

8 Advocacy

Its impact on the treatment alliance with gifted, self-destructive, and drug-abusing adolescents

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Abstract

This article is a plea to therapists, especially those who work with gifted, dysfunctional, and disenfranchised adolescents, to add advocacy to their armamentarium. These adolescents resist forming a therapeutic alliance, but they know they have compromised their educational and professional options. The most effective way to connect with them is to offer to be an advocate for them. This involves becoming a power broker to plead for a favorable outcome with authorities who have the power to grant or refuse the adolescent's access to upward mobility. The population described in this chapter remains immune to traditional psychotherapy, and indeed must be engaged quickly in therapy for success to occur. If the therapist fails to discuss his or her intention to work for the adolescent's best interests at the outset, the adolescent probably will not return for a second session. The actual advocacy efforts are made after the adolescent fulfills his or her part of the contract. Although this chapter will focus on advocacy in the college admissions process, advocacy can encompass other proactive activities: to convince an employer to hire, to persuade a family member or a friend to reconcile, to intervene in criminal proceedings by suggesting alternatives to incarceration, to secure housing, and so on.

Advocacy: A treatment innovation

Little has been written about the psychotherapist as advocate and about the impact of advocacy on the therapeutic alliance with adolescents. Indeed, Masterson (1989a) bemoans that his magnum opus on adolescence, *Treatment of the Borderline Adolescent* (1972), "was greeted with thundering silence" (p. xv). When reviewing advocacy, Myers, Sweeney, and White (2002) lament "a review of the literature in counseling...revealed few sources on advocacy for the profession" (p. 394). Eriksen (1997) observes that "no one has researched advocacy [for] the counseling field" (p. 2).

Agreeing with Stone (1971), I (Bratter, 1977) describe advocacy as "a unique relationship in which the psychotherapist...attempts to gain preferential

consideration for [persons in treatment]" (p. 121). Vash (1987) exhorts rehabilitation professionals to recognize that advocacy is a counseling imperative, but provides no therapeutic strategies.

Advocacy can favorably impact outcomes with various treatment populations, but it is essential when working with youth who do not respond to traditional psychotherapies—a group that includes many adolescents (Meeks and Bernet, 1990). Freud excluded persons in crisis from psychoanalysis. Acting-out adolescents create perpetual crises to which the therapist must respond, thus making an analytically oriented approach difficult.

Aichhorn (1935) warns "dissocial children do not come to us of their...free will but are brought to us [against their desires]. To the dissocial child we are a menace because we represent society, with which he is in conflict....It is hard to make some of these delinquent children talk. One thing they...have in common; they do not tell the truth" (p. 124). Aichhorn (1964) further notes that the burden to convince the teenager to return for the second session remains that of the therapist:

Most juvenile delinquents meet us at first with utter distrust and their suspicions must be swiftly overcome before we can win them over. Such suspiciousness is not...pathological; the child guidance worker appears as something dangerous to him....In keeping with the unpleasant experiences he has had so far with adults, he is entitled to expect something distasteful....He therefore feels immediately compelled to consider the personality of the counselor (p. 158).

As Hanna, Hanna, and Keyes have noted, gifted and alienated teenagers are defiant, suspicious, hostile, and resistant to therapy (1999). Despite Meeks and Bernet's (1990) attempt to modify psychoanalytic technique to include more types of adolescents, they are wrong to suggest that "effective confrontation... [shows] the patient what he is doing either without knowing it or without recognizing its importance" (pp. 163, 162). Perhaps this is the reason they are forced to acknowledge that some teenagers are untreatable. They state, "If the patient's mistrust of others, defensive structure, or living situation makes an alliance impossible, it is preferable to admit that and suggest termination" (1990, p. 287). Giovacchini (1985) believes adolescents possess a "propensity for creating problems within the treatment setting because of their reticence about becoming engaged, or their inclination to express themselves through action rather than words and feelings" (p. 447). Katz (1998) concludes "the establishment of the therapeutic alliance is one of the major...challenges faced by adolescent psychiatrists" (p. 89).

My position is that the therapist's offering to be an advocate may be the crucial link to forming a therapeutic alliance and, thus, to treatability. If the student rejects the therapist's offer to be an advocate (or refuses to make a commitment to change—part of the advocacy agreement), and assuming the risk of self-destructive behavior is extreme, the psychotherapist may need to consider residential treatment.

