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Problems occurring in the psychotherapy of adolescent patients with symptoms of pathological personality development

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SUMMARY

The aim of the article is to discuss, from the psychodynamic point of view, some of the problems that appear during individual and out-patient-facility-located therapies of adolescents with varied symptoms that give rise to the anticipation that their development may be directed towards pathological personality formation. The symptoms are often dangerous for their health or life (suicidal thoughts and attempts, self-injuries, eating disorders), or create severe conflict with their natural environment (social isolation, abandoned education, antisocial tendencies, etc.).

Based on the presented cases, diagnostic issues are discussed, for example: to what extent does the diagnosis of personality disorder make sense in the developmental age? What arguments can be used for and against the use of this category in a developmental age? To what extent is an adolescent's personality type determined in the period of adolescence? How can one understand and diagnose the presence of often dramatic symptoms in adolescents using psychodynamic categories? The aim of the author is to indicate the usefulness of describing difficulties appearing in the adolescence period, in the developmental categories.

Another area that is discussed describes difficulties appearing during the therapeutic process. The examples of such difficulties involve: connecting and maintaining a relation, lack of motivation for therapy, countertransference phenomenon, and dangers presented by teenagers' destructive acting out to themselves.

adolescents / **personality** / **psychodynamic psychotherapy**

INTRODUCTION

The aim of my lecture is to discuss the specificity of work with, and of understanding of, patients that I wish to describe in this introduction, i.e., persons revealing signs of abnormal personality development. By this I mean adolescents who function, from a psychological perspective, in a manner dominated by affective mechanisms; thus their functioning in a natural context, i.e., in a family, in school, in a peer group and in intimate relations, is significantly disturbed. My main interest here is to describe their difficulties in psychodynamic categories, mainly from the perspective of the anxiety experienced, defensive mechanisms used, ways of relating, and relationship perception. Addressing a well-known psychodynamic method of disorder classification, one might say that these problems are "tougher" than the neurotic ones, but not as "tough" as

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the psychotic ones; these patients – were they adults – would be said to have personality disorders. They might also give us reasons to believe, perhaps incorrectly, that if no personal, emotional resources are utilized, if no favourable influences are present in life, or no therapy is started, such patients may present personality disorders in adult life. These patients manifest a range of symptoms. They involve, for example, a significant level of social isolation, poor peer functioning, and, frequently, eating disorders. The most noticeable, however, are the teenagers who, in various situations, rigidly hold onto high-risk, self-destructive behaviours (e.g. suicide attempts, self-mutilation), and marked antisocial and other tendencies. Some of these patients manifest such spectacular symptoms that they are identified not only by their therapist, but also by other persons from the Centre's staff. They include such behaviours as: pouring water on therapists present in the reception area, threatening suicide after leaving the centre, or uncontrolled screaming for many minutes in the office in a manner that disturbs other therapists at work and "scares" somewhat "healthier" patients. One might say that their social/emotional development occurred in such a direction that their difficulties and emotional distress are expressed by acting out, so that inevitably they are condemned to conflicts with their environment. In other words, they are patients who may still benefit from therapy set in an out-patient facility; most frequently they do not require long-term hospitalization at an Adolescent Ward, although they are often directed to therapy from such a place.

I would like to describe difficulties present in working with such adolescents in the following order: first, I will present brief case illustrations, and, later, using them as examples, I will discuss difficulties associated with their understanding (therapeutic diagnosis) in a developmental context, and characteristic difficulties present in the process of individual therapy.

ILLUSTRATIONS OF THE THERAPEUTIC PROCESSES

Case illustrations will only be presented with regard to the symptoms reported, shape of the therapeutic relation, understanding (therapeutic diagnosis), and improvement or deterioration occurring in therapy.

