The Adolescent Journey by
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Leah, a bright fourteen-year-old, was failing several of her ninth grade subjects. She had been a straight-A student before this year. Both the school personnel and her single-parent mother were alarmed, and required Leah to be in psychotherapy. Leah, however, claimed to be indifferent about her grades and totally uninterested in treatment.

"What's the point?" she queried. "Ninth grade doesn't mean anything. No one looks at these grades."

Her mother came to see me first. A number of the school personnel called next. I counseled Leah's mother to tell Leah that I had heard from her mother and heard from her school, but really needed her point of view to understand what was going on.

Leah breezed in a few days later, five minutes late for her appointment.

"Am I late?" she asked, as she sauntered in, plugged into her Walkman.

"A few minutes," I responded, as I showed her into the consulting room.

"So, what's up?" she said, as she plunked herself onto the chair, folding her feet under her body as she sat down.

"I was just about to ask you the same question."

"My mother thinks I have to come here; my school is on my case, too. Personally, I see no reason for it."

"Well, what's it like having people pressing you this way?" I asked.

"It sucks. It's claustrophobic. I feel like screaming when I think about it...I don't really know what to talk about."

"You can talk about anything you want here — and it's just between us. The only exception would be if I were concerned about your safety for some reason."

"Oh, I'm fine. I'm just really bored in school and really sick of everybody being in my face about my homework and grades."

"That sounds like a good place to start"

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And so treatment began. It started with Leah's late arrival and her announcement to that effect. She was signaling both of us that she felt behind the times. Though the age of many girls entering middle adolescence, this daughter of 60's throwbacks was in no way ready to be part of her peer group's dating, parties, and school focus. She was late, developmentally, and trying to put a halt to her forward progress.

Leah had been brought up on a commune in which sexual promiscuity, chaos, and alcohol and drug use were commonplace. Her father, whom she adored, left the commune with a twenty-two year-old daughter of friends when Leah was eight. She and her mother left soon after. Leah had never heard from her father again. Rumor had it that he left the country; he sent a copy of a Mexican divorce agreement to her mother via mutual friends at the commune.

It seemed clear from our first contact that Leah needed to talk to an interested, dependable, informed adult about what her life was like. Her mother

harbored tremendous antipathy toward her father, which she voiced to Leah with great regularity. Her mother also let Leah know that there was a great fatherdaughter resemblance: both were bright, funny, music lovers. Leah's mother had come from a very different background from her former husband. He was an upper middle class, college-educated man who grew up in a city; she had been from a poor, rural family and had received a high school education.

Leah had never been able to mourn her father comfortably, identify with her mother, or relate to her peers. It was clear that treatment had to aid her in these processes of mourning, separation, and individuation. She needed to be able to see herself as having a history in order to live in the present; that is, she needed to come to a better resolution of her early adolescent tasks in order to move into middle adolescence.

The form of the treatment took hold early on: I saw Leah once-weekly and periodically saw her mother or spoke to her on the phone, usually at intervals of three weeks. Both mother and daughter agreed that sending the bills to her mother was the best way to ensure that her mother received them, for Leah was notoriously forgetful.

Establishing immediate contact with Leah was critical. She needed to see the treatment as something for her, rather than something that simply was imposed upon her by others. The opening exchange between us succeeded in doing this: Leah was able to continue with an agenda that felt self-defined and responsive to her own needs.

The opening exchange also began an educative process which continued for a number of weeks, in which the function and process of "therapy" increasingly became defined. In just the interplay described, several ideas were expressed about the nature of treatment: that Leah takes the lead in establishing topics, that her point of view is of particular importance, that she can discuss anything she wishes, and that what is discussed will be held in confidence.

During the initial period of treatment, these ideas and others are articulated and underscored. Leah (and other adolescent patients) must come to know what to expect. This is an important building block in the foundation of the working relationship that develops between the therapist and the patient.

Establishing the Treatment Relationship

The therapeutic situation must be both predictable and consistent, and the therapist someone that the adolescent can rely upon to be honest, interested, concerned, direct, matter-of-fact, and non-judgmental.