Even if these youngsters return for a second session, their problems persist. Countertransference and transference can become major obstacles to effective therapy. The psychotherapist can use an idealizing transference to build the treatment alliance by stating that the adolescent can excel and that such excellence will make the advocate's "mission impossible" easier. Early in treatment, I do not discourage idealization of the therapist. However, these feelings must be terminated so the student can become assertive and autonomous. Meeks and Bernet (1990), rightfully so, warn that omnipotent transference can be seductive but it impedes growth because it nurtures dependence.

The expectation that the therapist has answers...and solutions...bears enough similarity to some ordinary, or at least fantasized, relationships between the generations to be quite attractive....It is easy to drift gradually into a relationship in which the adolescent presents as a helpless, idiotic emotional cripple, repeatedly rescued from disaster only because of the brilliance of the therapist....As gratifying as such a situation may be to the therapist's narcissism and his infantile omnipotence, it is catastrophic to the goals of psychotherapy (p. 175).

The treatment goal is to create the conditions for helping the adolescent to individuate and separate from the family and therapist, and to become a mature individual who defines goals and wants to fulfill personal needs.

As Nagel (1989) points out, "acting-out behaviors can be disturbing to therapists and trigger countertransference feelings. The therapist may act out with the patient by becoming angry, attacking, or withdrawing.... Out of frustration, therapists may use interpretation to deal with their *own* [italics in the original] feelings...." (pp. 405-406).

Drug-abusing teens know that self-medication can provide temporary relief and, unless the psychotherapist assumes an active-directive approach, they will continue to abuse psychoactive substances. Amodeo and Drouilhet (1992) caution "therapists working with adolescents who use dangerous...drugs must examine their...values, attitudes, and visceral reactions to these patients....Some clinicians will struggle with feelings of moralism, anger, or anxiety... but in the end may realize that they will never be effective with this population" (p. 305).

Advocacy and the restoration of hope

The therapist's promise to intervene restores hope for future outcomes which, in turn, provides incentive for the adolescent to enter into a therapeutic transaction. The therapist needs to persuade the teenager to start a treatment relationship by reassuring the youth that success can be achieved when he or she works diligently. "Why," I ask the youth, "would I invest so much energy if I did not think you can succeed and are worth my effort?" By making poor choices, self-destructive adolescents have trapped themselves in a lose-lose labyrinth in which frustration,

fear, rejection, and failure become negative and painful self-fulfilling prophecies. Alienated students have lost hope because they feel impotent to escape from a self-imposed plight. Dejection is a realistic reaction to an environment that unconvinced juveniles feel is too pessimistic to endure. When the psychotherapist communicates "you cannot" rather than "you can," the impact on the therapeutic dyad is debilitating. The therapist who urges the youngster to reduce educational and personal goals essentially concedes defeat. Who wants to be a loser (or work with one)? Horney (1945) describes the corrosive impact of hopelessness and implores the psychoanalyst to communicate optimistic expectations. Frankl's existential view is particularly germane to the adolescent phase of life—"If we take man as he is, we make him worse; if we take him as he ought to be, we help him become it" (1967, p. 27).

There is abundant evidence from psychiatric and nonpsychiatric medicine to indicate that hope affects outcome. Oncologists know the difference between patients who have quit and those who retain the will to live. When patients feel they can surmount physical ailments, they are more likely to succeed than are those who refuse to try (Thompson, Soboloaw-Shubin, Galbraith, Schwankvosky, & Druzen, 1993; Petersen, 2000; Taylor, Kenneny, Reed, Bower, & Greenwald, 2003). Alexander (1962) asserts that "a change from a state of hopelessness to hopeful expectation revitalizes the integrative powers of the ego, which then reactivate the active personality" (p. 174). Armor and Taylor (1998) confirm that the restoration of hope is a potent curative force for self-betterment. Stotland (1969) suggests the "greater the expectation of attaining a goal, the more likely the individual will...attain it" (p. 17).

