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PSYCHIATRIC DISORDERS OF ADOLESCENCE

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Adolescence is a period dominated by the concept of development and its deviations and directly related to earlier childhood in the intense metamorphosis of behavioral manifestations. Although a number of relatively static psychiatric disorders emerge during the adult period of life, adolescence is the time during which physical and psychological elements surge ahead together to result in many changing combinations of normal and healthy characterological results, as well as a variety of psychological distortions.

As the normal sequence of development must be known accurately in order for the clinician to comprehend and be useful to adolescents, this chapter will refer often to developmental issues. However, it will concentrate, primarily, on deviations from usual growth patterns that result in behavioral distortions and psychiatric disorders that are characteristic of the age period.

Several factors relating to development must be kept in mind constantly in studying and treating adolescents. Most adolescent psychological problems are the direct results of exaggerations, fixations, or inhibitions in expected growth sequences. These sequences must be dissected separately and somewhat artificially in order to be understood effectively. Three different sets of coordinates must be kept in mind in order to understand the problems

of adolescence: (1) developmental and chronological age and their related deviations; (2) the historically based social, psychological, and cultural advances and problems of adolescence; (3) the psychiatric disorders that characteristically arise at this time. We will define adolescence as a tripartite sequence, beginning at approximately twelve years of age and concluding at approximately twenty-one years of age, or when the growing person becomes settled on a career and achieves relative autonomy and individuation and independence from his family. The following discussion of the relation of developmental-chronological age to various disorders is summarized in the following list.

1. Early adolescence (12-14 years)

    a. Continuation of childhood problems (enuresis, inhibitions)

    b. Learning problems (defects in ability to abstract; problems in larger social network of junior high school)

    c. Obesity

    d. Acne

    e. Menstrual irregularities

    f. Anorexia nervosa

2. Middle adolescence (15-17 years)

a. Rebellion and turmoil

b. Running away

c. Learning problems (inundation with primary-process thought)

d. Sexual acting out

e. Fighting

3. Late adolescence (18-21+ years)

a. Schizophrenia

b. Acute confusional states

c. Career choice uncertainties

d. Suicide

e. Depression

Age-Linked Concerns

In early adolescence, approximately ages twelve through fourteen, psychological and structural changes in the body are of major concern. The adolescent becomes preoccupied with the effective development of primary and secondary sexual characteristics. Important milestones for the young adolescent are increase in body hair, genital, breast, and body conformity

changes, and the onset of menstruation and seminal emission. Linear growth and changes in general body status are major sources of concern and anxiety. The myriad deviations in these developmental characteristics may result in a variety of symptomatic problems involved with growth. As the young adolescent needs to begin making a transition to a larger social network, it is exceedingly important that variations in body development be understood and dealt with in a healthy manner so that they do not become niduses for significant psychopathological problems.

In middle adolescence, approximately ages fifteen through seventeen, much somatic growth has been accomplished, and the adolescent, both because of greater ability and changes in his social situation, is ejected into a much larger society. During this time, the teenager must work out his relationship to his parents in a new way, develop external identification figures, and begin an exploration of questions of values and career.

Not unexpectedly, it is during this period that the most characteristic adolescent turmoil occurs. This turmoil is reflected in generally rebellious attitudes toward parents, an exceedingly self-centered quality, and turning away from traditional career and learning experiences. Because of the central importance of sexuality to the adolescent, many of his rebellious impulses are reflected in sexual disturbances.

During later adolescence, approximately ages eighteen through twenty-one or more, the primary challenges are those of developing a sense of identity and a relationship to the larger society. During this period the adolescent may well founder on issues of career choice, sexual autonomy and expression, and the beginnings of true intimacy and shared cooperative love and work responsibility. Though defects in these developmental challenges often are not recognized until some years later in marital difficulties and serious defects in child-rearing practices, their seeds are found during this age period. Thus, adolescence constitutes a long period of development whose deviations and problems reach far into the adult years. It is valuable for the clinician to identify the adolescent bases of adult psychiatric disorders, for it is in understanding and reworking adolescent themes that therapy is accomplished even with people of considerably mature years.

