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Psychoanalytic Therapies

Psychoanalytic therapies with adolescents rest on the general methodological basis of psychoanalysis. What is special in work with adolescents concerns the specific developmental dilemmas and conflicts of that age. These include rapid and dramatic changes physically and mentally. In the essay, central concepts of psychoanalytic method are presented, variations of opinion are noted, and challenges in work with adolescents are discussed. The author pays special attention to the problem of precarious rapport with the patient, and the need to combine ordinary method with more intuitive interventions in order to reach the young patient emotionally.

Psychoanalytic therapy with adolescents does not differ in its main features from general psychoanalytic method. Its aim is an understanding and working through of *unconscious conflicts* and *character traits*. Central therapeutic concepts are *free association*, *transference/countertransference*, and *resistance*. The medium for the therapeutic process is the relationship between patient and therapist. Moreover, for the therapeutic process to unfold, it has to be framed in *a setting*.

So, the dynamics of the interaction between patient and therapist is in the very center of the psychoanalytic understanding of the treatment situation. The patient is of course a highly subjective participant in the therapeutic process. Also, the therapist runs the risk of being drawn into subjective and irrational thinking and action. The therapist's subjectivity must be monitored and controlled. For this reason, the therapist needs concepts and ways of thinking, helping him or her to maintain a *therapeutical stance* and to remain in a *therapeutic position*. The concepts regulating the therapist's relationship to the patient will be discussed under the headings of *therapeutic setting* – the arrangements of the treatment situation and the *therapeutic attitude* of the therapist – the mental and intellectual attitude that guides the therapist in the work. So, the therapeutic process unfolds in the

relationship between patient and therapist. Central process concepts are *transference* – the patient's projection of internal object relations on the therapist; *countertransference* – the therapist's reactions to these projections; and the patient's *resistance* to the therapeutic method and to changing. The therapeutic action includes *interpretation* of repressed, unconscious conflicts, and fantasies, *working through* of these fantasies, *affirmation* of feelings, and *containment* of intolerable inner states.

Work with older adolescents conforms closer to adult psychoanalysis, *a talking cure* on the coach or sitting face to face. Work with younger adolescents is closer to child analysis. Drawing and modeling are activities that can accompany talking with the therapist. What is special for adolescent analysis concerns the intrapsychic dynamics and conflicts specific for that age. One challenge concerns the differentiation between more normal teenager turmoil and unrest of psychotic kind. This has to do with an instability related to extensive changes in the adolescent's inner world. The rapid and dramatic transition from child to adult in a number of areas, somatically, sexually, emotionally, and in terms of identity, is demanding. It easily awakens fears of chaos, break down, and psychosis. Paradoxically, these often quite rebellious years are also marked by an underlying anxiety for changes (Freud, 1958; Blos, 1962; Esman, 1975; Blos, 1979).

Inner pressures provoke regressive reactions, both within and outside the treatment situation. This in turn increases the tendency to more primitive maneuvers, such as abrupt transitions between contrary feeling states (splitting) and attempts to handle inner unrest by actions in the outer world (alloplastic adaptation). The identity crisis in youth concerns the task to gather different parts of the personality into a uniform experience of a coherent self. The development of a characteristic form – of an identity – of that which other people experience as the character of the individual is a dramatic process. This drama in the mental life of the adolescent has decisive treatment consequences (Hauser and Smith, 1991).

It is a difficult task to contribute to this process in a helpful way. The therapy aims at stimulating a development where impulses to act gradually are metabolized and transformed into mental pictures, symbols, and metaphors. The concern is the development of reflective functions and mentalizing capacity. The presupposition is that this development is promoted by analytic therapy; by interpretations and other forms for verbalizing preconscious and unconscious inner states; and by the therapist's efforts consistently to contain the patient's unbearable feelings and self-states (Sarnoff, 1987).