The predictability and consistency of the therapeutic situation permits adolescents to be more freely in their actual state of flux while they are seeing the therapist. When the therapeutic situation itself is less stable, adolescent patients will feel compelled to be more on guard. What this means is that a stable situation gives adolescents more latitude in displaying the full range of their development, both their most child-like and their most adolescent and/or adult-like states. Just as adolescents are most likely to show their widest range at home because of its familiarity and consistency, so will they be able to be the most themselves in the therapeutic situation if it becomes familiar. The predictability provides them with a

feeling of safety.
Once a full range of development is seen by the therapist, then the stumbling blocks to the adolescent's further development become more clear. In Leah's case, for example, the fact of her father's prepubertal disappearance and mother's fury about it made it harder for Leah to leave her childhood behind, and move from early to middle adolescence. She was too young to have the ego strength to contain fully the range of feelings she had about his leaving, and her mother's on-going rage at her father made it difficult for Leah to express loving feelings about him in her mother's presence. His absence also made it harder for Leah to form a more realistic picture of him, a necessary component of the deidealization process that accompanies early adolescent development. Without the deidealization, adequate identifications are far more difficult to form; thus, Leah's potential identifications with her father as an intellectual and educated person were steeped in conflict.
Therapists are important objects of identification for their patients, not only as non-parental adults in the adolescents' lives, but also as people who look inside at themselves and at their adolescent patients with warmth, understanding, and objectivity. One of the important processes of adolescent treatment is the

internalization by the adolescent of this way of looking at themselves. It is conveyed

both by the therapists' example of looking within themselves in this manner and looking at the adolescent patients they treat in this manner.

Leah

"You're late," Leah announced as she walked in the door.
"You're right. I'm sorry to keep you waiting."
"Well, if it were me — you'd be asking what happened, and looking for some deep psychological meaning. So, why are you late?"
"Good question. I could tell you about the telephone call I had trouble cutting short because of the nature of the conversation, but that probably wouldn't do it as an explanation, would it?"
"Well, for sure it wouldn't if it were you asking me about what happened. So I guess it shouldn't do it for you, either."
"I think I have some trepidation about hearing about what went on at that party you were going to over the weekend. As you probably could tell, I was a bit worried when you told me who was going to be there and what might be going on. The guys sounded like they were on the wild side, and the girls you were going with didn't sound like people with the greatest judgment. I was concerned about your feeling pressured again."
"I can't believe you're telling me this. I didn't think you'd be so honest. I could see you were worried when I was here last week, but I don't think I would have brought it up. But it had a big effect on me. I think you don't get worried that easily, and you seem to have a lot of faith in me, so it made me think more about the party ahead of time. And, you know, you had reason to worry — it was an unbelievable scene. I've never seen so many kids so high before. It was actually a really weird situation. Kind of scary, even."

In this exchange, Leah demonstrated her understanding of the therapeutic process, her internalization of it, and both her regard for and identification with me. She also showed that she felt safe enough to challenge me, in the very way I frequently challenged her. My choice to answer frankly provided her with an example that she readily followed.
What also is demonstrated in this snippet from the treatment is a kind of good-humored openness, one which encourages both parties to be honest and non-judgmental. This is a quality in the atmosphere of the relationship toward which I strive. When it is present, it is easier for adolescents to tolerate the inevitable mistakes, both theirs and their therapists', and to acknowledge vulnerability. This aids in toning down the potential harshness of the child-like superego formation and the possible grandiosity of the child-like ego ideal. Both the adolescents and the therapists can look at themselves in a bemused, matterof-fact way.
It will become increasingly clear in the case illustrations I present that I tend to be rather frank in my responses to adolescents and, sometimes, self-revealing. I do this with the intention of conveying my willingness to be as open with them as possible, in the hope that they will have the strength to act in a similar fashion with me. This differs from the way I might work with adults, who generally have greater ego development and identity formation, and therefore, a greater capacity both to be real and to tolerate the frustration of my being less self-revealing.
I see the role of the therapist as that of an observer of the adolescent's life, life in general, the therapist's own life, and life in the consulting room. In each instance, observations aid the adolescent in the development of ego functioning, particularly those aspects of ego functioning that involve sharpening perceptive and organizational capacities. Leah's trust in me and her awareness of my worry

about the party contributed to her thinking ahead about it and looking more carefully at

