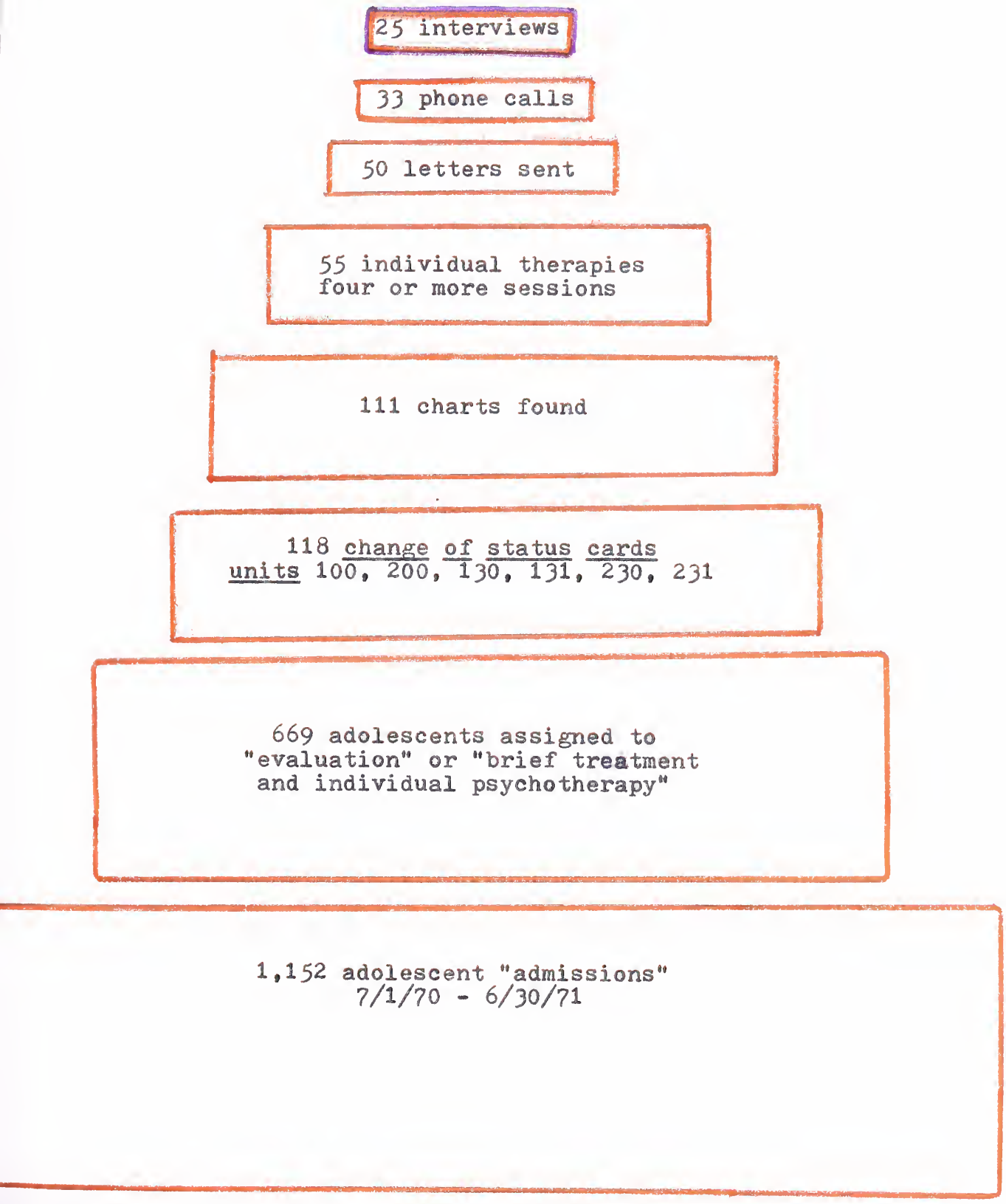
1. born between 1/1/49 and 1/1/56,
2. seen at C.M.H.C. as an outpatient in individual psychotherapy,
3. seen for a minimum of four sessions by one therapist,
4. interviewed by me between two weeks and three months after termination.

To date there is no computerized information which describes the type of therapy and number of sessions received by outpatients. This data is available only through change of status cards filled out by the individual clinicians. These cards detail the following information:

name
age
identification number (corresponds with chart number)

table six

Pyramid of Selection, detailed in text.



admission date
discharge date
address and telephone number
unit

The unit refers to the classification or type of therapy. While there was no information on the change of status cards mentioning the type or number of therapy sessions received, there were six units which contained my sample:

100 = general clinic evaluation
200 = Hill-West Haven evaluation (the "inner-city", a geographical grouping of patients)
130 = general clinic outpatient...individual treatment (brief)
230 = Hill-West Haven outpatient...individual treatment (brief)
131 = general clinic individual psychotherapy
231 = Hill-West Haven individual psychotherapy

From April to August, 1971, all change of status cards belonging to one of the six units and which corresponded to the age range of my sample were segregated. An additional selection criterion was that the interval between admission and discharge dates had to be greater than one month (thus eliminating all subjects seen for less than four sessions). Using these guidelines, 118 names were gathered. The above requirements determine that all subjects had to be in treatment between January and August, 1971, when the study was completed.

The charts were reviewed on 111 patients (although four separate attempts were made, seven charts could not be located). Information was collected on the number of sessions for which the adolescent was seen and the "chief complaint" upon initiation of therapy. The "chief complaints" were recorded by the individual clinicians and hopefully represent the patient's actual language. Fifty-six adolescents were seen for less than four sessions or were treated in group psychotherapy; there were several contradictions between units

on the change of status cards and what was reported in the patient's chart.

As a result, 55 letters were sent out to potential subjects (see Appendix B for a copy of the letter). The letters were "Xeroxed", but the date, address, salutation and signature were hand-written. Four letters were returned by the post-office, indicating that the addressee had moved with no forwarding address. One letter was returned indicating, "no such address".

The mailing of the letters was staggered over a three month period to allow time for the interviews to proceed. As indicated in the letters, the subjects were to be contacted by telephone within several days. Thirty-three telephone calls were placed to the subjects. Table seven details why eighteen adolescents were not contacted by telephone.

Of the thirty-three adolescents who were reached by phone, all but one had received my letter prior to the call. During the phone conversation, I again mentioned that I was a medical student at Yale who was "interested in discovering how younger people felt about their experiences in psychotherapy." I reviewed the content of the letter, re-assuring them of the confidentiality of the study, and made it clear to them that they would be doing me a favor by granting an interview. I was careful to mention that I would be able to meet with them either at C.M.H.C., their home, or a place of their choice. It is remarkable that of the thirty-three telephone contacts made with the potential subjects, twenty-five were interviewed. Table eight details why eight of the thirty-three adolescents

table seven

Discrepancy between fifty letters sent and thirty-three phone calls placed to potential subjects

| | number |
|---|---|
| phone disconnected | 6 |
| no phone number listed on change of status cards; instructions to call secretary at C.M.H.C. for appointment, but failed to respond* | 4 |
| spoke to parent; adolescent away from home - not available | 4 |
| no answer# | 3 |
| total | 17 |

*The letter (Appendix B) was amended with hand-written instructions to telephone C.M.H.C. for an appointment for an interview. Two subjects were successfully contacted in this manner.

#Telephone contact was attempted on four occasions for each potential subject.

## table eight

Explanation of eight phone calls to adolescents which did not materialize into interviews

| | number |
|---|---|
| appointment made, adolescent did not show up; second appointment made with same result | 2 |
| "No," followed by hanging up | 1 |
| "Went there for nothing, won't come again." | 1 |
| "Only went there for twenty minutes to see if I needed help; I never went back." (Record stated that adolescent had been seen for four sessions) | 1 |
| "Don't want to do it; I feel better and I'm too busy." | 1 |
| called back to cancel appointment: "I'm too busy, maybe later." | 1 |
| "My mother won't let me do it, even though I want to do it; she says I've been through enough." | 1 |
| total | 8 |

contacted by telephone were not interviewed.

Uniformly, those adolescents who were interviewed appeared quite eager to have the opportunity to talk about their experiences in psychotherapy. This response was seen in both those who were pleased and those who were dissatisfied with their psychotherapy. There was some concern expressed about confidentiality, although it was less than I had anticipated. Only one of the subjects interviewed expressed this issue on the telephone, while several mentioned the issue of confidentiality at the beginning of the actual interview. Prior to commencing the interviews, all of the subjects signed a "confidentiality release form" (see Appendix C). All of the interviews were tape-recorded. As a routine, the tape recorder was set up with the subject in the room. Several of those interviewed expressed some hesitance and feelings of self-consciousness about the tape recorder, although it was probably ignored during the bulk of the interviews. Table nine indicates the original chief-complaints, number of therapy sessions, place of interview and duration of the interview for the twenty-five subjects.

table nine

Chief complaint, number of therapy hours, place of interview and duration of interview for the twenty-five subjects.

| chief complaint* | number of# therapy sessions | place of interview | duration** of interview (minutes) |
|---|---|---|---|
| "nervousness" | 5 | C.M.H.C. | 25 |
| "wants letter for draft exemption" | 8 | home | 45 |
| "fear of going insane" | 8 | C.M.H.C. | 45 |
| "having trouble at home; my father is putting me down" | 12 | home | 25 |
| "depressed over loss of boyfriend" | 4 | C.M.H.C. | 40 |
| "depressed" | 6 | home | 30 |
| "marital difficulties" | 6 | home | 40 |
| "nervousness and inability to attend school" | 31 | C.M.H.C. | 30 |
| "emotionally upset sometimes; court case pending" | 4 | C.M.H.C. | 20 |
| "don't feel like doing anything anymore" | 5 | C.M.H.C. | 40 |
| "depressed, very upset; hysterical" | 6 | home | 50 |
| "marital problems" | 7 | C.M.H.C. | 30 |
| "I get very depressed at times" | 8 | home | 40 |
| "my head is always clogged up and I'm always nervous, shaky and weak" | 5 | C.M.H.C. | 40 |
| "anxiety attacks" | 4 | home | 40 |
| "very insecure; problems with parents" | 4 | C.M.H.C. | 25 |
| "worried about future" | 14 | C.M.H.C. | 60 |

table nine (cont'd.)

| | | | |
|---|---|---|---|
| "parents brought him to C.M.H.C. prior to driver's license; behavioral problem" | 6 | C.M.H.C. | 25 |
| "trouble at home with mother" | 11 | C.M.H.C. | 35 |
| "depression" | 10 | home | 60 |
| "anxiety, depression" | 21 | home | 70 |
| "very nervous, tense" | 11 | home | 50 |
| "identity crisis" | 36 | C.M.H.C. | 55 |
| "peaking of a lot of bad things" | 17 | C.M.H.C. | 45 |
| "I feel like I am in a daze" | 6 | home | 40 |

*The chief complaints are taken directly from the adolescent"s records.

