# No Direction Home:

# An Existential Perspective on Engagement and Change

# with an Adolescent

by

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A case study submitted to the

School of Social Work

Rutgers, The State University of New Jersey

in partial fulfillment of the requirements

for the degree of

Doctor of Social Work

Graduate Program in Social Work

New Brunswick, New Jersey

October 2015

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Abstract

This case study examines the use of Existential Theory as it relates to the complexity of the adolescent therapeutic alliance. Due to the unique psychosocial circumstances of adolescence, clinicians frequently encounter considerable barriers when attempting to engage and maintain a therapeutic relationship with an adolescent. Emotional trauma and the absence of effective coping skills can lead adolescents to express themselves through physical and verbal aggression that poses a unique challenge for clinicians in the engagement process. Clinicians often struggle with empathy during these encounters, consequently leading to a rupture in the therapeutic relationship and little therapeutic change. This case study will also consider how family therapy, phenomenology and intersubjectivity relate to the use of Existential Theory in practice and how this relationship can lead to a positive outcome in the adolescent working relationship.

**Privacy Disclaimer: To protect the confidentiality of the client, identifying information has been disguised and certain details have been concealed.*

## Introduction

A sense of meaninglessness in life is perhaps one of the most universal of human experiences, however, how one adapts to this experience is often overlooked. The challenge of finding meaning in our daily lives is familiar to most everyone – this does not exclude clinicians regardless of background or theoretical orientation. When engaging adolescents clinicians often do not keep in perspective the adolescent's own personal or subjective experience in their search for meaning. Many clinicians will reveal that they do not feel fully prepared to truly engage or even attempt to understand the emotional dysregulation and uncertainty of adolescence. It seems that clinicians will often address desired thought or behavior change – losing focus of the adolescent's internal struggle for self-definition or the adolescent's definition of his or her relationship with others. While not always needing to be the primary therapeutic modality, existential theory can stir a clinician's sense of empathy and put them back in touch with what the adolescent is experiencing. The use of existential concepts in therapy focuses on boldly letting the client take center stage with the clinician eventually becoming an active participant in the client's subjective experiences. In a sense the clinician becomes a co-author or perhaps a consultant in the process of meaning-making. This active participation is not possible without an understanding of how these concepts relate in practice to the client encounter. Considering an existential approach in our work with adolescents, individually or from a family perspective, is significant as we look to explore the development of meaning within the therapeutic encounter. It is by viewing encounters through this lens when we start to become acutely aware of the limitations of evidenced-based treatment and significantly more aware of the importance of humanistic concepts have on our clinical encounters with adolescents.

Beneath the surface of manualized treatment modalities lies a rich environment of context dependent knowledge that is often untapped by practicing clinicians, especially in regard to our understanding and use of existential concepts. Schneider and Langle (2012) when examining the recent resurgence of the humanities in psychotherapy suggested that a "fundamental shift may be occurring…a shift marked by elements that cross-cut particular approaches,

and that accents particular contexts – such as the therapeutic alliance, empathy, genuineness, the receptivity to client feedback and meaning-making" (p. 428). The idea that treatment can be led by a foundation of "meaning-making" and "cross-cut" treatment modalities is intriguing, but disappointing is the significant gap in writing regarding the application of existential concepts in relationship to the treatment of adolescents. Most notable is the near absence of existential concepts in literature regarding the treatment of adolescents. Bill Fitzgerald (2005), while addressing the relevance of an existential approach in adolescent development, presents in his work "An Existential View of Adolescent Development" some of the ideas that have stifled the use of existential concepts in our work with adolescents (p. 795). Fitzgerald suggests that critics of existential psychotherapy argue that it "requires advanced cognitive abilities" and that adolescents have not accumulated the "large amount and variety of life experiences" that is necessary to understand the concepts of existential psychotherapy. In this paper I would like to demonstrate that the adolescent need not to have superior intelligence or significant life experience to benefit from the use of existential concepts in treatment and that these concepts can be and should be considered more often in our work with this population.

While it may be temporarily denied, each one of us eventually lives life unable to escape human freedom, the creation of meaning in our lives, and the responsibilities that go with it. The idea that adolescents cannot reach an inner balance through their own self-exploration ignores the true depths of the human experience at this developmental stage. Berman, et al. (2006) write that, "adolescence is an important time to study the development of existential concerns. Models of social and cognitive development suggest that by the high-school years youth are able to comprehend the meaning of life and death and that broader life issues become salient" (p. 304). Later in his writing, Fitzgerald (2005) also funds this idea that adolescent conflicts can "closely resemble existential issues" and that the adolescent's sense of "freedom, choice, responsibility, and awareness", in the search for self-definition, "may result in increased anxiety and a sense of personal emptiness" (p. 795). It is my experience that there is a near absence of these ideas in most agency practice settings that treat adolescents. There is a tremendous focus on evidence-based treatment within agencies that creates a practice culture of avoiding fundamental issues of personal meaning-making, resulting in a hyper-focus on cognitive and behavior approaches. I would like to suggest that in every adolescent encounter that existential ideas are significant in the engagement process and in the creation of change within the adolescent, whether they are directly recognized or not. A sense of meaninglessness in one's life was referred to by Otto Rank as one of the "ultimate anxieties", anxieties that he believed could potentially be lessened by the combination of a strong therapeutic relationship with a client and their ability to exercise his or her own creative free-will – this notion complicates the very foundations of evidenced-based treatments (Shumaker, 2012, p. 379). It is by placing this careful attention on attending to the adolescent's personal experiences that strongly reflect the social work value of starting where the client is and ultimately create a unique perspective of the adolescent as an individual, outside of manualized frameworks. While a loss of meaning in one's life and the anxiety that it produces can affect someone at any developmental stage – few are more significantly influenced by this fear than the adolescent. It would be through my experience and interactions with Allison, a 16 year-old girl who was referred to a community-based family co-therapy program where I would become much more aware of the impact that existential theory can play in the process of therapeutic engagement and change with adolescents. The following is the story of Allison; this disguised case study symbolizes the potential use of existential theory in practice and the effort she had put into finding direction home.

## Initial Home Encounter

"Oh, great – you're the people that are going to make me go to school," she said. "Come on in, I'll show you around," her voice trailed off with a sarcastic tone as she quickly disappeared into the living room, leaving the front door wide open.