Case illustration I:

Parents and their 13 years-old son came in for therapy due to complaints from teachers and fellow students and due to the son's "unbearable" behaviour in the house. Robert had a tendency toward extremely provocative and arrogant behaviours, was detested by everyone in his class, and nearly all the teachers. He treated his peers from an attitude of superiority and said that they could be his servants. Robert didn't exhibit any planned cruelty, but he also saw no reason to apologize, when, for example, he unintentionally broke someone else's property. He could also painfully mock vices of others (including his parents and his brother); he insulted them in an impulsive, but not vulgar, manner. On a few occasions the enraged patient destroyed some objects, for example, broke a window. He was oversensitive with regard to his health, and his appearance (for example, an individual detail could embarrass him greatly and make him hide). He was successful in sciences, yet when he was not the best, when he didn't win competitions, and in a given area proved weaker than his brother, he would lose heart and state that it doesn't interest him any more. Right from the very beginning, a strong, though denied anxiety could be felt in the boy. It manifested, for example, in his inability to fall asleep without his bedside lamp turned on. Right away, from his first visit, Robert had difficulties in enduring the stay in the office. He cried with rage, screamed, strongly stamped on the floor. He said that: this visit is a disaster, that it ruins my life. The therapist understood that the patient, despite his young age, manifested a number of features characteristic for a Narcissistic Personality Disorder: grandiose fantasies, coldness, arrogance, superiority, difficulties in relating, and desire to exercise omnipotent control. In response to the therapist's attempts to connect, Robert would say that the therapist was a moron and that, should he force him to come to the office, he will throw himself under a car. For example, he would say to the therapist "It's a shame that Hitler persisted in prosecuting Jews not psychologists – you

wouldn't be here then." In the first stage of contact, the therapist felt a great deal of helplessness and confusion, which required supportive supervision consultations. When the boy's rage did not recede despite the attempts to calm him down, the therapist stated that such behaviour was disturbing and, in accordance with his evaluation, he must consider the boy's hospitalization. He explained to the patient, which of his behaviours he found disturbing, shared his belief that they result from intense distress and anxiety, and added that a possible transfer to an inpatient facility would result from the boy's inability to control his reactions of rage and aggression. In the blink of an eye the behaviour changed. The patient stated that it was not true that he could not control himself and that he was able to prove it. From this moment on, despite experiencing intense anger, the patient was indeed capable of distancing from it; eventually a similar change occurred in his relations with the environment.

The course of therapy – which was very difficult for the therapist, and was based on detailed discussions with the boy about his behaviour and by confronting him with his pathological behaviours – went in multiple directions. The patient exercised grandiose fantasies about being a great leader, glorified the USA because of its superpower status, and dreamed of a political career, best in the role of a dictator. In his experience the world was divided into his environment that did not understand him (e.g. school, family, therapist, psychiatrist), and into the idealized, imaginary realm of historical leaders, great politics, business and career. He claimed that there was nothing good in his present life and he agreed with the therapist only in stating that his world vision was a vision of "everyone being at war for survival" – and therefore that one must be on the winners' and leaders' side. He did not comply with the statement that this was only his way of experiencing relations with other people and not the "objective reality." The therapist understood that the dominant anxiety experienced by the patient at the moment was annihilation anxiety (associated with a high hostility level). The main defensive mechanisms were: splitting, projection (the creation of persecutory objects) and also intellectualization. The symptoms were ego-syntonic.

After two years of therapy, there is a marked change present. Robert is now very liked by his classmates, he has colleagues – it is a result of his unique ability to argue with teachers on behalf of other students. He started to manifest interest in the opposite sex, he states that his school is generally quite good, most of his teachers and classmates are okay, also that his parents have some advantages. Yet, still, his "therapist might be a bit more competent." His affective expression changed, so did his tension level, he started falling asleep without a lamp on. Distinct narcissistic traits are still perceptible, his behaviour, however, resembles more an adolescent's rebellion than a furious attack. The most negated figures at the moment are: one of his teachers, the therapist, and his mother.

