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General Principles

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In the morning I want to be dead, because I can't face the day. At noon I want to live forever, because Sarah smiled at me. In the afternoon I want a red sports car, because this geek next door has one. And in the evening I want to be anywhere but home because you are fighting with Mom again about nothing. Are you serious when you ask me "What do you really want?"

—15-year-old boy, in response to his father's question in the first month of treatment

One of the great joys of psychiatry is contributing to the personal growth and development of individuals who for a variety of reasons are off-course in their lives' trajectories. Nowhere is this task more gratifying than with patients in adolescence. To intervene early and in a timely fashion with teenagers can save them years of misery and can

prevent perceived wrongs from becoming a dominating influence in their lives. Such interventions are uniquely rewarding because they not only relieve suffering, but also prevent future pain.

This opening chapter is organized in three parts: First, we describe some general principles of development; then we address special problems that make working with the psychiatrically disturbed adolescent more challenging than working with adults and children; and finally we end by outlining a prototypical assessment and treatment plan that our teams utilize in our clinics at Stanford.

The treatment of adolescents is qualitatively different from that of children, a point easily understood by clinicians. Play, the major form of communication with children, is usually no longer useful with teenagers. Although verbal interchanges of adolescents resemble those of adults, communications with adolescents are certainly not identical to interchanges with adults. In particular, although the verbal and cognitive abilities of adolescents are comparable to those of adults, adolescent life experiences; interpersonal relationship patterns; stability of psychological structures, attitudes, beliefs, and behaviors; and capacities for working alliance and affiliation are not.

BASIC CONCEPTS OF ADOLESCENT DEVELOPMENT

The clinician working with adolescents must take into account the nature of normative (i.e., appropriate for this phase of development, but not necessarily in another, in other words, fluctuations in self-esteem, planning for the future, inhibiting impulsive behavior) developmental changes when reaching a diagnosis and planning treatment. One needs to recognize that the span of adolescence and emerging adulthood (from now on we use the term adolescence for both), approximately 10 to 15 years, is not a unified stage of life and thus, behavior that is appropriate (normative) for one phase of adolescence may be indicative of psychopathology in another.

The term adolescence generally covers the second decade of life and consists of three phases, demarcated for convenience by age: early adolescence (10–13 years), mid-adolescence (14–17 years), and late adolescence (18–20 years). Emerging adulthood is a new developmental phase that

encompasses ages 18 to 25. Developmental tasks to be completed are different in each of these subphases. In *early adolescence*, coming to terms with puberty, physical growth, and altered appearance tends to be center stage. These changes are the concrete reminder that one's relationship to the family is about to change in unprecedented ways. *Middle adolescence* usually brings on the realization that one's cognitive powers are equal to and even surpass some adults' abilities. This facilitates a more comprehensive look at oneself, the forging of a new identity, greater independence from the family, and an increasing reliance on peer relationships. Along with these changes comes a need for increasing privacy, which brings along new thrills and risks. *Late adolescence* is the stage where preparation for exit from the family of origin is central. Although this is usually not completed until the phase of emerging adulthood, there are many periods where the youth is completely independent, even responsible for others (such as younger siblings and peers). In *early adulthood*, there is a consolidation of independent living, extending to financial aspects as well. We also expect a consolidation of career choice and work trajectory, and partner choices become longer term, with an eye toward more balanced and binding relationships.

To some degree these tasks overlap and extend into other subphases, but there is merit for the clinician to keep an eye on how far a patient has come in resolving some of these dilemmas as they present for intervention. Very often, these tasks also are the triggers for whatever symptoms they present with. By helping the patient in resuming development after symptom control has been achieved, we can also use progress in these tasks as a measure for the resumption of maturity and continued growth.

Although there are individual differences within each phase of adolescence and gender differences, with girls proceeding through the sequence more rapidly than boys, each phase carries with it some information as to what is normative and acceptable in a given society or context. For example, in the area of heterosexual relations, in some middle-class communities boy-girl parties and school dances are acceptable in early adolescence, going out on dates is not acceptable until mid-adolescence, and sexual explorations, if acceptable at all, are condoned only at late adolescence. In other communities such as African American inner-city neighborhoods, the sequence can

be earlier, with dating acceptable in early adolescence and sexual activity acceptable or at least normative in mid-adolescence. Yet in other communities, such as Mediterranean, Mormon, or Muslim neighborhoods, opposite-sex relations occur relatively later, with dating unacceptable until after high school completion. Knowledge of community norms for each phase of adolescence permits a clinician to differentiate between "on-time" age-appropriate explorations of different roles and behaviors that may have risky consequences from genuine full-blown psychopathology. The social context of behavior differentiates normative (i.e., age appropriate) from pathological. As the U.S. populations increase in diversity, these considerations become ever more important.

The developmental changes that occur during adolescence are extensive and affect virtually every domain of a teenager's functioning. Other than infancy, in no other stage in life do so many rapid changes take place. These begin with pubertal changes affecting appearance, behavior, and mood, relationships with others, and risk-taking. Our bodies go through rapid growth and development. Our muscle mass seems to increase overnight. Secondary sex characteristics appear and become the source of attention, pleasure, worry, and concern. Our appearance, which for so many years has been quite stable, becomes altered to such an extent that we sometimes have difficulty recognizing ourselves. And yet, we cannot stop looking at ourselves in the mirror. Our minds begin their steady expansion to adult scope. When teachers demand that we perform unprecedented feats of learning, we discover to our amazement that we are indeed able to deliver, even contrary to our own expectations. We note a new tone in our interactions with adults. They now sometimes treat us as equals. They respect our privacy, as they should. They even solicit and earnestly consider our opinions. And, most importantly, there is a new undercurrent in our social interactions, an added new dimension and new excitement that suddenly turns age-old playmates and acquaintances into objects of desire.

At any given time, we feel out of synchrony with ourselves, strangely off balance. When everything in us and around us is changing, it is hard to find our bearings and remain solidly grounded; yet this is precisely what our families and society expect us to do. As we prepare the final exit from the protective social structures of childhood, we need to convince others—and

ourselves—that we are ready to take the big step. We need to rely increasingly on ourselves, or at least appear to, while taking on new tasks and unprecedented risks.

Adolescence is also a time of great excitement, an opening to the world and a discovery of what we stand to inherit. It is a time of growth and acquisition of new instruments, skills, and emotions. We discover that we know more and are able to do more (especially electronically) than our fathers, mothers, and grandparents—a frightening and exhilarating concept. We notice that others notice us in novel ways, and this provides a new thrill and threat at the same time, and raises questions as to how we will integrate sexuality into our lives.

What follows is just a brief synopsis of some of the details of major changes, and we direct the interested reader to a recent volume with state-of-the-art reviews of adolescent and emergent adulthood development (see the suggested reading at the end of this chapter).

Pubertal Changes

Puberty brings marked changes in a teenager's appearance, with accelerated growth, weight gain, changes in body configurations, the maturing of the reproductive organs, and the development of the secondary sex characteristics such as facial and body hair for males and body hair and breast development for girls. These changes, mostly visible and external, serve as signals both to the adolescents themselves and to others of their more mature status and their reproductive abilities. The hormonal changes that underlie these developments are implicated in the increased moodiness of teenagers, their newfound interest in the opposite sex, sexual strivings requiring some acknowledgment, and perhaps an elevated level of aggression.

There is significant variation in the age at which children enter puberty, and this variation is significant in its effect on their functioning. Early maturers in the two sexes fare differently: Girls who begin menstruation early and show the expected bodily changes are usually more at risk for teasing, inappropriate remarks, and associating with older peers and its attendant risk-taking (smoking, drinking, using drugs, and engaging in early sexual activity). Just at the time that early maturing girls are experiencing more

conflict and feeling somewhat more distant from their parents, their bodies provide a strong and mostly unwanted attraction for attention from the opposite sex. To deal with this multitude of changes is a challenge at any age, but it particularly stresses the younger, inexperienced adolescent whose psychological structures are relatively weak. Not surprisingly, there is some evidence that early maturing females—that is, those who start their menses a year or two ahead of their peers—tend to have a higher rate of psychopathology (especially internalizing pathology such as anxiety disorders, anorexia nervosa, or depression) than their "on-time" classmates. In contrast, early maturing boys seem to be at some psychological advantage in that they are given more leadership experience; are judged more attractive by girls; are at a competitive advantage in sports, which gives them status in the peer group; are generally popular with peers; and date more. This advantage, however, can come at a price: these early maturing boys are more prone to taking risks and exposing themselves to risky situations.

For boys, it is the late maturers who have more trouble in being "off-time" in their development. To lack facial hair in mid-adolescence, to be small and skinny rather than tall and muscular, to look "child-like" when others look "adult-like" makes for a difficult transition. Late maturing boys often seek attention by becoming bossy or unduly talkative, or taking the part of the classroom "clown." The unintended result of these behaviors is generally to make the late maturer less popular with both same-sex and opposite-sex peers.