"After you," Sue said grinning, motioning with her arms. In working with Sue over the past few years as part of a co-therapy team, I've learned to appreciate her uncanny ways of reducing tension and anxiety, especially during intense clinical encounters. After a brief hesitation, Sue and I followed her in, our eyes slowly adjusted to the dimly lit house. But before we could say a word, Allison exploded.

"How many times do I have to tell you? Don't run around like that in the house!" Allison sighed

and seemed to roll her eyes in disgust as a young boy who was maybe ten or twelve raced down the stairs past us and out the front door.

"So, who's the little guy?" Sue said softly, her head turning in sync with the young boy as he raced out the door, "Is that your brother?"

"Is your mother home, Allison?" I interjected.

"That monster is Jeff. My mother is at the store – she's supposed to be here now," Allison said firmly as she started walking up the stairs – one could easily hear a level of frustration in her voice, "You can see my room; it's where I spend most of the time anyway."

As we walked into Allison's room I remember thinking that it seemed significantly brighter than the rest of the house; sunlight pierced through the light blue curtains, the walls were a clean bright white – everything seemed in contrast to the dark wood panels and stained tan carpet downstairs. The room was decorated with dolphins – pictures of dolphins, paintings of dolphins, and figurines of dolphins.

"Ya know, my aunt was in Florida last summer, that one's from her," she said, as I studied a blue and pink marbled dolphin on her dresser. Allison flashed a smile. She began to tell us a story about how her aunt gave the dolphin to her as a gift, then she abruptly stopped talking. Her smile was replaced by a look of intensity that I would later learn is almost always on Allison's face. A look that was out of place – a look as if she is completely detached from those around her. A look that makes you want to be serious – but, you just become used to it if you ever get to know Allison. Whenever she smiles, it's like a glimpse of a deeper, distant part of her that she didn't really want you to see. Allison quickly jumped to show us a painting of flowers that she said she had been working on.

"You're close to your aunt?" I asked, searching for some meaning in Allison's smile.

"My mom's crazy, ya know… she's the one who needs help here." She refocused her attention to rearranging the paintbrushes and tubes of paint that were scattered all over her desk.

Something about Allison's behavior was throwing me a bit off balance and as if to ground myself I looked over at Sue. I had gotten used to interacting with Sue, relying on our non-verbal communication to help give understanding to some very intense moments when working with families. I was sure I looked confused; Sue's eyes widened as she nodded her head seemingly offering assurance to me that I wasn't the only one. I quickly changed the topic of conversation – and as we started to discuss with Allison her favorite music, food and clothing, Allison calmed. She became much more talkative; she showed us her art magazines and described the itineraries she had already planned for visiting places all over the world.

"Wouldn't it be great to just go wherever you wanted?" Allison's speech accelerated, "I mean, really; like just anywhere in the world – wherever." With her sarcastic tone she queried, "As if money and time didn't matter, right?" She went on to discuss her desires to someday go to art school and travel the world.

"Who would you travel with?" I asked.

"Oh, I'd just go on my own… or, maybe I'd just find someone along the way, ya know?"

Allison's ability to socialize and engage with us in conversation was actually far better than I had thought, especially for meeting with her only a short period of time previous to this encounter; however, now at sixteen-years of age, she said she spent almost all of her time at home and by her account she had no friends. This was hardly the adolescent that was described in the psychological report – the one that pushed her mother when refusing to go to school and the one that suffered from "extreme social anxiety". I thought to myself that this couldn't be the girl who displayed "frequent verbal aggression" and was being recommended for residential treatment.

"Allison, are they here? Can you please put this stuff away, I want to talk to them, okay?" As we heard her mother open the front door downstairs her voice filled the house - Allison flinched before turning and leaving her room. Sue and I followed her down the stairs and that is when Allison's demeanor completely changed.

"I don't think so, I'm leaving mom…I don't really want to be a part of this bullshit," she said. As she walked out the door, ignoring attempts by all to persuade her otherwise, I was thrown off by how Allison's attitude had just changed. Immediately sensing the disharmony, I could feel myself being pulled into the family dynamics and the void that Allison had just left.

As is often the case, adolescents were referred to this community-based program after there is much discussion regarding the possibility of the adolescent being referred for residential treatment. Allison's referral carried with it a history of refusal of services by Allison; she would frequently push others away and use threatening behavior to keep them at a distance, which often

led to much frustration from treatment providers. Allison had a reputation of being difficult to engage in a therapeutic relationship and not responsive to firm limit setting, cognitive or behavioral interventions. After being introduced to Allison and her mother, Mary, briefly in the mental health out-patient clinic a week prior to the initial encounter, myself and Sue, a co-therapist in the program, had visited them at their home for the first time. It was because of Allison's struggle with past services that we decided to place more emphasis on the engagement process and to focus less on her behavior and more emphasis at trying to gain insight into Allison's experiences. We sought to understand not how Allison could change her thinking or behavior, but rather what meaning was there behind her thinking and behavior. In other words, if we could enter Allison's world and truly begin to understand the reasons for her behavior while sharing this experience with her, perhaps there would be potential for engaging in a relationship with her.

Without understanding the motivation for Allison's behavior and the meaning that she attributed to it I thought there would be little chance of engaging her; I thought that it would only be in understanding Allison on much deeper level where the building of a relationship could take place. Empathy has been defined as the ability to place one's self, "into the psychological frame of reference of another" (Wynn and Wynn, 2006, p. 1385); Aristotle had referred to it as that which "makes [the other's] misfortune seem close to ourselves" (Rosan, p116). While now reflecting on how Allison's behavior had impacted me, I realize that I did not truly appreciate her "psychological frame of reference" at that point in time, nor could I feel genuinely connected to her "misfortune". The use of "meaning making" concepts in therapy can be closely tied to the development of empathy, the catalyst in forming any relationship. Without awareness of another's internal world, without understanding the meaning they attribute to their experience, it is impossible to move forward in any relationship. While there are many factors which would negatively impact this process including therapist objectivity or burnout, it is the clinician's ability to maintain a balance between an awareness of the self and an awareness of what the client is experiencing that is crucial to the interaction. Mathew Ratcliffe (2012) suggested in "Phenomenology as a Form of Empathy" that empathy is not necessarily always understanding the other, and can be "achieved, in part, by letting oneself be affected by [another] and by reflecting upon how one has been affected. He explains:

> In order to understand this, a great deal of interpretation is required. But we start with a distinctive kind of attitude. It does not involve replicating the patient's experience. Instead, interaction with the person makes one feel a certain way, and that first-person feeling is at the same time a presentation of his experience as somehow incomplete, lacking. It differs from how the patient himself experiences his world, but it is does incorporate a degree of experiential insight into what that world is like, and is thus an instance of empathy. (p. 20)