how she felt and thought about it at the time it took place. Her observing ego, objectivity, and self-protectiveness were strengthened. The fact that we were able to talk about this process in our session permitted her to integrate and frame the experience in a more thought-out manner.
An adolescent's place, developmentally, is highly related to what usually emerges in the treatment dialogue. In the most general terms, early adolescents are likely to talk the most about their family lives, middle adolescents about their peer and school lives, and late adolescents about their intimate relationships and struggles in defining who they are and planning for the future. Caution must be exercised by the therapist in making references to an adolescent's past; these references may push an adolescent backwards at a time when they are prepared (albeit fragilely) to move ahead. The past only needs to be evoked when it stands in the way of the adolescent living fully in the present.

Leah

"This school thing is really starting to get to me. I've been keeping up with my homework for weeks now, but I can't seem to get myself to go back and do the

stuff that's overdue. It just feels like there's too much there." Leah looked sad as she spoke.
"Something about revisiting the past, maybe?"
"I don't know. I'm not one for looking behind me or anything."
"Lack of interest, or fear, or what?" I asked.
"Well, in terms of homework — it just feels like it's history already. We're passed it in class. I either got the work already or I didn't. It seems pointless to go back and do busywork. But I have a feeling this thing about not looking back is bigger than just the homework thing. Must have something to do with what my life

was like when I was little. It all seems so long ago, so mixed up, and so recent, all at the same time."
"I have a feeling that some of it is with you a great deal in the present. It may be part of why it's so hard to look backwards. It may also have something to do with how comfortable you are doing as well in school as you might."
"You mean, doing well like my father did, for instance?" she asked with a big grin.
"Yes, for starters." I responded with a laugh.
"It was one of the things they used to fight about, you know. My mother would say my father was an elitist snob, my father would laugh and say she should go back to school if she's jealous. That really pissed her off."
"I can imagine."
"Don't think I don't worry that my mother will start to accuse me of being an intellectual snob or something."
"Has it ever happened?"
"Yeah, definitely. When I got a good report card last year, she said that I was going to be beyond her any day now... and that I better not become a smart-ass snot-nose like my father was."
"What was it like when she said that?"
"It made me really mad. Also, it made me realize how much I wished my father were around. I mean, she can't even help me with most of my homework now — can you imagine what it's going to be like later in high school?"
Leah clearly needed to speak about her past. In particular, she needed to talk about her father, for her conflicted identifications with him stood in the way of her performing adequately in the present. Her mother's difficulty in letting the past remain in the past also contributed to Leah's identificatory problems in the

present.

This clinical illustration demonstrates another important function of treatment during adolescence: its role in the differentiation process that is so critical to development at this time. Separating past from present (childhood from adolescence) and seeing ways in which the adolescent is like others in her family are important aspects of separation and individuation. Pointing out that Leah is capable of doing better than she is doing is another example of therapy in the service of differentiation; providing a realistic assessment of an adolescent's capacities contributes to the formation of a mature ego ideal and the refined sense

of oneself that comes from an adequate individuation process.
The relationship between the adolescent and the therapist is one in which there are likely to be strong transference and countertransference reactions, along with ready displacements from the parents (in the present) onto the therapist. I use the concept of transference to mean that the patient is relating to someone in the present in ways that derive from past relationships and ultimately distort or interfere in the present relationship. This implies that a way of relating has been internalized by the patient; there also are reactions that adolescents have in the present toward their parents that are simply and automatically displaced onto the therapist. Both of these must be addressed: displacements are seen more easily by the adolescent; transference interpretation requires that a therapeutic relationship of some stability and trust be in place. In either case, developing a pattern of discussing the relationship between the adolescent patient and the therapist is critical to the treatment.
Countertransference, which I see in the same way as Annie Reich (1951a, 1960a), is the flip side of transference: it implies that the therapist is distorting the relationship with the patient because of something that has been evoked in the therapeutic situation or the relationship with the patient from the therapist's past. This may happen because the patient reminds the therapist of someone from the

past or a situation has developed that is reminiscent of some prior experience for the therapist. In either case, the therapist is unable to be fully present when such a reaction occurs.
I regard countertransference as different from the therapist's having feelings, thoughts, or fantasies in response to the patient. These non-countertransferential responses must be expected and used as part of the way the therapist understands what the patient is communicating. Often, the therapist virtually functions as a container for the patient's strong feelings and reactions: a patient may simply not be differentiated enough yet to both recognize and hold a feeling or set of feelings that are intense or conflicted. In these instances, therapists may find themselves filled with the feelings that the patient cannot quite hold inside.

