Assessment

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The diagnostic assessment of emotionally disturbed children in late latency-early adolescence (9 to 15 years old) requires that the clinician acquire special techniques and background knowledge. The reader is referred to Chambers (1985), Goodman and Sours (1967), Herjanic and Campbell (1970), Puig-Antic and Chambers (1983), Rutter and Graham (1968), and Werkman (1965). In assessment of children in this age period, the focus is on areas different from those commonly dealt with when assessing the mental health of younger children or adults. Early-adolescent development is not marked by the expected homogeneity of development of the latency-age child, or the stability of adulthood. Early adolescents move toward maturity through a multitude of disparate paths. Any one of these could lead to a healthy adult adjustment or to chaos. At times, even an unruffled early adolescence can signify a rigorous defense against progress in drive expression, which pleases parents while leaving the child unprepared to deal with peer sexual partners in late adolescence and adulthood. Subtle indicators, such as persistent omnipotence, and a history of accidents of fate, such as the setting of initial sexual experiences, may be of greater importance in determining the developmental outcome of a child than do superficially chaotic patterns of adjustment, which may be short lived though overwhelming at the time of a clinical interview. Therefore, relevant therapies are often better aimed at the following functions than to the immediate correction of current behavior.

1. Strengthening reality testing
2. Strengthening self-reflective awareness
3. Expression of aggression that has been turned inward (depression) as a characterological response to anger
4. Understanding the future implications of present behavior
5. Disentanglement from the seductiveness of the symbol- and fantasy-dominated omnipotent adjustment of latency (the structure of latency)
6. Improving tolerance to passivity

7. Diminishing narcissistic vulnerability and omnipotent responses

Late latency-early adolescence is characterized by cognitive and psychological features which would be confusing at best and represent marked pathology at worst if found in a later adolescent or adult. Among the factors that sometimes create difficulty in the assessment of the adolescent are the protean nature of the ego structure in late latency-early adolescence; disrespect for the investigative aspect of the therapeutic process (this disrespect results in voluntary mutism, withholding of data, lying, tricks with words, and drug use during sessions); variations in the timing of onset of puberty and the onset of cognitive steps, so that one is required at times to judge a 17-year-old by the standards of development appropriate for a child of 13.

Assessing Adjustment to Sexuality during Early Adolescence

With so much to create anxiety in the child, it is no wonder that early adolescence is a period of great emotional stress. Many new experiences and events, which are totally real and will become a vital part of adult functioning, pour in on the adolescent. Sexual drive development is one of the strongest contributors to early adolescent stress.

Gradually, through trial and error, acclimatization, advice from others, and help from more experienced partners, the adolescent finds his way to an adult and mature attitude toward his drives and the demands they make. During the period between the onset of intense demands on the child and their resolution, the child uses the defenses of adolescence to keep his drives under control and provide himself with some comfort. Adolescence does not have such a well-defined and well-organized ego structure as has latency. Rather, the defenses selected are characteristic of the individual, and are highly variable. All have the capacity to provide momentary relief during periods of stress. All can offer a point of fixation from which persistent later behavior with pathological coloring can be derived. In themselves they are not pathological. Their persistence, not their presence, is the pathological indicator in assessing the child in late latency-early adolescence.

The many patterns of defense and adaptation to the burgeoning demands of the sexual drive can be resolved into seven groups. Five will be discussed presently. Drug addiction is described elsewhere in the chapter; transient adolescent homosexuality was discussed in Chapter 7.

The Ascetic

The ascetic adolescent (A. Freud 1958) responds to growing drives by eschewing them. Although he remains well in contact with his peers, he does not participate in the expressions of excitement, sexuality, and aggression that they do. He may attend parties, but will be found talking to the boys rather than pursuing the girls. Sports, abstruse knowledge, or schoolwork makes up the content of his conversations with them. If kissing games are played, the ascetic boy or girl may be distinguished from the others by such comments to the partner as "let's not and say we did." Drinking, smoking, gambling, and masturbation are excluded, too. Very early in adolescence, asceticism is a common technique for holding off the drives until the child is ready to deal with them. It diminishes in degree and in number of adherents as the older age groups are reached.