The feeling I had as Allison was leaving the room was certainly not a "replication" of Allison's experience; the void I felt as she left the room was quite similar to the feeling that Radcliffe described as "incomplete" or "lacking", yet this first-person feeling can serve as a catalyst, or a beginning, of understanding. It is this suggestion that simply recognizing or identifying the absence of understanding another could be not only an empathic approach, but also the first step in beginning to construct meaning within a relationship. One could imagine how I started to feel some level of connection with Allison as she started to open up regarding her interests and experiences with Sue and I; at times there was a level of comfort in her presence – it was as if she was revealing parts of her true and authentic self. Just after Allison had left during that initial encounter, prior to these reflections, we processed with Allison's mother her daughter's abrupt departure from the home, we had sat down with her and inquired about what approaches she had taken towards managing Allison's behavior in the past.

"I've tried everything; she doesn't care about rewards or consequences... it's like she has different personalities." Allison's mother, Mary, was only imposing in the sense that she could easily cause you, without even noticing it, to lower your guard. Mary was timid and disarming; she described how Allison had become physically aggressive towards her last year when she sided with the school over concerns about Allison's poor attendance.

"How did you try to handle her behavior?" Sue asked anxiously.

"I tried to do what the school said about setting limits… but, it didn't work out." As Mary sipped on her coffee, between taking long slow drags on her cigarette, she explained in detail the story of how Allison pushed her so hard that she had lost her balance, falling into the window of the kitchen door. She said it wasn't until the next day that she noticed a crack in the window and the deep bruise that formed on the back of her arm.

"It seems though there are times when Allison can be mature, what do you think?" I said, intrigued by the contrasts in her personality.

"She can be very mature, Allison. She's a great help around the house; sometimes she just explodes, I don't know why, really. I know she doesn't like counselors; you'll find that out."

## Reflections on the Initial Home Encounter and the Plan for Treatment

Eventually, we would find out. However, now, after reflecting on what Allison's mother had said, I thought about the impact we have as clinicians during the engagement process, especially when we are so focused on outcomes. I could understand, as a clinician, the feeling that Allison's behavior needs to be controlled; that there needed to be consequences for her behavior – I personally felt torn between trying to make a quick fix by focusing on her behaviors or trying to focus on engagement. We rarely measure success by looking at the development of a sustained therapeutic relationship and the responsibility of rupture in the relationship is too often placed on the client, who is seen as difficult or resistant to treatment. In considering this, concepts of existential psychotherapy can provide a uniquely different perspective on this therapeutic interaction and place challenges not only on the client, but the therapist, as well. This view of therapy may be counterintuitive to the clinician who places a great focus on being objective – as we could imagine in a more strict behavioral sense, possibly even placing objectivity above that of the client's own experiences. Throughout the therapeutic encounter clinicians may find themselves drifting towards this narrowed outlook and losing touch with the client's personal goals and experiences in therapy, perhaps staying focused on measured results or outcomes. As clinicians we often try to find a balance between remaining objective and venturing into our own subjective interpretations of the client's behavior. Jim Lantz, when considering the use of existential concepts in family therapy, discussed the importance of drawing a distinction between these different styles. Lantz (2004) illustrates what is taking place when a therapist puts emphasis on a more objective approach, a style that he describes as a "philosophy of essence":

> In such a relationship of distant objectivity and observation, the therapist keeps his or her distance in order to maintain scientific objectivity and to develop accurate clinical assessments (Jayaratne & Levy, 1979; Lantz, 1978). In essence oriented family therapy, objectivity and detached assessment are considered safeguards that protect assessment clarity (Jayaratne & Levy, 1979; Lantz, 1978). (p. 168)

Existential psychotherapy contradicts this idea of the client being externally managed and manipulated in an encounter that Lantz has referred to as "distant," and "clinical." Rather, the focus is on making attempts to engage the client within their unique world – a sort of attunement to their phenomenological experience. Lou Agosta (1984) described this attunement as a moment when an "anomalous experience-distant story is brought nearer to [one's self]", or when "the pairing of self and other in imagination or recollection is capable of guiding empathic receptivity back to experience when it has otherwise been blocked" (p.57). The therapist's goal is, in fact, not to be distant, but rather join with the client's "inner awareness," while assisting him or her in the heightening of their own experience (Krug, 2009, p. 338). These ideas are then placed far above the ideas of "scientific objectivity" or efforts to safely maintain "assessment clarity." It is important to note that the idea is not to eliminate any objective view or understanding of the adolescent – ideally we should be able to alternate our object and subjective positioning in response to the clinical situation. Rather the idea is more of re-envisioning how far we can take our subjective and intersubjective experiences when in the engagement process. While in opposition to therapeutic styles that operate from a "philosophy of essence," existential psychotherapy has been described as being grounded in a "philosophy of existence," with a primary focus on the client's ability to create meaning, take responsibility for their choices, and exercise their freedom. It is through engaging the client's world and

understanding their experiences that the clinician can truly establish a therapeutic relationship and initiate change. Medina (2010) further comments on how existential psychotherapy can provide a different perspective in engaging the adolescent even when using a family therapy approach:

> For the individual to be in a room with his family and a therapist is to send the unequivocal message that the need is to resolve and enact in ways that are first and foremost authentic and effective for the family and not the self. This subliminal message is even stronger in cases where the child is seen as the problem and is being 'forced to be helped'. (p. 267)

When treating an adolescent with family therapy, agencies often label the adolescent as the identified patient, presupposing that he or she must adapt to the family's expectations. The adolescent cannot be, as Medina stated, "authentic and effective" for his or herself, as this is seen as a potential threat to the goal of family harmony. This approach often leads to the adolescent choosing not to be engaged in treatment or demonstrating resistance to being a partner in the therapeutic process. Krug (2009) supports this notion by explaining that the therapeutic relationship should be a "partnership in which the therapist is facilitating his partner's self-exploration so that…constricting blocks can be dissolved" (p. 340). These assertions by Medina and Krug support the idea that as clinicians we must be acutely aware of how we are engaging an adolescent in treatment. Allison could have saw her mother as a threat to her "authentic and effective" self; for instance, while it could not have been avoided in our first encounter at her home, Allison's mother forced her to face the conflict of how she was defining herself versus how she was defined within the family, causing her significant anxiety – thus her reaction to leaving her room, then home, so abruptly. It is also important to think about the role that we as clinician's play in threatening the adolescent's sense of self. Considering this, the clinician must resist the temptation of becoming another external force of control that ultimately ignores the will of the adolescent. In integrating existential psychotherapy concepts into the frame of family therapy, the clinician should make efforts to not only join with the adolescent, but to assist the adolescent in finding his or her own meaning, as well as, his or her role in the family – even if this temporarily threatens the clinician's ability to create a balance within the family.

