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# The therapist's experience of psychotherapy with adult vs. adolescent patients : an empirical study.

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# THE THERAPIST'S EXPERIENCE OF PSYCHOTHERAPY WITH ADULT VS. ADOLESCENT PATIENTS: AN EMPIRICAL STUDY

A Dissertation Presented

By

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To John,

with love and gratitude

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ABSTRACT

The Therapist's Experience of Psychotherapy

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While impressive strides have been made toward the systematic investigation of those factors which characterize or define psychotherapy with adults, no substantive empirical research has ever sought to obtain normative data on the process of adolescent psychotherapy, or to determine any meaningful differences in clinicians' therapeutic conduct and affective experiences when working with adolescent versus adult patients. The results of this investigation provide clear evidence that experienced clinicians do, in fact, experience their psychotherapy sessions with adolescent patients quite differently than sessions with adult patients who are roughly comparable diagnostically and sociodemographically. Adolescent patients were viewed by their therapists as less distressed, more resistant to therapeutic engagement, less verbally expressive and open, and less organized in the presentation of material than their adult counterparts. In a complementary fashion, their therapists experienced themselves

as adopting a therapeutic stance which was more active and structuring (although generally not more confrontative), more "here-and-now" oriented than their approach to adult patients, and which placed a higher degree of emphasis on the goal of achieving a "real" relationship as opposed to one based on transferential distortions. On an affective level, clinicians reported feeling more affectionate towards and protective of their adolescent patients. No support was found for the emphasis accorded by the clinical literature to the countertransferential affective experiences of devaluation, envy, or sexual arousal in the treatment of adolescent patients. Finally, a significant relationship was obtained between a specific biographic variable of therapists--parental restrictiveness--and the degree to which limit setting was emphasized with adolescent patients. The implications of these findings for training in psychotherapy are discussed.

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# CHAPTER I

## INTRODUCTION

### Adolescent Psychiatry: A Neglected Specialty

Recent decades have witnessed a growing awareness of the critical position of adolescence in the epidemiological cycle of mental illness. Evidence from several major research projects (Douvan & Adelson, 1966; Masterson, 1967; Offer, 1969; Vaillant, 1978; Weiner & DelGuadio, 1976; Welner, Welner, & Fishman, 1979) suggests that, contrary to earlier impressions that symptom formation in adolescents is a normal, transient, and spontaneously remitting phenomenon (Freud, 1958; Gardner, 1947; Lindemann, 1964), symptoms of psychological disturbance in this age group are both relatively atypical and highly predictive of psychiatric disability in adulthood. This recognition coincides with a heightened concern about the effects of rapid social changes on our ever-growing adolescent population. There is widespread agreement that such sociopolitical factors as a lengthening of the adolescent period, affluence, urbanization, rapid shifts in moral standards, and the rising complexity of vocational opportunities are greatly complicating the psychological task of American adolescents (Meeks, 1980). The net result of these convergent forces has been a dramatic rise in the number of young people being referred for psychotherapy (Meeks, 1980).

In the face of these important developments, the field of adolescent psychiatry has continued to lag behind both child and adult psychiatry. The reluctance of otherwise skilled clinicians to treat adolescent patients and the very small cadre of therapists who are, in fact, trained to work with this age group are problems which are well known to practitioners in the field (Weiner, 1970). This reluctance is reflected in the frequency of references in the clinical literature on adolescent psychotherapy to the difficulties of treatment with this population. Anna Freud, one of the most esteemed contributors to our understanding of this period, described the analytic treatment of adolescents as "a hazardous venture from beginning to end" (1958, p. 261). Holmes (1964) characterized clinical work with the disturbed teenager as "an experience which constantly reminds one that there are many easier forms of livelihood" (p. 298). Other writers have noted the confused admixture of emotional reactions elicited by the adolescent patient; Josselyn (1957) has suggested that the treatment of the young adolescent is "perhaps the most baffling, the most frustrating, the most anxiety-arousing experience a psychiatrist can have" (p. 13). Still others (e.g., Lorand, 1961) have commented that the adolescent's characteristic impatience, uncommunicativeness, lack of insight, and refusal to cooperate can often discourage a therapist from even <u>attempting</u> to create a therapeutic atmosphere. It should not be too surprising, therefore, to find that as many as two-thirds of adolescents presenting

for services at U. S. psychiatric clinics never receive treatment beyond intake or diagnostic services (Rosen, Bahn, Shellow, & Bower, 1965).

At the level of research, a similar lacuna exists. The bulk of empirical research in the field of adolescent psychotherapy has focused on investigations of outcome. Moreover, over one-half of the outcome studies surveyed in a comprehensive review by Tramontana (1980) focused exclusively on a delinquent population, with the greatest attention being accorded to group psychotherapy. Of those outcome studies in which individual therapy was the primary modality of treatment, none of these gave any sense of the specific psychotherapeutic conditions involved, and many did not even bother to provide a minimal specification of therapist characteristics. Tramontana concluded his review with the assertion that the present status of research in this area lags fifteen years behind comparable research on adult psychotherapy. He writes:

> Not only is research on adolescents far from addressing psychotherapeutic issues that are especially of concern with this age group, but for the most part it has not even come to grips with many of the basic methodological problems elucidated some time ago in the adult literature. (p. 446)

If this claim is accurate with respect to the literature on psychotherapeutic outcome, it is even more true of research on the psychotherapeutic process. While impressive strides have been made toward the systematic investigation of those factors

which characterize or define psychotherapy with adults (e.g., Strupp, 1973, pp. 559-602) and, to a lesser extent, child psychotherapy (Landisberg & Snyder, 1946; Moustakas & Schlalock, 1955; Wright, Truax, & Mitchell, 1972), only one empirical study (Weisberg, 1978) has focused on the practitioners of adolescent psychotherapy in an effort to define how they conceptualize psychopathology in and psychotherapy for adolescent patients. While a good-sized clinical literature exists on this psychotherapeutic experience, it leaves much to be desired as a body of knowledge in any formal sense. Most texts and case reports suffer the limitation of being based on the experiences of a single observer, and are expressed almost uniformly in qualitative impressionistic terms that make systematic comparison virtually impossible.

The aim of this first empirical study is essentially an exploratory one. Its primary objective is to obtain normative data on the process of adolescent psychotherapy, with a particular emphasis on how this process is perceived by those involved in it. In this sense, it is an attempt to extend the generalizability of Orlinsky and Howard's (1975) important work on clinicians' experiences of the psychotherapeutic process, a contribution which, unfortunately, had a highly restricted patient sample of middle-aged females.

The emphasis on the subjective experience of the therapist is grounded in the belief that therapists' and patients' construals

of their involvement with one another are critical to a practical understanding of what has been called the "psychological interior" of psychotherapy (Orlinsky & Howard, 1983). Therapists' actions in therapy are, in part, a function of their experience of the patient and themselves in their common situation. Moreover, insofar as consequences of importance for the outcome of therapy actually follow from therapists' actions, the experiences that condition those actions have an eminently practical relevance. Finally, it is believed, along with Orlinsky and Howard (1983), that "research findings based on variables that are not couched in terms of the therapist's experience of psychotherapy...cannot be clinically utilized by practitioners" (p. 46).

A second goal of this investigation would be to identify any dimensions of therapist experience, particularly clinicians' therapeutic goals, conduct, and affective experiences, which reliably differentiate adolescent from adult psychotherapy sessions, and which can be meaningfully attributed to normative patterns of preoccupation and/or relating among the younger group. While numerous authorities on the psychotherapy of adolescents (e.g., Masterson, 1958; Meeks, 1980; Weiner, 1970) have suggested that the aims and techniques of clinical work with a youthful population should rightfully be modified from those of adult psychotherapy, no controlled study has ever compared the behavior of clinicians to patients of differing developmental and/or chronologic ages. This issue becomes especially salient when one considers the

fact that the vast majority of clinicians treating adolescents approach this group with concepts and techniques derived from training in adult or child treatment (Loeb, in Kremer, Porter, Giovacchini, Loeb, Sugar, & Barish, 1971; Weisberg, 1978). With respect to the affective experience of therapists, much of the clinical literature on adolescent psychotherapy suggests either explicitly or implicitly that a variety of therapist affective experiences (e.g., jealousy or feelings of devaluation) are directly related to the unique developmental stage of the patient. No empirical research has ever established, however, that the affective experience of clinicians working with a youthful population differs either qualitatively or quantitatively from that of clinicians working with adults.

A final goal of this investigation is to gather preliminary data on the relationship between selected life history variables and clinicians' experiences with adolescent patients. While a number of authors (Hammer & Kaplan, 1967; Malmquist, 1978; Meeks, 1980) have highlighted the importance of a number of such variables (e.g., parental loss during adolescence, perceived parental supportiveness) to clinicians' abilities to respond therapeutically to specific challenges presented by this age group, a search of the literature was unable to locate a single study--involving any population--in which specific biographic variables were related to specific behaviors in psychotherapy.

It is believed that data bearing on these issues would have

significant implications both for our understanding of the therapist's experience of psychotherapy in general, and for our ability to provide supervision and training which adequately address the nuances and complexities of clinical work with adolescents. As Tramontana (1980) has remarked: "Until there is a greater commitment to research in this area, psychotherapy with [this group] will continue to lack an identity of its own" (p. 448).

A brief review of the clinical literature on the goals and techniques of therapy with adolescents will be presented, with an emphasis on modifications from adult treatment. This will be followed by a survey of the literature on the affective responses elicited by youthful patients (usually subsumed under the heading of "countertransference"), and by a summary of the personality and life history variables which have been most consistently associated with therapists of adolescents.

## The Goals of Adolescent Psychotherapy

Discussions about the goals of any psychotherapy generally revolve around the degree to which the therapist and patient direct their efforts toward significant increments in self-understanding and personality reorganization, or rather at stabilization and improved functioning without major personality change. Closely related to this is the notion of "depth" of treatment, typically defined as the extent to which a patient's defenses are to be probed for whatever unconscious conflicts

and painful experiences have engendered them, or are instead to be supported and strengthened in reference to conscious concerns and current problem-solving (Weiner, 1970).

There is a general consensus in the clinical literature on adolescent psychotherapy that psychoanalysis, which embodies the twin goals of personality reorganization and defense analysis, is inappropriate for this age group (Adatto, 1966; Josselyn, 1957), and a variety of alternative formulations have appeared which characterize the appropriate task of the adolescent therapist. These modifications are based on a body of theory which suggests that the adolescent's psychic structure differs from that of the adult in important ways.

Masterson (1958) summarizes these differences as follows:

1. The adolescent's unconscious drives are believed to be poorly repressed and under precarious control by his/her relatively weak defenses. In contrast, the adult's unconscious drives are presumed to be well under the control of repression and other defenses.

2. The adolescent is believed to be actively trying to achieve a set of values by resolving the conflict between childhood superego demands and later environmental influences. The adult, on the other hand, is believed to have achieved a working set of values/standards which represent a compromise between these two sources.

3. The adolescent is believed to be striving to resolve

emancipatory and sexual conflicts with which the adult has also made some working compromise.

Weiner (1970) similarly notes that, in contradistinction to adults, most adolescents are experimenting with a variety of coping styles to which they have no deep or lasting commitment, and which should not be perceived as stable or well defined defenses. Meeks (1980) adds to this list of distinctions between adolescents and adults the former's inordinate fear of regression, the result of biologic and psychic pressures at this stage to renounce infantile ties to parents.

It is on the basis of these formulations of the emergent status of the adolescent psyche that an emphasis on consolidation as a treatment goal has supplanted the more orthodox analytic focus on personality reorganization (Berman, 1957; Gitelson, 1948; Josselyn, 1952; Lorand, 1961; Wittenberg, 1955). From this perspective, the goal of psychotherapy with adolescents is to provide them with a new emotional experience that will strengthen the functions of the ego and permit adaptive character synthesis. Fraiberg (1955) writes:

> What he [the adolescent] longs for most of all is the restoration of harmony. If our treatment is to have meaning for him, if we can hold out to him a concrete goal, we need to help him see therapy as a means...of helping him become master of himself. (p. 275)

Reservations concerning a depth approach have been voiced even with respect to many late adolescents. Blaine (1961) and

Braiman (1967) endorse nonanalytic psychotherapeutic intervention as the treatment of choice in the college setting, and Farnsworth (1966) draws the same conclusion from his experience with college students:

> The problems of adolescence usually cannot be treated by the development of deep insights. Sometimes the youngsters are angered by attempts to get at the deeper reasons for their behavior. There is little to be gained by such attempts. Instead, work should be done on the present situation, on the ego strength. (p. 34)

Weiner (1970) cites the comfortable management of biological tensions, the achievement of realistic relationships to parents and other adults and the capacity for sublimation as hallmarks of increased ego strength. Dubo (in Holmes, 1964), on the other hand, highlights the importance of working actively with the patient "to develop a realistic and attractive picture of his own future" (p. 4), while others (e.g., Lorand, 1961; Meeks, 1980) see the acknowledgement, by the adolescent patient, of a link between present behavior and inner feeling states as the critical step towards attaining mature ego control. Most authors agree, however, that the process of ego synthesis at this stage is likely to include many areas of unresolved conflict which are managed, bound, and partially neutralized by productive, growth-oriented compromise formations (Gitelson, 1942; Meeks, 1980).

Technical Issues in the Psychotherapy of Adolescents

The technical modifications which have been proposed for the psychotherapy of adolescents flow quite naturally from the emphasis on progressive development and character synthesis during this period, and are characterized by (1) a radical de-emphasis of defense analysis and historical exploration and (2) a substantial elevation of the therapeutic potential of the "real" relationship between therapist and patient.

In contradistinction to analysis and dynamic therapy with adults, where the therapeutic alliance is used to promote and regulate a controlled regression, psychotherapy with early and middle adolescents is oriented towards helping the patient recover from regressions. According to Meeks (1980), the degree of regression which would be necessary to correct early developmental defects and fixations would threaten the progressive and synthetic thrust of this developmental period. He describes as one of the most important tasks of the adolescent therapist the recognition of those times when the youngster is fearful of losing control, with the goal of assisting the adolescent to find ways in which he or she can deal with emerging impulses. The therapist is encouraged to support any defense which is adaptive (or even just harmless) that the adolescent can muster to regain a sense of self-mastery.

Weiner (1970) concurs with Meeks (1980), noting that efforts to strip away defenses are likely to mobilize considerable anxiety

in the adolescent patient, to the detriment of his/her engagement in the treatment. He writes: "Repetitive interpretations of his coping behavior not only constrain a youngster from the normal adolescent business of experimenting, but also convince him that the therapist is picky, hostile, disapproving, or pessimistic about his future" (p. 352).

Not surprisingly, therefore, the achievement of deep insights through the interpretation of unconscious content and reworking of previous experience is generally accorded only a minor role by authorities on adolescent psychotherapy. Meeks (1980) asserts that "nothing can be gained by pointing out the adolescent's homosexual, incestuous, and homicidal wishes even when they seem virtually conscious" (p. 138). As for historical exploration, Laufer (1964) notes that the recovery of past events and affects may threaten adolescents' efforts to free themselves from the past, and Miller (1959) observes that adolescents are usually correct in their conviction that current rather than past experiences are more relevant to resolving their psychological difficulties. He writes: "For an adolescent in search of an identity, overcoming the fears and failures of the moment is much more important than knowing the events which led up to them" (p. 774). Meeks (1980) concurs, similarly highlighting the adolescent's intense anxiety about the future as a contraindication for extensive focusing on the genetic determinants of behavior.

Replacing interpretation as the presumed catalyst of therapeutic

change is a new emphasis on the personhood of the clinician and on the provision of what Alexander (1963) would have called a "corrective emotional experience." Gitelson (1948) has observed: "If interpretation is the basic key in psychoanalysis, then the adolescent's relationship to the therapist, with the opportunities that this permits for new emotional learning experiences...is the comparable key in adolescent therapy" (p. 424). In contradistinction to what occurs with adults, the therapist of adolescents is expected to become a realistic figure who plays an active part in the growth process of the patient. It is for this reason, notes Masterson (1958), that the particular personality of the clinician is so often critical to the success of treatment.

This role shift necessarily implies modifications in the traditional analytic stance regarding transference. Meeks (1980) discourages therapists of adolescents from assuming the silent, "blank screen" approach which is most commonly associated with the induction of transference. Adolescents, Meeks claims, with their delicate narcissism, general distrust of adults, and expectation of moral criticism, usually react to silence and formality with anxiety and increased defensiveness. In fact, both Meeks (1980) and Masterson (1958) emphasize the importance of clarifying the irrationality of the transference when it does occur, quickly acting to diminish its impact in the therapeutic situation.

Several authors encourage a high degree of self-revelation with adolescent patients, both as a means of diluting potentially

regressive transference reactions, and as a way of fostering critical extra-familial identifications. Holmes (1964), a strong proponent of self-revelation in this context, notes, "(1) he can't hide it from the adolescent anyway, and (2) there is no good reason to try to hide it even if it were possible....Our efforts to operate as emotional technicians of some sort are transparent to him, and only increase his embarrassment and uneasiness in a situation that is already strained at best" (p. 103). Weiner and King (1977) similarly emphasize the centrality of therapist self-disclosure with adolescent patients, noting that properly timed disclosures and communications to adolescents enhance their contact with interpersonal reality and lead away from primary process material which can be especially disruptive to teenagers. Stressing the role of the adolescent therapist both as a role model and as a purveyor of important data about social reality, they cite examples in which clinicians share information about their own past adolescent concerns, e.g., about peer acceptance and dating, as well as experiences with other patients who have faced similar situations. The goal of such disclosures, which are advocated particularly in the treatment of severe ego decompensations, is to reassure the patient that he or she is not totally deviant (Long, in Weiner & King, 1977). Other indications for self-disclosure noted by Weiner and King are (1) to help a patient with markedly impaired ego function and reality testing perceive the therapist as a separate person rather than as a

projection of his own fears and wishes, (2) as a means of entering the emotional life of a patient who defends against emotional growth by detachment from others, (3) to demonstrate that one can experience feelings without being overwhelmed or acting on them, and (4) to demonstrate that one can be potent without being omnipotent. For example, "admitting to a patient that he is not physically able to restrain him can be a form of limit-setting based on the therapist's actual physical limitations" (p. 457).

Another aspect of becoming a more "realistic" figure is engaging in behaviors which might be considered unusual for the therapist of adults. Therapists of adolescents are discouraged from employing free-associative techniques (Axelrod, Cameron, & Solomon, 1944; Hellman, 1964; Schaeffer, 1962), or even from expecting patients to locate and identify their own emotions (Masterson, 1958). Rather, they are instructed to assume a much more active role, anticipating and clarifying their patients' emotional reactions for them (Masterson, 1958) and, in general, conducting the psychotherapy in a conversational style (Meeks, 1980).

The injunction to take a more active role includes serving a supportive or pedagogic function. Meeks (1980) encourages therapists of adolescents to give factual answers to troubling questions (e.g., concern about homosexual impulses, or masturbation frequency), and at the very least, to help patients distinguish those concerns which are realistic from those which are expressions

of psychological conflicts. He also advises adolescent therapists to admit their moral biases frankly and defend them energetically, noting that adolescents (unlike adults) expect to argue with their therapists and can greatly benefit from this type of interchange.

Finally, adolescent therapists are encouraged to intercede directly in their patients' environments. For example, Masterson (1958) described a case where the therapist intervened to prevent his patient from being expelled from school. Perhaps the most frequently mentioned form of direct intercession, however, is limit setting by the therapist, widely held to be an indispensible part of the treatment process with youthful patients (e.g., Holmes, 1964; Lorand, 1961).

## The Affective Experience of the Adolescent Therapist

While research on the character and quality of the patient's experience in psychotherapy has never been lacking (e.g., Snyder, 1961; Strupp, Fox, & Lessler, 1969), the therapist's experience has received far less attention. The clinical literature, of course, abounds with informal accounts of particular experiences--usually subsumed under the broad and obviously pejorative heading of countertransference--but these are unsystematic and of unknown generalizability. The empirical literature, on the other hand, has tended to rely heavily on reports of nonparticipant observers of psychotherapy (see Strupp & Bergin, 1969, for a

general review) and thus have not focused clearly on the phenomenal experiences of the participants. Moreover, those studies that have included a focus on the therapist's subjective experience suffer the limitations imposed by a highly restricted sample of therapists and patients.

Snyder (1961) was the only therapist to complete his own Personal Reaction Questionnaire, while the patient sample on which Orlinsky and Howard's (1975) therapist-subjects reported was composed exclusively of middle-aged women. Finally, several researchers (Meyer, Borgatta, & Fanshel, 1964; Saccuzzo, 1975) have assessed clinicians' experiences and reactions in intake interviews, although these are probably not very representative of the typical psychotherapy session. A review of the literature revealed not a single empirical study in which the patients were younger than a college student population.

Dominating the existing clinical literature on the affective experience of adolescent therapists are references to the therapists' efforts to deal with the reactivation of their own adolescent struggles, particularly with respect to the expression of sexual and aggressive impulses. In this context, the affective experience most frequently described is an envy of youthful freedoms, and a nostalgic longing for missed opportunities in one's own youth.