It is not rare for an individual to remain ascetic for a lifetime. Asceticism is rarely considered by the general population to be a form of psychopathology. Superficial relationships with people appear good, and there is a heightened capacity for creative and constructive, socially acceptable behavior. The individuals are well-controlled, well- organized, and contributing members of society. Ascetics as adults can find many social institutions that encourage and reward asceticism. There is a niche of respectability for the person who does not resolve the sexual and drive discharge problems of adolescence if that person chooses asceticism as the lifetime resolution of the problem. The old- maid school teacher, the maiden aunt, membership in abstinent religious organizations (e.g., Shakers) are examples of social institutions of bygone days that made it possible for an ascetic to fit into the adult world.

There is a good deal of resemblance between latency and ascetic adolescence. The capacity for work, peer relationships, strong superego, and the capacity for creativity are found in both. The tendency to resolve upsurges of drive with escape into fantasy is also present.

Fantasy formation becomes involved in sublimation to a greater extent and becomes more adaptive in the ascetic adolescent and adult. Thus, writing of poems, painting, and aesthetics become a part of the creativity of the individual.

In those who join ascetic groups, there may be participation in group activities in denial of body needs; abstinence with kinship to sado-masochistic torture situations (hairshirts and self-flagellation)

has been described. During the Middle Ages, the denial of the body and its needs by members of such a group became so extreme that a portion of a book *(Malleus Maleficarum* [Kramer and Sprenger 1489]) was devoted to a proof that the deity did not defecate.

It is possible to consider ascetic adolescence a continuation of latency, but it would be better to recognize that the defenses of latency are being used in a potentially pathological manner to deal with the problems of early adolescence. Whereas the latency-age child is doing what is expected of him, the ascetic adolescent is set apart from the others by failure to come to terms with and utilize the full potential of his body and mind.

Withdrawal

In the entire animal kingdom, one of the techniques most frequently used to deal with the new, the unknown and strange, the frightening, and the anxiety provoking is to run and hide. The ostrich supposedly hides its head in the sand; the opossum plays dead; the rat avoids new things. To paraphrase the old adage, "He who runs, lives." *Withdrawal* as a defensive technique in adolescence refers to the complete disengagement of the individual from any person, thing, thought, or situation that would result in the stirring up of inner drives. The withdrawing youngster avoids parties and such. Thus the internalized aspects of the superego need not be overly strong, since the person never puts himself into situations in which control would be necessary. There are few friends, no dating. Fantasy must be minimized or devoted to vastly displaced and innocuous-appearing thoughts having to do with dependency. These people are loners, uncertain of themselves, who rarely create, although they are always planning something.

A comparison with the ascetic might be of value in helping us to delineate the withdrawn adolescent. The ascetic makes contact with the world. He engages others in discussions to prove that his approach is right. He recognizes the drives. He feels holier than his peers, for he controls his feelings. He refrains from the exciting actions of others on conscious principle. The withdrawn child avoids contact with the drives. He does not recognize them. Since he avoids all stimulating situations, his failure to be aware of the drives is a reflection of the reality he has created for himself. The Judeo-Christian ethic has high praise for asceticism, which is historically a response to the temple prostitution of Biblical times.

There is no such praise for withdrawal. The withdrawn person who continues this technique beyond adolescence into adulthood finds himself alone and unsought.

The social world of adolescence serves as a test area in which drives can be dealt with and techniques of social intercourse learned. Failure to come to terms with biological reality, the drives, and this social world produces a misanthropic adult who is unsure of himself and unable to participate effectively in the sexual comforts and activities of adult life. Such an individual is described as *schizoid.* Withdrawal in adolescence is not pathological per se, since there is always the chance that situations, friends, and maturational factors will tip the balance in favor of another resolution. However, withdrawn adolescents are the ones most in need of help and least likely to be able to resolve the problem without outside guidance. Whereas the ascetic is trying to figure things out and is involved negatively, the withdrawn child is not involved at all. He is not even slightly engaged in an attempt to resolve his problems. The tragedy in these cases is that they are considered by parents to be "good children." They do not stay out late. They do not get into trouble. They get average marks. Therefore, no one leads them to help. The instinctual drives are strong in adolescence. The withdrawn child deals with them by withdrawal from stimuli and through masked masturbation. A calm world for the child and an apparent low level of sexual pressure should be taken by a clinical assessor as a danger signal that one should evaluate the child for excessive narcissism and immaturity. Withdrawn and ascetic adolescents have in common a disassociation from participation in the sexual and aggressive, exciting activities of adolescence, and so we have placed them together in spite of certain differences.