Advocacy in psychotherapy

Many youth, who are not amenable to traditional therapy, do respond positively to a treatment dyad motto of "us against the world." The advocate-psychotherapist becomes what Blos (1962) has termed a "special friend" (and, perhaps, an idealized parent). With each success, the teenager invests more in improvement, thus decreases resistance and regression. This dynamic can change when necessary to challenge and confront illicit and destructive acts. This transformation shifts the therapist (from the adolescent's perspective) into the critical parent/superego introject.

Fostering personal responsibility

Thirty years ago, I learned that when becoming an aggressive advocate, I could help the teenager (re)gain self-respect. My colleagues and I (Bratter, Bratter, & Bratter, 1995) have contended that this is the ultimate goal of therapy. Helping the adolescent to accept responsibility and accountability remains quintessential to the psychotherapeutic process.

The therapist needs to convince a skeptical youth about the long-term benefits of change. Acceptance by and graduation from a college of quality closes the door

on a painful past. Davis and Paster (2000) propose that the establishment of a mentor relationship helps the adolescent develop resiliency and optimism. Luthar and Zigler (1991) and Garmezy and Rutter (1983) confirm that a resilient child often can identify one adult who has taken a special interest. Such external validation restores hope that growth and success are realistic objectives. Advocacy places the psychotherapist in a charismatic role as a problem-solver–consultant-coach. Williams and Davis (2002) write, “Coaches aid clients in creating visions and goals for all aspects of their lives and in creating multiple strategies to support those goals” (pp. xiv-xv). When the adolescent begins to dare to dream about success, the probability of a positive outcome increases. The psychotherapist’s becoming an advocate has a salutary impact on the restoration of morale, which enables the professional to maintain high expectations for improved behavior performance” (Bratter, 1977). I negotiate a quid-pro-quo agreement that is held in abeyance until the student changes. The statement “*after* you do what you need to do, then I’ll help you achieve your goals” generates the leverage to demand improved performance.

My praise “to your credit, you have improved” not only reinforces empowerment but also communicates an expectation to improve. I do not respond, “I am proud of you”; that comment implies possessiveness, which can provoke a negative transference-countertransference response. Instead, I state “I’m happy for you,” thus giving credit to the adolescent for diligent work.

I do not guarantee that my efforts will be successful. This promise strengthens the treatment alliance because the student (and/or family) view me as an asset who can play a critical role to help them achieve a valued outcome. If the youth and parents verbalize appreciation, I emphasize the student’s performance. I acknowledge that my letter helped achieve a positive outcome but I assert “all I did was to describe your son’s or daughter’s behavior. The kid did the work.” A dean of admission once wrote, “You write the most amazing recommendations I have ever read! Truly incredible! I appreciated Matthew’s honest personal statement, as well as your helpful recommendation. My question, given no visit here, is whether you can shed any light on what the late application means. Are we are a distant choice?” Since the applicant used this college as a “safety,” I advised the dean that Matthew be placed on the waiting list which would not penalize the college for admitting a student who would not attend since the acceptance-attendance ratio often determines status. I did not discuss this correspondence with the student or the family.

The college admissions process

Selective colleges can fill first-year classes multiple times without compromising standards. College admissions never have been more competitive. Even academic excellence, high standardized test scores, impressive extracurricular activities, and superlative recommendations no longer guarantee admission to a college of quality. Bratter and Hammerschlag (1975) lament that “many...institutions have

become so complicated...that individuals no longer have direct access to them. There are waiting lists, esoteric admissions criteria....Bureaucratic barriers, indeed, are formidable" (p. 128). For the student with a flawed record, the obstacles are daunting. The advocate's task is to convince the committee of admissions to admit this student and in so doing, reject a qualified applicant.

In general, to maximize the chance of admission, noncompetitive applicants need to apply "early decision." The advocate must convince the committee of admissions that the student will attend; otherwise, the office of admissions will be reluctant to invest additional time considering the specialness of the applicant. There are some cases, however, in which the student should decline to apply early decision. Unless at least a one-year relationship exists, the therapist-advocate will have little credibility with the committee of admissions. In addition, if the student has not demonstrated for one year that he or she can excel academically, it would be folly to submit an early decision application. There are unique considerations in advocating for an applicant who has a troubled past. Mediocre academic performance, the least severe form of destructive behavior, cannot be camouflaged in a college application. In contrast, most other forms of dangerous acts—physical scars caused by self-mutilation, abortion, drug abuse, suicide attempts, incarceration, institutionalization, and so on—can be hidden. Confidentiality statutes prohibit disclosure of self-injurious acts and crimes.