While struggling with physical and social pressures, the adolescent must deal with a number of internal challenges and decisions. Biologically, he must come to terms with his own body and learn to regulate individually the great rhythmic patterns of food, sleep, sexuality, motor activity, and the need for sensation. Together with physical growth deviations, such psychosomatic problems as acne, obesity or unusual thinness, sleep disturbances, menstrual irregularities, and preoccupation with sexuality in the form of masturbation, inhibition of sexuality, or frantic heterosexual activity, as well as anger, aggression, and fighting, are seen.

Parental relationships must change. The adolescent must work through a healthy independence from parental domination, be able to accept his parents as they are, and work toward obtaining a non-incestuous love object.

Socially, the adolescent must work toward the development of a system of values and responsibilities, a tolerance for frustration, and the ability to achieve reasonable impulse control and direct himself toward an adult economic status as typified in a career.

Finally, the adolescent must work toward developing a sense of identity, a sense of "persistent sameness within oneself and a persistent sharing of some kind of essential character with others."

On a characterological level, the period of healthy adolescent development results in the solidification of a group of processes crucially important for understanding the technical problems and psychotherapeutic strategies of the period. Because of growth and hormonal changes, the adolescent is stronger, larger, more sexually mature, and capable of infinitely more effective, as well as destructive, cognitive, and aggressive acts than previously. All these factors, primarily expressed as a potential for competence, action, and overt motor skill, must be channeled, modified, and transformed in order for adolescence to be traversed in a psychologically effective fashion.

Because of this grouping of discontinuous forces, adolescence can result in most unusual problems. The intensity of impulses must be transformed and controlled in the direction of resistance to regression, while there must be an allowance for flexibility for the adolescent to experiment with and express impulses appropriately. The adolescent must have the good fortune to be offered appropriate role models in order that he may learn how to function effectively even during periods of great stress. He must direct himself toward a career, the crystallization of values, and a way of expressing sexuality that will be psychologically satisfying to himself and still acceptable by his general society.

Because of the large number of often competing pressures, adolescence is a period in which many lapses from psychological normality occur. Unless the diagnostician and psychotherapist are able to recognize grossly the difference between inevitable discontinuities in psychological integration, such as self-centeredness, moodiness, and rapid changes in identifications, as opposed to the deeply ingrained character problems centering around severe narcissistic regression or totally unresolved oedipal issues, they will make many errors in planning and carrying out treatment.

Specific Psychiatric Disorders

Adolescent disorders can be divided empirically into two groups. The

first group comprises those problems linked to the developmental stages described above. The second group consists of deeply ingrained intrapsychic difficulties and those of unknown etiology, such as schizophrenia, psychotic depressions, and some suicidal states. As we describe syndromes in some detail, it is important to keep in mind the various dimensions and coordinates described above, for they comprise a kind of interwoven foundation, each set of factors depending on the others for the understanding of the final development of categories of psychiatric disorders in adolescence (see outline which follows).

1.Disorders of regulation

a. Sleep

b. Eating

c. Work

d. Sexuality

e. Aggression

f. Defenses (asceticism, intellectualization, intense concentration on athletics or hobbies)