Case illustration II:

A mother came for therapy along with her 16 year-old son, who was diagnosed with micro-damages present in the CNS. He presented many problems in functioning both in school and with peers. His behaviour distinguished him from the rest of his class; occasionally he got attacked, but he did not want to defend himself. He would say that he despised aggression, even if it was of a defensive and harmless type. When he was asked about his attitude towards very difficult situations in the peer group described by him, he was disoriented, tense, and finally replied that he was neutral towards them. During the early stage of therapy, the therapist was very concerned about the inadequacy of the boy's functioning, the odd emotional colour of his relationships, and the religious, apocalyptic – specifically metaphysical – and other themes that were brought up by the patient. Only after the first few months of therapy did the patient's mother inform the therapist that she had been hospitalized in a inpatient clinic for "emotional problems" and she still is seeing a psychiatrist for her problems. As it showed, she suffers from a chronic delusional-hallucinatory disorder with a fluctuating course, and one that stays relatively resistant to pharmacotherapy. This knowledge, provided the therapist with an understanding of the patient's functioning, not only in terms of the results of his CNS micro-damages, but also

in the perspective of the mother-son psychotic symbiosis. The patient was incapable of separating his mom's experiences and beliefs from his own convictions, thus he was unable to construct his own, separate identity. The therapist concentrated on the difficulties mentioned above. For example, after the patient finished "reporting his/his mother's" visions of the world coming to an end, the therapist would provide an intervention: "I understand that this is your mom's belief, that you heard it from her, and that you discuss it with her quite often, but what is your opinion on it?" After a while this tactic resulted in a gradual separation from his mother and the creation of the patient's own world. The therapist's suggestion, given to both the mother and the patient, also contributed to it. He suggested that the patient should keep the content of his therapeutical discourse confidential. Before that, the mother controlled the therapist – patient relation, gently persuading her son to share everything that was said in the office. As expected, after a while, the mother started giving signals depreciating the therapy and the therapist; the patient himself also had more doubts. He didn't know if the therapy made sense, and he was late for meetings more often than before. Eventually the patient declared his will to continue therapy, and for the first time started discussing his mother's illness, keeping distance; at the same time the mother's condition improved and she supported the therapy. After a while, a very disturbing period of social withdrawal followed; the patient first changed his class and then quit two schools in a row. He fantasized about becoming a hermit, claimed that the therapy made no sense, was of no help, that he and the therapist differed in too many issues, and above all, that he did not want to change his way of life and his customs. He started planning how to gain a state pension. These notions caused a bitter, emotional reaction in the therapist, who indicated that, by planning this, the patient was abandoning all hope to live an adult, relatively independent life, to have the once-dreamed-of relationship with a girl, to gain education, occupation, his own money, and many other things. The patient did not break the relationship; his life however, acquired an exceedingly solitary and ritualized character. At the time he had no other social contacts, just his relation with the therapist. Yet, after a length of time, he started his schooling again, made contact with peers (although he obviously "differs" from them), and became more independent with regard to personal hygiene. Approximately every six months the patient enters the office with a plan to abandon the therapy; he repeats the same motives, i.e., "I don't want to change anything, I don't need a girlfriend, I can masturbate". That is when the therapist repeats the statement that in this way he abandons himself and his hopes for development. The therapist recognizes that the patient is developing in a schizoid direction, and that his experience of the world and himself is determined by splitting and very strong detachment from emotions. One might say, from the perspective of time, that two interwoven attitudes were manifested in the course of the therapy: negation of the therapist's position and his relation to the patient, followed by engagement into a relationship and improvements in the patient's functioning–and, after another six months, another negation and attempts to abandon contact. The patient either says that the therapy is pointless or claims that he has plans for attending it for ten more years, or at least until the end of decade.

Case illustration III:

Parents of a 15 year-old boy with symptoms of conduct disorder came in for therapy. The boy had changed his school three times already, but everywhere there were complains about his behaviour. He also had significant difficulties in learning, and already had contacts with the judicial system. Throughout the first session the boy behaved in a provocative, almost nonchalant, manner, and saw no reason for the therapy. During a discussion with the boy's parents, it turned out that they had not had contact with the school for six months because, as the boy's father put it: "we feel ashamed to show up there, every time hearing what he does in there." Additionally the boy's mother, in his presence, subtly devalued all fundamental social institutions (meaning school, the police, the courts), suggesting that these institutions were unjust in her son's valuation, as "he's really a good boy." Other information provided by the parents indicated that the son's behaviour might be associated with the family's in-

