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Outpatient Treatment of Adolescents and Their Families

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Treatment programs for adolescents are of relatively recent origin, for until a decade or so ago few psychiatrists studied the specific problems of adolescents in any depth, and treatment of adolescents by psychotherapeutic methods was generally considered difficult at best and most likely unrewarding. Changes have come about rather rapidly, both in regard to our knowledge about adolescents and in the relative pessimism with which treatment of adolescents had been considered. There is now a multiplicity of approaches to the troubled teenager, all practiced by an increasing number of interested professionals. A specialty of adolescent psychiatry as such does not exist as yet, but a number of psychiatrists have now a heavy load of adolescent patients.

It is possible to subdivide the knowledge and the corresponding treatment approaches into three major categories. (1) Knowledge primarily centered around the individual and his development during adolescence comes to a large extent from psychoanalytic sources. Erik Erikson's contribution on the identity crisis of the adolescent and Peter Blos's work on adolescence considerably illuminated the field of individual dynamics and outlined specific intrapsychic and psychosocial features of adolescence. (2) It was recognized that group formation and group behavior by peer

identification are an intrinsic part of adolescence. Various psychotherapeutic approaches now utilize groups. Adolescent discussion groups, activity groups, and work with natural groups, as in street corner work, have been widely practiced and described in the treatment of disturbed youngsters (group treatment of adolescents will be discussed in another chapter). (3) Approaches to the family as a whole, either by separate interviews with the patient, the parents, or other relatives, or by therapy for the total family have greatly increased the available knowledge of family dynamics. The emphasis in family therapy is not so much on the one disturbed adolescent as on the disturbance in the family as a whole. For instance, unhealthy family structure, communication gaps, or splits in the family are identified and understood in their pathogenic significance.

The Individual Adolescent and His Developmental Task

Erik Erikson defined the adolescent's predicament as "finding an identity" and, indeed, the words "identity crisis" have become a common diagnostic term used, and sometimes misused, when one talks about disturbed adolescents or young adults. Having an identity connotes both an inner oneness with oneself and the assurance of possessing a recognizable posture in society. The opposite of having an identity is identity diffusion. The adolescent or young adult who has not "found himself" and is puzzled as to who he is and where he belongs is often said to suffer from identity diffusion.

More specifically, Peter Blos in his work on adolescence recognized several stages, which can perhaps best be summarized by dividing them into two major sections. Two distinct and separate psychological tasks are there for the adolescent to master. During the earlier part, roughly between eleven and fifteen years, he must come to terms in one way or another with the issues of biological maturation. There is early in adolescence a marked upsurge in instinctual drives, probably caused by the hormonal changes during early puberty. On the psychological level, the young man or woman must relive the crucial, emotionally loaded family constellations that his earlier development has imprinted on him. Most of this reliving remains unconscious under normal circumstances, the only visible symptom being the well-known restlessness, unpredictability, and moodiness of the early teenager. Separation from the parents and in particular the abandonment of the powerful parental images will lead into the second major phase, perhaps most commonly associated with the ages sixteen to eighteen. This is the stage of individuation, in which an adolescent becomes the person he is to be and gains a feeling of selfhood, an identity, and hopefully a place of his own in society.

As for the first stage of adolescence, prepuberty or early puberty, its arrival is marked by the breakdown of what has been described as childhood identity or a preliminary identity by Theodore Lidz. This childhood identity emerges in the early grammar school years and the child's teacher in the

second or third grade often describes rather well his various assets and liabilities and, circumstances permitting, places him into the kind of educational setting most appropriate to him. This identity of the child is incomplete and, in particular, is characterized by the existence of two relatively separated psychological worlds, the outer world of school, family, and life performance and the rather more chaotic inner or fantasy world, which is fed by stories told, by reading, or by television. This latter inner world is by and large repressed and only rarely directly accessible to adults. It is the destiny of this repressed inner world to resurface. Its energy is destined to shake up the relatively smooth performance that is expected from an elementary school child. The turbulent teenage behavior will reveal much of the repressed inner world if properly listened to. Later, in a new synthesis, an even performance will once again become the expected norm.

The awakening of the forces of this second world, the unconscious world of fantasy fueled by the instinctual drives, takes place in somewhat different form for boys than it does for girls. In boys one sees characteristically a degree of developmental regression, in particular in the area of cleanliness, appearance, and readiness to accept authority. Dirtiness in physical habits, dirty language, and increased defiance toward all rules become prevalent and either a provocative or a passive-aggressive stance is taken by the typical twelve-year-old. There is also little inclination to open up to adults. Parental authority, in analogy to early childhood experience, is

perceived as inhumanly powerful, merciless, overwhelming, and very restrictive. In technical terms, the superego once again takes on the aspects of the archaic superpower that it was in early childhood. The defiant twelve-year-old takes the same stance vis-a-vis parental authority emanating from both the father and the mother that he once took toward his then much bigger parents when he was in the process of mastering his aggressive drives as a three- to five-year-old.

