1

WHOSE THERAPY, WHOSE LIFE?

Fostering the Patient's Ownership of Therapy

I don't know why I'm even here.

If only I had a dollar for every time I've heard a teen in therapy tell me that—most often using those exact words. I've heard that from adolescents dragged to me by parents, guardians, and as a result of a court order. I've heard it from teens in their first hours, and months, and even years, into therapy. I've heard it from teens just starting to face their despair and from others well into therapies that had already brought clear improvement. I've heard teens still saying it in the final weeks of therapies that had accomplished more than we'd ever hoped for.

Adolescents' "*I don't knows*" can be read in many ways: "*I don't know why I'm* even here" ("What can you, a therapist, offer me? Or, what can you as the person you are do anything useful for me"?) "*I don't know why* I'm *even here*" ("I'm not troubled." Or, "I'm not the one who needs your help, you should be treating my sister, parents" [fill in the blank]. Or, "This is a place for crazy or hurting people, not for someone like me.") "*I don't* even know why *I'm here*" ("Nobody told me why I was coming to a therapist." Or, "Nobody tells me anything." Or, the frequent, "Someone might well have told me why I'm

coming, but it's too overwhelming for me to hear and deal with.") We could likewise decipher teens' "*I don't need this* and *I don't need you*," as all being variations on the same theme. In other words, many adolescent patients feel that they haven't chosen therapy freely, knowingly, and willingly.

"*I don't know why I'm even here.*" These are big words that can baffle and frustrate us as therapists. What do they mean and what do our young patients wish to tell us? Taking this question seriously can lead the therapist to the heart of the adolescent's attitude and relationship to a beginning therapy. Understanding the answer can help therapists open their teenage patients to treatment.

MEET ADOLESCENTS WHERE THEY ARE

Adolescents often come to therapy because they've been referred by parents, schools, and other authorities who judge their behavior as bad, difficult, unhealthy, or somehow in need of remedy and change. They often arrive on our doorstep expecting their new therapist to be just another agent of that same authority, a disguised arm of the law who sees his or her mission as reforming them in just the ways their parents, teachers, or probation officers desire. How do therapists convince them otherwise?

Consider Isaac, who was attending his third school in four years. If not for the unusual patience of his teachers, he would not have lasted in those schools as long as he had. When we met, he was two months into the seventh grade at a private school for gifted children. And things were going poorly enough for Isaac's new school to urge his parents to pursue treatment. His behavior had to improve, the headmaster had told Isaac's

parents, or he wouldn't be welcome back to school after the New Year.

"They're all gay," Isaac said with utter conviction in this initial meeting.

"You mean homosexual?" I asked.

"No," Isaac replied with irritation. "They're all stupid." Isaac held his extended middle finger up and tightly wound a long pipe cleaner around it.

Isaac's father had filled me in. His son had received a list of behavioral warnings for whipping empty sodas cans at lower school students, repeatedly violating the dress code, using his cell phone during school hours, browsing unacceptable sites on the library computer, and mocking teachers during class. Though these transgressions were numerous, it was teachers' reports of his lying and defiance when confronted that fueled the headmaster's doubts as to Isaac's future there.

I told Isaac up front that I knew he was having a rough time at school. When he denied that and I brought up the incidents one by one, he glibly remarked on the incompetence and motives of every teacher who had reported him. His social studies teacher didn't like boys. His science teacher was jealous of his (Isaac's) genius. His math teacher didn't like teaching. The other teachers were, respectively, prejudiced, disgruntled, "blind," "retarded," or flawed in some other basic way. Isaac saw nothing amiss in his wholesale dismissal of more than a dozen teachers. He saw nothing to question in his assertion that so many teachers could be wrong and that he could be so right. "I don't know why my parents can't find one good school. They keep putting me in schools full of loser teachers. I don't know why I'm even here," he finally said.

"Loser teachers? You must be kidding. You're the problem and everyone but you knows that. Keep it up and you won't have to put up with the lousy teachers at your school because you'll be looking for a new one." I could have said all that and I would have been correct. But I knew from my experience—I'd blown this one before—that my natural reaction would not have helped Isaac and probably would have set us back, a foolish risk to take at this early juncture.

Rather than giving Isaac my view of reality, I instead entered his own version to meet him where he was.

"Would you like some help with those loser teachers?" I asked.
"Yes!" Isaac replied with a nod.

For all of his noise, Isaac's reaction said that he wanted to get along in his school community. His words and gesture were all the handshake we needed to commit to working together. I'd made clear that it was not his parents' discontents and disapproval that mattered most; it was his own.

WHEN TEENS BELIEVE THEY DON'T NEED US

Sometimes adolescents recognize that they have troubles and yet don't feel they need anyone's help, especially a therapist's. They may believe, or at least say, that they don't need professional counseling or therapy, just as 17-year-old Tamara did: "It gets in the way of everything," she said with sadness. "I don't want to live like this for the rest of my life."

Tamara had spent the first half hour of our first meeting describing her poor grades and underachieving. Her clear language and complex thinking demonstrated precisely what she claimed,

that she had the ability to excel as a student. She'd also told me about her social anxiety and documented several examples of how it had dampened her joy and life.

> *"It's nothing against you," Tamara said. "But I really don't want therapy. I think I can handle this better on my own."*
>
> *"But you said that you have been trying to do it yourself since you were 15, and it hasn't helped."*
>
> *"It doesn't matter. I'd rather do it myself even if it takes me forever. My parents want me here but I don't. I don't know why I even bothered to come."*

Teenage patients, like all of us, want to be listened to, especially if what they say is negative, oppositional, or somehow disregards the therapy process. Tamara's *"I don't know"* spoke to her discouragement that anything could ever help. It also spoke to the ambivalence that chased her every moment. As her therapy proceeded, we discovered her profound ambivalence about every aspect of life, including whether she should be in therapy and whether she wanted or deserved to feel better. Eventually, we learned that she was just as confused about growing up itself.

REMEMBER WHOSE LIFE IT IS

Although they may not be able or ready to say it, teenagers generally have some idea as to why they have come or have been brought to therapy. They know about such things as their failing grades, drug and alcohol use, probation, stealing and deceit, depressions, anxieties, parents' divorcing, chronic illness, anorexia, better than anyone. But being aware of one's issues does not equal wanting to do anything about them.

When therapists meet a new patient, they understandably view their role as positive, well-intentioned, and constructive. They know they strive to provide help, guidance, support, and kindness as an agent who acts in the child's best interest. Adolescent patients can see it otherwise. They are prone to see coming to treatment as a pronouncement that they are broken and in need of fixing. Because disruptive or worrisome behaviors are often what precipitate a referral, teens can take their coming to therapy as proof of their being bad people needing reform. Who of us could feel good and nondefensive about that? Who of us could see that (therapeutic) endeavor as something inviting and hopeful? It's little wonder that the teenagers who might need therapy the most are usually the ones who seek it least.

> *"Jerry and Angus cheated off Lou's paper but he covered up his answers." Robbie swallowed hard. "He covered up his paper when I tried to cheat. It's always like that." The burly high school junior squinted. "He would've even given Will the answers."*

Will was a malevolent acquaintance of Lou's, hardly the loyal friend that Robbie was.

> *"And that night Angus smoked everyone up. But later when everyone had left, and it was just me, he said he had to save some for Sunday." Robbie choked on his words as if he'd lost a lifelong pet.*

We were out of time and Robbie had spent his entire first hour talking about the mistreatment he'd received at the hands of peers. Robbie had told of generously sharing his weed no

less than his food, cigarettes, CDs, money, and help. He'd also described how he'd lie to protect friends and would readily jump into a fight on their side, noting with sadness that no one returned the favors.

Robbie's parents had requested therapy because of his poor schoolwork, addiction to marijuana, drinking, and shady behaviors. They'd warned me that he'd probably deny all of them. Instead, Robbie had brought them all up on his own, all in the context of his relationships with his so-called friends. I could have asked him what he and I were going to do about his many significant problems. I chose not to.

> *"Everyone wants you be a better student and boy," I observed. "But grades and success don't matter to you." Robbie nodded. "All you want is a good friend." His shoulders hunched, his head fell, and he cried.*

Over the course of his two-year treatment Robbie gave up drinking and smoking, cut back his use of marijuana, grew more honest, stopped fighting, and became a B- student. Virtually every one of our meetings, however, was built around his discussion of peers and the unhappiness of his social life. Robbie was most proud of the gains he made in starting to wean off old, unsatisfying relationships and finding himself the better friends he craved and deserved.

Therapy is a goal-oriented process. But whose goals lead the way? Is it the therapist's (e.g., stronger self-control, enhanced resilience), parents' (e.g., better grades, less rudeness), teachers' (more cooperation, less distraction), or the child's (e.g., relief from anxiety, more popularity)? While the obvious answer is all of the above, we can assume that it is the teenage patient's aims and motives that matter most. In the end, and as we'll discuss

further in the next chapter, we will probably find that everyone's goals are relevant and part of the solution.

ENGAGE TEENS

Any one who's ever tried to get a mule to budge or a horse to drink knows something about human nature. We can't make other people change. Similarly, parents and therapists can drag a teenager to therapy but they can't make him use it.