When writing an application, the college candidate cannot advocate effectively for him/herself by detailing personal changes; these explanations can appear self-righteous, arrogant, and/or disingenuous. The therapist has more credibility because the advocate possesses the expertise to provide reasonable assurance about the probability of success. The therapist, who is uniquely qualified, can describe the applicant's strengths and weaknesses, depict the humanity of the student, and document proactive changes. A letter of recommendation can be the difference between rejection and acceptance.

The letter of recommendation

A recommendation can resemble a case summary, with the caveat that the therapist should avoid the use of clinical and diagnostic terms. Psychobabble is disconcerting for admissions committees, who lack clinical sophistication. The writer needs to explain how the applicant has emerged from a painful pathological ordeal to become a stronger, more sensitive, and saner individual who has the courage of personal convictions, self-respect, a positive concept of self, plus a commitment to act proactively. The writer should avoid glamorizing hedonistic life styles, but should emphasize that recovering youth are less likely to regress (since they know the shame and pain they caused themselves) than the naive who have not been exposed to the painful verities of life.

I send my recommendation *before* the college interview, so the student can discuss his or her reaction to what I have written, thus partially structuring the interview. (Based on student reports and admissions personnel comments, more

than 90% of the recommendations have been read.) A thoughtful recommendation can impress the interviewer since the defiant youth's recovery is interesting and inspirational. In fact, kids who have acted out are often paradoxically alluring, owing to their emancipation from middle-class constraints. Frequently these self-destructive students are more charismatic, articulate, and socially sophisticated than those who have not been initiated into the adolescent counterculture. Most recommendations written by deans, counselors, and teachers are superficial (hence not likely to pique the reader's interest) because these writers do not know much about the applicant and they fear litigation if confidential information is disclosed. Since the applicant's cumulative record is not competitive, the advocate needs to explain to the student and family that acceptance depends on a realistic discussion of extenuating circumstances. A perfunctory letter is irrelevant. Prior to sending the recommendation, I give the candidate a copy to edit. This is to ensure the information is accurate and also to involve the student in the process. I request that the student sign a statement which gives permission to send the letter and releases me from liability.

When the recommendation contains disturbing material, the advocate needs to contact the reader to discuss the letter, answer questions, and provide assurance that the student has grown from painful failures and will become a moral leader, trusted and respected by peers and faculty members. After sending such a letter, the advocate should schedule an on-campus interview with the highest-ranking admissions professional available. If possible, the advocate should accompany the student for the interview because this commitment impresses the admissions counselor. I ask the admissions professional what the applicant can do to be admitted. Surprisingly, this question often is answered. I send a letter to confirm the agreement.

Hallowitz (1974) lists some additional strategies the advocate can use: making phone calls, writing letters, and attending conferences. Grosser (1965) counsels the advocate to be assertive. The advocate needs to understand the differences between assertion, aggression, and abrasiveness. I have contacted the president of the college, dean of admissions, and/or professors to gain support. I have spoken with trustees, alumni, and benefactors and have sent them a copy of my recommendation (with the permission of the student) to urge them to write letters.

An effective recommendation has five primary components: (1) a candid description of the applicant's destructive behavior; (2) an explanation of the candidate's corrective emotional experience; (3) evidence of the adolescent's growth; (4) assurance that the adolescent will improve the quality of life in the classroom and on the campus; and (5) documentation of the writer's expertise. The following recommendation illustrates these points.

I can answer the crucial question, "Why should [name of college] admit David?" David likes the camaraderie of the basketball team who studies together and...remains abstinent during the season. I assure the Committee of Admissions that David will never use drugs, including alcohol.