2.Transient behavior, mood, and thought disorders

a. Short periods of regression

b. Moodiness, anger, intransigence

c. Distorted sexuality

d. Egocentricity, grandiosity

e. Exaggerated ideological commitments

3.Characterological problems

a. Rebelliousness

b. Acting out and frank delinquency

c. Sexuality, homosexuality, promiscuity

d. Identity diffusion

e. Depressive, obsessive-compulsive, hysterical character

4.Neuroses

a. Hysterical and conversion reactions

b. Obsessive-compulsive reactions

c. Anxiety reactions

d. Depressive reactions

e. Phobic reactions

5.Schizophrenias

a. Borderline (schizoid) personality

b. Severe obsessional and panphobic reactions

c. Simple and hebephrenic reactions

d. Acute catatonic reactions

6.Psychotic disorders of affect

a. Psychotic depression and suicidal pressure

b. Manic-depressive reactions

7.Psychosomatic (psychophysiological) disorders

a. “Growing pains”

b. Orthopedic handicaps

c. Skin disorders

d. Rheumatoid arthritis

e. Diabetes

f. Peptic ulcer and ulcerative colitis

g. Anorexia nervosa

8.Historically and culturally linked symptom expressions

a. Drug use and abuse

b. Innovation and rebellion in life style

c. The communitarian movement and earlier separation from the nuclear family

Disorders of Regulation of Drives, Needs, and Motivation

It is tempting for the clinician to lump all adolescent problems together and see them as examples of the various configurations of rebellion against parents and society, the anxiety and guilt that constitute signals of unacceptable impulse, and the defenses that are erected to protect against the experience of anxiety. Such a classification, by its very global inclusiveness, ignores many facets of syndromes and disorders, even transient and historically based ones, that can be valuable in diagnosis, the prescription for treatment, and the treatment process itself. A description of specific disorders follows, but one must recognize the danger of being overly precise in a developmental period that is primarily characterized by alteration, movement, and transformation.

Sleep

As a means of evading reality, regressing, and returning to infantile

means of gaining satisfaction, sleep or spending a great deal of time in bed are important psychopathological problems. Unusual sleep patterns may also be a signal of the presence of overwhelming regressive fantasy activity and a preoccupation with masturbation. The inability to be roused from bed in the morning or staying up extremely late at night are examples both of attempts to stretch experience and of problems in internal regulation. Serious insomnia is a relatively new development of adolescence and in some ways mirrors the pavor nocturnus and sleep disturbances of very early childhood.

Eating

Difficulties in this area are represented by fasting, the development of unusual and faddish diets, or frank obesity. The ascetic wish to deny all impulse gratification out of guilt, identification with great leaders, or a sense of grandiosity may be seen beneath many of the dietary quirks of adolescent patients. Such denial of eating may also betray severe depression. Obesity, a prominent adolescent symptom, usually represents a problem in perceptual inaccuracy, an aspect of regression or of difficulty in external control between the adolescent and his environment. Like the other symptoms discussed here, it represents a regression to an infantile form of gaining gratification, a way that circumvents anxiety, and the need to deal persistently with contemporary reality.

Work

One sees intense spurts of concentrated activity in school work, recreation, and creative activity. It is during adolescence that the astonishing poetic spurts are seen, often as poorly disguised derivatives of drive activity. Excessive studying and an anxiety-ridden attention to learning, to the exclusion of other interests, are frequently seen in adolescence. A kind of work addiction may become a defense that hides the serious pain experienced by the adolescent. Conversely, many adolescents have great difficulty in marshaling their energies and spend endless hours in daydreaming, dawdling, and wandering. Together with work inhibition, one usually sees a regressive, compulsive masturbatory activity in the adolescent and a concomitant withdrawal from social activity. In such cases, the major issue is not that of sexuality but rather a pulling back from pressing personal problems.

Sexuality and Aggression

Orgies of denial, or direct expression of these impulses, are seen in episodic fashion during adolescence. The entire range of homosexual, heterosexual, and group sexual and aggressive activities are played out. Though sadistic or masochistic fantasies and acts, as well as directly sexual ones, are concomitants of most of the problems of regulation, they often are seen nakedly as expressions of direct impulse gratification and total difficulty

in deferring or transforming impulses.