We'd met for over a month. Gerard sat across from me as he had for every other session, his knit watch cap pulled down to his eyebrows, his face motionless, slowly kneading his hands. I sat quiet. I'd tried everything I knew to engage him. None had worked.

Gerard had been found guilty of a series of minor crimes, and his probation conditions required that he be in treatment. In his first hour he warned me that he came for no other reason than that he had been ordered to do so, and that he had no interest in talking or using therapy. He never told me this again, but his behavior was a constant reminder. We continued that way for another couple of weeks or so until I finally couldn't take it any longer.

"What are you doing?" Gerard asked me, his first real question since we'd begun.

"I'm reading," I replied.

"That's fucked up," Gerard observed.

I read on.

"Therapists aren't supposed to read when they do therapy," Gerard went on. "They're supposed to pay attention."

"I can't do therapy for the two of us," I replied. "It's hard enough taking care of my end."

"Well, you're getting paid to be with me," Gerard continued with his critique, the beginning of what would be his long road to self-determination and self-control.

For reasons too complex to mention here Gerard got much satisfaction out of foiling my wish to do therapy with him. Only when I retreated, when I gave up demanding that he comply, did he come to life and grab me and therapy by the horns. Like most of us, Gerard wasn't going to change unless he could see himself—his problems, attitudes, behaviors, thinking, and ways of living—more as he was. Only when people realize *what is* in their lives can they make decisions to continue their old ways or choose active paths toward change.

Teenagers do not magically become more studious and cooperative, less defiant and less bullying, lifted from depression and free of anxiety, more mature and better connected. Regardless of how skilled or talented a therapist is, until a teenager owns his or her problems, there will be little, if any, change for the better. Only when adolescents take responsibility for themselves can they grow. Taking that responsibility implies taking ownership of themselves, their behaviors, their current lives, and their futures.

Of course, many children, even older ones, are in many ways "victims" of the circumstances and conditions in which they live. Children do not choose their parents, IQ, temperament, neighborhood, school, and socioeconomic status. My experience, however, has convinced me beyond doubt that not just adolescents, but even young children can take less or can take more responsibility for how they cope with what they have been given in terms of such things as challenges, talents, weaknesses, resources, supports, or injustices. As teenagers come to

see their therapies as their own so do they take back not just their sense of responsibility in their lives, but they captain their destinies, too.

But how, we have to ask, can we help our adolescent patients see their therapies as their own, especially when we are just starting together? We show curiosity in their side of the story, patience with their way of telling it, and respect for the good reasons they have for not wanting to be there with us. We listen for what they want from therapy and their lives as well as their reactions to what others want or expect from them and their treatments. We try to keep parents in the background or in the waiting room, symbolically making clear that we are the teenager's person. And we take care to show the small but significant little courtesies that we'd show our adult patients, opening a window when they're hot, readily repeating ourselves when our questions have confused them, trying our best to schedule appointment times that fit their actual needs or merely what they prefer.

Fortunately, most therapists like their patients and are adept at welcoming them. This process of owning one's therapy and life, as we will soon see, grows more complex and challenging for both the adolescent and her therapist.

2

NEITHER VOODOO NOR MAGIC

Using Therapy to Help Teens Achieve Change

Many argue that doing therapy is more art than science. I suspect that therapy is a mix of both, a collaboration that advances in medicine and neurobiology will never make obsolete. Despite what critics may say, therapy is neither voodoo medicine nor an elaborate scam of psychic suggestion. The therapist's powers are not mediated through magic or a spiritual ether. There is much we understand as to why what we do as therapists aids the teenagers we do it with.

The discussion that follows will highlight some of these mechanisms. While I will be examining some general ways that therapists affect their adolescent patients, my list is neither exhaustive nor are its items thoroughly addressed. Consider this chapter as a necessary foundation to what will follow and be elaborated on in the remainder of the book.

LISTEN

No one will argue against the wonderful passion of sexual intimacy. Nor will they question the powers of attraction and

affection. And yet, my experience with patients, family, and friends suggest there is no more moving (and loving) experience than feeling deeply understood by another person. And no one craves such understanding more than adolescents.

Twelve-year-old Eli sat in the farthest corner of the room with his back toward me. He used magnetic rods and steel balls to build a beautiful and complex dome. As had become our routine, I would ask a handful of questions and he would ignore them. A couple of times, watching Eli struggle with the magnets, I wanted to walk over and lend a hand. But when I'd tried, the shy and self-conscious boy had pulled himself even more tightly into the corner. He'd done the same when I'd praised him more than he could bear.

Finally, his mother knocked on the door, signaling her return to pick him up. "Dr. Brom-" Eli stammered then gave up and walked out to the waiting room and his mother.

"Eli," I said, gesturing him to hold up a second. "Does anyone know how hard it is for you to be in a room with another person?" A wave of deep feeling swept over Eli's face, with both a big smile and tears. No, he nodded.

Eli had Asperger's syndrome and as a result was rather isolated. School, the soccer field, even his own home—or, I should say, the people who were there—could make him nervous. He was a bright boy who wanted to work on this in therapy, and yet, being with a therapist invoked much of the same social anxiety that dogged him everywhere else, a catch-22, if ever there was.

"He said he had a great session with you," Eli's mother called that night to tell me, "and that you're his best friend."

Eli's parents were thrilled, for they'd hoped, but had never imagined, that their son would ever be able to connect with me and his therapy. Eli's social deficits had blocked him from knowing the ease and grace of friend making that other children are born with. And as though that wasn't bad enough, he felt ostracized by many for appearing aloof, eccentric, unfriendly, or asocial. My simple comment confirmed the painful essence of his existence, acknowledging too, by implication, his lifelong yearning to feel happy and comfortable with others. From that hour on, Eli edged closer and closer, until he eventually sat at the same table with me, face to face, and talked about the hurts and frustrations of being him.

Really being heard and understood—not just being given lip-service, automatic back-talk, or automatic hmm-mmms—can be profoundly reparative, facilitating the child's ability to make contact with and integrate what she genuinely feels and who she really is. "*I understand why you are so worried,*" I might say. "*I get why you couldn't stay in school*" or "*Why you had to cut.*" As we'll see in a later chapter, such confirmation does not equal an endorsement of the behavior. A therapist's understanding of why a child felt he had to lie is not the same as encouraging or okaying it, nor in itself does it foster more untruthful behavior. Only with understanding and being heard can teenagers brave the next step of facing why they felt they had to lie and why they couldn't come up with a better alternative.

CONFIRM

Despite formidable learning problems that might have crushed the average person, Martin pushed himself to learn and achieve. His success did not come cheaply, however. He went to school early, left late, and hit the books pretty much every afternoon

and evening. Few if any tasks came without sweat. His reading probably would have been measured in words rather than pages per hour; his writing was just as labored. Spelling and math were like foreign languages. And yet, for all the enormous frustration that pervaded his studies, Martin kept at them.

"RB, you got to help me," Martin said. He was scared. "Tomorrow we're going to begin writing essays." Martin rocked his chair fast. "I'm not talking just any old writing, RB. I'm talking essays, real essays, with paragraphs and topic sentences. I'm not going to be able to do it."

"But you always figure out a way to do it, Martin."

"This is different. This is writing a whole essay from start to finish with everything in between. We're talking a whole page!" Martin hung his head. "I don't know why I beat my head like this. I should just give up and realize I can't do school like other kids. I just can't." Martin's eyes welled.

"You've met a lot of challenges before, Martin, but this is new and a big one. You're talking about a formal essay." Martin lifted his head and nodded. "One with all kinds of rules, and long, and with separate paragraphs," I went on.

"Yeah, that's why I'm afraid," Martin said, coming back to life.

"Will this be the giant rock that you finally can't nudge?" I asked.

"It might be," Martin said. "But you think if I give it a chance, I might be able to do it?"

"I don't know, Martin. This is a big one."

"But I'm willing to try and that's half the battle, right?"

"That's true," I said. "And it only leaves you half a battle to fight."

"But a half is plenty, right?" Martin asked.

"Plenty," I agreed.

Martin did fine, but that wasn't the point. Think of how much confirming we want when we face something overwhelming. Hearing "Hey, it's only [a major presentation, a court appearance, day surgery], so what's the big deal, you can do it" would not provide us with much comfort. At first, I'd tried reminding Martin of his constant and past successes. But my attempt to reassure Martin dismissed the reality he was trying to get me to grasp: he, so he believed, had finally reached the one hurdle he would not be able to clear.

The human spirit can bear all sorts of hardship and extremes, especially when its efforts and challenges are noticed. Conversely, there are few things that feel as maddening and unloving as having what we're going through minimized or disregarded. By confirming the hardship or pain of bitter divorces, chronic illness, academic challenges, and the like, therapists can dignify adolescents' best efforts to cope with difficult circumstances, and no price can be put on that type of life support.