This is CONFIDENTIAL, Misty. Any disclosure would haunt David when he enrolls. The spin would be that his intent was to "kiss ass" which is wrong because he did not brag. When David visited campus, he saw a member of the team who was inebriated. He notified the team captain...which takes courage....David knows the devastating impact of noxious peer pressure, but acted as he did because he knows his recovery depends on honesty. In so doing, David reinforced his sobriety. He knows that the captain of the team, who returns next year, will confront him harshly about being hypocritical if he were to relapse. Thus, he purchased insurance for his first year! Speaking of hypocrites, Misty, if the Committee of Admissions rejects David, I will take the next plane to come to campus to meet with the President and then confront your colleagues. I would be outraged if this young man were rejected because he used drugs. Only those who never used psychoactive substances possess the right to judge David's behavior.... The duration of David's drug use was brief because his parents intervened. I do not doubt, however, that had his parents been indecisive, this young man...would have escalated his use into abuse—perhaps addiction....

I would consider myself guilty of malpractice if I were to place David and/or _____ College in a lose-lose situation. David has acquired confidence, self-respect, academic skills, and a love for learning. I believe the chances for his success exceed 95%, a statement few writers of recommendations can make.

David's growth is remarkable. The transition from destructive to constructive for this adolescent has been swift.... Momentum accelerates, motivated by wanting to purge himself of the poisonous venom of self-hatred, shame, and guilt. The basis for my optimism regarding David's recovery...is that he...knows that not only fear, frustration, and failure are ubiquitous but also how...to preserve self-respect by doing the right thing for the right reason—to maintain a proactive perspective...even when pain is pervasive by failing or being rejected.... He has the strength, knowledge, and desire to succeed.

I contend that students like David do become catalysts who can build a more nurturing and healthy environment (Bratter and Parker, 1994). Recovering students often become trusted and respected campus leaders in the dorms. Failing to persuade peers to terminate life-threatening behavior, they...will...seek help by notifying college personnel who can intervene to prevent a [crisis] before it becomes a [tragedy]. Recovering students are motivated by an awareness of the pain...they caused themselves, their families, and friends....They possess the courage to confront the destructive-dysfunctional, alienated-angry, vicious-violent behavior of classmates without worrying about being viewed by them as informers.

Recovering students can provide...security for the administration. As part of their treatment, recovering adolescents have learned the concept of responsible concern, which views intervention to be an act of friendship rather than betrayal.... They retain a vested interest to control and contain anti-social and self-destructive acts as part of their recovery. (p. 27).

The following example is excerpted from a twenty-page letter which was written to advocate why a young woman who had survived a chaotic environment should be admitted by a most competitive college.

This letter of recommendation is the most remarkable written in my career, which approaches four decades....Ilyse M.'s flaw is her SAT scores, which measure nothing more than performance on a standardized test. She received the Academic Achievement Award, given to the best student, and the History Award. She has taken the most demanding schedule in school history....Her motivation, determination, and discipline are inspiring. Ilyse states it succinctly, "I love learning!" She knows taking nine majors next term will not impress you because her grades will be submitted after, hopefully, she has been admitted.

This young woman is endowed with superior emotional and intellectual intelligence. She can succeed at whatever task(s) she thinks is/are important....Ilyse never had a chance to be normal!...Her parents divorced when she was five. Devastated by the divorce, her father related to Ilyse as if she were the adult. [There follows a detailed description of her exposure to drug use, sexual promiscuity, and emotional abuse in her mother's home, together with lack of support from other family members.]

After listening to Ilyse describe the depravity of her mother, my respect increases for this young woman. Feeling overwhelmed and lonely, she attempted suicide and became addicted to amphetamines.

I understand the intensity of her passions which motivate her to become a psychologist. What needs to be stressed, however, is Ilyse has emerged intact from toxic parents and has retained not only her innocence but also her passion to learn....

At fifteen, she had an abusive sexual relationship which ended when she had an abortion....Mrs. M. acquiesced to her daughter's demand to be emancipated by using child support checks to rent an apartment for Ilyse when she was 16. This adolescent survived economically, living by her wits. Ilyse had a relationship with a twenty-one year old. A year later, she supported herself by being a hostess who convinced patrons who were drinking in the bar to eat upstairs in the restaurant. She also worked as a sales person in a women's fine apparel store. Freed from accountability, Ilyse was narcissistic and hedonistic.

Initially, Ilyse resisted the therapeutic school. I wrote her a letter spelling out the self-destructive nature of her behavior, intending to precipitate a

crisis. Rather than [leaving], Ilyse found it gratifying to help others to help themselves, at first in a detached way, but then she began to internalize her messages. Her confrontations are accurate. She possesses the intuitive genius and insight to persuade peers to change the wrongness of their ways....

