A TRAINING MODEL FOR CLINICAL WORK WITH ADOLESCENT GROUPS

Elaine Lipert Leader

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A TRAINING MODEL FOR CLINICAL WORK WITH ADOLESCENT GROUPS

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by

Elaine Lipert Leader

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INSTITUTE FOR CLINICAL SOCIAL WORK

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"A Training Model for Clinical Work with Adolescent Groups"

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To my children,

Denise Leader Stoeber

Malcolm Leader-Picone

Brian Frank Leader

Corinne N. Leader Gordon

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ABSTRACT

A TRAINING MODEL FOR CLINICAL WORK WITH ADOLESCENT GROUPS

Elaine Lipert Leader

The hyper-technological society that adolescents face today offers an infinite variety of choices, activities and stimuli. Yet, despite the identifications and support provided by a variety of their peer groups, today's adolescents are suffering from identity confusion--the negative stage of the identity crisis--in increasing numbers.

Erikson, Blos and others have discussed in depth the developmental problems and tasks of adolescents. That is, adolescents exist in the middle of a tumultuous "second individuation process" during which they attempt to break from infantile object ties and childhood dependencies. Adolescents have special problems and needs that are specific to this stage of development.

The purpose of this project is to present a model for training therapists to work with adolescent groups. A description and analysis of the format of the new training model emphasizes how the learning experience is enhanced by the conscious utilization of countertransference and parallel process phenomena.

Underlying the premise that there are specific methods of training adolescent group therapists is the belief that the process of adolescent group therapy involves special skills, and that training can be devised to adequately

teach these skills. In addition, the training model is structured to help therapist-trainees achieve a maximum awareness and understanding of the particular developmental issues of the adolescent stage of life.

The model introduced in this project, designed to enable intensive training of more than a select few, was developed and revised in practice over the past six years at the Thalians Community Mental Health Center, Cedars-Sinai Medical Center in Los Angeles.

The model represents an attempt to meet the specific need for more and better trained adolescent group therapists, and ultimately provide a socially useful and relevant training experience for all professionals and paraprofessionals who deal with adolescents.

TIAMAT

A white smooth pearl whispers sea dreams,
glows with the light of deep waters from which it was stolen--
freed from clam-shell bondage,
torn from familiar community to face with inner beauty an outer world.

So am I a singular pearl,
leaving behind me mother-water, goddess-womb,
glowing from the depth of my being,
I go forth to seek the clear sharp air.

for group, on the occasion
of leaving.
with love

D.S.

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CHAPTER I

INTRODUCTION

The hyper-technological society that adolescents face today offers an infinite variety of choices, activities and stimuli. Yet, despite the identifications and support provided by a variety of their peer groups, today's adolescents are suffering from identity confusion--the negative stage of the identity crisis--in increasing numbers.

Erikson, Blos and others have discussed in depth the developmental problems and tasks of adolescents. That is, adolescents exist in the middle of a tumultuous "second individuation process" during which they attempt to break from infantile object ties and childhood dependencies.

Adolescents face a formidable task of developing an enduring and distinctive sense of identity encompassing family, sexual, social and career areas. In their effort to navigate through the turbulent waters of this period of life, and complete the individuation process, adolescents may experience a broad range of problems. The significance of this journey is that if abandoned prematurely, adolescents may never extricate themselves from the bonds of infantile objects and parental dependency.

When they falter in their quest for emancipation and identity, adolescents may need assistance, to varying degrees, from psychotherapists and other professionals,

(i.e. social workers, counselors, probation officers, etc.) or paraprofessionals. The needs and problems of adolescents are unique enough to require special forms of psychotherapy. Individual psychoanalysis can be appropriate at times. But a specific group therapy approach may be more appropriate in the majority of cases for the following reasons:

1. The therapy group approximates the adolescents' peer group and can provide the kind of social support so needed by struggling adolescents
2. The group serves as an approximation of the family that ideally can help adolescents work out problems they experienced with parents earlier in life

Research Question

This project addresses the question: How can psychotherapists be trained to work with adolescent groups in such a way that:

1. They acquire a maximal awareness of the unique countertransference evoked as a result of clinical interventions with adolescents
2. They acquire a maximum awareness and understanding of the particular developmental issues of the adolescent stage of life

Statement of Purpose

The purpose of this project is to present a model for training therapists to work with adolescent groups. A description and analysis of the format of the new training model will emphasize how the learning experience is enhanced by the conscious utilization of countertransference and parallel process phenomena.

Underlying the premise that there are specific methods of training adolescent group therspists is the belief that the process of adolescent group therapy involves special skills, and that training can be devised to adequately teach these skills.

There are identifiable issues which are apecific to the developmental stage of adolescence and must be readily recognized and understood by therapists. Compared to working with other age groups, the task of dealing effectively with adolescents requires more specialized knowledge, techniques and sensitivities. Thus, this training model is based on the psychology of adolescent development.

Objectives of the Training Model

Ideally, effective models for training therapists present information in such a manner that it can be successfully integrated into the trainees' experiences in working in their own settings. Thus, this training model combines didactic, theoretical and experiental features which include observa-

tion of an acutal ongoing adolescent group. The purpose of observation--as part of this brief intensive training experience--is to provide a direct experience with adolescent groups, to demystify the therapist expert, allay anxiety in the beginning therapist and provide a behavior model for discussion of techniques and group process.

Most of the currently used formats for teaching of adolescent group psychotherapy skills have been adapted from the teaching of group or individual psychotherapy with adults. In some instances, these formats are supplemented with videotape presentations of the individual or group therapy.

Another teaching format traditionally used is that of co-leadership. In this model, an experienced therapist and a therapist-trainee co-lead a group. Teaching occurs either during the group session or in discussion afterwards. Unfortunately, this is available to only a small number of trainees and requires six to twelve months to be optimally effective. In addition, trainees are closely exposed to only one particular leadership style.

Two facets missing from other group training models that can enhance the learning experience are the conscious utilization of (1) countertransference and (2) parallel process phenomena.

1. Countertransference Phenomena Within The Training Group Context. The process of therapist training

evokes a complex of feelings and feeling responses toward instructors and observed adolescents that are comparable to transference and countertransference experienced in therapist-patient relationships. This project identifies and illustrates the transference feelings typically evoked in therapists working with adolescent groups.

2. Parallel Process Phenomena Within The Training Group Context. Parallel process has been identified as a feature of clinical supervision. The project describes and documents the extent that parallel process is manifested in therapist-trainee groups designed for work with adolescent groups.

Rationale For Model

The model described in this project is designed to enable intensive training of more than a select few. Out of a growing awareness of the need for specialized clinical skills for working with adolescents in groups, it was developed and revised in practice over the past six years at a large community mental health center that provides continuing education for mental health professionals.

The basic goal of a group therapy training program is to familiarize trainees with the character of the group as a therapeutic milleu, and to train them to understand the experience of the patient who comes to it. The use of a

group training format is based on an understanding that what is to be learned is related to the personality characteristics of the learner. The trainee is expected to become more aware of and sensitive to group events and phenomena by experiencing and simultaneously thinking about them. Although training in such a group is not the same as being a patient in a therapy group, similar feelings and experiences are generated.

Berger (1969), Horowitz (1967) and Mullan and Rosenbaum (1962) view an experiential group as the backbone of group therapy training. They believe that the great advantage of group training that emphasizes experiential processes lies in its potential to integrate theoretical and affective learning. Experiential and didactic aspects are both needed to help the aspiring therapist develop theoretical knowledge, technical skills and the personality traits to be effective.

Significance

Adolescent group psychotherapy is a special area of mental health intervention that has not received much attention until recently. Other forms of group psychotherapy are not necessarily transferable to the volatile domain of adolescents without adjustments or additional training for practitioners.

A large segment of this project presents a case for

different-ness of the needs of adolescents, when compared to adults. The extensive problems of adolescents in modern society are beyond debate. As Erikson (1958, 1960) noted, the pressures placed on adolescents seeking identity in today's society are enormous.

There is a need for specific models for training group therapists to deal exclusively with the needs of adolescents. The model presented here represents an attempt to meet that need, and ultimately provide a socially useful and relevant training experience for all professionals, paraprofessionals and other workers who deal with adolescents. Besides mental health practitioners, that specifically includes teachers, law enforcement officers, industry, the armed forces, medical personnel, youth workers and others.

Limitations of this Project

There is an enormous breadth and scope to the theory and practice of adolescent group psychotherapy. Thus, the development of a training model for adolescent group psychotherapists embraces numerous areas that have been the subject of thousands of articles and almost as many books. These areas include principles of psychiatry, studies of adolescent development, group dynamics, group psychotherapy and therapist training models. In many instances, entire books, or dissertations, are devoted to subjects that only receive a single chapter of attention in this project.

The design and implementation of a therapist training model is a complex task. Unfortunately, due to time and space limitations, not all areas that form the basis for the model can be given the attention they deserve.

This project presents a model that has evolved and been used for only a few years. Still, this training model has a firm foundation derived from the subject areas cited above.

In one sense, the model is complete. Many of the early flaws have been worked out. In another sense, however, this model in a descriptive sense is incomplete. That is, there are so many contingencies, factors and variables--historical and current--that influence the nature and practice of this model, that it is practically impossible to present a complete description that does justice to all of the key subject areas it embraces.

Organization

This project is presented in a seven-chapter format. The introductory chapter presents a brief discussion of the problems of adolescents along with a statement of purpose, limitations and significance of this project.

Chapter two is a literature review containing sections on adolescent development; the parallel process phenomenon in training and supervision; group therapy; theory and practice; adolescent group therapy; and finally, counter-transference.

Chapter three explores and briefly sumarizes the contributions of Erik Erikson and Peter Blos to the study of adolescent development. The works of Erikson and Blos provide a significant theoretical underpinning for the model presented in this project.

Chapter four uses a case study of an adolescent to demonstrate how the theories of Erikson and Blos are clinically applied.

Chapter five overviews and analyzes traditionaly and contemporary training models for therapists. This chapter includes a section on mental health workers' views of theory and training. The basic training models are described including the didactic seminar, the siumlation seminar, process groups, observational approaches, a faculty-observer technique, co-therapy model, clinical case conference, dual observational models and nontraditional models.

Chapter six presents the new training model. Initially, two sections describe the difference between group therapist characteristics and adolescent group therapist characteristics. Following the model, there are discussions on parallel process in the Thalians training group; the effect of group observers; countertransference; the demystification of the therapist-expert; and the need to maintain contact. This chapter presents a concentrated, yet abridged, description of the training experience on which a significant amount of data has been collected.

Chapter seven presents the summary, conclusions and implications for practice regarding the training model.

CHAPTER II

LITERATURE REVIEW

Introduction

The theoretical framework of the training model presented in this project is derived primarily from psychoanalytic theory. Thus, this study explores: (1) elements of structural theory; (2) developmental paths and phase-specific adolescent needs (i.e. ego, superego and ego ideal); (3) autonomy development; (4) identity formation; and (5) the separation-individuation process.

The value of psychoanalytic theory is that it gives the necessary in-depth attention to early, middle and late adolescent concerns, exploring issues of transference, resistance and countertransference (Sugar, 1975).

Clinicians working with adolescents are subjected to the same kinds of intense and fluctuating emotions typical of this developmental stage. These emotions inevitably impact on the adult's own unresolved adolescent issues. In order to develop a specific learning approach to adolescent group psychotherapy that can take into account such affecting phenomena, particularly countertransference, it is necessary to examine relevant literature dealing with therapist training and supervision. Since the training model that this project describes incorporates the format of a process group, including observation of an actual ongoing

adolescent group, specific works are examined that deal with the inter and intrapersonal dynamics of training groups. Particular attention is given to parallel process in this literature review.

Only two of the 64 works--Berkovitz and Sugar (1976), Russ, Leader and Berkovitz (1976)--examined deal specifically with the training of adolescent group psychotherapists. Although Stein (1975) has extensively reviewed the literature on the training of group therapists, he reports no sources specific to the training of adolescent group psychotherapists. Without stating his rationale, Stein (1975) recognizes the necessity of additional training in this specialty. Stein (1975) summarizes:

> ...the group psychotherapist needs to know something of the factors leading to mental and emotional illness and their treatment, especially the type that utilizes a group and a group method to facilitate communication in the group, both verbal and nonverbal, through the establishment of relationships and interactions with the therapist and among the members (p. 88).

To provide a thorough background for this project, it is necessary to examine works in the following related areas: (1) Adolescent Development; (2) Parallel Process in Training and Supervision; (3) Group Therapy: Theory and Practice; (4) Adolescent Group Therapy; and (5) Countertransference.

Adolescent Development

Adolescence is a period of life frequently characterized by intense change, turmoil and conflict. This period

of life creates problems for the adolescent, his family and society in general. However, the psychological development that occurs during this period is characterized by purposefulness and identity-seeking.

Judd (1967) describes essential psychological development tasks of the adolescent. First, adolescents must establish emotional and psychological independence from their parents and other adults. They must define themselves so as to develop a stable self-concept or identity. Adolescents must establish self-motivation, self-determination, self-control, values, empathic responses, intellectual skills and an ethical system. Second, they must learn to effectively function on a social level with peers and other individuals. Third, they must establish a sexual identity characterized by self-acceptance and self-security. Fourth, they must acquire training that can develop their technical skills so that they can achieve economic independence.

The establishment of a realistic self-concept or identity is the most basic task of adolescence. This task is most usually accomplished during the change-oriented and ambiguous period between childhood and adulthood. That is, at a time when adolescents' moods swing between omnipotence and helplessness, dependency and independence.

Although the training model presented here focuses on the developmental issues of adolescence, it is necessary to recognize the influence of early childhood experiences.

According to Mahler (1972), in developmental theory, there are two primary stages dealing with the separation-individuation process. These stages, however, are part of a process that "reverberates throughout the life cycle" (Mahler, 1972). The principal achievements in the first stage take place in the period from about the 5th to 36th months of age, during which four sub-phases occur. Although the boundaries in time overlap, these sub-phases account for specific tasks and behaviors in the progressive quest for identity and object constancy which confront the infant and mother. Two parallel and interacting processes are described by Mahler (1972). First, individuation, which leads to the development of a unique sense of self. Second, separation, which moves from the fusion of self and object to differentiation, object constancy and intrapsychic separateness.

In the "second individuation process of adolescence" (Blos, 1979, p. 141) what occurs appears to be "regression in the service of development." This concept is explored in more detail in Chapter III which focuses on the contributions of Blos and Erikson.

Since the model described here is conceived and structured to train clinicians to work with adolescent groups, it is important to understand how peer group involvement forms a prerequisite for adolescent emancipation. In this regard, Blos explores the psychodynamic and interpersonal aspects of adolescent peer group involvement.

The group context stimulates the investigation and deeper understanding of age-appropriate social relationship abilities. It serves as a medium for reattachment, then redetachment (i.e. a second separation-individuation).

As a social substitute for family, adolescent object hunger and ego impoverishment find compensatory relief in the group. According to Blos, the group permits many individual identifications as "role tryouts" that demand no permanent commitment. Further, experimentation with peer interactions serve as "severance actions" from childhood dependencies rather than as preludes to forming permanent personal or intimate relationships. Ultimately, the group shares and ameliorates individual guilt feelings produced by the emancipation from childhood dependencies, prohibitions and loyalties.

The Parallel Process Phenomenon In Training and Supervision

To facilitate an understanding of group process in the training model presented here, the concept of parallel process between the training group and the observed adolescent group is explored.

Rudolf Ekstein and R. S. Wallerstein in The Teaching and Learning of Psychotherapy (1972) were the first to delineate the parallel process between therapist-trainee and supervisor and therapist-trainee and patient. Recognizing

the powerful affective and interpersonal components of the supervisory process, they assess how problems between supervisors and trainees can be a reflection of problems between therapists and their patients. That is, the "trainee's problems about learning" share common elements with the "therapist's learning problems." The "parallel process" means there is a two way reciprocal relationship between the therapist-trainees' problems in supervision and the patients' problems in psychotherapy.

Beginning trainees, in particular, are frequently prone to respond to those aspects of their patients' problems that are similar to what they once experienced. The relatively small armament of technical skills possessed by beginning trainees creates a higher than normal surprise element in the frequency and places where parallel process appears. Since training designs, processes and teaching consist of more than just rational elements, the appearance of parallel process in varying degrees should be expected. Thus, Ekstein and Wallerstein (1972) conclude that it is naive to assume that a single prescription, or a single technique of instruction, may suffice never ceases to amaze and "is responsible for the experience of surprise and for the necessity to constantly rediscover what actually should be quite obvious" (p. 178).

What Ekstein and Wallerstein criticize here is a one-dimensional approach to instruction that attempts to address

all possible problems that arise during clinical training.

In the model presented here, the many dimensions of parallel process are utilized in the course of increasing the knowledge and awareness of trainees regarding group process. Further, the discussion of the parallel process phenomenon stimulates a more detailed exploration of countertransference issues. Coupled with didactic presentations about key issues of adolescent development, the conscious utilization of parallel process and countertransference phenomena contribute significantly to this multi-dimensional training model.