HOLD

In the best of worlds, therapists can handle a lot. They can hear their patients' darkest fantasies, stories of true pain and tragedy, suicidal wishes, and inconsolable sadness. They can sit with their patients' most intense impulses, physical, aggressive, sexual, without fear, indulgence, or the need to take distracting or counterproductive action. Likewise, they can bear witness to patients' inner conflicts, taking neither side, while tolerating the ambivalence that can torture adolescents. Therapists strive to create a therapeutic space that can absorb intense affect and insulate teenagers from their overwhelming sexual and aggressive drives. These functions in aggre-

gate are what help to therapeutically hold the teenagers we treat.

"I hate her. I'm going to kill her. She's such a fucking bitch, I hope she dies." Polly had come to her hour agitated over a fight she and her mother had just had.

Knowing this might go on for some time, I found a more comfortable position in my chair.

"I know she's going through my room while I'm here. She always goes through my pocketbook and my book bag. She looks in my underwear drawer. She's such a fucking pervert. I hate her! Oh, I want to just kill her." Polly picked up scissors from my desk. "Can I just use this to go home and stab her to death? If I could just kill her, I'd be so much happier."

And so the hour went.

For 50 minutes I listened with interest and empathy as Polly ranted about her hatred for her mother. "I should just fuck everyone from my mother's office and let her discover us, right on her desk." "I'm just going to become a junkie and show up at my mother's teas without sleeves." And, as you've heard, Polly was ever threatening to murder the woman.

But, Polly, you should know, was hardly the perfect child. She did miserably in school, had peer problems, and was defiant. On the other hand, her mother was cold, especially when it came to Polly. "How can you say that to someone you love?" Polly had once asked her mother in my presence, after she'd called Polly a "bipolar nut job." "But I don't love you," her mother had replied nonchalantly.

"She's lucky I have you," Polly eventually told me. "If I didn't have this, I probably would have killed her or myself."

Polly had reasons to hurt and she was at high risk for lots of destructive behavior. Fortunately, the high school student was willing to use therapy and me as safe depositories for her most intense pain and impulses. After screaming and pounding in my office, she'd leave calmer and more reasonable. She quickly understood that my therapy office could contain her loudest and most violent feelings, and that I had no need to squelch them. Nor did I show any fear that she would actually kill her mother (though I grasped why Polly wanted to). Her weekly meeting with me allowed her to release powerfully toxic feelings that would have eaten at her and led to uncontrollable acts of destruction.

OFFER INSIGHT

There are abundant papers in the psychoanalytic and psychotherapeutic literature that debate the concept of insight with much sophistication and subtlety. My conception of insight is comparatively basic and pragmatic. I see it as any moment in which a teen can see any aspect of herself or others more clearly. By my formulation, good examples of insight include:

- A high school student's realization that he smokes weed, not to be cool or expansive, but mostly to cope with unbearable social anxiety and a lack of inner security.
- A narcissistically vulnerable teenager comes to recognize that her constant rages at others have less to do with outside insult and more to do with her own underlying inability to stand the idea that she could ever say or do things to hurt other people.

- A school phobic girl comes to know that sometimes she skips school less out of fear and more because she just doesn't want to go.
- A learning-disabled middle schooler admits that his failing grades reflect his unwillingness to study more than any inherent inability to do the work.
- An eighth grader realizes it's her arrogant treatment of peers and not others' envy of her beauty that makes her unpopular.

The ease with which I recalled and wrote these down doesn't do justice to the colossal effort, time, and pain my teenage patients spend coming to these realizations. Any instance of adolescents' honest self-observation (perhaps a handy definition of insight) can require that they temporarily lay aside longtime defenses, self-deceits, and rationalizations for the ways they think, feel, and live. The power of insight is that it enables adolescents to realistically see what exists, allowing them to then decide what, if anything, they want to do about it. Do I, an adolescent girl may think, continue to be a sadistic and jealous older sister or would I prefer to deal with my feelings in a different way, maybe even start to nurture a more gratifying relationship with my little sister? Do I want to run away from every challenge that scares me or do I want to start taking steps toward meeting them head on?

PROVIDE A CORRECTIVE EMOTIONAL EXPERIENCE

I am not going to enter the controversy here. My experience suggests that something like this can occur in a relationship

that proves to be trusting, trustworthy, and encouraging. Spending time with an adult who does not repeat the parents' neglect, abuse, and mistreatment can allow teenagers to begin seeing themselves as more worthy of love, acceptance, attention, and the like. Though this power can be held by a number of people, such as mentors, Big Sisters and Brothers, or coaches, it also can be a beneficial side effect of the therapeutic relationship. When a teen appears not to be doing anything in therapy and yet values coming, I wonder if some kind of emotional feeding and repairing isn't occurring.

"I'm sorry," 15-year-old Kimberly said. "I didn't mean I didn't want to come. I like it here." Kimberly pulled her hands through her hair, stressed. "I'm just feeling real crummy, like I'm coming down with the flu or something. I meant I might be better off crawling into bed and resting. But I didn't mean I didn't want to be here. I'd much rather be here than sick. I can't believe my big mouth, listen to me. Why do I talk? I only make things worse." Kimberly went on with this self-whipping until the hour's final minutes.

"I hope you feel better," I said with a smile as she walked to the door.

"Now I really deserve to have the flu for being such a jerk."

"The only thing you deserve right now is a cozy bed and some TLC." She forced a smile and left.

Kimberly's mother was extremely self-absorbed and sensitive to feeling criticized. When Kimberly once expressed a bit of frustration over having to repeatedly wait for a ride home from school, her mother angrily denounced herself as the world's worst and most neglectful parent. While her mother's dramatic words sounded as if she felt remorseful beyond rea-

son, her reaction ironically suggested otherwise. Her anger actually punished Kimberly for suggesting a criticism. "*How dare you suggest that I hurt you,*" seemed to be the odd and underlying message. By loudly proclaiming herself a witch of a mother, she wholly diminished Kimberly's right to ever have a complaint worth taking seriously. "If she really felt so bad," Kimberly ultimately noted with sadness, "don't you think she would have stopped coming late all the time." And so, it was no surprise that Kimberly feared that I would react as her mother did, with rage and dismissal. But seeing that I didn't mind her feelings, and that she didn't have to tiptoe around mine, helped Kimberly to see that it was her mother's problem, not hers.

ENABLE GRIEVING

Life is full of losses. When such losses go without sufficient grieving, they can beleaguer a life and impede any chance of future satisfaction and joy. Hold back your tears and sorrow for a loved one's death and you may obstruct your ability to ever care that deeply about any other person. Grieving, letting go of the actual loss, while holding onto your love, memories, etc., is what enables someone to love a new puppy, a new home, or a new relationship.

Expressions of grief, however, can refer to losses of not just people but less tangible matters. Adolescents who realize that they'll never be that hockey star or Hollywood celebrity face the loss of an ideal and a dream. With its new powers of abstract thinking, the adolescent brain can grasp that this is the way it is going to be for the rest of the person's life (e.g., "I am not going to be six feet tall"; "I am never going to be thin and

sexy"; "I am going to have to live with my asthma, dyslexia, or broken home for the rest of my life"). When adolescents are unable or unwilling to grieve over their human conditions and limitations, they risk wasting psychic energy by chasing unrealistic self-images and visions, instead of spending time on more attainable, authentic, and satisfying skills, relationships, and selves.

> *"We watched old movies of us as kids over the weekend." Vic closed his eyes. "I can't believe how cute I was. I ran around and was always laughing. I was so happy."*
>
> *Vic covered his face with his hands.*
>
> *"I wish I could do it again," he said, crying. "I'd give anything to have a second chance."*

Vic was a bright and personable high school sophomore who'd been through a lot, most of it his own doing. Over the course of his therapy, he'd come to take responsibility for much in his life, including his bad attitude and mediocre grades. He'd begun to take charge of his life, but it seemed to him to be way too little way too late. "I've got no future," he said, deciding also that he had never accomplished anything of value. Vic's maturation in treatment had evoked in him that inevitable side effect of every sound therapy, regret. *If only he knew then what he knows now.*

Imagine a young woman who wishes she'd learned to play the trumpet but now feels it is too late. At 25, she thinks about it again, aware that if she'd started at 18, she would have learned to play. Again, at 40, had she taken lessons at 25, and so on. But Vic was ahead of that woman. He grieved over his lost opportunities the first time around, and that allowed him to get his life moving in the direction he wanted.

The ways that therapy can help to change teens are many. Each clinical orientation has its own theories and opinions as to how therapy works its powers. Some say it's the technique, others say it's the therapist's being and character, and others see it as a result of the chemistry of the patient–therapist relationship. In the end what probably matters most is having some sort of firm and reliable context that guides our work and signals when it's drifting across lanes or wholly running amok.

3

WHO WANTS WHAT?

Identifying and Prioritizing Treatment Goals

Why am I even here? Therapists can ask themselves that same question. Week after week, hour after hour, they sit across from teenagers who are in all kinds of shape, messes, and pain. *What can I do to help?* therapists can understandably wonder. *How can I make a difference?* That therapists are increasingly facing tougher cases that involve multiple problems with fewer resources and less time only heightens their dilemma. The challenge for recent graduates and therapists in training is even tougher.