#The therapy sessions were of fifty minutes duration, although there are some exceptions to this (see below).

**The order of presentation in this table corresponds to the sequence in which the subjects were interviewed by me. (see Design of Interview for a discussion of the gradually increasing length of interviews).

## DESIGN OF INTERVIEW

Of the twenty-five interviews, fourteen were conducted in offices of the Connecticut Mental Health Center and eleven at the subject's home. At the beginning of the interview, the nature of the study was again described, with my stressing that I was interested in learning how adolescents felt about their experience in psychotherapy, that I would be interviewing several younger people, and that I would ask them some questions in order to structure the conversation, but that they should feel free to elaborate - that I would like to hear any ideas they might have about their experience. I mentioned that I knew nothing about their therapy, or their therapist.

I explained that it would be most helpful to me if I were to tape-record our interview so that I might play it back and recall their responses more accurately. They were assured that anything they were to tell me would be kept confidential, and that if a report were written from this project, their identity would remain unknown.

Every attempt was made to allow the interview to proceed in as relaxed and informal a manner as possible. To this end, I endeavored not to appear as a therapist; I wore neither a white coat nor a tie.

During the interview, the following questions were asked:

Why did you come to therapy?

How did you think therapy would help you?

What did you think the therapist would do?

What did he do?

What did you do?

Did therapy deal with your problems?

Did therapy fulfil your expectations?

What was your relationship like with your therapist?

Did you like him?

What was most helpful to you in your therapy?

If you could have changed anything about your therapy, what would it have been?

How much did your therapist think treatment had helped you?

How much did you think your treatment had helped you?

How much did your friends think therapy had helped you?

Have your parents met your therapist?

Did your parents like your therapist?

Why did therapy end?

How do you feel about this interview?

While the first few interviews proceeded in somewhat of a structured manner, with the above questions being asked and responded to, there were two basic changes which evolved during the course of the interviewing. First, I began to incorporate the questions into a format which resembled a conversation more than a question and answer session. I discovered that the adolescents whom I was interviewing would often answer many of my questions without my having to ask them. As the interviews progressed, I often found myself becoming engaged in the conversations; often these were the most productive sessions. Afterwards, I would supplement the conversation with questions addressed to the material they failed to cover.

The second alteration was to add new questions to the format. Having listened to some of the responses of the earlier subjects, I became interested in the following questions and added them to the repetoire of the interview:

How old do you think your therapist was?

Was your therapist a man or a woman?

If you could have either a male or female therapist of any age, what would you choose?

What was the office like in which you met?

Did you have to pay for your therapy?

Was the Connecticut Mental Health Center a convenient place for you to receive treatment?

What is the difference between coming to talk to a therapist and talking to a close friend about your problems?

What would you do if you thought that you needed more help?

After the interview, information from the therapy was transcribed onto a post-interview data sheet (see Appendix D). In place of the name and unit number of the subject, I used a coded number which corresponded to one master list; this was to further ensure confidentiality. Although I listened to the tapes several times, I did not endeavor to transcribe the entire interview. I was generally able to have a post-interview data sheet which gave a clear picture of what the adolescent had to say. In addition, there were many things said by the adolescents which could not be placed with ease under one particular heading on this form. In short, this data sheet became only a rough form for transcribing the interviews. It was often necessary to use additional paper to transcribe what I considered to be relevant information. Naturally, much of what the adolescent subject said during the interviews was omitted

from the post-interview data sheets. My first obligation, however, was to answer all of the questions on the form using the subject's own language.

## ADOLESCENTS PERCEIVE THEIR PSYCHOTHERAPY

As discussed in the Preface, the clearest and most economical presentation of the "data" in this study is to report what the adolescents had to say about their experiences in therapy. The "data" in its pure form would necessitate presenting a transcription of sixteen hours and fourty-five minutes of taped interviews. It is expedient, therefore to edit and categorize their responses.

The most convenient method of reporting what the subjects had to say is to divide the interviews into three groups. These consist of thirteen interviews in which the adolescents felt therapy had definitely helped them; nine interviews in which the subjects were ambivalent about their therapy, and three who felt that therapy was either a waste of time or a generally disruptive experience. These three groupings were arrived at by judging the responses to the direct question, "Did therapy help you?"

In order to facilitate the process of inference, which will enable some logical statements to be made about the nature of psychotherapy as these twenty-five adolescents experienced it, the responses reported will address themselves to three areas in particular:

1. The adolescent's statement about the relative effectiveness of his therapy.
2. What he felt his relationship was like with his therapist; how this helped or hindered his treatment.
3. What he would have liked to be different about his

therapy, what should therapy be like for younger patients.

It is essential to state as clearly as possible that while the adolescent's own words will be used in all cases, much of what they had to say and what is reported here has suffered the influence of my directing the interview towards those areas which I considered important (i.e. age and sex of ideal therapist... the differences between a therapist and a friend) and my choosing which of their responses to report. The problems inherent in both directing the interview and editing the responses can be clarified by stating that I hope to provide material which will permit an exegesis of the nature of the patient-therapist relationship. To this end, I will report at least some of the responses from all of the subjects, but will select that material reported by these ex-patients which I consider to be both typical of their interview and directed most clearly to the three areas outlined above.

There is a good deal of variance in the amount of material presented from each subject. For the most part, the amount presented is directly proportional to the length of the interview. (The material presented from patient four is unusual lengthy; she was exceptionally verbal and it was difficult to limit the quantity of her thoughtful responses.) In all cases, I have adhered to the language of the subjects. The material is not always presented in the order in which it occurred during the interview. The occurrence of three dots (...) signifies a pause rather than a juxtaposition of non-sequential material.

In an effort to gain a clearer idea of who these twenty-

five subjects are viz a viz the entire adolescent population of C.M.H.C., and with regards to the three sub-groups of thirteen, nine and three, tables ten and eleven outline demography of the sample and the credentials of their therapists.

The presentation will adhere to the following order:

1. A general statement about the effectiveness of therapy;
2. Why the therapy was or was not helpful, focusing on the qualities of the therapist;
3. What, if anything, could have been different about therapy; what these adolescents feel could constitute a psychotherapeutic experience for themselves and their peers.

Demography of twenty-five subjects interviewed

total sample of twenty-five

| | number | percentage |
|---|---|---|
| **Sex** | | |
| male | 10 | 40 |
| female | 15 | 60 |
| **Ethnic group** | | |
| Caucasian | 24 | 96 |
| Negro | 1 | 4 |
| **Marital status** | | |
| never married | 20 | 80 |
| married | 3 | 12 |
| separated | 1 | 4 |
| divorced | 1 | 4 |
| **Religion** | | |
| Protestant | 2 | 8 |
| Roman Catholic | 17 | 68 |
| Jewish | 3 | 12 |
| none | 3 | 12 |
| **Resides** | | |
| with parents | 10 | 40 |
| away from parents | 15 | 60 |
| **C.M.H.C. admission** | | |
| first admission | 20 | 80 |
| re-admission | 5 | 20 |

table ten (cont'd.)

Demography of twenty-five subjects interviewed

| | thirteen "successful" subjects | | nine "ambivalent" subjects | | three "frustrated" subjects | |
|---|---|---|---|---|---|---|
| | number | percent. | number | percent. | number | percent. |
| **Sex** | | | | | | |
| male | 5 | 39 | 4 | 44 | 1 | 33 |
| female | 8 | 61 | 5 | 56 | 2 | 66 |
| **Ethnic group** | | | | | | |
| Caucasian | 13 | 100 | 8 | 89 | 3 | 100 |
| Negro | 0 | 0 | 1 | 11 | 0 | 0 |
| **Marital status** | | | | | | |
| never married | 9 | 69 | 8 | 89 | 3 | 100 |
| married | 3 | 23 | 0 | 0 | 0 | 0 |
| separated | 1 | 8 | 0 | 0 | 0 | 0 |
| divorced | 0 | 0 | 1 | 11 | 0 | 0 |
| **Religion** | | | | | | |
| Protestant | 1 | 8 | 0 | 0 | 1 | 33 |
| Catholic | 10 | 76 | 7 | 78 | 0 | 0 |
| Jewish | 1 | 8 | 2 | 22 | 0 | 0 |
| none | 1 | 8 | 0 | 0 | 2 | 66 |
| **Resides** | | | | | | |
| with parents | 4 | 31 | 4 | 44 | 2 | 66 |
| away from parents | 9 | 59 | 5 | 56 | 1 | 33 |
| **C.M.H.C. admission** | | | | | | |
| first admission | 10 | 77 | 7 | 78 | 3 | 100 |
| re-admission | 3 | 23 | 2 | 22 | 0 | 0 |

table eleven

Credentials of therapists who treated sample (five therapists saw two patients each).