The task to engage the young one in treatment starts before the first session. If the youth asks for treatment, the preparatory work is comparatively easy. An appointment is made. It is a point that the waiting time is not too long. Time is running faster and things change more rapidly in youth than later in life. For younger and sometimes also for more severely disturbed adolescents, the preparatory process is more intricate because the parents make the contact with the analyst. The treatment has better chances to be productive if the youth feels that it is his or her project, not the parents'. Actually, this is a necessary condition for a therapeutic process to begin – necessary but not sufficient. There are no fixed rules for how to proceed when other persons than the youth make the first contact. What is demanded is empathy with the situation of the young one and tact, respect – and wisdom, like so often else in this business.

In the opening phase of the treatment, the therapist tries to establish an alliance and a working situation with the patient, which can serve as a platform for the treatment. That goes for all treatments of this kind. But the situation is usually easier to handle with neurotic, grown-up, suffering patients. The rapid oscillations in the inner world of the adolescents often give their therapists a feeling of walking in a minefield, where a wrong step is very easily taken and where the consequences can be devastating for the treatment. Again, empathy and tact are called for; and acceptance of the patient's initial skepticism.

For the treatment process to unfold, it has to be framed in a safe and predictable setting. This setting consists of the concrete features of the treatment situation; of what can be called the analytic rules of the game; and of the relationship to a therapist offering mental space for emotions and other inner states. The concrete features comprise the consulting room, which has to be relatively sheltered and a contract, that is, agreements concerning sessions, vacancies, money, and cancellations. Traditionally, the analytic rules of the game includes instruction of the patient to free association, confidentiality, the rule of abstinence, and the boundary between the analyst's professional and private life-spheres.

In contemporary psychoanalysis, some of these features are under discussion. The analytic *basic rule* concerns the instruction for free association. The patient is encouraged to let the thoughts go, and as honestly as possible to tell whatever appears in the mind. It is recognized as a difficult task, the possibility to associate freely has even been questioned. And it certainly contains a paradox: I want you to be spontaneous! One way to surpass the paradox could be to say to the patients: "Take the time you need in order to say what is on your mind and in your heart." This formulation is fairly close to Freud's instruction. And it underlines the importance of honesty and sincerity.

The rule of *confidentiality* concerns professional secrecy. It safeguards the feeling of security when sharing with someone else the thoughts that are the most secret, the most shameful, and the most painful. The patient has to trust discretion and confidentiality on the part of the therapist. Working with younger adolescents, the therapist sometimes has a more complex situation and quite specific considerations to make. Shall he or she meet the parents or not? Shall the patient be present at the meeting? And how can the therapist prepare the adolescent to these meetings? Opinions may differ, but if the decision is made to meet the parents, the therapist usually has an easier situation to handle if the patient takes part in the meeting.

The rule of *abstinence* can also be called the rule of non-gratification. It was in 1915, in his observations on transference love, that Freud formulated the principle behind

the rule of abstinence. He encouraged the analyst to let the patient's needs and longings remain unsatisfied, and realize that they are forces driving man to work and change. The point is the basic view of psychoanalysis that it will not cure the patient to satisfy his infantile needs and longings rooted in unconscious conflicts. It is the infantile roots that have to be analyzed. This will open the way for more mature forms of satisfactions. These points of view represent the traditional view. The contemporary debate is more complicated. Now, a distinction has to be made between *affirmation*, understood as a validation of an experience (I can understand your emotional reaction) and *gratification*, understood as a direct gratification of infantile needs. (An inflation of the patient's self-image by direct praise or commendation.) Many therapists are of the opinion that this latter type of gratification has no place in psychoanalytic therapies. Others state that gratifications are unavoidable and play an important part in every analytic treatment. Actually, the question of gratification is not simple. The experience of being understood in a deep, existential manner is gratifying. This goes whether the understanding is expressed by an affirmation, or by an elucidating interpretation. In both cases, the patient gets a strong satisfaction: an experience promoting the therapy process. The decisive point is what is gratified, and in which manner it is done. And it is relevant to note the difference between drive needs, especially infantile drive needs on the one hand, and relational needs, for example, need for security, on the other.