In a pilot project geared to teach the psychoanalytic psychology of adolescence to psychiatric residents, Sachs and Shapiro (1974) found a parallelism between the interactions of therapist-trainees and supervisors in a continuous case conference and the interactions between therapist-trainees and their patients. Paralleling adolescents' views of their lives, residents were tempted to bypass intrapsychic factors, and instead, use psychosocial or interpersonal frames of reference as a form of rationalization.

The results of this pilot project, revealing the parallelism that occurs between the conference and treatment situations, is similar to the reciprocal relationship between remembering and repeating that was discussed by Freud (1914): "...the patient does not remember anything of what he has forgotten and repressed, but acts it out. He reproduces it

not as a memory but as an action..." (p. 150). In this sense, the transference is itself only a piece of repetition, rather than an "unwanted interference in the treatment" (Freud, 1914, p. 151).

The empathic response of trainees to adolescents--the parallel process--amounts to an "identificatory reproduction" (Loewald, 1973) in the trainees. That is, the therapist-trainee is placed in the position of identifying with the adolescent patients.

Parallel process phenomena between trainees and patients will no doubt exist as long as the value of empathy and identification is recognized in psychoanalytic theory. The extensive empathy that underlies parallel process phenomena is traceable back to Freud (1923), who described the state of mind of the analyst as an "evenly suspended attention... to catch the drift of the patient's unconscious with his own unconscious"(p. 239). Deutsch (1926) wrote that analysts' empathic identifications with their patients proceeds through the revival of memory traces based on the analyst's unconscious experience of the patient which is transformed into an inner perception. However, if the process stops at this point, therapists may remain unconsciously identified with their patients. According to Sachs and Shapiro (1974), this identification appears in the conference as a parallelism. That is, therapist-trainees re-enact their past through the ways they identify with adolescent patients. The extent of

their empathic responses are indicative of the heightened vulnerability and identity crisis that trainees remember from their adolescence. Since adolescence is an emotionally charged period of life, it mobilizes extremely youthful countertransference feelings--more so than occurs from working with younger children and/or adults.

Doehrman (1976) presents a concept of parallel processes in supervision and psychotherapy that addresses the special meshing of neurotic styles between a patient and his object world. The concept goes a step further than simply describing the "meshing" between patient and therapist-trainee or between therapist-trainee and supervisor. The meshing extends to other significant people in the lives of any one of the three individuals in the patient, therapist-trainee, supervisor triad.

For example, consider the following situation: a female therapist has a disagreement with her spouse prior to seeing a patient. The patient presents material about his own relationship difficulties. In supervision, the therapist, because of her own countertransference response to the patient's material as well as her own marital conflict, relates to the supervisor as if he or she were her spouse. The concept of a parallel process used in Doehrman's (1976) study illustrates how any one of these individuals can represent significant pressure points exerting subtle but powerful influences on each of the other relationships.

Walton (1971) and associates describe how the mirroring (or parallel process) phenomenon is due to the fact that the material reported from the treatment groups stirs up feelings and associations in the members of a peer supervision group that are similar to the original reactions of the patients. At the same time, the attitude and behavior of the therapist-trainee who is reporting may dispose the other trainees and the training group supervisor to react as patients reacted in the group session. Then, the therapist-trainee is likely to react to fellow trainees in the supervision group and to the supervisor in a manner resembling the reaction of patients to one another and to the therapist in the treatment group.

This mirror phenomenon is of practical importance to the supervisor or teacher. The training group is, as it were, an extension of the therapy group; what happens in the training group discussions may therefore, at times, be a guide to what may have happened in the treatment session being duscussed.

Group Therapy: Theory and Practice

Fleming and Benedek (1964) suggest that supervisors be viewed not as teachers or therapists, but as individuals who exemplify the qualities of both roles according to the specifics of the situation (i.e. supervisory skill).

According to Glatzer (1971) the group method is particularly suited to the supervision of group psychotherapy

because it provides a natural demonstration of group psychodynamics. Supervisors can encourage the evaluation of therapist-trainee problems by using the kinds of facilitative responses to the ideas, feelings and perceptions that they use with patients in their therapy groups. The group process approach to training is particularly appropriate for analytic group psychotherapy because the nuances of intragroup transferences, free association, multiple resistances and interlocking ego defense mechanisms can be demonstrated in actual situations.

No selected review of the literature on training and supervision in group psychotherapy is complete without reference to Yalom's definitive work on The Theory and Practice of Group Psychotherapy (1975). An essential part of the training model presented in this project is an understanding of Yalom's systematic approach and analysis of the group psychotherapies.

According to Yalom (1975), depending on their professional training and personal style, therapists attempt to master a system of therapeutic intervention that enhances the operation of eleven curative factors: (1) Instillation of hope; (2) Universality; (3) Imparting of information; (4) Altruism; (5) The corrective recapitulation of the primary family group; (6) Development of socializing techniques; (7) Imitative behavior; (8) Interpersonal learning; (9) Group cohesiveness; (10) Catharsis; and (11) Existential factors.

These factors may represent different parts of the change process. Whereas some factors refer to actual mechanisms of change, others describe conditions for change. Though the individual curative factors operate in every type of therapy group, the extent of their interplay can vary considerably from group to group. A major and explicit factor in one group approach may be a minor implicit factor in another. Moreover, patients in the same group may benefit from widely differing clusters of curative factors. In essence, therapy is a deeply individual experience that offers a seemingly infinite number of curative and growth pathways.

Adolescent Group Therapy

There are two historical factors relevant to the study of adolescent group therapy. First, professional specialization concerning work with adolescents in groups is a relatively recent development within the mental health field. Second, in terms of the history and systems of psychotherapy, the group approach is relatively recent.

According to Berkovitz (1972), a thorough grounding in the individual treatment of teenagers is an essential experience prior to attempting group therapy. During adolescence, the peer group is one of the major sources of support for attempting solutions to the typical individual problems of self-recognition. Membership in the group ideally "supports the comfortable or gratifying identity that can emerge from each

child's latency phase" (Berkovitz, 1972, p. 25). The group serves as a social arena in which adolescents struggle through the typically confused issues that characterize their stage of development.

Berkovitz describes the basic goals of adolescent group psychotherapy:

> The hope in these groups is that structure will foster, and not inhibit, the emergence of intrinsic energy [personal creative energies], understanding of interaction and verbalizing of fantasies. It is to be hoped that this energy and verbalizing will synthesize with useful adult feedback for mutually desired change (Berkovitz, 1972, p. 6).

The groups are intended to provide constructive experience that can assist individuals to feel differently about themselves and others.

During the course of a group therapy experience the group assumes an identity which supersedes the individual identities of each member. Further, each member attributes specific superego and nurturing roles to the group identity. To varying degrees each group member assumes a conscientious responsibility for the development of others in the group.

Grotjahn (1977) describes a transference to the group as a whole in which the group symbolizes the preoedipal mother figure (basic trust). According to Winnicott (1971), most mothers allow their infants to have some special object to which the infant can eventually become strongly attached (i.e. a transitional object). Utilizing Winnicott's concept, the group identity may be looked at as a transitional object

representing the mother that bridges the adolescent passage into adulthood.

The group provides social support and peer pressure to help individuals achieve desired behavior changes. In a safe and controlled environment, they can freely examine their individual problems and impact on others (MacLennan and Felsenfeld, 1968).

Arnold W. Rachman (1975) views group psychotherapy as a method to help adolescents successfully resolve their identity conflicts. In his works, noteworthy for their exclusive use of Erikson's theory of human development and concept of ego identity, Rachman provides a theoretical and clinical model for working with groups of adolescents in a variety of settings. Ego identity is viewed as a psychosocial concept which embodies a sense of personal, group and philosophical identity. He rejects the traditional negative view of adolescents as second-class clients who are not capable of being analyzed. He stresses the need for specific clinical expertise to effectively work with adolescents in every type of clinical setting.

Rachman further asserts that clinical group psychotherapy needs to incorporate aspects of the "encounter movement" to provide an antidote to the pervasive sense of loneliness, isolation, alienation and inauthenticity that characterizes contemporary society. Once that is achieved, the group can provide a positive but realistic climate for

ego identity resolution.

Adolescent group psychotherapy ideally offers individuals a new family type of setting where they can experience parent and sibling figures in a different, and hopefully more helpful, way. Hopefully, the group can become an emotional family experience that can correct individual problems. The curative features of group therapy described by Yalom (1975) are particularly relevant with adolescents in the process of developing who need group contact. It becomes evident, therefore, that for many adolescents group psychotherapy is the treatment modality of choice.

Countertransference

The majority of theorists and practitioners of group psychotherapy state that when countertransference occurs in the group situation, it is usually more intense, more recognizable by the patients and more difficult for the therapists to handle than when it occurs in individual therapy (Hadden, 1953; Loeser and Bry, 1953; Grotjahn, 1953).

As a therapeutic phenomenon, countertransference was recognized very early in the history of psychoanalysis. Freud (1910, 1915) ascribed the term to the unresolved unconscious conflicts of analysts which interfere and "color" their reactions to patients. As an unwelcome intrusion that impairs the outcome and the objective process of the analysis, Freud recommended that analysts make concerted efforts to overcome it. With few exceptions this negative view pre-

vailed in analytic circles until the early 1950's.

Investigators and therapists soon began to recognize (Gitelson, 1952) the importance of countertransference in the analytic process. The development of ego psychology and object relations theory for the treatment of schizophrenia and borderline disorders in general (Fromm and Reichman, 1952; Rosenfeld, 1952; Searles, 1967) increased the recognition of the positive aspects of countertransference.

According to the traditional view, the significance of countertransference is that the therapist is never fully free of archaic wishes, fears and associated defenses. The group therapist, like any other human being, projects, distorts and displaces. In group psychotherapy--and especially in adolescent group psychotherapy--the therapist is unable to maintain a neutral and inscrutable facade. Sooner or later, group members realize that the therapist is not perfectly objective, or is often more responsive to some phenomena, issues or situations that occur in the sessions. Functioning together, group members are in a much better position to recognize the therapist's human frailties than is the analytic patient on the couch.

Countertransference emotions, due to the very fact that psychotherapists are people and are involved in a relationship, albeit therapeutic, are inevitable. Slavson (1953) distinguishes countertransferences as positive, negative

and having aim-attachment--goal orientation. Goodman, Marks and Rockberger (1964) operationally define countertransference as a response or projection not in the therapist's awareness.

Flesher (1953) delineates three types of countertransference: defensive, reactive and induced. Defensive countertransferences are closely connected with unresolved conflicts in the therapist. Reactive countertransferences are conscious and may be carried over from one case to another. He defines the suggestive influence that goes from the patient toward the therapist as "induced countertransference." Defensive countertransference evokes extensive use of therapist defenses, reflected both in their attitudes and reactions to the patient and in their treatment approach. Projection plays an outstanding role in defensive countertransference, including warded-off impulses (id projection) and other psychic structures.

Countertransference tends to be more intense in therapists who deal with adolescents. A number of reactions are possible: (1) overidentification, or siding; (2) parent-like reactions; (3) envy; (4) arousal of sexual issues; (5) arousal of dependency issues; (6) arousal of aggressive impulses; (7) arousal of punitive, prohibitive impulses; (8) arousal of separation-individuation issues; (9) arousal of competitive feelings towards adolescents or their parents; (10) and other reactions such as moral or value judgements. There are many

contingencies involved in determining whether the therapist is exhibiting defensive countertransference reactions. However, the form these reactions take are linked to the therapist's own adolescent experience.

A tendency to side consciously or unconsciously with the adolescent patient goes far beyond its value during the initial stage in treatment. Initially, this attitude can foster empathy in the treatment of acting-out or impulse-ridden patients. These patients may have little insight into their illness, tend to blame others for their difficulties, and/or are only vaguely motivated for therapy. However, unlimited siding with the patient interferes with the understanding of the masochistic, self-punishing, provocative and other irrational trends that compel patients with this symptomology to structure relationships in a self-defeating way. While this may not necessarily be revealed in the therapist's opinions or suggestions, the unlimited siding can be conveyed to these patients by the therapist on a sub-threshold level, often against the therapist's conscious intentions.

Pumpian-Mindlin (1965) notes that therapist reactions in working with adolescent patients are somewhat similar to parental reactions. He points out the subtle interplay of parental-adolescent fantasy systems with omnipotence. For example, he observes how much the adolescent's tendency to be cavalier about day-to-day commitments is coupled with "omnipotentiality." The sheer energy and momentum of omni-

potent fantasies in their adolescent children may revive long dormant ones in parents. The dynamisms of envy, competitiveness, fear of change, identity shifts, separation anxiety, and so forth are consistent with Pumpian-Mindlin's observation. All of these are potentially pathological elements in the intricate network of parent-adolescent and therapist-adolescent relationships.

An overinvested ego ideal in the therapist may foster an inclination to mold the patient in Pygmalion-like fashion according to the therapist's idealized self-image. Since such a reshaping is inevitably done with disregard for the particular formative experiences and assets of the patient, it is to the detriment of the patient's maturation.

Regarding reactive countertransference, many patients have borne the brunt of hostile or anxious responses evoked by the therapist's other patients, which the therapist was either unwilling or unable to work through. For example, Winnicott (1971) describes how his anxious reaction to a specific disorder in a psychotic patient caused him to make errors with each of his patients for a few days.

The distinction between reactive and defensive countertransference--though both may co-exist in a given treatment relationship--is important because defensive countertransference is generally more difficult for the therapist to work through. The main reason is that defensive countertransference involves possibly entrenched defense mechanisms

that are deployed by the therapist to maintain effective functioning.

Many types and levels of defensive mechanisms--ranging from projection and denial to intellectualization and sublimation--are involved in defensive countertransference. If the more primitive defenses (i.e. projection) are employed by the therapist, defensive countertransference can be more detrimental. These are most likely to occur when unresolved conflicts in the therapist are involved. Generally, in reactive countertransference the likelihood of these primitive defenses being employed is less. In fact, if therapists become aware of their reactive countertransference feelings, they can use them to achieve a better understanding of the patient and thus, be a more effective therapist.

In summary, the following quantitative and qualitative factors can determine whether therapist encumbrances will appear in all or only in some of their cases: (1) the intensity and nature of the unresolved conflicts in the therapist; (2) the relevant defenses; and, (3) the transference stimulus for reactive countertransference (i.e. the hostile projections of an adolescent who rejects the therapist and devalues the therapy).

The therapist's unconscious readiness to accept or refuse specific material is an important suggestive factor in stimulating patients to surrender or withhold material.

Countertransference attitudes, therefore, may also have an inhibiting effect on the therapist's enthusiasm about a particular patient. Conversely, the patient's strong wish to see the therapist in a given role may induce the therapist to assume the defensive countertransference role without realizing it.

Flescher believes the term countertransference should include all emotions and attitudes in therapists that--whether or not they are linked with his personality--influence the comprehension and use of analytic psychotherapy. This definition leaves open the possibility that a conscious and non-judgmental awareness of the therapist's own countertransference can favorably affect the therapist's technique, as the model presented here asserts.

When it remains in the unconscious, countertransference may be evidenced by a repetition compulsion which both distorts the therapist's perception and has an adverse impact on the therapeutic movement within individual or group therapy.

In a related group evaluation study, Cohn (1961) conducted an experimental training workshop designed to produce skills in detecting and dissolving countertransference phenomena. The workshop was conducted to: (1) recognize and resolve the immediate countertransference disturbance in a specific treatment situation; (2) train for perception and skill in self-analytic countertransference treatment; (3) understand how the individual histories and analytic inter-

actions of therapist-trainees with supervisors, with other trainees and with patients affects their professional work; and, (4) to enlarge the scope of their group process awareness and diminish the need for theoretical dogma. Ultimately, the therapist-trainees appeared to benefit from the workshop in proportion to the integration of their training analyses, the solidity of their theoretical training, and their wealth of experience as analysts.

Benedek (1954) discusses the specific manifestations of countertransference in the analyst that are motivated by the particular conditions of the training analysis. She asserts that the most significant manifestation is the training analyst's unconscious or conscious tendency to foster the candidate's identification with and dependence on the analyst. This view is based on the extent that training analysts tend to project themselves unduly by identifying themselves--as parents to with their children--with the candidate. Thus, Benedek views the motivation for "parental overprotection" in families as a manifestation of insecurity in regard to their child. The parents are fearful of their inability to handle, treat and educate their child to the best advantage. The situation in the training analysis is very much the same. The overprotectiveness is often the result of the complexity of the goal in the training analysis.

In short, the literature indicates that the vicissitudes of countertransference in adolescent group therapy are greater than in individual therapy with adolescents or adults.

CHAPTER III

THE CONTRIBUTION OF BLOS AND ERIKSON

Together, Peter Blos and Erik Erikson form a complementary foundation for the model presented in this project. Blos is largely recognized as the foremost authority on adolescent development and psychodynamics. Erikson, literally equated with the concept of identity, or ego identity, developed the psychodynamics and social psychology of adolescent development.

Erik Erikson: Adolescence and Identity Formation

Human beings are social creatures. That is, an individual's growth and development is directly related to the quality and extent of their interaction with "significant others" throughout the life cycle (Mead, 1934). According to Erikson, peer group interaction and belongingness is a psychosocial need of individuals:

> Personality...can be said to develop according to steps predetermined in the human organism's readiness to be driven toward, to be aware of, and to interact with a widening range of significant individuals and institutions (1968, p. 11).