Affect Avoidance

Affect avoidance describes the act of participation in sexual activities without emotional involvement. Most individuals enter the adolescent period with an inability to sustain the excitements attendant upon the expression of their drives. We have already discussed those who dissociate themselves from social manifestations of drives (the ascetic and the withdrawn). We now turn to those who participate, but derive no enjoyment or gratification because, though the flesh is willing, the psyche is incapable. Inhibitions and defenses block pleasure, or shift the cathectic energies into symptoms, such as phobias or hysterical amnesia. It is not unusual to hear such a person say "I can kiss, but I just don't feel excited." They are not more capable of mature drive gratification than the ascetic. Social pressures

command that there be sexual activity. They participate to please others, to be able to say they have done "it."

Since these youngsters are participating, they have repeated opportunities to develop social graces and to attempt to resolve their inhibitions. Those who fail develop into adult neurotics. Unlike the adult withdrawn individual or the adult ascetic, they are superficially indistinguishable from normally oriented adults. Studies of symptoms and behavior patterns reveal them rather easily. They are in conflict as adolescents. They know that something is wrong. These children often seek psychiatric help. Unlike the withdrawn and ascetic individuals, whose behavior is syntonic, these people are dissatisfied with themselves.

It should be kept in mind that there is great variability between individuals. In extreme cases, neuroses begin with adolescence and—although it cannot be predicted from the start—continue into adult life. There is no capacity to involve a real object in unconscious fantasy that is defended against with the neurotic symptom. The fantasy is bound by the symptom. Intercourse will be possible, but internal inhibitions will make it less satisfactory than it could have been, and symptoms will take up the energies that should have been involved in the enhancement of the sexual act. Individuals who are unfamiliar with this fact criticize the psychoanalytic explanation of the contribution of sexuality to the formation of neuroses on the basis of the fact that the individual can participate in sexual intercourse. In less severe cases, the individual participates and finds gratifications, and so can relinquish the need to sustain the neurotic symptom. Conversely, there are individuals who are moving along satisfactorily and are precipitated into neurotic patterns of adjustment by events during sexual participation with emotional involvement which stir up affects which are so strong that it is difficult for the child to deal with them. This is an example of how the setting of initial sexual experiences can have more importance in determining the developmental outcome of a child than (unexpectedly) transient superficially chaotic patterns of adjustment.

> A 14-year-old boy who had been involved in a kissing relationship with a girl, with minimal excitation for himself, ceased further pursuit of the girl after he witnessed the masturbation and ejaculation of a friend. As in all these matters, it was not the ejaculation, but what it meant to the boy, that counted. In this case, he experienced an intense feeling of nausea. Analysis revealed that behind this was a desire to suck the penis of the other boy and to swallow his semen. In the next four years the boy developed a neurotic pattern manifested in superficial socialization, neurotic constipation, anal masturbation, and a moderate degree of asceticism.

> A girl of 15 partook of sexual play with boys whom she knew only casually. On one occasion she and a boy were in a face-to-face position with juxtaposition of genitals. She was fully clothed. His penis was exposed. He ejaculated on her dress. She became panicky. Here the ejaculate had a highly personal meaning. Her mother had died in childbirth. To her, the ejaculate meant pregnancy, and pregnancy meant death. From that day on, she disengaged herself from all sexual activity.

Social participation without emotional involvement is manifested in varying ways. It is not unusual to see young people who date, and involve themselves in kissing games and the other superficial trappings of incipient heterosexuality, but when alone with a person of opposite sex become sexual abstainers. This pattern is more common in girls than in boys. Furthermore, there are promiscuous girls who derive no gratification from the sexual act. They involve themselves in sexual relations, but do not participate emotionally. The defense of isolation is used to block a genuine emotional response; a genuine response would be overwhelming.

In girls, social participation without emotional involvement may take the form of promiscuity without orgasm; among boys, the adolescent Don Juan—the boy who recites to all who will listen tales of his conquests—comes close to this. He is interested in a sexuality through which he can manifest his masculinity to the world and at the same time hide his uncertainties from himself. He is not interested in gratifications from sexuality, but in proving himself a man to other men.