What is the therapist's private sphere has to be kept outside the therapeutic situation. The important boundary between *professional* and *private* is already anchored in the concept of professionalism. It is valid for all psychological and psychiatric activity and not only for psychotherapy. Keeping the boundaries against the private sphere is a protection both of the patient (against incestuous or other kinds of exploitation), and of the therapist (by reduction of the strain on the therapist's private sphere of life concerning emotional and other effects from exposure and engagement in the work). This boundary underscores the importance of the therapist's personal way of relating to the patient. His or her personality and

temperament play an inevitable part also of professional, and therapeutic, relationships. Adolescents can be very sensitive to these qualities in their therapist. In this connection, there is a related concept, namely authenticity. To be authentic means to be one without pretending. This premise ties up to a very important assumption: honesty, sincerity. The demand of honesty is invariable and complicated. This goes both for patient and therapist!

The establishment of a setting presupposes an internalized and integrated analytic attitude in the psychotherapist. The setting is a dynamic phenomenon, often attacked by the patient who wants to replace it by a more private relationship to the therapist, or in other ways move the frames for the treatment. This makes analytic attitude to a core concept in therapeutic therapies. It functions both as a motor for the establishment of the treatment situation and as a monitor for the maintenance of it. Just because the emotional exchange between the patient and the therapist is of such decisive importance for the process, a pure intellectual and "technically correct" effort on the part of the therapist will be insufficient. As therapist you "let yourself go" emotionally, permits yourself to be moved by the patient's suffering, experiencing it "as your own." Simultaneously, you preserve your ability to reflect about the patient, about yourself, and about what happens in the relationship. This ability of oscillating between attunement (feeling *with* the patient) and reflection (thinking *about* the patient) is a central factor in analytic work, and an important part of the concept of attitude.

In this oscillation lies a risk. The therapists let themselves be brought out of balance emotionally, by identifying with the inner condition of the patient, which so often is characterized by pain and anxiety beyond what is tolerable. They do this in the confidence in their ability to – in the next moment – to restore their capacity to reflect, and thus not just being as overwhelmed and helpless as the patient. A word of caution: whoever lets him or herself be moved runs the risk of getting out of position; whoever opens up empathically for the patient runs the risk of overidentification; whoever aspires to neutrality, risks becoming impersonal. The required openness and vulnerability implies that therapeutic attitude cannot be of a

static nature. If it turns static, it has become a defensive clinging. For these reasons, the therapeutic position is easily lost and has to be restored again and again.

The therapist's way of listening, the evenly spread attention, concerns letting everything that happens, everything that is said, initially be given equal importance. This builds upon the idea that the Unconscious neither works according to ordinary logic nor according to ordinary rules of disposition. What is important does not come first or is centrally placed, nor is the succession chronological, nor comes the cause before the effect. The orderliness of time, space, and causality is not valid in the Unconsciousness. And, because the patient himself is unaware of how things connect (this concerns unconscious connections indeed), it is impossible to approach the material by logical means. Instead, by unconditional, evenly distributed (and patient) listening the therapist tries to let the picture become visible and to discern the figure-ground relations in the patient's inner world. The point is that a pure intellectual endeavor is insufficient. So, a central part of therapeutic attitude is the acceptance of any feeling that is present in the situation. That every feeling in the patient is allowed to appear and is neither covered up nor run away from. When everything seems hopeless, the therapist avoids colluding with the patient that there is hope for a brighter future. He might think that there is "light in the end of the tunnel." Often however, the patient needs quite a long time to be able to see any light at all. In the meantime, the patient and the therapist must stay in a tunnel with no light. This is part of the strain in engaging in these processes. Several concepts of different theoretic standings refer to these processes. *Containing* (Bion) and *holding* (Winnicott) are the most central.