The most serious and pathologic identity problems occur when individuals are deprived of meaningful human contact and social stimuli. For example, feral children reared without human contact were severely impaired in their development (Bettleheim, 1954).

The social and historical aspects of identity formation initially were addressed by Freud when he spoke of an "inner identity" he shared with the tradition of Jewry. Freud felt that this inner identity--the capacity to live and think as a minority in isolation from the "compact majority" (Freud, [1926] 1959, p. 273) was at the core of his personality.

The development of a mature psychosocial identity is based on an individual being exposed to a community of people with specific traditional values and norms. These values and norms become significant as individuals grow and hierarchically integrate genuine life roles that are socially and historically meaningful to them. "Life roles" do not refer to transitory role playing since the latter cannot provide a solid basis for identity formation.

Psychosocial identity, in essence, is built upon the complementarity of an inner ego synthesis in individuals and of role integration in their respective peer groups.

According to Erikson, identity crises occur when infantile identifications must be adjusted to urgent--perhaps tentative--new self-definitions and irreversible, possibly unclear, role choices. The urge for new self-definition by each new generation is vitally related to the social and historical processes and events of particular eras. In order to remain vital, a society needs the energies, loyalties and creativity that emerge from the adolescent process. As individual identities gradually are "confirmed" positively,

a society regenerates. On the other hand, if there is mass identity disconfirmation and confusion, a historical crisis may be the result. Thus, psychosocial identity needs to be studied in part from the perspective of a complementarity of individual history and societal history.

Compared to other Neo-Freudians who integrate variables from the social sciences, Erikson (1950) has produced the most detailed version of the developmental sequence. His eight psychosocial crises in ego development--the first five paralleling Freud's libidinal crises--cover the years from infancy through old age. Although the sequence is universal, individuals work out solutions based on the alternatives offered by their socio-cultured institutions. Their success in finding solutions and resolving conflicts depends on their ego strengths developed during earlier conflicts and the meaningfulness of the environmental reinforcements provided by the current crises.

The First Four Psychosocial Crises

Corresponding approximately to what Freud described in his oral period of development during a child's first year of life, the first psychosocial crisis--occuring in early infancy--determines the extent that an individual's basic feeling toward others will be characterized by basic trust. A specific virtue develops from the successful resolution of each crisis. Ideally, the first crisis produces a capacity,

or virtues in the individual for faith in people, society and the world.

Corresponding to Freud's anal stage of development, the second crisis--occuring in the child's second year of life--determines whether the child will be defined by a sense of autonomy or by a sense of shame and doubt. The successful resolution of this crisis is the development of will power.

Corresponding to part of what Freud described as the Oedipus complex, the successful resolution of the third crisis--occurring during ages three to five years--of initiative versus guilt can result in a sense of purpose and goal-directedness.

Corresponding to the latency period, the fourth crisis is industry versus inferiority. During this period the child becomes competent, curious, and eager to learn and collaborate with others. Whereas the traditional Freudian concept characterized latency as a relatively dormant and quiescent period, Erikson, a leader in the post-Freudian ego psychology movement, asserts that the ego is actively functioning during the so-called latency period. In contrast to Freud's view of the post-Oedipal period, Erikson does not view the child's desire for learning to be a product of displaced or suppressed sexuality. Thus, learning is a driving force in and of itself due to the ego's motivation for competence. If the fourth crisis is successfully resolved, the result is a sense of competency, or skill.

Identity Versus Role Confusion: The Fifth Psychosocial Crisis

Erik Erikson (1965) describes adolescence as a "psychosocial moratorium" during which "the promise of finding oneself [and differentiation] are closely allied" (p. 10). Adolescents' crises integrate earlier formative stages of ego identity with current problematic stages. The major adolescent crisis, defined as "a conflict of identity versus role confusion," is marked by physical changes, sexual awareness and the self-threatening reactions of larger peer groups and significant persons. Adolescents are faced with the challenge of creating a constructive "I" that is both consistent with their earlier self-concepts and accomodative of the current "me" seen by their cultural or peer groups.

Industrialized society presents a major problem for adolescents in the selection of an occupational identity. At the beginning of this process, adolescents attempt to sustain themselves and make tentative decisions by plunging into their peer groups and overidentifying with the popular heroes (Erikson, 1950).

Since the 1960's, and perhaps earlier, this overidentification has occured with various popular music stars. The current styles, trends and fads place enormous pressure on adolescents to both follow an accepted "chic" image and develop a unique image.

Compared to the limited rôle definitions provided by yesterday's autocratic and agrarian societies, today's freer,

urbanized and technological societies provide a blinding array of identity choices. To analyze this phenomenon, Erikson contrasts the solutions, supports and difficulties of American and German adolescents. For instance, middle-class and upper-class Americans benefit from the "psychosocial moratorium" provided by a long adolescence during which they can experiment and establish an identity. Typical adolescent American males with well defined ego identities tend to be at peace with themselves. They are concerned with their sexual identities and occasionally relieve ego restrictions by engaging in various delinquencies. Unlike their German counterparts, American adolescents tend to be anti-intellectual and far from uncompromising idealists. Many of the differences in behavior are the result of significant differences in American and German history. In America, there is a heritage of contrasts--individualism; social revolution for freedom; diffusion of the father ideal; early independence from the mother; fraternal relationships with the father; and democratic views of individual interests within the family focusing on conflicts with peers. Consequently, rebellion and superego conflicts present fewer problems in America than in Germany.

On the other hand, the older rural and regional value systems of Germany do not as yet integrate societal ideals with educational methods in a way that gives meaning to the German father's authoritarian behavior. German adolescence,

then, takes the prototypical form of "storm and stress." In the absence of institutionalized outlets for adolescent experimentation, German youths tend to rebel and then submit.

According to Erikson ([1950] 1964):

> As the theoretical focus of psychoanalysis shifted from 'instincts' to 'ego,' from defensive to adaptive mechanisms, and from infantile conflict to later stages of life, states of acute ego impairment were recognized and treated (p. 38).

The syndrome of "identity confusion," according to Erikson, became useful in characterizing neurotic disturbances resulting from traumatic events such as war, interment or migration. But the syndrome also proved to be a powerful vehicle of characterizing disturbances during adolescence (Erikson, 1959, p. 124).

Identity confusion--concentrated in the form of a crisis--that is aggravated by social and maturational changes can evoke neurotic and psychotic syndromes which are "diagnosable and treatable as transitory disturbances" (Blaine and McArthur, 1961). Further, identity confusion can be recognized in perverse delinquent, or juvenile criminal, behavior which is fueled by technological changes and population shifts (Witmer and Kotinsky, 1956).

But generally, identity confusion is characterized by the feeling of uncertainty, ideological emptiness and social disconnection from meaningful peer groups. The successful resolution of this crisis is the development of a sense of fidelity, or the ability to be faithful to a specific ideo-

logical view, to oneself, and to a meaningful group.

In Erikson's multistage theory, personality development is viewed as a continuing process throughout the human life cycle. At specified times coinciding with biological, social and cultural conditions during each individual's life, a basic developmental task is encountered. It should be noted that when Erikson uses the term "crisis" in describing identity confusion, he means that the individual has a unique challenge to meet during each developmental period of life.

In this day of psychiatric concern, it must be emphasized that "crisis" does not necessarily mean a fatal turn. Rather, as it does in drama and in medicine, it means a crucial time, or an inescapable turning point, for an individual to make a turn for the better or worse. "Better" means a combination of the constructive energies of individual and society, as evidenced by mental alertness, authenticity, and emotional directness. "Worse" means prolonged identity confusion. However, "worse" can ultimately lead to "better." For instance, in repeated crises, extraordinary individuals can create the identity elements of the future (Erikson, 1958). Nevertheless, adolescence is a time of increased psychosocial vulnerability where either psychopathology or self-actualizing can occur. The successful resolution of the crisis produces psychological growth--increased ego strength, self-esteem and self-confidence.

Sooner or later, adolescents must join forces with the functioning society by combining their loyalty and competence

so as to achieve "fidelity" (Erikson, 1963). As both the beneficiaries and renewers of tradition and wisdom, adolescents criticize and rejuvenate style and logic. Although they may initially appear as rebels bent on the destruction of society, they eventually serve as workers and innovators in technology.

The identity crises of an era are least severe in those adolescents who are able to invest their fidelity in transforming society, thereby evolving new competencies and roles. However, adolescents who opt to identify "with a lifestyle of invention and production" (Erikson, 1963, p. 21) may feel estranged, or alienated, until society "catches up" to them.

As a consequence of the technological and cultural diversity of modern American society adolescents may experience an extended identity crisis period.

Clinicians who are inexperienced with adolescents may be baffled by certain syndromes presented by adolescent patients. Consequently, they make frequent diagnoses citing "existential neuroses" and/or "borderline schizophrenic reactions" when, in fact, the adolescent may be struggling with a severe case of identity confusion. Of course, if on further exploration (i.e. taking a detailed history) there are indicators of unsuccessful resolutions of earlier psychosocial crises, then a more severe diagnosis of psychopathology is necessary. In fact, severe identity confusion can lead

to serious psychopathology.

When adolescents develop their ego identities, they prepare themselves to engage in the intimate relationships that characterize adulthood. Individuals whose basic identity problems are not solved during adolescence will likely be haunted by continual crises throughout their adult lives.

Erikson (1968) cites a series of clinical symptoms, or pathonomic signs of severe identity confusion, that when taken as a whole, necessitates psychotherapeutic intervention:

1. A fear of a loss of self
2. Disintegration, a loss of inner continuity and sameness
3. Diffusion of time orientation (i.e. sleep cycle changes, night becomes day)
4. Diffusion of motion, ranging from the loss of the desire to work to the inability to derive a sense of achievement from any activity.
5. Fear of closeness, or intimacy
6. Deep depression, or suicidal wishes; powerlessness and alienation
7. Heightened sense of isolation (i.e. existing in a void)

To be sure, many of the concepts and practices of individual and adult group therapy are applicable to adolescent group therapy. However, as Erikson (1968) insisted, the analysis of adolescents in any context requires additional concepts and/or theoretical frameworks that are exclusive to the adolescent experience in society.

The training model presented here applies and, on occasion, extends Erikson's psychosocial theory of adolescence to the context of therapeutic groups conducted by clinicians, mental health practitioners and paraprofessionals. Erikson's theory provides a cornerstone for the lecture-workshops on adolescent development that form the first part of the training model presented here.

Blos on Character Formation: Four Adolescent Developmental Challenges

Blos (1979) identifies four adolescent development challenges that he views as closely related to character formation: (1) the second individuation; (2) residual trauma; (3) ego continuity; and, (4) sexual identity. If these challenges are not met with reasonable competence, character formation is either stunted or rendered abnormal.

The Second Individuation Process: The First Challenge

The second individuation (discussed in more detail in the following section) process encompasses the loosening of internal or "infantile object ties" (A. Freud, 1958). The adolescent development task of this process is in disengaging the "libidinal and aggressive cathexes" (Blos, 1979, p. 179) from internalized infantile love and hate objects. To the extent that infantile object relations are intertwined with the formation of psychic structure, they "activate and form ego nuclei" (Blos, 1979, p. 179) that form the basis for

future experiences. In addition, object relations stimulate and sharpen idiosyncratic sensitizations, including preferences and avoidances.

The superego is the "most dramatic and fate determining formation" that is derived from object relations (Blos, 1979, p. 179). That is, infantile and childhood conflicts produce a number of character traits and attitudes that can be observed. By the degree of its disintegration and disorganization at adolescence, the superego demonstrates "the affective affinity of this structure to infantile object ties" (Blos, 1979, p. 180).

The second individuation process is such a heightened period of vulnerability that it can wreck the psychic formations derived from early object relations. During this period of challenge, the crucial controls and adaptational functions pass over from the superego to the ego ideal of a narcissistic formation. In essence, the love of infants' parents is at least partially replaced by self-love or the drive for self-perfection. Rather than serving adolescent defensive functions, "regression functions in the service of development," (Blos, 1967) growth and autonomy. Unavoidable, obligatory (or phase-specific) adolescent regression uses the ego's advanced resourcefulness to "selectively overhaul" the personality of the protoadolescent child. This overhaul occurs as a result of behavioral experimentation that takes place throughout adolescence in order to meet the

developmental changes.

The process of the second individuation moves through "regressive recathexes of pregenital and preoedipal positions" (Blos, 1979, p. 181). Although these positions are revisited, the difference is that the more mature adolescent ego is able to produce shifts in the precarious balance between ego and id. In essence, Blos is referring here to late adolescence when impulse control generally begins to stabilize as a consequence of withstanding the pendular shifts and tumult of experimentation earlier in life.

During their emotional and physical withdrawl from childhood dependencies, adolescents form new identifications as friends and peer groups take over superego functions. Reflecting a transcendence of the confines of family, this adolescent period is noteworthy for constant shifting and experimentation, expressed in new speech, attire, gestures, posture, gait, value-belief systems and so forth. Erikson (1958, 1963) describes this process as identity seeking.

The Second Developmental Challenge: Residual Trauma

In considering the effect of trauma on adolescent character formation Blos (1962) intends to show that character takes over homeostatic functions from other regulatory agencies of childhood. His use of the term "trauma" corresponds with Greenacre's (1967) definition which includes "sexual (genital) traumatic events, or circumscribed episodes,...traumatic con-

ditions, i.e. any conditions which seem definitely unfavorable, noxious or drastically injurious to the development of the young individual" (p. 277).

The analysis of older adolescents has demonstrated to Blos (1979) that the resolution of neurotic conflicts--the weaning from infantile fantasies--will bring analytic work "to a good end," but will not necessarily eliminate the residues of its pathogenic foundation. Although by the end of the analysis, these residues generally lose their noxious valence as a consequence of ego and drive maturation, they continue to require sustained containment. According to Blos (1979), "the automization of the containment process is identical with the function or, more precisely, with a part function of character " (p. 182). These permanent sensitivities to specific dangerous situations--at a level of traumatic valence--are found in the experience of loss of control, passive dependency, decline of self-esteem, object loss and other injury producing conditions. The assumption is made here that trauma is a universal phenomenon during infancy and early childhood which leaves permanent residues, or emotional scars, to varying degrees.

During the adolescent period, this problematic traumatic residue is rendered ego-syntonic through assimilation within the process of stabilization of character. Depending on whether the trauma is brought into consciousness during any period of development, there can be positive or negative effects

fects (Freud, 1939). Whereas remembering the traumatic experience can have positive growth effects, the removal of any memory of the trauma leads to negative effects of reactive character formation through various phobias, avoidances, compulsions and inhibitions.

According to Blos (1979), "Character...is identical with patterned responses to prototypical danger situations or signal anxiety" (p. 183). That is, the conquest of residual trauma is "identical" with healthy character formation. In adaptive character formation, residual trauma is neither avoided nor made to disappear. Adolescents who sidestep the transformation of residual trauma--the challenge that a dangerous traumatic residue poses--project it onto the external world and thus forfeit their chances of coming to terms with it. The impasse that results from "sidestepping," frequently leading to belated or pathological character formation, has been described by Erikson (1956) as the adolescent psychological moratorium. In adaptive character formation, the residual trauma is transformed, or integrated, accepted and "owned" rather than projected.

In essence, the formation of character involves more than superego identifications, influences and defenses. A complex integrative principle is at work here that influences the forces that contribute to ego development. One of the most important integrative concepts for clinical use is Erikson's (1956) "ego identity."

In short, the "characterological stabilization of residual trauma" (Blos, 1979, pp. 184-185) increases human beings' independence from their environment and the infantile and childhood traumatic incidents which occurred at a time when pain was identical with the nonself.

The adolescent group provides an arena, a simulated family, that allows for the occurrence of a corrective emotional experience and personal/interpersonal development. When the derivatives of residual trauma are projected onto other group members, the group can then act to clarify the roots of the projections. Ultimately, group members can acknowledge the projections and the residual traumas, and begin a process of freeing themselves from the psychological encumbrances of these earlier experiences.

Ego Continuity: The Third Challenge

Extensive clinical observation has convinced Blos that adolescent development really progresses only when the adolescent ego succeeds in "establishing a historical continuity within its realm" (1979, p. 185). This occurs when adolescents perform a comprehensive critical re-evaluation of the personal, social and symbolic values held by their parents (i.e. through displacement). According to Blos, "the corrective adjustments made during adolescence restores the integrity of the senses to some degree" (1979, p. 185). When this effort to come to terms with the family milieu

falters, adolescent development, or psychic restructuring, may be suspended. To ensure their development, adolescents must face the challenge to restructure the "family myth," the distortion of family history that was "coercively forced" on them during childhood.

The establishment of historical ego continuity in adolescent analysis has an integrating and growth stimulating effect that is beyond conflict resolution. Blos quotes one adolescent who speaks for many, saying that, "one cannot have a future without having a past" (1979, p. 186). The ego maturation process--characterized by the definition of self, the re-evaluation of parents, and exploration of the social environment--produces the subjective "sense of wholeness and inviolability" (Blos, 1979, p. 186) during the adolescent period.