Parents or guardians bring their children to therapy because something is amiss. "He got caught coming to school high"; "She hasn't left her room for two weeks"; "She's cutting her legs"; "He threatened his mother with a fork"; "She's unhappy"; "I don't know what's going on with him!"

Early on therapists carefully watch and listen to gather all the information they can. They use that data to help identify goals that the teenager, his family, and they, as therapist, judge as relevant and important. Therapists will notice goals of treatment flying every which way: the child wants more freedom, the parents want better grades, and the school wants good citizenship.

But whose goals matter and which ones do therapists pursue? Take, for instance, 16-year-old Aaron.

Aaron's parents' goals were: good grades (As and Bs); no drugs or alcohol; no more accidents or speeding tickets; cooperating with curfews and home life.

Aaron's goals were: passing in school; not getting in trouble with drugs or alcohol; not losing his driver's license; getting his parents off his back.

For all their differences, we can't help but see the parallel between Aaron's and his parents' goals, both of which seem unrealistic. Aaron's parents expected him to make honor roll when he'd been getting Fs and Ds and for years had shown little academic motivation. They expected him to quit drugs and alcohol, unlikely given that more than 80% of his high school class were users. They expected his accidents and tickets to end (though they continued to fix his smashed cars, pay insurance surcharges for his bad driving, and hand him back the keys aware that some of the time he drove drunk). And as for their expectation that he would be a "good boy" at home, let's just say there was a whole lot of living and self-reckoning to do before getting there.

As Aaron had told me, he had no problem with As and Bs. He just didn't have the interest or energy to make that happen. What he wanted and was willing to work for was avoiding trouble with his parents, the police, and his school. Aaron sought to learn how to make good decisions before things got out of control. He wished to grow stronger at saying no to his friends and to not driving when intoxicated or stoned. That drugs could permanently harm his brain troubled him and had gotten him thinking, though he felt light years from sobriety. In some ways, Aaron's goals appeared more fitting and doable as starting points than did his parents' goals.

There were other goals held out for Aaron. School staff expected him to arrive on time, treat the teachers with respect, pass in his homework, and be medicated (they believed that ADHD accounted for his difficulties). They wanted him to not wear wear his baseball cap in school. A District Court judge had told Aaron he had a goal for him, to not show up in front of him again. And Aaron's probation officer, who perhaps held the wisest view, set the lone goal that Aaron reliably attend his weekly treatment for the next year.

Most therapists would have considered this a hefty enough laundry list of objectives. And yet, in the first two hours no one had mentioned what I took to be foremost: Keep Aaron alive and *wanting* to stay alive. Three weeks earlier Aaron had tried to kill himself.

CONCEPTUALIZE THERAPEUTIC GOALS

A therapeutic goal can take many forms. The most obvious are the goals we're trained to write for insurance companies and utilization reviews, by translating *DSM-IV* symptoms into measurable indicators. So, we target goals like increased attendance at school, fewer aggressive outbursts, less frequent self-destructive gestures, a reduced number of panics. Often, therapists think broadly, wanting to lessen depression and anxiety, improve self-confidence, or, in richer and less limited terms, to help their patients grow more comfortable in their own skins, more attached to their parents, and better able to bear the slings and arrows of daily life. We think in terms of coping with developmental disorders and chronic illness, in terms of mastering trauma and overcoming learning problems. Therapists can rightly see ourselves as balancers, helping an

overly shy child venture out and a wild girl to mellow. Therapists routinely work on multiple levels; for example, working on a fear of failure that interferes with a child's functioning at home, school, and on the basketball court.

Time frames can loom large and tricky when therapists think about therapeutic goals. Traditionally, short-term goals are concrete and behavioral, while long-term goals deal with such factors as personality, character, and identity. But, good long-term therapy involves no less clarity and no fewer goals than its briefer brethren. The difference lies more in the types of goals, how they're implemented, and at what pace. A short-term therapy might target a teenager's lack of assertiveness in the classroom, whereas a longer and more ambitious treatment might address the child's assertiveness in all of its manifestations, at school and home and with friends. These goals would all be in the context of her growing up, developing an authentic self, and growing stronger in the face of teenage perils.

Longer term therapies are guided by a hierarchy of goals that ebb in and out of every session. In a single hour we might work on a simple phobia, the adolescent's more encompassing tendency to see catastrophe everywhere, and her inclination toward recklessness. Overall, one therapy might hope to reduce suicidal behavior and thinking, diminish self-hatred, lift depression, mollify conscience, and reduce the need to criticize others. In longer therapies, "soft" goals such as trust and attachment are considered both hard requisites for treatment to forge ahead as well as way stations integral to an evolving therapy and self. Therapists who do longer term therapy know well that the goals of connectedness and positive regard, while in themselves developmental accomplishments, function as critical points of leverage when facing the harder therapeutic times to come.

SET PRIORITIES

In wartime crises of the past, medical units would triage the incoming wounded into three groups: soldiers who'd die even with medical attention, soldiers who'd live even without, and soldiers who'd make it only with medical assistance. The third group received treatment first. Fortunately, therapists don't have to make such decisions. However, therapists face teenagers and families where the problems are many and complex, and the time and resources are limited. How do therapists decide what to work on?

For Aaron, the boy who'd tried to kill himself, survival was paramount. School and the law would wait. Helping Aaron gain mastery over his suicidal impulses was primary. He and I established strategies to sense impending suicidality, ways to contact me in those moments, and ways to distract and soothe himself during moments of unbearable self-hatred and gloom. I did not rebuke his parents for pressing me to do something about his test scores, though their priorities told me something sad about their values and their relationship with their son.

But I would have been mistaken to push the goals of Aaron's parents to the back burner. Aaron got into trouble, he grew sullen quickly, and that was when his wish to die would escalate. And so he and I problem solved ways to do enough schoolwork—not to please his parents or his teachers, and not to earn As and Bs—but to get Cs and Ds, grades high enough to ward off his despair. We carved a similar trail alongside his other behaviors, doing what we could to support his doing good enough (avoiding bad enough) to keep thoughts of suicide at bay. Over time, his and his parents' priorities merged, synchronizing in ways I'd never have predicted.

The goals that parents seek, like improved school performance, come slowly and last. Many teens who come to therapy are conflicted as to whether or not they want to please their parents and teachers, serve authority, comply with rules, follow convention, and work hard. On the other hand, there are many parents whose goals for their children (e.g., relief from depression and anxiety) mesh with their child's and my own.

When therapy is conducted soundly, there is little straightforward about it. What therapists deal with is complicated, tender, and uncertain. If only our task were as easy as rehabilitating an old building. With one case, a therapist might have to attend to suicidal thoughts, generalized anxiety, self-loathing, fear of flying and heights, low back pain, binge drinking, romantic strife, school failure, plus more. Kind of like those amazing street jugglers who keep not just three balls in the air, but also a bowling ball, a curved saber, and a lit torch.

SHARE THE ADOLESCENT'S GOALS

Nothing is more frustrating than having a barber or stylist ignore your request, instead giving you the crew cut or curls or no. 212 champagne brown hair you'd rather be dead than wear. Though the comparison is superficial and weak, we all want our wants perfectly heard and heeded. What is true at the hair salon and restaurant, is even truer in the therapy office.

Teenagers' goals can speak to something basic in their adolescent lives. I saw a boy who, drowning in a sea of troubles, agreed to therapy only if I agreed to take his one goal seriously: gaining the courage to ask out and kiss a girl he'd liked for the past three years. Adolescents have worked hard in therapy with me to motivate themselves to lose weight (and look sexier), ac-

quire muscle mass (and look sexier), grow socially confident (to get more sex), and to get tougher and more assertive. One teen asked that I help her "chill the asshole" in her. I happily did.

The goals that adolescents set for themselves are bound to be more meaningful than the ones their parents hold forth. Parents are more likely to talk about grades and behavior. Teenagers may grunt, shrug, and stammer monosyllables at therapists' best attempts to engage them. But it's also true that when therapists hang in there and pursue the child's interest, or ask what might be lurking beneath the *I don't know*, teens can surprise us. In their own best words they try to capture the angst that tortures them. "I'm such a dork" (in that child's case, that meant, "Help me feel more socially adept and worthy"). "Just kill me" ("I am overwhelmed with life and the demands of adolescence.)" "I don't know, it's like, I don't, like, it's like I got nothing inside, like, I don't know, like [slaps his chest, with tears] its empty in here" ("I am depressed and unable to feel").

Teens in therapy can express their concerns in the frustration of the moment. "My boyfriend hates me"; "I just came from a detention"; "My head's killing me." These sudden headlines can foretell bigger issues to come, in these cases, a low sense of self-worth, an undiagnosed learning disability, and chronic migraines and the stress of being a perfectionist. Sometimes therapists discover adolescents' therapeutic aims by the tone and tenor of their complaints. A middle school student's hectic, scattered, and impassioned description of her awkward social life made clear that she wanted to get better at relationships. One teenager ended her first hour with me by apologizing for her defiant foiling of my questions, which made clear her ultimate wish to better manage her anger with parents.