Inhibiting Defenses

Asceticism, over-intellectualization, and intense concentration on work or hobbies or on athletics and body development are frequently seen. There is a tendency for the disturbed adolescent to concentrate on a single defense to the exclusion of other mechanisms that might be more adaptive and to become a kind of caricature of a whole personality. He often lacks flexibility, reality-testing capacity, or perceptiveness in social situations. Though the healthy adult may choose from a variety of adaptation mechanisms to relate himself to society, the intensely egocentric adolescent finds himself at best playing a succession of often jarring, incongruous, incomplete, and painful roles.

All the disorders of regulation represent either a legacy of inadequately internalized impulse control mechanisms from earlier childhood, unsolved characterological problems, or frank regression. A further complicating problem for the adolescent is his built-in need for sensation, the wish to stay up all night, to feel intense pain or cold, to extend his body as far as possible either in gorging or denying food. Joseph Conrad described this phenomenon magnificently in *Youth*:

> I remember my youth and the feeling that will never come back any more

> —the feeling that I could last forever, outlast the sea, the earth, and all men; the deceitful feeling that lures us on to joys, to perils, to love, to vain effort—to death; the triumphant conviction of strength, the heat of life in the handful of dust, the glow in the heart that with every year grows dim, grows cold, grows small, and expires, too soon, too soon,—before life itself.

Thus, although it is urgent that he begin effective self-regulation of basic needs and drives, the adolescent is caught in a period of the most intense internal pressure to express these very primitive kinds of desires, sensations, and wishes. If he is not helped in the process of developing self-regulation, he will forever remain an impulse-ridden character.

Transient Disorders of Mood, Thought and Behavior

Short periods of regressive messiness and obstinacy, moodiness, anger, acting out, withdrawal, arrogance, or grandiosity are the rule during adolescence. This large range of disturbing affects and behaviors is by far the most bothersome aspect of adolescence to therapists and families. In part, such disorders represent a normal phase of development and must be tolerated. In part, they express the need of the adolescent to individuate and his groping attempts to do so. Such disorders also may be the result of a desperate kind of role playing or an identification with an intensely cathected friend or leader. Finally, they may be early symptoms of serious disturbances in thinking or personality disorganization. However, it is their very transience, changeableness, and variety of expression that label them as

short-term problems, often of no ominous pathological significance.

Such disorders illustrate symbolically the discontinuity of development between growth and stability, rebellion and dependence, impulse and defense, and, at bottom, the struggle between love and hate. In this discontinuity and struggle, the adolescent, both consciously and unconsciously, reaches blindly for ways of gaining some stability and feeling of psychological comfort. It is in that reaching, which so often misses the mark, that we see the quick formation and disappearance of the symptoms described above.

Characterological Problems

Characterological disorders are the ultimate crystallizations of difficulties described under the category of transient disorders. If developmental stages are not traversed adequately or unfortunate identification figures become available during adolescence, serious, permanent character deformations may result. Inhibition in social activities and inability to separate from parents sometimes erupt, paradoxically, into frank rebellion by the adolescent. Similar basic problems may be expressed as a continuing dependence upon parents far into adulthood for all kinds of social and intellectual pursuits. Excesses of acting out expressed through fighting, destruction of property, and other antisocial activities may

crystallize into an antisocial character structure and, through harmful involvement with a punitive society, into a delinquent career. Sexual experimentation under unfortunate guidance may result in short periods of homosexual activity or a true homosexual character, promiscuity, unwanted pregnancy, or a continuing sexual search that is never satisfied. If adolescent problems are not resolved by the period of late adolescence, one often sees clinical examples of the continuing uncertainty, groping, self-deception, and turning away from life decisions so well discussed by Peter Bios in "Prolonged Adolescence." Extreme egocentricity and disregard for the needs of others may become a part of character structure and make the work of treatment difficult. Intransigent views held for defensive purposes may alienate adolescents from their peers and from life experiences. Inhibited characters, shading into schizoid adaptations, crystallize during this period of life.