The sharing experiences of the therapy groups helps adolescents to perform the critical re-evaluation of parental values. In addition, the group helps the adolescent to make connections between the past, present and toward the future.

Since adolescent group therapists function as parental models, they must be aware of their own unresolved adolescent conflicts regarding ego continuity. The training model presented here allows for the use of countertransference awareness to maximize the effectiveness of the therapy group.

Sexual Identity: The Fourth Challenge

Although Blos accepts the view that gender identity is established at an early age, he contends that a specific sexual identity with irreversible boundaries appears later, or during the time of puberty. Until puberty, shifting and ambiguous sexual identity--within limits--is the rule, not the exception. According to Blos, this ambiguity is more apparent in the social and personal acceptability of pre-adolescent girls in the tomboy stage and preadolescent boys who repress breast envy. Although the maturational exigencies of puberty normally stimulate integrative processes leading to psychic growth, their strength is undermined, asserts Blos, as long as sexual ambiguity persists. The maturation process, experienced subjectively by the adolescent as identity crisis (Erikson, 1956), is based on the assumption that sexual identity has become increasingly defined.

To place the above character formulation model in perspective, it should be noted that adolescents achieve psychic autonomy and emotional maturity when they meet and transcend the four challenges. The challenges are part of the character formation process; they are not equivalent to character. To most fully develop, adolescents must effectively select, use and learn from particular elements of the environment in an "anabolic" way. That is, they must ingest and absorb life sustaining substances and convert them into living tissue.

When this process works well in all stages, it can be considered the "most essential indicator and guarantor of normality and health" (Blos, 1979, p. 5).

A major basic assumption that underlies all of Blos' work on adolescent development is the existence of "a modicum" (1979, p. 5) of Winnicott's (1965) "good enough mother" and/or "facilitating environment." The rationale is that human development can proceed only if external sources of phase-specific experiences are available for the individual to use and derive benefits.

The following description elaborates on Blos' formulation. The emphasis is on the second individuation process and "regression in the service of development" because that is where he seems to explicate the key elements of his theory of adolescent development.

Blos on Adolescence: The Second Individuation Process

There is a common component throughout the phases of psychic restructuring from preadolescence to late adolescence. Blos calls this unrelenting component "the second individuation process of adolescence." Through this concept he emphasizes the heterogenity of the phases through the positions and movements of drive and ego. Moreover, Blos views the totality of adolescence as the second individuation process. The first individuation process is completed with the achievement of object constancy near the end of the third year of

life. In both periods, there is a heightened vulnerability of the personality and an urgency for changes in the psychical structure. The risk is that if either period "miscarries" or mis-individuates, a period of specific deviant development, or psychopathology, is likely to follow.

During adolescence, the disengagement from internalized love and hate objects of childhood opens the pathway for finding external or extrafamilial love and hate objects. This process is the converse of what happens in early childhood during the separation-individuation phase when the child gains psychological independence from a "concrete object"--the mother--while remaining dependent on the internalized object.

The progress from the early dependent symbiotic unity of child and mother to that of independence is based on the development of "internal regulatory capacities" (Blos, 1967, p. 157) that reflect advances in motor, perceptual, verbal and cognitive skills. This process is ongoing in a "pendular" sense because it occurs again in the second individuation process of adolescence. However, progressive movement is far from consistent as a result of the alternation of regressive movements in longer and shorter periods. Thus, a casual observer of the child could easily receive a lopsided, or distorted, impression of the maturation process. In order to effectively determine whether the behavior of the average toddler or adolescent is normal or deviant, it is necessary to observe them over a longer period of time.

The complexity of the adolescent individuation process, a reflection of those structural changes that condition the emotional disengagement from internalized infantile objects, is acknowledged by the amount of analytic attention it has received.

The ego differentiation from parents that occurs in this process takes adolescents out from under the sheltering umbrella of parental egos and exposes them to anxieties and other challenges of the social world. According to Blos (1967), it is "axiomatic that without a successful disengagement from infantile internalized objects, the finding of new, namely extrafamilial, love objects in the outside world either is precluded, hindered or remains restricted to simple replication and substitution" (p. 158). During the second individuation process, adolescents ideally become emancipated from both infantile libidinal and latency period dependencies. However, when they discard these dependencies and the shelter of parental ego support, newly independent adolescents experience ego weakness.

To be sure, the dynamics of the decreases in dependencies and increases in independence that result in adolescent ego weakness is important on both theoretical and therapeutic levels. The basic axiom is that the disengagement, or emancipation, from the infantile object is always paralleled by ego maturation. The dynamics of the converse of this--the extent that adolescent inadequacy or impaired ego functioning is

symptomatic of drive fixations and infantile object dependencies--becomes the central concern of clinical intervention.

There is little doubt from Blos' standpoint that new ego capacities and significant advances in the cognitive area (Inhelder and Piaget, 1958) occur during adolescence. However, Blos does doubt the extent of primary autonomy, or independence, of these areas from drive maturation. "Experience teaches us that whenever drive development lags critically behind adolescent ego identification, the newly acquired ego functions are, without fail, drawn into defensive development..." (Blos, 1967, p. 159).

Both drive and ego development continuously interact. While the loosening of infantile object ties paves the way for mature or age-adequate relationships, the ego becomes increasingly antagonistic to the re-establishment of the obsolete "partly abandoned ego states and drive gratifications of childhood" (Blos, 1967, p. 159). Although adolescencts are intensely concerned with their relationships, the extent of their object-directed drive manifestations or drive inhibitions is symptomatic of the radical changes in ego organization that occur during this time. Ultimately, the sum total of these changes survives adolescence to form enduring personality characteristics.

There is much to be learned, asserts Blos (1967, p. 60), from adolescents who "sidestep the transformation of psychic structure" by establishing a polarizing relationship with--rather than disengaging from--infantile internal objects

through idiosyncratic behavior. There are many visible symptoms of failure in disengagement, or failure in individuation: (1) learning disorders; (2) acting out; (3) ego disturbances; (4) lack of purpose; (5) procrastination; (6) moodiness; and, (7) negativism.

The adolescents' radical circumvention of the painful disengegement process can be seen as a wholesale rejection of their families. The avoidance, usually transient, can assume extreme forms that range from acts of criminality, to leaving school, to promiscuity. The adolescents who take this extreme route usually assume that the communication and generation gap between themselves and their families is a hopeless situation. Clinicians assessing such cases often conclude, Blos (1967) points out, that the adolescent is "doing the wrong thing for the right reasons" (p. 160). In these extreme avoidances, Blos recognizes how violent and unresolved ruptures with family can produce an overwhelming regressive pull to infantile object dependencies, grandiosities, gratifications and safeties. For some adolescents, this violent rupture serves as a "holding pattern" until progressive development can be re-ignited. But for many others, the rupture becomes a way of life of individuation-avoidance that leads to long term regression.

Although these particular adolescents may experience an intoxicating sense of triumph over their past, the physical, moral and ideational distance they put between them-

selves and their family only serves to suspend their progress and growth.

To compensate and maintain their psychological integrity during critical stages of the individuation process, adolescents may change their styles of dress, social roles, grooming, moral decisions and special interests. Their degree of maturity will depend on how far the individuation process advanced before they, in effect, left it suspended and incomplete.

The "second individuation process" is in essence a relative concept. That is, it depends on drive maturation. And, according to Blos, it acquires durability in ego structure. Individuation means that growing individuals take increasing responsibility for who they become, rather than assigning this responsibility to parents and others who have influenced them. Blos succinctly describes the tendency of adolescents in today's society to blame their parents for the problems, inadequacies and disappointments that haunt them throughout their lives. Further, he describes how adolescents who are unable to separate to a significant degree from internal objects, except through rebellion, experience a sense of alienation from parents, peer groups and society. This alienation is apparent in the "endemic mood of a considerable segment of present day adolescents, promising and gifted sons and daughters, having grown up in ambitious, yet indulgent, usually middle class, often progressive and liberal families" (Blos, 1967, p. 161).

Every historical era produces dominant styles, attitudes and roles that influence adolescents through the socialization process. The dominant character and lifestyle of a particular era can be absorbed by adolescents in a number of ways and at different levels. The essence of an era can become the displaced battleground for disengagement, or emancipation, from childhood dependencies and lead to individuation. However, the new forms, or lifestyles, can become permanent substitutes for childhood states, thereby precluding individuation. In this sense, individuation is both a process and an achievement.

Analytic work with adolescents consistently indicates that ego and superego functions are reinvolved with infantile object relations. Gēleerd (1961) suggests that a partial regression to the "undifferentiated phase of object relationship" occurs in adolescence. Expanding Hartmann's (1939) formulation of "regressive adaptation", Geleerd (1964) describes how the growing individual passes through a number of regressive stages in which all three structures--reality, superego and id--contribute.

Through regression at adolescence, the residue of infantile trauma, fixation or conflict can be modified when the adolescent uses the ego's resources, supported by the developmental strength derived from maturation. That is, the dangers of regression can be reduced and regulated to avert the dangerous regressive loss of self, or the return to the undifferentiated stage.

Clinical work has confirmed the extent that individuals pass through many regressive stages in which reality, super-ego and id participate. This alternating "stagic" growth and regression is now an integral element of the psycho-analytic theory of adolescence.

According to Blos (1967), adolescence is the only period in human life in which ego and drive regression are an "obligatory component of normal development" (p. 165). That is, adolescent regression functions to stimulate development.

The subject of Blos' (1967) investigation is the mutual interaction between ego and drive regression that produces changes in psychic structure. The phase-specific regression that initiates transient, maladjustive and/or self-destructive hazards accounts for much of the perplexing behavior and high psychic volatility (Blos, 1963) of this age.

In their quest for individuation, outwardly directed adolescents seek personal bonds and group experiences for emotional agitation, or "kicks," and to escape affective boredom and loneliness. They make frantic efforts to keep reality bound by keeping busy and moving about. Other, more "inward" adolescents, seek solitude and isolation in order to imagine and reach affective states that are extraordinarily intense. Whether directed outwardly or inwardly, adolescents exhibit affect and object hunger for states that bring exuberance, elation, pain and/or anguish.

In general, adolescents are confident that they have achieved independence from the love and hate objects of their

childhood. After their "selves" are flooded with the forces of the narcissistic libido, adolescents begin to overestimate their powers of body and mind. Moreover, these feelings of "omnipotentiality" have a negative effect on reality testing.

Adolescents' resistance to regression can take many forms. The drive for independence and self-determination in action, however, can become violent and reckless when the regressive pull is extremely strong. For instance, Blos (1967, p. 174) observes that children who were extremely clinging and dependent during childhood switch to detached distance from parents during adolescence. Unfortunately for most adolescents, that detachment is illusory. As stated earlier, it represents a "reactionary" circumvention of the individuation process that only gives the appearance of independence.

Adolescent object hunger and ego impoverishment are transient developmental conditions that are satisfied in the group, the club, the gang, the coterie and peers in general. Groups often literally serve as a substitute for adolescents' families in that they provide "stimulation, belongingness, loyalty, devotion, empathy and resonance" (Blos, 1967, p. 169). Further, groups provide an insular social envelope that enables adolescents to establish their individual, social and sexual identity. However, if peer group relationships merely replace childhood dependencies, then the group has not served its function.

Whatever the peer group may be, it does not necessarily serve the needs of its members in an egalitatian way. The

shift from object libido to narcissistic libido--from object to self--is reflected in adolescents' proverbial self-centeredness and self-absorption both inside and outside of the group.

The major implication of the second individuation process--adolescence--for general clinical practice is that regression is a psychical process that can serve progressive development, drive maturation and ego differentiation. It is reasonable to assume, asserts Blos (1967) that adolescents who frequently surround themselves with pictures of idolized "stars" and public figures not only repeat childhood patterns that gratified narcissistic needs, but simultaneously seek family-like "membership through participation in various symbolic, stylized" (p. 175) and tribal rituals with peer groups.

In conclusion, it is apparent that the adolescent development process is characterized by a dialectic two-way reciprocal interaction between primitiveness and differentiation, and regressiveness and progressiveness. Each opposite draws its energy from the other, creating a tension, if not synthesis, that is responsible for the many variations of success and failure in the individuation process. If regression takes its proper course at the appropriate time within the adolescent process, it serves to stimulate progress, growth and development.

CHAPTER IV

ERIKSON AND BLOS: A CLINICAL APPLICATION

Introduction

To demonstrate how the theories of Erikson and Blos are applied to clinical analyses involving adolescents, the following section focuses on a series of letters written over a six month period by Mary, an 18-year old girl who voluntarily terminated from the observed adolescent group.

The first part of this section introduces Mary, providing a brief background of her case. The second part analyzes her letters using six out of the seven clinical symptoms identified by Erikson (1968) as necessitating psychotherapeutic intervention. The third part presents a specific analysis of Mary's letters. The fourth part integrates Erikson's and Blos' theories with the case material of the letters. Finally, the fifth part describes how Mary benefited from the adolescent group.

Mary: A Brief Background

Mary lives with her father and stepmother. Normal anxiety regarding going away to college (separation) is intense. As a consequence of feeling emotionally abandoned and rageful towards the natural mother, she is unable to resolve the introject of the early mother-figure. As a

result, there is an overidealization of the stepmother. Despite occasional overwhelming feelings of depression and anxiety, there is also good ego strength, particularly in the area of intellectual achievement and taking responsibility. However, Mary's suppressed rage at her mother interferes with her ability to feel comfortable leaving her stepmother, leaving the "group-as-mother" and the group as surrogate family.

The group has attempted to help Mary "mourn" the fantasized good mother she never had. In Winnicott's terms, the group can be viewed as a "transitional object" serving the goal of separation-individuation. Similar to the toddler's need to touch base with mother, Mary continues, now that she has left the group, to correspond with the therapists and group members.

Erikson's Clinical Symptoms and Mary's Case

Of the seven clinical symptoms, or pathonomic signs of severe identity confusion, cited by Erikson (1968) as necessitating psychotherapeutic intervention, Mary has six.

In letter #2, the first symptom--a fear of a loss of self--is most evident. Mary expresses her inability to stabilize her extreme mood fluctuation to the point where feelings of panic and terror set in.

In letter #6, the second symptom--disintegration, a loss of inner continuity and sameness--is most evident. Mary

expresses anxiety about losing impulse control, feeling suicidal and her sense of self becoming hazy (i.e. when she goes off to school).

In letter #6, the third symptom--diffusion of time orientation--is somewhat evident. As a consequence of her extreme parental dependency, Mary perceives time spent away from parents as extremely long and time spent with parents as extremely short.

In letter #3, the fifth symptom--fear of closeness, or intimacy--is most evident. As a consequence of her experience with her mother, Mary associates closeness with emotional abandonment.

All the letters indicate her feeling of powerlessness--the sixth symptom--to control herself and others. Although Mary expresses a brief period of omnipotence in letter #2, in other letters she revisits the powerlessness, depression and anxiety she felt when she first entered the group. Her difficulty in developing a distinct sense of self is indicated by her use of the lower case "i" in all of her letters. Another aspect of the sixth symptom--suicidal wishes--is clearly evident in letter #6.

In letters #1, #2, and #4, the seventh symptom--a heightened sense of isolation--is most evident. Mary expresses anxiety about missing her family and loneliness.

A Specific Analysis of Mary's Letters

Letter #1

"i can't wait for my parents to come back from their trip because I know they'll come visit and take me out for a good meal. It has been hard not having them home. i wish that i could just call them up and talk with them. It would be really comforting to get some encouragement from them when i need it--like now! It is hard to be on my own. At times i feel so strong--i don't think anything could stop me; and at others, i feel so weak and lonely. i wish i could be home again, in my own bed and in my own room (where i am safe from everything!) i hate it here! i miss being at home and being involved with what's happening in my family. i know i'm not that far away but it feels as if i am. i want to be there--i wonder if they even miss me."

The above was written by Mary to the therapist two weeks after arriving at college for the first time. It exemplifies Blos' description of the second individuation process and is reminiscent of the rapprochment sub-phase of the first separation-individuation stage described by Mahler. The regressive pull is very strong--to feel safe and and to not have to face the pain and struggle of being independent.

Letter #2

"One of the things that i am struggling with still is my extreme fluctuation of moods. At times, like the past weekend, it seems as if everything is working out perfectly. i am flying as high as a kite and nothing can bring me down. i am enjoying my friends, having fun and feeling strong and confident. While at other times i fight desperately to keep myself together. i become weak and totally defenseless. That horrible feeling of emptiness sets in.

> Often i become homesick and realize that there is no one here to look out for me but myself. Being in the state that i'm in i find it hard to care for or be gentle with myself and i panic! (Like last Sunday when i was feeling so lonely and scared and i didn't know what to do so i called Elaine.) i hope that in time i can learn to control my emotions as the feeling of not being in control scares the hell out of me."

This graphic description of the mood swings, ranging almost from euphoria to depression, is typical of this stage of life. At times, Mary feels omnipotent, capable of tackling the world and being able to take pleasure in social activities with a sense of self-confidence. However, this seems to function like a facade. Mary's mood changes--from omnipotence down to a feeling of total helplessness--give an indication that there is no substance within her to sustain and comfort her. Thus, she turns to thoughts of home and reaches out to touch base with the therapist. Mary's inability to stabilize the extremes of mood fluctuation, or intense feeling states, brings panic to the point of terror.