Alternate Outlets in Defense of Virginity

Alternate outlets in defense of virginity describes an expression of the sexual drive in which the early adolescent child, either out of fear or as a result of inhibition, seeks to establish alternate outlets for the libidinal drives as a goal instead of sexual intercourse. The most common substitute techniques are mutual masturbation and juxtaposition of the genitals. Occasionally fellatio occurs. It would be naive to formulate an understanding of this activity solely on the basis of social elements already mentioned and to ignore psychodynamic factors. Conscious seeking of substitute outlets is rarely seen. From a psychodynamic standpoint, the clinical assessor should take a signal from detecting such intentions. It implies that the search for participation in sexual intercourse or the fantasy about it is inhibited. This is often the result of a near-surface fantasy which, if stirred up by situations or other manifest fantasies, would be anxiety-provoking. Such a fantasy might contain a confusion between the partner and the father on the part of a girl. Another possibility is the fear that sexual intercourse is “what the grown-ups

do," which would result in anger on the part of the parent whose place the child is taking in fantasy.

The situation is similar to that experienced during the oedipal period. At that time, we may recall, the child was confronted with threatening problems. Oedipal feelings and sexuality (genital fantasies) were resolved through regression to the anal-sadistic level. That was the starting point for latency. The course of events during adolescence is similar. Regression to pre-oedipal fantasy may also take place. Regressing from interpersonal sexuality, the child may begin to overeat to answer oral needs, or may develop a preoccupation with scatology. In interpersonal situations, sexual activity may be limited to oral sexual acts, or the entire relationship may be overshadowed by a motif of anal sadism in which sadomasochistic interactions become the acceptable area of interaction for the couple.

It is important to differentiate between common substitute techniques (e.g., mutual masturbation and juxtaposition of the genitals) as exploratory techniques being used by youngsters as a step in a constantly broadening armamentarium of sexual techniques, and the situation in which they are maintained as the ultimate technique over a long period of time. The latter is a case of a regression in which a less mature technique is substituted for a more mature one when the more mature technique is too threatening.

Age-Appropriate Gradual Involvement (Object Relationship with Gradually Expanding Heterosexual Activity)

Up to this point we have dealt with techniques used to hold the individual together and give him or her time to resolve the challenges of late latency-early adolescence, foremost among which are renewed fantasies, stronger drives, and social demands. Now we turn to a group of techniques used in resolving these problems. Nowhere else is the difference between adolescence and latency so clearly to be discerned. In latency, the emphasis is not on the resolution of problems, but on holding the line through a characteristic pattern of defenses, that is, the structure of latency. In adolescence, the emphasis is on working through the problems, while holding the line through a polyglot defensive structure, which is often transient, evanescent, and changeable.

One of the main sources of difficulty in regard to sexuality is the tendency of the child to confuse the characteristics of all drives (hunger, sex, and aggression) in such a way that they are seen as alike. The

typical way of dealing with the aggressive drive creates confusion in the response to the sexual drive in early adolescence. In our culture, the resolution of problems related to aggressiveness is routine. The child who is frightened or passive when it comes to fighting or shopping or new experiences, is encouraged by the parent through precept and example to be more assertive and to go after things. However, the capacity to unleash to the fullest the expression of *rage* is not encouraged. In regard to aggression, the latency standard is taken as the model for adulthood and adolescence. Therefore, the normal child has been prepared by experience to deal with aggression in an acceptable manner when adolescence begins. With the sexual drive, the situation is the reverse. The adult is expected to be assertive and go after things, and the adolescent is expected to work toward this. Contrary to the characteristics of the aggressive drive, the sexual drive calls forth a need to be able to surrender with abandon to the excitements of the sexual drive. The unlimited potential for escalating rage that marks the aggressive drive, which the child is taught to hold in check, becomes the characteristic of the sexual drive in the mind of the child. As a result, the adolescent often confuses the two drives and fails to realize that sexual excitement is self-limiting. Orgasm does not go on forever; aggression, in contrast, can mount continuously. Only by experience or reassurance can this confusion be dispelled.

At the beginning of adolescence, both aggression and sexuality are under rigid inhibition and control. Aggression must remain so, with little loosening up. Sexuality must be permitted to unfold and reach full expression. Through gradual physical progress and exploration in interpersonal contacts, trial action through fantasy, discussions with others, including therapists, and masturbatory practice to master the affects of orgasm, the early adolescent prepares for intercourse.

Zones of Assessment for Normalcy

As in the case of the latency-age child, the assessment of the child in late latency-early adolescence requires that two zones of function be considered: socially defined behavioral normalcy, and biologically defined maturational normalcy.