Cognitive Changes

Pervasive changes in cognitive functioning permit adolescents to deal with abstractions; project thought into the future; examine previously unquestioned attitudes, behaviors, and values; and to take themselves as the object of their own thought. David Elkind claims these changes precipitate a form of egocentrism in which adolescents act as if they are on stage, playing to an imaginary audience that is totally focused on them and on every nuance of their performance. Perhaps because they feel they are the focus of attention, adolescents come to construct a personal fable that they cannot be understood by others because their experiences are unique—no

one else has suffered so agonizingly or experienced such exquisite raptures. Most recently, we have new data extending these findings into the highest levels of cognitive functioning, that is, executive cognition. This has brought about new ways of measuring thinking, planning, and learning and has made us aware of a whole new array of disturbances, which were not at all understood at the first edition of this book. More on this is discussed in the chapter on learning and its disorders (Chapter 4).

The Construction of an Identity

Erik Erikson has claimed that the major task of this age is to develop an identity, a sense of self distinct from that of others, particularly that of the parents. The sense of identity must be coherent and meaningful, acknowledging the full complexity of the individual, and consistent with abilities and potential. Adolescents experiment with new roles both at home and in the peer group to help them define who they are. Erikson claims that adolescents often appoint perfectly well-meaning people such as parents to serve as their adversaries. Thus, teenagers may assume an oppositional stance and refuse to do what their parents want. Later on, as adolescents become more confident and acquire more sophisticated tools of assertion, they are able to present themselves as distinct in more refined ways, that is, by their tastes and preferences, beliefs and attitudes.

Adolescents integrate feedback from multiple sources, like teachers, friends, partners, and parents, in order to explore their similarities and differences with others, establish an identity distinct from their parents, and to make an age-appropriate tally of their strengths and weaknesses. This process leads the adolescent away from an idealized self-image, which all of us at some point endorse about ourselves, and toward a more realistic self-image. Developmental problems arise when an adolescent has a premature closure of identity, such as believing that he will become a doctor early in life without taking into account if he has the interests, talents, skills, or support to achieve this goal. Likewise, it can be problematic when an adolescent experiences identity diffusion, which is the persistent lack of an established identity, which usually results in lack of goals, determination, and pursuit of realistic life trajectories.

From an existential point of view, psychotherapy in this age range must not only address symptoms, but it also has the task of assessing how far along an adolescent is in the identity development process. Once the adolescent's symptoms have been stabilized, the focus moves from acute symptom control to encouraging a healthy developmental trajectory and identity formation in order to prevent future symptoms. Some adolescents are disinterested in or resistant to this work, and are happy to live with symptoms under control and without any further work on more in-depth psychological issues. In these cases, the therapist should not force identity development upon them, but rather agree to watchful waiting and tracking of normative progress. Others, usually the more psychologically minded ones, respond positively, and enjoy the process, which gets them to look at issues that have resulted in them not progressing through this stage as expected.

New Peer Behaviors and Contexts

The relationships with friends and acquaintances assume new complexities as adolescents use the peer group to explore their identities and as the peer group changes in composition to include opposite-sex as well as same-sex youths. In addition, early in adolescence, youths leave the protected, familiar neighborhood schools and established peer groups and attend larger, more impersonal middle schools and high schools with more diverse peer groups. Teenagers often find they are unsure of how to conduct themselves in the new settings and with the expanded peer group. This insecurity increases their conformity to peer values and frequently promotes a rather rigid adherence to sex stereotypes. These behaviors ensure the individual that he or she will not stand out as inappropriate or be socially ostracized.

Dealing with Sexuality

Adolescents, for the first time, must deal with the full range of their sexuality, aspects of which have an insistent quality that intrudes on their everyday functioning. Sexuality is now manifest in erotic dreams, attraction

to the opposite sex, masturbation, and for boys, nocturnal emissions; for girls, the sometimes unwelcome reminder that they are ready to bear children—their monthly periods. Complicating this task is the fact that in our society parents rarely communicate openly and comfortably about the psychological aspects of sexuality, leaving such information to be gleaned from unreliable sources such as locker room talk from the Internet, peers, and magazines of questionable content. Dealing with sexuality may be more complex for those youths who are out of step with their peers in terms of their pubertal development. The film *Revenge of the Nerds* is a clumsy but instructive introduction to that theme. The most important questions in this domain, that is, the careful orchestration of dating and sexual activity, rarely get discussed in sexual education classes or in families. Instead there usually is a tiresome focus on the mechanics of sex, sexually transmitted diseases, and prevention of pregnancy. Issues of gender, gay, bisexual, and lesbian development also rarely are brought up, let alone discussed, leaving youths who are struggling with questions regarding these domains at a loss. There has been some progress in educating primary care providers in pursuing these issues as needed, but we still are far from a comfortable array of services to offer adolescents regarding all these topics.

School and Achievement Pressures

On the academic front, life also changes significantly. Middle schools and high schools are much larger than the neighborhood elementary school; students no longer have a single teacher who knows them well and instead have different teachers every hour. There is a greater academic emphasis and more stress is placed on the pupil's performance. In addition to academics, adolescents have opportunities to excel in multiple arenas—sports, social clubs, extracurricular pursuits. The rhythm of daily life begins to resemble that of adulthood. Unmistakably, the stakes are higher, the consequences of success or failure have more direct implications for the future. Because college admission depends on a teenager's academic scores, academic pressures mount in high school. The school system by and large rewards the high achiever and the student invested in school-related sports and student-government activities.

Renegotiating Family Relations

A good place to start when working with adolescents is to ask them and their parents about their family memes. We are particularly interested in examining glaring omissions and conflicting messages, which then can be the platform for discussion in family meetings, as we help with clearing up conflict. The term *meme* was first introduced in 1976 by the evolutionary biologist, Richard Dawkins. Memes are the rules that an adolescent unconsciously lives by. They can be passed down from parents or caregivers through often-repeated sayings, like "honesty is the best policy," or they can take the form of thoughts, ideas, theories, practices, habits, songs, dances, images, gestures, phrases, or moods. Asking an adolescent and family to identify their memes can provide information about their belief system, motivations, and patterns, and can illuminate what they consider to be important in life. Memes can also give the clinician insight into the origin of maladaptive or distorted beliefs or behaviors.

The progressive path of development also demands a reworking of the adolescent's relationship with the family of origin, including new steps toward autonomy. The most palpable manifestation of this process is the teenager's greater need for privacy, frequently expressed by the closed or even locked door to the child's bedroom. Furthermore, adolescents, in contrast to elementary school children, express a clear preference for spending leisure time with peers rather than with family. Until children are about 11 years old, most parents know roughly 75% of their activities. By the time these children are 18, however, parents are lucky if they know 25% of what their sons or daughters are doing at school and with their friends. Adolescents use two approaches to limiting what their parents know about them: They withhold information about their daily activities and feelings, even in the face of patient and gentle questioning by parents. They answer questions by monosyllabic replies rather than an elaborated sharing of information. In addition, most adolescents report that they tell lies to their parents, at least on occasion.

For most parents, such a profound withdrawal of contact and intimacy is difficult. At the same time that adolescents cease sharing their thoughts and feelings with parents, there is an increase in family conflict centering on daily aggravations of living rather than on value differences. Parents put

increasing pressures on adolescents to be responsible (doing homework, keeping their room tidy, helping with housework) whereas adolescents put pressure on parents for increased privileges of adolescence and adulthood (a later curfew, more money, fewer restrictions on the type and amount of television viewing, and so forth). This conflict may serve positive functions in helping the adolescent differentiate from his or her parents, spend more time with peers, and develop greater behavioral autonomy and emotional independence. It is noteworthy, however, that protracted and very intense family conflict, with powerful negative emotions directed at family members, is not typical or age appropriate and usually signals pathology.

SPECIAL FEATURES OF PSYCHOPATHOLOGY IN ADOLESCENCE

Given these comprehensive normative changes, it is common to find that clinical cases typically contain aspects of the normal developmental tasks although magnified and perhaps distorted in nature so that they resemble psychopathology. Three aspects in particular present with some frequency: risk-taking and aggression (most common in externalizing disorders) that can be so marked as to jeopardize the life and well-being of the adolescent; self harm and suicidality (both more noticeable in internalizing disorders); and problems with identity (pervading almost all the syndromes discussed in this volume). With adolescents, these three aspects need to be considered as part of the case formulation regardless of the primary diagnosis. We present some case material to illustrate each of these themes.

Risk-Taking and Aggression

Perhaps the most disquieting aspect of working with adolescents results from their exploration of the limits of their newfound abilities, skills, and social contexts. Experimenting and risk-taking are ubiquitous in this age group and may be necessary for further development. Failure among adolescents to experiment with new roles and behaviors and avoidance of all risks may indicate undue constriction and hamper appropriate growing up and dealing with the age-appropriate issues of autonomy and identity.

The clinician must be prepared to work with adolescents who exhibit risky behaviors and must be able to help parents set appropriate limits if necessary. We describe some relevant scenarios that convey the complexity of the situation.