If by virtue of trauma or deprivation an adolescent remains in this preadolescent stance, we may expect something similar to the psychology of the delinquent. There is a defiant stance toward the world. The superego is harsh, punitive, and monumentally powerful. The delinquent tends to project these qualities on the outside world, and he then finds in them the characteristics of his future persecutors, be they the school authorities, the police, or whoever. The delinquent must continuously prove that he is really master of his own destiny by defying all these powers. He will ordinarily not show much evidence of the subsequent developmental phases of adolescence; in particular, he will remain friendless, he will be unable to experience loss or grief or depression, and the relations with the opposite sex will have a peculiarly possessive, almost impersonal, quality to them. Thus, delinquency may be understood as the result of a preadolescent fixation.

It may be understandable why an attempt at psychotherapy in this stage

has grave handicaps. The young adolescent will rarely trust a therapist to the point of sharing his inner world with him. The therapist will in all likelihood have to intervene in the family situation and may be the most useful as a counselor to the parents, who may well be puzzled and disturbed by the developments in their offspring.

Matters are somewhat different with girls. As with boys, a degree of developmental regression comes about in early puberty, but rather than leading to rebelliousness and defiance, the early pubertal girl will experience a feeling of helplessness and inadequacy, which, however, has to be denied vigorously. Conflict with the mother is likely over privileges that normally are assigned to older girls or grownup women, such as the purchase of articles of clothing, freedom to be out later at night, and the use of lipstick and other makeup. Inevitably, the young woman's demands for being in on whatever feminine fashions command appears premature to the worried mother. A feature of early adolescent years described by Helene Deutsch is the so-called adolescent triangle. It is observable that girls, much more than boys, develop best friends, also called "chum relationships," in the early teenage years. Sometimes some considerable affective freedom is permissible between two girls, and at any rate, it appears that the secure relationship with the girl friend is much more important than any heterosexual relationships, which may be tried as a great adventure but never carried too far. It is with the chum of the same sex that one exchanges confidences about what one does or

does not dare do, and it is the support of the chum that is most needed in a crisis.

If this derivative of the dependent relationship on a person of the same sex is not acknowledged in one form or another or is not available to the young adolescent girl, as in boys, the result may be delinquency and in particular, repetitive promiscuity. The denial of dependency may lead to acting extra grown up, and premature sexual behavior, often called pseudo-sexuality, is the common feminine equivalent of adolescent delinquency. The manifest sexual behavior should not deceive one, for here again truly affectionate and personal ties to the partner in love are out of reach for the promiscuous adolescent, whose main aim is to hide defensively her as yet strong dependency.

Psychotherapy with disturbed girls of this age group is equally difficult as that with boys of the same age. By and large, a female professional will do better than a male, precisely because of the existence of this developmental problem of dependency.

The characteristics of the second major phase of mid-adolescence and individuation are definitely less conspicuous for the onlooker but probably more painful for the adolescent himself. At the beginning, approximately age fifteen, phenomena referable to depression can often be observed. The

adolescent has moved further away from his family, perhaps not physically but certainly in his feelings, and he has, most importantly, relinquished some claims for fantasy satisfaction through the parents. The images of the parents as strong, powerful, and good people have vanished. Parents have been recognized as human and as failing. Adolescents will not fail to let their parents know how disappointed they are with them. Naturally, adolescents will seize on realistic weaknesses of their parents, but the great emotional push behind the sometimes violent criticism of the parents is not owing to real failures but to the great disappointment about the falling down of the once so powerful parental images. On the social scene, some of the same phenomena seem to occur: Young people are disappointed with what society, the university, the politicians should have been. Their request is for more contact with those who are older, with an order of things better than the present one and with recognition of the young as full persons. The middle adolescent, indeed, feels rather deprived. His parental images do not hold up, his own resources are not yet sufficient, his depressive moods are not easily understandable, often not to himself. Acknowledgement of this state of distress is particularly difficult since society expects the teenager to continue with the tasks he is involved in, be they in the direction of adaptation to a wage-earning position or further education.

Some typical defenses against this mid-adolescent depression are so general that they are often ascribed to adolescence per se. A common one has

aspects of grandiosity to it, and as such denies the basic feeling of helplessness. Heightened attention to oneself, narcissism, often appears in the form of self-righteousness, arrogance, or petulant argumentativeness. Sometimes the same narcissism may be manifested in a more passive way by a heightened concern with body, body building, or appearance. The importance of clothing for boys and girls and the concern with appearance, often with long hours spent before the mirror, belong here. A degree of exhibitionism is often part of this. Openness to ideologies belongs in this phase as well, as do the cultural fads, anywhere from unconventional clothing to drug use. Another defense against the depressive situation of the adolescent is delinquency. To make something happen is often a way out of having to bear unbearable tension. A delinquent act will release tension and will create a new situation where the enemy will be external, identifiable, and possibly fallible. A very transparent case example follows.