The source of the adolescent's unique capacity to revive such powerful feelings in the therapist lies to a large extent in the existence of potent cultural stereotypes about the adolescent's

impulse life. Schonfeld (1967) writes: "The adolescent appears to represent a prototype in our society of young vigorous individuals rebelling against conservative authority, working for immediate indulgence and gratification of libidinal and aggressive impulses" (p. 717). Meeks (1980) similarly observes that "our culture assigns the adolescent a comfort in instinctual expression far beyond that enjoyed by the mature American" (p. 42).

Many therapists, on the other hand, went through their adolescence when it was not culturally acceptable to express sexual drives. They may vicariously enjoy the descriptions of the sexual escapades of their patients and, under the guise of not appearing moralistic or judgmental, may avoid setting appropriate limits on acting-out behavior. The therapist may even justify or misinterpret an instance of sexual acting out in an unconscious effort to perpetuate it (Meeks, 1980). At other times, unconscious envy and competitiveness may lead to a stiff moralism and an excessively suppressive attitude that can stunt the adolescent's emotional growth.

The adolescent patient is not totally passive in the interpersonal transactions which may evoke such a diversity of affective responses. In addition to sexual acting out outside the session, the adolescent may, for a variety of reasons (e.g., intense needs for affection, desire to distance the therapist, or to undermine the hierarchical nature of the relationship), behave quite seductively towards the therapist. At these times,

the countertransference feelings may become erotic and disturbing, especially when the therapeutic alliance is a heterosexual one. The therapist has techniques for dealing with children and adults, but he is often at a loss to know what to do therapeutically with the adolescent:

> For want of anything better, he may simply combine the child and adult approach or move from one to the other. He may find himself defeated, whatever his approach. When, for example, he treats the adolescent girl with the open friendliness he reserves for his child patients, she may react disconcertingly like a mature woman, so that his innocent maneuvers take on the guise of seduction; and when he retreats to the adult position and keeps her at a distance, she melts away, leaving behind a little girl who cannot understand why she may not be loved in the old way. (Anthony, 1969, p. 64)

Such difficulties have led some clinicians to conclude that adolescents should be treated by therapists of their own sex. According to Anthony (1969), however, this combination may produce a situation which is different, but no less disturbing: "The blatant homosexuality of the adolescent under conditions of treatment may evoke countertransference responses in the therapist that may take the form of outright rejection" (p. 65).

The range of affective responses to adolescent aggression closely parallels that which has already been observed in relation to expressions of sexuality in this group. King (1976) notes the "twin lures" for the therapist working with this population: "attraction to an unbridled force and helpless rejection in

capitulation of an intransigent force" (p. 46). The therapist may envy the degree to which the adolescent gives free expression to aggressive impulses, wishing that he, if only for "one glorious moment," were not bound by a "mature" ego to repress, sublimate, and displace his own.

Masterson (1972) notes the conflicts experienced by some therapists during the "testing phase" of treatment with borderline adolescents, causing them to minimize the significance of containing the acting out. Moreover, therapists can, if not fully aware of their own reactions and needs, vicariously use their patients to act out for them and then, in a guiltless way, punish their patients for their (actually the therapists') instinctual wishes. In this manner, the impulse, guilt, and subsequent punishment may all be externalized (Johnson, in Eissler, 1949).

In some cases, therapists may, in what King (1976) has called "the ultimate extension of intrigue with violence in youths" (p. 46), adopt the dress, mannerisms, and language of their patients. In this process of "identification," clinicians are able to gratify an unconscious attraction to the guiltless, savage world of their patients without jeopardizing either their professional standing or their personal safety. At the opposite end of the countertransference spectrum from identification, King describes "rejection," a response which he attributes to feelings of rage and helplessness in the face of adolescent aggression. Rejection may take any of several forms, including the labelling of youths

as "untreatable psychopaths," and assessments that relegate them to "secure settings" where clinical services are often not available.

It would be misleading, however, to assume that the revived longings or envy of the clinician are directed exclusively at the apparent liberty with which the adolescent discharges sexual and aggressive impulses. The therapist of the adolescent cannot help but respond--along with the latter's parents--to the undeniable fact that, psychologically speaking, "the adolescent is on his way up while the caretaking adult is on his way down" (Anthony, 1969, p. 68). Holmes (1964) similarly alludes to the fear induced by adults who come in contact with the adolescent: "We sense that [he] is out to get what we have....The threat of being replaced by him, in time, is very real" (p. 49). According to Pumpian-Mindlin (1965), this fear and envy is fueled by the adolescent's buoyant sense of "omnipotentiality," i.e., the normative conviction on the part of the youth that he or she can do anything in the world, unbound by the reality of limitations and priorities.

Yet another potent source of countertransference problems for the therapist of adolescents is the reactivation of the therapist's own unfulfilled needs for parental support during the struggle for separation during adolescence (Akeret & Stockhammer, 1965). Anthony (1969) cites a case in which the deep clash between the unfulfilled adolescent fantasy of the therapist and the consummations achieved by the patient resulted in an overpowering surge of envy that almost brought the treatment to a premature

ending:

> In one instance, a therapist found himself becoming increasingly angry with an adolescent boy whom he had been treating for some years. On carrying out a little self-analysis, he found himself deeply envious of the boy's progress as a patient and unable to derive any satisfaction whatsoever from the excellent outcome. Not only did he feel the boy was getting more out of the treatment situation than he ever did, but moreover, he had had to wait until well into adult life for his help. He recalled struggling hopelessly and despairingly with his adolescent predicament to the point of contemplating suicide and now he was confronted with this rich child who obtained it as he needed it. (p. 70)

This type of emotional reaction is especially likely given the oft-noted observation (e.g., Hammer & Kaplan, 1967; Malmquist, 1978) that therapists who specialize in the treatment of adolescents are often unconsciously seeking compensation for some past deprivation or attempting to relive an unhappy adolescent period with a different outcome. The following section will contain a fuller discussion of genetic factors influencing the career choice of adolescent psychotherapy.

Also prominent in the clinical literature on therapists' affective responses to their adolescent patients are references to reactions based on "narcissistic injury" to the therapist. A number of authors have noted the relative absence in adolescents of the positive feedback responses (e.g., faith in therapy, respect for the therapist) which are present in treating most adult patients (Malmquist, 1978; Rinsley, 1980). The adolescent's continued

need to experiment with the object world, "cathecting and decathecting without much rhyme and reason," can lead to a situation in which the therapist "finds himself put on a shelf with a hundred other objects currently competing for the adolescent's attention" (Anthony, 1967, p. 67). Treated in the same "transitional" way as other objects in the adolescent's life, the therapist may experience a certain degree of resentment at the "disloyalty" of the patient as he or she struggles to break free of the reactivated infantile tie.

While feelings of being "unappreciated" and/or "devalued" are the result of a pattern of relating which is probably quite normative among adolescents, certain diagnostic groups pose even greater difficulties for therapists with too great a narcissistic investment in their patients. Proctor (1959) describes the range of narcissistic injuries incurred by therapists of character-disordered patients, who relapse frequently into acting out, may lie to and devalue their therapists and generally shatter the clinician's fantasies of "being in control." Meeks (1980), discussing special countertransference problems with suicidal adolescent patients, describes yet another source of narcissistic injury to the therapist: the patient's incessant complaints of not being helped. No matter how giving of himself the therapist may be, he or she may be continually seen as withholding and unfair. Not uncommonly, the therapist will alternate between anger at being asked to fill a bottomless pit, and self-blame

for his/her inability to meet the patient's insatiable demands. Finally, Marshall (1976) has described the sense of frustration and impotence elicited by the patient who refuses to speak ("the shrugger").

The range of countertherapeutic responses by the therapist, based on perceived narcissistic injury, includes premature termination (justified either by an exaggeration of progress or by a verdict of "untreatability"), emotional disengagement from the therapy in the form of fatigue/boredom during sessions, or laxity in notekeeping (Meeks, 1980). There may be an increased tendency--particularly with character-disordered patients--to respond to the patient's behavior in a manner which is both highly self-referential and presumes a degree of conscious control which is not present: "After all I've done for him, he has the nerve to...." Finally, there may be premature and inappropriate demands for conformity in order to validate the therapist's competence, as well as to exact a "proof of love" from patients whose ability to engage in a love relationship is ambivalent at best (Proctor, 1959).

Closely related to those affective responses which are based on the therapist's need for narcissistic gratification are those reactions to adolescent patients which are founded on a desire to rescue them from their parents. Ekstein (1966) has described this constellation of feelings as a "savior complex" (p. 420).

The results of therapist identification with the parental

role or "rescue fantasies" may in some cases be positive. Halperin, Lauro, Miscione, Rebhon, Schnabolk, and Schachter (1981) note that "such a desire can energize the rescuer and provide the therapeutic investment to overcome the despair and hopelessness of severely impaired children" (p. 577). Similarly, Eissler (1951) and Bettelheim and Wright (1955) consider a belief in one's omnipotence and a refusal to accept therapeutic failure essential in work with psychotic children. On the other hand, overidentification with the parental role may lead to the disillusionment, anger, and divisive displacements described by Ekstein, Wallerstein, and Mandelbaum (1959). According to Ekstein et al., fantasies of magically rescuing children from the wickedness of their parents, or of replacing parents more generically, frequently lead to anger at the child's resistance to being rescued.

## The Adolescent Therapist: A Breed Apart?

The relationship between biographic variables, particularly childhood experiences, and occupational choice has been the object of research with respect to a wide variety of professional groups (see Neff, 1968). Roe (1953, 1956), the leading exponent of such a connection, has long argued that the emotional quality of parent-child relationships is the decisive factor in determining the eventual occupational area one chooses to enter.

The choice of psychotherapy as a vocation has received its

share of attention, although there has been considerably more speculation than actual empirical research on background variables in the lives of mental health professionals. Moreover, despite existing evidence which suggests an essential commonality of background between psychotherapists and other persons of graduate education and professional interests (Henry, Sims, & Spray, 1971, 1973), numerous writers (e.g., Burton, 1978) persist in considering the clinician's dedication to therapy as a form of adaptive compensation to an unusually difficult or traumatic early life.

While most of the speculation has been directed at psychotherapists in general, the subgroup of psychotherapists who choose to serve a youthful population has been considered "a breed apart" even from within its own profession. What is particularly relevant for the purposes of this investigation, however, are the proposed relationships between an idiosyncratic personality makeup and behavior in the psychotherapeutic context. While an effort will be made not to rehash material from the previous section, the obvious connection between psychic organization as expressed in vocational choice, affective responsivity, and behavior make some degree of overlap inevitable. While the focus in the previous section, however, was on the affective responses of the therapist which are mediated by (1) cultural stereotypes of the adolescent, and (2) patterns of behavior which are normative for this period, this section will introduce the unique intrapsychic composition of the adolescent therapist as an additional variable

in the experience and conduct of psychotherapy.

Malmquist (1978) suggests that individuals who possess the urge to understand and become part of the life of the adolescent, and hence specialize in the treatment of this group, are often unconsciously seeking compensation for some past deprivation or attempting to relive an unhappy adolescent period with a different outcome. Meeks (1980) has proposed a restrictive background with respect to the expression of sexual and aggressive impulses, while others (Akeret & Stockhammer, 1965; Anthony, 1969) have suggested potent unmet needs for parental support for individuation during their adolescent years. There is, in fact, some empirical evidence (Henry et al., 1973) to indicate that psychotherapists, in general, have encountered more resistance than their peers to autonomous strivings during this period. It is suggested that either of these conditions may lead to the covert reinforcement of acting-out behavior. Meeks (1980) proposes that, at the very least, adolescent therapists, themselves locked in a chronic state of adolescent rebellion, may encourage patients to "wallow in their refractory rage toward their family." In this way, therapist and patient collude to "avoid facing the inevitable need to accept the burden of maturity," with each "[holding] on to a dream of a nirvana that might have been" (pp. 186-187).

Malmquist (1978), who repeatedly asserts the unique motivation of therapists who choose to work with a youthful population, believes that these individuals may possess a characteristic

makeup which is highly dependent on the receipt of certain types of narcissistic gratifications. He cites "omnipotent strivings" as an important feature in the selection of adolescence as a specialty area, noting that the need for an ego-ideal during this developmental period may be highly gratifying to the therapist who is nominated to fulfill this role. Hammer and Kaplan (1967), writing on the choice of child psychotherapy as a career,[1] described the rejection of personal dependency needs as another potent source of motivation to work with a younger population. As a child these therapists may have longed to reverse the vulnerability they felt as a consequence of being intimidated by very powerful and controlling parents, and the decision to treat youthful patients may be fueled by a need to maintain the dominant position in relationships. Related to this type of therapist are those who prefer to work with younger patients because of inadequately resolved oedipal impulses. Frustrated in early competitive efforts, they select patients who they believe will satisfy this need "to win."

Hammer and Kaplan (1967) have also identified as a basic motivation in these clinicians a need to be needed and loved:

> Usually they are trying to compensate for unconscious feelings of worthlessness precipitated by the fact that they were not valued by their parents. As a consequence they have

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[1]Perhaps the largest group of clinicians treating adolescents received their primary training in child psychiatry and psychotherapy.

> come to see themselves as unlovable. They recognize intuitively that by being nice to emotionally disturbed children they will receive in return affection from these children, which the therapist can then use as confirmation for the fact that he is really lovable after all. (p. 31)

For other child therapists observed by Hammer and Kaplan (1967), the most frustrated need has been finding someone they could love. It is proposed that these therapists, when they were children, tried to love their parents but received rejection in return for their love. This hurt them severely, causing them to erect a barrier against ever being intimate with anyone. They come to feel that disturbed children are relatively safe objects for this pent-up need to love, as these children are not likely to reject them because of their own tremendous needs for nurturance. When one contrasts to this set of needs the adolescent's typical resistance and/or inability to provide these much longed-for gratifications, the negative results--in terms of therapist disappointment, resentment, and even rejection--seem unavoidable.

Related to the adolescent therapist's proposed dependence on the love of his/her youthful patients is the "savior complex" described in the previous section. It has been suggested (Hammer & Kaplan, 1967) that these therapists may actually identify with their young patients, vicariously experiencing their own nurturing as that of the loving parents they never had. Consistent with this view is their observation that child and adolescent therapists

tend to be more comfortable in the company of younger people, and Friend's (1972) report that one of the most frequent supervisory problems he has encountered is with analysts who had incurred parental losses in their own adolescence. In this context, refusals by patients to be "rescued" may not only deprive therapists of an opportunity to experience themselves as loving and being loved, but may also frustrate personal fantasies of being rescued, through identification with their patients, and thus retaliating against their own parents. Moreover, overidentification with the role of "idealized parent" may interfere with the important task of limit setting, and even lead to the inappropriate exclusion of parents from treatment (Meeks, 1980).

On the other hand, several writers (Hammer & Kaplan, 1967; Malmquist, 1978) suggest that the desire to "love" children on a professional basis may represent a reaction formation concealing their genuine animosity toward young people--particularly a younger sibling--to whom hostility was not expressed in the past when it might have been appropriate to do so. These authors note that therapists whose emotions and behavior are dominated by this defensive operation may, in fact, rationalize punitive behavior toward their patients in terms of the importance of setting strict limits.

This section has reviewed the clinical literature on the goals and techniques of therapy with adolescents, as well as on the affective responses described as typical for therapists

of this age group. In the following section, a methodological design and series of hypotheses will be presented which address the differences between adolescent and adult psychotherapy.

# CHAPTER II

## OVERALL DESIGN AND HYPOTHESES

### Overall Design

The primary objectives of this investigation were, as described earlier, (1) to obtain normative data on the process of adolescent psychotherapy as perceived by clinicians, (2) to determine any meaningful differences in clinicians' therapeutic goals, conduct, and affective experience when working with adolescent vs. adult patients, and (3) to gather preliminary data on the relationship between selected life history variables and clinicians' experiences with adolescent patients.

Clinicians working with patients representing adolescent and adult age groups were asked to describe, by means of a Therapy Session Report (TSR), a structured response questionnaire developed by Orlinsky and Howard (1966), an individual therapy session conducted with one adolescent patient and an individual therapy session conducted with one adult patient. Adolescent therapy sessions were then compared to adult therapy sessions on a group of eleven process dimensions ("session factors") identified via factor analysis in Orlinsky and Howard's (1977) pioneering work with the TSR, as well as on a number of variables drawn directly from the literature on adolescent psychotherapy. The decision to use these preexisting factors as the bases for these analyses

was based on an insufficient subjects/items ratio in the present investigation from which a valid factor analysis could be generated (Nunnally, 1978). Finally, the mediating influence on therapist behavior of selected biographic and sociodemographic variables was assessed.

This within-subjects design assures that any obtained differences may be accounted for by patient variables rather than therapist variables. Precedents for this design may be found in at least two studies (Bieber et al., 1961; Rand & Stunkard, 1977), in which trained cohorts of analysts each provided information on two patients who differed from each other on some target characteristic.

Hypotheses

1. Collapsing across all eleven "session factors" (Orlinsky & Howard, 1977), adolescent sessions will differ from adult sessions.

1a) "Distressed, Anxiously Depressed Patient" (Factor I) Adolescent sessions are less likely than adult sessions to be characterized by this dimension of self-experienced distress on the part of the patient.

1b) "Open, Actively Expressive Patient" (Factor II) Adolescent sessions are less likely than adult sessions to be characterized by this dimension of effective role performance on the part of the patient.

1c) "Obstructive, Resistive Patient" (Factor III)

Adolescent sessions are more likely than adult sessions to be characterized by this dimension of general uncooperativeness to treatment.

1d) "Autonomous, Socially Effective Patient" (Factor IV)

Adolescent sessions are less likely than adult sessions to be characterized by this dimension of maturity of patient concerns and self-expression.

1e) "Patient Discussing Prospects in Marital and Domestic Involvements" (Factor V)

Adolescent sessions are less likely than adult sessions to be characterized by this dimension which emphasizes parenting and household responsibilities.

1f) "Patient Focusing on Therapist" (Factor VI)

Adolescent sessions are less likely than adult sessions to be characterized by this dimension of patient attention to process variables in treatment.

1g) "Patient Exploring Family Background" (Factor VII+)

Adolescent sessions are more likely than adult sessions to be characterized by this dimension reflecting discussion of current family issues.

1h) "Therapist Promoting Behavioral Change" (Factor VII-)

Adolescent sessions are more likely than adult sessions to be characterized by this dimension, reflecting an active, present-focused approach by therapists.

1i) "Warmly Involved, Empathic Therapist" (Factor VIII)

Adolescent sessions are more likely than adult sessions to be characterized by this dimension of intense affective involvement on the part of therapists.

1j) "Forceful, Confronting Therapist" (Factor IX)

Adolescent sessions are more likely than adult sessions to be characterized by this dimension of demandingness and structuring activity on the part of therapists.

1k) "Erotic Transference-Countertransference" (Factor X)

Adolescent sessions are more likely than adult sessions to be characterized by this dimension of mutual erotic attraction.

1l) "Dreading a Session with a Patient Seen as Angrily Concerned about Isolation and Intimacy" (Factor XI)

Adolescent sessions are more likely than adult sessions to be characterized by this constellation of variables.

2. The techniques and goals emphasized by therapists during adolescent vs. adult sessions will differ in the following ways:

2a) Therapists will report placing less emphasis on the induction of transference in adolescent psychotherapy.

2b) Therapists will report more self-revelation and emphasis on the "real" relationship in adolescent psychotherapy.

2c) Therapists will report placing less emphasis on the exploration of historical antecedents of behavior in adolescent psychotherapy.

2d) Therapists will report a greater emphasis on the support

of defenses with adolescent patients.

2e) Therapists will report more limit setting and emphasis on the acquisition of impulse control in adolescent psychotherapy.

3. The affective experience of the therapist during adolescent vs. adult sessions will differ in the following ways:

3a) Therapists will report feeling more protective toward adolescent patients.

3b) Therapists will report feeling more devalued and unappreciated by adolescent patients.

3c) (i) Therapists will report feeling envious and competitive during adolescent sessions to the extent that the patient discusses and/or demonstrates by his/her behavior the discharge of sexual and aggressive impulses. (ii) This relationship will exceed any similar relationship found in adult therapy sessions. (iii) The overall levels of envy and competitiveness reported by therapists during adolescent vs. adult sessions will be compared.[1] (iv) The patient variables most frequently associated with therapists' reports of envy and competitiveness will be identified.[1]

3d) (i) Therapists will report feeling sexually aroused and attracted during adolescent sessions to the extent that

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[1]For purposes of conceptual clarity, exploratory questions are listed along with a priori hypotheses. In all instances, alpha levels for the statistical analysis were adjusted accordingly.

the patient presents sexually-related material and/or engages in sexual/sexualized behavior both in and out of the session. (ii) This relationship will exceed any similar relationship found in adult therapy sessions. (iii) The overall levels of sexual arousal and attraction reported by therapists during adolescent vs. adult sessions will be compared.[1] (iv) The patient variables most frequently associated with therapists' reports of arousal and attraction will be identified.