ternal functioning. The therapist also sensed that the boy was left alone to cope with the trouble he made. Thus, the therapist decided to refer the parents along with their son to family therapy. The therapist also felt that he had no real control over the boy's behaviours, which, when accompanied with the boy's lack of motivation, gave way to a belief that individual therapy made no sense. He informed the parent's about all this, but they strongly insisted on getting help. Then the therapist decided to impose conditions: the parents were to re-establish contact with school, and to control the boy's, and own attendance, in therapy. Furthermore, when he called the mother's attention to the mentioned devaluation of social institutions, she accepted the notion. The therapist also attempted to support the parents in fulfilling parental duties, and they reacted well to it. As a result, two simultaneous therapeutic processes took place, and the therapist felt that, as time passed by, he established contact with the boy and that his behaviour improved. After a while the therapist found out from external sources that the putatively manifested improvement did not exist, and that the patient was holding back many facts during the therapy. The boy yet again started causing trouble at school, he joined an unfavourable peer group, avoided sessions. The therapy was aborted, also by the boy's parents. After six months, the therapist was asked to write a psychological opinion for another of the boy's trials.

PROBLEMS RELATED WITH THE THERAPY OF SUCH ADOLESCENTS

Difficulties related with the psychotherapeutic diagnosis

Both in the title and in the introduction, I use such terms as "pathologically developed personality" or "abnormal personality development", because I agree with the opinion that using the term "personality disorder" with regard to adolescents is premature. On the other hand, the therapists who work with adolescents often use the term as an analogy to adult patients. It is an outcome of a situation where the majority of psychotherapuetic trainings teach a therapeutic diagnosis, therapy, and other professional rules only with regard to work with adult patients. It seems, however, that another reason is the existence of a specific theoretical (diagnostic) void in the realm of such specifically disturbed youth. Certainly the therapists, especially the ones who care for the therapeutic diagnosis in terms of defensive mechanisms and object relations, are not helped by psychiatric classifications that strive to create atheoretical systematics. For example, the category of "conduct disorder" raises controversies among the psychiatrists themselves. Both clinical literature and therapeutic experiences indicate that a variety of affective mechanisms can lie beneath antisocial behaviour. They can, for example, include depressive mechanisms masked by anti-social acting-out or abnormal development in a sociopathic direction. The first group of teenagers, despite their difficulties, can, in the course of therapy, create a good relation and a warm emotional atmosphere – the prognoses are good for them. The other group shows difficulties in emphatic relating, with dominating coldness and absence of motivation to change After reaching a certain age the prognoses are poor for them [1, 2]. The issue of using the category of "personality disorder" in adolescent patients has been widely discussed. Now I would like to take a moment to present pros and cons for such use and it's importance, from my perspective, for conducting therapy.

The main argument against it is the fact that adolescence is by definition a period of time when the personality is shaped, when it is flexible and incoherent. Thus, one can hardly discuss lasting, pathological personality patterns, and the presence of such patterns is a condition for giving such a diagnosis. Making reference to the DSM-IV personality disorder definition, Efrein Bleiberg [3] says:

"Ultimately, personality disorders are defined as relatively lasting and strongly disadaptive patterns of experiencing, relating and coping. Children and adolescents participate in a very fluent developmental process, where each bodily and personality aspect constantly undergoes transformation, at different paces, creating new states of balance and imbalance in themselves and in their relations to the environment. Maturing and experiencing provides children with constantly changing tools for coping with, perception and organization of their experience, and for relating with other people thus rendering a ruling on the presence

of "rigid and lasting patterns" difficult, if not impossible" [3].

Mechanisms that characterize adult personality disorders, such as splitting, dissociation, denial, intense projection and others, from the analytical perspective constitute the chaos of the adolescence period. To a significant degree they are a part of a normal development, especially of the recrudescent separation-individuation process [4]. Anna Freud described the adolescence period as a time of "normal abnormalness"; when she was asked if the emotional disturbances of that time are inevitable she replied that maybe they are not, but it is better for them to occur [then] as that makes a better prognosis for a mature individual [5]. There are also data indicating that a certain degree of opposition expressed by, for example, reaching for such "forbidden fruit" as alcohol, or by a passing contact with less dangerous drugs, may in consequence lead to better social adaptation in adulthood – unlike excessive anxiety and inhibition [2].