Socially Defined Behavioral Normalcy

In industrial cultures, adult pursuits emphasize regard for abstract knowledge, reading, and the

expansion of products, customs, and interests into the world and lives of their neighbors. The child in late latency-early adolescence faces the task of changing from calm learner to purveyor and user of these skills. The identifying abstract elements of the culture which have been absorbed in the latency years are now to be applied in making one's way in the world. The child begins to remove his drives and fantasies from his family and, turning to the real world, effects insertion and integration of his unique self into the main culture. Adult adjustments with sexual partners and aggressive realignment of the environment are now just within reach. Fantasy becomes ever less the organ for discharge and mastery. Instead, the world itself stands ready to be used, and the early adolescent must try, test, and practice using his weapons and skills in the realignment and rearrangement of reality to fit his needs. The key to the successful attainment of maturity in this respect is the ability to understand quickly when the world will not or cannot bend.

In evaluating the child from this point of view, the assessor should investigate the ability of the child to set his own preconceptions and fantasies aside when confronted with the limits the world places on him. The role of parents in guaranteeing survival should also be examined. Many times a child seems to be doing very well, and it is found that parents are buying the world to fit the child's fantasies and thus protecting the child from the impact of reality. Another impairment to growth is the tendency of parents to respond to the anguish and clamor of the child rather than to the child's logic. In these situations, the child's omnipotence is encouraged. This ill prepares the child to go it alone in life.

Biologically Defined Maturational Normalcy: Phase-Specific Considerations

Symbols in Late Latency-Early Adolescence. The symbolizing function during late latency-early adolescence is characterized by shifting forms. Ludic demise removes the child from the arena of expressive play through toys. Real objects replace fantasy figures as symbolic representations of unconscious referents. When symbols are used, there is greater potential to employ them in a communicative rather than an evocative mode. As a result, speech and language become more communicative. This leads the evaluator to expect that along with the apparent verbal maturity of the child, there will be an adultiform use of words and speech to convey truth. In clinical settings one expects to believe what one is told. This is one of the pitfalls of interviewing adolescents. The shadow of latency play falls on their use of words. If the child has come for treatment through his own will, the likelihood is

that one can trust the words. One should keep in mind, though, that in cases in which the child comes grudgingly or against his will, there may be disrespect for the investigative process and disdain for the assessor. These last may produce an unwillingness to talk ("I'll go but I won't talk to him"). Withholding often occurs. I remember that once in one week I was told by three girls that they had had no sexual experience. Each was pregnant at the time, and knew it. Such tricks with words reflect a tendency in early teenagers to insist that their words be taken as truth, and a belief that if they can make words dance, people will believe that the world of reality is changing. This is a manifestation of grandiosity and poor reality testing.

Readiness in Comprehending Environmental Phenomena. The cathexis of the object world, which is one of the prime developmental events of late latency-early adolescence, depends upon the ability to make a consistent and accurate interpretation of that which is perceived. This level of interpretation is achieved through the development of the abstract conceptual memory organization. The *abstract conceptual memory organization* consists of the ability to interpret events in terms of their intrinsic substance, coupled with the retention of knowledge so acquired in memory through reduction to abstractions. The abstract reductions are represented by words whose relationship to the abstraction must be learned. At times, they are wordless. By the age of 12, the abstract conceptual memory organization should have acquired a body of abstractions concerning environmental observations that can be used to interpret proverbs and other verbal abstractions. At this point, the child is prepared to interpret and make conclusions when dealing with a multitude of verbal sources. Indeed, at this point interpretations and opinions can be formed about things that have not been seen, and never could have been seen (for instance, images of distant stars borne by ancient light which give clues to the origins of the contemporary universe, or times in the distant past, which when recalled to memory give clues to the content of the unconscious and to those motivations that silently give rise to the events of private contemporary worlds). This provides a great intellectual potential. At the same time, this efficient style of memory and thought gives rise to a potential handhold for mental pathology. When perceptions are reduced to abstractions, details must be lost. In detecting similarities, a certain amount of experience and talent is required in order that abstract reductions that seem identical, but have been reduced from disparate observations, not be taken for the same thing.