4. Therapist characteristics will influence session ratings in the following ways:

4a) Parenthood will be positively associated with (i) self-reported capacity to empathize and feel affectively involved with adolescent patients; (ii) feelings of protectiveness toward adolescent patients; (iii) an emphasis on limit setting and the acquisition of impulse control.

4b) Therapist experience level will be positively associated with self-reported capacity to empathize and feel affectively involved with adolescent patients.

4c) Personal psychotherapy will be positively associated with self-reported capacity to empathize and feel affectively involved with adolescent patients.

4d) Therapists' ratings of their own parents' permissiveness/restrictiveness during adolescence will be related to their own emphasis on limit setting and the acquisition of impulse control.

# CHAPTER III

## METHOD

### Subjects

The primary subject sample consisted of 1,000 psychotherapists, randomly selected from a population consisting of potentially eligible members of the National Register of Health Service Providers in Psychology (1984 edition). This compendium, which briefly lists the clinical populations served by its members, guided the selection of questionnaire recipients. To be considered eligible to participate in this study, clinicians had to include among their professional activities the provision of outpatient psychotherapy to both adult and adolescent patients (the latter being arbitrarily defined for the purposes of this investigation as between 13 and 16 years of age). A supplementary sample of clinicians practicing in Franklin and Hampshire Counties of western Massachusetts were recruited by telephone in order to increase the final sample of participating therapists.

All potential subjects were informed, in the cover letter accompanying the questionnaires, that they were being asked to participate in an empirical study of the adolescent psychotherapy process (see Appendix A). A slightly modified cover letter (see Appendix B) accompanied questionnaires received by those respondents who had provided prior consent by telephone.

## Instruments

The Therapy Session Report. The primary instrument used in this study was Form T (Therapist) of the Therapy Session Report (TSR), designed by Orlinsky and Howard and published by the Institute for Juvenile Research (Chicago, 1966). Slight modifications were made in the TSR for purposes of this investigation and are described below. The Therapist Form of the TSR is a structured response questionnaire consisting of 158 items, and can be completed by most individuals in 15-20 minutes. The 158 items are designed to cover ten categories of a therapist's experiences during a session; six of these focus on the therapist's experience of his/her patient, and the remaining four address the therapist's self-experience.

With regard to the therapist's experience of the patient, the TSR contains 20 items which survey the topics that were talked about during the session, 15 items which require the therapist's appraisal of what the patient seemed to want from the session, 13 items which survey the patient's current concerns, 34 items selected to cover the patient's affective state, 10 items focused on the patient's interpersonal behavior, and 9 items covering the therapist's perception of the patient's self-experience and level of adaptation.

With regard to the clinician's self-experience, 14 items survey therapeutic goals during the session, 8 items cover his/her interpersonal behavior, and 28 items focus on the therapist's

affective state. Finally, the original instrument includes 7 multiple-choice items which focus on the therapist's perception of the session as an ongoing interpersonal act and on his/her evaluation of it.

A parallel form of the TSR designed for completion by patients (Form P) was not used in this investigation.

The Therapy Session Report has been used in over thirty published research projects, and has led to information concerning patient sense of progress (Orlinsky & Howard, 1968), patient concerns in psychotherapy (Hill, 1969; Sacuzzo, 1975a), normative data on dialogue in psychotherapy (Howard, Orlinsky, & Hill, 1969; Sacuzzo, 1975b), empirical correlates of "good" and "bad" therapy sessions (Orlinsky & Howard, 1967), and the frequency and structure of patient and therapist affective experience in psychotherapy (Howard, Orlinsky, & Hill, 1970).

The Therapist Form of the TSR has been factor analyzed to yield eleven dimensions of therapeutic experience within the session. These factors represent the product of a factor-analyzed intercorrelation matrix of 53 "facets" of therapist experience previously derived from individual factor analyses of the ten subscales comprising the instrument (e.g., dialogue, patient concerns, patient feelings, etc.). Thus, these 11 factors can be seen to be organized hierarchically: each factor consists of a variable number of component facets which load with that factor and which, in turn, are comprised of a variable number

of TSR items loading with that facet.

The eleven dimensions derived from the TSR were, in turn, grouped into those which focused primarily upon patterns of patient participation (Factors I to VII+), of therapist participation (Factors VII- to IX), or of mutual involvement in the session (Factors X and XI). A detailed description of this statistical procedure is available in Orlinsky and Howard (1977) and in materials available from the authors. However, insofar as scores on these eleven factors served as dependent variables in part of the comparative analysis of adolescent and adult therapy sessions, they will be briefly outlined here:

Session Factor I: "Distressed, anxiously depressed patient." This factor focuses on the degree of self-experienced distress the therapist perceived in the patient during the session.

Session Factor II: "Open, actively expressive patient." This factor delineates a perception of effective role performance on the patient's part, with the therapist, in a complementary manner, refraining from intruding his/her own structuring of the session.

Session Factor III: "Obstructive, resistive patient." This dimension reflects the cooperativeness or uncooperativeness of the patient, in contrast to ability to perform effectively in the patient role. It includes the therapist's perception of his/her patient as seeking to avoid therapeutic involvement, as wanting neither insight nor advice, and as relating in a

domineering manner.

Session Factor IV: "Autonomous, socially effective patient." This dimension, along with the other three remaining patterns of patient participation, focuses on the content of what was discussed by the patient during the session. This cluster of items includes the patient talking, in a self-possessed manner, about issues of self-assertion in work and peer relations.

Session Factor V: "Patient discussing prospects in marital and domestic involvements."

Session Factor VI: "Patient focusing on therapist."

Session Factor VII+: "Patient exploring family background."[1]

Session Factor VII-: "Therapist promoting behavioral change." This dimension reflects the extent to which the therapist actively attempted to suggest and encourage new ways of dealing with self or with others to the patient. In Howard and Orlinsky's original research, Session Factor VII was construed as essentially bipolar (hence the positive and negative valences), with self-exploratory activity by the patient (VII+) being inhibited by the active therapeutic style implied by this dimension.

Session Factor VIII: "Warmly involved, empathic, effective therapist." This dimension reflects the joint experience of effective role performance and positive affective involvement on the part of the therapist (with the patient seen as responding

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[1]For Session Factors V, VI, and VII+, the titles are self-descriptive.

in an accepting manner).

Session Factor IX: "Forceful, confronting therapist." This dimension delineates a self-perception on the part of the therapist of relating in a domineering, demanding, and highly structuring manner with a patient who is perceived to be equally domineering. According to Orlinsky and Howard (1977), this factor essentially describes a "head-on collision between the participants in which conative and affective elements seemed to predominate over any particular contents that might have occasioned the conflict" (p. 582).

Session Factor X: "Erotic transference-countertransference." This dimension refers to a pattern of mutual involvement in which the patient's feelings of eroticized affection, confidence and desire for greater therapist involvement are associated with feelings of intimacy and disturbing sexual arousal on the part of the therapist.

Session Factor XI: "Dreading a session with a patient seen as angrily concerned about isolation and intimacy." This dimension refers to a pattern of mutual involvement in which the therapist reported dread at the prospect of seeing a patient who, while angrily concerned about issues of isolation and intimacy, tended (perhaps defensively) to relate in a domineering manner.

In the present investigation, the original TSR items were somewhat modified and expanded from 158 to 181 in order to include items believed to reflect the therapeutic goals and affective states

frequently cited in the literature on adolescent psychotherapy (see preceding review). For example, adjectives such as "envious," "helpless," "protective," and "unappreciated" were added to the subscale dealing with the therapist's feelings, and the "patient goals" subscale was supplemented with such choices as "to test my limits" and "to fill time to get through the session." Some of the supplemental items were drawn from an earlier version of the TSR, presented in Orlinsky and Howard's Varieties of Psychotherapeutic Experience (1975); other items were devised by the author in accordance with the relevant literature. In Appendix C, which contains the revised version of the TSR used in this investigation, all supplemental items are clearly indicated. Full permission was provided by the instrument's authors for these modifications (Orlinsky, personal communication).

Additionally, a brief section was included in the TSR for therapist-respondents to record relevant data about the patients on whom they were reporting. Such information as age, sex, and DSM-III diagnosis was requested, as well as a rough estimate of the phase of treatment (beginning, middle, or terminal) from which the target session was obtained.

Finally, in addition to modifications in the content of the instrument described above, the 3- and 4-point response alternatives offered by Orlinsky and Howard were extended to 5-point alternatives in order to facilitate finer discrimination

of respondents' experiences.

Demographic questionnaire: Therapist characteristics. All respondents completed a cover sheet (Appendix D) requesting background information about themselves. Variables selected for this questionnaire were drawn from those which have been consistently related to therapists' feelings and behavior in psychotherapy, e.g., sex, age, theoretical orientation, years of postdoctoral clinical experience, personal psychotherapy, and parental status. Additional items investigated aspects of the therapists' own adolescence: unusual experiences during this period (e.g., loss of family members through death or divorce), presence of emotional/behavioral difficulties meriting professional attention, perceptions of parental permissiveness and support. A number of items were drawn or adapted from the questionnaire and interview schedule developed by Henry, Sims, and Spray (1971, 1973) for use in his large-scale study of the personal and professional histories of mental health professionals.

## Procedure

All potential subjects received a packet of materials consisting of the following: (1) a cover letter describing the purpose of the study and outlining eligibility criteria, (2) two copies of the modified Therapy Session Report (TSR), labelled Form A: Adolescent and Form B: Adult, (3) the demographic questionnaire, (4) a pre-stamped return envelope in which to return the completed

forms, and (5) an eligibility card (Appendix E) on which nonparticipating clinicians were asked to indicate whether their failure to return the completed questionnaire was a result of not meeting eligibility criteria for participation. The inclusion of this card represented an effort by the investigator to approximate the "true" response rate, which would be based on the number of questionnaire recipients who did in fact meet the eligibility requirements. All forms were coded with an identifying number to assure the confidentiality of therapist and patient.

Participating clinicians received instructions to complete the appropriate form of the TSR as soon as possible following sessions with one adolescent and one adult patient of the same sex. The use of the TSR to investigate single sessions, a variation of the original use of this instrument (which required that a minimum of six consecutive sessions be reported on) has precedents in several studies (Sacuzzo, 1975a, b) which employed the TSR to evaluate therapists' and clients' perceptions of intake interviews.

To reduce therapist bias in the selection of target sessions, clinicians were asked to report on those patients whose last names began with the letter closest to the beginning of the alphabet, and who otherwise met the criteria for patient eligibility. All patients on whom TSRs were completed were required to be nonpsychotic. Moreover, for the purposes of this study, "adolescents" were defined as 13 to 17 years of age, "adults" as 21 to 65. The arbitrary omission of patients 18 to 20 years of age was

intended to reduce contamination between the target populations.

Therapists wishing to obtain an abstract of the study's results were asked to include a self-addressed stamped envelope, which was separated by a clerk upon receipt to insure the confidentiality of the accompanying data.

Therapists who had not returned their questionnaires within four weeks from the date of the initial mailing (or telephone contact) received a follow-up letter urging their prompt response (Appendix F).

# CHAPTER IV

## RESULTS

### The Therapist Sample

The final therapist sample consisted of 77 subjects returning usable data. This included 62 clinicians from the initial National Register mailing and 15 respondents who completed the questionnaire in response to personal telephone solicitation. An approximate response rate of 16% for the mail sample was calculated based on the number of clinicians who, by virtue either of their completion of the questionnaire or affirmative response on the Eligibility Card, indicated that they met the criteria for participation.[1]

Chi-square tests were performed to detect differences between the mail and personal contact samples that might contraindicate their being pooled for subsequent analyses. While the personal contact sample was found to differ with respect to gender ($\chi^2 = 9.8$, $df = 2$, $p < .01$), consisting primarily of female clinicians, and professional degree ($\chi^2 = 30.3$, $df = 8$, $p < .0005$), with a greater representation of master's level therapists, the relatively small number of individuals involved in the personal

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[1]This admittedly rough figure was obtained by inferring a potential subject pool of 390 subjects from the finding that only 39% of the 475 subjects who provided eligibility data met the requirements for participation.

contact sample, coupled with the absence of significant differences with respect to theoretical orientation, years of professional experience, frequency of specialized training with adolescents, and history of personal psychotherapy, was seen as sufficient justification for pooling the two samples. The creation of an interdisciplinary sample was, moreover, consistent with Howard and Orlinsky's (1977) inclusion of mental health professionals of varying degree levels in their original research with this instrument.

Not surprisingly, the final therapist sample was predominantly male (63.6%), with the vast majority of participating clinicians holding a Ph.D. in clinical psychology (79.2%). They had a median of 11 years of postgraduate experience in the practice of psychotherapy, and just over one-half of the participants had received specialized training in the treatment of adolescents (56%). Seventy-one percent of the sample were parents; 59% had adolescent children of their own. Additionally, 81% of the sample had had personal psychotherapy. Consistent with the general trend toward theoretical eclecticism reported by Garfield and Kurtz (1974), 49% of the sample described their predominant orientation as "eclectic." When these individuals were asked, however, to identify the primary theoretical orientation which informed their clinical work, the most popular psychological orientation (of the sample as a whole) was found to be analytic (45%), followed by behavioral (17%) and humanistic/existential

(10%).

In response to questions about their own developmental histories, 47% of the clinicians rated their own adolescence as "somewhat positive" or better. The greatest number of clinicians described their parents as "somewhat restrictive," although most experienced their parents as being somewhat to very supportive in their attitudes toward them. A relatively small percentage of these therapists incurred losses through death of significant others either during or prior to adolescence; 19% suffered parental divorce or separation during this same period. Interestingly, while only 9% of the clinicians surveyed had received psychotherapeutic services during their adolescent years, nearly 39% of those not receiving treatment during this period felt that their behavior and/or psychological condition had merited professional attention.

A comprehensive breakdown of the therapist sample on all sociodemographic and developmental variables appears in Table 1.

## The Patient Sample

### The Adolescents

The adolescent patients comprising this sample were predominantly female (62%), and ranged in age from 13 to 18 (median = 15.5 years). Seventy-seven percent were of middle class origin or higher, and the overwhelming majority (83%) were seen in a private practice setting. Only 21% of these therapies were self-initiated,

TABLE 1

Therapist Sample Characteristics

| | | |
|---|---|---|
| **Sex** | | |
| Male | 64% | |
| Female | 36% | |
| **Degree** | | |
| Ph.D. | 79% | |
| Ed.D. | 6% | |
| M.A. | 5% | |
| M.Ed. | 5% | |
| M.S.W. | 5% | |
| **Years Experience** | | |
| Range | 1-40 | |
| Median | 11 | |
| **Specialized Training with Adolescents** | | |
| Yes | 55% | |
| No | 42% | |
| **Personal Psychotherapy** | | |
| Yes | 82% | |
| No | 18% | |
| **Orientation** | | |
| Eclectic | 49% | (---)* |
| Psychoanalytic | 18% | (27%) |
| Sullivanian | 1% | (4%) |
| Object Relations | 10% | (14%) |
| Learning Theory | 3% | (5%) |
| Cognitive-Behavioral | 4% | (12%) |
| Humanistic | 1% | (10%) |
| Existential | 1% | (2%) |
| Other | 12% | (22%) |

*Parenthesized figures were obtained by redistributing the "eclectic" sub-sample according to the theoretical orientation identified as most influential of their clinical work.

| | |
|---|---|
| **Parental Status** | |
| Yes | 71% |
| No | 29% |
| **Has Adolescent Children** | |
| Yes | 39% |
| No | 52% |
| **Rating of Own Adolescence** [Scale: 1 - 7, high = very positive] | |
| Median | 4.1 |
| Mode | 3.0 |
| **Parental Restrictiveness** | |
| Median | 3.8 |
| Mode | 3.0 |
| **Parental Supportiveness** | |
| Median | 5.1 |
| Mode | 5.0 |
| **Had Adolescent Psychotherapy** | |
| Yes | 9% |
| No | 88% |
| **Felt Needed Adolescent Therapy** | |
| Yes | 35% |
| No | 56% |
| **Significant Losses During Adolescence** | |
| Death of father | 4% |
| Death of mother | 3% |
| Death of significant other | 10% |
| Parental separation of divorce | 9% |
| **Significant Losses Prior to Adolescence** | |
| Death of father | 5% |
| Death of mother | 0% |
| Death of significant other | 13% |
| Parental separation or divorce | 10% |

with parents being the most frequently cited source of the request for psychological intervention (60%). A median of 12 sessions had taken place prior to the target session.

Not surprisingly, the most frequently assigned Axis I diagnosis was adjustment disorder (27%), followed by depressive disorders (18%), conduct disorder (16%), anxiety disorder (16%), and eating disorder (6%). Twenty-eight percent of the adolescent sample was assigned an adjunctive diagnosis on Axis II. On this dimension of personality and developmental disorders, the most frequently assigned diagnoses were borderline and dependent personality disorders (each representing 7% of the overall sample), followed by passive-aggressive personality disorder (5%). With respect to specific problem behaviors/issues which were a focus of treatment (and which may not have been reflected in the diagnosis), the most frequently cited was suicidal ideation/attempt within the last year (38%), followed by sexual acting out (27%), aggressive behavior (21%), and substance abuse (20%). Eighteen percent of the sample were identified as victims of physical and/or sexual abuse.

Chi-square tests were used to elicit differences between male and female adolescent patients on all sociodemographic and diagnostic variables. Female adolescents were more likely to be described as sexually acting out than were their male counterparts ($\chi^2 = 4.26$, $df = 1$, $p < .05$). Males, however, were more frequently described as having difficulties with aggressive behavior

($\chi^2$ = 4.06, df = 1, $p < .05$), and were more likely than female patients to engage in violent behavior against property ($\chi^2$ = 6.64, df = 1, $p < .01$). Female adolescents were also more likely than male adolescents to have engaged in recent suicidal ideation or attempts ($\chi^2$ = 4.60, df = 1, $p < .05$). No significant differences were found between male and female adolescent patients with respect to age, social class, diagnosis, frequency of violent behavior against persons, substance abuse, physical or sexual victimization, or in the source of referral for psychotherapeutic services.

The Adults

The adult patients comprising this sample were predominantly female (62%),[2] and ranged in age from 22 to 53 (median = 34 years). Seventy-nine percent were of middle class origin or higher and, again, the overwhelming majority (87%) were seen in a private practice setting. Ninety-one percent of these therapies were initiated by the patients themselves. A median of 16 sessions had taken place prior to the target session.

Psychodiagnostically, depressive disorders accounted for the largest number of patients (49%), followed by adjustment disorders (22%), and anxiety disorders (15%). Fifty-one percent

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[2]It will be recalled that the adolescent and adult patients reported on by a given therapist were required to be of the same sex as one another.

of this group received adjunctive diagnoses on Axis II. Borderline personality disorder represented 12% of the overall adult sample, followed closely by dependent personality disorder (11%), and passive-aggressive personality disorder (8%). Other behavior problems/issues which constituted a focus of treatment included suicidal ideation or attempt within the previous year (34%), sexual acting out (18%), substance abuse (17%), and aggressive behavior (15%). Finally, 23% of these adult patients were described as victims of physical and/or sexual abuse.

Chi-square tests were used to elicit differences between male and female adult patients on all sociodemographic and diagnostic variables. Female adult patients tended to be somewhat younger than male patients ($\chi^2 = 38.2$, $df = 25$, $p < .05$), and were more likely to have been sexually victimized ($\chi^2 = 4.76$, $df = 1$, $p < .05$). Male patients were more likely to be described as having substance abuse problems than their female counterparts ($\chi^2 = 6.19$, $df = 1$, $p < .05$). Otherwise, no significant differences were found between the male and female adult samples.

A comprehensive breakdown of the adolescent and adult patient samples on all sociodemographic and diagnostic variables is presented in Tables 2 through 4.

## The Adolescent and Adult Samples Compared

Chi-square tests were used to elicit differences between the adolescent and adult patient samples on all sociodemographic

TABLE 2

Distribution of Patient Diagnoses by Age Group: Axis I

| Variable | Adolescents (N=77) | Adults (N=77) |
|---|---|---|
| Axis I | | |
| Substance Abuse Disorders | 1.4* | 4.6 |
| Depressive Disorders** | 19.7 | 49.2 |
| Anxiety Disorders | 16.9 | 15.4 |
| Somatoform Disorders | 1.4 | 1.5 |
| Psychosexual Disorders | 1.4 | --- |
| Adjustment Disorders | 29.6 | 21.5 |
| Conduct Disorders | 16.9 | --- |
| Eating Disorders | 7.0 | 4.6 |
| Anxiety Disorders of Childhood and Adolescence | 1.4 | --- |
| Other Disorders of Childhood and Adolescence | 4.2 | --- |
| No Axis I Diagnosis Assigned | 7.8 | 15.5 |

*All numbers refer to percentages of that age sample.
**Includes diagnoses of major depression, dysthymic disorder and unspecified "depression."