What we deal with here, is the issue of developmental and mental health norms in the period of adolescence. From the psychodynamic perspective, elements that are considered pathological in an adolescent's experience often depend not so much on the types of defensive mechanisms used, but on their domination and the degree of their intensity. If they reflect negatively on the ability to self-regulate, threaten health or life, isolate from peers, then we move in our evaluation along the health-disorder continuum towards the category of developmental crisis. Such a crisis can recede with little or no help at all or, when there are unfavourable conditions present, it can lead to pathology. In order to make this issue more distinct I will provide a few examples of teenagers' behaviour that in our opinion fit the norm, but which would be considered disturbing for us, the therapists, were they to be present in an adult's functioning.

1. Usually, analytical concepts that are directly or implicitly different, assume that ordinarily during the adolescence period, one can experience to some extent a separation anxiety (associated with uncertainty about own self-dependence, ability to cope, own competence, etc.). The anxiety is caused by the recrudescent process of separation-individuation. Depressive anxieties appear – they are associated with the child imagining that being angry with its parents will cause their anger, i.e., the withdrawal of their love. There are also neurotic anxieties associated with developing impulses. Occasionally, the persecutory anxiety might appear when the world experienced by the adolescent becomes hostile or at least abandoning for a while.
2. To some extent, and to a certain age, it is considered normal to use acting out as one of the many mechanisms for coping with stress. Colloquially, it is said that an adolescent needs to get "his/her stride"; sometimes, however, an excessive self-control, or unnatural "maturity" is disturbing.
3. We also tolerate adolescents' oversensitivity, self-concentration, or living in a fantasy realm, which constitute reactions to developmental dilemmas – in other words we tolerate adolescents' narcissism.

Now let's see the arguments for using the diagnosis of personality disorder in the developmental age. Most frequently, the category of personality disorder used with regard to children and adolescents can be noticed in writings of authors with a psychoanalytic background. For example, Paulina Kernberg [6] does not hesitate to diagnose "narcissistic personality disorder" in children (which she confirmed during her visit in Krakow). I located such a claim in Polish literature, in writings of, for example, Katarzyna Schier. These are the arguments:

According to psychoanalytic theory, and a number of research results on the development of young children, the basic frameworks of personality, meaning the type of object relations – the way of relating; the person's primary identity, the so-called self-image; primary pattern of impulsive reaction; and others, develop by the time child reaches age of six or seven. Naturally, modifications can occur in a later time, especially, it seems, in the adolescence period, but often they do not take place at all. Thus, since our personality develops in an early stage, it can also develop in a pathological way. Bleiberg, quoted before, states elsewhere:

"Can a child's personality fixate in such a rigid way on the disadaptive patterns of coping, experiencing and relating, that it can be qualified as referring to a "personality disorder"? (…) During the last fifteen

years, developmental research and prospective development studies provided more and more accurate, empirically-tested grounds for understanding the interaction of the genetic and developmental elements in generating, organizing, and structuring a child's subjective experience, coping mechanisms and patterns of relating. These studies confirm Paulina Kernberg's opinion that children manifest distinctive features and patterns of cognition, relation to, and thinking about, their environment and themselves – including such features as egocentrism, inhibition, socializing, activity and many others. Kernberg adds that these features and patterns last over time and in a variety of situations and allow us to use the term "personality disorder" regardless of a child's age, when: (1) they become rigid, disadaptive and chronic; (2) cause substantial decrease in functioning; and (3) cause intense subjective suffering." [8].

In a review paper about the pathology of personality, Western and Chang [2] describe a number of research studies supporting the thesis that, although an adolescent's personality is not fully developed and stable, it still manifests a significant continuity starting at the age of 3, through the adolescence years, and beyond. For example, little children who are shy and inhibited are more likely to be anxious and inhibited in the adolescence period. Infants who do not posses a stable and reliable attachment between the 12th and 24 months of their life are more likely than their safely-attached peers to manifest interpersonal difficulties in childhood, and to have lower indicators of emotional health, self-esteem, ego flexibility and peer competence in the adolescence period. Boys who are aggressive in childhood are more likely to be anti-social, or otherwise dysfunctional, adults.