A sixteen-year-old boy was caught stealing hubcaps in a shopping center. He was easily caught by a police officer and was sent by the court for treatment. His counselor heard in the first interview that he had lost a girlfriend and therefore had done what he did. The story of the lost girlfriend and the young man's concern about how to gain her back became very repetitive, and ultimately his terrible disappointment with his parents came to the fore. His father had not achieved the status of suburbanite that some of his friends' fathers had. His mother was impervious to him when he craved

her attention. He saw his home situation and by implication himself, as mediocre or poor, and he had not as yet found comfort with a peer group nor was he comfortable with young girls. His depressed state had become unbearable to him, and by acquiring a Mustang hubcap, he had asked for help, unconsciously and yet fairly obviously.

The later phase of individuation is characterized by the adolescent's search for someone or something to get involved with. Since the retreat to the safety of an affectionate relationship with the parents becomes more definitely closed, the adolescent is looking for affectionate ties with contemporaries of the opposite sex. Inevitably, frustrations ensue, and a first disappointment of a significant love relationship often constitutes a major crisis in the life of an adolescent and will revive the earlier state of depression and helplessness. Vice versa, a steady boyfriend or girlfriend relationship can do a great deal for the maturation of a teenager. The formally unattached and seemingly drifting young person now has a focus and acts in general much more purposefully. While the relationship with the sexual partner may not progress and may eventually end, much else in the life of the adolescent may progress. A characteristic of adolescent choice of partners is that it is very strongly based on similarity. The prerequisites of understanding each other completely, feeling the same about everything, having all the same interests are telltale signs that identification is a stronger binding force at this stage than object choice. The two adolescents who are boyfriend and girlfriend

frequently belong to the same group, have double dates with other group members, and in general will do everything to create the impression that they are alike. Such a relationship will often protect an adolescent from exploring further relationships and will provide a safe haven where he has temporary freedom from coming to terms with himself, with his future career, and with society at large. In a larger sense, the questions of choice of work or career and choice of education will usually be posed at this stage. An adolescent may here identify with the values of his family and embark on living a life very similar to that of the parents, or he may choose the avenue of conflict and identify with others or with other causes. Expectably, the great majority of adolescents between sixteen and eighteen will appear more or less in harmony with their parents. Often the identification of the young person with the parent of the same sex is a premature one, and undesirable traits of the parents are taken over along with the desirable ones, unreflected and unrevised. A delay in late adolescent identity formation may bring about the dangers of identity diffusion. But it may also provide what Erikson has called a moratorium for the adolescent to find his own separate identity and may as such provide a more creative solution to the issue of finding an identity.

Perhaps it is apparent that, both in the phase of adolescent helplessness or depression and in the later individuation phase, a therapist can be extremely helpful. The later adolescent is usually much less reluctant to talk about matters with someone recognizable as genuinely concerned and able to

understand.

The Adolescent in His Peer Group

Group formation is not particular to adolescence. From at least age four onward, group formation takes place among children and is effective in influencing their behavior. Group phenomena are observable through childhood, and their presence is not only acknowledged but widely utilized by teachers, educators, recreational directors, and others. What makes adolescent group formation different is that it has escaped from the control of the adult world and is the first and principal vehicle for self-assertion of the adolescent against parental authority. The authority of the group in time takes precedence over the authority of the parents, and as all parental rules are challenged, they are in the early teenagers' mind superseded by the rules that the group demands. Group rules often are far more stringent than parental rules, but also are far more binding on the teenager. Early adolescent boys are particularly prone to rely on their group, often called a gang, for protection, recreation, and activity. Considerable cohesiveness is usually achieved, leadership is contested and eventually decided on, internal rules are enforced, and strangers are unwelcome. Manifestations of affect within the group are usually poorly tolerated; there is no overt display of feeling, the emphasis is on action and on impressing one's peers with one's achievements, be they aggressive or sexual in nature. By comparison, girls are relatively less

groupy. They tend to form closer relationships on an individual basis and are less amenable to organized collective activity. In later adolescence, groups are often mixed, and while activities are less rigidly controlled and the group does not have the gang-like quality of the earlier boys' groups, the group of friends may be a great support in times of crisis. In particular, the somewhat narcissistic or grandiose mid-adolescents will tend toward group formation as a tool for finding a common goal or purpose, ultimately as a solution to the inner tension, which sometimes is unbearable. It is evident that the disturbed youngster who does not have a group of friends to fall back on will have fewer resources to deal with his problem than his contemporary who is a solid member of a group of friends.