Case Study 1: John

John, a 16-year-old boy, was incarcerated at the California Youth Authority after he was adjudicated for stealing a car and assault with a deadly weapon. He and some friends had been celebrating the victory of their baseball team. As a backup pitcher, his position on the team was somewhat tenuous, and to be fully included in the celebration was a matter of great importance to him.

As the party wore on, the group consumed beer liberally. Shortly after midnight, one of the boys suggested they make a beer run. However, they were without a vehicle, as they had wanted to avoid the temptation of driving while intoxicated. After a lengthy debate, one of the group suggested they take the neighbor's truck, which was unlocked in the driveway, keys in the ignition. There was some hesitation on everybody's part, but as soon as one of the boys pointed out that the neighbors were good friends, their worries dissipated, and they all agreed it would be inappropriate to wake the owners to get consent.

The group left, with several friends piled in the back of the truck, despite John's protests. The urge for more beer got greater, and so the truck left, driving slowly at first, but accelerating on the highway. They encountered friends in another truck, and there was joyful banter about the status of each group's engine, resulting in a challenge to race to the store. Shortly thereafter, John lost control of the vehicle, and several youths, including himself, were severely injured in the accident.

This case certainly has a familiar ring to it and conjures up many drag racing and "chicken" scenes from movies such as *American Graffiti* and *Stand by Me*. The gradual escalation of risk throughout the evening,

without appropriate counterchecks by any member of the group, is quite typical of a group whose functioning is impaired by alcohol. None of the youths involved had a criminal record; most of them came from well-functioning families. None of them intended for the evening to end this way, but nobody came forward and pointed out that the next step—although it seemed small—was a huge escalation compared to the baseline behavior. Although this case has a distinct male flavor to it, girls are not immune to such events.

Case Study 2: Anne

Anne, a 14-year-old girl attending an adolescent medicine clinic, presented after she had been sexually assaulted by several boys. Following her parents' divorce, she initially lived with her mother. However, she did not get along with her mother's live-in boyfriend, so she moved to her father's home. He lived in a southern California community where she found herself somewhat isolated. In addition, her father was greatly upset by the unexpected divorce and less than able to deal with his own grief, let alone that of a daughter entering puberty.

Anne made one new friend at school, someone not part of the mainstream group. This girl introduced Anne to her brother, who turned out to be a charming individual with a past. His mother was quite dysfunctional, intermittently abusing drugs and alcohol. His father was a free spirit, who appeared and disappeared as he saw fit. The young man had formed affiliations with a local gang without becoming a full-fledged member, in order to help himself and his sister deal with the problematic family situation. Anne was acquainted with some of her new boyfriend's friends, although mostly from a distance. She found the group interesting and romanticized their antisocial exploits. She was impressed by their strong attachment to each other and the protectiveness they showed toward their own.

One day, as she was going home from school, several of the boys invited her to join them in their car. Facing a lonely afternoon at home

and a surly father in the evening, she accepted the invitation. The trip led to several stops in amusement parks and fast-food places, terminating in a remote park, where everybody was invited to try some cocaine. Curious, Anne agreed. Following that, she was asked to "pitch in," but when she could produce no money, she was asked to perform fellatio on the boys. She refused, and the boys subsequently raped her.

Although this case has a more typical female theme to it, the gradual escalation of risk over time is similar. The increase of risk from one step to the next was modest, as when Anne went from the bus to the car, and from the amusement park to the fast-food place. But with each step she progressively put herself in the debt of an exploitive group. She was blinded to that realization by her own dependency needs, activated by the divorce in her own family, although she had heard her boyfriend describe beatings of gang members by other members when they were out of line.

Both cases illustrate risk-taking in this age group. It usually involves engaging in new, adult-oriented activities—to drive, to drink, to use mind altering substances, to have sex, to face danger and survive, to perform in some way to impress others, to become in some form a primus inter pares—the first among the peers. Except in the most pathological cases, risky behavior is rarely an enterprise that is foolish or dangerous from the start. Most often, risk-taking is a series of small, incremental steps in which judgment is suspended sufficiently that the young people do not examine the whole picture—only its immediate constituent parts. Thus they fail completely to see how far they have come from the baseline of acceptable conventional behavior. Under normal conditions, neither of these two patients would have agreed to a car chase while they were drunk, or an evening in a park with gang members doing cocaine. However, the slope they were on was slippery, leading them to engage in behavior they would not usually condone, and into situations over which they had no control.

Often, adolescents find that they take unnecessary risks and get away without consequences or damage. At that point they usually reason that since nothing happened, some kind of immunity has been conferred on

them, or conversely, that the adult estimations of risk were grossly exaggerated. Both the cases above show the limited ability of this age group to deal with probabilistic outcomes and to project into the future the possible risks and negative consequences of current actions and circumstances. From the adolescents' perspective, parents and adults are hopelessly out of date and as a result do not understand the realities of the adolescent's world.

In dealing with adolescents engaging in risky behavior, we need to give them calm and persistent reassurances that risk is risk, and probability is not certainty. Each scenario, such as the ones above, can be dissected to show the gradual accumulation of risk; this exercise is quite helpful to adolescents when they are able to reflect more rationally on the situation, that is, when they are not caught up in the heat of the moment or surrounded by peers on whose acceptance they depend.

As part of the routine assessment and periodically throughout treatment, we need to address issues related to risk-taking. A nonmoralistic, matter of fact, nonseductive approach is usually quite effective. Most adolescents, in the cool light of day, are quite able to examine properly their behavior and are grateful when the clinician shows interest, concern, and absence of judgment. The discussion is most easily begun by examining what happens in the leisure and recreation domain of the adolescents' life, what they do for fun, and how far they take it.

Care is needed, though, in how the investigation is structured. Sometimes patients clearly do not want to share some of this information for fear of self-incrimination and punishment. It is tempting for clinicians under these circumstances to offer premature guarantees of confidentiality to find out more, but such assurances can be tricky and counterproductive. For example, after the full extent of risk-taking becomes apparent, it may be necessary and in the patient's best interest to involve his or her parents, which, under the given guarantees, can happen only with the patient's consent. If he or she refuses, the clinician is left with the problem of either going ahead with the report to the parents and risk losing the working alliance with the patient, or of being unable to ensure that appropriate limits will be set by the parents and thus, perhaps, leaving the adolescent at risk.

Identity Crises

Adolescence is a time of taking stock of one's strengths and weaknesses, all that one possesses, all that one has been through, and all that one hopes for in the future. This process should lead to a reasonably accurate image of who one is and hopes to be in the future. The adolescent must be able to step back and appraise the self and the situation with some honesty and accuracy and summarize it accordingly. The cognitive advances of adolescence permit a majority of adolescents to perform this task, and thus it is during adolescence that issues of identity and self-examination first emerge in psychopathology.

Issues of identity need to be assessed as part of the initial diagnostic exam and again in the course of treatment, as major shifts can occur as a normal part of successful treatment. Such shifts, however, are usually experienced as somewhat threatening and anxiety producing; sometimes patients are tempted to return to their previous status because they are unable to cope with the ambiguity of the "psychological birthing process."

An additional complication is that very often parents are worried and concerned about the new emergent identity, which the patient forges in treatment. They may feel threatened by what treatment progress brings about, wishing that their quite obedient child would return. This sometimes even leads to open conflict with the therapy team, which can be labeled as leading the patient into the wrong direction. Calm reassurance that the team's task is supporting the patient's voice, but not necessarily their decisions, usually settles this problem. Given the patients' state of dependency (financial and otherwise), they of course have to bring the parent along as they change directions in their studies, pursuits, and interests.

Case Study 3: Gayle

Gayle, a 17-year-old girl with anorexia nervosa, was initially diagnosed at age 14 and has been in treatment ever since, first as an inpatient and then an outpatient. Preoccupation with weight and appearance has not been an issue with her for the past year. She is at a

low normal weight, and although she is not menstruating, her body is beginning to show pubertal changes that indicate she could start regular cycling soon. In school, she has developed a new group of friends, and her academics have been—as always—quite successful. In treatment, issues such as applications to college, interest in certain boys in her class, and dealing with conflicts with her parents about privileges have been raised and are usually addressed fairly well. Nursing staff at clinic visits has made several comments on how "healthy" the patient looks, carefully avoiding other adjectives.

Three events, however, triggered a session in which the patient was intensely preoccupied with being "fat," a concern she had not voiced for more than a year. A boy asked her out to a formal dance; she was accepted into five of her seven college choices—some of them quite prestigious; and her clinic visits for weight check were reduced from once a week to once every 3 weeks. The exploration of her defensive stance led to a detailed discussion of her extreme discomfort with each of these changes in her life.

Gayle felt that her current successes would lead to a stream of increasing demands, which she would not be able to control, and thus she lost sight—again—of why she was striving so hard for success and who she was trying to please. She felt fragmented and torn, and experienced the reduction of clinic visits as a decrease of the treatment team's interest in her personally. Her parents also exhibited reduced concern and publicly voiced considerable relief at her recovery. Facing her imminent departure from a constricting, overly structured but well-known and familiar environment, she became increasingly anxious, and fled back to her former identity as an eating disorder patient, where all the trouble in the world could be reduced to a simple "I am too fat."