The hallmark of all the characterological problems described here is a relative lack of anxiety on the part of the adolescent about his behaviors and symptoms, together with extremely limited reality-testing ability, poor judgment, and little concern for future results of his acts. He is driven to continue his compulsively destructive demands on himself, his parents, and society and cannot easily learn to modify his voracious wishes and fantasies.

The basis of transformation of transient disorders into characterological ones often is the unconscious reinforcement of such symptoms by parents or

society. Adolescents have great difficulty in finding reliable people with whom to share their perplexity and from whom, through sharing, to gain some insight into the meaning of their distorted behavior. In addition, if the society offers a great deal of secondary gain for disturbed behavior in the form of support of unusual behavior or increasing tolerance for alloplastic solutions to conflicts, the adolescent is faced with a great struggle to internalize his problems and then, necessarily, live with considerable anxiety and guilt. The easier and more usual way is for symptoms to become ingrained into character structure.

Neuroses

Though neurotic reactions may manifest themselves from early childhood through adult life, and all adult neuroses have at their core a childhood neurosis, it is rare for a true, well-structured neurotic reaction to occur until relatively late in the teenage years. The very interplay of surging motor development and activity, increasing societal involvement of the adolescent, and his need to turn from parents and other adult figures works against the internalization of conflict into anxiety, hierarchically organized defenses, and the ability to develop a sustained, therapeutically useful transference relationship.

Younger adolescents often express conflicts through neurotic

mechanisms, particularly phobic and conversion symptoms, but the symptoms are short-lived, changeable, and unintegrated into character and defense structure. Such symptoms, like the transient disorders described above, are almost the rule rather than the exception in adolescence. They represent, for the most part, examples of partially integrated sexual thoughts and fears that are rampant during this age span. Highly dramatic symptoms, such as fainting, seizures, blindness, and paralyses, still occur with great frequency in young adolescents and are often mistaken for neurological disorders.

Similarly, adolescents may experience overwhelming anxiety or panic reactions in response to loss, sexual fears, or guilt feelings. Such reactions present the clinician a difficult problem in differential diagnosis, for they may border on schizophrenic disorganization. Adolescents experience an intensity and anguish in their anxiety reactions that leaves little room for reality testing and investigation of the bases of an act or concern they have experienced. In all these symptom reactions, separated from those of character problems by the presence of extraordinarily intense anxiety, a striking peculiarity is the unintegrated, almost catastrophic quality they project to the clinician. Like a summer lightning storm, their pathological significance can only be assessed by observing them over time. Fortunately, many such reactions are completed in a few days, and the adolescent is able to return to his previous level of healthy functioning, often with little recollection or concern about the depth

of danger or pain he had experienced.

Many adolescent depressive reactions and suicidal attempts are examples of the results of overwhelming anxiety that cannot be endured. They develop in response to what seem to be small stresses, are almost totally unamenable to immediate therapeutic correction, and are totally alien to the adolescent's usual way of functioning. They tax the therapeutic ingenuity and strength of the clinician.

Only in middle and later adolescence do we see a crystallization of obsessive compulsive neuroses with their attendant rituals, highly organized ambivalent thought patterns, and barely controlled anxiety. Though such reactions have their roots deep in early childhood and, retrospectively, can be seen as developing earlier in life, it is only when they begin to cripple the patient that they are clinically visible. Many compulsive adolescents get a great deal of secondary gain from their compulsive activity because of a number of factors. They often are highly productive and effective in prescribed, organized school work. Their hobbies and recreational activities, involving intricate, demanding skills, as expressed in stamp collecting or model making, are highly prized by the adult society. It is only when the adolescent must make his own social and career decisions and become more independent that his compulsive way of life is threatened by anxiety and disorganization.