Strategies for group psychotherapy with adolescents generally take into consideration the developmental needs of the adolescents in regard to group formation. Groups of younger teenagers are generally of one sex and led by a leader of the same sex, whereas groups of older adolescents, fifteen and over, are often sexually mixed. By and large, it is easier to bring a group of younger boys together than it is to collect a group of younger girls for therapeutic purposes. In the practice of community mental health centers, it is often opportune to form a group of adolescents, for instance, in an effort to deal with problems around drug abuse. The generally favorable response from such groups may be understood through the phenomenon of identification; it is often easier for a teenager to identify with a contemporary than with an

adult and what the peer-group member misses in sophistication, he may gain in terms of intensity of emotional involvement. The newer programs of adolescent self-help for drug problems in particular—crisis intervention through hot lines, where help is given over the telephone, or home counseling —all bespeak the power of adolescent peer identification. A phenomenon as complex as the epidemic of drug use, however, also requires dealing with the parents of the teenagers involved, and quite often a parents' group will meet as well as a teenagers' group. There is a definite advantage in having the same group leader or group leaders for the parents as well as for the adolescents, as will be discussed later. The often used argument that confidentiality is jeopardized when the therapist also deals with parents presupposes a concept that therapy is done by revelation of confidential secrets. The relative power of peer-group identification and the advantage of having a fuller picture of family interaction more than make up for what lack of trust may result from the therapist's dealing with parents as well as with the teenagers.

The Adolescent and His Family

As private practitioners or clinics tried to render service to young people and their families, it became apparent that the traditional medical model of treating an adolescent problem situation as a disease suffered by an individual member of the family, was totally unsatisfactory. To begin with, finding the so-called disease becomes an elusive task, as for instance in the

rebellious youngster who tries to emancipate himself from his overbearing mother or father through an attempted runaway episode. Moreover, excessive focusing on one-to-one individual psychotherapy, if necessary with several family members, results in long waiting lists, which in turn create dissatisfaction. A clinic or practitioner then can serve only a small fraction of those in need of help. More specifically, a waiting list, or any delay in providing help, often results in a situation quite different from the one for which help was originally sought. If one allows an acute problem to wait for a number of weeks, and many adolescent problems are acute problems, then the problem is no longer an acute one but may have been resolved in an unsuitable fashion. In practice, it is often the case that if no help is given immediately, no help can ever be given to meet that particular situation. However, speedy evaluation by looking at the situation as a whole will provide clues for a possible conflict resolution.

Perhaps a change in focus must be specified: rather than treating disease in one person, one tries to define a problem in interpersonal terms. The solution then is not to cure the one person labeled as the patient, with no change in the others, but to change the entire system, which is, in this case, the family. In practice, one would try to understand any adolescent problem situation from at least two viewpoints: On the one side are the concerns of the adolescent in his development, and on the other side is the ongoing family interaction as described by the various participants or as observable in a

family interview.

Any practice of adolescent psychiatry, whether by an individual or by a clinic team, should contain the following types of diagnostic interviews which should ideally be held within a relatively short time of one another: (1) an interview with the adolescent alone, which should cover his own view of himself, his complaints, and his view of his family; (2) an interview with the available parents, either separately or jointly, to review their point of view about the youngster's problem and their point of view of their respective spouses; (3) a family interview involving parents, the adolescent himself, and as many siblings as can be present. There need not be a set order in which these interviews are held. What is most important is that findings from all three settings be pooled or brought together to bring about a full understanding of the situation.

A fifteen-year-old girl, a high school student in a suburb, was referred after having taken several aspirin tablets. She reported disagreements, especially with her father, about discipline, in particular about privileges of going out and going with a boyfriend. She described her father as drinking too much and being irritable while recovering from coronary heart disease. She appeared mildly depressed in the interview and appeared somewhat fearful, particularly when describing her father's behavior. She also described some claustrophobia in elevators and recalled fears of the dark as a child. However,

her side of the story was not the only one. The parents, in a joint interview, first confirmed the father's coronary heart attack, his drinking, and his irritability. However, as far as the patient's behavior was concerned, they had noted for some two years that she had become inconsiderate of others, in particular her younger siblings, that she had begun to skip school quite frequently in the last few weeks, and that she had started to lie to them about her whereabouts and to go out on the sneak during the night. Moreover, she had begun to tell her younger siblings stories about her supposed sexual exploits. In addition, the parents volunteered information that alcoholism had been a problem in both their respective families. Both the father and the mother as teenagers, had been forced into deceiving their own peers about their parents' sad state. They had, in a sense, been lying out of shame. Their view, however, was that the present problems were all with their daughter. An interview with the full family finally revealed a marked split between the three older children and the parents over the issue of discipline and, in particular, the restrictiveness of the parents. Reassuringly, however, during the interview, some serious negotiations took place in which parents and children for the first time confronted one another with the intent of solving some problems. During subsequent interviews, the young patient realized in her individual interviews that she had indeed been fearful for her father's life, in particular, in view of his irrational behavior after his heart attack. She recognized that her suicide attempt had been in a sense an imitation of her

father's own carelessness about himself. The family as a whole continued the negotiations started in the family session, and to the parents' surprise, the children's requests were much more reasonable than they had anticipated. Inasmuch as the parents had been deceiving others when teenagers themselves, they had assumed that their children would surely deceive them. When this did not turn out to be the case, common plans for the family could be made, and communications were reestablished.