This case illustrates some typical dynamics around the issue of identity. The patient was aware that her old identity of a pseudo-mature, subservient, and unassertive young woman had allowed her to show only certain sides of herself. And although she was very much dissatisfied with such an

existence, she could not withstand the simultaneous onslaught of becoming an independent, healthy, sexual, and high-achieving person in the eyes of others. The anxiety about continued expectations, which she was afraid she could not fulfill, was too much for her and she retreated to safety: back to the self who was simpler, lacked all these complex parts, and above all, was familiar. After continued intervention involving exploration of her fear of success and responsibility, rooted in her distorted self-image and lack of trust in her own abilities, she successfully continued her journey toward health.

To assess a young person's identity at any given point in treatment, clinicians must form a judgment as to how appropriate the youngster's appraisal is, how different from reality as judged by parents and other important members of the youth's circle. We can anticipate many problems if the gap between the adolescent's perceived and actual identity is too great, especially when there are discrepancies in most domains of functioning. The direction of the discrepancy leads to some important clues about the adolescent's status. Depression and related disorders usually lead to underestimation of abilities; psychosis and conduct disorders result in overestimation, sometimes to a grotesque degree; anxiety disorders are usually accompanied by excessive constriction of the self, with many important domains of functioning omitted from the appraisal; borderline adolescents exhibit a highly diffuse self-image, fragmented and markedly lacking integration. The most extreme cases of identity disturbance are the dissociative disorders, as they are known in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*). In this rare variant, the individual has distinct alters at different times, and usually has little or no knowledge of the other identities residing within.

ISSUES IN DIAGNOSIS: DISTINGUISHING BETWEEN NORMAL ADOLESCENT BEHAVIOR AND PSYCHOPATHOLOGY

The distinction between normal and abnormal adolescent behavior is complicated. In the following subsections we give a case illustration of the difficulty in ascertaining whether the presenting problem is part of normal

developmental issues or whether it represents serious pathology. In the second subsection we consider some of the factors that complicate making such a determination and give some suggestions for dealing with them.

Case Study 4: Kirsten

Kirsten, a 15-year-old German exchange student, was brought to our eating disorders program by her "American host family" with whom she had been placed 3 months earlier. They observed in Kirsten some dietary restriction, some vomiting, rapid weight loss, some episodes of intoxication, and drug use. They described Kirsten as weepy and anxious but did not link this behavior to the absence from her family. Their immediate concern was to ascertain whether she was suffering from major psychopathology and whether to return her to Germany.

We employed two strategies to determine whether these episodes were indicative of an eating disorder or merely a perturbation of normal development. First, we obtained an extensive developmental history and looked carefully for antecedents that might have appeared previously and even required some intervention. A lengthy phone interview with the parents in Berlin revealed no such occurrence. The girl had always been an excellent student—responsible, friendly, with a wide circle of friends. She was usually careful in dealing with her bodily needs and sought appropriate advice from her physician parents. The parents seemed warm, supportive, and appropriately involved.

Second, we set up a contract with Kirsten for four consecutive outpatient visits to our clinic, when she would allow us to follow her weight and vital signs, and do blood and urine chemistries as deemed appropriate to rule out drug use and improper nutrition and hydration. In assuming responsibility for her care, we relieved the pressure on the host parents and reassured both the biological parents and the exchange student agency. Our hypothesis was that the eating problem resulted from normative experimentation with new behavior that had gotten out of hand because of the special circumstances in the situation.

The patient later confirmed our hypothesis: She completed the tracking period without problems and ultimately completed the whole

student-exchange year successfully. The ingredient that had created some of the difficulty was that this European youngster was placed in an adolescent peer group that was socially 1 to 2 years ahead of her German peer group in terms of experimentation. Not being acculturated, she mistook the age-appropriate experimentation in the American peer group for license to experiment more seriously herself. Lacking the usual access to reliable parent figures and not wanting to appear "out of sync," she slipped into risk-taking that bordered on pathology; she responded quickly, however, once her host parents were apprised of the situation and appropriate limits were set for her.

Many of the fluctuations in adolescent functioning can be understood as a natural accompaniment to the acquisition of new skills: Adolescents find themselves in possession of new abilities to think about problems and formulate solutions; they relate to others in new and exciting ways; they are eager to test themselves under pressure and without manifest adult supervision and support; and they achieve physically like never before in their lives. New competencies and new opportunities need to be tested, taken to the limit, and then reintegrated into a solid image of self. This substantial task takes several years, is rarely linear in its progress, and requires patient and flexible support from others.

Kirsten's case demonstrates temporary regression (the reemergence of separation anxiety) and precipitous progression (risk-taking in terms of dietary behavior and drug use in someone who had no experience in these domains) induced by special external circumstances (separation from the family of origin, complicated by some transcultural complexities). As we reinstated age-appropriate supervision, the patient responded positively and cooperated well. Mere tracking rather than intervention was enough to bring this case to a successful outcome. To state the main point succinctly: When in doubt, wait, observe, and track the symptoms. Positive response to tracking differentiates developmental crisis from pathology in most cases and often tracking bypasses the need for unnecessary and costly treatment. Our motto should be "primum nil nocere"—first do no harm; sometimes treatment, if not needed, can be harmful.

In general, it is not a trivial task to ascertain whether presenting problems are part of normal experimentation of the age (perhaps gone awry) or are harbingers or actual manifestations of major pathology. The situation is complicated by the fact that the course of development is complex and there are many variants of normal development. Next we list some of the factors we need to keep in mind in assessing adolescent problems as a case formulation is developed.

The Nonlinear Course of Development

During adolescence, the course of development is not always linear or forward moving. Some development proceeds slowly and gradually whereas other aspects of development proceed with fits and starts in which there are lengthy plateaus punctuated by periods of rapid growth. In general, progression (orderly and regulated advancement of skills and functioning) is normative during the teen years and suggests that development is continuous over time. For example, we find that children with the best social skills continue to have them in adolescence, even when they change schools or peer groups and experience change in the nature of peer activities and the basis for friendships. However, progression is not the only form of normal development. Regression (backward movement to less complex, less mature forms of behavior, and abandonment of more advanced functioning) also occurs and can be normative, especially in stressful times, such as when struggling with other illnesses or surgeries. Normal regressions are usually temporary retreats in level of functioning, often made in response to major stress such as family dissolution or real or threatened separation from a significant other. In contrast, pathological regressions, as in schizophrenia or manic disorder, are generally long term and even permanent and involve profound dysfunction in one or more domains.

Intraindividual Variability in Functioning

The distinction between normal and abnormal in adolescent behavior is complicated by the fact that there may be different fates or patterns of development in different domains. For convenience, we classify

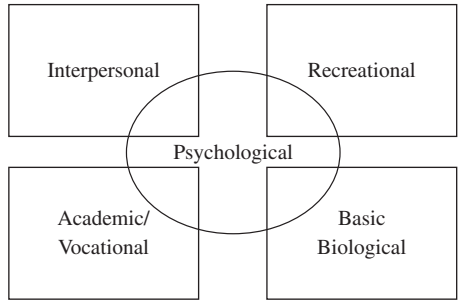

Figure 1.1 Developmental Domains of Functioning

important domains of adolescent functioning into five categories: (1) basic and body needs, which includes attention to health and hygiene; (2) interpersonal functioning, which includes ability and motivation to get along well with others including parents and same- and opposite-sex peers; (3) mental health functioning, which includes such relevant aspects as affect, mood, attachment status, self-esteem, motivation, conscience, defense and coping behaviors, and ability to observe oneself; (4) academic and vocational achievement with appropriate planning for the future; (5) recreation and leisure activity, which includes an ability to "recharge" one's batteries, relax and enjoy oneself, and utilize free, unstructured time.

Given the multiplicity of domains, it is not uncommon to find youths with different trajectories in different domains of functioning. For example, a student may make linear progress and achieve well in school and in planning for college and a professional career. At the same time, his interpersonal behavior might show regression with avoidance of intimacy and commitments and manifestation of risky sexual behavior. In the recreational domain the youth might show age-appropriate but excessive experimentation with alcohol and drugs. Finally, his relations with his parents might be turbulent at some points, but at other times there might be a reasonable accommodation between them. We are interested in how adolescents put all these domains together, how they succeed in constructing and maintaining a consistent and coherent sense of self, by observing how they function in these different domains.

Contextual Influences on Functioning

Adolescents find themselves in a variety of different social contexts including the school setting, the peer group, the family, the part-time labor force, and a variety of leisure and recreational contexts (on the sports field, in student government, at a party). Each of these settings makes different demands. Individual responses to these demands (expressed as adequacy of adolescent functioning) can be quite variable across diverse contexts.