Letter #3

> "First of all let me thank you for making yourself so available for me while i was home. Seeing you the two times that i did were very important to me in that they reassured me that i still have some sort of a connection. Although i was home for longer than two weeks i decided that i would not see you (as much as i wanted to--and thought it could be helpful) more than twice as i knew that i would be getting too involved and before i knew it, it would be time to leave again. Saying goodbye is just too painful for me, so i chose to take the easy way out. Being in group on that Tuesday was also an important experience for me. i think that what it did was end things for me. While at school, i was constantly thinking about the group. Part of that was

> out of anger--just when i began to use the group and get something out of it, i had to leave. The other part was out of concern. i was wondering how everyone was and how their situations were working out. i realized while i was there, that i really didn't belong anymore. It made me sad in a way and scared as well. But it also made it clear that it is time for me to move on."

The ambivalence about feeling close to the therapist becomes clear because, as with her relationship with her mother, closeness is too threatening. In Mary's experience of feeling abandoned, closeness has become associated with loss. For her, the group's meaning and importance emerges as the "transitional object" described by Winnicott. While away from the "group-as-mother" there is the longing to return as indicated by Mary's fantasizing of what takes place in her absence. Upon visiting the group, she realizes that, in fact, she has moved on. While she is able to mourn the loss of the group, Mary is still fearful about her ability to sustain herself without its support.

Letter #4

> "Another reason why it was so hard for me to leave is because i was home for such a long time. In the month that i was home i got used to being there again, having people watch out for me and be there when i need for them to be. It got too comfortable. Now i am back, and on my own again, i have to look out for myself and to be honest, i'm not sure if i have enough strength right now to do that."

Spending Christmas vacation at home for a month brings Mary back into the dependent role and makes it more difficult for her to separate and leave home. She has not as yet

achieved sufficient feelings of self-confidence in her capacity to self-nurture. In addition, the regressive pull she feels results in some ego weakness. However, Mary does not question this ability by declaring "I do NOT have the strength." Rather, she expresses her uncertainty by saying, "i'm not sure."

Letter #5

> "It took a great deal of strength and energy for me to make the trip to visit my mother last weekend. As i'm sure you could tell, i was disappointed and extremely frustrated with the results of my endeavor. Before attempting the journey, i had myself believing that this time, things would be different. i thought i had an understanding of the situation. i thought i had come to terms with the situation. But apparently i was wrong, i haven't! Now i am back again exactly where i started out...ugh!
>
> On a number of occasions you have told me that i need to give up my ideas, hopes and dreams of her being the mother that i want her to be. This time, i honestly thought i had. i went into it with a completely different frame of mind than ever before. i was doing this for her, spending time with her and at all costs to myself avoiding a confrontation--i held everything back. Yet i still came out of it hurt and angry. i know that means i haven't changed. What did i do wrong!?! i am beginning to wonder if i'll ever be able to deal with her. At times like this it becomes so tempting to just tuck it all away and not deal with any of it. i know that i can't and that too is frustrating to me. i am lost somewhere in the middle and i don't know what to do next."

A visit to the emotionally abandoning mother evokes considerable frustration, disappointment and despair in Mary. She is not yet ready to give up the wish for the Ideal Mother, or not ready to come to terms with, or accept, her mother as she really is. Thus, she has not yet given

up this fantasy.

Letter #6

> "...then he gives me a prescription for muscle relaxers and tells me to come back in a month (this time he gave me a prescription for 100, refillable 3 times!). i call it my 'ticket to paradise' it seems as if it's become almost comforting for me to know that its all right there at my disposal. At the same time i worry about losing control one time too many and turning to the pills as an unrealistic option. i guess i just don't know how much i can trust myself.
>
> ...it was so easy to fall into 'my place' while i was home. It was as if i had never even been gone. i felt so needed and so looked after while i was there. i had such a hard time leaving on Sunday! i caught myself feeling more and more detached as the afternoon went on and i realized that i'd have to be leaving soon. It was scary as i felt myself slipping into my old ways. The strangest part is that i'll be going home this weekend (i knew it then too) but it didn't seem to make things any easier for me though. i can't understand why i've a need to cling so tightly.
>
> ...in general i haven't been feeling very strong. It seems as if even the littlest things have been tearing me to pieces. i have been on edge all quarter. i've been feeling so distant and unconnected. i'm here, but i'm out of it. Then i go home on the weekends--it feels so good, i get so excited but it goes by so quick--2 days just isn't long enough. i cling on so tightly then i have to let go...ugh!"

Anxiety about losing control of her impulses leads Mary to inform the therapist that she has felt suicidal. The wish here is for the therapist to take control for her and tell her to get rid of the pills. (In fact, this occurred in a phone conversation a few days later.) As the time approaches for Mary to return to college, her sense of self becomes hazy.

It seems as if she still has problems seeing herself as a competent, separate person outside of the parental environment.

An Integration of Theory and Case Material

Personality development depends on an individual's willingness to interact with a successively broader range of "significant individuals and institutions" (Erikson, 1968, p. 11). Mary, by her inability to differentiate and achieve individuation from her parents, and difficulty in remaining comfortable for significant periods of time with her peer group, impaired her own personality development.

When Mary came back to town during Christmas vacation, she decided to restrict her therapy sessions to only two over a one month period. Even though a major crisis occurred in her family--her father was hospitalized with a bleeding ulcer--she would not renegotiate her decision. The rigidity of her defenses against closeness, intimacy and losing her sense of self led her to set arbitrary limits on her therapy sessions.

Mary has difficulty finding solutions to problems and/or resolving conflicts primarily because she has not developed the necessary ego strengths that are the product of successful resolutions of significant conflicts earlier in her life. Further, throughout her adolescence, Mary has been hesitant to engage in "experimentation" to test various roles with

peers. While she occasionally sticks her toe into the water, she has not learned to really swim, or intermingle with peer groups.

Despite suffering from unresolved aspects of the first, second and third psychosocial crises in ego development, Mary was able to use her good intellect to benefit in the fourth crisis, latency. Though motivated and capable of responsibility, Mary lacks a constructive "I" that is consistent both with her earlier self-concepts and accomodative of her current "me" in reference to her peer group. Considering the fact that the adolescent therapy group was essentially Mary's first close and meaningful peer group experience, the previous constructive "I" had only one reference point--her parents.

Mary's problems are entirely consistent with Erikson's description of identity confusion--a feeling of uncertainty, ideological emptiness and social disconnection from significant peer groups. The fact that she has had only one boyfriend--recently, at that--gives some indication that her ego identity is not sufficiently developed to engage in the kinds of intimate relationships that characterize adulthood.

Since Mary has avoided behavioral experimentation--outside of school or work experience--during her adolescence, she lacks enough ego strength to stabilize and manage the precarious shifts between ego and id. That is, her inability to transcend the confines of her family, indicated by the persistence

of her emotional and physical childhood dependencies, preclude the healthy "selective overhaul" of her personality.

The trauma of being emotionally abandoned by her mother significantly influenced her character formation (Blos, 1962). As a consequence, amidst a powerful regressive pull, she developed a fantasy about her mother, refusing to accept the fact that the mother was less than Ideal. This was just one aspect of her inability to conquer her residual trauma, seen by Blos (1979, p. 183) as "identical" with healthy character formation.

There is little evidence in Mary's case that she has performed a comprehensive critical re-evaluation--through displacement--of the personal, social and symbolic values held by her parents. In other words, she has not come to terms with her family milieu. Instead of challenging the "family myth," the "distortion of the family history" (Blos, 1979, p. 185) that she abosrbed during childhood, Mary appears to wholeheartedly accept the "myth." Moreover, her motivation and ability to take responsibility may be more indicative of Mary's desire to be like her parents rather than to forge an independent identity and "move on." Mary's inability to disengage from infantile internalized objects precludes or hinders her chance of finding love objects that are not "restricted to simple replication and substitution" (Blos, 1967, p. 158). While it is healthy for adolescents to absorb the dominant character and lifestyle of their particular era, it

is not necessarily healthy for adolescents to wholeheartedly --and without question--absorb the dominant character and lifestyle of their parents.

Mary and the Adolescent Group

When Mary came to the group, she looked depressed and anxious. While she had difficulty making eye contact, Mary's self-critical attitude made her unable to accept a compliment without embarassment. She sat quietly in the group, eyes cast downward, waiting--as a child would--for someone to ask her about what was bothering her.

By the time of her final group session, Mary developed both a greater awareness of her problems and a desire to change her situation. Moreover, she tried to change her relationship with her mother. Rather than waiting to be noticed, Mary learned to really use the group by spontaneously introducing and discussing issues that were important to her. She learned to make eye contact and accept a compliment with less embarassment.

The group appeared to help Mary strengthen her sense of self. At times, however, she would lose some of her "inner continuity and sameness" (Erikson, 1968), depending on the stress she felt. Her ability to maintain eye contact also changed in relation to the stress she felt.

Ultimately, Mary learned to trust the group enough to "let go" and cry, a healthy emotional release for her depres-

sion and anxiety. The fact that she knew that she had a place to come helped Mary's ability to stabilize her mood fluctuations. She had recourse to come to group and/or call the therapist. In her later sessions, Mary readily took suggestions from the group, particularly about being less self-critical.

CHAPTER V

TRAINING MODELS: AN OVERVIEW

The Diversity of Group Therapy Techniques

Although the field of group psychotherapy has a long history featured in thousands of theory articles, research studies and clinical reports, it has only recently attracted broad public interest. The proliferation of various marathon, encounter, sensitivity and personal growth groups beginning in the 1960's has attracted the media and focuses attention on group therapy as a whole (Dies, 1974).

Meanwhile, articles dealing with a variety of training techniques for group psychotherapists have continued to appear in the professional literature. The techniques discussed include didactic learning (Winder and Stieper, 1956) through lectures and readings; participant learning (Limentani et al., 1960) as recorder-observer; alternating therapist and observer (Jarvis and Estey, 1968); role playing exercises (Winder and Stieper, 1956); seminars and discusssons (Stein, 1963); apprenticeship learning vis a vis a co-therapist experience in an ongoing group (Block, 1961); and exposure to group therapy through audio-tapes, film and videotape (Berger, 1970).

In the more traditional therapy area, the advantages and disadvantages of these and associated derivative methods have been debated at length (Laken et al., 1965; McGee, 1968). As for more popular phenomena, the growing use of marathon, sensi-

tivity and encounter groups has concerned many (Bach, 1967; Yalom, 1970) regarding the credentials, adequacy and leadership skills of the group facilitators.

Mental Health Workers' Views of Theory and Training

Significant differences of opinion remain as to the efficacy of a number of methods for training group therapists. According to Dies (1974), the differences are probably related to identifiable factors such as level of clinical experience and specific professional affiliation. Since group therapy training is an area where none of the established mental health professions--neither psychiatry, psychology, nor social work--can lay exclusive claim, the biases and controversy can be attributed to interdisciplinary rivalries (Hunt, 1965).

To assess and clarify the separate effects of both professional identity and level of clinical experience, Dies (1974) completed a survey using questions about the importance and relative contribution of various group training models, theories, research and case study methods. He found that respondents systematically expressed a preference for training methods that involved direct therapeutic intervention combined with supervisory feedback. Other results confirmed the relationship between known interdisciplinary rivalries and attitudes toward specific approaches and techniques. For example, regardless of their level of clinical experience,

psychologists were uniformly negative in their assessment of insight-oriented approaches such as psychoanalysis and ego psychology for training group therapists. On the other hand, experienced psychiatrists consistently rejected the importance of behavioristic theories, so valued by psychologists. Reflecting the importance of the age variable, "inexperienced social workers were negative while their experienced counterparts were positive toward behavioristic approaches" (Dies, 1974, p. 73). However, both experienced and inexperienced groups of social workers favorably viewed the contribution of insight theories.

Dies' (1974) findings are consistent with current trends in the training of group therapists. Participants in group therapy training have increasingly insisted on group process workshops that stress group interaction and experiences. Strupp and Bergin (1969) have observed an increasing trend toward pragmatic and experiential learning in the training context. Their observation is significant in light of Dies' (1974) overall findings that less-experienced mental health workers favorably assess experiential learning and unfavorably assess insight-oriented theories. That is, reflecting the diversity of today's society, younger professionals are less willing to identify themselves with the dominant views, techniques and approaches of the analytic establishment.

While key methods of training group therapists may be based predominintly on insight-oriented theories, the implication here is that these methods would best serve their own

purposes if they assume a systematic and pragmatic approach that takes into account the diverse therapy backgrounds of participants.

Training Group Therapists: The Basic Models

The Didactic Seminar

The didactic teaching or seminar model--the most traditional of all models--relies on lectures, readings and/or discussions to provide a strong cognitive base. As the least involving and anxiety provoking of all the models, the didactic seminar attempts to provide a conceptual framework for understanding group dynamics, or how individuals are helped through group experiences. Many theorists and clinicians (Lakin et al., 1969) object to the singular use of didactic seminars, arguing that facilitating a therapy group is a skill that must be learned through practice. Considering the overall goals of therapist training, the singular use of an analytic group theory seminar, for example, is not particularly valuable. However, the didactic seminar serves as an effective method to supplement all other training models (Berman, 1975).

The Simulation Seminar

The simulation seminar is a variation of the didactic seminar that uses role playing exercises to enable trainees

to feel what it is like to be a patient and a therapist. This approach is most useful when the traditional lecture approach fails to convey affective issues or when other forms of teaching--involving patients or observational media--are unavailable. MacLennan (1971) has discussed the use of a variety of simulation situations which allow trainees to experiment in therapeutic and patient roles during 20 hour seminars in an academic setting. Lakin et al., (1969) outlines four role playing exercises used to deal with: (1) trainee expectations of therapist role; (2) trainee experience in the therapist role; (3) trainee experience in the patient role; and, (4) differences in the theoretical perspectives within observing groups.

The main disadvantage and danger of role playing is trainee competition and acting out if there is little or no atmosphere of mutual trust. However, if an atmosphere of mutual trust is established, simulation seminars can be a useful supplement to content-oriented coursework during the later stages of course meetings.

Process and Therapy Groups

Trainee participation in a group experience involving both cognitive and emotional elements is essential for high yield learning in group psychotherapy (Yalom, 1971). Berger (1969) asserts that an experiential, or "observant participation" (Yalom, 1971), enhances tremendously the learning

of individual and group process. First, trainees can broaden their perspective on the importance of group acceptance through their experience of the member role. Second, trainees can more readily understand the power of the group--as a small social system, or micro-society--to wound or heal. Third, through their identifications, dependency on and unrealistic appraisal of the leader-supervisor's knowledge and power, trainees can get a more clear idea of the limitations of therapists (Yalom, 1971; Lakin et al., 1969; Horowitz, 1968). That is, they see the struggle of an experienced group therapist, and as a result, maintain their expectations of themselves and their patients at a more reasonable level.

These groups assume many forms and raise issues worthy of further discussion. Woody (1971) describes a sensitivity group designed to help counselor trainees better understand themselves and their interpersonal styles. Grotjahn (1970) and Horowitz (1968) describe "group-as-a whole" Tavistock and Bion-Ezriel approaches designed to provide non-structural analytic group experiences. Finally, Saddock and Kaplan (1970) present their model of "personal group therapy" that is designed for psychiatric residents.

Aside from the question of where these types of group experiences fit in sequentially with other models, questions can be raised regarding the role confusion that may be expected by trainees. The main question that is raised con-

cerns whether trainees identify with patient, member or leader roles. Another question concerns whether trainees are being trained in group therapy, group dynamics, or to be a group therapist. There is a dual identification--teacher and therapist--that inevitably must be assumed by trainees. It is difficult to imagine trainees divorcing themselves from the teacher role within a group designed to further acquaint them with group process. Yet, if trainees assume a teacher-leader role in the process group, they are likely to be labeled and scapegoated by the "group as a whole" (Berman, 1975, p. 333).

Although Lakin (1969) expends considerable energy to rationalize why the trainee is not actually a patient in training groups, he curiously asserts that a major advantage of his group design lies in its ability to control maladaptive personality patterns. Thus, there are troublesome contradictions that result when one of the dual roles is discounted to the advantage of the other. Berman suggests that the best way to escape this quagmire is "to accept the notion that all education is therapy, and all therapy is education, and leave it be at that" (1975, p. 333).

Another major question is often raised around the issues of trainees' developmental readiness and coursework requirements to enter a group process at a particular time during the program sequence. Regarding the first issue, training programs can benefit from a flexibility in allowing trainees to choose their own time to be a therapy patient without out-

side ostracism. Regarding the second issue, theorists and clinicians are divided in the question of whether there should be voluntary or compulsory participation. While most training programs currently require group participation (Berger, 1969), others including Yalom (1971) and Horowitz (1968)--citing the Menninger program--urge voluntary participation in order to optimize trainee motivation and learning.

However, Yalom (1971) argues against placing trainee-peers who will continue to work together in their training program in the same process group. If trainee-peers are placed in the same process group, Yalom and Hildreth (1971) caution that problems of competitiveness, complaining about the training program administration, low level risk taking (i.e. to protect ignorance or personal problems), passivity, dependence and intellectualization frequently result.