As we continued gathering information from Allison's mother, we learned that Allison's father, Mark, divorced Mary when Allison was 10 years old. The circumstances for the divorce, according to Mary, were due to infidelity, and by all accounts Allison was able to process the divorce during that time with significant success in a previous episode of out-patient therapy. Mary indicated that Allison displayed mostly age-appropriate behaviors associated with the grieving process during that time period; she noted that the following school year Allison's school attendance started to drop. According to a psychological evaluation, Allison was diagnosed with Agoraphobia and had missed over two hundred days of school since elementary school. She would frequently complain of somatic symptoms related to her anxiety and complained of difficulty being in groups, especially in the school environment. The evaluation also noted that she had been diagnosed with an Adjustment Disorder, Generalized Anxiety Disorder and Major Depressive Disorder while in treatment. Mary said that she had a history of sporadic compliance with outpatient treatment and that the school was very concerned about Allison due to her poor school attendance. To assist in addressing her symptoms of anxiety and depression Allison had been treated with an antidepressant, which Mary said Allison now took with some irregularity. From a family therapy perspective, Allison had become a parentified child and that the absence of Mark from the family unit, along with the emotional vulnerability of Mary at that time, created an atmosphere that encouraged an enmeshed relationship between Allison and Mary. Very early in treatment with Allison we found that she in fact spent most of her days at home, often living out her life as a parent to her brother and arguing with Mom about household decisions. The initial goals established in treatment were to allow for Allison to increase her independence, shifting her focus away from her parental role in the family. This would require Mary to change her parenting style drastically and begin to parent Jeff and Allison equally. It would also require us to form a relationship with Allison.

**Engagement**

At first, and as was expected, Allison was not entirely cooperative. While there were isolated times when Allison would talk to us on a superficial level about her day, Sue and I were

frequently dismissed by her. We did meet some success in forming an alliance with Allison's mother. This was accomplished by frequent visits with Mary when Allison was not present. For the first few months of treatment, when checking our voice mail we would often receive messages that simply said, "You wanna meet for coffee?" or "What are you doing for lunch?" We learned that the coded messages meant Mary was overwhelmed, struggling to understand her role in Allison's behaviors and asking for help. Mary was supportive of treatment and a steady advocate for change in the family. It was because of this therapeutic alliance with Mary that I felt we could become instruments of change in altering the family structure. We would join with Mary, both assisting and modeling a new parenting style alongside of her, encouraging Allison to break away from this subsystem of the family. While a struggle for her, Mary began to set more appropriate limits with the support of the therapy team. She started removing Allison's input regarding general household and parenting decisions, she also began to set expectations of how Allison should treat her as a parent. This soon drew the interest of Allison whose previous role in the family was now being threatened. The team's hope was that pulling the family out of homeostasis and into a crisis would create an opportunity for change within the family – especially for Allison. This shift created a tension between Allison and Mary; however, this situation also created an opening for a member of the therapy team to attempt to engage Allison in treatment. Allison could no longer look only towards her family for meaning; she would have to face questions about the foundations of her life on her own. She would be drawn deeper into what Frankl (2000) called an "existential vacuum"; he described this as a place where one knows, "…neither what he must do nor what he should do…" (p. 94). This is a place where one must confront absolute unknowns – where one is forced to rely on oneself to take action in manifesting meaning in his or her experience. Berman, et al (2006) writes about this type of experience when referring to Paul Tillich's three domains of existential anxiety: fate and death, emptiness and meaninglessness and guilt and condemnation. Berman, et al. (2006) expands on the second domain – what he referred to as, "the least studied aspect of existential anxiety in youth" – emptiness and meaninglessness; in his writing, he captures Allison's dilemma:

> The anxiety of emptiness is relative and is apprehension that specific beliefs no longer have the meaning that they were once believed to have by the individual. In other words, that a belief has been threatened by non-being. Meaninglessness is an absolute concern and is about the loss of the significance of life, the future, the world, and everything. (p. 304)

It can be a moment of weakness for anyone, a place where we must face our anxieties head on and battle alone against the forces around us. Allison's previous beliefs about herself and her role in the family were now "threatened by non-being"; Sue and I were concerned that Allison may not be able to handle this tension and that perhaps we may have been pushing her too far, too quickly. I was unsure if our relationship with Allison was strong enough to even survive if such an intrapersonal battle took place. I wondered if what we were doing was going to be effective at all. If not, Allison may choose to seek out other sources of meaning in her life; Allison could be drawn towards one of the many behaviors that often plague adolescents during times of crisis, including escalating violence, substance abuse or even suicide. The things that can fill a void like this for an adolescent are usually a quick fix, unforgiving and often not the result of serious contemplation; it was for this reason that we hoped we could successfully keep Allison engaged in treatment.

The idea of pulling a family member out of enmeshment and becoming more differentiated is often an important concept in family therapy. From an existential psychotherapy perspective, Allison's enmeshed relationship with her mother may be seen as her defense against the anxieties of the isolation and the responsibility that goes with having to face her life choices on her own. Allison was aimlessly adrift and would cling to the only source of meaning that she would have faith in – her family. Wright suggests that the difficulty one experiences in creating differentiation, or asserting their own self-definition, lies in the illusion of protection from life stressors that the family system can create (Wright, 1985). This appeared true for Allison and her family – we thought that if Allison in some way could have recognized this "illusion" she just might be able to realize that she could directly influence the course of her life in a positive way. As clinicians, recognizing patterns in family relationships that directly influence family members is paramount in

treatment and we are remiss if we don't pay careful attention to the meaning-making and subjective changes that occur in adolescents as these relationships change. It was, in part, the goal of the therapy team to increase Allison's level of differentiation, with the hope that she would be able to face these anxieties on her own. In facing her anxieties head-on we thought that she would have the opportunity to develop her own coping strategies and insights that over time might decrease her anxiety and depression, while increasing her self-esteem.