For example, the student who works constructively in student government may spend hours crying after altercations with her parents. The altruistic high schooler who spends hours planning a fundraiser for disabled children may draw graffiti on the school walls after learning that his parents are seeking a divorce. The adolescent who threatens to kill herself because her boyfriend has broken off their relationship may continue to be a soccer star on the playing field and a high achiever in the classroom. As a result, it is important to rely on multiple observers and to examine functioning in all relevant domains in assessing whether a teenager is suffering from problems requiring treatment or is simply showing the normative perturbations of adolescence. Teachers, classmates, close friends and partners, parents, and other family members all have somewhat different views of the adolescent's functioning; these all contribute in important ways to the formation of an accurate picture of the adolescent's strengths and vulnerabilities. When marked problems and compromised functioning emerge in multiple domains, it is more likely to be due to psychopathology than when problems are limited to a few areas or occur only in times of elevated stress.

The Importance of Developmental History

Psychiatric examination in adolescence must include a careful developmental history. Specific milestones should be reached by certain ages and there should be a general picture of continuity of development across ages. Developmental phases follow each other and to a large degree build on one another. The successful resolution of prior developmental tasks makes it possible for the individual to progress and take on new challenges of greater complexity. In order to run, one has to be able to walk. In order to relate

successfully to peers one has to relate reasonably well to parents and siblings. In order to do calculus, one has to master arithmetic and algebra. In order to anticipate possible outcomes of a course of action, adolescents have to be able to face facts squarely, without withdrawing from the situation or denying elements of significance. For example, the available evidence in Kirsten's case suggested such an orderly progression had taken place, thus reducing the likelihood that her current behavior was the sign of emerging psychopathology.

Not all skills and competencies are acquired in a linear and sequential fashion. Jerome Kagan, a Harvard developmental psychologist, has challenged the universality of the model of developmental continuity, using a series of elegant and important studies. Some skills appear de novo—out of the blue—in a kind of quantum leap. But the majority follows a predictable developmental progression and children and youths show considerable continuity in functioning over time.

Since the first edition of this manuscript, Jeffrey Arnett has proposed a new developmental phase called *Emerging Adulthood* that refers to the stage between adolescence and adulthood, typically between 18 and 25 years of age. Young adults in this stage are transitioning from the role of dependent to independent adults and often feel that they have outgrown adolescence, but are not yet fully adults. This is in contrast to the former cultural expectation that one transitions from adolescence to young adulthood by the age of 22. Emerging adulthood has come to be during the last half century and is most applicable to developed countries. It is particularly applicable to individualized cultures that promote higher education, and marriage and parenthood in the late twenties. Emerging adulthood occurs most often in the middle and upper classes and lasts for a longer period of time in upper classes, but can be found in all socioeconomic classes.

Although emerging adults have reached full hormonal maturity, brain development continues throughout this phase that allows for a greater degree of emotional processing, planning, processing risks and rewards, and more complex thinking and self-reflection. Due to these cognitive developments, emerging adulthood is often the time period during which an individual decides on a worldview and becomes capable of recognizing that there are other equally valid worldviews out there. In addition to

establishing worldviews, emerging adults are forming their identity, preparing for a career, and exploring their life possibilities.

Emerging adults often experience a changing child-parent relationship as they move toward independence. There is a continuing need for parental financial and emotional support, but the nature of the support changes from that needed in adolescence. Recently, the number of emerging adults living with their parents has increased. This allows young adults to explore career options, but it can hinder an emerging adult's adjustment and autonomy and can have a negative impact on the child-parent relationship.

Psychiatric disorders are commonly developed during this time period. Fifty percent of emerging adults experience at least one psychiatric disorder, and 75% of anxiety, mood, substance use, and impulse-control disorders onset prior to age 24. By age 28, the risk of developing a disorder decreases. Emerging adults are also more at risk for unintended pregnancy and sexually transmitted infections.

Throughout all developmental stages, biological endowment has a significant impact on how one develops. An adolescent who has a talent for athletics early on, for example, will often be put on a different trajectory than an adolescent who develops this skill later in life. Sexual development also has a concrete impact on psychological development, as previously discussed. In the United States, early maturing girls and late maturing boys are usually faced with more psychological challenges. Height and weight are also good examples of how biological factors can significantly affect an adolescent's psychology. Generally in the U.S. culture, those who are overweight or of shorter stature face more challenges. In addition, we now know from research on temperament that from an early age, there are basic differences in personality traits that impact development by influencing how an individual habitually handles stress. These traits are most likely highly heritable, but can also be reinforced while growing up based on the individual's environment.

That being said, an adolescent's developmental trajectory is not predetermined by biology, genetics, or personality traits. If it were, the whole enterprise of psychotherapy would be obsolete. An individual can, to a certain degree, effortfully override his biological limitations. An adolescent can go against his personality tendencies, but it is difficult to maintain

What are the steps in setting up integrated treatment?

- What is the problem?
- What is the symptom?
- What is the syndrome?
- Who is this person?
- How did she/he arrive at this point? Where have they been?
- Why did she/he get ill now?
- Who else is in the picture?

Figure 1.2 Steps in Setting Up Integrated Treatment

those changes over time, and they consequently will not necessarily become permanent. Instead, the effortful changes are eroded by situational demands.

This has strong implications when working with adolescents, because the clinician must understand that although an adolescent can, with effort, exert changes in behavior, when he is put in situations with limited energy or attention capabilities, or when he is stressed, anxious, or depressed, he is likely to relapse and go back to the old way of functioning. A good example of this phenomenon is when working with an adolescent with a substance use disorder. The adolescent may relatively easily stop using substances, but it will be much harder to create a psychosocial context where he is likely to continue not to use substances. If peer influences and environmental stressors remain the same, the adolescent will likely relapse back to substance use, despite his efforts to change the behavior. However, this does not mean that treatment is not working, or that the adolescent is beyond reach. Relapses in behavior are to be expected, and only indicate a need to go back and do some additional psychotherapeutic work.

The Need for Multidimensional Assessment

A perspective based on "developmental psychopathology," which takes account of the developmental tasks past and present, is useful for mental health clinicians, regardless of the age group with which they are dealing.

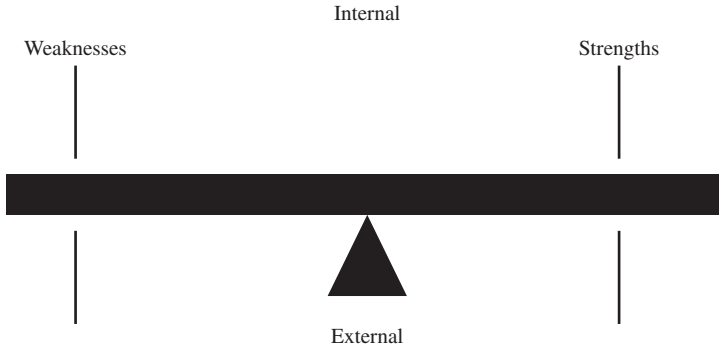

Figure 1.3 Healthy Adjustment in the Balanced Position

But knowledge of normal development is indispensable for those who treat persons "under construction," as they become afflicted by a variety of psychiatric disorders.

To simplify thinking about a case, it is helpful to imagine a balance beam (see Figure 1.3) that represents healthy adjustment in the balanced position. After examining all the relevant domains in the patient's functioning, the clinician can construct a list of strengths and weaknesses and place these in their respective positions on the balance beam. Strengths might include the patient's intelligence, academic tenacity, ability to form rewarding relationships, and coping skills for dealing with adversity in a flexible manner. Weaknesses might include tendencies to withdraw from confrontation, inability to speak in one's own defense, and a tendency to isolate oneself from others when distressed. Then below the beam the clinician lists external stressors (such as recent losses and major transitions) and external supports (such as the adequacy of primary family relationships and degree of economic security). As treatment progresses, the balance of the beam is often upset — an expectable and predictable event. Periodically, during the course of treatment, the position of the beam balance should be

rethought. Sometimes, especially in times of crisis, it is useful to ask the patient and his or her parents to construct the factors that impinge on the balance of the beam.

In summary, as part of the assessment, an extensive case formulation must be developed. This represents a first attempt to summarize and synthesize information, including diagnosis, developmental history, functioning in diverse domains, and manifest strengths and weaknesses. Hypotheses suggest causal connections that draw attention in a logical order to particular targets for treatment.

Developmental Psychiatry Steps in Assessment

The primary steps in conducting a developmental psychiatric assessment are below. Please refer to the *Handbook of Developmental Psychiatry* (Steiner, 2011) for a more in-depth discussion on the assessment process.

- Chief complaint, history of present problem
- Past health history (including family)
- Descriptive diagnosis (diagnosis comorbidity)
- Expansion of functioning in all domains to assess strengths and weaknesses in systems of self-regulation
- Temporal ordering of emergence of problems, aligning them with developmental phase
- Formulation of interactions of intra-individual interpersonal and systemic factors—assign a process of causation

THE COURSE OF TREATMENT

We now have a broad array of evidence-based treatments for adolescent psychiatric disorders. With so many options and no single treatment that will work for every adolescent, careful treatment selection that is tailored to the individual case becomes extremely important. Clinicians must diversify their intervention portfolios, either individually or by putting a team of experts together, in order to offer optimal care for adolescents. This portfolio must target a patient's biology (medications, fitness goals, dietary changes, etc.) and psychology (psychodynamic therapy, family therapy,

cognitive behavioral therapy, etc.), as well as include psychosocial context interventions (peer groups, residential treatment settings, elevated levels of care, etc.). It is important to always think about biology, psychology, and environmental factors as possible targets for treatment.