Observational Models

The observation of ongoing group therapy sessions is probably the most widely used training model. It occurs through the use of one-way mirrors, audio and/or videotape, or in some instances by having a trainee-observer function as a silent-recorder within the group (Berman, 1975). The most typical models of observation use a concept of "post-grouping," whereby leader-supervisors (therapists) and observers meet after the sessions to debrief each other re-

garding styles, techniques, problems and issues evident during the group session. Wolman (1970) notes that observers seem to experience a developmental sequence of identifications. Acting as supervisors, they may attack therapist-supervisors' techniques or reject them entirely. In another way, they may identify with patients or the therapists. During this process, it is important that observers be helped to better understand and cope with their affective reactions so that their psychotherapeutic approach evolves fully, rather than remaining stunted from the mere imitation of the model they observed.

Although the word "observation" connotes non-involvement, the observation model demands an active involvement and self-analyzing confrontation with what is observed.

Pre-dating Wolman's (1970) assessment, Krasner et al., (1964), and Levin and Kanter (1964) found that observers tend to identify with patients. This identification intensifies the transference and countertransference problems between observers and therapist-supervisors that is produced by the tendency of trainee-observers to assume a supervisory role in relationship to the therapist-supervisor.

The effects of observation on group patients, process and therapists vary in relation to a number of individual, supervisory program and situational factors. Goforth (1966) found that observation exerted a profound effect on group dynamics. Namely, there was an increase in defensive man-

euvers, requests for individual appointments with the therapist and in unannounced absences. Evidently the group harbored a hidden resentment toward the therapist for being aware of and bringing in observers, and toward the observers for not contributing. Thus, the therapist-supervisor's commitment is divided between training and therapeutic intervention.

While Fielding et al., (1971) also notes various effects on the therapist, he lists therapists' reactions to criticism, fear about revealing, personal pathology and exhibitionist tendencies as possible interfering factors. If the therapist is able to overcome inhibitions, minimize conflicts with observers, and strike an agreement with group patients (i.e. if observation interferes with the therapy group, it will be discontinued), then the group is likely to be more of a success (Bloom and Dobie, 1969).

The Problems of Observers: A Faculty-Observer Model

Observers, or trainees, commonly go through a number of phases in their reaction to the therapy (Goin et al., 1976). Initially, they may be awed by the abilities of the therapist-supervisor and consequently express doubts and anxieties about their own abilities. But as time passes, their criticism increases, fueled by doubts about psychotherapy and their chances of being effective. If the therapist is defensive, and there is harsh criticism by

observers, the teaching seminar may turn into a pointless argument.

Observers may become restless and bored as they project their own fantasies onto patients. According to Goin et al., (1976), "Good therapy is not necessarily good theatre, and once the initial voyeuristic excitement abates the demonstration can seem quite dull" (p. 116). Aside from lightening the tedium, observers' fantasies about patients' involvement express transference attitudes and reactions that are useful for discussion. However, like other problems mentioned, the fantasies can disrupt the seminar.

The Goin et al., (1976) model of teaching dynamic psychotherapy for residents in psychiatry uses faculty-observers --members of the teaching staff who are experienced psychotherapists--to challenge resident-observers to think about the problems they see and how they would handle them. While pointing out nuances of verbal and nonverbal communication, faculty-observers raise questions about the effectiveness, validity and/or consequences of an intervention. Thus, they help avoid the passive acceptance that is present in many observation seminars. In addition, faculty-observers help turn discussions by distinguishing realistic shortcomings or "countertransference reactions of the therapist from the emotional overreactions, transferences, or countertransference of the observers" (Goin et al., 1976, p. 117).

The teaching responsibilities of faculty-observers continues into the post therapy discussion. Since they know

the questions, confusions, interests and criticisms of the observer group, they can take the lead in facilitating group interaction, especially when residents are reluctant to express themselves. Combined with therapists, faculty-observers can demonstrate the link between theory and clinical practice. However, ideally they must respect and refrain from competing with therapists, and vice-versa. It helps when both professionals believe they have something to learn from each other. That forms the basis for a complementary relationship, as revealed by effective teamwork that includes the contribution of resident-observers.

The chief advantage of the demonstration psychotherapy seminar is that trainees can be relieved of unrealistic self-expectations through the "cinema verite" (Goin et al., 1976) approach of watching the struggles of an experienced therapist.

The Co-therapy Model

The co-therapy model, used as a supplement or independently, can enhance or hinder the dynamics and the learning experience for the training group. When the definition of the co-therapy relationship has not been adequately worked out, emotional needs and problems tend to surface more frequently. This is particularly true when one of the therapists is in a training capacity. "Junior" therapists may feel that insufficient attention is directed toward the co-

therapy model. They may feel competitive with the training group or identify with them. In any event, unless time is found for the co-therapists to explore and clarify their relationship and roles, there is a higher likelihood of difficulties being acted out during the training program.

Some of the issues that must be dealt with in the co-therapy model are status, sex roles, competitiveness, a desire to look good to the peers in the training group, and feelings of general insecurity in the role of therapist. Additionally, there is the issue of the different personality and styles of leadership that each brings to the co-therapy model.

Unless these issues are decisively dealt with, serious problems with the adolescent patients and with the training group can develop. "Co-therapy conferencing" during training group sessions provides an important learning experience for trainees and an arena for resolution of co-therapy issues.

Triadic Co-therapy

McGee (1968) advocates a triadic model of training involving the pairing of two trainees as co-therapists with an experienced therapist-supervisor. Since the trainees are completely responsible for the group, there is less opportunity for distortion in the retrospective reports used in the supervisory process. This assumes, of course, that there is no collusion between the trainees to dupe the supervisor.

The Clinical Case Conference

The clinical case conference, involving the supervision of trainees in groups of other trainees, is perhaps the most applicable supervisory model. Though similar in form to the didactic seminar, the content and the process in this model are related to the trainee's group experience. While the trainees' report on their roles as therapists, they experience their role as group members where anxieties, learnings and problems are shared. According to McGee (1968), clinical case conference is best applied in established therapy programs that feature many ongoing groups.

Dual Observation Models

Finney (1968) introduced a "double reversal group psychotherapy" model in which trainees initially observe a supervisor-led group session for 40 minutes. Then trainees are observed by patients and the results are discussed with the supervisor for 20 minutes. Finally, there is a 30 minute discussion between the supervising therapist, the trainees and patients.

The main advantage to this model involves its similarity in structure to actual therapeutic communities characterized by a mutual interdependence between therapeutic and training functions, and open communication between all members of the system.

Bern (Yalom, 1970) advocated an approach where supervising group therapists whose groups are observed through

one-way mirrors reverse the roles at the end of the meeting. That is, patients are allowed to observe while the supervising therapists and the trainees "rehash," or discuss, the group process.

Berkovitz and Sugar (1976) took this approach a step further, developing a model using a group of adolescents. In the first step of this model, six therapist trainees observed 90 minute group therapy sessions through a one-way mirror. After each session, as suggested by Bern, the observers and patients changed places. That is, the teen-agers observed the supervising therapist and trainees discuss the group process. After the fifth training session, both groups combined to discuss the whole group process. The combined meeting was suggested as a result of adolescents' frustration regarding the fact that they had to wait a full week before they could reply to comments made by observers.

Russ, Leader and Berkovitz (1976) developed the Berkovitz and Sugar (1976) model further for the purpose of training adolescent group psychotherapists. In this model, the two groups followed a pattern of changing places for the post-group session following the first three sessions. Whereas the trainees observed from behind a one-way mirror during the regular group session, the adolescents observed the trainees in the post-group session. The two groups combined during the fourth week for post-group discussions. Meanwhile, the 50 standard observation continued during the regular adolescent

group session. In order to enable the adolescent group therapists to remain exclusively responsible for their patients without conflicts of interest, a separate leader-facilitator was used to observe the trainees and lead post-group discussions.

Through this training model, Russ, Leader and Berkovitz (1976) aimed to increase both cognitive knowledge and affective empathic responses that are so necessary in therappists. Simultaneously, the model provided trainees with the opportunity to react in a limited way to adolescents while using supervision and teaching in an apprentice-like situation.

In their evaluation of an initial application of their model, Russ, Leader and Berkovitz (1976) discussed that a fusion occurred between trainees and adolescents. Compared to the Berkovitz and Sugar (1976) experience, the observers identified more strongly with the adolescents' anxieties and individuation strivings. Moreover, reflecting a mirroring effect, the trainees re-experienced the wish for parental protection and security rooted in their own character development.

Although Russ, Leader and Berkovitz (1976) expected the topics of trainees' discussions to parallel the process and, at times, the subjects of the observed adolescents, they were somewhat surprised when the mirroring effect also included the adoption of the overall therapeutic process. For

example, the trainees expressed their anger towards their female therapist's lengthy absence by criticizing her facilitative leadership with the adolescents. They criticized the training leader for the stringent rules in the joint post-group discussions. In addition, following the lead of the adolescents who acted out rebellious feelings toward authority figures, observers began to meet after the training to achieve the same kind of anxiety-relieving cathartic experience. Further, adolescents and trainees colluded in secret activity to discuss the group and other issues. Thus, towards the end of the training an almost parallel process could be observed between adolescents and trainees on a week to week basis.

Nontraditional Models

Over the past 15 years, a number of alternative models have been introduced that attempt to ameliorate the disadvantages of traditional models. Jarvis and Esty (1968) describe an alternate therapist-observer technique in which the trainee and trainer switch roles between that of therapist and observer. The objective in this model is to provide an opportunity "for shared responsibility and mutual observation of work between trainee and supervisor" (Berman, 1975, p. 340). As for the disadvantages of this model, Jarvis and Esty (1968) dismiss the possibility of one therapist getting "played off" against another or basic disruptions of group functioning.

The most unusual alternative appears to be Boyleston and Tuma's (1972) direct instruction model, or technique, in which trainees wear a receiver in their ears to receive immediate comments from supervisors. Indeed, advances in communications technology may encourage more techniques of this kind in the future.

CHAPTER VI

THE NEW MODEL

Group Therapist Characteristics

Even assuming a background in individual psychotherapy, the task of training group psychotherapists poses a considerable challenge. As distinguished from the process of one therapist working with an individual, Grotjahn (1949) discusses the special challenge and difficulties faced by group therapists. That is, group therapists must be constantly aware of themselves, the participants' interaction and their personal motivations and countertransference feelings during their facilitation of the group.

After viewing various training manuals, articles and books for training therapists, some theorist-clinicians assert that the main ingredient for a good therapist has more to do with common sense and an individuals' empathic ability to deal with the problems of others than that which is learned during a training program (Strupp, 1973; Alexander, 1963; Barrett-Lennard, 1962). Of course, even the finest of training institutes cannot wholly bestow common sense and empathy. But, effective training programs can provide trainees with the kind of theory-knowledge, clinical experience, self-understanding and interpersonal skills to qualitatively increase the use of common sense and empathy. In fact, the highly specialized learning that occurs in some training pro-

grams can provide trainees with a kind of "sense" that is far more than common.

The basic therapist requirements of this model--and adhered to by other experienced group therapists--are essentially the same as those suggested in the American Group Psychotherapy Association (AGPA) Training Guide. These are: (1) Group psychotherapists should have acquired a thorough knowledge of normal human development; of psychopathology and psychodynamics; of family dynamics, group behavior and culture; and of the different schools and techniques in group psychotherapy and group approaches. (2) They should be knowledgeable at the clinical level of principles of individual psychotherapy and in personality theory. (3) They should have experienced personal analysis or other psychotherapeutic techniques. (4) Participation by the group psychotherapist trainee in a psychotherapeutic group is considered necessary in helping the trainee further work out personal problems, especially those connected with difficulties in relation to peers and authority figures, as well as giving the trainee a firsthand knowledge of group psychotherapy. (5) Participation in a personal group training experience is considered essential. Additional training is considered necessary to work with children, adolescents and families.

Competent group therapists are characterized by the following qualities:

1. Sensitivity to their own unresolved emotional conflicts and consequent responses

2. Awareness of the subjective ways in which they react to specific events in the group

3. An increasing ability to understand patients in the therapy group

4. The ability to react and respond with empathy

5. The ability to identify with what they jointly experience with patients in the therapy group by selectively using their subjective responses to understand.

6. Adequate perception and knowledge of the interpersonal dynamics in the sessions

7. The ability to control their reactions and to determine when--and to what degree--to invervene in the interests of overall group functioning

8. The ability to tailor the expression of their interventions to suit the event, situation and/or needs of the individual member or the group

9. The ability to facilitate therapeutic group interventions that permit members to change outmoded, counterproductive or inappropriate patterns of behavior into appropriate behaviors that effectively deal with present day situations, yet remain consistent with their respective personalities.

10. The ability to deal with harmful interactions among group members

Adolescent Group Therapist Characteristics

Additional therapist qualities aside from the above--adapted from the list of characteristics by Walton et al., (1971)--are necessary to competently facilitate adolescent groups:

1. A specific awareness and alertness to detect countertransference tendencies and reactions in themselves

2. An understanding of past and current identity problems faced by adolescents in their interaction with peer groups and society as a whole

3. A sensitivity to the vulnerability of adolescents in their particular stage of development

4. A tolerance for the frustrations and lack of immediate positive results that is encumbent in the treatment of adolescents due to their emotional volatility and experimental behavior

5. A commitment to remain accessible--on call--to help adolescents resolve their frequent existential or behavioral crises

6. An awareness of the problems that can arise from therapist overidentification--to the extent even of being seduced into forms of adolescent experimentation. This particularly applies to younger therapists who may not have fully completed their own adolescence

7. A resistance to whatever elements of sexual seductiveness exist in adolescents

8. A consciousness of how easily therapists can take on parent nurturance roles, thereby setting up a competition with adolescents' parents

9. A willingness to be more self-disclosing about their feelings, more direct, and employ a greater sense of humor

10. A capability to function as a family therapist and/or to be available for family meetings

Perhaps more than other types of clinical practice, adolescent group therapy requires a comprehensive and meaningful theoretical framework. Since they are more vulnerable than their adult counterparts in therapy, adolescents need the freedom to experiment with forms of communication, problem-solving, decision-making, self-management and identification. During their process of emancipation from childhood ties and

ego differentiation from their parents, adolescents may require more substantive inputs from therapists. Thus, to most clearly understand the dilemmas faced by adolescents in an increasingly technological society, a systematic (i.e. including aspects of other psychotherapeutic approaches) psychoanalytic therapeutic framework for adolescents must be supplemented by an awareness of current social conditions and trends.

The Application of a Group Approach: A Qualification

The model introduced in this project is not meant to take the place of individual therapy. There are times when individual psychotherapy is a more appropriate treatment for adolescents. In short, the choice of therapy is contingent on the dynamics of adolescents' pathology and their particular stage of development.

The group approach is advantageous because it replicates somewhat the normal peer group relationships that happen during adolescence. The group can help isolated or withdrawn adolescents with a history of poor peer relationships perhaps dating back to the preschool stage. Although these adolescents may be terrified of structured peer group experiences, they can benefit most from participation in this area.

The Dynamics of The Training Group

The training of mental health professionals in groups confronts all the common themes which emerge in therapy groups.

It also has some unique characteristics. For instance, in no other group do concerns around the issue of competition and competence play such a pervasive role. Members often experience one another as competitors--they view each other as professional models against which they measure themselves. Their competence is a function of their personal integration in that they fear that revelation of perceived weaknesses or flaws will result in negative professional judgment from their peers.

Groups respond to this tension in several ways. The most common response is a tacit or open pact of equality. That is, the group denies any intermember differences and often bands together against the evaluatory menace of the hostile outside world and/or the group leaders.

Even though all of the members may have experience as group leaders or individual therapists, they do not always feel able to exercise these skills in the group. Instead, the training group--even more than most patient groups--often becomes dependent upon the leader to make even the simplest and most natural inquiries. There is a distinct confusion of roles. In this training group, members are neither "patients" nor "leaders," but are both. They become involved in their own feelings, yet must focus on process and learning. It's a difficult balance to maintain.

A Model For Training Adolescent Group Therapists

A Description of The Training Program

The basic program is presented as a three-part, 27-hour intensive training experience involving mental health professionals from a variety of backgrounds, disciplines and practice settings. The program is offered by the Thalians Community Mental Health Center, Cedars-Sinai Medical Center as part of its continuing education function as a community mental health center. The rapid development of a training group identity and cohesiveness is encouraged through a program structure and environment designed specifically for the training and facilitation of adolescent groups. However, the backbone of the training is the six week observational experience.

Participants accepted in the training area are at post-masters level. The illustrative material included in this project's description of the model derives from the ten trainees who participated in the Advanced Adolescent Group Psychotherapy Training Program at the Thalians Community Mental Health Center in Los Angeles in the Spring of 1979. All trainees had some experience working with adolescents in groups. Initially, they were requested to write a 1-2 page description of their adolescent group experience, theoretical orientation and issues of concern prior to the commencement of the training (see Appendix A). In addition, trainees are asked to bring a picture of themselves as ado-

lescents by the third session of the observation part. Generally, a package of relevant articles and reading materials is sent to trainees to be read, ideally, before the first lecture. When they attend the first meeting, the therapist-trainees receive an additional package of materials (see Appendix B).