Leah

"You looked mad just now when I said I wanted to try 'shrooms."
"I'm surprised I looked mad... I wasn't feeling mad at all, just a bit concerned. I was thinking about that kid you mentioned last week who got so sick from the mushrooms that he ended up in the hospital."
"Maybe that's the look, then; maybe it wasn't that you were mad."
"Some people get mad when they're worried."
"My mother is definitely like that. She hates being worried, so she's always getting mad when she's worried."
"This makes me wonder if you expected me to be mad, for some reason."
"Well, my mother would be mad as hell."
"About what?"
"She thinks messing around with your head is really stupid. She says we should all consider our brains to be precious, 'cause once they get fucked up, it's

hard to get them back. She also talks about all her friends who got screwed up

from drugs in the sixties, how the drugs ruined their lives and stuff."
"Sounds like she's seen some upsetting things happen from drugs."
"Yeah, definitely."
"You ever worry about anything happening to you?" I asked.
"Sometimes. But I'm careful. I never go driving with anyone who's high, for instance. I never smoke up with people I don't know really well."
"Do you feel comfortable saying you don't want to smoke pot if other kids are doing it and you don't want to?"
"Usually. But, sometimes, I get too intimidated. Then, I smoke up just to fit in with the other kids. Like I don't want them to think I'm too straight or afraid or something."
"Let's go back for a minute to your thinking I was mad at you for thinking about trying mushrooms. Maybe, in a way, you wanted me to tell you not to do it?"
"I don't know. Then, I would have been mad at you for telling me what to do."
"Yeah, but it would have made you focus on what I thought, rather than what you thought. You would be concentrating more on something happening between you and me than on something happening inside you. I have a feeling that you have your own doubts about these mushrooms."
"Well, that's true. I don't really want to mess up my head, either. Sometimes I feel like it's plenty messed up without adding the drugs to it."

This example contains an articulation of a transference reaction (Leah thinking I was mad when I was worried), an externalization of a conflict (her thinking I was mad when she was conflicted about trying the mushrooms), and a displacement from Leah's mother to me (her mother would have been mad). In

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each case, explicating the defensive process aided Leah in coming to terms with what she

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actually thought, felt, and observed. All of these contribute to her differentiation and integration processes, and fuller experience of the present. The fuller description of her inner experience permits Leah to see, feel, and contain her inner experience. All of this is in the service of achieving a sense of mastery through more self-knowledge.

In talking with Leah, when she mentioned that her mother had friends who had been damaged by drug use, I had a moment of feeling quite frightened. The timing of the feeling and Leah's apparent indifference was what led me to ask her about whether she was ever worried about something happening to her. I sensed that it was difficult for her to hold and express this feeling, and asked the question to support her in her capacity to do so. This is an example of my becoming a container for a patient's feelings.

In the course of treatment, adolescents often speak about ideas, books, or movies. The way this kind of discussion unfolds and its meaning is different from what occurs in child and adult treatment. Adolescents use words in these discussions the way that children use games: for symbolic articulation and exploration of personal issues and themes.