Ilyse has incentive to pursue self-respect. She can identify at-risk students and knows what to do to limit self-destructiveness by confronting them and/or notifying someone who can help. She has become a positive force.... Often, her contributions in group psychotherapy qualify her to be a co-therapist! Ilyse now knows what she needs to do.... I am confident she will do the right thing for the right reason(s). Her contributions to the University of _____ will be vital. Given her experience and training, she can identify potential problems before they escalate. Stated succinctly, I contend with absolute conviction Ilyse M. will be a positive, rational force who will be respected, trusted, admired, and loved by peers and professors, as has been the case at the John Dewey Academy.

I make the most emphatic assertion I have made in any letter of recommendation written.... If Plato's "philosopher-king" government were in effect, and women were needed to sire children to become leaders, Ilyse M. would be [one of only three females] I would nominate. Please assure the Committee of Admissions you know that I do not exaggerate. In addition, please tell them that less than ten percent of graduates feel the need for psychotherapy or pharmacology.

I am confident Ilyse will contribute to the common good of the University of _____ by making life in the classroom and on the campus a better place....

Follow-up

If a student is rejected by one college, despite efforts to advocate for him, but excels elsewhere, I inform the office of admissions, not to gloat or verbalize bitterness, but to emphasize I have the expertise to predict success based on extensive knowledge of the applicant. This follow-up serves to foster a relationship that can benefit future applicants. Conversely, when a student fails or, worse, creates problems, I acknowledge my error. Twice, when I learned from a third party that students sold drugs on campus, I notified the president and dean of students and sent copies of the correspondence to the student and office of admissions. My purpose was not to take revenge on the student. My intent is not only to force cessation of a dangerous act but also to preserve a relationship with the college. A serendipitous payoff occurs when admissions personnel notify me about a student's problem, so I can intervene before the problem becomes a crisis or a tragedy.

Fees

Undeniably, advocacy is time consuming. In independent practice, the practitioner needs to decide in advance an equitable hourly rate or retainer structure. Families appreciate the importance of being admitted by a college of quality. Some SAT tutors charge \$500 per hour. Wealthy families will contribute millions of dollars to the college to increase their child's chances to be admitted. Fees should not be contingent on admission (after all, surgeons do not charge a bonus if the patient is restored to health), nor should they be excessive. In my view, an excessive fee can prevent the formation of a positive treatment alliance because the teenager feels the therapist's only incentive is money, not genuine concern.

Transference and countertransference issues in advocacy

Countertransference is a part of psychotherapy, and being an advocate is associated with unique feelings on the part of the psychotherapist, which must be understood. Defining countertransference as "all those emotions stirred in the therapist that interfere with the conduct of the treatment," Masterson (1989b) views it as "the greatest obstacle to treatment—second only to a lack of knowledge" (p. 275). Azima (1972) asserts, "It is a myth...that any therapist can escape manifestations of countertransference reactions" (p. 244). Weiner (1975) defines countertransference as when the therapist "feels or acts toward a patient in ways that are neither part of the real relationship, rationally justified by the circumstances, nor part of the working alliance, appropriate to the terms of the treatment contract" (p. 54). If the psychotherapist tries to become a peer or feels offended that the youngster wants to wound the analyst, this signals a negative countertransference. Negative countertransference reactions may emerge when the youth frustrates, disrespects, disappoints, disobeys, and angers by acting out. Danger signs include wanting to punish the youth, feeling relief when the adolescent misses a session, and being envious of student exploits. Based on work with patients with borderline personality disorder, Adler (1985) identifies three types of countertransference that adversely affect outcome and which apply to working with alienated and angry adolescents: the therapist's "(1) wish to maintain the gratifying position of nurturing mother, (2) response to the biting attacks of the patient, and (3) wish to have a well behaved patient" (p. 148). Maltsberger and Buie (1974) advise the clinician to realize that the teenager can provoke rage and can view the advocate who enforces behavior limits as the enemy. Winnicott (1992) warns that countertransference can produce hateful feelings: "An analyst has to display all the patience and tolerance and reliability of a mother devoted to her infant, has to recognize the patient's wishes as needs, has to put aside other interests in order to be available and to be...objective, and has to seem to want to give what is really only given because of the patient's needs" (p. 48).