TABLE 3

Distribution of Patient Diagnoses by Age Group: Axis II

| Variable | Adolescents (N=77) | Adults (N=77) |
|---|---|---|
| Axis II | | |
| Paranoid Personality Disorder | --- | 1.3* |
| Histrionic Personality Disorder | 3.8 | 3.8 |
| Narcissistic Personality Disorder | --- | 5.2 |
| Antisocial Personality Disorder | 2.6 | --- |
| Borderline Personality Disorder | 6.5 | 11.6 |
| Avoidant Personality Disorder | 2.6 | 3.8 |
| Dependent Personality Disorder | 6.5 | 10.4 |
| Compulsive Personality Disorder | --- | 3.8 |
| Passive-Aggressive Personality Disorder | 5.2 | 7.8 |
| Atypical/Mixed Personality Disorder | --- | 2.6 |
| No Axis II Diagnosis Assigned | 71.4 | 49.3 |

*All numbers refer to percentages of that age sample.

TABLE 4

Problem Behaviors/Therapeutic Issues by Age Group

| Variable | Adolescents (N=77) | Adults (N=77) |
|---|---|---|
| Sexual acting out | 27.3* | 18.7 |
| Violence against persons | 14.3 | 10.5 |
| Violence against property | 18.2 | 6.6 |
| Suicide attempt/ideation within last year | 37.7 | 34.2 |
| Substance abuse | 19.5 | 17.1 |
| History of sexual victimization | 7.8 | 14.5 |
| History of physical victimization | 10.4 | 9.2 |

*All numbers refer to percentages of that age sample.

and diagnostic variables. The two groups differed with respect to the distribution of Axis I diagnoses ($\chi^2$ = 28.9, df = 11, $p < .005$). Adolescent patients were less likely to be diagnosed as depressed (20% vs. 49%), and more likely to be diagnosed as conduct-disordered (17% vs. 0%) than their adult counterparts. Not surprisingly, then, adolescent patients were also more likely to be described as engaging in aggressive behavior against property (18% vs. 7%). Finally, significant differences were found in the source of referral for psychotherapeutic services. Adult patients were significantly more likely to be self-referred ($\chi^2$ = 78.5, df = 1, $p < .0001$). Conversely, adolescent therapies were significantly more likely to be initiated by parents ($\chi^2$ = 59.9, df = 2, $p < .0001$), and schools ($\chi^2$ = 10.9, df = 1, $p < .001$), and somewhat more likely to be initiated by the courts ($\chi^2$ = 3.3, df = 1, $p$ = .07) than adult therapies. No significant differences were found in the probability of referrals by social service agencies.

No significant differences were found between the adolescent and adult patient samples with respect to social class, distribution of Axis II diagnoses, frequency of sexual acting out, aggressive behavior against persons, suicidal ideation/attempt within the last year, substance abuse, or history of physical and sexual victimization. Finally, no differences were found on variables comprising the immediate context of the therapy session being described. Specifically, no differences were detected in the

general setting of treatment (patients of both age groups were seen predominantly in private practice), in the number of prior sessions, or in the phase of treatment from which the target session was drawn.

Hypothesis I: Overall Difference

Collapsing across all eleven session factors, adolescent sessions were found to differ significantly from adult sessions ($F = 5.46$, $df = 10, 143$, $p < .0001$).

Hypotheses 1a - 11

The analysis of differences between adolescent and adult sessions on the eleven session factors was conducted in a hierarchical fashion which paralleled the organization of the factors themselves (see p. 40). For each factor, a Hotelling's $T^2$ test, including all of the items loading with its component facets, was employed to determine whether overall differences existed between adolescent and adult sessions on the dimension represented by that factor. If a significant difference was obtained at this stage of analysis, a Hotelling's $T^2$ test was then performed on each individual facet comprising the relevant factor. This second set of analyses yielded an overall significance level for group differences on the facet, as well as $t$ values for its component items. These values could then be used to assess the directionality of the

obtained differences.

In general, significant differences are reported at the level of the facets only, the names of which will be underlined for clarity of presentation. Differences on component items are presented, however, (1) when such elaboration would greatly enrich the reader's understanding of the therapist experience described by the facet, (2) when one or a few significant items seem to account for the finding of overall significance at the facet level, or (3) when obtained t values fail to point in a unified direction. The reader will note that individual item differences are described with a t-, rather than an F- statistic.

Hypothesis 1a: "Distressed, Anxiously Depressed Patient" (Factor I). Consistent with this hypothesis, adolescent sessions differed significantly from adult sessions on the overall constellation of facets comprising Factor I, "distressed, anxiously depressed patient" ($F = 1.9$, $df = 23, 48$, $p < .05$). These differences were, moreover, in the predicted direction. Analysis by facet revealed that therapists describe their adolescent patients as feeling less anxious ($F = 5.9$, $df = 2, 73$, $p < .005$), less concerned with matters of conscience ($F = 4.4$, $df = 2, 72$, $p < .05$), and less self-critically aroused ($F = 7.2$, $df = 3, 73$, $p < .0005$) than their adult counterparts.

Hypothesis 1b: "Open Actively Expressive Patient" (Factor II). Consistent with this hypothesis, adolescent sessions differed significantly from adult sessions on the overall constellation

of facets comprising Factor II, "open, actively expressive patient ($F$ = 3.1, $df$ = 10, 60, $p < .005$). These differences were, moreover, in the predicted direction. Analysis by facet suggests that adolescent patients are perceived as less structuring of the session (e.g., talk less, take less initiative in discussions) than their adult counterparts ($F$ = 6.0, $df$ = 3, 72, $p < .001$), with their therapists, in a complementary manner, assuming greater responsibility for structuring the interactions than they do in sessions with adults ($F$ = 3.6, $df$ = 2, 74, $p < .05$). Adolescent patients were, moreover, described as less open when it came to focusing on and expressing matters of personal concern ($F$ = 9.3, $df$ = 3, 73, $p < .0001$).

Hypothesis 1c: "Obstructive Resistant Patient" (Factor III). Three items (TSR 25, 36, and 39) not appearing in the published version of the TSR were added to this factor because of their apparent relationship to the constructs being measured. In an effort to secure empirical justification for these additions, the relationship between each of these items and the original items on Facet 13 (to which they were added) was explored. Significant correlations were found between all three of the supplementary items and both original items for both adolescents and adults (all $p$'s $< .05$). Furthermore, this new group of five items was found, by means of Cronbach's alpha, to represent a reliable scale for both adolescents ($\alpha$ = .74) and adults ($\alpha$ = .76). In fact, the removal of any of these five items reduced,

rather than increased, the reliability of the new facet, suggesting a high degree of homogeneity with respect to item content.

Consistent with this hypothesis, adolescent sessions differed significantly from adult sessions on the overall constellation of facets comprising Factor III, "obstructive, resistant patient" ($F = 3.5$, $df = 14, 56$, $p < .001$). Obtained differences were, moreover, in the predicted direction. Adolescent patients were perceived as seeking, more than adult patients, to avoid therapeutic involvement ($F = 2.4$, $df = 5, 68$, $p < .05$). Specifically, they are described as wanting more to withdraw from effective contact with their therapists ($t = 2.1$, $df = 1, 72$, $p < .05$), and as tending, more than their adult counterparts, to approach sessions with the aim of simply filling time to get through the hour ($t = 2.6$, $df = 72$, $p < .01$). Additionally, adolescent patients differed from adults on the facet reflecting the degree to which insight was sought as a goal of treatment ($F = 8.9$, $df = 4, 70$, $p < .0001$). Specifically, adolescent patients were described as less interested in understanding the reasons behind problematic feelings or behavior ($t = -5.6$, $df = 73$, $p < .0001$), in exploring emerging feelings and experiences ($t = -4.1$, $df = 73$, $p < .0001$), in working through a particular problem ($t = -2.7$, $df = 73$, $p < .01$) and in obtaining help in evaluating feelings and reactions ($t = -4.0$, $df = 73$, $p < .0001$). Relatedly, on the facet reflecting advice-seeking behavior on the part of the patient, adolescents were somewhat less likely than adults to seek advice on how to

deal more effectively with self and others ($p < .10$).

Interestingly, in light of the disproportionately high level of adolescent resistance apparent on this factor, adolescent sessions were characterized by a significantly greater emphasis by therapists upon the enhancement of the relationship ($F = 6.4$, $df = 2, 73$, $p < .005$), and particularly upon the patient's feeling of acceptance in it ($t = 3.33$, $df = 74$, $p < .001$).

Hypothesis 1d: "Autonomous, Socially Effective Patient" (Factor IV). Consistent with this hypothesis, adolescent sessions differed significantly from adult sessions on the overall constellation of facets comprising Factor IV, "autonomous, socially effective patient" ($F = 4.8$, $df = 18, 52$, $p < .0001$). These differences were, moreover, in the expected direction. Adolescent patients were rated lower by their therapists on the facet reflecting the overall degree of self-possession manifested in the session ($F = 8.5$, $df = 2, 74$, $p < .0005$). This difference was, moreover, attributable to the fact that adolescent patients are described as significantly less able than their adult counterparts to present their thoughts and feelings in a logical and organized fashion ($t = -3.9$, $df = 75$, $p < .0001$). Adolescent patients were also described as demonstrating less relief during the session than adult patients ($F = 3.8$, $df = 2, 71$, $p < .05$). Finally, adolescent patients were described by their therapists as less concerned than adults with issues of self-assertion in significant relationships ($F = 7.4$, $df = 2, 73$, $p < .001$).

Hypothesis 1e: "Patient Discussing Prospects in Marital and Domestic Involvements" (Factor V). Consistent with this hypothesis, adolescent sessions were found to differ significantly from adult sessions on the constellation of factors comprising this dimension of "patient discussing prospects in marital and domestic involvements" ($F = 13.5$, $df = 7, 63$, $p < .0001$). These differences were, moreover, in the expected direction. Adolescent patients were significantly less likely than adults to discuss domestic relationships, i.e., with opposite sex, spouse and children ($F = 30.7$, $df = 3, 68$, $p < .0001$) or domestic responsibilities ($F = 4.0$, $df = 2, 72$, $p < .05$).

Hypothesis 1f: "Patient Focusing on Therapist" (Factor VI). Consistent with this hypothesis, adolescent sessions differed significantly from adult sessions on the constellation of facets comprising Factor VI, "patient focusing on the therapist" ($F = 2.4$, $df = 6, 65$, $p < .05$). These differences were, moreover, in the expected direction. Examination of the component facets reveals that adolescent patients differed significantly from adults on the facet reflecting the discussion of feelings about therapy or the therapist ($F = 6.6$, $df = 2, 71$, $p < .005$), this finding being primarily attributable to the comparative reluctance of adolescent patients to discuss their reactions to psychotherapy and the patient role ($t = -3.56$, $df = 72$, $p < .001$).

Hypothesis 1g: "Patient Exploring Family Background" (Factor VII+). Consistent with this hypothesis, adolescent sessions

differed significantly from adult sessions on the constellation of facets comprising Factor VII+, "patient exploring family background" ($F = 2.7$, $df = 21, 47$, $p < .005$). Obtained differences were, moreover, in the predicted direction. Adolescent sessions were characterized by a greater emphasis by patients on talking about parental family ($F = 21.0$, $df = 5, 64$, $p < .0000$) than were adult sessions.

Hypothesis 1h: "Therapist Promoting Behavioral Change" (Factor VII-). No support was found for this hypothesis. No differences were obtained between adolescent and adult sessions in the degree to which therapists emphasized behavioral change.

Hypothesis 1i: "Warmly Involved, Empathic Therapist" (Factor VIII). Consistent with this hypothesis, adolescent sessions differed significantly from adult sessions on the constellation of facets comprising Factor VIII, "warmly involved, empathic therapist" ($F = 2.4$, $df = 17, 55$, $p < .01$). Obtained differences were generally in the predicted direction. Adolescent sessions were characterized by a higher degree of self-experienced warmth ($F = 3.8$, $df = 2, 73$, $p < .05$) and intimacy ($F = 9.8$, $df = 3, 73$, $p < .0001$) on the part of therapists, the latter finding being primarily attributable to the significantly higher level of affection felt by therapists for their adolescent patients ($t = 3.4$, $df = 75$, $p < .001$). Adolescent sessions were also found to differ on the facet reflecting expansive confidence on the part of their therapists ($F = 3.14$, $df = 7, 66$, $p < .01$).

Examination of the specific items comprising this facet, however, revealed that the two items which attained significance pointed in opposite directions. Specifically, while therapists described themselves as feeling more playful in sessions with adolescents ($t$ = 3.34, $df$ = 72, $p < .001$), they also felt less effective with their youthful patients than they did with adults ($t$ = -2.85, $df$ = 72, $p < .01$).

Hypothesis 1j: "Forceful, Confronting Therapist" (Factor IX). No support was found for this hypothesis, with no significant differences found between adolescent and adult sessions on this constellation of facets comprising this dimension.

Hypothesis 1k: "Erotic Transference-Countertransference" (Factor X). Consistent with this hypothesis, adolescent sessions differed significantly from adult sessions on the constellation of facets comprising Factor X, "erotic transference-countertransference" ($F$ = 4.2, $df$ = 8, 66, $p < .001$). Obtained differences were, moreover, in the predicted direction. Examination of the component facets reveals, however, that only the facet reflecting therapists' experiences of intimacy differentiated adolescent from adult sessions ($F$ = 9.8, $df$ = 3, 73, $p < .0001$). No significant differences between adolescent and adult sessions were obtained on facets reflecting therapists' experiences of disturbing sexual arousal or their perceptions of their patients' experiences of eroticized affection.

Hypothesis 1l: "Dreading a Session with a Patient Seen

as Angrily Concerned about Isolation and Intimacy" (Factor XI). Consistent with this hypothesis, adolescent sessions differed significantly from adult sessions on the constellation of facets comprising Factor XI, "dreading a session with a patient who is angrily concerned about isolation and intimacy." The obtained difference was, however, in the opposite direction. Adult patients were significantly more concerned than their adolescent counterparts with issues relating to isolation and intimacy ($F = 3.0$, $df = 4, 70$, $p < .05$). This finding was primarily attributable to the significantly greater concern demonstrated by adult patients with their ability to give love to others ($t = -3.51$, $df = 73$, $p < .001$), although nonsignificant differences obtained on other component items (e.g., concerns with dependency, loneliness, and worthlessness) consistently point to a greater emphasis by adult patients on this configuration of interpersonal issues.

Hypotheses 2 through 4

As noted earlier, these hypotheses were based directly on the adolescent psychotherapy literature, and relied on the face (rather than statistical) relationship of TSR items to the theoretical constructs being explored. In some cases, these hypotheses involved two or more TSR items which were grouped together for purposes of statistical analysis. In an effort to determine whether there was an empirical justification for these groupings, Cronbach's alpha was computed--separately for adolescents and adults--to

ascertain the degree of relationship between grouped items. Overall differences on the clustered items were computed even if the scale proved to be reliable ($\alpha > .50$) for only one of the two populations; thus, the reader should be cautious in interpreting the findings at the level of overall differences for hypotheses where this was the case. Differences between adolescent and adult patients on these groups of items were then examined with Hotelling's (multivariate) $T^2$ tests. For other questions and hypotheses, Pearson's correlations were obtained, using adjusted alpha levels when appropriate.

Hypothesis 2a: Therapists will report placing less emphasis on the induction of transference in adolescent psychotherapy. Overall, no support was found for this hypothesis.

Hypothesis 2b: Therapists will report more self-revelation and emphasize the "real" relationship more in adolescent psychotherapy. For adolescent patients, Cronbach's alpha for the grouped TSR items was .56, with item-total correlations ranging from .24 (item 121) to .46 (item 142). For adults, Cronbach's alpha was -.11, with item-total correlations ranging from .08 (item 141) to -.47 (item 130).

Overall, a significant difference was found between adolescent and adult sessions on this dimension ($F = 7.4$, $df = 4, 70$, $p < .0001$). Moreover, examination of the four component items revealed significant differences in the predicted direction for each one. Therapists reported sharing more information about

their personal lives and values ($t$ = 3.37, $df$ = 73, $p < .001$), expressing more feelings ($t$ = 2.27, $df$ = 73, $p < .05$) and spontaneous impressions ($t$ = 3.37, $df$ = 73, $p < .001$), and emphasizing the development of a "genuine, person-to-person" relationship ($t$ = 2.85, $df$ = 73, $p < .01$) to a significantly greater degree with their adolescent patients than with adults.

Hypothesis 2c: Therapists will report placing less emphasis on the exploration of the historical antecedents of behavior in adolescent psychotherapy. For adolescent patients, Cronbach's alpha for the grouped items was .61, with item-total correlations ranging from .38 (item 5) to .45 (item 127). For adults, Cronbach's alpha was .58, with item-total correlations ranging from .35 (item 5) to .41 (item 127).

Overall, a significant difference was found between adolescent and adult sessions on this dimension ($F$ = 7.8, $df$ = 2, 72, $p < .001$). Examination of the component items reveals that adolescent patients were less likely than adults to discuss childhood memories and experiences ($t$ = -3.7, $df$ = 73, $p < .0001$), while their therapists, in a complementary fashion, were less likely to make the exploration of the historical antecedents of present conflicts/difficulties a focus of treatment ($t$ = -2.76, $df$ = 73, $p < .01$).

Hypothesis 2d: Therapists will report a greater emphasis on the support of defenses with adolescent patients. Overall, no support was found for this hypothesis.

Hypothesis 2e: Therapists will report more limit setting and emphasis on the acquisition of self-mastery and impulse control in adolescent psychotherapy. For adolescent patients, Cronbach's alpha for the grouped items was .62, with item-total correlations ranging from .26 (item 126) to .52 (item 120). For adults, Cronbach's alpha was .58, with item-total correlations ranging from .28 (item 122) to .49 (item 124).

Overall, no support was found for this hypothesis. A trend in the predicted direction was noted ($p < .15$), however, which was primarily attributable to the significantly greater propensity of therapists to emphasize the setting of firm limits with adolescent patients ($t = 2.33$, $df = 73$, $p < .05$).

Hypothesis 3a: Therapists will report feeling more protective toward their adolescent patients. A significant difference was found on this dimension in the predicted direction ($F = 6.9$, $df = 1, 69$, $p < .01$).

Hypothesis 3b: Therapists will report feeling more devalued and unappreciated by their adolescent patients. For adolescent patients, Cronbach's alpha for the grouped items was .37, with item-total correlations ranging from -.15 (item 63) to .50 (item 25). For adults, Cronbach's alpha was -.05, with item-total correlations ranging from .01 to .27 (item 25).

Overall, a significant difference was found between adolescent and adult sessions on this dimension ($F = 2.89$, $df = 8, 62$, $p < .01$). Examination of the significance levels of the component

items, however, suggests a distinct clustering of items which may in fact account for the especially poor reliability of this scale. Adolescent patients were perceived by their therapists as more bored ($t = 2.94$, $df = 69$, $p < .005$), less motivated to attend the session ($t = 4.24$, $df = 69$, $p < .0001$), and more likely to want to simply fill time to get through the hour ($t = 2.78$, $df = 69$, $p < .01$) than were their adult counterparts. At the same time, no significant differences were found between adolescents and adults with respect to therapists' assessments of the levels of gratitude, attentiveness, or criticalness directed at them by patients, or in the degree to which the therapists actually felt unappreciated or devalued.

This pattern of results suggested the need for a distinction between patient behaviors and the set of attributions formed by clinicians in response to those behaviors. In this case, it appeared that therapists, while perceiving the relative unwillingness of their adolescent patients to actively participate in treatment, did not respond with the predicted increase in negative feelings and self-attributions. This, in turn, led to the evolution of a new set of questions: Could it be that "resistant" behavior by adolescents in treatment is perceived by therapists as so normative for this age group so as to not be "taken personally"? And, if this is true, might therapists be more likely to take personally, i.e., respond with feelings of devaluation, the same behavior manifested by adult patients?

To attempt to answer this question, all of the items on Factor III ("obstructive, resistant patient") were added to obtain a single "resistance" score for each patient, which was then correlated with therapists' self-reports of devaluation. While a significant relationship was found between adult patients' resistance and their therapists' experience of being "devalued" ($r = .31$, $N = 77$, $p < .005$), no such relationship was found for adolescent patients ($r = .01$!).

Hypothesis 3c:

(i) Therapists will report feeling envious and competitive during adolescent therapy sessions to the extent that the patient discusses and/or demonstrates by his/her behavior the discharge of sexual and aggressive impulses. No significant relationship was found between therapists' experiences of envy or competitiveness during adolescent sessions and the degree to which patients discussed relationships with the opposite sex or sexual feelings and experiences, or with the degree to which sexualized feelings or behavior were manifested by patients in or out of the session. A significant negative correlation was obtained between therapists' experiences of envy and competitiveness and the degree to which adolescent patients expressed concerns about angry feelings and behavior (envy: $r = -.23$, $N = 74$, $p < .05$; competitiveness: $r = -.21$, $N = 74$, $p < .05$). No relationship was obtained, however, between therapist envy and competitiveness and the description of patients as engaging in aggressive behavior outside the session.