The Choice of Treatment

A wide range of data substantiates the efficacy of many forms of mental health treatment. Recently, neuroimaging studies have demonstrated the efficacy of psychodynamic psychotherapy by demonstrating the normalization of brain metabolic or synaptic activity after treatment for a variety of psychiatric disorders. These neurological changes occurred alongside improved clinical outcomes. Today we have moved beyond the question of "Does therapy work?" and focus instead on "How do treatments work?" and on identifying which treatment works best for different problems. Recent summaries can be found in the 2004 publication, *Handbook of Mental Health Interventions in Children and Adolescents: An Integrated Developmental Approach*, and the 2011 publication, *Handbook of Developmental Psychiatry*.

As we mentioned in the introduction, treatment needs to be embedded in a strong working relationship with both the patient and family, which requires considerable skill on the part of the clinician. Because loyalties and confidentialities differ, this usually becomes apparent when the clinician clarifies the flow of information in the treatment of adolescents: with some important exceptions (harm to others, harm to self, inability to care for self), the content of the patient's therapy is protected. The communications by parents are not, and the clinician may use them to structure sessions, explore avoided material, and gauge level of deception.

Clinicians require a rich armamentarium of interventions if they are to deal with a wide range of pathology. Specific ingredients are at work in different therapies, and different kinds of treatments are effective for specific disorders (please consult each of the chapters for a diagnosis and domain-specific array, either supported by evidence, practice guidelines, and/or clinical practice). To know which therapy is likely to be effective, clinicians must collect information about a patient's biology,

psychology, and social environment. Biological factors can be assessed using laboratory tests, which are mentioned specific to disorders throughout this book. Taking a complete family history usually provides an idea of what biological factors may be at play in the patient. Laboratory tests designed to help set up treatment are emerging. Many of these can be left to the management of the primary care physician in close collaboration with the treatment team (e.g., cardiac health in preparation for treatment of ADHD; growth and development and body mass index; pubertal status and progress).

Not all available interventions will be necessary in every case. For example, it is well established that cognitive behavioral therapy and drug treatment are equally effective in treating bulimia nervosa, and that there is little to be gained from combining the two. The decision about which to use in a particular case therefore will come down to the individual patient. An adolescent who is psychologically minded may benefit more from cognitive behavioral therapy, while an adolescent who has no interest in therapy may be better suited to medication.

Whatever the choice of intervention, the clinician must be very clear about what the intervention specifically targets, as this target will be the outcome measure for the success of treatment. Treatment targets can be grouped into five main domains of functioning—interpersonal, recreational, psychological, academic/vocational, and biological. The General Health Questionnaire (GHQ) is a readily available and easy-to-administer brief questionnaire that can be used to quickly assess functioning in each of these domains. In addition to assessing the patient for impairments in functioning, it is equally important to determine which areas of functioning are preserved. In most cases, the patient will have areas of strengths and weaknesses, rather than deficits in functioning across all domains.

It is important to establish who will deliver the chosen interventions and who will be responsible for managing the case and integrating all aspects of treatment. This may be the primary care physician, psychiatrist, or the family therapist, depending on the primary issue to take center stage.

The final stage of developmental assessment is formulating the case. At this point, all of the gathered information is put together into a cohesive picture that drives future treatment decisions. The clinician must identify

the variables in an adolescent's life that promote healthy development, and should take both the patient's protective and risk factors into consideration. Writing up a case formulation aids the clinician in organizing the data and helps to determine which treatment interventions are best suited to the patient. The case formulation should be culturally sensitive, as cultural factors can influence the adolescent's psychology, interpersonal relationships, and communication patterns. Cultural sensitivity also helps to build a therapeutic alliance between the clinician and patient.

Once treatment is initiated, it is crucial to assess and reassess treatment efficacy and progress at regular intervals. How and when this is done will vary according to the case. There are many scales and measures used for specific disorders that are discussed in the following chapters. In some cases, practice parameters are helpful guides in choosing which scales to use at what intervals, but for other disorders the standard of care is less clear. In addition to classical psychological testing, computer-based, neuroscience validated assessments are beginning to be used to compliment traditional assessments in small private practices. The treatment of learning disorders is a field that is embracing these newer assessments. We discuss specific assessment scales and tools in more detail in each chapter.

Once the adolescent's acute symptoms have been assessed and a treatment plan is in place, the clinician will also need to evaluate the patient's overall personality traits and patterns. This is the difference between state assessments (how the patient is functioning in the current acute time period) and trait assessments (how the patient behaves habitually). This helps the clinician assess how well the adolescent routinely manages stress and generally functions in life. Understanding overarching personality traits can help a clinician gauge how to best approach therapeutic work with an adolescent.

There is a multitude of different ways to assess trait personality characteristics. The method that we prefer is the Weinberger Adjustment Inventory (WAI-84), an 84-item self-report questionnaire. The main measures in the WAI-84 are Distress (comprised of anxiety, anger, and depression scores), Positive Emotions (happiness and self-esteem scores), Restraint (impulse control, consideration of others, and responsibility scores), Denial of Distress, and Repressive Defensiveness. Restraint is a

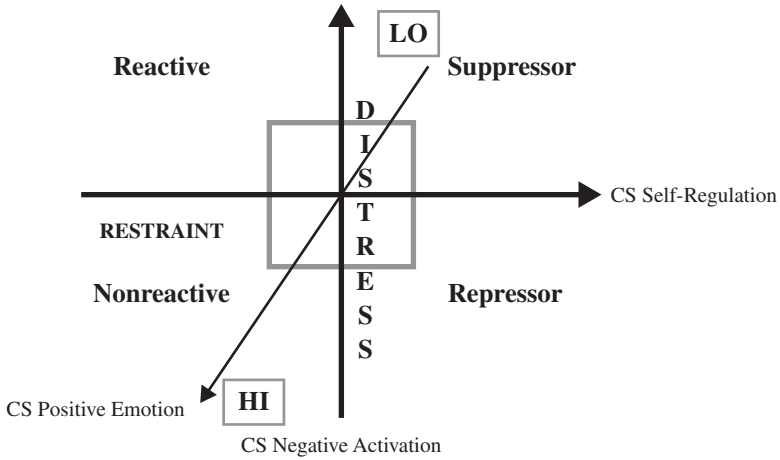

Figure 1.4 Adaptive Style by Distress and Restraint

measure of conscious self-regulation. Denial of Distress measures the adolescent's tendency to unconsciously minimize negative emotions, and Repressive Defensiveness refers to the unconscious repression of distress that completely eliminates negative feelings from consciousness.

The WAI uses Distress and Restraint scores to assign the respondent to one of four personality typologies (see Figure 1.4). The intersection of the *x*-axis (Restraint) and the *y*-axis (Distress) represents the age-matched norms of these scores—for the adolescent age range, the norm for Restraint is 3.7 and the norm for Distress is 2.6. If the adolescent scores higher than average in Distress and lower than average in Restraint, he is classified as a Reactive individual. This personality type tends to easily access negative emotions, but has a difficult time regulating behavioral and emotional reactions. They need structure and predictability, encouragement to down-regulate excessive emotions. This may not be enough and medications may be helpful.

High Distress and high Restraint corresponds to the Suppressor personality. A Suppressor individual also has easy access to emotions, but has control over how and when he expresses them. These individuals tend to be the ideal candidates for expressive, explorative, and depth psychological approaches. They need little encouragement to explore their

lives, they show strong emotional reactions, but simultaneously have a good capacity to reign in their emotions and get back on an even keel.

The Repressor personality is defined by low Distress and high Restraint. This individual employs such a high degree of self-regulation that he tends to bury his feelings away, making it difficult to access distressing emotions. These patients need a great deal of psychoeducation up front to help them recognize the full range of their emotions. A paradigm of "stress and strain" or CBT usually suits them better than a truly dynamically based approach.

Finally, the Nonreactive individual has low Distress and low Restraint. The Nonreactive reports a generally low level of affect. He does not easily access emotions or self-regulate behavioral reactions. Once activated, they may be difficult to contain and one has to make sure that appropriate social structures are present to buffer them. Their low affectivity may also spill into lack of motivation or even disdain for treatment, making them hard to engage and retain in treatment. For both the Repressor and the Nonreactive, medications may be a better choice than psychotherapy. Both Reactive and Nonreactive may have problems with impulsivity that may manifest in drug and alcohol abuse, which requires monitoring, especially if medications are part of the treatment plan.

The diagonal line in the graph represents positive emotions and self-esteem, which act as a reservoir that can offset negative emotions and symptoms. In severe cases, this positive reservoir disappears.

What Does the Typology Tell Us About a Patient's Outcome?