Parents bring their children and pay for treatment (or their insurance does). They are the child's guardians, and in most

cases, have the child's best interests at heart. And yet, experience teaches us the hard way that replacing the teenager's goals with those of the parents will get us nowhere very fast. Whatever their goals—whether altruistic or self-centered, big or small, ephemeral or long-lived—our adolescent patients are the ones who'll come, sit with us, and endure the discomfort of therapy. How can we not honor what they wish for a better life?

4

PRECIOUS GOODS

Valuing the Adolescent

As I first described in *Playing for Real* (1990), adolescents are years removed from the show-and-tells in which they'd flaunted missing teeth, pet turtles, miniature palm trees from Florida vacations, and one-finger one-note concertos. But, as any parent or teacher of a teen will attest, these older children do not differ from their kindergarten selves as much as the sheer number of years gone by might suggest.

Teenagers still want to show off their stuff. Go to any middle school talent show and you'll see girls and boys giggling their way through self-conscious and toes-stepping-on-toes lip-syncs. Give them the stage and the spotlight, and many will perform until their throats and legs give out or until the hook pulls them off. It doesn't even seem to matter whether they have any talent. *Look at me, just me!* is what they cry. Their love, if not hunger, for attention has not shrunk at all from the time when they were 5-year-olds waving their hands for the teacher to call them to the front of the classroom. If seventh graders or even high schoolers could have a show-and-tell, we know they would. Sure, the stuff they'd show would probably be some

variety of X-rated, scary, and discouraging. But they'd be up there, vying to be heard and seen.

GIVE ATTENTION

When adolescents come to therapy, they also want to be noticed. Tell an angry and off-putting teen that his decal-covered jacket is cool, and watch the calm nod, thanks, and deep appreciation. Invite a cheerleader to tell you about her cheers, and she will come to life. Whatever the nature of their troubles, teens want to find their place in the world, a place where they can be special and count. No one taught me this better than Fiona, a high school freshman whom I treated while I was a psychology intern.

As she was prone to do in her first few sessions, Fiona stood at the window dancing in place in a low-key sexy kind of way, singing quietly as she'd do when she wasn't talking.

"They're all bitches?" I asked.

"All of them. They think they're all so cool. But they're all fat, stupid bitches."

From afar Fiona's words and her behavior might put readers off. But in person she was engaging and sympathetic. Despite her provocative flair she looked and felt more like a little girl trying, against her grain, to be grown up. Her guardian aunt had brought her to therapy when she found her in bed with an unemployed 24-year-old man from their neighborhood. Fiona hadn't understood her aunt's concern.

"Like a Virgin . . ." Fiona sang softly while I checked my book to schedule our next meeting. "Let me just finish the song," she

asked, "it'll only take a minute." When she finished, I applauded and she took a proper bow, something befitting an elementary school recital.

How does a therapist convince a young girl whose slept around to stop? How does a therapist persuade her that she's worth taking care of herself, that her promiscuity will lead to bad places? After more than twenty years of doing therapy, I have few answers to those questions.

Some weeks later Fiona came to her hour wearing an outfit that I recognized from a recent MTV award show. She wore a black leotard, leather vest, fishnet stockings, miniskirt, and black heeled boots. Large hoops hung from her ears and heavy chained necklaces hung around her neck and waist. A red band held her bleached blond hair back.

Despite her dramatic dress her mood was flattened. As always, she looked out the window, but she neither sang nor danced. I could see her hands reach to her face.

"What's the matter, Fiona?" I asked.

After some time, she turned. "It's not fair. It's not fair." Streams of wet mascara ran down her cheeks. "I'm the real fake Madonna. Not them. I am."

As her therapy went on, we learned just how hungry for love Fiona was. Never having gotten what she should have from her parents, she'd turned to the outside world, to adolescent girls and older guys, neither of whom were equipped or wanted to give her the healthy love and attention she sought. Fiona came in tough and invulnerable. My taking seriously the ways she tried to be special touched her deeply, and led to greater closeness and attachment to spur our work.

RECOGNIZE WHAT IS PRECIOUS

It's obvious that I am not talking about material worth here. I refer to the precious that defies blue book value, like the rusty Red Sox key chain that a boy holds dear because his beloved grandfather gave it to him. As one adolescent boy once asked me, "At what age do kids start making nostalgia?" He answered his own question, "At about 5," deciding that the basis of nostalgia making was the losing of something—a person, place, thing, pet, experience—that you'd never have again. As he showed me, growing up even under the best of conditions requires a lot of giving up.

Precious can mean something well done (an award-winning science project or self-portrait). It can include efforts that are substantial and which result in recognition or applause, such as being a member of a state award-winning math club, quarterbacking the football team, playing second flute in the city-wide jazz band, or serving as senior class president. But using a criterion of public notice would leave the great majority of us without anything to cherish.

A teenager can hold precious anything that matters to her. It may be a poem that will never see the page of a book or that earned only a C- from her English teacher. It may be a heart that she embroidered on her denim jacket or the cookies she baked for her father's birthday. Precious can be the memory of watching the 2004 Red Sox win the World Series on TV or learning to beat a favorite drum solo on a math book with a pencil. It can be found in display cases, tucked away in jewelry boxes, lost in crowded book bags, or carelessly strewn on a teenager's messy desk. We can also assume that almost anything an adolescent thinks, feels, says, and creates in therapy is precious, too. After all, it is all an extension of themselves.

HELP TEENS CELEBRATE THEMSELVES

Far too many teenagers are incapable of truly taking pride and joy in their accomplishments and themselves. For every adolescent who cannot work or study, there's another who drives herself past midnight, ever accumulating higher grades and more honors that she is unable to relish for more than mere seconds, if at all. Drew was such a teenager.

Thirteen-year-old Drew studied the scene before him. He'd arranged some 40 colored, cardboard blocks to replicate an airport terminal and runway. Every time Drew appeared done, he'd take it apart and reassemble it.

Drew scratched his head. "I'm not crazy about the way the wings of the plane come so close to the walls." He pushed the brick wall down and rebuilt it so as to give the plane a wider berth. He then did the same to accommodate an ambulance that he parked beside the terminal.

Drew was a bright and good child. His mother had brought him to me because he was so unhappy. Despite his brains, looks, and good nature, he hated life. Schoolwork, and his failing quest for perfection, led to nightly tantrums of screaming self-hatred and bloody accusations that his parents didn't care.

"There." Drew turned a block on its end. The small change lent a more pleasing proportion to his intricate model. Again, Drew scrutinized the airport he'd made. "Ahhh." Drew quickly pulled out blocks from here and there, replacing them so that the simulated brick lines ran in the same directions. "That's better." Before he could rest for a second, he rushed

back to flip blocks so that none of their folded seams showed. Drew fell back in a large overstuffed winged chair and sighed. "Done."

"We never see him smile," Drew's mother had explained. "He brings home a beautiful report card but all he sees is the one A- he got. He's a young boy. He's supposed to be happy," she said with tears. "He's way too young to be this miserable." I knew what she meant for I'd been seeing the same boy. He neither played nor smiled in his sessions; he only talked soberly about his shortcomings.

Time was up. Drew, being the good boy he was, started to take his model apart so that he could put the blocks away. "Hold on!" I blurted. He stopped. "You can't just tear that apart. It's gorgeous. Look at that scale, how the terminal matches the tower, and how the plane and truck fit perfectly inside." My praise stunned Drew. "Do you have any sense of what a fine piece of work you've done here." I swept my arm over the airport.

"Don't you want me to put stuff away?" he asked, his eyes reddened.

"No way," I replied. "I want it left out so that I can look at it again later."

It was time to go. Drew walked slowly toward the door as he let himself survey what he'd made. He walked out the door then ran back in.

"Did you notice anything about the bricks?" he asked with a newfound vigor.

"You mean how they all face up?"

"Exactly," Drew confirmed with a glimmer of joy in his face, the first I'd seen in two months. "And I tried to . . ."

My next patient waited. I had to end Drew's thought midway. But I didn't kill his enthusiasm. That hour was the beginning of the road back toward loving himself, as worthy a goal as there is.

BE A SOUL MATE

Young children want it all, all of the time. They want to be 100% certified. They want their parents to examine and touch every scratch, itch, and blemish. They want every moment of hunger and fatigue noted and soothed. "*Watch me take my first steps. Listen to my first words. Delight when I crawl around the corner then celebrate my return.*"

Young children want the adults and older children they love to be part of every new adventure and triumph. Somehow when mom oohs and aahs at the rainbow it feels complete. "*Come look, come see it!*" children yell, wanting their parents to be there that very second before the experience is gone. As if emperors and empresses in waiting, they wish to have every minute of their lives documented, validated, and stored away for safe-keeping.

This wish for perpetual self-confirmation does not simply disappear at age 6 or 10 or even 17. The teenagers we know also want us to notice their hurts, their victories, and their despairs. They want their favorite music seen and duly noted. They even want their seemingly most unreasonable perceptions agreed with (which can lead to some frustrating family

moments). But who else do these teenagers look to for admiration and confirmation?