The training is divided into three sections.

Part I: Didactic Presentations

Introduction

Part I focuses upon gaining an understanding of adolescent dynamics from the perspective of therapeutic work with adolescents in groups. Six hours of lecture and workshop participation are used to provide a theoretical overview of adolescent development and adolescent group psychotherapy. It includes the use of videotaped materials as well as discussion of required and recommended readings, group dynamics, techniques, acting out, transferences and resistances.

Rationale for Didactics

The trainees who come into the program have different levels and types of knowledge. Many of them do not have specific knowledge or experience with adolescent groups. The task of becoming an effective therapist with adolescents requires trainees to possess a specialized body of knowledge over and above the basic requirements for psychotherapeutic

practice. Thus, didactic presentations were deemed necessary.

The Two Didactic Sessions

The didactic lectures, or workshops, cover a broad range of theory and issues directly and indirectly related to the preactice of adolescent group psychotherapy (see Appendix C).

The first lecture explores the "Indications and Contradictions for Adolescent Group Therapy." In this session, co-therapists Elaine Leader, L.C.S.W., and Miguel Ramirez, L.C.S.W., use videotaped group sessions to illustrate issues of group composition, selection, process, cohesion formation, leadership styles, etc. In addition, the composition, dynamics and history of the current group are discussed in preparation for the observation experience.

To minimize the chances that trainees would be too fatigued to function effectively after a "long week," these didactic sessions are held on Saturday mornings from 9:00 A.M. to 10:00 Noon. This lecture also overviews "The Impact of Group Experiences on Adolescent Development."

In the second session, one of two outside guest lecturers --Walter E. Brackelmanns, M.D., or Irving H. Berkovitz, M.D.,-- lecture and lead the discussion of separation-individuation, narcissism, phases of adolescence, transference and countertransference.

A history of the adolescent group to be observed, including the group's selection, composition and dynamics, is pro-

vided. Confidentiality as it pertains to group members and observers is discussed as well as the use of adjunctive therapies. Yalom's (1975) curative factors are discussed to the extent they operate in various types of groups. In addition, the issues discussed include the following (see Appendix C for a more complete outline of lecture II):

1. Collaboration with other therapists
2. Being an observer and what it feels like to be observed
3. Parallel process between observer group and therapy group
4. Transference and countertransference
5. Comparison of normal with deviance in adolescence
6. Roles in the group

Generally, before the first lecture, the supervising co-therapists review the "mechanics of the program" with the trainees.

Part II: The Observation Experience

Part II is a six-week segment focusing upon the observation of an ongoing adolescent group composed of four boys and four girls between 15-18 years of age. Before and after each session, therapist-trainees meet with the group therapists to review occurrences affecting the adolescent group members between sessions, and to discuss group process, group techniques, etc.

There are six sessions in this part of the program (see Appendix D). The first session is intended to familiarize observers with the group. That includes increasing trainees' awareness of the effects of observation on the adolescent group and the effects of the observation on the training group.

The second session focuses on the co-therapy relationship. Particular attention is given to the purpose for having two therapists, one male and one female. For instance, they serve as behavioral-leadership models for respective male and female patients and trainees.

In the third session, the observers are divided and assigned individual group members to focus their attention. They are instructed to observe their subject for normality; individual psychopathology; individual strengths; the role their subject takes; and how individual goals are addressed in the group. In addition, they are asked to be aware of transference and countertransference issues in themselves as observers.

In the fourth session, observers are randomly assigned to observe different group members. A variation of this procedure involves asking the trainees to observe the adolescent with whom they would most like to work. On the positive side, this seems to elicit good material for countertransference discussions. On the negative side, problems can arise if all trainees select the same adolescent to observe. That is, if the training group focuses only on one or two adolescents, the ensuing discussion is not as comprehensive as compared

to when the group focuses on most or all of the adolescents.

Session five, focusing on group process, examines how the group functions as a substitute family and how it develops and expresses an identity. Trainees are encouraged to notice who in the group facilitates or inhibits the group process. Specifically, trainees are asked to observe the adolescent they would find most difficult to work with.

In session six, Yalom's (1975) curative factors are reviewed. The trainee-observers are asked to focus on when and where these factors occurred in the therapy session (i.e. Who facilitates, "therapists" or "patients"?).

Part III: The Review Workshop

Part III consists of a three-hour review workshop focusing upon the synthesis of all theoretical and experiential materials (see Appendix E). This workshop is perhaps the most dynamic part of the whole training experience. As termination of the training is discussed, the countertransference and parallel process is brought into the forefront. At this point, therapist-trainees have become attached to both the adolescent group and their own training group. This workshop explores therapist-trainees' feelings about the particular adolescents they identified with. Frequently, therapist-trainees express concern and curiosity about the future of the adolescents (i.e. "Let us know what happens to Mary"). Since it is difficult for the therapist-trainees to

detach from the adolescent group and the total training experience, they express regret at not being able to continue observing for a longer period.

Whereas faculty elicit criticisms of their leadership and of the structure of the training experience, they provide an opportunity for the sharing of unmet expectations by therapist-trainees. At the same time, the faculty acknowledges what they learned from the particular training experience, pointing out how their techniques were influenced by therapist-trainees' responses.

In the review workshop, trainees are asked to reply to variations of the following questions:

1. What did you get out of the program? What was most meaningful and what stood out as the main emphasis of the training program?

Responses to Question #1

> "Despite the fact that I've been doing groups for years, I still have this notion about the perfect group therapist. And you made mistakes. That really was one of the major benefits. Because I do tend to believe that that's somehow what I'm supposed to be."
>
> "Seeing that even with real experienced professionals, things didn't always go smoothly. I think you have to start with adolescents, where they are at. And go from there. The main emphasis I think in it for me, was in seeing other people and myself have to deal with the difference between expectations and what actually happens."
>
> "Observing how you actually do a group, and that everything doesn't have to have a set answer and/or therapeutic statement. It's really a whole process. That was just a validation--when you read stuff it makes it all sound so perfect and that doesn't have

to happen. The emphasis I would say....integrating the theory with the practice."

"Being able to observe and my not having the anxiety of being in the actual situation helped me really think through some ideas of how to intervene, when to intervene, and when not to intervene."

"Being able to see other people work with adolescents in a different way than I had experienced before. Listening to the whole group of people come up with a variety of ideas besides what we just saw here....Adolescents have...different problems, they require different ways of relating to them than the adult patients or children."

2. What do you see as the main issues in working with adolescents in groups?

Responses to Question #2

"Dealing with family issues in view of their growing up. Becoming independent and the conflicts around that. What might be getting in the way in terms of family or personal issues and having to tease that out."

"The fight for independence versus dependence. In your group I saw it much, much more clearly--that stood out for me more than in any adult group. Peer relationships. Trust. Sexual role identity."

"Trust. Which is behind almost all the others. The ability to be open. The need to relate to adults and each other for the adolescent. Fostering that climate."

"Issues of identity, emancipation, control, authority, sexuality."

"Basically, feelings about authority. Resistance. Wanting, fighting, independence--individuation."

3. What stood out at the beginning of the program as being most difficult in working with adolescent groups? And did the program address those concerns?

Responses to Question #3

"What has always been difficult for me regarding adolescents is how much to interpret, when to talk about feelings, and when not to. Things that can be real threatening to an adolescent, even saying the word "feeling." For instance, it was meaningful to watch the process of the group and observe the times when adolescent feelings were addressed. Just being able to think about that and actually see a group operating helped me think through those issues. It was explored in depth in the discussion group."

"One of the difficulties was understanding all the phases of adolescence theoretically. I didn't get a lot of that from the discussion but there certainly were some things to read that helped."

"I suppose its because of my lack of clear knowledge about how the group leaders create change in groups. And how they focus on and deal with home situations. Remaining in the here and now--the present--was the most difficult for me. At the time when I started the program, I was conducting an adolescent group. The training made me realize that remaining in the present was difficult for me. Afterwards, I felt more comfortable conducting my adolescent group."

"Countertransference issues working with adolescents. And I certainly did get involved in the discussion. I think countertransference got involved in a roundabout way through the group process of watching the group behind the mirror. Some of the comments indicate that strong feelings about the leaders' styles or members of the group were shared behind that mirror. Everybody got stirred up."

To the extent that the review workshop synthesizes the total training experience, it is the most meaningful to the therapist-trainees. In this workshop, they reflect upon their experience and examine ways of applying and adapting what they have learned to their own group settings.

Parallel Process in The Thalians Training Groups

In training adolescent group therapists, Goodman, Marks and Rockberger (1964) found the peer supervision group an excellent setting in which to bring into consciousness many of the binding images which interfere with the therapist's work. The peer supervision group often mirrors the complex of forces operative in the therapeutic group situation, and as such may be more immediately helpful than the didactic supervisory relationship, which is more appropriate in the individual treatment situation.

Unresolved problems of therapist-trainees often parallel those of adolescence and can be reflected in their therapeutic work. One significant aspect of the concept of parallel process in a training context is that alert and flexible therapist-supervisors can help their trainees to work out these unresolved past problems. However, an awareness of parallel processes can be imaginatively used to both illuminate problems that emerge during supervision and be a powerful vehicle to resolve the conflicts they produce (Ekstein and Wallerstein, 1972).

After observing the adolescent group, therapist-trainees are asked about how they felt as they observed in order to capitalize on the fact that the training group sometimes mirrors the adolescent group in terms of affect. Thus, the trainees were encouraged to observe the adolescent group and then discuss what they saw and felt.

Parallel process and countertransference reactions are pervasive phenomena that can occur at any time during the training process. Usually, the topics of the trainee's discussions will parallel the process and, at times, the subjects of the observed adolescents. The following example illuminates this process:

> One adolescent group member threatened to boycott the group during the observation period as possibly an expression of rebellion rather than a real objection. During the training group discussion, one trainee very strongly identified with this adolescent. What emerged then were feelings of frustration about being controlled by the discussion leader who had set rules of behavior for the trainees while they were seated in the observation room. The trainee, in identifying with the non-conformity of the adolescent group member, was expressing the unspoken rebellious feelings of the trainees against the authority figures of the supervisor-therapists.

The Effect of Group Observers

One of the factors that the teaching therapist must take into account is the effect of observers on the process of group therapy. As reported in the literature (Bloom and Dobie, 1969), the disadvantages vary according to the training type, learning situation and the supervising therapists. For example, the presence of the observing group can be used as a source of resistance by the therapy group. This has to be dealt with as does any type of resistance. Some investigators (Powdermaker and Frank, 1953; Kadushin, 1967) suggest, however, that spontaneous reactions and behavior may be facilitated by the presence of observers. In the training

program described here, the effects of the observing on patients are dealt with as another therapeutic issue.

One common effect is that the observing group's presence splits the responsibilities of the therapist. Martin et al., (1977) discuss how the group process in the therapy group and the group process in the observing group may sometimes be in opposition. On these occasions, the therapist must give priority to the therapy group. Simultaneously being a teacher to the observing group and a therapist to the therapy group, however, may lead to the choosing of an approach to the therapy group that fits the particular educational needs of the observing group. For example:

> Recently, in one of the post-observation discussion meetings, trainees expressed a wish for us to "work more with the process in the therapy group." The suggestion was made that trainees do further reading on group process and that we spend the following week concentrating on group process issues. In the following week's group therapy session, the therapists paid more attention to process, which was beneficial to the therapy as well as the training group.

When the observers and therapists come together to discuss what transpired during the therapy session, they are frequently in a highly charged and emotional state. As passive observers, unable to enter into the action of the therapeutic group to relieve inner tensions, the observers tend to be more distraught than the therapists. Compared to the observing group, the therapists may be relatively satisfied with what transpired during the group session.

While the contract between faculty and the trainees is considerably more educational than psychotherapeutic, the

emotional needs of the particular trainees affect their involvement in the whole process. Thus, the teacher may recognize and utilize transference and/or psychopathologic reactions to maximize the education, growth and development of the trainees. Or the teacher may choose to leave such material untouched so as not to upset the trainee.

In this training model, both the educational function and the intense transference/countertransference interactions are considered. In dealing with such dilemmas, group process interpretations that both involve and teach the training group are useful. An example of this occurred as follows:

> A trainee stated in one meeting that he was getting very frustrated with a particular adolescent. He then attacked the author for not expressing her frustration with the adolescent group member. Rather than directly interpreting the trainee's projections, the therapist asked the training group members what they were experiencing. The discussion that followed then allowed interpretation to the training group of their frustrations when the therapists seemingly rejected their ideas, much as the adolescent group member had rejected suggestions made to her by other group members.

Countertransference and The Thalians Training Group

The precarious situation of identity-seeking adolescents, and the form in which their conflicts emerge, revive hidden unresolved conflicts in the adults with whom they interact. The therapist's conscious or unconscious emotional reaction to the adolescent patient can be a most difficult variable to cope with in the course of treatment. That is, the empathic role of the therapist, coupled with a possible lack of aware-

ness of countertransference, or possible identification with the patient, may cause inner turmoil. Although the patient's problems may be similar to the therapist's problems, the therapists must not allow their own "sensitive areas" to impair the fulfillment of the therapeutic role.

Are the countertransference problems which arise in the course of therapy with adolescents different in degree from those formed in working with adults?

For most adults, certain aspects of adolescence are forgotten. Repression is much less successful in dealing with the unpleasant memories of this phase of development. Often there is an attempt on the part of the therapist to work through--perhaps unconsciously--those unresolved problems of adolescence which persist into adulthood. This forms the nucleus of many countertransference reactions.

An adolescent girl can use her newly awakened sexual awareness in an aggressive assault on a male therapist in a number of ways. Adolescent boys with their increased size and muscularity can challenge, and in the process possibly activate unconscious homosexual tendencies. It is important that therapists be made aware that unconscious fears of sexual assault and bodily harm often lead them to make aggressive counter moves toward adolescents in the group.

One factor that explains the increased countertransference problems of adolescent group therapists may be adult jealousy or envy of the adolescent's freedom from adult re-

sponsibilities. The adolescent has an ability to explore new experiences that are denied to the therapist as a result of age, role, convention, or just plain inhibition. Group therapy is a situation that facilitates the unconscious use of the adolescent for gratification of one's own unattained adolescent strivings. At the same time, the young person's ability to fool us, let us down or use us may then generate aggressive retaliatory feelings.

The countertransference problems arising in a particular group will be determined by the nature of the group, as well as by the training, personality and character structure of the therapist.

In the third observation week, although they are assigned an adolescent to observe, therapist-trainees inevitably tend to identify with one adolescent towards whom they have countertransference feelings. In the next week, they are asked to observe the adolescent they would find easiest to work with. Then in the following week they are asked to observe the adolescent they would find most difficult to work with.

The issues commonly dealt with in the training group go beyond those of countertransference. The memories and issues stirred up in therapist-trainees must not be held up to personal interpretation of their dynamics. Even without such intervention, some therapist-trainees elect to return to therapy as patients to resolve what was stirred up in them.

Although countertransference and parallel process happen all the time in virtually every conceivable situation, the

challenge is to capitalize on their occurrence in a positive and sharing way.

The Demystification of the "Therapist Expert"

Establishing a particular focus for each observation contributes to increasing trainees' awareness of counter-transference and their own unresolved conflicts dating back to adolescence.

At the beginning of each post-observation discussion, trainees are asked how they felt during the observation experience itself. In most instances, they respond by criticizing the therapists who facilitate the group. Instead of becoming defensive, the therapists admit their mistakes, vulnerability and human frailties in a way that demystifies them as experts. As in Goin's (1967) training model with the psychiatric resident trainees, the Thalians trainees tend to hold the supervising co-therapists in considerable awe at first. Later this respect gives way to more hostile reactions. Frequently, trainees arrive with idealistic attitudes that there is some perfect "therapist expert" who can teach them all they need to know.

It is important that such authoritarian myths about therapists be dispelled because they can negatively affect the facilitation of adolescent groups. Compared to other age groups, adolescents are more sensitive to adult-like authority and censorship. They need to be able to freely

express their views and have them accepted by their peers and the facilitator.

The Need to Maintain Contact

In individual therapy, the ex-patient occasionally remains in touch with the therapist by letters, visits and/or phone calls. However, when the group with a consistent therapist continues as an ongoing entity despite changes in membership, the chance for repeated useful contact becomes more feasible and immediately supportive. Some of the values of this continued contact can be viewed in terms of the concept of the group as a transitional object helping to bridge and support the change from reliance on the group-as-mother to a more autonomous identity and sense of self.

Therapists report that occasionally some adolescents, after a period of group therapy, seek continued therapeutic contact, such as intermittent attendance and periodic recontacting of the therapist and/or the group. This can be viewed as similar to the toddler needing to "touch base" with mother in the first separation-individuation phase (Mahler, 1972).

CHAPTER VII

SUMMARY, CONCLUSIONS AND IMPLICATIONS FOR PRACTICE

The purpose of this project was to present a model for training therapists to work with adolescent groups. A description and analysis of the format of the new training model emphasized how the learning experience is enhanced by the conscious utilization of countertransference and parallel process phenomena.