Total sample of twenty-five subjects:

| | |
|---|---|
| second-year psychiatric resident | 9 patients |
| intern in psychology | 5 patients |
| psychiatric nurse | 4 patients |
| third-year psychiatric resident | 2 patients |
| chaplin | 1 patient |
| psychiatrist | 1 patient |

(of the twenty therapists, males saw ....13 patients
females saw.....12 patients)

Thirteen subjects experience "successful" therapy:

| | |
|---|---|
| second-year psychiatric resident | 4 patients |
| intern in psychology | 4 patients |
| psychiatric nurse | 2 patients |
| psychiatric social worker | 1 patient |
| third-year psychiatric resident | 1 patient |
| chaplin | 1 patient |

(males saw.....9 patients
females saw.....4 patients)

Nine subjects "ambivalent" about their therapy:

| | |
|---|---|
| second-year psychiatric resident | 4 patients |
| intern in psychology | 1 patient |
| psychiatric nurse | 1 patient |
| psychiatric social worker | 1 patient |
| third-year psychiatric resident | 1 patient |
| psychiatrist | 1 patient |

(males saw.....3 patients
females saw.....6 patients)

Three subjects "frustrated" by their therapy:

| | |
|---|---|
| second-year resident | 1 patient |
| psychiatric social worker | 1 patient |
| psychiatric nurse | 1 patient |

(males saw.....1 patient
females saw.....2 patients)

THIRTEEN ADOLESCENTS EXPERIENCE SUCCESSFUL PSYCHOTHERAPY

Patient one (19 year-old male* 14 sessions, chief complaint: "worried about future")

Yes, therapy helped me; you really have to want to help yourself...I've changed. My mother says I'm like my old self. I want to make other people realize about psychiatry.

* * *

I liked my therapist. He gave it to me straight. He told me to ask kids at school what they really thought of me and I did. After a while I talked about everything, he didn't rush me...he drew me out. He was very happy when I stopped coming; he was all smiles. He told me from the first that I could help myself.

* * *

My therapist was 25 or 26. They should be young so that they can understand. Live life by experience. I would definitely want a male therapist...I was always rebelious and didn't like my old man...he always resented me. I can't think of anything that he [therapist] should have done differently. I hope this helps other kids.

Patient two (18 year-old female 10 sessions, chief complaint: "depression")

I needed someone I could talk to. Therapy didn't change my problems, 'cause I'm me...it helped me deal with them. I was able to release my emotions and talk...learn not to hide my emotions.

* * *

He got me on the right track, he dug things out of my head. He wasn't impersonal...he looked at me and he talked. A psychiatrist should love people. It's a question of *trust*#. It took me five times before I could trust him.

* All ages are at time of interview (i.e., therapy could have commenced three to eight months earlier).

\# Underlining (italics) represents special emphasis by interviewee.

You have to get to trust them first...
I'd been given tranquilizers and had tried suicide at one point, and he asked me if there was any kind I preferred and I said, "no, not really," because I'd had a lot of experience with Thorazine, you know, zombie juice, and so he recommended, like, Valium and I was shocked because I'd never been allowed to take Valium before. And so he gave them to me and said, "take them when you feel you need to take them," and so he gave me quite a large bottle, and it may seem like a silly thing, but to me that made me feel that he trusted me so I trusted him.

I know I could call him up and talk to him if I needed to... He would hear me hint at something that needed to come out, like my mother's suicide, and he would command that I talk about it, so I would try.

* * *

I used to try to talk to my physician, but he didn't have time, and that was still a problem with my therapist... having to stop after an hour...sometimes you need fifteen minutes, sometimes three hours.

I guess he was thirty years old, but I might choose somebody younger...there are so many things, like bad trips which are important to describe and have somebody understand... he's never tripped...it's something that's simpatico, necessary to understand.

I always trusted men more than women; I have a house full of brothers.

Even people who are eighteen could be psychiatrists.

I'm very happy you wrote, I'm glad someone's finally noticing you have to adapt therapy to adolescents.

Patient three (20 year-old female 11 sessions, chief complaint: "very tense, nervous")

Therapy has helped me very much; I'm divorced, I've gained weight and I don't have any more stomach pains. I stopped therapy because I was better.

* * *

I didn't know what therapy would be like...I thought she was going to make my decisions for me. I was able to talk to her; I trusted her immediately. She just asked me questions and after a while I just talked...about everything. I was really able to talk to her; she really helped me find myself, which I think all people should do first.

* * *

A therapist should be young...around my age...understand more. A friend can't be as objective as a therapist. Because of my upbringing, I thought you had to be mentally disturbed to go to a psychiatrist...now I would recommend anyone to go.

Patient four (21 year-old female 21 sessions, chief complaint: "anxiety, depression")

Therapy was a very good experience. I feel a thousand times better...I miss her a lot [the therapist] .. My situation is much worse than it's been, but I'm feeling better about myself than I ever have in my life. The stuff we dealt with was dealt with, but there were whole areas we never got to.

* * *

I really trusted her a lot. She's like someone I would like no matter what situation. I always thought of her by her first name.

She reacted...something I didn't expect from my last experience...and I really liked that...nod her head up and down...by the end of the year I could see what she was thinking just from her face...when I did something smart, she supported it and when I did something dumb, she tried to figure out why I had done it and what it had meant to me... I guess that what I felt from her mainly was, like, support for all the good things I did.

She could also pick out the most important thing that was happening, like, the best example is one time when I was really upset...I was crying and moaning and she said, "But, look, at least you can feel pain, now isn't that a good thing?" which was for me absolutely the best thing she could have said and was the most important thing that was going on and made me aware of my strengths and realize that nothing was falling apart and that I could work things out...had she said, "Oh, come on. Don't worry, you're strong enough, it'll all work out; you know it's not the endoof the world," that wouldn't have done any good at all, but she picked out what was most important in terms of my own growth. She gave me support for the healthy things.

I thought a lot about the power that a shrink can have with patients...one thing was I talked to her about it... about my fears, and she said, "Look, what can I do to you?" Just like talking about it in front of her made me realize how ridiculous it was.

I knew I trusted her when I told her I was having a relationship with a woman, but she just laughed and she said, "My god, I'm really happy for you," when I was just very frightened of what everybody would think and say...I knew I'd get at least some kind of liberal bullshit about how

homosexuality isn't sick etcetera, but she just sort of recognized that gayness was something to be dealt with... she concentrated on the human relationship.

Knowing how nice it felt to trust her made me know that I could trust other people and made me realize that's what I wanted to do. I think it's her...she didn't accomodate herself to me.

The first few weeks I just talked about myself in terms of the other people, that I never talked about myself alone and she pointed this out to me...when I talked about myself, she reacted very positively and she seemed interested in what I had to say, so I just kept saying it. She had a lot of respect for me and didn't push me.

I felt it was very much of a two-way relationship. She was very gentle. Sometimes she was wrong and it was o.k. that she was wrong, not just that she would own up to the fact that she was wrong, but that I was right, that she trusted me.

Therapy ended because C.M.H.C. terminates at the end of the year. I'm sort of glad it ended with her because I don't want the one-way relationship anymore. We decided to keep in touch at the end of the therapy. I really should hope that our relationship will change drastically, because I really care about her and I am very limited by that relationship...six months ago, I wouldn't have wanted it to ever change.

* * *

Going to a psychiatrist is an elitist thing; she wanted to break it down, but there wasn't enough time. I don't like that fifty minute deal, having it end at a given time just isn't right.

It wouldn't be fair to have a relationship like that with a friend; this was a relationship about me and had nothing to do with her...I wouldn't want to have a relationship like that with any of my friends. I think it's just off the wall that you can't get help from somebody as long as you consider that person so much better and wiser than yourself. Psychiatrists are humans too. The idea of paying for this is ludicrous.

Patient five (21 year-old female 8 sessions, chief complaint: "fear of going insane")

In the long run, I feel therapy was the best thing for me. It releived me from the outside world...just the fact of knowing that I could come to therapy.

* * *

I felt at ease with my therapist...I had much more of a human feeling than with any of the other doctors. He cared about me and I think that he cared about all of the patients that he had. He listened to me, asked a few questions and didn't give me answers, which sort of pissed me off... didn't feel he was trying to analyse me...didn't feel I was another patient or experiment. He was concerned about how I felt about things. He was a younger doctor and that was good. Therapy ended because I moved to Vermont, although I came down twice.

* * *

If young people have problems, they should have both private and group therapy...compare with each other... so they don't have to feel so alone and so isolated.

Patient six (21 year-old male 6 sessions, chief complaint: "marital difficulties")

I had this problem...went to a psychiatrist...couldn't get an erection, an ejaculation...but now the problem's gone; he helped me.

* * *

I talked a lot and he talked a little less. He gave me information. He explained a lot to me. It was easy to talk to him...other people go and sit like a bump on a log...figured I wouldn't waste time, so I talked. He helped me out; he cared about me.

* * *

I saw another psychiatrist in his forties...he gave me pills. This therapist didn't give me pills because he was young. He tried to help me without pills and he did. It's good they charge you what you can afford.

Patient seven (20 year-old female 4 sessions, chief complaint: "very insecure, problems with parents")

My problems don't bother me that much now...eating better, no stomach pains...problems at home are better now.

* * *

He let me talk. I was able to tell him everything... he'd heard things worse than that...if you go to a psychiatrist,

you have to tell the truth...having someone to talk to... getting things off your chest. He's a pretty nice person... he had braces on too. He didn't think I needed therapy... told me that if I had any problems, I should call.

* * *

My doctor was around thirty-five. I might like to have a psychiatrist closer to my own age...they understand you more. Older doctors are like me talking to my grandmother. The difference between a psychiatrist and a friend is just that word; he's a mind doctor.

Patient eight (17 year-old male 4 sessions, chief complaint: "emotionally upset; court case pending")

Therapy dealt with a good percentage of my problems. He got me and my father on the same wavelength. For a while, my school performance went up. I haven't been arrested in a long time. Therapy had to stop because I couldn't get here...my father used to drive me in.

* * *

After I got to know him, he was a pretty nice person. Therapy was just talk sessions; he asked quite a few questions. He spoke 2/3 to 3/4 of the time...he spoke of his ideas, his philosophy. He tried to release tension; while I was here, tension built up, but I felt better afterwards.