If one proceeds with treatment on the basis of one single aspect of the information only, treatment may well be ineffective. An adolescent who reports at length about the irrational behavior of parents and the parents' restrictiveness often fails to reveal to the therapist his or her own destructive behavior. An exclusively individually oriented therapist may easily accept the thesis of the persecuted adolescent, and therewith he is no. longer helpful. If the parents only are consulted, the teenager may emerge as the victimizer of the family and the cause of all the problems, and a therapist relying on parents only may overlook the tendency of the same parents to have the child stand in for their own negative qualities, for instance, the quality of deceitfulness.

James Anthony outlined typical schematized attitudes that prevail about adolescence, including the adolescent as the victim as well as the adolescent as the tyrant or victimizer. Family therapy has introduced the new notions

that pathology in adolescents may be owing to faulty family structure, to communication failure, or to existing rifts within the family. Family structure and, in particular, the nature of the marriage of the parents has been related to psychosis by Lidz, Fleck, and Cornelison, while communication failures, such as the "double bind," have also been seen as closely related to psychosis. While family therapy has gained much information from the study of schizophrenia, quite often total family problems become visible also in families with less disturbed adolescents. A persistent alliance between father and teenage daughter with sexual or seductive overtones may lead to the teenager's inability to be successful with boyfriends and eventually to leave home. An overbearing mother who constantly checks on her teenage daughter may force her into sexual exploits by constant provocation without being aware of it. A depressed father may force a son into major and dramatic acts to get him to pay attention. Each time, the family setting per se will be most revealing. Quite often such circumstances are not talked about, and the participants usually are not aware of them.

Family treatment has become a much practiced modality in the treatment of adolescent problems and has found wide acclaim, in particular for those problems that tend to be more refractory to individual approaches, such as delinquency, drug abuse, and psychosis. It presupposes that a family is present and available for therapeutic work. It is likely to be more successful where the family is more or less intact and where problems are clearly due to

family circumstances rather than, for instance, to social problems. It is a particularly suitable vehicle for the treatment of adolescents in a crisis situation, such as a suicidal attempt or gesture, a runaway episode, or a sudden change in the adolescent's behavior. Flexibility should be maintained. In some sessions the adolescent himself, about whom the problem was in the first place, may not show up for the family sessions; yet the family may profit.

From the preceding considerations, it should follow that diagnosis of an adolescent problem has several dimensions to it. The following will be considered in sequence; (1) the overt symptomatology; (2) the individual dynamics and, in particular, the issues of adolescent development; (3) peer-group and societal influences on adolescent behavior; and (4) the interaction and the dynamics of the adolescent's family.

1. The overt symptom has perhaps sometimes been underestimated in its importance, in particular, for the prognosis of the adolescent disorder under consideration. The manifest disorder can be presented as lying within the adolescent himself; that is the representing difficulty is in the areas of thought or feeling of the teenager. A teenager who presents his discomfort openly is able, for instance, to talk about his depression, display appropriate affect, or report his inner difficulties, and will, by and large, have a fairly good chance to overcome his problems with proper help. This is true even for pictures that at first appear rather menacing, such as expressed feelings of

unreality, dissociation, or, even occasionally, hallucination. Such psychotic-like symptoms should not automatically lead to hospitalization of the young person but first to a detailed investigation of his own development and the pertinent family circumstances. The same is true with symptoms manifested primarily in the physical area, which are not uncommon in adolescence. Endless physical tests are usually of no avail, whereas recognition of, for instance, a depressive situation, will go a long way toward reversing the disability.

In contrast with symptoms that point inward, such as the ones described above, action symptoms that point outward are of different clinical significance. While indeed a runaway episode or an episode of drug taking may be due to the same depressive constellation that in another youngster will show as manifest depression, the fact that outward action has been taken will of necessity change the nature of the intervention. Dealing with outward action and its significance is often very painful for the teenager, and more likely than not, he will try to avoid confrontation with the therapist rather than translating his actions into words or feelings. The same is true where aggressive action or delinquency has been chosen as the way of dealing with unbearable tension. Confrontation is usually avoided and any one-to-one psychotherapy has an additional hurdle to overcome. The patient sees himself as having been caught and wants to deal only with the realities of the situation, while the therapist is seeking evidence for inner problems or inner

feelings. Quite often the two will not meet on any common ground.

It is with these latter action symptoms that a socially oriented approach shows more promise. Exploration of family dynamics leading to the problematic action is often fruitful. Treatment will, more likely than not, proceed along the lines of group therapy, or if severe delinquency is the problem, treatment in a structured milieu is indicated. In summary, one would try to distinguish principally between two types of presenting symptoms, those directed toward the inside, such as feeling, thought disorder, and to an extent, physical symptoms based on emotional grounds and, on the other hand, action symptoms where pathological interaction with the environment is the main issue.