During late latency-early adolescence, when this process is beginning to approach the level that it

can be applied to reality, communication is quite vulnerable to disorders within the process. Ordinarily, the errors of false similarity are corrected by memory of the original percepts that the abstract concept is meant to represent. An automatic de-abstraction occurs, and this permits accurate interpretation of new percepts. This need only occur once. In people who have never experienced the percept, education schools the mind to make the proper connections. There are those whose grandiosity is such that they create equalities out of similarities and refuse to bother with the origins of the abstract reductions, often in the service of a false belief. During adolescence this usually grows out of a lack of experience and education, or an omnipotent position held so as not to admit to being wrong. The therapist must beware such omnipotence, since it may be a sign of schizophrenia. Persistence of such belief in identities based on similarities of abstract reductions is the basis for predicate identifications, a form of thought disorder.

Zones of Assessment for Pathology

In late latency-early adolescence, the child is beginning to be independent of his parents. In many areas, especially in regard to sexual play, he is somewhat autonomous. The presence of "secret" areas of function often brings the child for therapy at his own request. Quite often, though, concerns about passivity and about the therapist as a spy for the parents cause the early adolescent to be a mostly reluctant participant.

The capacity to create higher-order abstractions to be utilized while making interpretations in psychotherapy becomes functional in adolescence. With the development of these skills, conversations with children produce verbal insights that have a chance of being remembered. Assessment should take the development of these skills into account, since they will help in determining the efficacy of psychotherapy or the need to add to the psychotherapeutic task the requirement that skills in abstraction be introduced. Because attempts to provide logical answers and lines of association may stir up affects in the cognitively immature, ego building sometimes must come before interpretation and insight.

As the child grows older, the nature of the assessment process shifts from a primary dependence upon parents for facts to use of the interview with the child as a major source of information.

Drug Use during Early Adolescence

After silence of the negativistic adolescent, one of the prime forms of resistance is the use of drugs just prior to a consultation for the assessment of the child. The drug is usually marijuana. The youngsters actually believe that its use cannot be detected, but the experienced therapist has a good chance of detecting it. The characteristics of acute drug use are concrete thinking, bloodshot eyes, and easy giggling. When left to free-associate, they create lists instead of pursuing logical progressions of thought. The therapist senses that time is passing at a different rate for them than it is for himself. Typically, their answers to questions follow a different cadence from the rhythm at which they are asked. Of course there is the telltale odor, which if present (usually in the waiting room) gives the secret away. More chronic use of marijuana is reflected in any or all of the following: development of loss of motivation and falling-off of school grades; a change of friends to those with antisocial leanings; loss of self- reflective awareness; inability to recognize the danger in the drug; a history of immature sexual development (in those with very early onset of addiction, the drugs are used to relieve sexual tensions, obviating the need to overcome the hurdles in the way of sexuality common in early-adolescent experience), and persistent and sustained separation reactions in a child with formerly normal progress.

A history of an isolated hallucinatory psychotic episode followed by the intensification of preexisting neurotic concerns should suggest marijuana abuse. The promise of a state of comfort offered by drugs in the face of disquieting affects is an equivalent of the lost world of defensive fantasy that had been made available by the structure of latency.

Assessment of Adolescent Psychopathology

The assessment of adolescent psychopathology involves the following avenues of approach:

1. Parent interview
2. Clinical interview with the child
3. Educational testing
4. Reports from schools

5. Reports of previous therapists and other professionals

6. Medical examination reports

The assessment of adolescent psychopathology requires that the following zones of pathology be considered and, where indicated, investigated:

A. Social maladjustment

1. Separation problems

2. Affect starvation

3. Drug use

4. Physical or sexual abuse

5. ;Sibling rivalry

6. Lack of socialization

7. Ethical individuation conflicts

B. Organicity

1. Cognitive problems (central processing disorders)

a. Learning disabilities

b. Cognitive social discordance

c. Retardation versus isolated innate flaw

2. Mental retardation

3. Hyperactivity (with attention deficit)

4. Epileptic disorder

a. Petit mal

b. Epileptic explosive personality traits

c. Fugues

d. Temporal lobe epilepsy

5. *Pavor*

a. *Nocturnus*

b. *Diurnus*

6. Confusional states

a. Postconcussive

b. Tumor

c. Hemorrhage

d. Granulomatous meningitis

e. Other emotional illnesses associated with physical conditions

C. Mental disease entities

1. Schizophrenia (disorders of relatedness and the sense of testing of reality)

a. Residual childhood

Autism

Symbiotic psychosis

Persistent schizophreniform psychosis of late childhood Prepubescent

Associated with cognitive impairment

b. Adult schizophrenia of early onset

Hebephrenia

Undifferentiated

Paranoid type associated with premature puberty

Paranoia

Asparger syndrome

2. Depressions (affect disorders)

a. Reactive

b. Endogenous

c. Bipolar

3. Neuroses (consistent symptom patterns, with anxiety)

a. Phobia

b. Hysteria

c. Obsessive-Compulsive

D. Psychosomatic disorders

1. Anorexia nervosa

2. Ulcerative colitis

3. Anesthesias

E. Transient disorders associated with sexual adjustment problems of early adolescence

1. Asceticism

2. Withdrawal

3. Affect avoidance

4. Alternate outlets in defense of virginity

5. Age-appropriate gradual involvement

6. Drug abuse

7. Homosexuality

F. Adolescent derivatives of masochism

1. Masochistic braggadocio

2. Masochistic perversions

3. Adolescent shyness

4. Incipient masochistic character traits

Interviewing the Parent

A great deal of the information needed by the examiner in the search for clues to the contribution of the child's psyche to his current

problems is to be found in historical patterns of growth matched to the child's developmental history. To acquire this information, one turns to the significant adults in the child's life. Personal histories of parents and other family members are needed for the establishment of a family history of mental illness. The interview with the parent provides information that helps in the child's interview. It aids one in formulating the problems to explore and the questions to ask during the interview with the child. Often, the diagnosis or problem can be identified quickly when the interview with the parents has helped to focus attention on the appropriate portion of the differential diagnosis.

It is not required that parents be seen to make a diagnosis. Early adolescents have patterns of signs and symptoms in their behaviors and personalities which can be discovered, named, and treated by a psychotherapist.

Parents should be seen early in the assessment if at all. Because the confidentiality required by the material might make it impossible to see the parents without the child being present, an interview with them before the child is seen is essential. Otherwise, very personal data may be unavailable.

Clinical Interview: Direct Examination of the Child

Many early adolescents have asked for help. Others, especially those who are involved in antisocial activity, would rather not see a therapist. These people are particularly difficult to interview. They tend to lie and to obstruct. If possible, the interview should take the form of getting to know one another. Rare is the angry, defiant early adolescent who is willing to tell very private troubles to a complete stranger to whom he or she has been introduced by an angry parent in a punishing mood. Still the situation is easier than with a young latency-age child. In the case of the early adolescent, the child speaks somewhat the same language as the therapist. It is of value for an interviewer to be familiar with teenage idols and movie and music trends. This will save much time otherwise devoted to asking questions about teenage culture.

For the early adolescent, the request to draw a person is a good starter. It provides a nonverbal access to the psychology of the child. I have found that drawings suggest interview topics and questions. Some therapists (DiLeo 1970, 1973, Fein 1976, Machover 1958) have reported being able to assess level of cognitive development, body image, sexual identity, organicity, mood, intelligence, presence of hallucinations, superego formation, reality testing, and fantasy through figure drawings.

The initial interview is shaped by the examiner's personal technique. Aggressive questioning tends to put children off. One should start with neutral areas such as school facts, sports, television, and movies; show the child that talking can be fun. Often ludic demise is recent and poorly sustained. For this reason, it should be possible for the child to turn to toys after a moment of silence. Try to remember the material the child was dealing with before the silence, for it may be a key to the areas of stress that cause his regressions. It often indicates internalized relationships (such as punisher/victim fantasies) that are sources of repeated neurotic patterns of behavior.

As with the assessment of the latency-age child, it is necessary to differentiate between information concerning direct representations of happenings that traumatized the child and fantasies, which represent a distorted internalization of past experience. The former usually gives rise to reactive behavioral difficulties in the places of the trauma, either at home or in school. The internalized fantasy goes everywhere the child goes and contributes strongly to fantasy-derived misbehavior. Internalized

fantasy is one of the factors that produce psychopathological signs and symptoms. Although depression is sometimes a reflection of ongoing family troubles requiring parent counseling, and is seen as the province of the family therapist, internalized conflicts usually require a psychoanalytically oriented, dynamic approach and are the province of the child therapist or analyst.