Even if it is a question under debate, many analytic therapists are of the opinion that *neutrality* is an indispensable attitude. Neutrality in this context does not mean absence of engagement or interest or closeness; neither does it mean an ambition to be "a white screen" to the patient. These are misunderstandings. Neutrality refers to a position suited for observing the inner conflicts of the patient. It has been called a strategically favorable position in relation to the patient's conflicts; a position

equidistant to the id, the ego, and the superego. A position, which makes it possible to observe, understand, and interpret the oppositions and struggles between drives and desires on one side and the demands of conscience and morality on the other.

The neutral position, equidistant to the conflicting needs of the patient, corresponds in a rough way to an intermediate position between the youths and their parents. With acting, abusing, and self-destructive adolescents, there is a real temptation that the therapist sides with what is reasonable, healthy, and well ordered; thus turning into a parent, feeling responsible to guide the youth in the right direction even if he knows well that it is a vain attempt. The therapist is easily seized by an educational zeal and imagines knowing what are right and wrong, good and bad for the patient. In such a position, it is hard to avoid the fact that the youths feel exposed to accusations of disobedience and attacks on their self-esteem.

A related form of repairing zeal can be the ambition to be a "good parent," capable of correcting the faults of the real parents. And related to this attitude is the ambition to be a "pal," on the side of the young who often is in conflict with or in opposition to the grownups. To steer free of these pitfalls, it is also necessary to avoid an over-tolerant attitude, to avoid finding excuses for everything and accepting any behavior without questions. It also means to avoid identifying with immature protest: "we against them," the young ones against the adults.

To avoid these pitfalls, it is necessary that the treatment is framed in a setting that is firm, explicit, and predictable. This does not mean that it has to be rigid. On the contrary, a firm, explicit setting gives the therapist a more secure basis for flexibility, when that is needed. With a vague and indistinct setting, the therapist easily enters situations where it is necessary to tighten the borders in a more rigid way than he or she likes to. In addition, the analysis of the patient's attacks on the setting is impeded with. Often it is at the borders of the setting that one finds the "frontier of analysis" in the sessions. A distinct setting is reassuring for the patient. So is an attitude of the analyst, marked by friendliness, predictability, calmness, and space for thinking. Such means aim at promoting the emotional contact with the patient,

which constitutes the very medium for the treatment. The therapist gathers an extra bonus if the youth's curiosity can be awakened. It usually is there, somewhere, and it can contain a hint of hope for the future.

This kind of work presupposes a basic feeling of safety and trust in the relationship. The question of trust and lack of trust – whether the patient can trust the therapist – is a problem in most analytic work with adolescents, and frequently mistrust and skepticism are central problems. Simultaneously, a quantum of trust is a necessary part of the working alliance, one of the conditions for therapeutic work to take place at all. Here one faces a paradox. The patient has an attitude to the treatment, which affects a central condition for the therapeutic process to take place. For this reason, some therapies need quite a long time for the process to develop. And the importance of a predictable, secure, and distinct frame for the treatment becomes clear.

The therapist knows of the traps and steps into them all the same. The adolescent patient puts a strong pressure on the attitude of the therapist. All the time he or she runs the risk of acting instead of thinking. This means to give advice, evaluate, encourage, and criticize instead of analyzing. It is so easy to be trapped in collusion with the resistance of the patient or to pretend to understand the patient, but in reality let "the baby in the patient" down. The therapist's own resistance to the pain and trouble in the process may make him or her unconsciously enact in response to the demands of the patient and thus fall out of therapeutic position. Actually, this is the exact opposite of helpful empathy. The therapist may also be provoked by narcissistic attacks and respond with condescending interpretations. This catalog of ways to break the analytic frames and fall out of the therapeutic position can easily be prolonged.

Central aspects in the psychoanalytic conceptualization of the treatment process are *transference*, *countertransference*, and *resistance*. They are parts of the *relationship* between patient and therapist, which is the *medium* for the therapeutic process.