2. An individual developmental assessment of the youngster will often need to be made with the help of parents or others who may have information on the teenager s behavior. One may search for characteristics dating from childhood, such as relative activity or passivity of the child, energy spent at various activities, such as studying, sports, games, relative sociability with peers or grownups, openness of contact, or closed-mouthness. In particular, one would look for the main adolescent developmental landmarks. Was there an upsurge of aggression in early puberty? Were there good peer relationships at that time? Was there a renewed interest in the parent of the opposite sex? Were there episodes of

depression or moodiness? Has there been a boyfriend or girlfriend? One might finally explore the topic of identification through the individual adolescent's development. Does he physically resemble his father or his mother? Has he acted like his father? Has his father fostered some closeness during the grammar school years and brought interests to life? Does he have at present hero figures or adored celebrities? Would he like to grow up like his father and choose work similar to his? The answers to questions such as these will often go a long way to reveal salient conflicts within the adolescent as, for instance, passivity in the face of an active achieving father and resulting conflicts or similar syndromes. It must be stated that quite often the adolescent alone will not be able to answer a good number of these salient questions. While the matter of confidentiality has been stressed in individual therapeutic work with adolescents, it must be said that quite often salient conflicts will not come to the fore without extraneous information being available to the therapist.

3. Peer-group and sociocultural influences are of definite importance in understanding adolescent problems. One is, however, ill advised to accept at face value statements frequently made both by the parents and the adolescent that the cause of all difficulty lies with the group of friends that the patient hangs around with. Peer-group influences are certainly one influence, but by no means the only one. Group codes are very binding on the adolescent, yet in most instances there is a way out from the particular group

with which he has chosen to affiliate. It is the same with cultural influences. Assumptions about upbringing of children held by immigrant parents are frequently at variance with current norms in the United States. A degree of cultural conflict results, with the teenager caught in the middle. Reconciliation of the conflicting value systems is often not an easy task and may be accompanied by symptoms of stress. Exposure to racial discrimination may be another stress that will affect the teenager with particular severity. The solution lies often in a strengthening of the home base, which will make the teenager's origin acceptable in his own eyes and in the eyes of his parents. Parents who are highly critical of themselves for being different from what they perceive as the dominant segment of society will tend to underrate their own authority and leave the youngster to establish his own values, often by destructive rather than constructive means. The therapeutic intervention may be then primarily along the lines of supporting the parents' authority or cultural or racial identity. The challenging teenager will then encounter a clearer message from his family as to his ethnic, cultural, or racial identity, which he then may choose to accept or reject.

4. A clear assessment of family interaction is of the utmost importance in adolescent problem situations. A look at the parents' marriage and at the parents' interactions with both the identified patient and other siblings will reveal a great deal of the origin of adolescent behavior. Typically, the advent of sexuality in the pubertal girl will have an effect on the father. He may either

defend himself against the impact of a young mature woman in the family and pay no attention to the growing daughter, or he may by contrast accede altogether too much to her seductive attitudes and therewith put her under a burden of guilt, at least in her fantasy life. Where the father and mother are alienated from each other, quite often the children are expected to take sides with one or the other. Destructive splits and guilt-laden alliances result from such marital alienation. Where the father is often absent or ineffectual, an adolescent son will come under considerable pressure to be the man in the house. He can avoid this predicament by being absent as much as possible, or in turn he will suffer from unconscious guilt, which quite frequently can be acted out in aggressive or delinquent behavior. Delinquency will externalize the guilt and give it a quality of reality where the most immediate concern becomes dealing with the realistic adversary. Scapegoating behavior is not uncommon in families, and some adolescents make good scapegoats, who will by their problems, as it were, hide the conflicts between the spouses. A youngster who destroys household goods in order to reunite father and mother against himself may in fact preserve the marriage, which without his destructive behavior would fall apart. Knowledge of family dynamics quite naturally will lead to a different focus in treatment, and instead of dealing with a defiant youngster, one may choose to remedy the marital situation between the parents.

Strategies and Tactics for the Treatment of Adolescents

It should be understood that for an area as complex as the one discussed, no single treatment will yield consistently satisfactory results. Just as diagnosis has to be multidimensional, treatment approaches must be of many sorts and adapted to what the situation requires. Each approach has its strong sides and its drawbacks, often several approaches have to be used simultaneously, such as individual, group, and family treatment. Imagination must be used to devise the proper method, and frequently the approach may have to be changed as necessities require. Flexibility and openness to change are perhaps the two most useful rules. In the end economics and available resources often dictate what type of treatment will be given, and a wise clinical decision for treatment planning will, of course, consider feasibility along with desirability of a given approach or technique.