We reported on a 20-year follow-up of 34 patients who I (Hans Steiner) treated using the developmental psychiatry approach. The group consisted of 18 women and 16 men in the upper middle class, with a mean follow up age of 30 (standard deviation 6 years; age range on follow-up = 23–42 years). The mean age of disorder onset was mid-adolescence, and diagnoses included major depressive disorder, eating disorders, generalized anxiety disorder, oppositional defiant disorder, attention deficit disorder, and substance use disorder. Integrated treatment packages were utilized with all patients, such as sociotherapeutic treatment, family therapy, individual psychotherapy, and

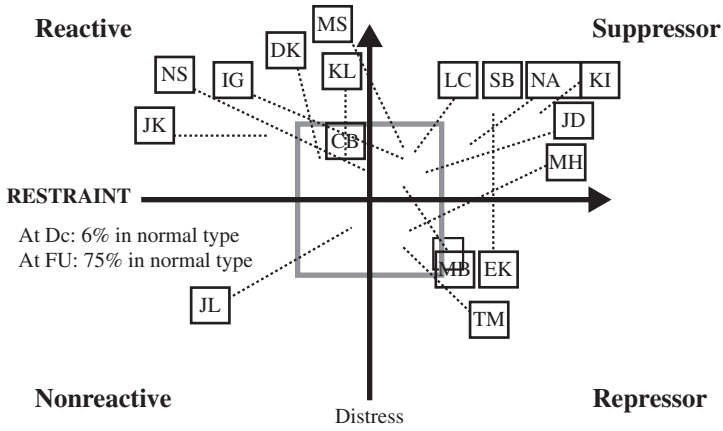

Figure 1.5 Adaptive Style by Distress and Restraint, Follow-Up Study

medication management. All patients completed the Weinberger Adjustment Inventory both at diagnosis and on follow-up.

The graph above depicts the 14-year prospective follow-up of a representative subcohort of patients from this study. It uses the four WAI-84 personality typologies discussed earlier (Reactive, Suppressor, Repressor, Nonreactive) to demonstrate how patients' personality tendencies changed over time. As a function of treatment, the patients' Distress and Restraint scores moved in toward the mean over time, regardless of personality type. The patients' original Distress and Restraint scores are given by the boxes, and their scores at follow up are given by the end of each dotted line. Before treatment, 6% had Distress and Restraint scores within the normal range, versus 75% at follow-up. This illustrates how patients' personality tendencies can become less extreme as a result of treatment. This study is discussed in detail in Chapter 3 of the *Handbook of Developmental Psychiatry* and in Chapter 36, "Integrating Treatment: The Developmental Perspective," of *Handbook of Mental Health Interventions in Children and Adolescents: An Integrated Developmental Approach.*

Duration of Disturbance

Short-term problems are likely to be "state" disturbances and require targeted approaches that deal with the presenting symptoms. Treatment is generally short term and contains many supportive ingredients. A classic

example would be uncomplicated catharsis after trauma—such as the loss of a loved one, reaction to a car accident, or trauma induced by medical procedures. Long-term problems, such as anorexia nervosa, suggest a "trait" disturbance, which is more complicated to treat and which often entails a complex and changing therapist-patient relationship. Appropriate therapies contain exploratory elements designed to promote self-reflection, observation, and insight. Treatment is usually multifocal and involves building on existing psychological strengths as well as use of interventions such as social skills training intended to build "psychological muscle."

Patient's Psychological Mindedness

Patients differ in terms of their processing of psychological information. With psychologically minded patients who think in more abstract terms and are comfortable with mental categories, exploratory, insight-oriented approaches are likely to be effective. The detail-oriented behavior approach is likely to bore these patients. In contrast, patients who tend to be more detail-focused and concrete, and have trouble with concepts such as "conflict," "emotion," and "insight" respond better to the use of a "bottom up" approach, where they track symptoms and precipitants of stress, and make connections between events only after psychoeducation by the clinician.

Extent of Impairment

When symptoms affect many areas of basic functioning, such as sleep, appetite, mood, and behavior, medication may be indicated. For an isolated symptom such as a specific phobia of snakes, a targeted behavioral approach utilizing desensitization or exposure treatment is often helpful. For problems of a very complex nature, such as underachievement or trouble selecting an appropriate mate, a depth psychological, psychodynamic psychotherapeutic approach may be the most helpful. Because this type of intervention sometimes does not get taught or receives relatively short shrift in today's training, we sketch its predominant characteristics below in table 1.1. For those interested in becoming proficient in the technique, we refer them to our 2004 *Handbook of Mental Health Interventions in Children and Adolescents: An Integrated Developmental Approach*, which provides an entire

Table 1.1 Characteristics of Psychodynamic Psychotherapy

1. We focus on affective expression and understanding of events from an affective/emotional perspective.
2. Attempts to avoid or repress distressing thoughts and feelings are explored and treated.
3. Patient and doctor work together to identify recurrent themes and patterns in people's lives.
4. We focus on personal growth and development and understanding of past experience as it determines current behavior and thinking.
5. We concentrate on interpersonal relationships.
6. The therapeutic relationship itself serves as a vehicle to understand real-life relationships.
7. By exploring their fantasy life, patients gain access to their innate creativity.

chapter on psychodynamic therapy in adolescents by Michael Loughran. What we have found is that the essence of this modern approach to dynamic treatment is rapidly learned and applied, and it most definitely is not necessary to enter psychoanalytic training and/or personal analysis, as is often claimed by analytic institutes. Many of our trainees have chosen the path of analytic training after completion of their clinical training, but many of them never complete it, realizing that such a comprehensive and expensive approach is simply not needed.

As Shedler has so efficiently outlined in his 2010 paper, the psychodynamic therapy approach draws on a wide variety of experiences (such as fantasies, dreams, present and past behavior, and transference-countertransference observations) to detect maladaptive patterns in behavior. Shedler shows that recent broad-based and convincing evidence has demonstrated that psychodynamic psychotherapy is the most potent of all psychiatric interventions, having triple the efficacy of medication treatment and double the efficacy of behavioral treatment. Most encouragingly, the effects of this treatment do not seem to become weaker after treatment has stopped, as happens with behavioral treatment. Weakening of treatment effect also happens with almost all medication treatment, as drugs lose their initial power. In psychodynamic therapy, benefits seem to accrue far beyond active treatment. The goal of psychodynamic therapy is not just symptom reduction and elimination, but restoration of health and personal growth.

We have found this to be the most efficient way to forge a strong working alliance in the context of which we then apply medications, psychoeducation, CBT with homework and effortful emotion control exercises, exposure with response prevention, parent education, and family therapy.

The Clinician's Preferences

No single clinician is equally good at all types of treatments, and no single treatment is suitable for all kinds of problems. A therapy inappropriate to the problem can be outright dangerous. For example, exploratory therapy with severe delinquents is likely to be useless at best, dangerous to you at worst. Most clinicians build their practices around problems they are good at dealing with and feel comfortable treating. Practitioners of the future will reflect this trend even more.

The Treatment Setting

Treatment can be carried out in a variety of settings, depending on the safety requirements of the situation, the intensity or extensiveness of treatment needed, and the complexity of the problems to be addressed. Hospitalization is the most intensive, safe, but costly alternative. Partial hospitalization, day treatment, therapeutic schools, and outpatient care are all important alternatives. And as previously described, consultation and tracking can be an efficient way to deal with some problems.

The Treatment Contract

A treatment contract is planned after the clinician has reached a diagnosis and formulated a treatment plan. The treatment contract is negotiated in one or two sessions and has several different components. It includes communicating the preliminary diagnostic findings and treatment alternatives first to the adolescent, then to the family; giving the family time to decide jointly the treatment plan they wish to pursue; and then meeting with the family as a whole to establish the course of treatment, and sometimes even signing a real contract as to the number of sessions and the nature of the intervention.

In a naturalistic prospective study, we found that the mean doses of treatment interventions were 28 days of sociotherapeutic treatment (inpatient, day treatment, or residential), 20 family therapy sessions, 40 months of medications, and 110 individual psychotherapy sessions. Clearly this will vary by age, diagnosis, and complicating illness and such factors, but it gives the clinician at least some guidelines as to what to expect. Specific recommendations for each diagnosis will be made when possible in each of the following chapters.

Discussions with the Patient

After a brief meeting with the patient and all parents, during which we ascertain that the patient knows why they are here, who they are meeting, and there is at least some consensus regarding the presenting problem, we usually ask the parents to step out and continue with the patient alone. When meeting with the adolescent alone, we review the contents of the case formulation. The information is tailored to the particular characteristics of the patient, taking into account defense structure coping skills as well as sensitivities and particular areas of conflict. In general, it is helpful to begin with domains of strength and the least defended topics. For example, this may include asking the adolescents to describe relationships about which they feel unconflicted or areas of success (for example, academic achievement in a patient with anorexia nervosa).