Depending on their age and maturity, children may begin to look outside the home toward peers for some of this attention. Looking to peers can involve a healthy drive toward separation from beloved parents or it can signal a premature and indiscriminate need for attention that isn't available at home. Adolescents commonly form intense friendships with peers, and they just have to see or talk to them every instant. They use each other to share the minutiae of their daily existence—the stuff that most parents would lack the patience and stomach for—as well as its roller-coasting frustrations and hurts. For all of their inherent difficulties, these relationships help the teenage to regulate the intense and ever-shifting moods that plague them.

"Do you understand it, do you get it?" Pepper asked. "Do you?" She stared at me, demanding an honest reply.

"Do you get why I want to die?" Pepper nodded.

"Because you feel so ugly, stupid, lonely, and unlovable." I spoke quietly and matter-of-factly, though looking at this pretty, bright, and talented middle-schooler I knew her self-critique was twisted.

Pepper shook her head, no. She waited. I knew why.

"Because you're stupid, ugly, and unlovable."

"At least someone gets it," she said, months from finding any real comfort or self-love.

The adolescent patient is stuck and torn between two obvious worlds. She looks to the therapist as some kind of transitional amalgam of both the parent she is giving up and the people on the outside who will assume their place. Either way, she wants the therapist to admire her ideas, take her jealousies

to heart, grasp her sense of lostness, do everything that will confirm what she feels, thinks, believes, does, and dreams. The adolescent may even want the therapist to cherish the parts of herself that she herself cannot stand, parts that provoke her self-hatred, self-injury, and suicidal thinking. "Appreciate all of me," she says, even through her misbehaviors and worrisome words, "so that maybe someday I can do the same."

5

TRUTH OR CONSEQUENCES

Assessing and Promoting Honesty in Therapy

The first step toward seeing oneself in therapy is to commit to honesty in that endeavor. More than any other trait—such as intelligence, suffering, verbal ability, or psychological insight—I have found the patient's degree of candor, or efforts in that direction, best predict a successful outcome. Because honesty permeates a person's words, actions, and being at such a basic level, therapists can start to appreciate the adolescent's level of honesty from the very first hello through the initial hours.

MAKE AN HONEST START OF IT

"It must have been tough getting up so early to come here"; "It's too beautiful a spring afternoon for therapy"; "What a drag to have to meet me on the first day of the World Series." These are the kinds of comments I make upon meeting a teenage patient. Beyond conveying my understanding that they might not want to be here, such remarks offer a safe and inviting place to get a first and honest reaction. Often teens will politely

reply, "No problem" only to later qualify that they would have still been sleeping, been able to go the mall with friends, or maybe, just have been home playing video games in the comfort of their basement (in other words, not here with a therapist). A child's bothering to tell me where they'd really prefer to be lays the first small stone of a path toward an authentic therapy and relationship.

Obviously, on its surface, hearing the adolescent tell us about their lives reveals much. Teenagers who volunteer that they have been cheating, doing drugs, worrying about their sexuality, and so on, surely are presenting with an honest foot forward. Acknowledging that they have troubles in their lives usually is an encouraging sign (though, of course, it does not guarantee an earnest therapy to follow). Some teenagers will freely describe the details of their pornographic web browsing or drug habits. Some will suggest that things aren't great without saying how or why. But the majority of the teenagers that therapists meet will not be so forthcoming. Our search for the truth will need more than careful listening and watching. For example, one boy's shrug, when we ask if he ever steals, might appear dismissive and denying, while another's shrug suggests remorse. Likewise, one girl's repetitive "Fine" to our questions about school and home can blow us off while a second girl's engages us with its undercurrent of shame. Nonverbal gestures, facial tension, avoidance of eye contact, or a catch in the voice are all fair data that therapists can draw on to help figure out whether an adolescent cares about herself and her life.

Candor does not necessarily equate with confessing misdeeds. For many adolescent patients, spoken revelations can relate to personal suffering and life challenges. Some teens can tell about their anxiety, how it obstructs their school and social life, the shame and distress it evokes, and the self-defeating

ways they try to manage it. Others will keep their obsessions and compulsions secretive for long into treatment. Does the obviously shy girl talk of her shyness, does the visibly and audibly depressed boy mention his loss of energy or dour life view? Or do they neglect to mention or even deny what anyone, including their therapists, can see? Needless to say, reluctance to say something that is painful or embarrassing, and perhaps hidden from one's awareness, is not deceitful. Being able and willing to broach such subjects, however, often signals a motivation to use therapy and an accompanying hope to find relief or master some challenge.

Although therapists can feel the burden of collecting factual information at a first meeting, leaving room for other kinds of input may be wise. Open ended questions and patient pauses leave space for teenagers to react. Commonly an adolescent's last minute of genuine emotion will betray their previous 49 minutes of seeming bravado or self-deceit, as when a bragging school drop-out shed a lone and real tear over a teacher who'd once believed in him, or when a flicker of self-doubt singes a girl who's normally full of herself. In a majority of cases it is the interpersonal sense of who an adolescent is, the subjective experience of sitting with her, that can illuminate the state of her factual and emotional honesty.

And what about omissions? As with much else in psychology and human existence, they can mean many things. Who of us hasn't "forgotten" to tell something that we'd rather someone didn't know? A veil of omissions can be an adolescent's understandable ploy to protect the opinion that others hold of him or her. Why would a teenager admit she picks her nose or harbors hidden thoughts of greed to a therapist she's just met and who she wants to think well of her? We don't need Freud to persuade us that our patients' omissions can be wholly out of their

awareness. Omissions that are big and critical and deliberate, however, can be an ominous sign. Adolescents who purposely neglect to tell us about their upcoming arraignment for assault, having been thrown out of school two months earlier, or using their mother's ATM card to steal drug money, will likely be tougher patients with less optimistic prognoses.

Sixteen-year-old Cara was an attractive and personable girl who took pride in her accomplishments. She seldom drank and it was assumed by her friends that she'd be the designated driver once she got her license.

> *"I'm doing really well in history. I think I might have a B+ after today's quiz."* Cara smiled easily.
>
> *"And how about your other subjects?"*
>
> *"Even better. I think I've got the highest average in science, and my English teacher used my essay to show the other kids as an example of how to do it."*

She was an honest girl, she told me also, who practiced safe sex and who felt bad for the immigrant clerks that other kids stole from at the local convenience store. Unfortunately, everything she'd said to me was a lie. We met for a few sessions but she soon enough stood by her conviction that looking at herself and life more directly was not something she wanted. "Honesty is for suckers," she explained, believing that she'd given me some good advice.

PROVE CONFIDENTIAL AND TRUSTWORTHY

What more needs to be said. There are no more essential aspects of the therapeutic relationship. Few patients, whatever

their age, will open up to a therapist unless they sense that she can, for lack of better words, know when to keep her mouth shut. The therapist who runs to share everything with the parents or school may find his patients hide from therapy. And self-proclamations of how trustworthy we are or how confidential we can be will offer the child about as much security as the promises of a shady used car salesman. Nor can we demand that the child trust us before she is ready to. The therapist's attitude and behavior over time, including her respect for her teenage patients' mistrust of her, ultimately will prove what her character is really made of.

Confidentiality doesn't mean that a therapist must rigidly take a vow of silence, however. As I've grown older and more clinically experienced, I have learned more flexible ways of preserving the child's privacy and being able to communicate with parents and schools effectively on the child's behalf. While the typical adolescent doesn't want what he says in therapy broadcast to the world or to his family, he often will endorse his therapist's tactful attempts to help his parents understand him better.

INVITE HONESTY

Catching others in their lies is second nature to many of us. But to what good purpose? Trap teenagers in their lies, which is easy to do, and what do therapists accomplish? At best, they make teens suspicious and put them on guard. At worst, therapists alienate and make their patients hate them. Instead of coercing honesty, therapists aim to engineer situations and conversations that foster an adolescent to grow more frank.

Try asking questions in ways that facilitate adolescents telling the truth, without cornering them in impossibly uncomfortable

positions. Asking questions that we already know the answers to is an insincere trap that can shame a child. If you know that your young patient is prone not to admit his stealing, ask, "Did you behave this weekend as you would have liked?" A subdued "not really" allows the teen patient to save face, gives the therapy all it needs to know, and enables her to express her wish that she was a more honest human being, one who'd spent her weekend doing deeds she could proudly speak of to her therapist. When I work with grossly dishonest teenagers who cannot own any of their misbehaviors, I'll hand them a pad of paper and ask that they write down everything they have stolen, cheated on, and lied about in the past week, adding the all-important proviso that they not show me the list. Many patients have taken to the task eagerly, and have been amazed at what they discovered they'd done. My refusal to read their lists fosters their sense of trust and confidentiality as well as underscores the ultimate truth: being honest with themselves is what counts.

SEEK THE MEANING OF DISHONESTY

The kind of therapy in this book does not suit the true sociopath or delinquent, meaning one who wholly lacks conscience. Yet, many delinquents have some conscience along with other redeeming traits. For sure, we'll know moments when we must confront their double-talking and sidestepping. More times, though, we'll want to do what we can to enhance their realizing when and why they duck the truth. Why, we'll strive to learn, can't they admit the troubles in their lives? Often we'll find that fear, shame, and other strong emotions prevent their being truthful.