Leah

"I saw the greatest movie on video last night. It was called 'Smooth Talk.' Did you ever see it?"
"Yes, a while ago. What did you like about it?" I asked.
"I thought that it really portrayed what it's like to be a teenager. I mean, that girl felt so young and so old at the same time. And I could really understand why she wanted to go out with those guys, how it felt so good and everything. And her
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mother, who was such a bitch. The movie was so good, I even felt bad for her some of the time. The girl was all into her life, and the mother kind of missed her. The girl also missed her mother some of the time, but there was nothing they could do about it. It was, like, too hard, to get over it. Maybe they can in a few years. Also, the mother seemed so sad."
"How'd the daughter react to her mother being so sad?"
"She tried to ignore it. She didn't want to deal with it. What kid would?"
"Like, it's hard enough being a kid and trying to deal with your own problems — having to think about your mother at the same time is just too much?"
"Yeah, something like that."
Staying within the framework of the movie, encouraging the patient to look from within the plot and from outside it, but not extrapolating from the movie to the adolescent's actual life is often extremely productive. In this instance, Leah explores the feelings and motivations of the central character in the movie and expresses some sympathy for the character's mother. She demonstrates a capacity for observing a wide range of feelings in each of the characters, much wider, in fact, than she has yet been able to observe either in herself or her mother. However, if I had made a comparison between Leah and the movie character, she, most likely, would have rejected it.
In the context of an adolescent's evolving capacity for self-observation, dealing with movies, books, or ideas, in the manner that Leah and I dealt with this movie is a transitional step. It permits Leah to stretch her capacities for observation, without pressing her in such a way that she defensively moves away from using these observing capacities. It is much like the way child therapists respond to a child's play: they stay within the play, rather than immediately suggesting that the play resembles the child's family's life.
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Over the course of treatment, therapists must attempt to move adolescents from observing others carefully and good-naturedly to observing themselves in this fashion. This is often done by a combination of talking about characters in movies and books, and using the therapist's self-observations. Both of these pave the way for the therapist and patient to talk more openly about their relationship with one another.
Talking about the relationship between the therapist and the patient provides opportunities for transference interpretation and descriptions of characteristic ways the adolescent acts. These contribute to the adolescent's differentiation processes. Transference interpretation aids particularly in the process of separation from the significant objects in the adolescent's life. Forming a picture of the adolescent's customary ways of interacting helps in articulating both character formation and aspects of the individuation process.

It is just at the time when adolescents feel comfortable with the therapist
and have formed a relatively clear picture of themselves, including their histories
and their current lives, that questions about the value of their continuing in
treatment often are raised. These questions are raised by parents, the adolescents
themselves, and the therapists. Ending with adolescent patients poses challenges
to all involved in the decision.

Ending Adolescent Treatment

This section is not entitled "Terminating Adolescent Treatment." The concept
of termination is one that suggests a process of ending treatment. In most
instances, adolescent treatment ends abruptly. Indeed, as adolescents leave
consulting rooms for the last time, it is often their therapists who are reeling, while
the adolescents themselves seem comparatively unbothered. The adult in the dyad

is filled with a

wide range of feelings, while the adolescent seems calm and even-tempered.
Some of the wide range of feelings that the therapist feels belong to the
adolescent, some to the therapist.

The psychic structures of adolescents are in a state of flux. This leaves them
with an ever-growing capacity to feel, see, identify and contain their affectual lives.
Along the (developmental) way, adolescents may have difficulty being aware of
their feelings. Adults who are close to them, including parents, teachers, and
therapists, may find themselves feeling feelings FOR the adolescents. As
mentioned earlier, the adult becomes a container for the adolescent's feelings.
What happens inside an adolescent therapist as treatment ends is a prime
example of an adult becoming such a container for an adolescent's feelings. As
therapy comes to an end, the adolescent is likely to feel a good deal about the
treatment, the therapist, and saying goodbye. Where the adolescent is,
developmentally, will determine how great a capacity is present for being aware of
the feelings and how much of an ability is there to articulate them. It is often not
until the close of late adolescence that adolescents are differentiated enough to be
able to tolerate a wide range of feelings, identify them, and describe them to
someone else. Up until this time, they are likely to have only partial views of their
inner lives.

Adolescents struggle mightily with their dependency needs. Most seek to be
independent and have greater and greater capacities for being so over time. They
become more able to use their cognitive and emotional resources to make
informed decisions, live fully in the present, and relate to others in an honest,
open, and intimate manner. Their dependency needs often leave them feeling
hampered in the use of their personal resources; they end up relying too heavily on
the views and wishes of others, especially those upon whom they rely for
emotional sustenance.

The adolescent's balance of dependence and independence is critical to the
decision of whether or not to end treatment. It is time to end treatment when an
adolescent is on track in terms of the significant features of their subphase
development. The most important of these features is the balance between

dependence and independence.