Allison became more aware of the changes going on within the dynamics of her family and would frequently attempt to divide her mother from the therapy team. It was four months into working with Allison's family and she was becoming more belligerent, defiant, and verbally aggressive towards her mother, as well as Sue and myself. She would suggest that her mother no longer cared about her or Jeff, and that the treatment team was simply "ruining her family." Her behavior was getting worse; I started to become fearful that the psychological report that at one time left me baffled would now be coming into light. It would be during an unannounced home visit where I would fully experience the true intensity of Allison's anxiety.

### Rooting for Allison

"Yes, Mr. O'Connor, I know; but, I don't think you understand... I've tried that," she said, "How, Mr. O'Connor? She won't listen to me." Mary answered the back door, phone in hand; she barely acknowledged us as we walked in. I thought to myself that she was probably was having the same conversation Sue and I had with him a couple of weeks ago. No matter how many times I've talked to Principal O'Connor he always had a simple answer to family problems, "Parents just need to take back control," he'd say; I knew that's what he was telling her. As I gathered some paperwork that we brought over for Mary to sign, she was wrapping up her conversation with him, "I agree, I know… well, her therapy team is here now, I have to go… Okay, all right. Good-bye."

"Everything okay?" Sue asked as I placed the paperwork out on the kitchen table.

"It's the school, they said I should have Allison placed somewhere, they're not happy with her progress; Mr. O'Connor said that when the school tested her she was PTSD, or something."

"Just go away!" Allison's voice echoed down the staircase and through the living room, "Go away!"

"Allison, honey, are you all right?" Mary, after quickly glancing at Sue, left the kitchen and walked into the living room; she then looked upward as she approached the staircase. Sue started to follow and we could hear the pounding footsteps upstairs. Allison then darted down the stairs; she was looking straight towards myself and Sue.

"Allison, stop! Right now!" Mary tried to control her, but it all happened so fast. She leaned towards Allison and threw her arm out as she reached the bottom of the stairs. They both spun around once before Mary lost control, with Allison slipping away from her. Allison quickly walked towards the kitchen; Mary followed close behind. I remember feeling fearful that Mary would escalate the situation and felt I had to prepare for the worst.

"Allison, it's okay," Sue said, her voice in a higher pitch as she quickly traced her steps back into the kitchen, "We don't have to stay."

"Mary, please," I asserted, while briskly motioning for Mary to stay back in the living room. As Allison walked towards us her posture was rigid – I could hear the quick and shallow sounds of her breathing. As she approached I thought we would have to physically intervene, until she abruptly stopped in the doorway – as she stood, the heel of her right foot repeatedly tapped the floor.

"I can't fucking stand this; the two of you don't give a shit about me!" Allison took a few steps forward, raising her voice and posturing. "I don't want you to come back here! You have no idea what the fuck you're doing!"

I felt myself become tense and my heart rate increasing – why was she doing this? I was stunned by her behavioral display, and without time to process, started rolling through the training that one receives when working with high-risk adolescents for many years. I started thinking about safety, the environment; I thought about Allison being violent in the past, *Is anything therapeutic going to come out of this situation? What if she does become physically aggressive*? I have been in this situation many times. I felt that rush of anxiety – the pull for control; those feelings as a clinician where you think you must do something. I don't think it was anxiety for me, as much as it was an intense curiosity of what Allison would do next that was the cause for my restraint. Unfortunately, I've experienced many

times how fear of an adolescent's potential aggression can easily cause us to be a catalyst for that very same aggression. In potentially dangerous situations there is a unique tension created between the therapist and client, between maintaining safety and effectively maintaining a trusting relationship. For the clinician this tension can easily create a mental and physical state of trying to defend one's self and a focus on behavioral threats – a potential trigger for a traumatized adolescent.

There was a long pause as we all stood in silence. As awkward as our response seemed, the lack of any reaction at all caught Allison off guard. We wanted Allison to break this cycle; I wanted Allison to choose how this moment ended. I wonder now if Allison, too, was waiting – for us. At this point, I hoped that Sue, who I thought Allison reacted better to, would say something; once again, I found myself looking over towards her.

"I'm always willing to listen, Allison…and I am open to the possibility that we don't know what we're doing," Sue, with her head bowed, carefully walked over towards a dining room chair as she spoke; she then sat down.

"You don't know what it's like to be in my situation," Allison's words were steady, but calmer – she glared toward Sue. I started to worry that Allison's anger might be starting to escalate again.

"Well, I'd like to hear about it. You're angry – it's not what you want."

Allison started to turn away, and then quickly spun around and as angry and aggressive as she was, I found myself, in some way, rooting for her. I recall once reading a quote from Jean-Paul Sartre, "We do not know what we want and yet we are responsible for what we are – that is the fact." As I look back now, I was rooting for Allison's voice and for her to take on that responsibility – of all the times I've encountered Allison, she always walked away. Walking away from every opportunity to be herself, whoever that was. Allison would never assert what she truly wanted; often relying on what others thought she should be. This time she stood her ground; this wasn't aggression – it was courage. I thought this was Allison – unfiltered, but perhaps on the brink of self-actualization.

"Of course not! I didn't ask for this! Now you're telling me that I shouldn't be a part of my own family. Fuck you!" Allison took another step towards Sue, and for a moment they would both lock eyes; I took a step further into Sue's visual field and waited for her to look towards me. This wasn't the first time Sue and I worked in a potentially dangerous therapeutic situation. I knew if Sue didn't look away, if she didn't look toward me – then she was okay.

"You're right – it's not up to me to decide who should be a part of your family… I'm just wondering who Allison is, if she's not investing all of herself into her family; you've taken on a lot of responsibility, this has to be hard on you Allison." Allison silently stood over Sue – there was a hesitation before she responded.

"I'm done with you!" Allison turned from Sue and walked away.

"I think you have a lot more to say, Allison, and I'm willing to talk again when you're ready to," before Sue could finish her words, the kitchen door slammed shut.