* * *

I used to think a therapist was a little nut running around with a hat on and a little bag [laughs], now, just a person...just like a social worker...don't want someone eighty-years old talking to young kids.

Patient nine (15 year-old female 6 sessions, chief complaint: "nervousness")

Therapy helped me...life's been going pretty good...only problem is finding a place to live...my boyfriend's a drug addict. Therapy helped me to make decisions and be honest.

* * *

I really think of my doctor as a person and a friend, I really think he wants to help people, he really understands

me as much as anyone can understand me; I don't think it's because he's read a lot of books. It built into a friendship...I'm sorry to see him leave...he gave me his phone number and future address. I wish he would take me for a ride on his motorcycle. I call him at home for support.

* * *

I sort of wanted to get into psychodrama, though...I thought that might help me get more feelings out. I think doctors should do things with their patients outside of the hospital.

Patient ten (19 year-old female, 4 sessions, chief complaint: "depression over loss of boyfriend")

I had high expectations of therapy...I thought that when we stopped, it didn't fulfill them to the extent that I thought it would, but now it seems to really have helped. She helped me to do things for myself...change myself.

* * *

She spoke of my need to comfort him [boyfriend]. She helped me realize that my reasons for being uptight were issues of depending...she made me see that maybe I needed him too. I liked my therapist a lot...just knowing that I could come here was really helpful. She was in her early thirties or twenties...made it easy to identify with her; initially I didn't think she was too competent because of her age.

I only spoke about symptoms, not the root of the problem. I had a lot of problems at home...didn't talk about family situation...time...she didn't think I needed it anymore. She didn't think there was anything else she could do for me from that point on, I would have to do it for myself... like I'm a pretty stable person

* * *

A younger person...a therapist...is more prone to change with society. Harder to relate to an older person... identification is important.

Patient eleven (20 year-old female 36 sessions, chief complaint: "identity crisis")

Therapy helped me to make the decision to leave my husband.

*  *  *

He left a lot up to me. He was normal, easy-going; I was comfortable in the therapy...that voice of his...if I were blind...he was comfortable and that helped me to feel comfortable...he was what I wanted my husband to be like.

*  *  *

There should be no time limit in therapy...can't stop talking at exactly fifty minutes. The difference between a friend and a therapist is that you can put your arm around a friend.

Patient twelve (21 year-old male, 8 sessions, chief complaint: "letter for draft exemption")

Therapy helped me...like I'm working nights now; I don't get my wife anymore...we're trying to have a baby.

*  *  *

He really straightened me up...he didn't give me a lot of suggestions; he made me feel like he understood what I was saying. He made me feel like he was involved in my problems. He made some suggestions, sometimes. He did very little talking. Anything that came to me, I talked about...he acted like he cared. He made me feel that there was a better, different bag...he made me want to try different things.

The last week I seen him, here I am and I get a letter from the draft board...I was all ready to get mad at him, and so he knew my problems with heroin, like I sweat, you know... he knew I was nervous...he understood, so the next day he wrote me a letter.

*  *  *

One day this other doctor didn't have time to see me, I came late and she just said, "You have enough Thorazine?" I said, "no," and she wrote me out a prescription. Some doctors, if you told them you did heroin, like they'd ask you all these questions...like all they wanted to do was find out for their own sake, you know. I told her I tripped a few times and she'd ask me what it was like...I don't want to tell her...you tell me all about it...you tell me how to get out of it.

A good therapist is like a friend, but there are things you can't tell a friend on the street.

Patient thirteen (18 year-old male 12 sessions, chief complaint: "having trouble at home; my father is putting me down")

I feel more sure of myself now, less depressed. If I didn't want to go there anymore, it was up to me. She made me want to go to school.

* * *

You really don't do anything...she did more talking than I did...sometimes it was harder to talk to her than it is to talk to your parents because you don't know her as well...kind of hard first meeting her. Now I want to go back down to C.M.H.C. and say hello.

She went to talk to my guidance counselor, but she wouldn't talk to my boss.

* * *

I think therapy really helps you...more helpful if they keep you more...they should make decisions for you... I would be just as frustrated when I leave as when I came. If you want a better time, it's better to go to a therapist when you're young.

## NINE ADOLESCENTS SPEAK AMBIVALENTLY ABOUT THEIR PSYCHOTHERAPY

Patient fourteen (18 year-old 31 sessions, chief complaint: "nervousness and inability to attend school")

There was really no change in therapy, it removed frustration. ..someone I could talk to...it didn't do no good...it was myself that snapped myself out of it. A lot of it was a waste of time. It got across to my parents that I wasn't pretending.

* * *

He didn't really explain problems...didn't really care about me...gave the impression that he didn't care...he pushed me to change...to go to school. He knew I couldn't do it. He just told me to change...leave home...I couldn't. Just at the peak of therapy, he dropped me...he thought group therapy would be better. I don't want group therapy... it didn't work...don't have problems of others...he said it don't make no difference.

* * *

No family, no friends to talk to...I felt he was trained to understand, to evaluate. He was cold, he wasn't my friend...he should be more understanding.

I really think psychotherapy is a game; I don't really think it helps.

Patient fifteen (20 year-old male, 17 sessions, chief complaint: "peaking of a lot of bad things")

It's hard to say if therapy helped...what is attributed to my getting older or to my therapy? I felt I would be more comfortable taking care of my own problems...I was very conscious that I was going there one hour a week to spew out my problems.

* * *

The only logical way of getting help was sharing my problems with somebody...I liked this therapist...would have terminated with anyone I didn't like...it was an out, it was there.

* * *

I think I would have liked to change the structured part of therapy...it's why I left school. If I could define the ideal therapist, then I wouldn't need one.

Patient sixteen (19 year-old female, 6 sessions, chief complaint: "I feel like I am in a daze")

I don't know how much therapy helped me...I have a scary feeling that the daze will come back.

* * *

Someone was there to talk...could do more than my parents. She asked what was bothering me...she asked a lot of questions, like on television. She was sharp, she wouldn't let things slip by...she used a lot of psychology on me. The best thing she did was to be cold when I came back the last time...I wanted someone to feel sorry for me. She said, "You're angry; face up to it."

* * *

I wish I could have talked longer; I didn't want to leave. It isn't easy to sit down with a friend and say, "I think I'm going out of my mind."

Patient seventeen (15 year-old female, 5 sessions, chief complaint: "I don't feel like doing anything anymore")

Therapy didn't deal with my problems...it was all things I had to do, she couldn't do them for me. Everything I wanted to work out, worked out...I looked at everything and I found the answer myself.

* * *

To me she was a complete stranger...I couldn't relate to her. I wanted her to sit there and say, "Well, here's what you have to do; here are your problems." We talked a lot, but I didn't know what to talk about...I talked about things I thought I should, but nothing came out of it. All she knew was that I came in an hour every week, every two weeks.

* * *

Therapy should be more personal...more on a personal basis. She should have talked about herself a little so I'd feel that I knew her as a person.

If I were a psychiatrist, I'd go somewhere else and talk, like get out of this office, get out of this atmosphere... say, "Well, that's happened to me." I get nervous going to a doctor.

I can read books, what you need is experience. I think the only way to treat an alcoholic is by other alcoholics; same thing with a drug addict...if you went through it yourself and you know...did she go through it? No.

Patient eighteen (19 year-old female, 8 sessions, chief complaint: "I get very depressed at times")

I didn't have that many expectations and I don't think that therapy helped me. She said she thought I didn't need therapy,and I agreed. Would have come longer if I could have come for free.

* * *

I think that the problem was that she didn't know how to help me. I wanted specific information...someone to tell me what to do...I had a lot of trouble just talking. I had no idea what was happening, so I think it was her job to form the type of relationship that would help me. A friend, maybe, can understand a little better than a psychiatrist.

* * *

Right now the only thing I'd do is Primal Therapy. She should have been like Janov...would have liked to have expressed what I felt...therapist should know more than me. Don't think any therapy but Primal Therapy could possibly help anyone.

Patient nineteen (20 year-old female, 7 sessions, chief complaint: "marital problems")

I wonder if I'll ever completely get over the things I feel inside. Before I went to therapy all I wanted to do was kill myself...when she said I didn't have to come, I was shocked, but now things are good.

* * *

We just talked like friends...it was just like going to a tea party every week. She told me a lot about her life,

like when she was younger...she always sided with me... I couldn't talk about what was really on my mind...I felt like I was talking to a girlfriend or something...I thought she was going to figure out all these deep things in my head. She took everything I said so lightly, it really depressed me. I felt let down because although I didn't think she helped me, I needed her...I felt she didn't want to be bothered anymore. I would have liked her to find some fault in me...she was a sweet little-old-lady who didn't find fault in me...maybe she hates men [laughs].

* * *

I was surprised because I thought all therapists were men... I thought she might not understand; I would probably have chosen someone younger...maybe a male therapist.

Patient twenty (20 year-old male, 5 sessions, chief complaint: "my head is clogged up and I am always nervous, shaky and weak")

Therapy dealt with my problems only as much as I dealt with them. I used to complain a lot, but now I accept the situation I'm in...I felt like I was wasting his time. He said to me that he was there for me...like that was what I was there for...I never really spoke to him formally... I just didn't want to go anymore.

* * *

He mostly let me talk...said that if I was afraid it would cause a block...I just talked. I wanted him to give me alternatives...like I was running out of them. He talked to me about all the things that bothered me...an open ear... my parents...I don't really talk to them very much. We're not on the same level...like, I could identify with the doctor better. He told me I had to be patient...like I was down on females...defeat the whole purpose, he said.

I would have liked to work with him...learn more about his job and how he functions...he's a really interesting person.

Like when I would talk to my friends they would agree with me when I say, "This sucks, you know," and they'd say, "yeah, I know," and he would just like, you know, be positive about it and say, "well, it's not that bad," and it started to rub off on me and, like, people would act depressed around me and I'd sort of be happy...it was really good."

* * *

Therapy should be oriented towards younger people...jobs, boredom, which cause increased anxiety. I think it helps you to understand yourself a little more.