Adolescents with hysterical character structures combining a great deal of histrionic quality, a seemingly infectious quality of relationship to others, a wish to please at all costs, and a brightness of affect, traverse the early years of adolescence quite successfully and without anxiety because they do please their teachers, parents, and other adult figures. When an hysterical mode of adaptation is no longer effective in life, a great deal of anxiety, depression, acting out, and disorganization may supervene. This occurs when the support and reflected appreciation of his elders are no longer sufficient, and the adolescent must begin to function independently and gain a sense of his own autonomy and significance from within himself rather than from others. Such adolescents founder when the supports of the adult world are taken away and they are exposed to the competition, sexual realities, and societal demands of an increasingly independent existence. Their symptoms may take the form of histrionic suicide attempts, hysterical psychosis, and caricatures of family roles. When a family has depended on a great deal of repression, superego control, and overly rigid unwritten rules in order to control its children, the confrontation with the larger world is both painful and disorganizing for the adolescent.

Schizophrenia

Schizophrenia is the characteristic major psychiatric disorder of adolescence. It increases in incidence dramatically from the age of fifteen and

reaches a peak during late adolescence and early adulthood, leveling off toward the end of the third decade. The borderline, or schizoid, personality, which had been protected by the dependent world of childhood, finds life made more difficult by the greater freedom and demand of adolescent social, educational, and sexual experience. Such schizoid, or borderline, adolescents find their adjustment made more precarious during this time, become anxious, and often regress into overt schizophrenic reactions. At times these reactions are slow in development, and at others they may be catastrophically acute in onset.

Though simple and hebephrenic schizophrenic reactions become visible during early and middle adolescence, the characteristic reaction is that of an acute catatonic episode. Catatonic reactions are by far the most frequent schizophrenic disorganizations seen during this period and, side by side with the acute conversion reactions, constitute the bulk of emergency psychiatric difficulties during adolescence. Catatonic episodes can develop in a matter of hours and express themselves in great motor inhibition or over-activity, highly overactive and paranoid thought and speech patterns, totally inhibiting panic or desperate grandiosity. Fears centering around homosexuality, sexual inadequacy, or sexual guilt, together with a remarkable concern with philosophic and religious issues of a grandiose nature, almost universally accompany such reactions. Characteristically, catatonic patients have the ambivalent wish to change themselves or feel that they have been

transformed into another sex. They wish to change the world immediately, to purify it and bring news to everyone else that has been given them in a revelation. Quite often such wishes are put into action in totally inappropriate and aggressive ways that are disturbing to the people in the patients' environments.

Though not clearly schizophrenic reactions, we see a number of severely obsessional and panphobic syndromes in adolescence. These patients suffer from all manner of doubts, fears, inhibitions, distressing thoughts, and severe relationship problems. It is the very pervasiveness, changing quality, and life-inhibiting nature of these symptoms that characterize them.

Fortunately, most schizophrenic reactions in adolescence, if well treated, result in successful compensations, entire restitution, or cure. The clinician may be surprised to observe a severe catatonic reaction clear up within a matter of several days. However, such resolutions are dependent on prompt attention and accurate knowledge of a patient's preoccupations.

Psychotic Depressions

True psychotic depressions and manic episodes begin to express themselves overtly toward late adolescence. It is rare to see a full-blown manic episode during middle adolescence, and totally hopeless, self-

castigating, delusionally impoverished depressive syndromes accompanied by weight loss, lack of pleasure in life, and total inhibition of external activity occur infrequently during the early and middle adolescent periods. However, syndromes of extreme withdrawal and psychotic suicidal pressure may, on occasion, be seen during middle adolescence.

Finally, it is most rare to see a cyclical manic-depressive syndrome until late adolescence. It is of passing interest that mania appears to be the last major psychiatric disorder to express itself in the human life span, except for the systematized paranoid schizophrenia disorders that may occur occasionally during later life.