It is necessary to approach more sensitive topics with "trial balloons." In patients with anorexia nervosa (who tend to defend tenaciously against aggression), the clinician might raise obliquely issues of assertiveness and anger by noting that the patient had said little about angry situations and wondering aloud what she would do with such an emotion when it arises. If the patient reacts with curiosity, the topic can be further pursued; but in the face of a blank stare or a noncommittal smile, the clinician might move on to the next area. In communicating the findings to the patient, it is helpful to give examples, preferably verbatim ones from interviews, describing specific problems and discussing possible explanations.

The clinician then suggests a plan of treatment, estimates duration of treatment, and notes alternatives and options. It is important that the

patient follows the discussion and feels free to ask questions. The usual treatment package consists of weekly individual sessions complemented by family sessions every other week or so. Medication and conditions for hospitalization, where appropriate, are also discussed. The therapist describes the anticipated length of treatment together with the caveat that such estimates are preliminary and subject to revision based on periodic reviews of progress.

While staying firm about the need for intervention, the clinician will find it helpful to describe to the adolescents their options and choices regarding therapists, location of treatment, and split family assignment (whether the adolescents prefer that their parents be seen by a therapist other than their own). Because good patient-clinician matches lead to good outcomes and not every match works equally well, it is always important to take account of the patients' preferences. These may be influenced by clinicians' gender, personality or interpersonal style, or age. It is appropriate to offer your services but also to recommend other therapists, if required.

Discussions with the Family

Once patient and clinician have reached a reasonably clear understanding, parents are invited into the therapist's office and the discussion is repeated. After answering questions raised by the parents, the clinician asks the family to return in a week for the beginning of treatment or the finalization of referrals. He emphasizes that decisions about the treatment should be made jointly by the patients and their families in the privacy of their homes, taking into account their own psychological needs as well as such practical issues as money, time, and travel. Families should be encouraged to find the solution that will allow them to work in therapy for as long as necessary.

The Need for Family Involvement in Adolescent Treatment

It is usually necessary to involve the family in treatment unless the adolescent is emancipated or the problems are very circumscribed. There are at least three reasons parents should be involved. First, the adolescent frequently

perceives them to be part of the problem. Even internalized problems (which can be treated on an individual basis) are often externalized to other family members and therefore require the parents to be involved in the therapy. Picking fights with one's parents is usually very effective for adolescents seeking to avoid awareness of their own intrapsychic conflicts. It is easier for teenagers to say: "My stupid parents won't let me go to this party (where there will be drugs and sex)" than to acknowledge "I don't want to go because I am afraid of how I am going to handle myself there." "My parents are lame" is easier to accept than the attribution "I am lame."

Second, adolescents' attachment to their families is usually strong, despite all their protestations to the contrary and their counterphobic avoidance of family members. Particularly in crisis situations, all but the most severely disturbed teenagers show considerable tendency to turn to their parents for comfort and support.

Third, because the family is the context in which recovery occurs, clinicians can help parents understand the nature of therapeutic progression and regression. For example, the clinician sees progress when an anorexic patient dares to go to a party, whereas an anxious overprotective mother sees this as acting out or a threat. Progress in psychotherapy is maintained only when supported by significant others such as parents, and thus parents need to become the allies of clinicians. The psychotherapy outcome literature is very clear on this point.

One of the great challenges in working with this age group is to forge and maintain good working alliances with both patients and parents without appearing to be ineffective, taking sides, or being "two-faced." This can be accomplished in a number of different ways. Some families are receptive to dealing with adolescent problems within a systems framework in which the child's disturbance is understood in terms of its function within the family. The basic idea is that symptoms serve to reestablish the homeostasis of family relationships when irritants and changes have been introduced. Other families are resistant to the systems perspective, and, in such cases, individual treatment augmented by some family sessions is useful. Both approaches have merit and neither is preferable in terms of results; the choice depends on the clinician's training and preference and the family's style of problem solving and level of functioning.

The need for family involvement in treatment often extends to emerging adults as well as adolescents. Regardless of whether a patient in this age range is legally independent, emerging adults can still be emotionally and financially dependent on their parents. This can necessitate their involvement, particularly if the parents are financially responsible for the patient's treatment.

Resistance to Proposed Treatment

If there is resistance in the family to recommendations for treatment, it is necessary to determine which aspects of the treatment contract seem to be creating difficulties. For example, it may be finances, time involved, perceived stigma, or time diverted from schoolwork. The clinician can highlight the importance of the intervention in preventing the problem from becoming chronic. If such an argument still fails to convince the family, it may be necessary to give them a referral for a second opinion. At times an acceptable alternative is a contract for fewer sessions (most often 10) followed by a review of progress.

A knotty problem presents itself if the adolescent is clearly in need of intervention but the parents express vehement opposition. In such cases, more sinister forms of pathology such as severe marital problems, abuse, or family secrets may be suspected. Clinicians then need to redefine their role from being potential providers (those who will be part of the treatment team) to change agents (those who, without treating the problem, effect some change in the family). In such a situation, it is necessary to keep the adolescent's safety and health foremost in mind, even at the risk of total alienation of parents and family. Sometimes a brief period of hospitalization for the patient permits more intensive assessment and gives the clinician a chance to get to know the parents and form a better alliance with them. If the youngster is a clear danger to self or others, it will be necessary to proceed with involuntary commitment; in less clear-cut cases, contacting child protective services and reporting the situation as medical neglect is an alternative.

None of these situations is a particularly good solution to the problem, and such dispositions usually lead to termination of contract without good long-term prognosis. That is why formal contracting, after appropriate

assessment, is still the best possible solution and should be regarded as the preferred standard.

PRACTICE IN OUR CLINICS

For an in-depth discussion on our clinical practice, please refer to the *Handbook of Developmental Psychiatry* (Steiner, 2011). Below is a brief overview of how we approach assessment and treatment in our clinic.

We view taxonomies, like the *DSM* and the World Health Organization's International Statistical Classification of Disease and Related Health Problems (ICD), as important but insufficient methods of describing mental health disorders. A developmental model maintains that a clinician must take all factors into account, including biological, psychological, and social factors, in order to sufficiently understand the complexities of a case and to best develop a treatment plan. This treatment plan should be based on evidence-based medicine, practice-based evidence, and practice parameters and guidelines.

It is important to gather information from multiple sources, including the patient, parent(s), school personnel, primary care physicians, and any additional care providers. Adolescents are developmentally capable of self-reporting their symptoms, but may be hesitant to report symptoms that they believe will be viewed negatively. Subjective mental states are fundamental to psychiatric diagnoses. Patients may deliberately deceive the clinician, they may be genuinely mistaken about their emotions and symptoms, their report might be defensively distorted, or they may be unaware of certain mental processes. Likewise, parents are often biased reporters of their child's symptoms and behavior. Consequently, we must obtain a subjective report from the patient that is supplemented with additional informants.

Initially we usually meet with both the patients and parents, followed by the patient alone. We inquire about the chief complaints in the patient's own words. This discussion is supplemented with standardized screening instruments. Next, we expand our discussion to include the history of the symptoms, including their onset, development, and any associated environmental stressors that may be contributing factors. We assess functioning in all five of the major life domains (biological, psychological,

recreational, academic/vocational, and interpersonal) and how much symptoms are interfering with each domain.

We then obtain a family history and medical history of the patient, before conducting a mental status exam. We require that the patient have a physical exam on file with their primary care physician within the past 6 months. We gather basic information such as height, body mass index, resting heart rate, and blood pressure and refer the patient to pediatric physicians for more in-depth exams as appropriate. We complete detailed psychological assessments when evaluating for neuropsychiatric syndromes, and also recommend these assessments when evaluating for aggression, social behavior, and attention. For all other disorders, these assessments are tailored to the individual case.

Patients' social environments also play an important role in their development, the causation and maintenance of symptoms, and treatments and should be adequately assessed. This includes their microsystem (family, school, etc.), their mesosystem (two interacting microsystems), their exosystem (indirect influences, like their mother's workplace), and the macrosystem (their community, culture, etc.).

A thorough developmental timeline is created, in which we evaluate the patient's maturational history, its temporal sequences, and any important events that occurred. This portion of the assessment includes how well the patient has mastered developmental tasks throughout her life, and any remaining issues. The patient's self-regulation is assessed, such as coping mechanisms, defense reactions, and self-image. We evaluate what developmental phase the patient is currently in, including developmental tasks currently at hand. Using the *DSM* or ICD diagnostic system, we then create an initial tally of disorders.

When consolidating all of this information into a case formulation, we list the patient's risk and protective factors for disorder. We also look for any residual symptoms and dysfunctions of previous disorders, and note any discrepancies or deficiencies. Finally, we assess for any positive impact that the patient's present disorder has had on his life. We aim to integrate all of the information into an overall clinical picture that provides an overview of how the disorder developed and how it is affecting the patient in all aspects of his life. The developmental case formulation will ultimately

guide treatment and maintains a lifetime perspective of disorder. Rather than aiming to immediately remedy all issues, the developmental clinician understands that some problems may resolve on their own as the patient matures, while keeping in mind that preventative interventions and/or treatment may be required.

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