(ii) This relationship will exceed any similar relationship found in adult therapy sessions. Obviously, the failure to find the predicted relationship in Hypothesis 3c-(i) indicates a failure to confirm this hypothesis as well. In fact, it appears as if the relationship between envy by clinicians and the discharge of sexual (but not aggressive) impulses by patients may be, in direct opposition to what was predicted, a much more salient relationship in adult psychotherapy. For adult patients, therapists' experiences of envy were significantly correlated with sexual acting out outside the session ($r$ = .25, $N$ = 75, $p < .05$), as well as with sexualized feelings ($r$ = .33, $N$ = 76, $p < .005$) and behavior ($r$ = .44, $N$ = 75, $p < .001$) manifested by patients within the session. Interestingly, envy by therapists was also significantly related to their own feelings of attraction ($r$ = .31, $N$ = 77, $p < .005$) and sexual arousal ($r$ = .50, $N$ = 77, $p < .001$) during these sessions, lending some additional support to the notion that the feelings of envy may derive from the constraints that they, unlike their patients, must exercize over experienced sexual impulses. No relationship was found between therapists' experiences of envy or competitiveness and the degree to which adult patients expressed anger or aggression in or out of the session.

(iii) The overall levels of envy and competitiveness reported by therapists during adolescent vs. adult therapy sessions will

be compared. T tests failed to demonstrate significant differences in the levels of envy or competitiveness reported during adolescent vs. adult sessions.

(iv) The patient variables most frequently associated with therapists' self-reported experiences of envy and competitiveness will be identified. To attempt to answer this question, Pearson correlations were computed between the two target variables and all other patient variables on the TSR.

Because of the exploratory nature of this question, the alpha level was set at .001, the lowest probability reported by the SPSS computer program for Pearson correlations. At this stringent level, no patient variables, other than those sexually-related items previously reported under Hypothesis IVb, demonstrated a significant correlation with therapist envy or competitiveness. One finding worth mentioning, although it did not attain the .001 cutoff for acceptance, was the relationship between therapists' experience of competitiveness and the discussion, by their adolescent patients only, of body and appearance ($r = .26$, $N = 74$, $p < .01$).

Hypothesis 3d:

(i) Therapists will report feeling sexually aroused and attracted during adolescent sessions to the extent that the patient presents sexually-related material and/or engages in sexual/sexualized behavior both in and out of the session. Consistent with this

hypothesis, therapists' reports of sexual arousal and attraction during adolescent therapy sessions were significantly correlated with the discussion, by patients, of relationships with the opposite sex (sexual arousal: $r = .22$, $N = 75$, $p < .05$; attraction: $r = .27$, $N = 75$, $p < .01$), with their perception of their patients as feeling sexually attracted (sexual arousal: $r = .27$, $N = 74$, $p < .01$; attraction: $r = .45$, $N = 74$, $p < .001$), with seductive behavior by patients within the session (sexual arousal: $r = .44$, $N = 74$, $p < .001$; attraction: $r = .30$, $N = 74$, $p < .005$) and, finally, with sexual acting out by patients outside the session (sexual arousal: $r = .27$, $N = 76$, $p < .01$; attraction: $r = .32$, $N = 76$, $p < .005$). No relationship was found between therapists' reports of sexual arousal or attraction and the degree to which adolescent patients discussed sexual feelings and experiences.

(ii) These relationships will exceed any similar relationships found in adult therapy sessions. No support was found for this hypothesis. In fact, the degree of correlation between therapists' reports of sexual arousal and attraction and the extent to which adult patients manifested the constellation of sexually-related feelings and behaviors described in Hypothesis 3d-(i) was essentially similar to (and perhaps even a bit stronger than) that obtained for adolescent patients. Therapists' reports of sexual arousal and attraction during adult therapy sessions were significantly

correlated with seductive patient behavior within the session (sexual arousal: $r = .60$, $N = 75$, $p < .001$; attraction: $r = .52$, $N = 75$, $p < .001$), sexual acting out outside the session (sexual arousal: $r = .21$, $N = 75$, $p < .05$; attraction: $r = .28$, $N = 75$, $p < .01$), perceptions of their patients as feeling sexually attracted (sexual arousal: $r = .68$, $N = 76$, $p < .001$; attraction: $r = .53$, $N = 76$, $p < .001$), and discussions by patients of sexual feelings and experiences (sexual arousal: $r = .30$, $N = 76$, $p < .005$; attraction: $r = .31$, $N = 76$, $p < .005$). No relationship was found between therapists' reports of sexual arousal or attraction and the degree to which patients discussed relationships with the opposite sex.

(iii) The overall levels of sexual arousal and attraction reported by clinicians during adolescent vs. adult therapy sessions will be compared. T tests failed to demonstrate significant differences in the levels of sexual arousal or attraction reported during adolescent vs. adult sessions, although the difference obtained was in the direction of greater arousal towards adult patients and greater attraction towards adolescents. It is essential to keep in mind, however, with respect to this and all hypotheses involving sexual arousal and attraction that these were not, by any means, frequently reported experiences for the clinicians surveyed. Feelings of attraction were reported to be present "a moderate amount" or greater in 16% of adult sessions and 18%

of adolescent sessions, while sexual arousal to a similar degree was reported in 3% and 0%, respectively, of adult and adolescent sessions.

(iv) The patient variables most frequently associated with therapists' self-reported experiences of sexual arousal and attraction will be identified. At the alpha level of .001 which was set for exploratory questions involving Pearson correlations, therapists' reports of sexual arousal during adolescent sessions were correlated with their perceptions of patients as feeling strange ($r$ = .38, $N$ = 74), and with seductive patient behavior ($r$ = .44, $N$ = 74; see Hypothesis 3d-(i)). Self-reported attraction was associated with patients' discussions of their bodies/appearance ($r$ = .40, $N$ = 74) and personal aspirations ($r$ = .40, $N$ = 75), as well as with therapists' perceptions of patients as feeling affectionate ($r$ = .39, $N$ = 74) and sexually attracted ($r$ = .45, $N$ = 74; see Hypothesis 3d-(i)).

During adult sessions, therapists' reports of sexual arousal were correlated at the .001 level with seductive patient behavior ($r$ = .60, $N$ = 75; see Hypothesis 3d-(ii)), and with their perceptions of patients as feeling confused ($r$ = .34, $N$ = 76), affectionate ($r$ = .43, $N$ = 76) and sexually attracted ($r$ = .68, $N$ = 76; see Hypothesis 3d-(ii)). Finally, self-reported attraction was associated with patients' discussions of relationships with same-sex peers ($r$ = .36, $N$ = 75), personal aspirations ($r$ = .46, $N$ = 76) and

feelings about dependency ($r$ = .35, $N$ = 77), and with perceptions of patients as feeling close ($r$ = .44, $N$ = 76), affectionate ($r$ = .35, $N$ = 76) and sexually attracted ($r$ = .53, $N$ = 76).

Hypothesis 4a:

(i) Parenthood will be positively associated with self-reported capacity to empathize and feel affectively involved with adolescent patients. Pearson correlations failed to establish a significant relationship between parental status and the degree to which clinicians reported understanding their adolescent patients' communications or felt "sympathetic" during sessions. There was, however, a nonsignificant trend, in the predicted direction, for therapists who were parents to feel more interested ($p < .10$) and "in touch" with their patients' feelings ($p < .10$) during adolescent sessions.

(ii) Parenthood will be positively associated with heightened feelings of protectiveness toward adolescent patients. Pearson correlations failed to provide support for this hypothesis.

(iii) Parenthood will be positively associated with therapists' self-reported emphasis on limit setting and the acquisition of impulse control. Pearson correlations failed to demonstrate a significant relationship between parental status and the degree to which clinicians emphasized self-control, behavior change or limit setting with their adolescent patients.

Hypothesis 4b: Therapist experience level will be positively related to self-reported capacity to empathize with and feel affectively involved with adolescent patients. Pearson correlations failed to establish a significant relationship between experience level and the degree to which clinicians reported being "in touch" with their patients' feelings, understanding their patients' communications, feeling sympathetic or interested during sessions. This was true for both adolescent and adult patients.

Hypothesis 4c: Personal psychotherapy will be positively associated with self-reported capacity to empathize with and feel affectively involved with adolescent patients. Pearson correlations failed to establish a significant relationship between personal psychotherapy and the degree to which clinicians reported being "in touch" with their patients' feelings, understanding their patients' communications, feeling sympathetic or interested during sessions. This was true for both adolescent and adult patients.

Hypothesis 4d: Therapists' ratings of their own parents' permissiveness/restrictiveness during adolescence will be related to their own emphasis on limit setting and the acquisition of impulse control. Consistent with this hypothesis, a significant relationship was obtained between this dimension of historical parental behavior and clinicians' current therapeutic emphases. Specifically, parental restrictiveness during adolescence was

significantly correlated with limit setting with adolescent patients ($r$ = .23, $N$ = 75, $p < .05$) but, interestingly, not with adults. A similar trend was noted with respect to clinicians' emphasis on facilitating a sense of acceptance in the therapeutic relationship; clinicians who had experienced more restrictive backgrounds were somewhat more likely to emphasize this goal with adolescent patients ($r$ = .15, $N$ = 74, $p < .10$), but not with adults. Finally, no relationship was found between early parental restrictiveness and therapists' relative emphases on the achievement of self-control or insight for either patient group.

## The Effect of Diagnosis on Therapists' Experiences

As noted in an earlier section, some significant differences were noted in the distribution of Axis I diagnoses among adolescent and adult patients. Specifically, adolescent patients were more likely to receive a diagnosis of "conduct disorder" (a diagnosis typically reserved for patients under 18), while adult patients were more likely to receive a diagnosis of depression. Thus, the question which must be asked is: Could the obtained differences in therapists' experiences of adolescent and adult sessions be attributed to the diagnostic (rather than developmental) dissimilitude between the two age groups?

In an effort to answer this question, a multiple regression was done on each of the eleven Session Factors. The variables

which were entered in this analysis were (1) patient age, (2) depression, and (3) conduct disorder. (Dummy-coding was used to represent the presence or absence of the two diagnostic variables.)

The diagnosis of depression was found to have a significant positive relationship to Factor I, "Distressed, anxiously depressed patient" ($\underline{F} = 6.49$, $\underline{p} < .05$), accounting for 7% of the variance on this dimension. However, patient age was also found to be significantly related to the factor ($\underline{F} = 3.14$, $\underline{p} < .05$), accounting for 4% of the obtained variance. Thus, even on this dimension, the differences in therapist's experiences in adolescent and adult sessions would have been found irrespective of diagnostic differences between the two populations.

The diagnosis of conduct disorder was found to have a significant inverse relationship to Session Factor II, "Open, expressive patient" ($\underline{F} = 4.3$, $\underline{p} < .05$), accounting for 3% of the variance on this dimension. However, patient age was also found to be significantly related to this Factor ($\underline{F} = 5.4$, $\underline{p} < .05$), accounting for 6% of the obtained variance. Thus, on this dimension as well, the differences in therapists' experiences in adolescent and adult sessions would have been found irrespective of diagnostic differences between the two populations.

Neither of the two diagnoses which differentiated adolescent from adult patients were found to exert a significant effect on any of the remaining Session Factors.

Exploratory Factor Analyses

As noted earlier, the lack of a sufficient subjects:variables ratio in the present data set on which to base a valid factor analysis (Nunnally, 1978) led to the decision to employ previously derived factors (Orlinsky & Howard, 1977) as independent variables for many of the statistical analyses required by this investigation. Nonetheless, a heuristic factor analysis was attempted, independently for the adult and adolescent psychotherapy sessions (1) to elicit any provocative differences in adult vs. adolescent factorial structure that might either be consonant with other reported findings of this investigation or generate hypotheses for future research on the salient elements of adolescent psychotherapy, and (2) to determine if the factor structure obtained for adult sessions resembled that identified by Orlinsky and Howard (1977) with their population of adult patients. The finding of a significant congruence between the two factorial structures obtained for adult patients would not only extend the generalizability of the original findings with this instrument, but would also lend additional justification to the use, in this investigation, of the previously derived factors.

The 49 facets served as the variables which were entered into the factor analysis, which was assisted by an oblique rotation of the factors. With an oblique rotation, the requirement of orthogonality among the factor axes is relaxed; thus, this rotational

method may be considered more realistic because the theoretically underlying dimensions are not assumed to be unrelated to each other. The decision to employ an oblique rotation of the factors, despite the fact that Orlinsky and Howard's original factor analyses relied on an orthogonal Varimax rotation, was determined by the quite different goals of this factor analysis. While orthogonal rotations have a mathematical purity which is sacrificed in oblique rotations, the latter can better provide an impression of how the actual data clusters. Thus, given the exploratory nature of this factor analysis, and the fact that mathematical purity was already unattainable given the inadequate subjects:items ratio, the oblique rotation was considered most appropriate.

For the adult sessions, nine factors were retained, accounting for 76.3% of the variance. For the adolescent sessions, eight factors were retained, accounting for 76.9% of the variance. Factors were deleted only if they were both unintelligible and accounted for a minimal degree of variance ($< 5\%$). Tables 5 through 21, modeled after Orlinsky and Howard (1977), delineate the retained factors, along with the amount of variance accounted for by each factor. The reader should note that, while several of the factors have names which closely approximate the names of the original factors (reflecting their similarity of content), these are in fact newly derived factors.

TABLE 5

Adult Factor 1: The Distressed Patient

| | |
|---|---|
| Therapist views patient as: | |
| Being self-critically aroused | .75[a] |
| Not feeling confident | .63 |
| Feeling inhibited | .60 |
| Feeling depressed | .58 |
| Feeling confused | .58 |
| Not being self-possessed | .46 |
| Therapist views self as: | |
| Not feeling confident | .39 |

[a]Only loadings .35 or higher are shown.
Variance accounted for = 22.9%.

TABLE 6

Adult Factor 2: Motivated, Cooperative Patient

| | |
|---|---|
| Therapist views patient as: | |
| Not wanting to avoid therapeutic involvement | .79 |
| Wanting insight | .37 |
| Relating in an accepting manner | .35 |

Variance accounted for = 17.5%.

TABLE 7

Adult Factor 3: Forceful Therapist with Resistant Patient

| | |
|---|---|
| Therapist views patient as: | |
| Not relating in a structuring manner | .56 |
| Relating in a domineering manner | .40 |
| Not being open | .38 |
| Therapist views self as: | |
| Relating in a structuring manner | .70 |
| Relating in a domineering (vs. accepting) manner | .38 |

Variance accounted for = 8.7%.

TABLE 8

Adult Factor 4: Erotic Transference-Countertransference

| | |
|---|---|
| Therapist views patient as: | |
| Feeling eroticized affection | .81 |
| Therapist views self as: | |
| Feeling disturbing sexual arousal | .70 |
| Feeling intimate | |

Variance accounted for = 7.3%.

TABLE 9

Adult Factor 5: Therapist Promoting Behavioral Change

| | |
|---|---|
| Therapist views patient as: | |
| Wanting advice | .88 |
| Feeling relieved | .47 |
| Therapist views self as: | |
| Aiming to promote behavioral change | .36 |

Variance accounted for = 6.5%.

TABLE 10

Adult Factor 6: Patient Focusing on Therapist

| | |
|---|---|
| Therapist views patient as: | |
| Talking about therapy and therapist | .74 |

Variance accounted for = 3.8%.

TABLE 11

Adult Factor 7: Cold, Detached Therapist

| | |
|---|---|
| Therapist views self as: | |
| Not relating with warmth | .67 |
| Feeling detached | .49 |
| Therapist views self as: | |
| Feeling tired (vs. alert) | .43 |

Variance accounted for = 3.8%.

TABLE 12

Adult Factor 8: Therapist Enhances Relationship

| | |
|---|---|
| Therapist views self as: | |
| Aiming to enhance relationship | .56 |

Variance accounted for = 3.1%.

TABLE 13

Adult Factor 9: Patient Concerned About Relationships

| | |
|---|---|
| Therapist views patient as: | |
| Concerned about sexuality | .72 |
| Concerned about isolation vs. intimacy | .46 |

Variance accounted for = 2.7%.

TABLE 14

Adolescent Factor 1: Patient Concerned with Issues of Identity and Impulse Control

| | |
|---|---|
| Therapist views patient as: | |
| Wanting emotional relief and control | .39 |
| Concerned about identity conflict | .35 |
| Therapist views self as: | |
| Aiming to provide catharsis | .63 |
| Aiming to enhance relationship | .39 |

Variance accounted for = 26.2%.

TABLE 15

Adolescent Factor 2: Distressed, Anxiously Depressed Patient

| Therapist views patient as: | |
|---|---|
| Feeling depressed | .75 |
| Being self-critically aroused | .67 |
| Feeling inhibited | .59 |
| Not feeling confident | .57 |
| Feeling anxious | .53 |
| Feeling angry | .48 |
| Concerned about isolation and intimacy | .39 |

Variance accounted for = 18.9%.

TABLE 16

Adolescent Factor 3: Patient Seeking Help with Current Life Situation

| Therapist views patient as: | |
|---|---|
| Talking about work and peers | .70 |
| Talking about domestic relationships | .64 |
| Wanting advice | .38 |

Variance accounted for = 8.5%.

TABLE 17

Adolescent Factor 4: Detached, Discouraged Therapist

| Therapist views self as: | |
|---|---|
| Feeling tired (vs. alert) | .67 |
| Feeling detached | .59 |
| Feeling inadequate | .56 |

Variance accounted for = 6.9%

TABLE 18

Adolescent Factor 5: Forceful, Confronting Therapist

| | |
|---|---|
| Therapist views self as: | |
| Relating in a domineering (vs. accepting) manner | .77 |
| Aiming to promote behavioral change | .60 |
| Aiming to provide control (vs. support) | .47 |

Variance accounted for = 6.5%.

TABLE 19

Adolescent Factor 6: Motivated, Cooperative Patient

| | |
|---|---|
| Therapist views patient as: | |
| Relating in a structuring manner | .83 |
| Being open (focusing and expressive) | .67 |
| Wanting catharsis | .51 |
| Not wanting to avoid therapeutic involvement | .41 |

Variance accounted for = 3.9%.

TABLE 20

Adolescent Factor 7: Warmly Involved, Empathic Therapist

| | |
|---|---|
| Therapist views patient as: | |
| Feeling relieved | .49 |
| Therapist views self as: | |
| Relating with warmth | .78 |
| Feeling expansive confidence | .54 |
| Feeling intimate | .48 |

Variance accounted for = 3.6%.

TABLE 21

Adolescent Factor 8: The Reticent Patient

| | |
|---|---|
| Therapist views patient as: | |
| Not wanting therapist involvement | .79 |
| Not talking about parental family | .55 |
| Therapist views self as: | |
| Not aiming to provide insight | .35 |

Variance accounted for = 2.4%.

# CHAPTER V

# DISCUSSION

## The Adolescent in Treatment

John Meeks, in his oft-cited text on adolescent psychotherapy, The Fragile Alliance (1980), includes a chapter titled "Adolescents are Different." The results of this investigation lend ample support to the notion that adolescent patients do, in fact, bring to the psychotherapeutic encounter a set of attitudes and expectations which reliably differentiate them--at least in the eyes of their therapists--from adult patients. A review of their presenting difficulties (p. 58) should make it clear that the adolescents whose sessions are described in this study were engaged in a wide variety of highly dysfunctional and potentially self-destructive behaviors; over one-third of them had contemplated or attempted suicide in the previous year. Most importantly, however, for the purposes of this discussion, the degree of dysfunction based on the frequency of these "problem behaviors" was essentially equivalent among the adolescent and adult samples. Nonetheless, the adolescent patients described in this study were consistently viewed as less concerned about their difficulties than were comparably impaired adult patients, as evidenced both by their apparently lower levels of anxiety and self-criticality, as well as by the overwhelming majority (79%) who consented to treatment only on

the initiative of parents and other institutions. This finding is thoroughly consistent with Weiner's (1982) observations that, for early and middle adolescents, "even thinking about being unable to cope can make them feel that they are being unacceptably childish or dependent" (p. 274). It is for this reason, he notes, that even profoundly depressed adolescents are unlikely to experience or display the feelings of helplessness and self-deprecation which typify adult depressives. Furthermore, the behavior of these adolescents within the session was construed by their therapists as indicating a significantly greater resistance to therapeutic engagement and collaboration; consistent with Anthony's (1967) description of the adolescent patient as forcing his/her therapist to "compete for attention with a hundred other objects" (p. 67), the adolescent patients depicted in this investigation tended to defy most conceptions of what constitutes a "good" patient (Garfield & Bergin, 1978). On the contrary, when compared to their adult counterparts, they were less motivated to attend sessions, less open in expressing concerns, less verbal, more resistant to insight as a goal and, in general, less willing to share with their therapists the burden of work which is entailed by all psychotherapies. Moreover, in what might be construed as yet a further denial of the relevance to them of either the psychotherapeutic process or of their therapists, adolescent patients were far less likely than adults to discuss sentiments about treatment or about their relationship to their clinicians.