Patient twenty-one (19 year-old female, 11 sessions, chief complaint: "trouble at home and with mother")

Therapy ended at a bad point; at times I'm still desperate. It had to stop because he was leaving...he asked me if I wanted to see someone else, but I wanted to avoid the hassle... I wasn't sure if I needed it anyway...it kind of helped me to deal with my own self, but I don't know if I did a good job of it.

* * *

He was a nice guy. He didn't give me advice...forced me to think...wouldn't make decisions for me. I felt I was talking to a computer who analysed what I said instead of to a friend...he suggested why I was doing things, but much of it sounded like it came out of a soap opera. I wanted to know him...have a two-way thing. I wish he'd asked me questions...I didn't know anything about him and he knew everything about me.

At times I wished I was talking to a girl instead of a guy...I felt I had to watch what I'd say. In trying to avoid any silences, which was worse, I kept contradicting myself and it made me feel very stupid. I wanted to know him.

* * *

A lot of kids feel that psychiatrists are trying to fit them into the norm, but they don't like that...I felt I would have liked that, but it couldn't happen.

Patient twenty-two (16 year-old male, 6 sessions*, chief complaint: "parents brought him to C.M.H.C. prior to driver's license...behavioral problem")

If you're not willing, it doesn't help you very much...I didn't want to come...I would tell him things were going well, so I wouldn't have to come. It helped a little, I guess.

* * *

*Patient's parents were included in part of three sessions.

He mostly talked...said what was wrong and what I could do. I didn't talk about nothing...I didn't want to come and that was that...tried to make me look at the good side of things...he made my mother talk a lot...made her admit a lot of things. You have to reveal a lot of things and reveal personal feelings. I didn't want to encourage him to make me come more. If I felt it would help me, I'd come...if I had a bad problem.

* * *

Younger people's biggest problem is pressure, I guess... what you're going to do and how you're going to do it.

## THREE ADOLESCENTS EXPERIENCE FRUSTRATION IN PSYCHOTHERAPY

Patient twenty-three (16 year-old male, 4 sessions, chief complaint: "anxiety attacks")

Therapy didn't help me because I really never went there... they never called me back...I'm supposed to go into group therapy. I still have the anxiety...I've been busy.

* * *

She was pretty nice...she listened to me tell my problems. She asked me about my homelife...she gave me pills that I was supposed to take three times a day. I tell them about myself, but I want them to tell me about me...why these things happen...could seem a little more concerned. I feel if I could get up there and talk to somebody and knock this nervousness out, I'd feel better.

* * *

There's nothing wrong with going to a psychiatrist... if you're not feeling well and it's nothing physical, there"s no sense hiding it.

Maybe if they went through it, they could tell me what's going on.

Patient twenty-four (16 year-old female, 6 sessions, chief complaint: "depressed, very upset... hysteria")

Therapy didn't help; only the Librium that they gave me. My parents couldn't be involved and they wouldn't treat me without my parent's consent...I was divorced from my parents.

* * *

What she said was bad, she should have said, "You're under age." She really wanted to talk about my parents... I don't think our personalities got along very well. She wanted my parents to come! I wish things could have been set up easily...there was to be no talk about my parents. I would have preferred to have a male therapist...I have problems with women...I couldn't identify with her...I don't want to get involved with any thirty-year-old woman and her problems.

* * *

I really don't think my problems relate to the majority of adolescents...their problems are most likely in terms of drugs, putting diaphragms on their heads...I passed the stage of drugs when I was twelve. Planned Parenthood has a not-too-legal way...legal enough...to hand out pills to younger people...the whole thing boiled down to money... at V. D. clinics you don't have to have your parents' permission. An institution that's Yale affiliated and everything affiliated can get around it.

Patient twenty-five (20 year-old female, 6 sessions, chief complaint: "depression")

Therapy did not help me...it was a waste of time...there were things I wanted to talk about which I couldn't. I don't think anything was helpful.

* * *

She's a nice person, but I never felt relaxed...she never kept things confidential...she brought my mother in once and told her things I didn't want her to know.

She did most of the talking...had a very hard time getting me to say anything...I never felt relaxed...she was working on my family mostly, but that wasn't my main problem. She thinks she helped me by telling me that my mother didn't care and that my sister was acting like my mother. She kept pushing that subject...I just let her go on talking... couldn't stop and say, "Hey, this is what's really bothering me, not that."

It was a very small office and people kept coming in and out...should have been uninterrupted. I could have talked more with a doctor, but she said, "Our doctors are very busy with a lot more important cases." She asked me if I was going to attempt suicide again, and I said, "Yes," but then I lied to her and said, "no," so she wouldn't sign me in.

She was maybe two years older than me at most...I felt funny talking to her...I didn't feel she had lived long enough to understand and help me.

* * *

They're supposed to make you relax, but I didn't. A man may have been able to understand more.

## DISCUSSUION

The methodology of this paper - twenty-five open-ended interviews - provides an ususual and perhaps unique perspective towards understanding the adolescent psychotherapeutic relationship. While it is tempting to propose a generalized construct for what makes "good therapy" or "bad therapy" with the younger patient, it is outside the realm of a phenomenological paper to do so. The "data" of the previous section is the reported language of those interviewed; any questions or points raised about the psychotherapy of adolescents, in particular the adolescents interviewed for this study, are inferential.

It is expedient prior to the discussion and interpretation of the material presented in this paper to digress for a moment and examine the usefulness of the phenomenological approach in psychiatric research. How do we know and understand what happens in psychotherapy? How do we measure success in this interpersonal system? What are some of the variables and how can we correlate one experience in psychotherapy with another? What are the implications for change?

In all likelihood it is an historical "accident" that psychotherapy - the talking cure - as practiced with outpatients at the Connecticut Mental Health Center is based upon the medical model of disease and therapy. The notion of inference as applied to medical disease differs from inference in the psychotherapeutic, interpersonal verbal and non-verbal communicative system. The medical model of disease is grounded in

the concept of an objective framework, an idealized set of recognition and pure criteria which signal linear and rather precise directives for human interaction. This model of interaction between therapist (physician) and patient attempts to limit the variables of response; error is minimized through the teaching and promulgation of a more or less uniform code of behavior. The literature of medicine is based upon an ever-changing, yet precise system of therapeutics where inference demands support from objective evidence. The medical clinician may use the term inference in citing disease and determining intervention, but rare is the clinician who does not support his judgments with the concrete evidence of physical examination, statistics or laboratory data. There is a consensual validation of what constitutes proper evidence in support of inference in Western physical medicine.

A tremendous difficulty in psychiatry, perhaps its legacy from the "medical model" of disease, is the lack of a uniform and generalized methodology for understanding and treating patients in the psychiatric interpersonal system. In purely interpersonal psychiatry (the treatment of outpatients in this study, for example) there are none of the objective tools medicine has learned to use and rely upon. There is little uniformity in the training, techniques and personalities of the several therapists. Indeed, the variation among the therapists is certainly matched or exceeded by the assortment of psychic identities and complaints of the twenty-five adolescent patients. There is no compendium or "handbook" of objective criteria which measures interpersonal phenomena without subtracting from or fragmenting the whole - the gestalt -

of the experience. Of what use is inference, how can it become scientifically valid where there is no uniform system or common agreement to validate or support it? How can separate interpersonal experiences be compared or weighted against one another where the variables are overwhelming? Is the psychiatric literature a Tower of Babel? For certain, it is questions such as these which are responsible for the absence of any published study of this kind.

To proceed with a discussion, it is necessary to examine the quotation from Sullivan appearing before the preface of this thesis:

> "There are no purely objective data in psychiatry, and there are no valid subjective data, because the material becomes scientifically useable only in the shape of a complex resultant - inference."

When Sullivan uses the term inference, he must be speaking of a particular and personal type of inference. The necessities for consensual validation are removed because Sullivan is writing of inference that is special and unique; it is his own. The difficulty in teaching psychiatric clinical judgement as opposed to medical clinical judgement is that one human cannot communicate all of the information necessary to arrive at identical inferences.

The appreciation of this problem has led me to devise this paper in as phenomenological a mode as possible. I arrive at my own inferences about the nature of the transcribed interviews; anyone who reads them is surely entitled to arrive at his own. Indeed, it is entirely probable that others would choose to categorize and understand the responses

in a completely different manner than I have. In an attempt to justify my organization, I have detailed how the subjects were selected and interviewed and have stated the criteria for presenting the material in the manner which I have chosen. A "purer" approach would have dictated that the interviews not be edited or transcribed at all, but would have presented the actual tapes of the interviews,-or, better still, have those who would share the findings of this study present at all of the interviews - an impossibility. I believe, however, that there is much to learn in briefly reviewing what these three categories of younger patients had to say about their various experiences in psychotherapy.

How can the data of this study be examined? Essentially, there are two models available for ordering material of this type into a discussion which will create a coherent picture of what these adolescents had to say about psychotherapy and allow the inferential process to occur - an intensive, protracted technique and a synthetic, horizontal one. The first model, in a more psychoanalytical tradition, involves a detailed analysis of each individual subject's responses. This would necessitate paying close attention to the language and affect of the subject. It would be desirable to present much if not all of what the adolescent said during the interview and to listen to the rhythm and tone of his speech as well as to the content. Much of what the subjects said makes for quite provocative material and it would be interesting to interpret each ex-patient's responses individually. Realistically, however, given the modalities of time and patience,

this cannot be accomplished. If the study were defined differently, perhaps choosing only one or two adolescent ex-outpatients at random and reporting in detail the results of an interview with them, this method of analysis would be both practical and useful.

The model which this discussion will follow is employed in an attempt to sort out some of the ideas which run through each of the three groups. This method, looking only at some common themes, obviously will ignore much of what may appear to be important statements or attitudes expressed by the subjects. Although it may help to create a conceptual framework for handling the large amount of information contained in the subjects' comments on their therapy, this discussion makes no claim to be the "heart" of the paper; it is only a minor commentary on what proceeded it.