Any therapist who's worked with a teenager or adult who cuts herself, for example, knows how tenacious and lasting that behavior and urge can be, even when treated with more intensive and residential interventions. Controlling the teen usually doesn't help her to cut less any more than yelling at her might. Such young women frequently keep their cutting and self-injuries to themselves, sometimes for years, sometimes even when in treatment.

Browbeating these patients or repetitively challenging what they say leaves them unsupported and alone. What are the good reasons, we must ask, and be assured, there are such reasons, for our patients not being able to share this horrible hurt and shame? Why do they (have to) say that they are fine when they are in such pain? Why do they say they have been keeping themselves safe even as they have been slicing? Only by withholding our judgment and permitting our wonder can we convince the adolescent child to do the same, maybe enabling her to come out from the dark. This dynamic applies just as well to other instances when teen patients are unable to fess up.

Of course and sadly, therapists sometimes discover that the meaning of an adolescent's dishonesty is pretty much as it appears: to deceive others so as to keep doing what they want. Teenagers who are well on their way to becoming criminals, drug addicts, and the like, may defeat a therapist's finest attempt to promote their coming clean.

EMPATHIZE

I learned this lesson well over 20 years ago. I was then a trainee in graduate school working with an impulse-ridden 12-year-old

boy who, that morning, had started a wastebasket fire in his school cafeteria. School and fire officials had generously given me a chance to find out what had happened before deciding how they'd punish Flynn.

"What were you thinking?" I asked Flynn for the third time.

"About what?" Flynn replied again. I'd spent half an hour pressuring him every which way to admit what he'd done. Flynn bounced a beat-up stuffed lion on his feet. I'd found nothing out. I thought of what I'd say to the school principal and fire chief and the trouble that Flynn would soon find himself in. In a moment of desperation, changing my tack, I quietly suggested that the boy who lit that fire might have had his good reasons.

"Yeah," Flynn agreed. "Maybe he worried that the little kids were cold and needed more heat. Maybe he was mad that the teachers didn't care."

"I wonder if that boy wishes he'd done something different."

"I didn't think it would get so big," he said in a whimper, his denial evaporating in a flash. "They just get me so mad."

Frightened by what he'd done and what he imagined would be the consequences, Flynn hadn't been able to admit anything. When he finally felt his experience heard and understood, he was able to lay his gun down. Over the next week, Flynn wrote a letter of apology to his principal, began to explore why his teachers enraged him so, and followed through with the playground cleanup duty that was the heart of his punishment, and one that he judged fair and deserved. To this day, I am awed by empathic understanding's near

miraculous power to soften children's and adults' defensive resolve.

NURTURE HONESTY

No less than ourselves, few of our teenage patients are perfectly honest. Therapy is a process that aspires to nurture and shape good things. How do therapists nurture the honesty that's there so it grows strong and more natural?

Therapists try not to punish a child for telling the truth. When he admits that he's done this or that, therapists do not run to tattle to his parents or school or react with horror or angry censure (unless, of course, the crime is of a magnitude that demands it). Therapists do not take the fact that a teenager has opened the door a crack as an invitation to kick it down with critical and probing questions. Instead, they reward the child for taking the risk of being honest by showing interest and patience, and by recognizing the bravery of his act. "You know you didn't have to tell me that," I've said on such occasions.

Therapists can feel as if it's their job to get the child to be more honest, law-abiding, and rule-adhering. That burden can lead us to confuse our role as therapists, causing us to use heavy-handed questions and tactics, making therapy just one more place where the child cannot be herself. The therapist's job is to help the adolescent better see her difficulties with reality, and help her to find better ways of dealing with it. We must take care that a patient's dishonesty outside the office doesn't blind us from seeing her burgeoning honesty within therapy.

We'll know we are making progress when one of our teenage patients self-corrects an earlier lie. I've witnessed lying scoundrels reform themselves in startling ways. One boy

brought in a thick notebook tallying every dishonest act he could recall. Another boy wrote letters to people from his past, telling them how he'd deceived or taken advantage of them and asking for their forgiveness. And one adopted teen, a girl who was a shoplifter and compulsive liar, carried in large trash bags full of stuff she'd stolen or permanently borrowed. She ceremoniously sorted it out so she could return years-overdue library books, friends' clothing, and her mother's jewelry. As she discovered, the greatest peril of growing honest is the guilt and remorse we feel for how we lived before.

STAND ON SOLID MORAL GROUND

This perplexes me. I know there are talented therapists who, despite their own dishonest lives, help their patients enormously. I suspect there are extraordinarily honest therapists who are not so adept. And yet, it does seem important that we as therapists offer our adolescent patients an honesty and sincerity to match that which we want from and for them. Do we make up white lies when we run late or err? Do we own the hurtful or unhelpful things we say and do, or do we deny them and throw the blame back on our patients? Do we knowingly break their confidentiality behind their backs then feign surprise when an adolescent confronts us? Does it make a difference? I like to think it does.

Its logic is undeniable. Taking responsibility for one's life requires that one look at it and oneself honestly, and so it goes for therapy, too. My experience has taught me well that a therapy void of honesty or one in which honesty, rather than growing, diminishes, is a failed treatment. If a therapist does nothing more than help his teen patients grow more and more open, with him and themselves, he has traveled far toward finding a successful treatment and a restored life.

6

POLISHING YOUR MIRROR

Facilitating Self-Revelation

Most people like mirrors best when they know they'll see something that is flattering or corresponds to how they wish to look. Some people will go clothes shopping only when they are in the right mood, when they feel strong enough to see their chins and butts in the department store's multifaceted mirror booth. Many people stay away from mirrors just as they sidestep cameras and bathroom scales. That is why we can more easily face the funhouse mirror. We don't take its crazy image of us seriously for we know we're neither a 4-foot by 4-foot by 4-foot cube nor a 38-pound, 6-foot, 3-inch string bean.

If looking in the mirror at a store can be hard, then looking at oneself in therapy is utterly daunting. What can we as therapists do to make this necessary effort easier, less painful, and more therapeutic for the adolescents we treat?

CREATE A SAFE ENVIRONMENT

What does it mean for the therapy office to be a safe place? An office with deadlocks on the doors and wrought iron grilles over

the windows? Is it an office that has no scissors or pointed letter openers, or one with padded walls and nothing breakable? By *safe* I refer to a space and context in which adolescents are relatively free to experience themselves without fear that their therapist will criticize, rebuke, embarrass, punish, or take advantage of them for doing so. My work with one 5-year-old boy, the only nonadolescent patient in this book, illustrates this concept better than any I've experienced.

Five-year-old Kenny touched the doll then pulled his hand away as if burned. He turned to me with a worried expression.

"It's okay," I said. "It's just a toy."

Kenny smiled nervously as he used both his hands to hold the doll above him by both its arms. He giggled self-consciously, lowered the doll to his lap, and again turned to me.

"This is silly. I feel silly."

Kenny's parents had brought him to me in a panic. Their pediatrician had referred them to a renowned clinician in Boston who, after meeting Kenny for 20 minutes or so, told them to get used to the idea that their son would at best grow up to be transvestite, but more that he'd be transgendered. Kenny's ever being heterosexual was out of the question the doctor said, adding that his certain homosexuality would be the least of Kenny's and their problems.

Kenny picked up the doll and made some quiet singing sounds in a high voice, his version of a girl's. Once more, he put the doll down. "I don't know what to do next," he said. "Can't you tell me?" His lip quivered. "Can't you, please?"

His parents had told me that Kenny always wanted to be a girl. Once, when he was younger. He'd even pulled at his penis in the bathtub and said that he wished he didn't have one. This was the event that propelled their seeking professional help. And that was all that senior clinician had needed to hear before making his assured and gloomy prediction.

"Please!" Kenny leaned against my leg. "Can't you tell me what to play next?"

I looked at Kenny. I saw a handsome young boy wearing a skirt that he'd spent his last session making out of copy paper on which he'd drawn pink hearts. On his head he wore a golden princess crown that he'd fashioned from cardboard. Around his neck hung a beaded necklace that he'd made out of Lego pieces, and in his hand he held a magic wand, actually four drawing markers stuck end-to-end. He wore paper pink-hearted bracelets on his wrists, and pretended that he'd put perfume on from a bottle of white crafts paste.

Kenny had already made much progress since we'd begun meeting. He'd grown more comfortably affectionate with his parents and was showing more boyish behaviors. His parents noticed that he put on the girlie voice mostly when he was frustrated and angry that he was not getting his way at home. He was using it less and throwing fewer and less tumultuous tantrums. He also was growing more openly assertive with peers and siblings. Talk of hating boys, himself, and his body had faded.

Kenny started to cry. "I thought it would be fun."

"But it isn't?" I asked.

"No," he said, sober. "It isn't fun at all." Kenny gently took everything off and put them on the desk with sadness and resignation.