These findings are thoroughly consistent with Hoffman, Becker, and Gabriel's (1976) delineation of the normative relational style of early to middle adolescence, a period in which independence/dependence conflicts involving parental figures are at their peak, and in which heightened self-centrism (or "narcissism") mitigates against involvement in any relationship which requires the adolescent to take a consistent interest in another person (Blos, 1962).

## The Therapist's Response

How do therapists experience themselves in relation to these patients? The hypotheses of this investigation roughly divided therapists' self-experiences into (1) therapeutic goals and strategies and (2) affective responses. With respect to the former, no support was found for the predictions that adolescent sessions would be characterized by a greater emphasis on the bolstering of defenses or by a diminished emphasis on the induction of potentially regressive transference reactions. It must be kept in mind, however, that both of these hypotheses, based as they were on responses to single TSR items, may have failed to attain statistical significance because of the marked diminution of power which results from analyses of this type. This explanation seems especially likely with respect to the emphasis placed by clinicians on transference induction and interpretation, as a variety of other analyses clearly demonstrate the significantly

greater emphasis accorded in adolescent sessions to the goal of enhancing the "real" relationship.

Therapists of adolescents reported sharing more information about their personal lives and values, expressing more feelings and spontaneous impressions and, in general, emphasizing the development of a relationship in which they might serve as extra-familial identificatory figures in the present rather than as "blank screens" onto which distorted images from the past might be projected. It should not be surprising, therefore, that, also consistent with what was predicted, clinicians reported placing less emphasis, in adolescent psychotherapy, on the historical antecedents of behavior.

It is only when one begins to review the self-reported emotional responses of the participating clinicians that real "surprises" begin to surface. As predicted, clinicians tended to experience heightened feelings of protectiveness toward adolescent patients, presumably the product of conscious or unconscious parental imagos summoned up by the age differential. Also as predicted, therapists experienced a significantly higher level of affection and warmth in adolescent sessions. What is particularly interesting, however, is that, while feelings of warmth and intimacy toward patients were, for Orlinsky and Howard's (1975) adult patients, positively associated with feelings of therapeutic effectiveness, the opposite was found to be true for these adolescent patients. That is, concomitant with enhanced feelings of closeness toward their

adolescent patients, the clinicians in this study reported a significantly lower sense of therapeutic effectiveness with this population than with their adult patients! Moreover, despite the markedly higher level of resistance to and devaluation of treatment communicated by their adolescent patients, no support was found for the hypothesis that therapists would report feeling more unappreciated/devalued in sessions with their youthful patients.

A variety of explanations might account for this unexpected finding. One possibility is that "resistant" behavior by adolescents in treatment is perceived by therapists as so normative for this age group so as not to be "taken personally." In other words, the chronologic age of the patient might act as a mediating variable between the observed behaviors and the set of attributions (including self-attributions) formed by clinicians in response to these behaviors. Preliminary support for this possibility comes from the finding that therapists' self-reports of devaluation were significantly correlated with patient "resistance" for adults only. An alternative, but related explanation for the failure of clinicians to report increased feelings of devaluation in adolescent sessions stems from the phase of treatment from which the typical session was drawn. As noted earlier, a median of only 12 sessions of adolescent psychotherapy had taken place prior to the session on which participating clinicians reported. Numerous authors (e.g., Meeks, 1980; Weiner, 1970) have noted that the initial phase of treatment with adolescents is particularly

likely to be fraught with challenges to the clinicians' authority and competence, particularly insofar as he or she is associated by the patient with parents and other authorities who may have insisted upon treatment. Thus, the failure of the participating clinicians to report increased feelings of devaluation by these resistant adolescent patients may be related to their recognition of this behavior as phase-specific to the initial months of treatment with this population and their expectation that a more gratifying and productive therapeutic alliance would develop in time. Finally, it is conceivable that the self-report format of the TSR, which can elicit from respondents only conscious or possibly preconscious aspects of experience, and which is so subject to the pressures of responding in a socially desirable manner (Alexander, 1980; Crandall, 1974), leaves us with a seriously truncated view of the range of affective responses actually experienced by participating clinicians. This measurement issue is one which will be taken up in greater detail later in this discussion.

Drawing on the literature regarding typical countertransference reactions to adolescent patients, a number of hypotheses focused on the therapists' experiences of envy and sexual arousal in adolescent psychotherapy. No empirical support was found for the emphasis accorded by the clinical literature to the notion that an envy of youthful freedoms, particularly around the liberal expression of sexuality and aggression, uniquely characterizes the therapist's response to adolescent patients. Not only did

the overall levels of envy and competitiveness fail to differentiate adolescent from adult psychotherapy sessions, but these particular affective responses simply did not prove to be highly salient features of the therapeutic experience in general. Envy and competitiveness were not described as salient (i.e., were rated as present "a moderate amount" or greater) in a single adolescent therapy session, and in only 0% and 2%, respectively, of adult sessions. Moreover, no support was obtained for the hypothesized relationship between therapists' envy and the discharge of sexual and aggressive impulses by adolescent patients. There was, in fact, some suggestion that the relationship between therapists' self-reports of envy and the discharge of sexual, but not aggressive, impulses may be a more salient relationship in adult psychotherapy.

A similar pattern of nonconfirmatory results were obtained with respect to clinicians' experiences of sexual arousal and attraction. Again, the overall levels of sexual arousal and attraction reported by clinicians failed to differentiate adolescent from adult psychotherapy sessions. Furthermore, these particular affective responses did not prove to be anywhere near as commonplace in adolescent sessions as one might have predicted from the clinical literature's repeated references to "erotic" countertransference and even injunctions against cross-gender matching of therapists and adolescent patients. In fact, feelings of attraction and arousal were reported to be present "a moderate amount" or greater in only 18% and 0%, respectively, of adolescent sessions, suggesting

that neither of these experiences might be considered to be modal in the treatment of youthful patients. How can we reconcile what appears to be such a vast discrepancy between these findings and a clinical literature which portrays the practice of adolescent therapy as a veritable "jungle" of primitive impulses and drives (newly intensified for the patient, reactivated for the clinician)? Perhaps the most obvious explanation is that these experiences, while statistically quite rare, are so severely disruptive to the therapeutic process so as to require serious and repeated review in the literature. Alternately, it is possible that these relatively infrequent occurrences have garnered an unwarranted share of attention due to their highly sensationalistic quality. One might even wonder whether the explicit and implicit claims that these experiences are, in fact, normative, reflect efforts to "normalize" or justify some extremely troubling countertransference responses. Another possibility, and one which has been suggested earlier in this discussion, is the inadequacy of self-report measures in the assessment of feelings and attitudes which (a) may be primarily unconscious, and (b) are likely to be actively suppressed if considered by the respondent to be deviant or discrepant with other consciously held beliefs. Feelings of sexual arousal and envy in response to patients, particularly minors, violate powerful cultural and professional taboos. Thus, it is quite likely that the frequency with which these items were endorsed represents an underestimation of the degree to which these were

actually experienced by participating clinicians. The marked discrepancy between the number of therapists reporting "attraction" (18%) and those reporting "arousal" (0%) during adolescent sessions lends some support to this suggestion, i.e., the more general and, hence, less threatening of two related variables was reported with much less hesitation.

It must also be recognized, moreover, that, the methodology of this investigation instructed clinicians to confine their reports to single sessions with one patient. Thus, the failure to obtain support for the presence of frequently described countertransference issues may be due to the overly restrictive data base. Tentative support for this explanation comes from Weisberg's (1978) study of adolescent psychiatrists, in which, in response to the question, "In which of the following situations has negative countertransference impaired your clinical work?", a full 18% selected "seductive behavior by patients." Presumably, this mode of questioning, which was both more abstract and hence less threatening than the session-based format of this investigation, and allowed the clinician to survey in his/her mind the entire gamut of patients and sessions in which these experiences may have occurred, led to the higher figure.

Overall, the patient variables associated with therapists' experiences of sexual arousal and attraction were quite similar across adolescent and adult sessions. In general, clinicians tended to feel attracted and/or aroused when they perceived their

patients to be feeling sexually attracted or as behaving in a seductive manner towards them. This finding is consistent with the observation, frequently made in clinical contexts, of a mirroring of emotional responses between therapist and patient. Several differences appear worthy of mention, however. First, therapists' sexual arousal was significantly associated with the discussion of physical appearance by adolescents only, lending some support to the notion that the emergent sexuality of these youngsters is particularly stimulating to clinicians. Second, the relationship obtained, for adult sessions, between therapists' arousal/attraction and a constellation of patient variables including affection, confusion and concerns about dependency suggest that expressed vulnerability may be an important factor in the binding process that takes place between clinician and patient.

Impact of Therapist Variables on Experience of Therapy

As predicted, a significant relationship was obtained between clinicians' ratings of their own parents' restrictiveness/permissiveness and the degree to which limit setting was emphasized with adolescent patients. Specifically, limit setting with adolescent patients increased as a function of the degree to which therapists had experienced more restrictive parental attitudes during their own adolescent years, with a more permissive therapeutic environment being associated with permissively reared clinicians. This finding is consistent with

studies of child-rearing practices which have documented a high degree of correlation between the way one raises one's own children and the way one was raised (e.g., Sloman, 1948). Moreover, the fact that this relationship was found to exist for adolescent patients only suggests that the direct assumption of parental functions by the therapist, with the concomitant evocation of identifications with parental images, may be more relevant to adolescent than to adult treatment.

Contrary to expectations, no systematic relationship was found between parenthood of adolescent children and the degree to which clinicians emphasized limit setting or felt protective toward their youthful patients. These results differed from those of Orlinsky and Howard (1975), who found that parenthood was positively associated with an "attitude of nurturant commitment to helping others" (p. 186).
Moreover, no support was found for a relationship between either personal psychotherapy or experience level and clinicians' self-reported capacity to empathize with and feel affectively involved with adolescent patients. This finding was highly discrepant with a substantial body of literature linking both of these therapist variables with higher "empathy" ratings of therapists by patients and nonparticipant observers (Barrett-Lenard, 1962; Cartwright & Lerner, 1963; Strupp, 1958). While it is clearly difficult to assess why such divergent findings were obtained with this sample, one possibility is that the effects of these therapist

variables were obscured by a self-report format which tended both to "homogenize" and to bias, in a socially desirable direction, therapists' reports of their own responses. Perhaps if the empathy ratings had been completed by the patients, or even by observers (as in Strupp's 1958 study of the impact of personal analysis on therapists' behavior with disliked patients), differences on this variable would have emerged more clearly.

Another possibility which might account for the failure to elicit differences as a function of experience level, is that the impact of this variable tends to be less pronounced after a certain level of proficiency has been reached. Many of the studies which obtained significant differences in therapists' behavior as a function of years of experience compared student psychotherapists at varying points in their professional training with one another or with degree-holding clinicians (e.g., Mitchell & Hall, 1971; Mullen & Abeles, 1971). It seems possible, then, that comparing experienced clinicians to one another, as this investigation did, led to the finding of no significant differences.

## Other Findings

As noted above, this investigation sought to gather preliminary data on selected biographic variables which have been repeatedly cited in the clinical literature as both prototypic of adolescent psychotherapists and as particularly relevant to the ability to respond therapeutically to the specific challenges presented

by this population. Overall, the results of this study fail to provide support for the view that the dedication to treat adolescents necessarily constitutes a form of adaptive compensation for unusual affective deprivation or loss during this period of life. In fact, the therapists surveyed in this study reported fewer disruptions in the form of deaths, illnesses, and marital dissolutions than did the general sample of clinicians studied by Henry (1977), and which was itself found not to differ significantly from a national sample on these dimensions. No less than 47% of the therapists surveyed in this investigation rated their own adolescence as "somewhat positive" or better, and 64% described their parents as "somewhat to very supportive." There did, however, appear to be a subgroup of clinicians whose experiences tended to be somewhat more troubled; these individuals described their adolescent period as negative, their parents as unsupportive and themselves as requiring but not receiving psychological help during this period. Nonetheless, there is no reason to assume that these painful experiences are any more common among adolescent clinicians than among the general population, and thus cannot possibly be construed as influencing the career choice or ongoing clinical behavior of more than a subgroup of adolescent psychotherapists.

Another interesting yet unpredicted set of findings relate to the assignment of diagnostic labels to adolescent patients. Consistent with previous reports on the epidemiology of adolescent

psychopathology (e.g., Rosen, 1965; Weiner & DelGuadio, 1976), the relatively benign diagnosis of adjustment disorder was the most frequently assigned diagnosis for adolescent patients; this label, which replaces DSM-II's "transient situational disorder" nonetheless retains the latter's implication that the phenomenon being observed is phase-specific and thus potentially subject to spontaneous remission. The too frequent use of this diagnosis for adolescents has been sharply criticized by those who feel that its assignment to patients often obscures more serious pathology; one study (Weiner & DelGuadio, 1976) found that no less than 52% of adolescents diagnosed with "situational disorder" required subsequent psychiatric treatment during a 10-year follow-up period, with the original diagnosis frequently giving way to the more weighty diagnoses of psychotic, neurotic, and personality disorders.

The results of this study may be seen as lending further support to the assertion that adolescent patients as a group tend to be "underdiagnosed," particularly with respect to the Axis I diagnoses of substance abuse and depression. While no differences were found between adolescent and adult patients in the frequency with which "substance abuse" was recorded as a "problem behavior," adults were almost four times more likely than adolescents to be given a diagnosis which reflected this aspect of their dysfunctional presentation. Moreover, therapists were more likely to report "setting limits" with adult substance abusers than with adolescents who engaged in this behavior.

While one might hypothesize that the frequency of experimentation with various psychotropic agents during adolescence dissuaded clinicians from assigning this diagnosis to their youthful patients or making it a focus of intervention, the failure to take this behavior seriously can have profound implications for the individual's future adaptation.

An equally striking finding is the significantly greater frequency with which adult patients were assigned Axis I diagnoses of depression despite the fact that adolescent and adult patients were not described as different on two critical indices of depression: feelings of depression and inadequacy (reflected in Orlinsky & Howard's "depression" facet) and recent suicidal ideation/attempts. The under-diagnosis of depression in children and adolescents has been noted by numerous authors (Carlson & Cantwell, 1980; Easson, 1977; Hudgens, 1974) and may reflect a variety of factors, including (1) the traditional belief that even prolonged depressive periods are normative for adolescents; (2) the unsubstantiated notion that adolescent suicidal behavior tends to be impulsive rather than indicative of true affective disturbance; and (3) the failure to identify as potential "depressive equivalents" such behavioral manifestations as drug abuse, sexual promiscuity, restlessness, school problems, etc. In any case, what may appear to the clinician as "giving the benefit of the doubt" to patients who present with mixed or equivocal symptom pictures may result in a failure to provide clinical services

which are commensurate with the actual degree of pathology present.

## Exploratory Factor Analyses

The finding that a number of the newly derived adult session factors (Factors 1-6; see Tables 5-10) closely parallel, in tone if not in actual facet content, several of the dimensions of therapist experience extracted in Orlinsky and Howard's (1977) factor analysis may be seen as providing at least tentative support for the generalizability of the delineation of therapist experience described by those authors. Specifically, those dimensions of adult psychotherapy which were replicated, at least to some degree, in the present study included clinicians' perceptions of their adult patients as Distressed[1] (the most salient factor in both the original and the present investigation), Open and Expressive and Focusing on Therapy and the Therapist, and of themselves as Forceful and Confronting, Promoting Behavioral Change and, finally, engaged in an Erotic Transference-Countertransference paradigm.

Turning to a comparison of the factorial structures obtained in this study for adult vs. adolescent sessions, one cannot help but be impressed by the number of dimensions that they share with each other (as well as with the dimensions of therapist

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[1]Underlined words indicate Orlinsky and Howard's (1977) session factors; see pp. 41-43.

experience delineated by Orlinsky and Howard). These common dimensions, which describe such patterns of patient participation as patient distress, motivation, and resistance, as well as such patterns of therapist participation as forceful confrontativeness and emotional detachment may, in fact, represent elements which are intrinsic to the psychotherapeutic endeavor, regardless of the patient population.

What, then, of the differences in the factorial structures obtained for the adult vs. adolescent patient samples? Perhaps most striking was the emergence, for adolescents only, of the factor which was labelled "Patient Concerned with Issues of Identity and Impulse Control" (Adolescent Factor 1; see Table 14). Not only was this factor unique to the adolescent sessions, but it accounted for a larger portion of variance (26.2%) than any other factor on the adolescent factor structure. This finding is, of course, consistent with the emphasis placed by numerous theorists of adolescence (e.g., Blos, 1979; Erikson, 1968) on the critical place of identity concerns and the regulation of impulses during adolescence.

The remaining differences in factorial structure are generally highly consistent with previously described findings. The finding that a constellation of facets which was termed "Motivated, Cooperative Patient" (Adult Factor 2; Adolescent Factor 6) accounted for a far greater share of the variance in adult psychotherapy than in adolescent psychotherapy (17.5% vs. 3.9%) is consonant

with the generally higher level of resistance and lower level of expressiveness among adolescent patients which emerged in other analyses. Similarly, the emergence, for adolescent sessions only, of a factor which was termed "Warmly Involved Therapist" (Adolescent Factor 7) is consistent with the significantly higher level of therapist-experienced intimacy and affection during adolescent sessions which was elicited in analyses using the pre-existing factors. The emergence, for adult sessions only, of a factor which was termed "Patient Focusing on the Therapist" (Adult Factor 6) is likewise consistent with the previously described reluctance of adolescent patients, relative to adults, to discuss their reactions to therapy and the patient role. Finally, the emergence, for adult sessions only, of a factor reflecting "Erotic Transference-Countertransference" (Adult Factor 4) appears to mirror the generally higher levels of mutual arousal recorded by therapists during adult sessions.

To summarize, while this factor analysis must be considered highly speculative given the relatively small number of observations on which it was based, the finding of (1) an impressive degree of congruence between the adult factor structure and that obtained in the original TSR research, and (2) differences between the adolescent and adult factor structures that are consistent with the results of analyses using the original factors lend further validation to the use of these factors as independent variables in this investigation.

Issues in Interpretation: Limitations of the Findings and Suggestions for Future Research

For a variety of reasons, the conclusions of this study must be interpreted with caution. The relatively small number of clinicians providing usable data may have prevented other potentially important differences from reaching statistical significance. To be sure, the small sample made virtually impossible the exploration of any differences which involved splitting the sample into yet smaller components, e.g., male versus female therapists. A related problem involves the generalizability of the results beyond this sample. Although the distribution of diagnoses and problem behaviors among both the adult and adolescent patients suggest that these groups were roughly comparable to the general pool of individuals of both ages seeking outpatient psychological services (Rosen, 1965; Weiner & DelGuadio, 1976), the disproportionate number of sessions which occurred in a private practice setting, along with the relatively low representation of working and lower class patients of either age, make it difficult to determine how typical of adolescent psychotherapy in general were the experiences described by the clinicians who participated in this study. Certainly, the restriction of the sample to nonpsychotic patients seen in outpatient treatment would preclude the generalizability of the findings to the treatment of patients who are more severely disturbed and who might be seen as part of a hospital practice.

The composition of the therapist sample poses yet other problems for the interpretation of the findings. It must be kept in mind that the clinicians who responded to this questionnaire constitute a highly select group; not only are these individuals part of the relatively small cadre of therapists who choose to include adolescent patients in their clinical practice, but these individuals were willing to make what is, for many clinicians, a highly private enterprise--the psychotherapeutic process--the object of scrutiny. Thus, the possibility cannot be ruled out that the relatively benign view of adolescents in treatment which emerged from this investigation was, in large part, a function of the high level of personal comfort and professional confidence experienced by this group of therapists. Future research which attempted to minimize the self-selection bias, e.g., an investigation which involved all the clinicians at an agency serving an adolescent population, might provide a wider diversity of responses. It would also be quite interesting to compare the attitudes toward adolescent treatment of practicing adolescent psychotherapists with those of clinicians who have abandoned work with this age group, as well as to explore which, if any, characterologic or biographic variables are associated with the ability to meet the challenges posed by this population.

The limitations of the self-report format of this investigation have already been raised. To summarize, self-report measures, like the TSR, are capable, at best, of providing information

about subjects' conscious and possibly preconscious experiences. Its inability to tap into feeling states that may have been more out of the awareness of the respondent, coupled with both the bias towards socially desirable response sets and the general tendency of subjects to respond, on Likert-type scales, with the "middle" answer makes it difficult to assess how accurate a picture of the therapists' experiences was actually obtained. An equally thorny question involves the degree to which the therapists' representations of themselves and their patients in the sessions would correspond with ratings made by the patients themselves. Explorations into the interrelations of therapist experience with patient experience have already been reported (Orlinsky & Howard, 1975), and provide evidence of significant discrepancy between the TSR reports of adult patients and therapists on the same sessions. Future research, involving both the therapist and patient forms of the TSR with adolescent patients, might assess the informational value of the therapist's experience as a predictive guide to the patient's concurrent experience, with the goal of helping the clinician to use his/her experience to anticipate and capitalize on subsequent events in treatment.