Thirteen of the subjects reported that their experience in psychotherapy was successful. Demographically, they are quite representative of the total sample; of some significance is the fact that nine were seen by male therapists and four by female therapists (as opposed to thirteen male therapists and twelve female therapists for the entire sample). Overall the number of therapy sessions for which they were seen does not differ from that of the group of nine patients more ambivalent about the success of their therapy. Eight of the thirteen stated that therapy changed or cured a specific problem that had brought them to psychotherapy. All but one of the thirteen (patient five) stated specifically that they had changed as a result of

their treatment; this change was most often one of behavior or situation; in a few cases the change was attitudinal.

It is striking that these thirteen subjects spoke of how easy it was to talk to their therapists, that they liked their therapists and felt relaxed in therapy with them; they sensed their therapists as real, caring human beings - perhaps in the way they envisioned the less troubled, happier parts of themselves: "I liked my therapist (pt. one); "He wasn't impersonal" (two): "I was really able to talk to her" (three); "She's like someone I would like, she reacted...I thought of her by her first name" (four); "felt at ease, more of a human feeling" (five); "It was easy to talk to him; he cared about me" (six); "I was able to tell him everything, he's a pretty nice person" (seven); "He was a pretty nice person, therapy was just talk sessions" (eight); "I really think of my doctor as a person and a friend, he really understands me as much as anyone can understand me" (nine); "I liked my therapist a lot" (ten); "He was normal, easy-going, he was comfortable and that helped me to feel comfortable" (eleven); "he acted like he cared" (twelve); "kind of hard first meeting her, now I want to go back down to C.M.H.C. and say hello" (thirteen).

What contributed to this sense of ease and rapport between patient and therapist? Undoubtedly there is some process of positive identification taking place. In perceiving their therapists as a "person" or as "normal", therapy has become less of a foreign entity. Patients one, two, three, four, five, six, seven, eight and ten mentioned that their therapist was young or that good therapists should be young. Patient two

claimed that even eighteen-year-olds could be psychiatrists. Clearly the factor of young therapists for young patients facilitated the feelings of comfort which these adolescents sensed in their therapy. Several of the subjects made it explicit that a young therapist has had similar life-experiences and problems.

It doesn't seem that these therapies were perceived as helpful only because the therapists were young and had "worked through" for themselves the difficulties that had brought their adolescent patients to them for help. Something besides the life-experiences of the therapist made for successful therapy in the eyes of their patients, something in the psychotherapeutic relationship.

We are dealing with short-term outpatient psychotherapy. It would not be valid, here, to speak of positive transference or even of dependency, as many of these "successful" therapies lasted for a very short time. What we are looking for in an exegesis of relationship is immediate and available. Perhaps it is the nature of the trust with which these subjects regarded their therapists: "He gave it to me straight" (one); "It is a question of trust; you have to get to trust them first" (two); "I trusted her immediately" (three); "I really trusted her a lot" (four); "didn't feel he was trying to analyse me, didn't feel I was another patient or experiment" (five); "He cared about me" (six); "If you go to a psychiatrist, you have to tell the truth" (seven); "It built into a friendship, he gave me his phone number and future address" (nine); "A good therapist is like a friend, but there are things you can't tell a friend on the street" (twelve). The creation of trust is related to

both a feeling of closeness between therapist and patient and a formalized notion of psychotherapy as a situation where trust is expected. Naturally the conditions which established a trusting relationship were different for each subject. Patient four offers a lucid explanation of how the trust for her therapist developed. Her therapist responded to her talking about the "power that a shrink can have with patients" with the comment, "Look, what can I do to you?" Surely an interjection of reality. The same patient reports: "Knowing how nice it felt to trust her made me know that I could trust other people and made me realize that's what I wanted to do. I think it's her...she didn't accomodate herself to me."

In reading the comments of these thirteen subjects a sense of the dynamics of the relationships begin to take form. By and large the adolescents view their therapists as someone who by virtue of experience in life understands their difficulties, whom they can trust with their problems and whom they can speak with freely. There is a difference, however, between these "good therapists" and a friend: "The difference between a friend and a therapist is that you can put your arm around a friend" (eleven); "I wish he would take me for a ride on his motorcycle" (nine); "a friend can't be as objective as a therapist" (three); "It wouldn't be fair to have a relationship like that with a friend; this was a relationship about me and had nothing to do with her...I wouldn't want to have a relationship like that with any of my friends" (four); "The difference between a psychiatrist and a friend is just that word; he's a mind doctor" (seven). In short, it is reasonable to assume that the fact

that the therapist is a professional plays an important part in these patients' perception of him. He is both removed and capable of empathetic identification. It becomes apparent, also, that these adolescents felt that their therapists played a rather active role in the relationship. Undoubtedly, this contributed to their perceptions of the therapist as a real person: "I used to think a therapist was a little nut running around with a hat on and a little bag, now just a person" (eight); "Psychiatrists are humans too (four).

It is not clear how the role of the therapist as a model of behavior helps to create a sense of successful therapy. Certainly it plays an important part and must be related to all of the qualities mentioned above. All of these adolescents view their relationship with their therapist as an active one; their therapy was an engaging process.

Nine subjects were placed in a group that was ambivalent about the relative success of therapy. They are demographically representative of the total sample. A disproportionate number were seen by female therapists - three by males and six by females. Uniformly this group felt that if they improved during the course of treatment it may have been due to their own virtues and not to those of the therapist. Three of the subjects reported that there was no change in therapy (fourteen, eighteen and twenty-one). Patient sixteen worried that the change she experienced was only temporary. The remaining five stated that any change that did occur in therapy was probably not due to the therapist.

It is important to restate how I arrived at placing these

nine adolescents in the category of "ambivalent" psychotherapy. It could be argued that if a patient feels he has improved in psychotherapy and that it had nothing to do with the therapist, then this is the most successful therapy of all. While we could agree that a Zen Master or a Psychoanalyst may call this successful psychotherapy, within the phenomenology of this paper, it is not successful therapy. Here, we have only the language of the subjects to tell us if it was a "successful" experience or not. Through our own inferences, however, we are free to judge what is "successful" psychotherapy and what is "unsuccessful".

While the words trust and comfort appeared throughout the first group of patients' comments, they are conspicuous in their absence here. Acknowledging that the therapist was someone they could talk to, many reported that they felt the therapist did not care about them - there was a human element lacking: "He didn't really care about me; he was cold; he wasn't my friend...he should be more understanding; I really think psychotherapy is a game" (fourteen); "The best thing she did was to be cold to me when I came back the last time" (sixteen); "To me she was a complete stranger...I couldn't relate to her; therapy should be more personal...more on a personal basis" (seventeen); "A friend, maybe, can understand a little better than a psychiatrist" (eighteen); "I felt like I was talking to a computer who analysed what I said instead of talking to a friend; I wanted to know him...have a two-way thing" (twenty-one). Patient sixteen felt it was beneficial that her therapist was not her friend; she was aware that this helped to foster

her own sense of independence. Patient eighteen also made it clear that her therapy would not have been more successful if the therapist were her friend; she believed that she needed a more expressive therapeutic experience (Primal Therapy).

There is a pervasive feeling of disappointment in the comments of this group coupled with a consciousness of the separation between themselves and their therapists. Patient fourteen felt that psychotherapy is a game. Several reported comments of this nature: "She asked me a lot of questions, like on television; she used a lot of psychology on me" (sixteen); "I wanted her to sit there and say, 'Well, here's what you have to do; here are your problems'...all she knew was that I came in an hour every week" (seventeen); "I felt I didn't want to be bothered anymore; she was a sweet little-old-lady who didn't find fault in me...she always sided with me. I couldn't talk about what was really on my mind...I felt like I was talking to a girlfriend or something." (nineteen). These comments reveal a sense of failure to become engaged in a relationship perceived as real and offering an opportunity for collaborative change. Patient twenty wanted the therapist to act differently, while patients twenty-one and twenty-two felt that their therapies never really got under way because the therapist had to leave (twenty-one), and the patient wasn't willing to participate (twenty-two). Patient fifteen reported that he felt his therapy was more ritual than romance, having somewhat of a confessional quality: "I was very conscious that I was going there one hour a week to spew out my problems."

These nine adolescents raise a point with an interesting

implication about the nature of short-term psychotherapy for younger people. Seven of them state explicitly that their therapy did not meet their expectations; they wanted something to be different about the therapy: "I would have liked to change the structured part of the therapy" (fifteen); "I wished I could have talked longer" (sixteen); "She should have talked about herself a little" (seventeen); "I wanted specific information" (eighteen); "I would have liked her to find some fault in me" (nineteen); "I wanted him to give me alternatives" (twenty); "I wished he'd asked me questions" (twenty-one). All twenty-five subjects offered suggestions on how therapy - ideal therapy - for adolescents could vary from their experience, yet this group felt that the failure to meet their expectations interfered with the therapy's becoming "successful". Does the failure to meet the patient's expectations play as important a role in therapy with older patients? Is the fulfillment of expectations as important in long-term psychotherapy? Although they are more conscious of the separation between themselves and their therapists - of the formalities involved in attending weekly sessions, this group as opposed to the others conceptualized their therapists as "an open ear" (twenty). While they did not feel that their therapy was as successful as those in the first group, they did not perceive their therapy as unsuccessful.

Can we assume that these nine patients did not feel their therapies to be as nurturing as the previous group's? Again, it becomes tempting to theorize. The growing pains and difficulties of adolescence focus on the issues of separation and dependence. The thirteen subjects who felt that therapy was successful

for them spoke of developing a warm and relatively trusting relationship with their therapist. Their judgement of success seems to follow the perception of therapy as meeting their needs and allowing them to form a two-way relationship where they viewed themselves as independent, maturing individuals. Successful therapy permitted an interplay between a comfortable relationship where expectations and supportive needs were met and the experience of autonomy. Those adolescents in the second group who felt that they had experienced some positive change in overcoming the difficulties which brought them for help reported that they accomplished this change themselves. They experienced some autonomy yet little nurturence and support.