Sue took an approach of unconditional positive regard with an unflinching desire to listen to Allison without judgment, even in the face of her verbal aggression. This type of "empathic availability" or sincere desire to acknowledge the client's problem is paramount in existential psychotherapy, often second to the technical competence of the clinician (Lantz, 2004, p. 170). Lantz argues that while the clinical skill of the clinician is important, "…such competence is believed to be less important than the client's awareness that the therapist has been touched by the client's pain and is available to provide empathy for such client pain" (Lantz, 2004, p. 170). While this approach was initially unsuccessful, after repeated attempts, we could notice that Allison was not going away; she would later begin to seek Sue out, at times only to vent or to continue to lament about her mother, often times in a verbally aggressive manner. Once an alliance started to form, we were able to gradually assist Allison in talking more about her own thoughts and feelings, and how they impacted her own life as an individual. Shumaker comments on the impact of developing a positive therapeutic relationship through the use of existential concepts by suggesting that "acts of will" by clients should not be interpreted as "resistance" (Shumaker, 2012, p. 379). Krug (2009) explains:

> Cultivating presence means a focus on the client's subjective processes, listening less to what is said, and more to how and when the saying occurs; his aim is to have the person in therapy recognize their actual but unregarded ways of being that are avoidant or distortive

and begin to take responsibility for their life choices. (p.338)

In her interaction with Allison, Sue was able to tolerate her "resistance" by focusing not on the behavior, but rather on the message. In doing so, Allison's message was heard and validated, rather than ignored. It was paying attention to "how" Allison communicated her feelings and "when" she decided to do so that was the primary focus of the encounter. With Allison allowing us to explore this enactment with her and enter a vulnerable therapeutic space was perhaps a sign that she saw us a safe place to try to communicate her feelings. Assisting Allison in identifying these "unregarded ways" would be of great importance to assisting in moving forward with her life and finding meaning. As we continued to build a therapeutic relationship with Allison we attempted to give freedom to her in identifying where her sessions would take place and the direction of these sessions. It was during this time that Sue and I would often spend time with Allison listening to her life story, at times prompting her to tell us what her life was about; assisting her in pulling out what meaning her past actions had for her, and how these circumstances had impacted her life now. As we would find out from Allison, she found herself lost in life, a year behind in school, and very much depressed. Eventually, she began talking about her recent feelings of guilt for not being there for her family and would often use her diagnoses as a reason for her inability to interact with others or to go to school.

As we continued treatment, Allison would occasionally avoid Sue and myself; at times, she would spend days staying with her aunt Carolyn who lived in a nearby town. During these episodes, Allison would experience exacerbations of her depression and anxiety, as well as expressions of suicidal ideation when confronted with her behavior by her mother. We saw this as Allison now struggling with having to face her own independence in her new role and responding by seeking support from her Aunt. After several weeks, we would see a reduction in the frequency and intensity of these episodes. Also, after frequent refusals, Allison began to finally accept our invitations for her to spend time with other adolescents that were in our therapy program. Allison was now reaching out towards us; she inquired about attending an annual trip that the therapy program took to a local fair that offered an opportunity to socialize. It was during this time that we were really surprised with her ability to interact quite well with others her age; she even developed a close friendship with another adolescent in the program.

**Standing on Her Own Two Feet**

"So, what do you think they're talking about?" Sue inquired, apparently unaware that I was focused solely on unloading items from the van. An inaudible announcement over the park's public address system blared as I turned around and scanned the small hill that was close by on the fairgrounds. A few adolescents were throwing handfuls of leaves at one another and laughing aloud as they waited for everyone else to arrive. I saw Lisa, another staff member from our program appearing to try to set limits to their escalating level of excitement.

"Yea, doesn't that look like fun?" I chuckled, returning my attention back to a cooler in the van.

"No. Look at Allison," Sue replied.

"Where?" I responded, unable to make out anyone resembling Allison in the small group.

"John, over there," Sue pointed dramatically over towards a large oak tree, "She's actually spending time talking with Shawna… and I think they're laughing; can you believe it?"

As I focused in on Allison I could see her closely watching Shawna who was unsuccessful in her attempt at completing a cartwheel. I could relate to Sue's curiosity, Allison and Shawna were an unlikely match as both were usually very anxious and struggled with creating and maintaining relationships. As Sue and I continued to talk about the encounter we soon understood why there might be a connection between the two. Shawna's father had passed away while serving in the military five years ago and she was also having difficulty in school. Both Shawna and Allison came from similar family situations – both had parentified roles within their families, and a younger sibling. As we continued to watch, Shawna tumbled to the ground again, with Allison laughing.

"You're ridiculous!" I heard Allison shout to Shawna, "How can you expect to do a cartwheel the right way – if you can't even stand on your own two feet?"

It was during moments like this when we could see the once frequent intense look upon Allison's face replaced by a warmer, brighter affect when interacting with others – a sign, we thought, of Allison revealing a side of her to others that she

had been afraid to share before. It was also around this time that we learned that Allison enjoyed writing and she eventually allowed Sue to read part of her journals about how she had been feeling during this time. Allison would now write more about her past, as well as, how she felt her family changed after her father had left and how these changes impacted her direction in life. She once wrote that she felt responsible to help care for her younger brother because she "didn't want him to feel alone like I do a lot of times." She later wrote, "I could never do to him [brother] what he [father] did to me." She would talk to us about how she now struggled with these feelings of guilt, along with the anxiety and uncertainty of her role changing within the family. She appeared to be torn between being a parent and her desire to be teenager. Within her writings Allison would describe this anxiety and tension as her "mind going blank", "her heart exploding" and her "world spinning out of control."

**Change**

It was clear to us that Allison was an anxious person; however, the increase in her level of functioning now allowed us the ability to more directly challenge her perception of being agoraphobic and the belief that she could not go to school. We began to examine what evidence now existed to support her beliefs and how these changes in her perceptions could possibly impact her future. One day I was having a discussion with Allison about this while in a mall parking lot; it certainly wasn't a traditional therapeutic setting – it turned out to be the location of a critical moment in her treatment. After spending a day with other adolescents at an out-of-town mall as part of an outing, I can recall walking back to the car with Allison. After spending time actively socializing with others at the mall she had become uncharacteristically quiet for the last hour or so. When people tried to engage her she was short with her answers and would often became very sarcastic. I was leaving a bit earlier than the other staff to get the van for a return trip and Allison had actually offered to walk back with me because she said she was "tired of the mall crowds, anyway." She was quiet and stared at the ground as we walked back together. After a couple of moments of silence, Allison looked up and eventually spoke – I now wonder if she somehow was aware of the opportunity that was created for us to talk.

"I just can't stand being around them sometimes," Allison complained as we headed towards the car, the parking lot was still wet from the brief rainstorm, it was windy – and I can remember the sun just starting to breakout, making very long shadows across the pavement. "Danielle and James – all they do is talk about themselves."

"It looked like you were having fun with them earlier – were you having fun?"