Whenever possible the treatment of an adolescent problem situation should first be attempted on an outpatient basis and with active participation of the family. Even in cases where psychotic syndromes are present, much understanding can often be gained from an exploration on an individual and family basis. Institutionalization for acute situations should be reserved for life-threatening circumstances. For chronic situations, it will be important first and foremost to assess the strength of the youngster and the family's resources to deal with a given problem. Repetitive crises, which often occur in the matrix of a chronic unsatisfactory situation, can sometimes be dealt with

by crisis intervention methods. However, where it has become clear that neither the teenager nor the family has means at their disposal to extricate themselves from a destructive situation, a change in milieu may be necessary. It is in those circumstances that school away from home or institutionalization may be necessary. A structured milieu has often beneficial effects in those cases where clearly no structure had been provided by the parents and where either physical or emotional deprivation had been a problem. It needs to be understood that institutionalization for chronic problems will usually require some considerable time, and the adolescent hospitalized or institutionalized will often fight hard battles with the caring personnel.

Individual psychotherapy with an adolescent has a better chance the more the adolescent is able to develop trust in the therapist and with this trust create a unique relationship with him. Several factors stand in the way of such a trusting relationship. A young adolescent sees a therapist as a mouthpiece for the parents, the school, or the established order, and will deny the therapist any personal identity of his own. The therapist will not be treated as a person, much less as someone with whom one would share intimate feelings. Sharing of such feelings is reserved for peer-group members. The therapist may be viewed as of little use when action has been in the foreground of the picture. A youngster who is hospitalized or treated for his actions in one way or another will usually find a therapist only

important when he agrees to act as an advocate to secure freedoms, privileges, or supplies which the youngster feels he needs. Acceptance then is a conditional one and is predicated on the therapist's actions rather than on his skill or his willingness to deal with underlying feelings or problems. Choras and Stone remarked that a therapist under those circumstances will only begin to make an inroad with a patient when he can in some ways become important to the patient for something that he, the patient, himself wants. The difficulty of playing along with the patient for the sake of a good relationship should, however, be mentioned. A therapist who compromises himself or his own ways for the sake of an adolescent will often get into considerable difficulty, inasmuch as sooner or later there will always be a point where a therapist will have to say no. His skill will be tested by the manner in which he will be able to refuse something to a young patient without losing the young patient's respect or affection. It deserves to be said that where individual therapy comes about, even if it is on a short-term basis, a beneficial openness and fluidity of the situation are created for the individual adolescent. Where an ongoing relationship is available on a personal basis, development may take place and a very personal and meaningful experience ensues. This is much in contrast to family confrontation or crisis intervention-oriented maneuvers with a number of people. In these situations, an actual pressure for quick resolution of the pathogenic issue is present, and obviously a practical advantage comes about

because everyone tries to come to terms with the matter; yet no therapeutic relationship ensues, and the role of the therapist is limited and tied to the crisis only. In the individual setting, the process of progress may be slower but possibly more meaningful for the individual adolescent.

In establishing indications for individual psychotherapy with an adolescent, one should first take stock of the individual adolescent's ability to cooperate with a therapist. Much useless individual treatment might be done when this precondition is not met. However, the symptoms and complaints that the adolescent may present can be of great variety and number. Given the teenager's ability to make an investment in the therapeutic relationship, possibly even only a small one, symptoms of feeling disorder, thought disorder, and also, to an extent, action disorder are amenable to psychotherapy. Technical difficulties are considerable. The question of "How does the patient get to the doctor's office or to the clinic?" will always have to be settled. How much should the parents know of what is being said in the therapeutic hours? What are the limits to which the therapist can go in hiding potentially dangerous information from the responsible relatives? Questions such as these will usually have to be answered and by and large will have to be answered in each case differently. The younger the adolescent, the more necessary the communication of one sort or another with the family will have to be. One frequent issue that therapists of adolescents have to deal with is the "no show," that is, the patient who does not come for appointments, and

once again, procedures will have to be worked out in a flexible manner rather than according to a rule set once and for all.

Group treatment with adolescents has a natural advantage inasmuch as the forces of identification with a potential peer group can be made to work. The emotional impact of observing one's own experience expressed by someone else in the same situation is quite usually a powerful one and one that facilitates personal involvement and emotional interchanges. It is possible to organize adolescents either in groups containing only one sex or in mixed groups. Younger adolescents between ages twelve and fifteen usually are seen in groups containing only one sex, with a leader of the same sex. Commensurate with one's developmental stage, the opportunity to come to terms with members of one's own sex, forming identifications and ego ideals, is the most urgent task. The therapist will proceed somewhat in the manner of a child therapist, and activities of one sort or another are usually required. Young adolescents in particular need movement for tension release, and they will mediate their difficulties through action more readily than through words. Moreover, activity groups will need to be more structured than the typical group psychotherapy of the adult, and the leader acts more as a role model than as an interpreter of feelings. Groups of delinquents, even if they should be older than fifteen, by and large fall into the same pattern of the leader-centered and well-structured group containing members of only one sex. This is once again in consonance with the developmental level, which is

often preadolescent or early adolescent for the delinquent. Jacobs and I have described the need for structuring and limit setting in such groups. Characteristically, regressive stances occur in an adolescent group. Flight, fight, and resorting to eating are common and need to be built into the group's climate. One may socialize fighting tendencies by bringing in competitive games and the tendency to resort to eating by having some organized means for providing refreshments during the session. The management of the group per se can become a task for the participants, and in recognizing their feelings toward one another and ways of dealing with one another, they may learn the elements of democratic procedure.