All the time, transferences color and distort the youth's image of the analyst. The term *transference* refers to the fact that elements of internalized object-self relations (usually comprising important caretakers persons from the adolescent's childhood) are activated in the therapeutic relationship. The therapist "becomes" the person of the activated relation. The transference is a projection, or displacement, of an earlier relationship to a present one. It is the quality, the emotional stamp, of the internalized relationship, which is transferred. The qualities of this coloring give the therapist hints of *who* the youth is relating to for the moment, i.e., who the therapist is for the patient here and now. To address the transference is a strong, although not always a simple, way to approach the patient emotionally; to break through different kinds of avoidances and get to the heart of the matter – where the patient actually is, emotionally, for the moment.

Countertransference denotes the therapist's response to a transference reaction. Some psychoanalysts take the view that all feelings the therapist has for the patient are countertransference feelings. It may be questioned whether this statement is valid all the way. Even if the therapist all the time is subject to the transferences of the patient, and is reacting emotionally to them, this is not the sole source of the therapist's feelings in a session. Working with young people, it is inevitable that the silent, unhappy, stubborn, anxious, antagonistic, resentful, and furious young boy or girl evoke strong feelings in the therapist. And these reactions are not only countertransference, but also transference reactions. The patient is, potentially, the daughter or son of any therapist.

Nowadays, most psychoanalysts consider countertransference to be a double-faced phenomenon, both a potential distortion of perception of the patient and a potential means for a better, and deeper, understanding of the patient's inner life. Perhaps countertransference can best be conceptualized as a multilayered process, on its best being intuitive, sometimes creative, but all the time under pressure of leading to irrational and distorted reactions and the activation of blind spots.

The therapeutic work and the experiences and insights it gives evoke resistance in the patient. The resistance is caused by an anxiety that the insights will disclose something worse than the present misery. From this point of view, it can be seen as an attempt to protect a precarious self-state. To address the patient's resistance, the therapist has to address this anxiety. This means to recognize the conflict between the patient's wish for self-recognition and the opposed, defensive clinging to a deceptive self-picture, and then comment upon it and analyze it. When this endeavor is successful, the patients' inner horizon is extended. That gives them more space for curiosity and makes them bolder to approach more of their hidden parts. This can be the start of a good circle.

For the young patient, the therapeutic relationship is almost always marked by tensions between skepticism, mistrust, insecurity, and anxiety on the one hand and a measure of trust, security, peace, perhaps even hope on the other. In reality, the aspects considered here are closely interwoven. The tension between skepticism and trust in the patient, the changing qualities of transference and the anxiety and resistance evoked by the therapeutic process are, all of them, significant aspects of the patient's inner state at any moment – and therefore at the very center of the therapist's attention.

Not all, but probably most youths in treatment are, in one way or another, victims of unfavorable or traumatic circumstances, inadequate childhood conditions, rejections, losses, and humiliations. At the same time, they are active agents in their own lives. If the treatment is to be of any value for them, they have to strengthen the active grip on their lives and give life a constructive direction. For that reason, it is a central point – even a basic ambition – for the treatment to promote an active attitude in the youths toward their life and its course, a consciousness of the choices they has to make and a relative autonomy in making them. Therapeutically, this requires a simultaneous focus on these two conflicting conditions of human life; individuals are at the same time *victims* of circumstances beyond their own control and – with these circumstances as a background – active agents in their own life.

In classical psychoanalysis, the aim of the treatment was the patient's insight. An extended and deeper self-knowledge was the way to overcome neurotic inhibitions and symptoms. And the insight had to be emotional, not only intellectual, meaning that the insight had to be experienced in a relationship to be effective. This view is still valid. However, the picture is more complex today. Interpretation of unconscious thoughts, wishes, and conflicts and working through of what comes to the fore are not the only means for psychic change. Also, containment of unbearable inner states and affirmation and validation of feelings and experiences are part of the therapeutic toolbox. In schematic outline, interpretation aims at new insights and extended self-knowledge; working through aims at strengthening the capacity for symbol formation and mentalization; and containment aims at strengthening the capacity to deal with and stand strong (intolerable) feelings and inner states.