Though, I have to admit that a divorce and a family move led to Kenny's treatment ending abruptly, the trajectory of his work was defined. The more he allowed himself fantasies of being a girl, the less gratifying it had become. During this same phase, he'd grown more aware of ways in which his wish to be a girl related to his anger at a passive and unavailable father, a sexually abused mother who was very angry at men, and a twin brother with whom he couldn't compete. Being a girl, at least in his head, was a handy, if magical solution to problems that he could not fathom solving as a boy. The safety of therapy had permitted him to increasingly face and try on his secret and shame-ridden fantasies. Though the experiment left him saddened and disillusioned, and initiated a grieving of much in his life, it had helped him to begin growing more accepting of who he was, as a boy who in many ways felt like a girl, as a boy who felt overwhelmed by much in his life and family.

RESPECT WHAT PATIENTS NEED TO SEE

It is not rare that we meet adolescents who hold onto their perceptions of themselves with tight fists. We see the folly of what they perceive but we go along quietly. We know that fast held illusions have their reasons. Why else would they be grasped so rigidly and desperately? Consider Julie, an eighth grader from a well-to-do and apparently intact suburban family.

Julie stood at my desk. Using the gift paper and tape that she'd brought with her, she used her therapy hour to wrap Valentine gifts she'd bought for her parents. As she made and wrote gift cards, she read them aloud. Each declared her deep love and affection.

"They love me so much!" she crowed.

It was hard for me to witness that scene. I knew the emotional neglect that had been Julie's life. I also was sure that her parents would not be putting the same thought and effort into her February 14th, in fact, it would turn out, that they wouldn't remember her at all. I wanted to shake Julie and tell her to get over it, to let her parents go for they, it was sure, would never love her as she deserved and yearned for. But I knew better. To admit that neither her mother nor her father loved her would have been too much to bear.

Having finished her parents' gifts, Julie threw an unwrapped candy bar on my desk. "Happy Valentine's Day," she said unceremoniously. "I was going to make you a card but I never got around to it. You know how it is." Sad to say, I felt diminished for a moment, until I saw a second candy bar fall from her coat. "Ooops," she said. "I don't want to lose that. That's for Mrs. Flaherty." Julie casually threw the candy back in her pocket.

Mrs. Flaherty was an older woman who worked in the kitchen at Julie's church. Even though they'd never spent more than a handful of minutes before and after each weekly youth group meeting, they'd been friends for years. Mrs. Flaherty had often brought Julie homemade treats, books that her grandchildren had enjoyed, and hand-me-down clothing from her daughters. "It's a lucky mom who has a daughter like you," she'd once told Julie, and Julie had held onto those words even more tightly than she did her dream of being her parents' favorite. More than being cruel, to have popped that illusion, would have been clinically destructive.

DON'T RUSH TO PROTECT CHILDREN FROM WHAT THEY SEE

When we hear a parent blame herself for her child's autism or mental retardation, we comfortably counter her faulty reasoning. When we hear neglectful or abusive parents blame themselves for a child's woes, we may feel less eager to challenge their thinking. And yet, we may wish to protect them from the unbearable hurt such awareness can bring. The same is true when we work with teenagers like Myles.

Myles was a high school student whom I began to treat after a hospitalization for his attempt to hang himself. When I'd met him he was a school-failing, stealing, drinking, defiant teen on the verge of violence. For the first year of treatment we moved slowly. Feelings and revelations easily overcame him and would quickly lead to regression, rage, and suicidal impulses. The need to walk on eggshells at times especially frustrated his mother and father who felt handcuffed in their parenting. When Myles felt better he'd grow more arrogant and irresponsible. But when his parents came down on him, he'd disintegrate and start talking about his wish to die. They'd understandably back off, and so on and so forth. No parent wants to risk pushing their child to the edge of a bridge. It took a good deal of therapy before Myles could begin to see himself for who he was.

"And I can be a real asshole," Myles continued, having already that hour argued why I should also think him self-centered, immature, and a coward. "Don't you think?"

I nodded, agreeing with all that he'd said. "Yeah, you can be."

This hour was not nearly as dramatic as it may sound. Myles was ready for this clarity in self-perception and I saw no good

reason to persuade him otherwise. For months I'd heard firsthand about the cruelty he'd show others, especially his family, and the ways in which he'd mercilessly intimidate younger children. Myles had finally grown enough to begin facing himself. There was no justifiable reason for my preventing him from doing so. Running to save teenagers from their own self-condemnation may feel supportive in the short term, but in the long run what are we telling them?

POKE PATIENTS' PERCEPTIONS

Therapists tend to agree that we show respect for our patients' perceptions even when they clash with our own and others' views. Teenage patients' version of reality, we understand, represents the truth that they know, a truth that is as significant and worthy as it is unverifiable. Yet, even as we strive to honor our teenage patients' ways of seeing themselves, we reserve the (clinical) right and obligation to sometimes test their eyesight.

Belinda was a 12-year-old girl with a history of anxiety and stomach pain, and more recently, a diagnosis of chronic fatigue syndrome, a collection of symptoms for which there is no definitive medical test or treatment. Belinda took that diagnosis to heart. She'd walk into my office at a inchworm's pace, shuffling her feet, eyes barely open, appearing in search of steady ground, easing herself shakily into a chair as if finding an oasis after weeks lost in the Sahara. She felt horrid, it was real, and I appreciated that. But she saw herself as much sicker than she was, and that misperception had branded itself into her self-image. When I learned that for months she'd avoided the daily, low intensity aerobic exercise that her doctor, a national expert on the syndrome, had recommended, I spoke up.

"Belinda, I've seen dying people, people with cancer and people recovering from open heart surgery who walk faster than you."

"Yeah, so what's your point?"

"I've seen 95-year-olds live with more pep," I continued.

"Yeah, well I'm not most people."

My questioning Belinda's sickly self-image eventually led to her acknowledged reluctance to get herself better, and insights to the reasons why. That she began exercising at a local health club was just a bonus to the therapy. Belinda, like most patients I have met, did not resent my plodding toward reality as long as she felt I was being fair, honest, and caring in my assertions.

CONFIRM PATIENTS' PERCEPTIONS

Many children grow up in homes where they are dissuaded, if not punished, from seeing clearly. The child is in so many ways told that they do not see drunk or abusing parents, anger and neglect. In subtler ways, narcissistic families can subtly demand that their children devote themselves to sensing and meeting a parent's needs. Out of fear of parents' rage or losing their love, these children become experts at forsaking what they think and feel. For teenagers to lose touch with themselves and come to mistrust their own reactions to life can be one of the most unsettling and chilling of human experiences. "*Who am I?*" these teens wonder. "*What do I really think and believe? What do I really feel?*"

How does a therapist answer these questions, or more aptly put, how does a therapist help his teenage patients answer their own questions? Mostly, by accompanying adolescents through their experiences and relationships via active listening and em-

pathic responses. It may not matter that I've set the office thermostat to 73 degrees, and that I'm comfortable. My patients say they're chilly. My natural reaction might be to express amazement that they could be cold, wonder aloud whether they're falling ill, and query whether they ate breakfast. But, by asking patients to rethink how they feel, or to point out how their feelings wrongly contrast with my own, I risk repeating the narcissistic relationships they suffer at home. I'd also miss the therapeutic boat. By simply offering a shawl, closing a window, or throwing another log on the fire, I show patients who can't trust their feelings that their sense of being cold is accurate, important, and worth my confirming and tending to it.

Of course, teen patients can ask that we confirm more than what their bodies feel. They will want their therapists to share their mirror, understanding and confirming all of their experiences—how mean the other girls are, how impossible the math homework is, how uncaring the teachers can be, how selfishly her parents live. If therapy goes well, they will want you to own, also, the inevitable moments when you fail them. As these adolescents grow more trusting of their own self-perceptions, they will grow more agile at handling the grit of life. But, for sure, the therapeutic road can be long and painful. Consider, when childhood goes well, how full each day is of parents' confirming and responding to their children. When that goes awry, there's a lot of catching up to do.

POLISH YOUR OWN MIRROR: THERAPIST MISPERCEPTIONS

Being a therapist to teenagers is a noble endeavor and carries great responsibility. If therapists are the guides on the child's

journey toward self-discovery and understanding, shouldn't they strive to be as solid, steady, and self-knowing as possible? We can easily imagine the effect that a therapist's need to be right might have on his patients. How about a narcissistic therapist who needs his patients to confirm *his* perceptions? His own vanities, insecurities, blind spots, psychological scars of his past, and strains in his own family can adversely influence a therapist as can pressures from the outside. Therapists are liable to see their patients inaccurately through lenses (mis)colored by the constraints of HMOs, the increasing workloads at their clinics, their weakening private practice, or perhaps, the costs of their alimony and children's college tuition.

We as therapists are compelled to use whatever means we can to guard against our own misperceptions in the office. Talk with trusted colleagues, seek consultation, and, of course, partake in your own treatment. Many therapists have never had their own therapies, and are the first to claim they're too busy or don't have the money. Observe the trends of your work. Note the types of difficulties you most experience and the kinds of teenagers you experience them with. Try pondering to yourself, whether you dislike or fear adolescents, see them as master manipulators, or, conversely, whether you like them too much and wish to be more their buddy than a therapeutic ally. And for therapists who have children, ask whether you use your teenage patients to seek closeness or other things lacking with your son or daughter? Therapists can likely come up with better and more relevant questions to ask and monitor themselves.