Groups of adolescents past the age of fifteen can often be mixed and may follow the pattern of becoming a group of friends. While it becomes possible here for members to thwart the purpose of the group, for instance, by pairing off and taking oneself in this way out of the group, by and large the needs of even these older adolescents to have group support will permit these groups to be successful. A measure of structure is necessary even in groups of older adolescents, and adult leadership will still need to be rather more active. However, at this stage it becomes possible to institute groups on the discussion model that are not very different from adult psychotherapy groups. Such groups may be called "rap sessions," "club meetings," or by any other name; quite often the impact on the adolescents is strong and, if properly conducted, very therapeutic.

Indications for group treatment of adolescents are usually wider than those for individual treatment. Disorder manifested as action is apt to be the most common cause for referral to group treatment. A group by its nature provides a relatively protected social system in which the adolescent can test out his social skills or, vice versa, become aware of his social shortcomings. The problem one faces in the treatment of a disturbed youngster usually is not the one of deciding on the benefit of belonging to a group but on finding the right type of group and the proper setting in which he can work therapeutically. Many adolescent groups are sponsored by recreational organizations where the activity model by and large prevails. Mental health centers have been somewhat slow in providing appropriate settings for adolescents, which would mean several kinds of groups—younger adolescents, older adolescents, activity-related, or more discussion-like groups. Finally, closed institutions, such as hospitals or penal institutions, may utilize group approaches, usually of the variety containing only one sex, as a means toward better social adjustment in delinquent or very disturbed youngsters. In the main, groups are indicated when the goal is a change in social behavior. The technical difficulties of such groups usually have more to do with the operating assumptions of the particular social setting, such as hospital, clinic, or recreational organization, that is, where the group takes place, than with the individual adolescents themselves. It is important for the therapist of adolescent groups to have a clear view of where he and his group

fit in with the sponsoring organization or what type of interaction he may bring into the adolescent group. Trying to fit oneself into a larger social system is in a sense the task of the adolescent, and a relatively protected therapeutic group provides one of the best introductions to this end.

Family treatment may follow a rigorous model, where the total family and only the total family is seen by the therapist, or, better, may follow a more flexible arrangement where the treatment may be family oriented and yet an opportunity may be provided for individual sessions and sessions with the parents alone, as well as total family sessions. It is this less rigid, family-oriented model that seems to yield in most instances fairly precise information on the nature of the adolescent problem and often permits relatively short treatment focused on the salient issue and concentrated on the place or people who are most capable of solving the problem. In other words, where rapid problem-solving is needed, one may not only try to identify a suitable focus for intervention but also try to find the important people who are most likely to respond to helpful intervention. It may be noted that a family of any size called together to deal with a crisis around an adolescent might be considered a group or, perhaps more specifically, a problem-solving group. The family perceives itself as having been called together to deal with an issue, the issue being the problem around the adolescent. Ordinarily, such a family would not come together for problem-solving purposes, and in many cases, the experience of sitting together and

trying to resolve the difficulty is a new experience itself. A family that is, as it were, forced together for the specific purpose of solving a crisis will usually do so in fairly short order, if only to relieve discomfort. The more important therapeutic issue is to arrive at a rational solution rather than a makeshift solution based perhaps on attaching blame or guilt to someone either inside or outside the family. Quite likely the identified patient will serve as scapegoat in a poor crisis solution, and his ejection from the family might be decided upon. If outsiders are to be blamed, quite often the school authorities, police, or peers of the adolescent will do, and occasionally the therapist receives the blame. One may find in family problem-solving sessions that crises will calm down rather quickly to a point where most family members are no longer anxious or helpless. However, crises, even if they are solved quickly, are not always solved adequately with family sessions alone. Long-term family therapy has been practiced and described and has resulted in profound attitude changes in parents as well as in the younger members of their families. It may be indicated in cases of psychosis or serious behavior disorder.

In summary, it may be said that treatment of adolescents by whichever method is a challenging and oftentimes difficult task. Unfortunately, experiences with medication are rarely positive, so that the psychological and social approaches remain the most important tools in the treatment of the adolescent. It is important to apply all approaches—individual, group, and

family—in a flexible manner in order to arrive at the best understanding and the most expedient handling of adolescent problems.

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