The third group, consisting of three adolescents who reported unsuccessful and frustrating experiences in therapy, felt that they obtained neither comfort nor the support to work things out for themselves. Patient twenty-three was seen for four sessions, while the others were seen for six each. This is less than the average number of hours for the entire sample.

Patient twenty-three reported that he "never really went there...they never called me back." While he was eager to receive therapy, he was disappointed that no arrangements had been made for him to continue. "I still have the anxiety... I've been busy." He was coping with his problems outside of a psychotherapeutic setting and was disillusioned that he could not obtain treatment.

Patients twenty-four and twenty-five were quite bitter about their experiences in therapy. Both perceived their

therapists as being dishonest with them; their comments are hostile and angry. Patient twenty-four, being sixteen years old, could not be treated without her parents' consent. She did not want her parents involved in her therapy ("I was divorced from my parents") and desired her experience with therapy to be supportive of her struggle for autonomy. Her expectations contained ground rules ("there was to be no talk about my parents") which the therapist could not meet.

Patient twenty-five reported that there was no freedom of communication between herself and her therapist. "She never kept things confidential...she brought my mother in once and told her things I didn't want her to know; she asked me if I was going to attempt suicide again, and I said 'yes,' but then I lied to her and said 'no,' so she wouldn't sign me in." She related her difficulties to the fact that her therapist was young and inexperienced: "She was maybe two years older than me at most...I didn't feel she had lived long enough to understand and help me." This comment sharply contrasts with what was said by the first group. Perhaps it is the absence of a trusting relationship which makes patient twenty-five view her youthful therapist as incompetent; or was she simply a poor therapist?

Any explanation which attempts to account for the phenomena of successful or unsuccessful therapy may lead the explicator away from the reality of the experience. These three patients all have theories to account for their "unsuccessful" therapy: The therapist did not contact the patient to make arrangements for further work; the therapist could not circumvent legal regulations and treat a youth without the parents' consent

and would not make a contract excluding an important therapeutic issue; the therapist was too young and inexperienced and was unworthy of trust.

Every patient-therapist interaction is unique. It would be just as foolish to qualitatively compare any two of them as it would be to assume that what these adolescents have to say about their therapies is an accurate representation of what really occurred.

If the temptation to explain - to use the word <u>because</u> - can be resisted, there is much to learn. The suggestions the subjects offer on how psychiatry can meet the needs of adolescent patients are useful. All twenty-five speak only for themselves about what occurred for them and what could have occurred for them. It would be interesting to weigh their notions of what would constitute the "good therapy" for adolescents against how they judged the outcome of their therapies. Any generalizations derived from this process would be conjecture, not fact. It would take another study, entirely different in its methodology, measuring and classifying the personalities of the patients as well as their therapists, comparing their impressions of the psychotherapeutic experience and following the patients' evolving histories long after termination to give any guidelines supported in "fact" for changing or directing adolescent psychotherapy.

Every clinician is continuously evolving his style, constantly changing and arriving at a greater understanding of the psychiatric interpersonal experience. These changes are not supported in quite the same manner as a physician might alter his treatment

of liver disease - relying upon journal data and double-blind studies. The psychotherapist's clinical judgement and techniques of interaction with his patients are altered and honed by the feedback that his senses offer his intelligent psyche. It is hoped that by reading and listening to what these young ex-outpatients have to say that the wealth of feedback will increase.

# BIBLIOGRAPHY

Aarons, Z.A. "Normality and Abnormality in Adolescence", Psychoanalytic Study of Child. 25: 309-39, 1970.

Adatto, C. P. "Ego Reintegration Observed in Analysis of Late Adolescence", Int. J. Psa. Vol XXXIX, 1958.

Aldrich, C.K. "Brief Psychotherapy: A reappraisal of some Theoretical Assumptions", Am J. Pschiat. 125: Nov. 1968. pps. 585-592.

Alexander, J. F. "Dependency Changes in Psychotherapy as Related to Interpersonal Relationships", J. Consult.Clin. Psychol. 32: 685-69, Dec. '68.

Basler, B. H. "Psychotherapy of the Adolescent,, Int. Univ. Press, Inc. New York, 1959.

Beatty, F. S., Beatty J. M. "An Evaluation of Psychotherapy at a Community Mental Health Center", J. Psychol. 76: 45-55, Sep. '70.

Becker, B. J., et.al. "A Clinical Study of a Group Psychotherapy Program for Adolescents", Psychiat. Quart. 37: 685-703. Oct. '63.

Benjamin, J.D., "Methodological Considerations in the Validation and Elaboration of Psychoanalytic Personality Theory", Am. J. of Orthopsychiatry, 20: 139-156, 1950.

Blos, P. On Adolescence. New York, Free Press, 1962.

Boulware, D. W., Holmes, D. S. "Preferences for Therapists and Related Expectancies", J. Consult. Clin. Psychol, 35: 269-77, Oct. '70.

Boyer, L. B."Brief Psychotherapy", Am. J. Psychiat., 125: 1452-53. Apr. '69.

Chassen, J. B. "Stochastic Models of the Single Case as the Basis of Clinical Research Design". Behavioral Science, Vol. VI, No. 1; Jan, 1961.

Choras, P., Stone, A. A. "A Strategy for the Initial Stage of Psychotherapy with Adolescents", Am.J. Psychother., 24: 65-78, Jan '70.

Corday, R.J."Limitations of Therapy in Adolescence", J. Clin. Psychiat. 6: 526-38, 1967.

Easson, W. M. "The Continued Non-patient, An Adolescent Dilemma", Arch. Gen. Psychiat., Vol. 16, March 1967.

Erikson, E. "The Nature of Clinical Evidence", in Insight and Responsibility, W. W. Norton, 1964.

Erikson, E. Identity, Youth and Crisis. W. W. Norton, New York, 1968.

Erikson, E. "The Problem of Ego Identity", J. Am. Psa. Assoc., Vol. 4: 56-121, 1956.

Escalona, S. "Problems in Psychoanalytic Research", Int. J. of Psychoana. 33: 11-21; 1952.

Feffel, H. Eells, J. "Patients and Therapists Assess the Same Psychotherapy", J. Consult. Psychol. 27: 310-18, 1963.

Freud, A. "Adolescence", Psa. Study of Child, 13: 235-78, 1958.

G.A.P. Report, No. 68, Normal Adolescence: Its Dynamics and Impact, 1968.

G.A.P. Report, No. 42, Some Observations on Controls in Psychiatric Research, 1959.

Glover, E. "Research Models in Psychoanalysis", Int. J. of Psa. 33: part 4, 1952.

Godenne, G. D. "A Psychiatrist's Techniques in Treating Adolescents", Children, 12: 136-9. Jul-Aug, '65.

Goldberg, I. D., et.al. "Effect of Short-term Outpatient Psychiatric Therapy", Med. Care. 8: 419-28, Sep-Oct '70.

Green, "Psychotherapy with Adolescent Girls", Am. J. Psychother. 18: 393-404. Jul. '64.

Haskell, D. et.al. "Time-Limited Psychotherapy for Whom", Arch. Gen. Psy., 21: 546-52, Nov. '69.

Hendrickson, W. J. "Treating Adolescents: Transference and Counter-transference Problems", Front. Clin. Psychiat., 4: 1, 1967.

Holmes, D. J. The Adolescent in Psychotherapy, Little, Brown, Boston, 1964.

King, L.J. et.al. "A Six-year Follow-up Study of Sixty-five Adolescent Patients: Predictive Value of Presenting Clinical Picture", Brit. J. Psychiat. 115: 1437-41, Dec. '69.

Knobel, M. "On Psychotherapy of Adolescents", Acta. Paedopsychiat. (Basel), 33: 168-75, Jun-Jul '66.

Koegler, R. R., Brill, N. Q. Treatment of Psychiatric Outpatients, Appleton-Century-Crofts, New York, 1967.

Langen, D., Sonnenberg, R. "Treated and Untreated Persons in Psychotherapy from Viewpoint of Follow-Up Examination", Psychother. Med. Psychol., 17: 132-8, Jul '67.

Laufer, M. "Assessment of Adolescent Disturbances", Psa. Study Child, 20: 1965, pp. 99-123.

Lewis, M. Clinical Aspects of Child Development, Lea and Febiger, Philadelphia, 1971.

Lorand, S. Adolescents, P. B. Hoober, New York, 1961.

McLaughlin, B.E. Long-Term Results of Psychiatric Outpatient Treatment. Chas. C. Thomas, Springfield, 1965.

McNair, D.M., et.al. "A Three-year Follow-up of Psychotherapy Patients", J. Clin. Psychol. 20: 258-264. Apr. '64.

Mattson, A. "The Male Therapist and the Female Adolescent Patient", J. Am. Acad. of Child Psychiat., 9: 707-21, Oct. '70.

Meunch, G.A., "An Investigation of the Efficacy of Time-Limited Psychotherapy", J. Counsel Psychol. 12: 294-99, 1965.

Miller, L. C. "Short-term Therapy with Adolescents", Am. J. Ortho-psychiat., 29: 772, 1959.

Mumford, E., et.al. "Overcoming Difficulties in Follow-up Studies of Adolescent Psychiatric Patients", Hospitals, 43: 58-62, Jan., 69.

Orlinsky, D. E., et.al. "The Patient's Concerns in Psychotherapy", J. Clin. Psychol., 26: 104-11, Jan.'70.

Pattison, E. M. "The Patient after Psychotherapy", Am. J. Psycho-ther.,24: 194-215, Apr. ,70.

Reisman, J.M. "Ratings of Self and Therapist: Two Studies", Psychiat. Quart., 42: 116-23, 1968.

Rosen, B.M., et.al. "Adolescent Patients Served in Out-patient Psychiatric Clinics", Am. J. Pub. Health, 55: 1563, 1965.

Rouslin, S. "The Adolescent in Psychotherapy", Perspect. Psy. Care., 7: 263-6, Nov.-Dec., '69.