One might add in passing that the image of adolescence, seen as a period of constant "stormy weather", that emerges from clinical practice and research associated with it, differs completely from the image that emerges from the research of developmental psychologists, insofar as the latter concentrate on other areas than the conditioning of pathology. It is sometimes said that only 20% of teenagers from the USA who experience such turmoil during the adolescence period require therapeutic intervention.

There are also suggestions that this area should contain diagnostic categories that would be used with regard to adolescents only. Westen and Chang made an attempt to form a classification of adolescent personality disorders based on research, in order to avoid inevitable mistakes that occur when extrapolating from personality disorder categories for adults. They say: "… personality pathology may be less differential or may have other features at the age of fourteen or fifteen than in adulthood, therefore it may require other categories or criteria" [2]. They propose six types of pathological personality development that they designate as personality styles and disorders of the adolescence: the self-critical dysphoric style; the oppositional dysphoric personality style; the anti-social-psychopathic personality disorder; the emotionally dysregulated personality disorder (similar to borderline); the schizoid personality disorder; the narcissistic personality disorder; and the histrionic personality disorder.

This may seem to be only a conceptual struggle, but indeed it is not. Its' substance seems to address the question of the persistence of certain personality predispositions and their susceptibility to modification, including by the means of therapy. From the perspective of time, looking at the first therapy described above (the "narcissistic" boy), one might say that the changes in the boy's functioning appeared relatively quickly, and that they would not be possible in an adult patient with similar symptoms. Therefore, it is doubtful that the case described was a type of personality disorder. When we look at the second therapy (the patient with schizoid mechanism), we may see how the patient oscillates between fixation and fossilization, in a certain way of lifestyle that can deprive him of social life, and in the undertaking of developmental challenges. Undoubtedly, yet another factor that hampers the development here, other than obvious psychological conditions, consists of organic deficits. I believe that every therapist working with adolescents could describe numerous therapies similar to the third case (the patient with antisocial tendencies). These are therapies that are unsuccessful; they occur when an adolescent and his/her family cease their struggle for development and, as a result, manifest no internal motivation to change. As a result, a more or less pathological pattern of behaviour and experience becomes fixated until adulthood, when a person once again notices that his/her functioning causes un-

wanted suffering. Sometimes, however, the pathology stays preserved, for example, when antisocial behaviour becomes a part of one's identity, of character, when it brings secondary gains (e.g., financial ones, which help to define identity). Consequently, the internal conflict and feeling of suffering dissolve; internal doubts, self-reflection and the need of change fade away.

Where lies the pathology in the cases described above? From the psychodynamic point of view, one might answer that it lies in the immaturity of the utilized defensive mechanisms (splitting, projection, dissociation, acting out, isolation). These mechanisms are inadequate when compared with the person's age and developmental challenges – they are used for coping with anxiety. Such situations either cause the prevalence of the archaic, psychotic anxieties (in cases one and two), or precludes proper socialization (case three). This description requires supplementary developmental categories. In my opinion, the crucial element is a certain emotional flexibility, a potential for a change, openness to modifications of experiencing and relating. To what extent is this a temporary situation and to what extent a permanent fixation, retention or regression of the development? To what extent have the pathological patterns become a part of identity (self) that remains unchangeable? Deliberating on the issue I turned to the category of "developmental foreclosure" used by two British psychoanalysts Moses and Eagle Laufer [9]. In their theory, which is overly occupied with sexuality, this category was mainly used for describing a premature consolidation of perverse structure in teenagers – a consolidation that brought the therapy process to an end. Still, it seems to fit well with a loss of a tendency of practicing various solutions by adolescents. In the case of the first boy, the foreclosure did not take place, in the second case the therapy was a struggle against its occurrence or scope, in the third boy's case that is the process that took place.

Difficulties emerging in a therapeutic process

Difficulties emerging in the process of therapy with a patient exhibiting an abnormal personality development resemble difficulties appearing in the therapy of adult patients with personality disorders [10]. There are, however, a few additional elements resulting from the specificity of age.