Usually, an interpretation of the patient's unconscious wish or fantasy has to be prepared in several steps by the therapist. The first step is empathic listening, a sharing and standing the painful feeling state. This is quite necessary for the therapists in their attempts to approach and know the patient's inner world. The result is an understanding making it possible for the therapist to validate the patient's feeling state in the moment; maybe also contain what is intolerable for the patient to stand alone. It also makes the basis for the therapist's reflections toward an understanding, which can be formulated and expressed to the patient in the form of an interpretation. Many contemporary analysts hold the view that already the preparatory steps of empathic listening, affirmation, and containment are effective parts of the treatment beside interpretation proper. Opinions differ concerning the value of deep interpretations compared to interpretations close to the patient's conscious surface. However, recognition and interpretation of the actual anxiety are considered important both in the establishment of contact and working alliance with the patient, and in analysis of resistance (Anderson and Dartington, 1998).

The methods for change in psychoanalytic treatment: containment/affirmation and interpretation are connected both to differences in the nature of mental material

addressed by the intervention and to differences in personality structure of the patients. Neurotic patients, mainly suffering from internal conflicts and inhibitions and repressed wishes and fantasies, can make use of interpretations of their unconscious and repressed material. For patients suffering from personality disorders and with various degrees of developmental, structural deficits, there may be need for more preparatory work in the form of affirmation and containment before the patient can profit from interpretation of unconscious material. This difference corresponds to the distinction between patients wanting to understand themselves (wish for extended self-knowledge) and those primarily wanting to be understood by the therapist (need of validation and acceptance). In therapeutic work with adolescents, this choice of therapeutic strategy is important, and their need for affirmation preparing for interpretations should not be underrated.

In the therapeutic process, an internalization of parts of the therapist takes place; a partial identification with the therapist's ways of behaving and thinking. The therapist becomes an object, maybe a good one, in the internal world of the patient. However, the "helpful" aspects and functions for the adolescents are not to get the answers to their questions or being told what is right or wrong in a given situation. What has to be promoted is the ability to think and understand before acting and capacity to contain feelings and inner states instead of acting as response to emotional pressure.

Psychoanalytic therapy with adolescents is not in principle different from work with other patients. Nevertheless, the adolescent patients confront their therapists with some challenges that seem more frequent and more pronounced at that age than in patients of other ages. A common denominator can be the therapist's helpless feeling of not reaching the patient – a situation, which may call for unconventional means to bridge the gap to the patient. Generally speaking, the language is extremely important in analytic work with adolescents. The therapists have to find, or develop, a language they can have in common with the youth, and they have to find areas of relevance where they can talk with the patients in this language and in that way try to establish a space for reflection, where symbols can be formed.

Especially later in the career, when the therapists may have less contact with adolescent mentality than earlier in life, the question of teenager language and culture can present a problem. And the question of language is central, because it concerns a crucial step on the way from (impulsive) action to thinking. In classical analysis, the capabilities for impulse *delay* and *detour* are hallmarks of the strong, reflecting ego. In contemporary thinking, *mentalization* and *reflective functioning* refer to closely related phenomena.

In analytic work with neurotic adults, *silence* is usually looked upon as resistance to the basic rule of free association. In adolescents, and also in more severely disturbed adults, silence can be an expression of quite different states. It can be a protest against the treatment or a rejection of the analyst. It can express a feeling of abandonment; a conviction that there is no bridge, no connection to the other, and therefore talking has no meaning. It can express an inner state of emptiness that can be even more terrible than the feeling of abandonment; the ultimate desolation, where talking feels completely meaningless. Sometimes silence can be an expression of an inner work, a work with something that is unknown or un-experienced by the patient. Alternatively, more correctly, the silence hides such an inner work.