Allison looked ahead, she quickened her pace; without taking a breath between her words, she replied, "But, that's not really me – I don't let my guard down. I don't really socialize; I don't do that."

"What if that was you?" I inquired. Allison immediately stopped walking and quickly turned around; she looked back at me as if I'd just offended her in a way that she hadn't been before.

"Oh – so, I'm just a normal teenager now, right…?"

"What if you are?"

Allison paused; her eyes started to fill with tears – her voice quivered, it was an expression of uncertainty, it was a voice I didn't know.

"What about my diagnosis? What about all the time wasted then? How could they do that?" It was at this moment that I could sense Allison's personality shift – it was as if I could experience, just by watching the expressions on her face, the intensity in her eyes, a new self-awareness developing. I never did answer Allison's questions; but, if as a clinician I could pick a moment where I thought therapy happened, even if it couldn't be captured in a treatment plan – this was it.

It was through this interaction with Allison where I felt for the first time that she extended herself towards another, willing to share in the co-creation of meaning in her life. It was a moment where Allison truly allowed her real self to emerge, expressing her sadness and genuine self-image. Jenson Rasmus and Moran Dermot (2012) wrote about what Maurice Merleau-Ponty called "intertwinement", or what Thomas Fuchs and Tom Froese had referred to as the "extended body", it is a "process of interaction with another embodied being and it is normally experienced pre-reflectively in situations where two persons are attending to and instantly responding to one another" (p. 131). Rosan (2012) comments on this form of interpersonal connectivity, or "dance with the other" that greatly supports the existential meaning-making process between the therapist and client:

> He/she becomes "the instrument which another plays." A shared operation is at play here; the subject receives from the other the discovery of a world different from his/her own and, in turn, he/she lends or uses his/her own sensibilities to knowing this world (p.116). Berman, et al. (2006)

It was during this "dance" that Allison allowed herself to fully open up to an alternative form of self-definition or meaning; also, it was during this interaction where I could say that I truly felt connected – or engaged, in a therapeutic exchange with Allison. There was no script; I wasn't thinking about the best strategy or approach – I wasn't thinking; I was guided more by intuition and responding to Allison's reactions. This time, not only did Allison not walk away, but truly opened herself up to another "world different from [her] own". I felt like for the first time, even if for a moment, I could understand Allison.

As we continued working with Allison we focused on ways of assisting her in taking responsibility for her actions that would reflect how she felt about herself as a person. As an even more active participant in treatment Allison was appearing to demonstrate significant insights regarding her life, and the team began to talk with the family about soon transitioning to a less intense level of services. Overall, it had been a slow process for Allison and we were pleased to see the progress she was making; however, over the next few weeks Allison surprised us again. Her mother told us that she had been receiving information about colleges in the mail, and that to her surprise Allison was inquiring about art programs at local colleges and technical schools; she also was talking about the possibility of getting a job. Allison transitioned from being bewildered about the direction of her life – angered that her own desires were thwarted by the expectations of others around her, to now being an active participant in defining her life. Lantz (2004) comments on the power of this type of therapeutic change:

> In existential family therapy, it is believed that to honor rather than defeat client resistance helps…find their freedom, exercise their freedom, and discover their own path and their own way toward growth (Whitaker, 1989). In existential family therapy, the therapist is not a director, but rather a guide (Whitaker, 1989). (p. 173)

Allison was making changes; changes that were her own and, as with many clients, born out of their original "resistance." While Allison's academic goals may have been a bit unrealistic, these surprises were now viewed by us as Allison exercising her own "freedom;" using her own "internal locus of control" to define herself and take responsibility for her actions (Lantz, 2004, p. 173). She was no longer, as Lantz had earlier described, living a life defined by its "essence," but rather, she was living a life of "existence." It was by creating a genuine, trusting therapeutic space that allowed Allison the opportunity to explore who she was on her own. By creating this space, she then allowed us to become a guide in that exploration. As Allison further progressed in treatment, there were fewer and fewer messages from Mary asking us to meet her for coffee. It was during these last couple of months of treatment when the frequency and intensity of conflicts between Allison and her mother lessened significantly. While some level of conflict remained, she had increased her level of socialization with peers and her level of independence within the family. The hope was that Allison would continue to move forward and eventually reach her goal of attending school in the fall. The therapy team reduced the frequency of visits with her and after twelve months of treatment she was eventually transferred to out-patient services in the agency clinic.

When we try to balance the changes in relationships with the changes that are taking place within the individual, we should not avoid the battle for meaning that is taking place. Allison's definition of herself was complicated by those around her, including Sue and myself. As Allison became more engaged with us in treatment, the level of complexity in how she might define herself increased greatly because of these relationships. I believed that Allison was on some level aware, and later accepting, of the genuine empathy and support that was being offered to her, which was critical in her progression in treatment. This was especially evident in the encounter that Sue had with Allison in her home, but is also relevant to my encounter with her in the parking lot. In their work "Teaching Intersubjectivity: Paradox and Possibility", Berzoff and Mattei (1999) discuss the importance of recognizing this sensitivity the client has towards the clinician's approach:

> Every therapeutic encounter includes aspects of the therapist subjectivity, and clients are active observers of their therapist's unique character styles, affects, and traits (Aron, 1996b). The therapist is always conveying parts of him or herself to the patient whether consciously or not… There is more general agreement that the goal of psychotherapy is no longer exclusively about the attainment of insight, but is also about the achievement of more mutual and authentic engagements between client and therapist. (p. 378)

This could be seen in my interaction with Allison, as well as, Sue's; although, it is also important in the sense that there may be significant unconscious contributions to these encounters, as aspects of the encounters are played out intuitively. This focus on "mutual and authentic" engagement was demonstrated by Sue in her approach with Allison while she was being verbally aggressive and threatening. Sue's style was one of sustained empathy; this was reflected in her affect – her behavior, the words she chose and the tone of her voice. Realizing that clients are in fact "active observers" is an important aspect of engagement and crucial in co-constructing meaning with the client as it paves the way for them to consider an alternative view. This is especially important when working with emotionally reactive adolescents, as they must feel that their voice matters in the development of who they are. Without believing that they have the capacity to explore or develop their own "authentic and effective" self, the adolescent's self-definition would be left to the mercy of others – as one could imagine with Allison, this can be a potential tragedy as they enter early adulthood. Often a family or therapist creates an environment where the adolescent is coerced to conform to behavioral expectations, with little value placed on the meaning behind their behaviors. A part of Allison's goals were to reduce the anxiety she was experiencing; though she did not realize that she had the ability to make these changes within herself. In taking a risk, Sue and I made efforts to create this space for Allison to become self-aware.