Early adolescents need to be independent enough to see their parents with greater objectivity than they had in childhood. They must have the capacity to be realistic about when they need their parents and when they do not. They also should have formed a sense of personal history, a childhood that they have left behind. Finally, they need to be able to form satisfying, reciprocal friendships among their peers. If this describes an early adolescent, then this is an adolescent who does not need further treatment.

Middle adolescents need to be able to choose freely among their peers, in terms of forming friendships and physically and emotionally intimate relationships. They have to think of themselves as owning their bodies, thus, be independent in caring adequately for them. Personal hygiene, eating habits, and physical protectiveness (i.e., not taking unnecessary physical risks) are examples of independent adequate physical care. They also need to be sorting out a personal sense of morality and ethicality, one that includes thoughts about both sexual and aggressive behavior. If a middle adolescent is dealing competently in all these areas, then this adolescent is ready to leave treatment.

Late adolescents need to have a self-defined set of ideas about who they want to be, how they want to be, and what they want to be. They should view their parents as other people, and not invest them with powers beyond adult human capacity (as children do, and developmentally younger adolescents are still feeling disillusioned about). They should be able to choose intimate partners and pursue reciprocal relationships with them that are both emotionally and sexually satisfying. Treatment is no longer necessary when a late adolescent patient is conducting life in these ways.

The decision to end adolescent treatment is not one based on behavior; it is a decision based upon how ensconced an adolescent is in the subphase development that is age-appropriate. It is not necessary (nor possible, in most instances), to wait for adolescents to be well-formed as people; this really does not occur until the end of adolescence. Among other considerations, it is not clear that the end of adolescence can be reached while an adolescent is in treatment. Most of the time, adolescents must consolidate their identities on their own. Treatment may actually impede this last aspect of the adolescent developmental process.

Adolescents may know instinctively that they cannot integrate their identities while being scrutinized by someone else (as is the case in psychotherapy). They need to have a strong (personal) observing ego, more than they need to have an adult auxiliary ego (in the form of a therapist). Instinctive knowledge often leads adolescents to act; they attempt to figure out why they acted after the fact. At times, adolescents act as a way of ascertaining what they think or feel. This must be distinguished from acting out, in which patients put some affectual or cognitive experience into action rather than words; they act instead of remembering (Blos, 1963). Leaving treatment may be an acting out or one of those instinctive acts of adolescents in which they take an action without fully knowing why.

An abrupt leave-taking may be precipitated by adolescents or by their

parents. It may be difficult for parents to have their children in treatment for a host of reasons. Having their adolescents talking frankly to another adult at a time when they may not be speaking so openly to their parents, for example, may create conditions for competitive feelings between the parents and the therapist. Having their intimate lives revealed to a stranger leaves some parents feeling quite uncomfortable, especially when they are often having only very limited contact with the therapist "stranger." Adolescents' external lives may dramatically improve when they are in therapy, thus leaving parents questioning the need for further treatment, given its attendant financial and time commitments. In any case, parents may feel that it is time for their adolescent to leave treatment before the therapist or adolescent feel ready to end. They may exert pressure on the adolescents, by asking whether they still really need treatment or by raising concerns about the finances or time constraints entailed in continuing.

The various reactions parents may have to their adolescent's treatment make clear the importance of the therapist sustaining a working relationship with the parents of their adolescent patients. Therapists need to be able to convey to parents the importance of treatment continuing; to do so requires that there be a good relationship between them. The relationship is built around their joint objective of serving the best interests of the adolescent they both know and care about.

At times, however, parents may want adolescents to remain in treatment when both the therapist and the adolescent feel it is time to end. The parents may feel overwhelmed by having an adolescent child, or overwhelmed in their own lives. Single parents, for example, sometimes welcome the presence of another adult in their adolescent's life. They see the therapist as a person to whom they can turn when their child is difficult for them to understand, and fear being left

alone to contend with their adolescent when treatment ends. In these instances, a good working relationship with the parent(s) is important as well. More often than not, compromises are formed among the therapist, parent(s), and patient, about when ending makes sense.