The main problem is merely to connect and keep the therapeutic relation. An early relationship disorder lies beneath this difficulty. Therefore, a person who experienced an early trauma in a relation with a caregiver, will percept intimacy with severe anxiety, will fantasize about the therapist's hostile intentions, etc. At times, the therapist – along with the parents – must himself make the decision about starting therapy. Each time when there are dangerous behaviours present – such as suicidal thoughts, self-injuries – one may need to reconsider the decision about conducting the therapy in an out-patient facility, at least at the beginning of the process. As a result, there is the necessity of imposing a distinct therapeutic frame, of setting conditions in which the therapy can take place. I wish to point out that the above means not only holding the frame, but, occasionally, it also means a contract to control weight (when there is anorexia present), agreement on being informed about increasing suicidal thoughts, expressing consent to a temporary hospitalization or at least simultaneous psychiatric consultations. At times, is may be necessary for parents to take action or participate in the therapeutic process. It is not sufficient simply to discuss and interpret a strong charge of aggression that these patients may bring in, it is also necessary to set some safety conditions. Now and then one may need to confront and explicitly name what he/she finds disturbing or pathological; most often we are the ones seeing the need for therapy of a patient, not the other way around. Such an approach, which may seem a bit aggressive on the therapist's part, will obviously cause the conscious opposition of adolescents. Simultaneously, however, on a different, preconscious or unconscious level, it is received in a positive manner, as it makes them feel that there is someone who can set boundaries, explain what is happening to them, introduce order, perhaps with some authority, into the previously chaotic world of their experiences. The moment when a teenager feels that the therapist knows what he/she is doing, and feels that it brings relief, is a moment in which the therapeutic relation gets stabilized.

What is crucial in the therapy of adolescents in general, and these adolescents in particular, is handling the defensive mechanism used by them – the destructive acting out. An adolescent acts instead of talking. For example, he/she starts a fight instead of an argument, abandons school (sensing that it will cause their parents' great distress) instead of starting a quarrel with parents or instead of telling them that he/she is afraid of failing. A teenager inflicts self-injuries, or does not eat, or vomits instead of trying to cope with the separation anxiety, with anxieties resulting from such impulses as the feeling of guilt, internal hostility, desire for revenge and other difficult ones. Most frequently, they cannot access these feelings; a therapist can rather suspect their presence, than find them in an adolescent's statements. Many theoreticians indicate that the reason for this disorder lies in a insufficiently developed psychological mindedness, in a disability to name one's affective states, resulting either from psychic reasons or from being brought up in a culture where emotions are released by acting out rather than by talking about them. In such a situation, therapy supplements an adolescent's development with precisely that aspect.

All the elements mentioned above clearly demonstrate that one should embrace a notion of therapy as a specific support for emotional development and a notion that such help needs to continue for a long time in order for its effects to be lasting. The main therapeutic elements here are the therapeutic relationship itself and what is known as a "corrective emotional experience". The latter includes, for example, the ability to withstand a patient's aggression, care for the patient, patience, empathic naming of the patient's condition, behaving in such a manner that does not confirm a patient's worst anxieties about the important adult figure's behaviour – meaning not abandoning them, showing interest in them, providing them with emotional exchanges rather than intellectualizations, etc.

Another group of problems result from a therapist's emotional reaction to such patients, i.e., from countertransference. They often cause strong anger, sometimes also sadistic impulses, reluctance to work, as well as anxiety. Still, work with them also gives way to positive feelings, especially during its later stages. Such therapies are sometimes described using the "re-parenting" metaphor, which means a renewed, corrective experience of the parental relation. Thus, these cause reactions similar to the reactions present in a parental dyad: care, the will to battle for them, strong identification with one's "own" patients, feelings of omnipotence, grief when they give up therapy and a specific pride when they change and adapt socially. Naturally, the transference is not a worrying phenomenon by itself, although in this type of therapy it can be so intense that it may cause the therapist to take some not-well-thought-out actions.

What I wanted to communicate through this lecture is the thought that the basic problem, but also the task, for a therapist working with patients with abnormally developing personalities is preventing any developmental foreclosure, attempting to maintain flexibility typical for the adolescence period, giving support for their testing of various solutions and integrating developmental failures, and making sure that the latter do not cause excessive developmental disturbances.

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