Discrimination of these different qualities in the patient's silence has to be done in the therapist's countertransference feelings evoked by the patient; and interpretations are based on such countertransference analyses. This work has to take place in the wordless contact between the adolescent and the therapist and in the inner world of the therapist. It is a work with one's own feelings and states. And the "muter" the patient is, the more difficult becomes the task to reach the youth in a way that bridges the gap.

A frequent situation for adolescent patients is *lack of friends*. They are lonely and often have a feeling that nobody can be trusted. They are convinced that if they start to like a person, this person will disappear the next day. Often, this state is rooted in a dilemma concerning intimacy and closeness. The adolescent's longing for close, loving relationships activates an anxiety to be devoured and destroyed by the loved

one, who in the inner world becomes a persecutor. But if they try to protect themselves against the annihilation by withdrawal and keeping distance, another, not less intensive, anxiety namely the feeling of total loneliness and desolation, overwhelms them. It goes without saying that this dilemma constitutes a formidable first obstacle to the establishment of a tolerably secure working alliance in therapy. At the same time, such a dilemma sets the tone for the transference and countertransference material that develop in the process and the way these reactions affect the therapeutic work (Barrett, 2008).

A deep feeling of loneliness is often a part of suicidal states, and among the scenarios the adolescent patients present are those marked by violent *self-destruction* often combined with violent *destructiveness* (Laufer and Laufer, 1984; Laufer, 1995). These patients always impose a heavy load on the therapist, a load that is not lessened by the fact that the rapport with the patient often is fragile in these cases. In their efforts to address very complex and at the same time emotionally highly charged states, the therapists have to use metaphors and elements from the whole cultural and ideational field they have in common with the patient. Such elements form a kind of transgressive steps, which the therapists take to communicate their understanding of the patient's inner state. These are more or less intuitive, creative, sometimes with a touch of playfulness. And they are not always easy to catch in strict sets of rules and techniques (Zachrisson, 2006). An example can be the therapist quoting some lines from a song by Leonard Cohen and in that way manages to establish a new and closer contact with his patient. Another example describes the therapist in a desperate situation. The violently suicidal young patient was going to hunt in the weekend and was explicitly threatening to kill himself. The therapist invited him to imagine what would happen after he had shot himself, his body still warm with the bullet in his heart, and the funeral when the casket is closed and they bury him. He interrupted her, covered his face with his hands, perhaps weeping. It was a moment of intense feelings. However, the therapist's attempts to talk with him and get him to desist from going were rejected. Some minutes before the end of the session, he got up to

leave. Standing face-to-face with him, filled with despair and angst, not knowing if she would see him again, the therapist heard herself say: Since you are going to go hunting anyway, you can bring me a present (!). On Monday, the boy did come back alive and handed her a piece of raw amethyst. He told her that her request had caused him quite a bit of work. What could he bring her from the middle of the countryside? Finally, he found the stone. It is valuable, he said. If you work on it, it is semiprecious. The analyst replied that for her it had the value of life. After finding a place for the stone in the bookshelf, he told her how scared he had been of her description of his funeral after a suicide. He noted how he avoids thinking things through, not seeing the consequences of his actions and the analyst stated that now he can think a little further and in that way counteract his impulsiveness.

The therapist's interjection can serve as an example of working in the countertransference. Such work is based on intuition. Working with adolescents, you have to trust your feelings. It has to be added that work in the countertransference usually unfolds in a more down-to-the-earth way. But when intuition hits the mark, it establishes a strong contact and a feeling of mutuality with the patient. This intuitive element in analytic work, especially in work with adolescents, appears as a supplement to tried-out analytic techniques. However, it is important to underline the necessity for psychoanalytic therapy – in its point of departure and in its procedures – to remain based on a contemplated and carefully described method. At the bottom, it rests on a craft *lege artis*. And this craft concerns the therapist's inner work, in which theory, experience, reflection, empathy, countertransference feelings form a field that gives direction to intuition and creativity. Without such a methodological grounding, intuitive interventions easily become magical guesses, which often run the risk of leading into dead ends instead of opening up new vistas.

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