Endings of treatment are often linked to external circumstances, such as graduations or summer vacations. The adolescents themselves rarely feel enough internal structure to gauge when they are "ready" to end; they are far more likely to look for some external structure within which they can plan an ending. Novick (1976), who wrote one of the very few articles about the process of termination in adolescent treatment, notes that adolescents often enter treatment with a preestablished unilateral termination in mind. Such an ending permits the adolescents to feel safer, because it gives the treatment a shape that aids them in containing their dependency needs. He also suggests that active leave-taking helps adolescents in contending with these needs.

Leah

Leah was now sixteen. A year of once-weekly psychotherapy was followed by almost a year of twice-weekly psychotherapy. She was now coming in once a week. At this point, Leah was doing well in school, and was satisfied with her relationships with her friends and mother. She had traced her father and had spoken to him over

the telephone and written him some letters. She also had had her first boyfriend, and was pleased both with what had happened and how things were left when they broke up.

“So, Levy-Warren. Maybe it’s time to say goodbye. Don’t you think I’m all better?”

Although I had been thinking about talking to Leah about ending treatment, I still felt somewhat taken aback when she spoke. “I certainly feel like you’re doing well these days. I’m not so sure what ‘all better’ means, though. What were you thinking?”

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“Oh, you know. My grades are fine, I’m getting along with my mother and everything, I like my life. I even like myself. Can’t get much better than that, right?”

“Definitely truth to that.”

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“So, what’s the problem?”

“There really isn’t one. I guess I was just thinking about how it would be to say goodbye.’

“Well, that’s the hard part. But it’ll be okay. You won’t get rid of me that easily — I’ll call you, stop by... whatever. Anyway, my mother will be happy.”

“What makes you say that?”

“She’s been on my case about the money. She asked me the other day how much longer I was going to need this; said that it was a lot for her to deal with. Made me feel bad. But then I realized that I would come forever, just because I like it. And maybe I don’t really need it anymore. You know, it just made me think more about this whole thing. Don’t you think I’ll be okay?”

“Actually, I do think you’ll be okay. And I’m glad you said you’d be in touch. I would hope that you would feel comfortable doing that, and I would always be glad to hear from you.”

“So, is this it, or what?”

“I would pick the ‘or what.’ I think it makes sense to live with this idea for a little while before we take action on it. So, how about if we choose a time in the future to stop meeting regularly and see how it is to know that this is the plan?”

“Okay with me. You have a time you think would be good?”

“I would rather leave that up to you, with the understanding that you can change your mind if you want to. I don’t want to make assumptions about what you’re thinking or feeling.”

“This sounds heavy to me. But, all right. Let’s see. How about the end of this month?”

“That gives us three more weeks. I can live with that.”

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In the ensuing weeks, Leah spoke very little (directly) about ending treatment. What she focused on was a project she was working on in school which involved her setting up a tutoring program for homeless kids in her neighborhood. She described how daunting the responsibility felt and yet how excited she was about doing it. She looked forward to helping the kids and to running the program. The message I inferred was that Leah was ready to be on her own.

Leah remained relatively light-hearted throughout the month. I felt sad, at times, and pleased about who Leah had become, at other times. In our last moments, I was the one who spoke about how I would miss seeing her. Leah acted as if that were not an issue for her.

"Don't worry. I'll be around. You won't have to miss me."

It was many months before I heard from either Leah or her mother. Toward the end of the following year, however, I got a message from Leah on my answering machine.

"Hey, Levy-Warren. It's Leah. Remember me? I just got into Wesleyan early. Pretty good, huh? I'm psyched. Wanted to let you know."

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Adolescents or their parents often have contact with therapists after treatment ends, but not in the majority of cases. Treatment often seems to become associated with a past that both want to leave behind. Therapists are left wondering how their former patients are and who they are, and quite conscious of the fact that treatment ends before the adolescent process ends. Thus, inevitably, adolescents leave treatment unformed in many ways. The best result that treatment can reap is that the adolescents ending therapy are merely as unformed as others are at their time of life.

Treatment ends as treatment begins, with a host of questions, negotiations, and contacts with both the parents and the adolescents, and a therapist who is attempting to look to the adolescent's past, present, and future. In looking, at best the therapist will see an adolescent who has a clear sense of a past, firm family and peer connections in the present, an ability to make good use of personal cognitive and emotional resources, and a capacity for balanced self-observation that will serve to stave off future crises.