The therapeutic space that can be created within the clinician and client relationship is related to many variables. Our fears that Allison could not tolerate the "existential vacuum" that was created were only met head-on, and later defeated, by her own resiliency. Allison's strengths were in her curiosity, creativity and her own "resistance". The very things that Allison used to push others away – within this space, she would later use to push herself forward. There were times during treatment when Allison was completely disengaged from others; she was guarded and could easily isolate herself. Even during these moments during which Allison was withdrawn we continued with attempts to make space for awareness of what she might be experiencing. In maintaining this approach, experience and imagination became therapeutic tools in creating opportunities for engagement, or "cultivating presence" with Allison. Being able to intuitively take risks and extend empathy when a client is repeating disruptive patterns of behavior, or simply pushing the clinician away, can create a profound change in the therapeutic relationship. The concepts of empathy and intersubjectivity play a significant role when taking risks in the use of existential theory. While considering the importance of taking these types of risks, in his work "Winnicott and the Paradoxes of Intersubjectivity", Applegate (1999) captures the complexities that we faced in creating this therapeutic presence with Allison:

> Today's clinicians are routinely treating clients whose deprivation and developmental vulnerabilities lead them to act out rather than talk out their relational difficulties. These clients, many of them "dropped" rather than "held" by their psychosocial environments may approach the clinical encounter with fear, suspicion, and mistrust. As issues of dependency begin to arise, they are likely to engage the clinician in enactments of old relationships, both as a means of sustaining old attachments and as a way of finding out whether the clinician can offer something different. Many of these enactments seem to coalesce around aggression. With the client needing to test the clinician's durability by "destroying" her in order to find out if she can survive and become a "useful" subject in the client's world. (p. 217)

Allison would test our "durability" throughout our encounters and it was through the moments when genuine empathy was sustained that Allison would feel drawn into the therapeutic relationship. These moments were learning experiences for Allison, as well as, for us as clinicians. This type of interaction is not simply an intersubjective experience, but rather a synchronized therapeutic awakening that occurs between both the clinician

and the client. It is a realization that something has transpired that is actively changing within both the clinician and client in the therapeutic relationship. Creating this presence requires the clinician to tolerate some level of disruptive behavior; to become a "useful subject" the clinician must find the delicate balance between offering empathy and setting strong limits within the context of the relationship. In order to achieve this, as discussed earlier, the clinician must have an understanding of the conflicts occurring within the adolescent and be able to consider the possible range of meaning behind their behavior. This exchange between therapist and client will create an opportunity for the adolescent to consider alternative ways of creating meaning and can only occur when the clinicians actively pursue an ongoing awareness of their own intrapersonal dynamics. Applegate (1999) further comments on the importance of the clinician's self-awareness:

> It helps insure a safe clinical space in which clients are free to relate to the clinician with a full range of affects, including hatred. Should the clinician fail to survive the client's hatred (or destructiveness), the result may be expressed in the clinician's retaliation, withdrawal, defensiveness, diminished receptivity or, as Ghen (1990) puts it, "a kind of crumbling" (p.123) that compromises the clinician's therapeutic capacities. (p. 210)

This type of "crumbling" may have occurred within those individuals that made attempts at trying to control Allison's behavior, rather than making attempts at understanding her behavior, as well as, their own reactions to her behavior. Berzoff and Mattei (1999) explain that each therapeutic relationship that is seen through the lens of intersubjective theory can be, "understood to be co-created between two people whose subjectivities influence one another. Not only the idea of the patient as object is challenged, but the idea of therapeutic objectivity is challenged as well," calling it a "radical epistemological and clinical stance" (p. 373). I believe it is crucial to consider this in relationship to direct practice; when viewing the client interaction through this lens the clinician is no longer a separate authoritative power, but truly is a "guide," or consultant, with the patient providing a certain subjective expertise about his or her own life.

## Conclusion

So, as we look through manuals full of treatment suggestions searching for the perfect strategy that will satisfy even the staunchest critic, many of us continue to feel unprepared as clinicians. I believe that there is a certain level of comfort provided to the clinician by focusing on the use of evidenced-based therapies; however, they will never account for the uniqueness of the individual and his or her relationship with the therapist in any given moment; they cannot "cross cut" through each encounter. Much is now being written about the evidenced-based therapy relationship, Norcross and Wampold (2012) suggest that evidenced-based therapies are less effective without consideration of the nuances that each client and therapist brings to the therapeutic encounter. Norcross and Wampold (2012) assert that "science can, and should, inform us about what works in psychotherapy, be it a treatment method, an assessment measure, a patient behavior, or, yes, a therapy relationship" (p. 101). I would argue that the humanistic values that construct our therapeutic relationships should not be seen as an adjunct issue, but rather the primary focus in treatment. Evidenced-based treatment is not less effective, but rather cannot be effective, without first considering what clinicians bring to the therapeutic encounter and how this impacts the process of engaging in a relationship with a client. When I thought that change happened within Allison, I was not thinking about manuals, I found no comfort or satisfaction in techniques or statistical proof. Perhaps what constitutes therapy does not lie not in a binder, but within us – a composite of our past actions, perceptions and beliefs – the art of human experience, imagination and intuition. To me this concept becomes more and more important as many of us are moving in a direction of evidence based treatments, where by focusing on results it becomes less important to truly understand ourselves, the process of how we interact within a relationship or to our environment. It is true that no adolescent will have a perfect clinician that has the perfect treatment designed for helping them define their own lives; perhaps we as clinicians can revisit how our knowledge of the human experience can impact other. Perhaps we can explore how we may be able to approach adolescents in a different way, where the safety of "assessment clarity" does not become an excuse to avoid the whirlwind of emotions that come out of truly engaging with adolescents as they live out their own perceptions and beliefs in their search for meaning. As clinicians we should become more aware of how

incorporating humanistic values in treatment can significantly alter how we connect to the adolescents that we encounter in our practice. In order to create this therapeutic presence we must "honor rather than defeat client resistance"; this is only possible when we are receptive to the diverse meaning that exists within the range of emotions and behavior that we encounter within our clients, as well as, ourselves – an existential perspective. This cannot be accomplished without a more serious look into how we connect with others through the use of humanistic values. While we can consult the intelligence that is given to us by science – it is only through understanding our own human experiences that creating a safe clinical space is possible.

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