Perhaps the most prevalent and detrimental countertransference is the desire for gratitude and recognition for the awesome gift given to the adolescent. I deal with this directly by saying, "If you want to show your appreciation, do well; then it will be easier to convince the college to admit another. Please, send me a transcript."

A significant age differential complicates transference because often the teenager views the advocate as the parents' surrogate, who possesses the power to prevent the youth from using psychoactive substances.

As I have written:

Most adolescents in my practice have infuriated and alienated school personnel, the clergy, employers, and agency professionals who could help them educationally and vocationally. Aggressively negotiating the most favorable deal for the adolescent is an integral part of the treatment relationship....The therapist-advocate must be prepared to assume a variety of roles: negotiator, protector, intervener, broker, supporter, representative (Bratter, 1973, p. 594).

The psychotherapist must help the adolescent resolve the symbiotic bind that he or she is in by teaching the youth self-assertive skills, thus allowing the teen to move beyond the treatment relationship. This means moving beyond the gratification provided by fantasies of the therapist's omnipotence. Adler (1985) writes:

The omnipotence that the patient ascribes to the therapist as [the patient] recreates the mother-infant dyadic tie can give the therapist much pleasure.... As the patient works through the infantile regression and as more mature choices become open to him, he may begin to take steps away from the therapist-mother....Because...wishes cannot be totally gratified by the therapist, the patient's...rage may destroy the sense of gratification the therapist was receiving from the previous, positive relationship with the patient (1986, pp. 148-149).

The psychotherapist should avoid using advocacy to fulfill unresolved conflicts, for example, by entering into competition with parents, or wishing to punish them for neglect, or feeling that the student owes him because he has secured preferential consideration. Advocacy can become therapeutically detrimental when the psychotherapist...rob[s] the [youth] of a sense of success, of achievement, of accomplishment (Bratter, 1977).

Regardless of the therapist's theoretical orientation, his or her narcissistic needs can adversely influence outcome. When the youth remains deceitful and insulting, I respond, "I am wasting my time. I would be dishonest to deny feeling devalued and disrespected." Depending on the severity of behavior, I warn, "If your deceitful acts continue, I will consider terminating our relationship." On the one hand, the therapist needs to be cautious about issuing an ultimatum, which can create a noxious power struggle. On the other hand, however, there are consequences for irresponsible, inferior, impulsive, illicit, and dishonest acts. In extreme cases, I

have rescinded recommendations, knowing this act will result in rejection of the student's application. In these cases, truth can have a compelling therapeutic and cathartic effect (Bratter, Coiner, and Parker, 2006).

The adolescent is overwhelmed by relief, joy, and pride when a college admits him or her. Never should the therapist demand appreciation or claim it is his or her victory. It does not matter whether the teenager or family express their approval. The therapist knows, which is sufficient gratification. The need for more approval makes the therapist vulnerable; this need may be traced to parental withholding of praise and approval in his or her own youth. Being on the winning team should suffice. Indulging the wish to be a hero might entice the psychotherapist to be dishonest or to exaggerate, thus endangering the brittle alliance and treatment outcome. Consumed by the guilt associated with an undeserved admission, the youth may sabotage success. Conversely, rejection by the college will provoke a negative reaction. Never blame the student for a college rejection (unless the student did not continue to progress); such criticism could prompt a premature termination of treatment.

Lessons from Shaw's *Pygmalion*

Shaw's *Pygmalion* (1916) has implications for therapists/advocates. The fictionalized professor, Henry Higgins, became involved with his student (as did Freud when he housed and fed patients). Higgins helped Eliza Doolittle improve her lot by escaping from the shackles of the lower class. Had the professor not mobilized social contacts, Eliza would have continued to sell flowers on the street.