Underlying the premise that there are specific methods of training adolescent group therapists is the belief that the process of adolescent group therapy involves special skills, and that training can be devised to adequately teach these skills. In addition, the training model was structured to help therapist-trainees achieve a maximum awareness and understanding of the particular developmental issues of the adolescent stage of life.

The model introduced in this project, designed to enable intensive training of more than a select few, was developed and revised in practice over the past six years at the Thalians Community Mental Health Center, Cedars-Sinai Medical Center in Los Angeles.

The model represents an attempt to meet the specific need for more and better trained adolescent group therapists, and ultimately provide a socially useful and relevant training experience for all professionals and paraprofessionals who deal with adolescents.

It would not be an overstatement to say that adolescent problems are rampant in today's society. Beyond highly publicized gang violence, teen suicides and other negative abberations, there is a great deal of general information about the nature and extent of the many psychosocial problems of American youth. But there is far less in the offing about approaches--or attempts to ameliorate the problems--that may improve the psychodynamic and social situation of adolescents. A major area of concern in society is that the more serious criminal manifestations of adolescent problems have risen dramatically in recent years.

According to Erikson, today's technological society presents a significantly more formidable challenge to adolescents searching for identity than previous, less technological and more agrarian societies. Indeed, today's technological society has directly and indirectly increased the extent of dehumanization in society. On one level, the widespread use of machines or computers has directly decreased the overall amount of human interaction in society. However, anti-technology social critics seem to exaggerate how much machine use increases dehumanization. Machines, or computers, are tools that can extend human capabilities, not vice-versa. On another level--and more importantly--the widespread use of machines, or computers, seems to have increased the tendency of people to treat each other like inanimate objects, to increase their sense of personal power at the expense of others.

American society maintains a peculiar type of love-hate relationship with adolescents. While adolescents are frequently resented for their youthful powers (i.e. sexual), styles and opportunities, they are just as frequently emulated by the rest of the population. A considerable value is placed on being or acting young, a phenomenon that encourages teenagers to extend their adolescence well into adulthood, and adults to engage in adolescent forms of "experimentation." In a sense, the relationship between adolescent and adult behavior has become confused, if not interchanged at times. Today's extended period of adolescence poses a greater challenge to adolescents. It begins with earlier pubescence and is characterized by a longer economic dependence on parents, a consequence of the accessibility of higher education and competitive employment problems. On the other hand, family disruption, financial and/or other problems have forced some adolescents to grow up faster and prematurely perform adult roles (i.e. working to support the family) perhaps before they have achieved a full and distinct identity.

The identity confusion of some adolescents persists well into chronological adulthood, evidenced by their participation in various cults and/or alternative living groups. These young adults supplant their previous dependence--or unmet dependency needs--on parents with a strong leader, as in a cult, and/or family-type living group.

At the same time, many adults have decided to compensate for their adolescent period--perceived as inadequate--by regressing and indulging in various forms of experimentation (i.e. drug use). If this phenomenon was not widespread, Playboy Enterprises and other business concerns that address, or target, this "market" would not exist.

In short, today's technological society is characterized by extensive identity confusion in the adolescent phase of development. Adults with unresolved adolescent conflicts are prone to experience identity confusion in a way similar to that of adolescents in the second individuation phase, or fifth psychosocial stage, of development.

Therapist-trainees are not immune to the effects of harboring unresolved adolescent conflicts are not brought into awareness, they can negatively affect therapist-trainees' performance in clinical interventions and other areas. Thus, the model presented in this project is structured to maximize therapist-trainee awareness of countertransference and parallel process.

In traditional psychoanalytic circles, adolescents were not regarded as good therapy patients. Indeed, adolescents can be more difficult for therapists. But, adolescents have their own special needs that must be dealt with in therapy and other interventions.

To be sure, there is a shortage of adequately trained professionals, paraprofessionals and others who work with ado-

lescents. That may be related to the high incidence of adolescent crime (and prison recidivism), suicide, alienation and lack of goal directedness. In this regard, there is a shortage of adequately informed parents!

This model, while applicable to all disciplines, has particular significance for social work practitioners. This is because social workers, while traditionally having worked with adolescents, have not had the opportunity to avail themselves of this kind of training experience. Not only are the training groups well attended by social workers but both therapist-instructors are clinical social workers themselves.

An effective program to train adolescent group psychotherapists can have far reaching positive effects on society. Moreover, mental health workers ranging from psychiatrists to probation officers can be trained to more specifically meet the needs of adolescents.

As stated in the opening section of the final chapter, it is important that practicing therapists--and other professionals, paraprofessionals and workers for that matter--acquire or use special sensitivities to deal with adolescents.

The group approach can be helpful to adolescents whose problems vary from the most serious to the most benign since it provides a safe arena for communication, peer group identification, social support and personal feedback.

This model is structured to train not only psychothera-

pists but to be adapted to train the following groups of professionals, paraprofessionals and others who regularly interface with individual and groupings of adolescents:

1. Teachers and other school personnel
2. Law enforcement, including police officers, probation officers and the juvenile justice system
3. Industry--the effective and healthy management of adolescent personnel
4. The armed forces--administration for and training of adolescent recruits
5. Medical personnel--training physicians, nurses and others
6. Youth workers (i.e. neighborhood, religious camp, conservation corps, boy/girl scouts, gang intervention, non-gang related street workers)
7. Organizations dealing with cult de-programming
8. Social welfare and child placement, including child care workers
9. Sports coaches and recreational leaders
10. Advertising agencies, television producers, filmmakers and other media professionals who use adolescents
11. School bus drivers

Each of the above groups represents a major area of application and/or future adaptation of the model for training adolescent group therapists presented in this project. Although tempting to pursue, the time and space limitations of this project do not permit an explication of the dynamics of applying the model to each of the above groups of professional, paraprofessionals and others. That task will be

accomplished infuture articles and/or research.

If adolescents are to effectively carry their generation and society into the future, their problems of emancipation, individuation and identity confusion must be competently addressed. Aside from the training model presented here, there are other areas of undergraduate, graduate and vocational education that need to more competently address the challenging and exciting period of adolescence. Hopefully, this project will stimulate further investigation and concern about key issues of adolescents.

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APPENDIX A

APPENDIX A

CEDARS-SINAI MEDICAL CENTER

Reply to:
Box 48750
Los Angeles, California 90048

Direct Dial Number:

Dear Colleague:

We are pleased to accept you in our Training Program for Adolescent Group Psychotherapy commencing March 17, 1979.

In order to provide a meaningful training experience we are asking each of you to please submit by March 8, 1979, a one-two page description of your experience, if any, in working with adolescents in groups. This should include the following:

1. Your theoretical orientation
2. Classification of your leadership style
3. Age range and number of members in your group
4. Length of time you have been leading your group
5. If you have a co-therapist, his/her orientation style, etc.
6. What materials from your group sessions you would like to present for discussion. (This might be from a single session or over a period of time.) Presentable video tape material may be included.

Enclosed is the schedule of meeting times* and Bibliography.

Looking forward to your participation.

Sincerely yours,

Elaine Leader

Elaine Leader, LCSW
Coordinator
Training Program for Adolescent Group Psychotherapy
Thalians Community Mental Health Center

EL:it
encs.

*Parking will be available in the Thalians' parking lot for Saturday meetings.

CEDARS-SINAI MEDICAL CENTER

Thalians Community Mental Health Center

Presents

ADOLESCENT GROUP THERAPY

Starting March 17, 1979

Saturday, March 17, 1979
Workshop:
9:00 A.M.-12:00 Noon
Room E226

Indications and Contraindications for Adolescent Group Therapy: Elaine Leader, LCSW, Miguel Ramirez, LCSW. Video taped group sessions will be used to illustrate issues of group composition, selection, group process, developing cohesion, styles of leadership, etc. The composition, dynamics and history of the current group and preparation for observation experience.

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Saturday, March 24, 1979
Workshop:
9:00 A M.-12:00 Noon
Room E226

The Impact of Group Experiences on Adolescent Development:
Irving H. Berkovitz, M.D., Elaine Leader, LCSW, Miguel Ramirez, LCSW
Issues of separation-individuation, narcissism, phases of adolescence, transference and countertransference.

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Saturday, May 24, 1979
Review
9:00 A.M.-12:00 Noon
Room E226

Integration of Training Experience with Participants' Practice Setting
Irving H. Berkovitz, M.D., Elaine Leader, LCSW, Miguel Ramirez, LCSW
Varities of groups according to setting, population, task and structure; integration of group with individual and family treatment; co-therapists, etc.

Bibliography

1. Group Counseling and Psychotherapy with Adolescents, B. W. MacLennan and N. Felsenfeld, Columbia University Press, 1968, esp. Ch. 5, pp 134-163.

2. Combined Family and Group Therapy for Problems of Adolescents: A Synergistic Approach, D. Mendall, pp 231-247 in the Adolescent in Group and Family Therapy, ed. M. Sugar, N.Y. Brunner/Mazel, 1975.

3. Adolescent Group: "A Must" on a Psychiatric Unit--Problems and Results, F. Blaustein and H.B. Wolff, pp 181-191 in Adolescents Grow in Groups, ed. I.H. Berkovitz, Brunner/Mazel, 1972.

4. "Playing It by Ear" in answering the needs of a group of black teenagers, D. B. Stebbins, pp 126-133, ibid.

5. "Turning On" The Turned Off: Active Techniques with Depressed Drug Users in a County Free Clinic, P.A. Slagle and D.S. Silver, pp 108, ibid.

6. When Schools Care; Creative Use of Groups in Secondary Schools, ed. I.H. Berkovitz, N.Y. Brunner.Mazel, 1975.

7. Mintz, E.E. Male-Female Co-therapists in American Journal of Psychotherapy.

8. McGee, Thomas F. and Benjamin N. Schuman, The Nature of the Co-therapy Relationship, Vol.20, No. 1 1970, pp 25-36, American Journal of Psychotherapy.

*Recommended to be read prior to workshops. Some books and articles are available on reserve at the Thalians' Library, Room E205.

APPENDIX B

APPENDIX B

ADOLESCENT GROUP PSYCHOTHERAPY TRAINING PROGRAM
CONTENTS OF PACKETS GIVEN TO TRAINEES AT LECTURE-WORKSHOP I

I. Bibliographies (If not already mailed)

- A. Lecture outline with bibliography
- B. Bibliography
  1. Specifically about groups
  2. General works about adolescence

II. List of Participants

III. Group Recording Forms

- A. Cedars-Sinai group psychotherapy contact sheet
- B. Record of family/group therapy session

IV. Reprints (If not already mailed)

- A. Berkovitz, Irving, "On Growing a Group: Some thoughts on Structure, Process and Setting" Reprinted from Adolescents Grow in Group, ed. by Irving H. Berkovitz, M.D., 1972, Brunner/Mazel, Inc., New York.
- B. Berkovitz, I. H. and Max Sugar, "Indications and Contraindications for Adolescent Group Psychotherapy" Reprinted from The Adolescent in Group and Family Therapy, ed. by Max Sugar, M.D., 1975, Brunner/Mazel, Inc., New York.
- C. Berkovitz, Irving, "Expression and Understanding of Anger in Adolescent Group Psychotherapy" Presented at Annual Meeting of the American Academy of Child Psychiatry, Houston, Texas, October 20, 1977.
- D. Martin, Peter A.; Tornga, Muriel; McGlorin, James F. Jr.; and Steven Boles, "Observing Groups as Seen From Both Sides of the Looking Glass" in Group, 3 (Fall 1977).

E. Pumpian-Mindlin, E.,"Omnipotentiality, Youth and Committment," Journal of the American Academy of Child Psychiatry, 1965.

F. Judd, L. L., "The Normal Psychological Development of the American Adolescent: A Review," California Medicine, 1967.

G. Blos, Peter. "The Second Individuation Process of Adolescence," The Psychoanalytic Study of the Child, 22 (1967):162-186. New York: International Universities Press, Inc.

V. Program Evaluation Questionnaire

VI. Adolescent Group Roster

VII. Facts About Thalians Community Mental Health Center

APPENDIX C

APPENDIX C

PART I OF TRAINING MODEL: OUTLINE OF MATERIAL COVERED IN DIDACTIC WORKSHOPS I AND II

Introduction of Staff and Trainees

A. Sharing of background experiences with adolescents

B. Videotapes of group sessions are shown to give focus to discussions

I. Theoretical Overview of Adolescent Development

A. Contributions of:

1. Mahler

2. Blos

3. Erikson and others

B. Statement of our theoretical orientation

II. Selection For Group

A. Indications and contraindications

B. Screening and evaluating potential new group members

III. Adjunctive Therapies

A. Such as individual, family, etc.

IV. Confidentiality

A. As it pertains to group members and observers

V. Collaboration With Other Therapists

VI. Transference and Countertransference in Working With Adolescents

A. Including preparation for bringing in photos of selves as adolescents

VII. History of The Group Including Continuing Group Contacts

A. Visits to group by old members

B. Reunion party

VIII. Current Composition of The Group

IX. Yalom's Curative Factors As Follows:

A. Imparting of information

B. Installation of hope

C. Universality

D. Altruism

E. The corrective recapitulation of the primary family group

F. Development of socializing techniques

G. Imitative behavior

H. Interpersonal learning

I. Group cohesiveness

J. Catharsis

K. Existential factors

X. Being An Observer And What It Feels Like To Be Observed

There will be an experiential opportunity as trainees will be taken up to the observation room and will take turns being observed.

XI. The Following Areas Will Be Focused On During Observation of The Group and in the Pre and Post Discussions:

A. Roles in the group.

B. Transference and countertransference

C. Co-therapy relationship and leadership styles

D. Individual dynamics and how they are expressed in the group

E. Examination of goals for specific group members, how do trainees see them being worked on, or not, within the group context

F. Comparison of normal with deviance in adolescence. How is this expressed in the group?

G. Curative factors. How do you see them in the group? When and where, by the therapist, by the patients?

H. Examination of group process in dealing with group deviation and distraction, as well as development of cohesiveness and group identity

I. The group as a substitute family--corrective emotional experience

J. Group imago and imago for each group member

K. Identification by observer with group members, with particular attention being paid to observers' own adolescent experiences

L. Where is the evidence of group cohesiveness and group identity--how is it expressed within the group

XII. Exploration of Parallel Process Between Observer Group and Therapy Group

XIII. Themes In Adolescent Group

A. Examples

1. Separation

2. Confidentiality

3. Trust and distrust

4. Family dynamics

5. Sexuality

6. Friendship and peer relations

7. Creativity

8. Emotionality, particularly depression

XIV. Leaving The Group

A. Who decides--patient or therapist?

B. How is this handled ?

APPENDIX D

APPENDIX D

OUTLINE FOR DISCUSSIONS DURING OBSERVATION EXPERIENCE

SESSION I

This session will be devoted to observers becoming familiar with the group, its members, purpose, the effect of the observation on the group and the effect of being the observer on the training group.

SESSION II

A. Co-Therapy relationship

1. Purpose of having two therapists particularly male and female co-therapist as:

   a. models

   b. examples for problem solving

   c. how they support one another or disagree--and effect on group

   d. role of the therapist within the group process

   e. style of leadershop

SESSION III

The observers will be divided and assigned individual group members upon which they will focus during the observation of the group. They will be instructed to particularly look for the following:

1. Individual psychopathology
2. What is normal
3. Strength of the individual group member
4. What role does this member take in the group
5. Examination of individual goals and how they are met or not within the group
6. Transference and countertransference
7. Identification issues and countertransference issues of the observer

OUTLINE FOR DISCUSSIONS DURING OBSERVATION
Page 2
Continued

SESSION IV

There will be a reassignment so that observers will be assigned different group members to focus on during observation of the group therapy session.

SESSION V

This session will focus on group process and will examine the following:

1. The use of group process as:

   a. substitute family and corrective emotional experience, development of group cohesiveness and how this is expressed, both overtly and subtlely, verbally and nonverbally

   b. the group identity, how this is expressed, verbally, nonverbally.

   c. who in the process facilitates or inhibits group process

SESSION VI

A. Curative factors in the group

We will review again Yalom's Curative Factors in the prediscussion. Observers will be asked to focus on when and where these are occurring in the therapy session and who facilitates, therapists or patients.

APPENDIX E

APPENDIX E

TRAINING MODEL: PART III

Outline of Review Workshop

Integration of Training Experience With Participants' Practice Setting

I. Synthesize total training experience

II. Feedback to faculty regarding whether expectations were met or not met of the training

III. Summary of the parallel process and counter-transference phenomena experienced by trainees

IV. Relevance of training to trainees' own practice

V. Examination of ways to incorporate, adapt and implement learning to trainees' own settings

VI. Termination from observing adolescent group and from training group

VII. Feedback from faculty to trainees of the contribution of trainees to their (the faculty's) learning

VIII. Examination of relevance of reading materials to the training experience

IX. Examination of what was most meaningful to trainees about the training experience

X. Integration of group therapy with other treatment modalities, (individual, family, etc.) and collaboration with other therapists involved with the patient (i.e. total case management)

XI. Trainees complete evaluation forms

Elaine Lipert Leader PDE Ph.D. 1981