Ryle, A., et.al. "The Measurement of Relevant Change after Psychotherapy", Brit. J. Psychiat. 115: 1297-304, Nov. '69.

Samorajczyk, J. "The Psychotherapist as a Meaningful Parental Figure for Alienated Adolescents", Am. J. Psychother., 25: 110-6, Jan., '71.

Schonfeld, W.A., "Trends in Adolescent Psychiatry", Curr. Psych. Ther., 9: 52-62, 1969.

Schorer, C.E. "Improvement with and without Psychotherapy", Dis. Nerv. Syst., 31: 155-60, Nov.,'70.

Settlage, C.F. "Adolescence and Social Change", J. Am Acad. Child Psychiat., 1970.

Spiegel, L. "Disorder and Consolidation in Adolescence", J. Am. Psa. Assoc., 1961.

Strupp, H. H. "Research in Individual Psychotherapy: a Bibliography", H. E. W.,U. S. Gov't. Printing Office, 1969.

Strupp, et.al. Patients View Their Psychotherapy, Johns Hopkins Press, Baltimore, 1969.

Staples, H. D. "Modern Psychiatry for the Adolescent", Int. J. Psychiat., 5: 492-4, Jun., '68.

Steinholder, J. C. "Bias in the Assessment of Psychotherapy", J. Consult. Clin. Psychol., 34: 37-42, Feb., '70.

Sullivan, H. S. The Psychiatric Interview., W. W. Norton, New York, 1954.

Symonds, A. "Special Problems in the Treatment of Adolescents", Am. J. Psychother., 17: 596-605, Oct. '63.

Weinroth, L. A., et.al. "Youth and Psychiatry", Am. J. Psychiat., 127: 972-3, Jan.,'71.

Weiner, I. B. Psychological Disturbance in Adolescence, Wiley, New York, 1970.

White, A.M., et.al. "Measurement of What the Patient Learns from Psychotherapy", J. Nerv. Ment. Dis., 149: 281-93, Sep., '69.

Williams, M. "Five Adolescents: Case Notes and Comments", Clin. Pediat. 3: 651-9, Nov., 64.

Wolberg, L.R., ed. Short Term Psychotherapy, Gruene and Stratton, New York, 1965.

Young, H. B. "Special Needs of Adolescents", Int. J. Psychiat. 5: 494-5, Jun., '68.

Zucker, H. Problems of Psychotherapy, The Free Press, New York, 1967.

# APPENDIX A

## Initial Research Protocol

ADOLESCENTS PERCEIVE THEIR PSYCHOTHERAPY

TATEMENT OF PROBLEM:

The purpose of this thesis will be to define and measure some of the variables n an adolescent's impression of his psychotherapy. I will be particularly nterested in determining how the adolescent feels those problems which brought im for psychiatric help have changed, what caused them to change, and how their xperience in psychotherapy corresponded to their expectations.

EVIEW OF THE LITERATURE:

I have begun and am continuing an extensive review of the literature in the rea of psychotherapy of adolescents. Although there is a plethora of literature iscussing the problems of adolescents and their particular needs in a psycho-herapeutic experience, there have been no published accounts measuring the dolescent's own impressions of his experience in psychotherapy.

YPOTHESIS:

I have constructed a tentative model of the possible psychotherapeutic elationships which can exist between therapist and adolescent patient. The wo principle categories are change-oriented therapy and supportive therapy.

I. Change-Oriented therapy
   A. Discrete-change

      1. Personality change...learning about <u>focal personality problem</u>
         a. therapist explains patient's particular problem (therapist active)
         b. therapist creates condition of self-learning...patient learns about his own focal problem himself (patient active:therapist facilitating)
         c. therapist gives information about a discrete problem of personality in abstract...third-person education about discrete problem of personality

      2. Environmental change...social learning about <u>focal environmental problem</u>
         a. therapist explains what's happening to patient in environment which maintains particular problem...the therapist is active and the therapy focuses on the patient's environment and how he can change it
         b. the patient takes his own initiative in understanding and changing his environment (therapist facilitating)
         c. the therapist gives information about how to change a discrete environmental problem...the therapist teaches the patient about the environment and how one changes it

I. Change-Oriented Therapy (continued)

B. Global Change

1. Personality change

a. insight-oriented therapy - explore patient's personality; therapist helps him build formulae for himself

b. "Guru" therapy - therapist serves as role model; communicates style of perceiving world. ie. teaching of philosophy

2. Environmental chage

a. social learning - therapist educates patient about changing environment

b. patient takes own initiative in learning to change environment - therapist faciliatating

c. therapist serves as model for societal interaction, for changing environment

II. Supportive Therapy

A. Therapy cathartic...release of emotions

B. Crises oriented therapy...therapist emotionally supportive

Using this model, the following areas can be explored:

1) Which categories of patient-therapist role model does the patient fall into?

2) How will the model chosen correlate with the adolescent's impression of the success of his therapy?

3) Will the sample attribute particular models to certain therapists?

METHOD OF DATA COLLECTION:

1) Adolescents who have terminated therapy will be chosen from change of status reports.

2) I will review their charts and draw on the data of the Panel of Adolescence to determine chief complaints and demographic data.

3) A letter will be sent to each prospective subject explaining the nature of my study: "I am interested in learning about how adolescents view their psychotherapy..." I will ask them for a one-hour interview which can be conducted at CMHC, their home, or a place of their choice.

4) I will follow the letter with a telephone call to arrange an appointment.

5) The interview will be taped on a tape recorder. There will be no questionaire present at the interview.

6) The following questions will be asked:

1. Why did you come to therapy?
2. How did you think the therapy would help you?
3. What did you think the therapist would do?
4. What did he do?
5. What did you do?
6. Did therapy deal with your problems?
7. Did therapy fulfil your expectations?
8. What was your relationship like with your therapist? Did you like him?
9. What do you think was most helpful to you in therapy?
10. How has your life been going since therapy?
11. How do other people think you're doing?
12. How did your therapist feel the therapy helped you?

7) Following the interview, I will play back the tape and record the responses to the questions, rating

a) what category does the adolescent-perceived therapy belong to?

b) on a scale of 1-8, how does the adolescent rate the success of his therapy?

c) how does he feel others rated its success?

d) how does he feel his therapist rated its success?

8) As a control, others will listen to a selection of the tapes and rate the responses.

ANALYSIS OF DATA:

I will have a large amount of data, including not only the responses to the questions, and a rating of therapeutic success plus a categorization of the therapist-patient role model, but artifacts (who responded to being interviewed, who didn't), cheif-complaints and demographic data will also be available for analysis.

Primarily, I hope to prepare a paper on Adolescents' perceptions of their psychotherapy which will formulate criteria for measuring and determining their particular needs and a unique criteria for evaluating what goes on in psychotherapy with adolescents.

In addition, this study may provide clues for future measurement of the mental health needs of adolescents.

APPENDIX B

Yale University *New Haven, Connecticut 06519*

SCHOOL OF MEDICINE
*Department of Psychiatry*
*34 Park Street*

Dear

I am a fourth-year medical student at Yale and a member of the Utilization Review Committee of the Connecticut Mental Health Center studying Adolescents and their treatment. The purpose of this Committee is not only to improve adolescent services here,but at other mental health centers throughout the country.

The particular aspect of the work I am interested in, is learning more about adolescents' feelings and impressions of their experience in Psychotherapy. I understand that you recently terminated as an outpatient at the Connecticut Mental Health Center, and would like to speak with you about your experiences there. The purpose of my interview with you will be to obtain a first-hand impression of what happens in psychotherapy and how therapy meets the particular needs of younger patients. In accordance with the policies of confidentiality of the Department of Psychiatry and of the Medical School, this information will be kept completely confidential.

I would greatly appreciate if you would be able to meet with me for approximately one hour at the Connecticut Mental Health Center, your home, or a place of your choice. I will contact you by telephone within the next few days, and hope that we'll be able to arrange a mutually convenient time for us to meet.

Thank you,

JHM:ff

Jerry H. Meyer

# APPENDIX C

CONNECTICUT MENTAL HEALTH CENTER
RECORDS CENTER

The confidentiality of this record is required under Chapter 899 of Connecticut General Statutes. This material shall not be transmitted to anyone without written consent or authorization as provided in (these) statutes.

The purpose for this video or sound recording has been described and the nature of the study has been explained to me. I hereby agree to this procedure.

Patient's Signature

Authorized Clinician

Date

12/4/69

# APPENDIX D

## POST INTERVIEW DATA SHEET

Name
Unit #
Date of interview
Duration of interview
Place of interview

I. Short responses:

1. Recollection of chief complaint

2. Did therapy help you?

3. Did therapy deal with your problems (i.e. c.c.)?

4. Did you like the therapist?

5. How has life been going since therapy?

| Success of therapy: | made me worse | | | | | | very successful |
|---|---|---|---|---|---|---|---|
| Adolescent's rating: | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Adolescent's impression of others' rating | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Adolescent's impression of therapist's rating | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

Did therapy fulfill expectations?

Why did therapy end?

II. Longer responses:

1. What did you think therapist would do?

2. What did he do?

3. What do you think was most helpful to you in therapy?

4. What would you have liked the therapist to do that was different?

5. How did your parents feel about your being in therapy?

6. Have your parents met the therapist?

What category does the adolescent-perceived therapy belong to?
(see proposal, pps.1,2.)

Other remarks by patient

Impression of patient--
attitude towards interviewer
interested in more therapy?
what does he see as purpose of this interview?

YALE MEDICAL LIBRARY

Manuscript Theses

Unpublished theses submitted for the Master's and Doctor's degrees and deposited in the Yale Medical Library are to be used only with due regard to the rights of the authors. Bibliographical references may be noted, but passages must not be copied without permission of the authors, and without proper credit being given in subsequent written or published work.

This thesis by Wallingford Cinn has been used by the following persons, whose signatures attest their acceptance of the above restrictions.

| NAME AND ADDRESS | | DATE |
|---|---|---|
| [illegible] | | 5/19/76 |
| [illegible] Murphy | 3343 45 | 6/22/77 |