Higgins's goal was to prove he was "the greatest teacher" (p. 40) of linguistics. He wagered Colonel Pickering he could teach Doolittle elocution and etiquette so that Eliza would be accepted as a member of the upper class. Shaw portrayed Higgins as an arrogant and egotistical bully whose primary concern was self-aggrandizement. The contemptible and irascible professor's plan was based on guile. To gratify egotistical needs, Henry reduced Eliza to an object, which prevented the formation of a helping relationship. The transference-countertransference dynamic was toxic. This negative reaction could have been avoided had Higgins felt, "I helped you to help yourself. You worked hard. You deserve the credit." Being competitive with his student, Higgins destroyed what Meeks and Bernet (1990) term "the fragile alliance." He was, however, an effective advocate, so an astute clinician can learn from the professor's errors. Eliza Doolittle's primary presenting problems were poor speech and a negative attitude that limited her professional and social options. She needed habilitation, not rehabilitation. Eliza lacked the breeding and knowledge necessary to be accepted into upper-class English society. Higgins negated Eliza's achievement by boasting that her educational and social successes were his.

Eliza:I've won your bet for you haven't I? That's enough for you. I don't matter.

Higgins: You won my bet! You! Presumptuous insect! I won it!

Eliza: What's to become of me? What's to become of me?

Higgins: How the devil do I know?...What does it matter?

Eliza: You don't care. You wouldn't care if I was dead. I'm nothing to you (p. 100).

Higgins earned accolades as a mentor-advocate who maintained high expectations for Eliza's improvement. But his demanding credit for Eliza's achievements crippled his effectiveness and resulted in an adversarial relationship.

The need for innovation: Not a conclusion, but a beginning

Eighty percent of students with whom I work are accepted by colleges of their first choice. Admissions personnel know I am a passionate and candid advocate. My recommendations exceed fifteen pages. I write several letters, each of which documents improvement. For the first half of my career, I was in independent practice. During the last half I have headed the John Dewey Academy, a college preparatory therapeutic boarding school, whose graduates attend competitive colleges and seventy percent graduate from these institutions of higher learning. These statistics exceed those of other schools—proof that when the advocate writes realistic and persuasive recommendations, colleges of quality will be responsive and, more importantly, recovering students can succeed.

Before a student leaves the John Dewey Academy to attend college, I write a letter with the final transcript:

When a...self-destructive adolescent who possesses superior intellectual... potential participates in a prolonged corrective emotional experience and has returned intact from a painful detour caused by indulgent and stupid conscious choices with a positive sense of self and a need to justify his existence to himself, I am confident he will assume a positive leadership role in the classroom and on the campus. This reality justifies admission. I assert that the contributions of recovering students are more valuable than the performances of others because they frequently enhance the common good, not just that of a select few.

Recidivism is high in this treatment population because, until adolescents are convinced that diligent work can restore upward mobility, they will not invest energy to escape from self-imposed no-exit prisons in which they have entombed themselves. Unless prepared to extend treatment parameters to include advocacy, the therapist needs to decline to treat troubled and troublesome teens.

There are occupational rewards. Many adolescents achieve greatness by improving the quality of life for others. It is gratifying to know that I possess a special expertise, indefatigable resilience, and the necessary toughness to help a population of adolescents who have been viewed as untreatable and uneducable.

I love the urgency, knowing that it is the brightest and the best who reject and are rejected by an environment they feel is inimical to affective, artistic, intellectual, and moral needs. I love the therapeutic challenge of finding the symbolic key to unlock the door, and am willing to blast open the door, when indicated, by using confrontation. Only a few keys are lost. There are occupational hazards (Bratter, 2003). Four committed suicide. Four died of drug overdoses. Two were murdered for drug-related activities. I have delivered three eulogies.

Most teenagers with whom I have worked reclaim their lives from destruction and drug dependency. To paraphrase Henry Adams, a therapist can affect eternity; (s)he can never tell when his or her influence ends. It is gratifying to learn about achievements: graduation from college or graduate school, job promotions, marriage, and the birth of a child or grandchild. When attending a family celebration, it feels good to be remembered by family members and friends who comment, "You're Tom. I know you." The most important test, as my career nears its conclusion, is knowing that if I could start again, I would select the same group of adolescents with whom to work. I have few regrets. Successes significantly outnumber the failures, although this does not minimize the pain of defeat.

No research has evaluated the impact of expanding the helping relationship to include advocacy, since this is not common practice. Extending the psychotherapeutic alliance dramatically increases the probability of success when working with a population heretofore not amenable to treatment. My forty-year career supports this a priori assumption.

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