Further reservations with respect to the interpretation of the present findings relate to the use of single sessions as valid indications of the experiential quality of the ongoing treatment. Orlinsky and Howard's (1975) pioneering research with the TSR employed five randomly selected sessions from each

treatment, the TSR results of which were averaged to obtain more stable estimates of therapists' (and patients') experiences throughout the treatment. This procedure also had the advantage of eliminating any systematic effects of treatment phase; as noted earlier, the sessions which comprised the data base for this investigation tended to be skewed towards the early and middle phases of treatment. Future research on adolescent psychotherapy using this instrument might well employ this "random sessions" technique, particularly insofar as there is some reason to believe, based on the clinical literature (Holmes, 1964; Meeks, 1980), that the treatment of this population tends to be more variable in its course than the treatment of adults. In a related vein, it might also be quite interesting to compare groups of sessions from various points in the treatment in order to assess the degree and nature of changes in the experience over time.

Perhaps the ultimate reason for studying the therapeutic process is the determination of the effects of different kinds of process on treatment outcome, both in terms of staying in therapy versus premature termination and personal functioning at various points of follow-up. The cross-sectional methodology of this investigation, in concert with the lack of complementary data on patients' experience, leaves us without a basis on which to evaluate the ultimate meaning of a variety of findings. For example, is the increased frequency of protective and affectionate feelings reported during adolescent sessions facilitative or

detrimental to the treatment? Do these feelings enable clinicians to persist in their therapeutic efforts despite what may be active resistance to engagement, or do they constitute a countertransferential overidentification with the parental role (a situation which 41% of Weisberg's (1977) subjects found impaired their abilities to function)? Are they associated with increased feelings of acceptance on the part of the patient, and hence an improved therapeutic alliance, or are they experienced as oppressive and infantilizing? And, finally, how might psychotherapies characterized by varying degrees of these experiences, both individual and conjoint, fare as far as symptom relief, improved sense of well-being, etc.? Future research might include adjunctive measures such as the SCL-90 (Derogatis, 1975), administered at repeated points during the treatment, to address this relationship between therapeutic process and objective change.

## Summary and Conclusions: Implications for Psychotherapy Training

While impressive strides have been made toward the systematic investigation of those factors which characterize or define psychotherapy with adults, no substantive empirical research has ever sought to obtain normative data on the process of adolescent psychotherapy, or to determine any meaningful differences in clinicians' therapeutic conduct and affective experiences when working with adolescent versus adult patients.

The results of this investigation provide clear evidence

that experienced clinicians do, in fact, experience their psychotherapy sessions with adolescent patients quite differently than sessions with adult patients who are roughly comparable diagnostically and sociodemographically. On 9 of 11 session factors identified by Orlinsky and Howard (1975) in their preliminary work with this instrument, as well as on a variety of dimensions described in the clinical literature, adolescent sessions differed significantly from adult sessions.

As predicted, adolescent patients were viewed by their therapists as less distressed, more resistant to therapeutic engagement, less verbally expressive and open, and less organized in the presentation of material than their adult counterparts. In a complementary fashion, their therapists experienced themselves as adopting a therapeutic stance which was more active and structuring (although generally not more confrontative), more "here-and-now" oriented than their approach to adult patients, and which placed a higher degree of emphasis on the goal of achieving a "real" relationship as opposed to one based on transferential distortions. On an affective level, clinicians reported feeling more affectionate towards and protective of their adolescent patients.

Contrary to what was expected, no differences were found between adolescent and adult sessions in the degree to which clinicians stressed behavior change or the support of existing defenses as goals for treatment. Moreover, no support was found for the emphasis accorded by the clinical literature to the

countertransferential affective experiences of devaluation, envy, or sexual arousal in the treatment of adolescent patients. Not only did the frequency or intensity of these experiences fail to differentiate adolescent from adult sessions, but they were statistically quite rare in the treatment of both populations.

Finally, a significant relationship was obtained between a specific biographic variable of therapists--parental restrictiveness--and the degree to which limit setting was emphasized with adolescent patients. No relationship was obtained, however, between therapists' experience level, parenthood, or history of personal therapy and their self-reported capacity to empathize with adolescent patients.

The implications of these findings for training in psychotherapy are essentially two-fold. First, the results of this investigation highlight the critical importance of didactic instruction in the basic developmental tasks and normative modes of adaptation and relationship in adolescence. This would include a review of the typical behavior of adolescents in psychotherapeutic treatment. Not only does such information provide an essential baseline against which to assess psychopathological behavior, but it provides the clinician with a framework within which to understand what might otherwise be experienced as a massive narcissistic injury. Particularly for the beginning therapist, who is typically overinvested in feeling "needed" by or "helpful" to patients, the comparative lack of verbalized distress by these

patients, in concert with their manifest resistance to therapeutic engagement and general disavowal of the importance of what the clinician has to offer, can be a confusing and demoralizing experience. The fact that the experienced clinicians who served as subjects in this investigation did not seem to react to these behaviors with heightened perceptions of discouragement or devaluation only serves to underscore the importance of realistic expectations in approaching this population. To be sure, theoretical knowledge is not a substitute for the internalized set of norms against which experienced clinicians evaluate patient behavior. Nonetheless, for the beginning psychotherapist who, when confronted with a sullen, resistant adolescent, begins to ruminate about his/her own capacity to invite a therapeutic alliance, the knowledge that he or she is experiencing a relatively typical sample of adolescent behavior in the initial phase of treatment can be both comforting and useful.

A second implication of these findings is the necessity for clinical training that emphasizes the importance of flexibility of psychotherapeutic approaches both within and across patients, and provides exposure to diverse models of psychotherapeutic intervention. A number of recent articles (e.g., Halgin, in press) have called for a more eclectic or approach to training in psychotherapy. The results of this study suggest that therapists modify a number of aspects of their therapeutic style when working with adolescents, e.g., demonstrate a higher level of activity,

and are more self-revelatory, presumably to facilitate engagement and to model more mature strategies of problem-solving and self-observation. Training programs should equip future clinicians with the broadest possible repertoire of clinical tools, as well as with the confidence to abandon the "classical" stance of technical neutrality when dealing with populations for whom such an approach is inappropriate or even countertherapeutic.

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APPENDIX A

Cover Letter/Instructions for National Register Sample

The Commonwealth of Massachusetts
University of Massachusetts
Amherst 01003

March 26, 1984

Dear Colleague,

I am writing to invite you to participate in the Adolescent Psychotherapy Project, a nation-wide survey of clinicians being conducted in the Department of Psychology, University of Massachusetts, Amherst. This large-scale investigation represents the first empirical study of therapists' experiences of adolescent psychotherapy and is expected to culminate in numerous presentations and publications relevant to both training and practice.

Your name was selected from the National Register because of your expressed interest in working with both adolescent and adult patients. If you are willing to participate in this project, please read carefully the eligibility criteria on the next page. Total confidentiality for yourself and your patients is, of course, assured. Questionnaires are coded for the purpose of data management only. If you decide not to participate, please use the enclosed envelope to return the brief form titled "Eligibility Status".

Your completion of the enclosed questionnaire will be assumed to indicate your informed consent to participate in this investigation. If you would like to obtain an abstract of the results (which should be available by December, 1984), please enclose a stamped self-addressed envelope. This will be separated by a clerk upon receipt to insure the confidentiality of the accompanying data.

While we do not have any funds to reimburse research participants, please accept our deepest appreciation for your help and cooperation on tbis project.

P.S. Your prompt reply within 10 days would be greatly appreciated
A. G.

Thank you so much.

Alison Gartner

Alison Gartner
Project Coordinator
Adolescent Psycbotherapy Project

## Eligibility Criteria

To be eligible to participate, therapists must:

1) be providing individual psychotherapy
2) to both adolescents (13-17) and adults (21-50)
3) on an out-patient basis (privately or in a clinic/hospital setting)

If you do not meet these requirements, STOP HERE. If you are eligible and would like to participate, please read on.

## Instructions for Participants

The focus of this research is on the encounter between therapists and patients in their therapy sessions. The study is not concerned with the personal reactions of individuals. Rather, it seeks to determine the typical or average kinds of events that take place in therapy. Enclosed you will find two (2) identical booklets, labelled Form A: Adolescent and Form B: Adult. Each booklet contains a series of questions about a therapy session you have recently completed. These questions have been designed to make the description of your experiences in the session simple and quick.

Please complete these booklets following a session with one adolescent patient and one adult patient. Please choose patients of the same sex (i.e., both male or both female). In addition to the age restrictions outlined above, we ask that psychotic patients be excluded. Moreover, to reduce therapist bias in the selection of target sessions, we are asking that you report on your patients whose last names begin with the letter closest to the beginning of the alphabet, and who otherwise meet the diagnostic and age criteria for inclusion. Finally, we ask that you complete the Therapist Background Information sheet enclosed.

We appreciate your participation, and we will be pleased to receive any further help you can give in the way of suggestions and comments.

# APPENDIX B

## Cover Letter/Instructions for

## Personal Contact Sample

April 24, 1984

Dear

Thank you for consenting to participate in the Adolescent Psychotherapy Project, a nation-wide survey of clinicians being conducted in the Department of Psychology, University of Massachusetts, Amherst. This large-scale investigation represents the first empirical study of therapists' experiences of adolescent psychotherapy and is expected to culminate in presentations and publications relevant to both training and practice.

Your completion of the enclosed questionnaire will be assumed to indicate your informed consent to participate in this investigation. Total confidentiality for yourself and your patients is, of course, assured. If you would like to obtain an abstract of the results (which should be available by December, 1984), please enclose a stamped self-addressed envelope. This will be separated by a clerk upon receipt to insure the confidentiality of the accompanying data.

While we do not have any funds to reimburse research participants, please accept our deepest appreciation for your help and cooperation on this project.

Thank you so much.

Alison Gartner

Alison Gartner
Project Coordinator
Adolescent Psychotherapy Project

P.S Your prompt response would be greatly appreciated!
A.G.

# APPENDIX C

## Therapy Session Report (TSR)

THERAPY SESSION REPORT

FORM A: ADOLESCENT

Thia booklet contsins a series of questions about the therspy session which you have just completed. These questions have been designed to make the description of your experience in the aession simple and quick. Plesse feel free to write additionsl comments on s page when you want to say things not eaaily put into the cstegories provided.

BE SURE TO ANSWER EACH QUESTION

Sex of Patient ____ (196)
Age of Patient ____ (197)

Of what social class is your patient? (198)
Upper clsss ____ Upper middle clsss ____
Middle class ____ Working clsss ____ Lower clsss ____

DSM 111 Diagnosis (Axis 1 and 11 only)

Axis 1. (Clinical Syndrome) _____ (199)
_____

Axis 11. (Developmental or _____ (200)
Personality Disorders) _____

Which, if any, of the following, apply to this patient? (201)
____ Sexual acting out
____ Aggressive or violent behsvior
____ agsinst persons
____ against property
____ Suicidsl ideation/attempt within past year
____ Substance sbuse
____ Victim of physical abuse
____ Victim of sexual abuse

In whst setting (e.g., private practice, community clinic) is this patient being seen? _____ (202)

Approximately how many prior aessions have you had with this patient? (203)
_____

Would you consider yourself to be in the BEGINNING, MIDDLE, or TERMINAL phase of therspy with this client? (Circle one) (204)

At whoae request was thia therapy initisted? (205)

Patient ____
Parent(s) of patient ____
Spouse of patient ____
School authorities ____
Court ____
Social Service Agency ____
Other (please specify) ____

THERAPY SESSION REPORT

FORM B: ADULT

This booklet contains a series of questions about the therapy session which you have just completed. These questions have been designed to make the description of your experience in the session simple and quick. Please feel free to write additional comments on a page when you want to say things not eaaily put into the categories provided.

BE SURE TO ANSWER EACH QUESTION

Sex of Patient _____ (196)
Age of Patient _____ (197)

Of what social class is your patient? (198)
Upper class _____ Upper middle class _____
Middle class _____ Working class _____ Lower class _____

DSM III Diagnosis (Axis I and II only)

Axis I. (Clinical Syndrome) _____ (199)
_____

Axis II. (Developmental or _____ (200)
Personality Disorders) _____

Which, if any, of the following, apply to this patient? (201)
_____ Sexual acting out
_____ Aggressive or violent behavior
_____ against persons
_____ against property
_____ Suicidal ideation/attempt within past year
_____ Substance abuse
_____ Victim of physical abuse
_____ Victim of sexual abuse

In what setting (e.g., private practice, community clinic) is this patient being seen? _____ (202)

Approximately how many prior sessions have you had with this patient? (203)
_____

Would you consider yourself to be in the BEGINNING, MIDDLE, or TERMINAL phase of therapy with this client? (Circle one) (204)

At whoae requeat was this therapy initiated? (205)

Patient _____
Parent(s) of patient _____
Spouse of patient _____
Child of patient _____
School authorities _____
Court _____
Social Service Agency _____
Other (please specify) _____

1

1. HOW DO YOU FEEL ABOUT THE SESSION ON WHICH YOU ARE REPORTING? (Circle the one answer which best applies.)

THIS SESSION WAS:

1. One of the best sessions we have had.
2. Excellent.
3. Very good.
4. Pretty good.
5. Fair.
6. Pretty poor.
7. Very poor.

WHAT SUBJECTS DID YOUR PATIENT TALK ABOUT DURING THIS SESSION? (For each subject, circle the answer which best applies.)

DURING THIS SESSION MY PATIENT TALKED ABOUT:

| | Not at all | Slightly | A moderate amount | Pretty much | Very much |
|---|---|---|---|---|---|
| 2. CURRENT RELATIONSHIP WITH MOTHER. | 1 | 2 | 3 | 4 | 5 |
| 3. CURRENT RELATIONSHIP WITH FATHER. | 1 | 2 | 3 | 4 | 5 |
| 4. CURRENT RELATIONSHIP WITH BROTHERS OR SISTERS. | 1 | 2 | 3 | 4 | 5 |
| 5. CHILDHOOD MEMORIES AND EXPERIENCES. | 1 | 2 | 3 | 4 | 5 |
| 6. ADOLESCENCE. | 1 | 2 | 3 | 4 | 5 |
| 7. RELIGIOUS FEELINGS, ACTIVITIES OR EXPERIENCES. | 1 | 2 | 3 | 4 | 5 |
| 8. WORK, CAREER OR SCHOOL. | 1 | 2 | 3 | 4 | 5 |
| * 9. RECREATIONS, HOBBIES, INTERESTS. | 1 | 2 | 3 | 4 | 5 |
| 10. RELATIONS WITH OTHERS OF THE SAME SEX. | 1 | 2 | 3 | 4 | 5 |
| 11. RELATIONS WITH THE OPPOSITE SEX. | 1 | 2 | 3 | 4 | 5 |
| 12. FINANCIAL RESOURCES OR PROBLEMS WITH MONEY. | 1 | 2 | 3 | 4 | 5 |
| 13. HOUSEHOLD RESPONSIBILITIES OR ACTIVITIES. | 1 | 2 | 3 | 4 | 5 |
| 14. FEELINGS ABOUT SPOUSE OR ABOUT BEING MARRIED. | 1 | 2 | 3 | 4 | 5 |
| 15. FEELINGS ABOUT CHILDREN OR BEING A PARENT. | 1 | 2 | 3 | 4 | 5 |
| 16. BODY FUNCTIONS, SYMPTOMS, OR APPEARANCE. | 1 | 2 | 3 | 4 | 5 |
| *17. DEATH OR LOSS OF SIGNIFICANT OTHER. | 1 | 2 | 3 | 4 | 5 |
| 18. STRANGE OR UNUSUAL IDEAS AND EXPERIENCES. | 1 | 2 | 3 | 4 | 5 |
| 19. HOPES OR FEARS ABOUT THE FUTURE. | 1 | 2 | 3 | 4 | 5 |
| 20. DREAMS OR FANTASIES. | 1 | 2 | 3 | 4 | 5 |
| 21. PERCEPTIONS OR FEELINGS ABOUT ME. | 1 | 2 | 3 | 4 | 5 |
| 22. THERAPY: FEELINGS AND PROGRESS AS A PATIENT. | 1 | 2 | 3 | 4 | 5 |
| 23. OTHER: _____ _____ | 1 | 2 | 3 | 4 | 5 |

WHAT DID YOUR PATIENT SEEM TO WANT THIS SESSION?
(For each item, circle the answer which best applies.)

| THIS SESSION MY PATIENT SEEMED TO WANT: | Not at all | Slightly | A moderate amount | Pretty much | Very much |
|---|---|---|---|---|---|
| 24. A CHANCE TO LET GO AND EXPRESS FEELINGS. | 1 | 2 | 3 | 4 | 5 |
| * 25. TO FILL TIME TO GET THROUGH THE SESSION. | 1 | 2 | 3 | 4 | 5 |
| 26. TO LEARN MORE ABOUT WHAT TO DO IN THERAPY, AND WHAT TO EXPECT FROM IT. | 1 | 2 | 3 | 4 | 5 |
| 27. TO AVOID DEALING WITH ANXIETY-AROUSING CONCERNS. | 1 | 2 | 3 | 4 | 5 |
| 28. RELIEF FROM TENSION OR UNHAPPY FEELINGS. | 1 | 2 | 3 | 4 | 5 |
| * 29. TO WIN ME OVER AS AN ALLY IN A DISPUTE OR CONFLICT. | 1 | 2 | 3 | 4 | 5 |
| 30. TO UNDERSTAND THE REASONS BEHIND PROBLEMATIC FEELINGS OR BEHAVIOR. | 1 | 2 | 3 | 4 | 5 |
| 31. REASSURANCE, SYMPATHY OR APPROVAL FROM ME. | 1 | 2 | 3 | 4 | 5 |
| * 32. TO GAIN INFORMATION ABOUT MY PERSONAL LIFE AND VALUES. | 1 | 2 | 3 | 4 | 5 |
| 33. TO EVADE OR WITHDRAW FROM EFFECTIVE CONTACT WITH ME. | 1 | 2 | 3 | 4 | 5 |
| 34. TO EXPLORE EMERGING FEELINGS AND EXPERIENCES. | 1 | 2 | 3 | 4 | 5 |
| 35. TO GET ADVICE ON HOW TO DEAL MORE EFFECTIVELY WITH SELF AND OTHERS. | 1 | 2 | 3 | 4 | 5 |
| * 36. TO PROVOKE ME TO CRITICISM OR ANGER. | 1 | 2 | 3 | 4 | 5 |
| 37. HELP IN CONTROLLING FEELINGS OR IMPULSES. | 1 | 2 | 3 | 4 | 5 |
| 38. HELP IN EVALUATING FEELINGS AND REACTIONS. | 1 | 2 | 3 | 4 | 5 |
| * 39. TO TEST MY LIMITS. | 1 | 2 | 3 | 4 | 5 |
| 40. TO WORK THROUGH A PARTICULAR PROBLEM. | 1 | 2 | 3 | 4 | 5 |
| * 41. TO PROVOKE OR DISTRACT ME WITH SEDUCTIVE BEHAVIOR. | 1 | 2 | 3 | 4 | 5 |
| 42. MY FRANK OPINION OR EVALUATION. | 1 | 2 | 3 | 4 | 5 |
| 43. OTHER: _____ _____ | 1 | 2 | 3 | 4 | 5 |

WHAT DID YOUR PATIENT SEEM TO BE CONCERNED ABOUT THIS SESSION?
(For each item, circle the answer which best applies.)

| THIS SESSION MY PATIENT WAS CONCERNED ABOUT: | | | | | |
|---|---|---|---|---|---|
| 44. BEING DEPENDENT ON OTHERS. | 1 | 2 | 3 | 4 | 5 |
| 45. MEETING OBLIGATIONS OR RESPONSIBILITIES. | 1 | 2 | 3 | 4 | 5 |
| 46. BEING ASSERTIVE OR COMPETITIVE. | 1 | 2 | 3 | 4 | 5 |
| 47. THE DEMANDS OF CONSCIENCE: SHAMEFUL OR GUILTY FEELINGS. | 1 | 2 | 3 | 4 | 5 |
| 48. BEING LONELY OR ISOLATED. | 1 | 2 | 3 | 4 | 5 |

3

| THIS SESSION MY PATIENT WAS CONCERNED ABOUT: (cont'd) | Not at all | Slightly | A moderate amount | Pretty much | Very much |
|---|---|---|---|---|---|
| 49. SEXUAL FEELINGS AND EXPERIENCES. | 1 | 2 | 3 | 4 | 5 |
| 50. EXPRESSING HER (HIS) SELF TO OTHERS. | 1 | 2 | 3 | 4 | 5 |
| 51. LOVING: BEING ABLE TO GIVE OF HER (HIS) SELF TO OTHERS. | 1 | 2 | 3 | 4 | 5 |
| 52. ANGRY FEELINGS OR BEHAVIOR. | 1 | 2 | 3 | 4 | 5 |
| 53. PERSONAL IDENTITY AND ASPIRATIONS. | 1 | 2 | 3 | 4 | 5 |
| 54. FEARFUL OR PANICKY EXPERIENCES. | 1 | 2 | 3 | 4 | 5 |
| 55. MEANING LITTLE OR NOTHING TO OTHERS: BEING WORTHLESS OR UNLOVEABLE. | 1 | 2 | 3 | 4 | 5 |
| 56. OTHER: _____ _____ | 1 | 2 | 3 | 4 | 5 |