In addition, the move into early adolescence is accompanied by maturational steps that produce clinical changes in object relations, overtness of private masturbatory activity, and the experience of uncomfortable affects. Each of these requires a change in the content of the clinical interview as compared with the interview of the latency-age child. Relationships with opposite-sex peers are pursued to determine where along the march of adolescent dating patterns the child is functioning. The pattern of adjustment to the sexual drive can also be explored. An important factor is the evaluation of the strength of narcissistic vulnerability and responsive grandiosity in establishing adjustments in these areas during late latency-early adolescence. This gives the child an idea of the possibility of giving up idiosyncratic reactions, such as asceticism, withdrawal, and substitutive sexual acts—tinged with disdain and a sense of superiority—with the arrival of maturity.

Even though the child now masturbates overtly, the action is still private. Pursuit of information about masturbatory activities and fantasies should be conducted with delicacy to avoid reactions that could interfere with the development of a therapeutic relationship. After the patient is secure in a therapeutic relationship, it is possible to ask how the child comforts himself when lonely or emotionally uncomfortable. Within the context of a free and comfortable answer to that question, one has the best chance to obtain information about masturbatory practices. Because the structure of latency is harnessed to the task of future planning at this age, the latency-age faculty of extinguishing uncomfortable affects in a flood of fantasy is no longer available. Depressive affects are more apt to be conscious and techniques for dealing with them very much on the mind of the child. For this reason, suicide becomes more frequent at this age. For a like reason, suicidal potential should be evaluated in each child with depressive mood changes. The potential is more intense when one or both parents are dead, when there are strong symbiotic elements and removal has been faulty, and when the child speaks of stopping the discomfort with a potentially dangerous activity, such as taking sleeping pills.

In conducting the diagnostic interview with a child in late latency-early adolescence, it is difficult to

avoid a nonstructured session. The best the interviewer can do is to ask questions that follow ideas suggested by the patient which can be guided to cover the following areas:

1. Appearance and behavior, orientation and relatedness
2. Thought content and primary fantasies and fantasy structures (including whether internalized, and if productive of regressions)
3. Organization of cognition, thought, and memory
4. Affect and mood (including wish to hurt self, if present)
5. Impulse control in session
6. Major interests and reported relatedness to friends
7. Future planning and life ambitions
8. Capacity to stand apart and look at self
9. Degree of ludic demise
10. Narcissistic vulnerability and degree of omnipotent response
11. Nature of the symbolizing function (communicative versus evocative mode?)
12. Superego development (content of observing object in the mind's eye)
13. Suicidal ideation
14. Minor neurological findings
15. Status of the central processing system

Educational Testing

Educational testing is useful when there are learning problems. Such testing can demonstrate and delineate central processing disorders and related learning disabilities. These are often the hidden source of low self-esteem and poor academic performance. Through such testing, cognitive problems can

be quantified and prescriptive teaching used to gear the child's education to his needs.

Outside Data

Increasingly as he or she grows, the person's life in late latency-early adolescence moves into areas far removed from home and semi-structured situations. The permissiveness of the noncaring world brings out symptoms, and also many strengths. Schools, previous therapists, and other professionals, especially the child's pediatrician, can often give an objective, long-term view of the child's family and problems that would not be available within the time limitations of the average assessment.

Summary

Assessment in late latency-early adolescence has been presented from the standpoint of the specific features of maturation and development that change and add to the basic interview as it was designed for work with the latency-age child. The move into early adolescence is accompanied by maturational changes that influence the development of object relations; overtness of private masturbatory activity; relationships with opposite-sex peers; initiation of the pursuit of adolescent dating patterns; adjustment to the burgeoning of the sexual drive, coupled with the loss of latency-age defenses; strengthening of narcissistic vulnerability and responsive grandiosity; new directions in symbol usage (ludic demise and the appearance of communicative speech, tertiary elaboration, and emphasis on the communicative pole in symbol formation), and new exposure to uncomfortable affects in the face of the effective loss of present affect control accompanying the reorganization of the structure of latency to serve the task of future planning at this age.

There is so much that is new, typical of late latency-early adolescence, and unavailable to those who would try to understand what characteristics mark that special age from reconstructions of events and symptoms removed in time and place. Remarkably, late latency- early adolescence, a very font of future personality activity, is mostly transient. It soon passes into adolescence and then adulthood, when bridges bring the object world into position to welcome, and attend the metamorphosis of the early-adolescent child into an adult.