HOW DID YOUR PATIENT SEEM TO FEEL DURING THIS SESSION?
(For each item, circle the answer which best applies.)

| | | | | | |
|---|---|---|---|---|---|
| 57. CONFIDENT | 1 | 2 | 3 | 4 | 5 |
| 58. EMBARRASSED | 1 | 2 | 3 | 4 | 5 |
| 59. RELAXED | 1 | 2 | 3 | 4 | 5 |
| 60. WITHDRAWN | 1 | 2 | 3 | 4 | 5 |
| 61. HELPLESS | 1 | 2 | 3 | 4 | 5 |
| 62. DETERMINED | 1 | 2 | 3 | 4 | 5 |
| 63. GRATEFUL | 1 | 2 | 3 | 4 | 5 |
| 64. RELIEVED | 1 | 2 | 3 | 4 | 5 |
| * 65. BORED | 1 | 2 | 3 | 4 | 5 |
| 66. CLOSE | 1 | 2 | 3 | 4 | 5 |
| 67. IMPATIENT | 1 | 2 | 3 | 4 | 5 |
| 68. GUILTY | 1 | 2 | 3 | 4 | 5 |
| 69. STRANGE | 1 | 2 | 3 | 4 | 5 |
| 70. INADEQUATE | 1 | 2 | 3 | 4 | 5 |
| 71. LIKEABLE | 1 | 2 | 3 | 4 | 5 |
| 72. HURT | 1 | 2 | 3 | 4 | 5 |
| 73. DEPRESSED | 1 | 2 | 3 | 4 | 5 |
| 74. AFFECTIONATE | 1 | 2 | 3 | 4 | 5 |
| 75. SERIOUS | 1 | 2 | 3 | 4 | 5 |
| 76. ANXIOUS | 1 | 2 | 3 | 4 | 5 |
| 77. ANGRY | 1 | 2 | 3 | 4 | 5 |
| 78. PLEASED | 1 | 2 | 3 | 4 | 5 |
| 79. INHIBITED | 1 | 2 | 3 | 4 | 5 |
| 80. CONFUSED | 1 | 2 | 3 | 4 | 5 |
| 81. DISCOURAGED | 1 | 2 | 3 | 4 | 5 |

4

| DURING THIS SESSION, MY PATIENT FELT: (cont'd) | Not at all | Slightly | A moderate amount | Pretty much | Very much |
|---|---|---|---|---|---|
| 82. ACCEPTED | 1 | 2 | 3 | 4 | 5 |
| * 83. SUSPICIOUS | 1 | 2 | 3 | 4 | 5 |
| 84. FRUSTRATED | 1 | 2 | 3 | 4 | 5 |
| 85. HOPEFUL | 1 | 2 | 3 | 4 | 5 |
| 86. TIRED | 1 | 2 | 3 | 4 | 5 |
| 87. ILL | 1 | 2 | 3 | 4 | 5 |
| 88. SEXUALLY ATTRACTED | 1 | 2 | 3 | 4 | 5 |
| * 89. SUPERIOR | 1 | 2 | 3 | 4 | 5 |
| 90. OTHER: _____ | 1 | 2 | 3 | 4 | 5 |
| * 91. OTHER: _____ | 1 | 2 | 3 | 4 | 5 |
| DURING THIS SESSION, HOW MUCH: | | | | | |
| 92. DID YOUR PATIENT TALK? | 1 | 2 | 3 | 4 | 5 |
| 93. WAS YOUR PATIENT ABLE TO FOCUS ON WHAT WAS OF PRESENT CONCERN TO HER (HIM)? | 1 | 2 | 3 | 4 | 5 |
| 94. DID YOUR PATIENT TAKE INITIATIVE IN BRINGING UP THE SUBJECTS THAT WERE TALKED ABOUT? | 1 | 2 | 3 | 4 | 5 |
| 95. WAS YOUR PATIENT LOGICAL AND ORGANIZED IN EXPRESSING THOUGHTS AND FEELINGS? | 1 | 2 | 3 | 4 | 5 |
| 96. WERE YOUR PATIENT'S FEELINGS STIRRED UP? | 1 | 2 | 3 | 4 | 5 |
| 97. DID YOUR PATIENT TALK ABOUT WHAT SHE (HE) WAS FEELING? | 1 | 2 | 3 | 4 | 5 |
| 98. WAS YOUR PATIENT SELF-CRITICAL OR SELF-REJECTING? | 1 | 2 | 3 | 4 | 5 |
| 99. WAS YOUR PATIENT ABLE TO FREELY PRODUCE IDEAS AND ASSOCIATIONS? | 1 | 2 | 3 | 4 | 5 |
| DURING THIS SESSION, HOW MUCH: | | | | | |
| 100. WAS YOUR PATIENT WARM AND FRIENDLY TOWARD YOU? | 1 | 2 | 3 | 4 | 5 |
| 101. WAS YOUR PATIENT SPONTANEOUS? | 1 | 2 | 3 | 4 | 5 |
| 102. DID YOUR PATIENT TRY TO PERSUADE YOU OF HER (HIS) OWN POINT OF VIEW? | 1 | 2 | 3 | 4 | 5 |
| 103. WAS YOUR PATIENT ATTENTIVE TO WHAT YOU WERE TRYING TO GET ACROSS? | 1 | 2 | 3 | 4 | 5 |
| 104. DID YOUR PATIENT TEND TO AGREE OR ACCEPT YOUR COMMENTS OR SUGGESTIONS? | 1 | 2 | 3 | 4 | 5 |
| 105. DID YOUR PATIENT RETAIN EFFECTIVE CONTROL OVER HER (HIS) ACTIONS AND EXPRESSIONS? | 1 | 2 | 3 | 4 | 5 |
| 106. WAS YOUR PATIENT NEGATIVE OR CRITICAL TOWARDS YOU? | 1 | 2 | 3 | 4 | 5 |
| 107. WAS YOUR PATIENT SATISFIED OR PLEASED WITH HER (HIS) OWN BEHAVIOR? | 1 | 2 | 3 | 4 | 5 |

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108. HOW MOTIVATED FOR COMING TO THERAPY WAS YOUR PATIENT THIS SESSION?
   1. Very strongly motivated.
   2. Strongly motivated.
   3. Showed positive motivation for therapy once here, but didn't seem to hsve snticipated coming in particular.
   4. Not positively motivated; just kept her (his) appointment.
   5. Definitely not motivated this session, and manifested clear resistance to being here.

109. HOW MUCH PROGRESS DID YOUR PATIENT SEEM TO MAKE IN THIS SESSION?
   1. A great desl of progress.
   2. Considerable progress.
   3. Moderate progress.
   4. Some progress, but not very much.
   5. Didn't get anywhere this session.
   6. Seems to have gotten worse.

110. HOW WELL DOES YOUR PATIENT SEEM TO BE GETTING ALONG AT THIS TIME?
   1. Very well; seems in really good condition.
   2. Quite well; no important complaints.
   3. Fairly well; has ups snd downs.
   4. So-so; manages to keep going with some effort.
   5. Fairly poorly; having a rough time.
   6. Quite poorly; seems in really bad condition.

IN WHAT DIRECTION WERE YOU WORKING WITH YOUR PATIENT THIS SESSION?
(For each item, circle the answer which best applies.)

I WAS WORKING TOWARD:

| | Not at all | Slightly | A moderate amount | Pretty much | Very much |
|---|---|---|---|---|---|
| 111. HELPING MY PATIENT FEEL ACCEPTED IN OUR RELATIONSHIP. | 1 | 2 | 3 | 4 | 5 |
| ★112. SUPPORTING MY PATIENT'S DEFENSES. | 1 | 2 | 3 | 4 | 5 |
| 113. HELPING MY PATIENT TALK ABOUT HER (HIS) FEELINGS AND CONCERNS. | 1 | 2 | 3 | 4 | 5 |
| 114. HELPING MY PATIENT GET RELIEF FROM TENSIONS OR UNHAPPY FEELINGS. | I | 2 | 3 | 4 | 5 |
| 115. HELPING MY PATIENT UNDERSTAND THE REASONS BEHIND HER (HIS) REACTIONS. | I | 2 | 3 | 4 | 5 |
| 116. SUPPORTING MY PATIENT'S SELF-ESTEEM AND CONFIDENCE. | 1 | 2 | 3 | 4 | 5 |
| 117. ENCOURAGING ATTEMPTS TO CHANGE AND TRY NEW WAYS OF BEHAVING. | I | 2 | 3 | 4 | 5 |
| 118. MOVING MY PATIENT CLOSER TO EXPERIENCING EMERGENT FEELINGS. | I | 2 | 3 | 4 | 5 |
| ★ 119. ENCOURAGING THE DEVELOPMENT OF MY PATIENT'S TRANSFERENCE. | I | 2 | 3 | 4 | 5 |
| 120. HELPING MY PATIENT LEARN NEW WAYS FOR DEALING WITH SELF AND OTHERS. | 1 | 2 | 3 | 4 | 5 |

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| I WAS WORKING TOWARD: (cont'd) | Not at all | Slightly | A moderate amount | Pretty much | Very much |
|---|---|---|---|---|---|
| 121. ESTABLISHING A GENUINE PERSON-TO-PERSON RELATIONSHIP WITH MY PATIENT. | 1 | 2 | 3 | 4 | 5 |
| 122. HELPING MY PATIENT GET BETTER SELF-CONTROL OVER FEELINGS AND IMPULSES. | 1 | 2 | 3 | 4 | 5 |
| 123. HELPING MY PATIENT REALISTICALLY EVALUATE REACTIONS AND FEELINGS. | 1 | 2 | 3 | 4 | 5 |
| ★ 124. SETTING FIRM LIMITS ON MY PATIENT'S ACTING-OUT BEHAVIOR. | 1 | 2 | 3 | 4 | 5 |
| 125. GETTING MY PATIENT TO TAKE A MORE ACTIVE ROLE AND RESPONSIBILITY FOR PROGRESS IN THERAPY. | 1 | 2 | 3 | 4 | 5 |
| ★ 126. HELPING MY PATIENT TO MAKE DECISIONS ABOUT VALUES, THE FUTURE, ETC. | 1 | 2 | 3 | 4 | 5 |
| ★ 127. EXPLORING THE HISTORICAL ANTECEDENTS OF MY PATIENT'S PRESENT CONFLICTS AND DIFFICULTIES. | 1 | 2 | 3 | 4 | 5 |

128. HOW MUCH WERE YOU LOOKING FORWARD TO SEEING YOUR PATIENT THIS SESSION?
   1. I definitely anticipated a meaningful or pleasant session.
   2. I had some pleasant anticipation.
   3. I had no particular anticipations but found myself pleased to see my patient when the time came.
   4. I felt neutral about seeing my patient this session.
   5. I anticipated a trying or somewhat unpleasant session.

129. TO WHAT EXTEND DID YOUR OWN STATE OF MIND OR PERSONAL REACTIONS TEND TO INTERFERE WITH YOUR THERAPEUTIC EFFORTS DURING THIS SESSION?
   1. Considerably.
   2. Moderately.
   3. Somewhat.
   4. Slightly.
   5. Not at all.

130. TO WHAT EXTENT DID YOU REVEAL YOUR SPONTANEOUS IMPRESSIONS OR REACTIONS TO YOUR PATIENT THIS SESSION?
   1. Considerably.
   2. Moderately.
   3. Somewhat.
   4. Slightly.
   5. Not at all.

131. TO WHAT EXTENT WHERE YOU IN "TOUCH" WITH YOUR PATIENT'S FEELINGS?
   1. Completely.
   2. Almost completely.
   3. A great deal.
   4. A fair amount.
   5. Some.
   6. Little.

132. HOW MUCH DO YOU FEEL YOU UNDERSTOOD OF WHAT YOUR PATIENT SAID TODAY?
   1. Everything.
   2. Almost all.
   3. A great deal.
   4. A fair amount.
   5. Some.
   6. Little.

133. HOW HELPFUL DO YOU FEEL THAT YOU WERE TO YOUR PATIENT THIS SESSION?
1. Completely helpful.
2. Very helpful.
3. Pretty helpful.
4. Somewhat helpful.
5. Slightly helpful.
6. Not at all helpful.

| DURING THIS SESSION, HOW MUCH: | Not at all | Slightly | A moderate amount | Pretty much | Very much |
|---|---|---|---|---|---|
| 134. DID YOU TALK? | 1 | 2 | 3 | 4 | 5 |
| 135. WERE YOU ATTENTIVE TO WHAT YOUR PATIENT WAS TRYING TO GET ACROSS? | 1 | 2 | 3 | 4 | 5 |
| 136. DID YOU TEND TO AGREE WITH OR ACCEPT YOUR PATIENT'S IDEAS OR SUGGESTIONS? | 1 | 2 | 3 | 4 | 5 |
| 137. WERE YOU CRITICAL OR DISAPPROVING TOWARDS YOUR PATIENT? | 1 | 2 | 3 | 4 | 5 |
| 138. DID YOU TAKE INITIATIVE IN DEFINING THE ISSUES THAT WERE TALKED ABOUT? | 1 | 2 | 3 | 4 | 5 |
| 139. DID YOU TRY TO CHANGE YOUR PATIENT'S POINT OF VIEW OR WAY OF DOING THINGS? | 1 | 2 | 3 | 4 | 5 |
| 140. WERE YOU WARM AND FRIENDLY TOWARDS YOUR PATIENT? | 1 | 2 | 3 | 4 | 5 |
| 141. DID YOU EXPRESS FEELING? | 1 | 2 | 3 | 4 | 5 |
| * 142. DID YOU SHARE INFORMATION ABOUT YOUR PERSONAL LIFE, VALUES, ETC. | 1 | 2 | 3 | 4 | 5 |
| * 143. WERE YOU MENTALLY COMPARING YOUR PATIENT'S EXPERIENCES AND ASSETS WITH YOUR OWN? | 1 | 2 | 3 | 4 | 5 |

HOW DID YOU FEEL DURING THIS SESSION?
(For each item, circle the answer which best applies.)

| DURING THIS SESSION, I FELT: | | | | | |
|---|---|---|---|---|---|
| 144. PLEASED | 1 | 2 | 3 | 4 | 5 |
| 145. THOUGHTFUL | 1 | 2 | 3 | 4 | 5 |
| 146. ANNOYED | 1 | 2 | 3 | 4 | 5 |
| 147. BORED | 1 | 2 | 3 | 4 | 5 |
| 148. SYMPATHETIC | 1 | 2 | 3 | 4 | 5 |
| 149. CHEERFUL | 1 | 2 | 3 | 4 | 5 |
| * 150. UNAPPRECIATED | 1 | 2 | 3 | 4 | 5 |
| 151. FRUSTRATED | 1 | 2 | 3 | 4 | 5 |
| 152. INVOLVED | 1 | 2 | 3 | 4 | 5 |
| * 153. EMBARRASSED | 1 | 2 | 3 | 4 | 5 |
| 154. PLAYFUL | 1 | 2 | 3 | 4 | 5 |

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| DURING THIS SESSION I FELT: (cont'd) | Not at all | Slightly | A moderate amount | Pretty much | Very much |
|---|---|---|---|---|---|
| 155. DEMANDING | 1 | 2 | 3 | 4 | 5 |
| *156. HELPLESS | 1 | 2 | 3 | 4 | 5 |
| 157. APPREHENSIVE | 1 | 2 | 3 | 4 | 5 |
| 158. EFFECTIVE | 1 | 2 | 3 | 4 | 5 |
| 159. PERPLEXED | 1 | 2 | 3 | 4 | 5 |
| 160. DETACHED | 1 | 2 | 3 | 4 | 5 |
| *161. ENVIOUS | 1 | 2 | 3 | 4 | 5 |
| 162. ATTRACTED | 1 | 2 | 3 | 4 | 5 |
| *163. PROTECTIVE | 1 | 2 | 3 | 4 | 5 |
| 164. CONFIDENT | 1 | 2 | 3 | 4 | 5 |
| 165. RELAXED | 1 | 2 | 3 | 4 | 5 |
| 166. INTERESTED | 1 | 2 | 3 | 4 | 5 |
| *167. DEVALUED | 1 | 2 | 3 | 4 | 5 |
| 168. UNSURE | 1 | 2 | 3 | 4 | 5 |
| *169. REPELLED | 1 | 2 | 3 | 4 | 5 |
| 170. OPTIMISTIC | 1 | 2 | 3 | 4 | 5 |
| 171. DISTRACTED | 1 | 2 | 3 | 4 | 5 |
| *172. COMPETITIVE | 1 | 2 | 3 | 4 | 5 |
| 173. AFFECTIONATE | 1 | 2 | 3 | 4 | 5 |
| 174. ALERT | 1 | 2 | 3 | 4 | 5 |
| *175. INTRIGUED | 1 | 2 | 3 | 4 | 5 |
| 176. CLOSE | 1 | 2 | 3 | 4 | 5 |
| 177. TIRED | 1 | 2 | 3 | 4 | 5 |
| 178. SEXUALLY STIMULATED | 1 | 2 | 3 | 4 | 5 |
| 179. HEADACHEY OR ILL | 1 | 2 | 3 | 4 | 5 |
| *180. DEPRESSED | 1 | 2 | 3 | 4 | 5 |
| 181. OTHER: _____ | 1 | 2 | 3 | 4 | 5 |

IF YOU WISH, GIVE A BRIEF FORMULATION OF THE SIGNIFICANT EVENTS OR DYNAMICS OF THIS SESSION?

ADDITIONAL COMMENTS:

# APPENDIX D

## Demographic Questionnaire

Therapist Background Information

Sex _____ (182)

Highest Degree Held _____ Year Granted _____ (183, 184)

Theoretical Orientation (check one): (185)

Eclectic _____ Psychoanalytic _____ Learning Theory _____
Sullivanian _____ Object Relations _____ Humanistic _____
Existential _____ Rational-Emotive _____ Rogerian _____
Other (please specify) _____

If you have checked "eclectic", please circle the orientation which most informs your work.

Have you had specialized training in adolescent psychotherapy?

Yes _____ No _____ (186)

If yes, please describe _____

_____

Are you a parent? _____ Sex and ages of children (if applicable) (187)

_____

Have you had personal psychotherapy? _____ (188)

HOW WOULD YOU CHARACTERIZE YOUR OWN ADOLESCENCE? (189)
(Please circle the appropriate number.)

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Very Negative | | Somewhat Negative | | Somewhat Positive | | Very Positive |

Did you receive the services of a mental health professional during your adolescent years? (190)

Yes _____ No _____

If not, do you feel that your behavior and/or psychological condition during that period warranted professional attention? (191)

Yes _____ No _____

(OVER)

HOW WOULD YOU CHARACTERIZE YOUR PARENTS' ATTITUDES TOWARD YOU DURING YOUR ADOLESCENT YEARS? (Please circle the appropriate number.)

A. (192)

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Very Restrictive | | Somewhat Restrictive | | Somewhat Permissive | | Very Permissive |

What effect, if any, do you feel this has had one your approach to adolescent psychotherapy?

_____

_____

_____

B. (193)

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Very Unsupportive | | Somewhat Unsupportive | | Somewhat Supportive | | Very Supportive |

What effect, if any, do you feel this has had on your approach to adolescent psychotherapy?

_____

_____

_____

WHICH, IF ANY, OF THE FOLLOWING DID YOU EXPERIENCE DURING YOUR ADOLESCENT YEARS?

Death of father _____ Death of mother _____ (194)

Death of other significant figure (please specify) _____

Parental separation or divorce _____

PLEASE CIRCLE ANY OF THE ABOVE WHICH OCCURRED PRIOR TO YOUR ADOLESCENCE. (195)

What effect, if any, do you feel this experience(s) has had on your approach to adolescent psychotherapy?

_____

_____

_____

Most people can recall a particular event from their adolescence which they regard as especially significant or meaningful in their personal development. What would that event be for you?

_____

_____

_____

_____

_____

What effect, if any, do you feel this event has had on your approach to adolescent psychotherapy?

_____

_____

_____

# APPENDIX E

## Eligibility Card

**ELIGIBILITY STATUS**

Please check one:

____ I do not meet the eligibility requirements for participation in this project.

____ I meet the eligibility requirements for participation in this project, but have decided not to participate.

# APPENDIX F

## Follow-up Letter

May 1, 1984

Dear Colleague,

On March 26, you were sent a questionnaire along with a request to participate in the Adolescent Psychotherapy Project being conducted at the University of Massachusetts at Amherst. If you have not already responded with either the completed questionnaire or the Eligibility Card indicating your decision not to participate in this investigation, your prompt attention to this matter would be greatly appreciated.

Thank you again for your cooperation.

Yours truly,

Alison Gartner
Project Coordinator
Adolescent Psychotherapy
Project