Psychosomatic Disorders

Psychosomatic or psychophysiological disorders are particularly prevalent in adolescence because of the easily disrupted balance between surging bodily growth and psychological and social development occurring during this period. The teenager, pushed by hormonal changes and asked to take over regulation of himself in many new aspects of his life, may well express the conflicts engendered by such challenges either in the creation or exaggeration of somatic symptoms. Beginning with growing pains and motor awkwardness and extending into well-defined psychosomatic disorders, the adolescent is subject, because of the immense developmental pressure he is

undergoing, to a large variety of psycho-physiological stresses. Stresses may affect the functioning of the autonomic nervous system, motor activity, or sensory function. They may result in emotional conflict complicating the problems of acne, control of diabetes and other endocrine diseases, and in prolonging invalidism and regression following major orthopedic procedures. During adolescence, the most studied psychosomatic disorders, such as asthma, peptic ulcer, ulcerative colitis, certain types of headaches, and vascular problems, become significant medical and psychiatric entities.

Anorexia nervosa is, perhaps, the most characteristic adolescent psychosomatic disorder and will be described in some detail. It is a relatively rare, exceedingly intriguing, and serious disturbance of metabolic and psychological functioning that can be considered either a disorder of regulation or a psychosomatic disorder. Its onset is primarily in early adolescence, and it is far more frequent in girls than in boys. Symptoms include decreased ingestion of food, hyperactivity, and general bodily dysfunction. Patients with this disorder refuse food, maintain that they have eaten more than they do, and dispose of food or hide it so that it does not have to be ingested. They also induce vomiting in themselves and, being exceedingly concerned about food, eat foods with minimal caloric value. Additional symptoms are amenorrhea and the secondary symptoms of inanition including electrolyte imbalance and slowed metabolic functioning in general. It is because of the electrolyte imbalance and the results of starvation

that the disorder is so serious a medical emergency.

Because of the exceeding perfectionism, unusual and profound fears of oral impregnation, and depression, anorexia nervosa patients often consider suicide and make suicide attempts. Character structure in the disorder varies, primarily on the continuum of the severity of anorexia. Anorexia nervosa can be seen in hysterical characters, schizophrenic reactions, compulsive reactions, and frank depressions. However, the primary qualities are a refusal of food together with a denial that intake has been diminished, a frantic attempt at activity to decrease weight, and an intense preoccupation with food and food preparation. Regardless of general reality functioning, the patient with anorexia nervosa is truly delusional in regard to the fear of ingesting food.

The course of all these disorders, whether they are primarily psychological in origin or exaggerations of somatic disease, often is crucially determined by the conflicts and challenges experienced by the adolescent.

Historically and Culturally Linked Symptom Expressions

A new group of psychiatric disorders has descended on the clinician in the last decade. The symptoms, if they may be called clinical symptoms, present as antitheses to or caricatures of conventional values and life styles of adult society. They are more a reflection of world view than any variety of

conventional psychopathology. However, these problems do confront the psychiatrist because of medical-legal difficulties arising from them, appeals from frantic parents, and rare requests for help from adolescents themselves. Keniston summarized the issue as a "continuous disengagement by youth from adult institutions, confrontation with alternative moral viewpoints, and the discovery of corruption in the world."

The symptoms of these disorders include drug use and abuse, changes in living habits, and radical departures from previous modes of movement into the adult world. They confront the psychiatrist as a turning away from conventional expectations about thrift, a future orientation, ambition, usual career patterns, the importance of higher education, concern for amassing property, and living within the legal system. Instead of settling down, the late adolescent wants to be nomadic and moving. Instead of a belief in doing and accomplishing, his thing is "being" and not thinking about consequences. Language and conceptual thought have given way to quietude, contemplation, and meditation. Instead of an interest in developing greater competence in rational technological procedures, he has turned to mystic, magical, irrational routes of seeking his fate. Adult standards of dress, life style, and decorum are jarred by the adolescent's hippie clothes, seemingly casual sexuality, politically revolutionary ideas, comfort with violence, concern with transcendental meditation, loud rock music, mystical need for being on the road, and belief in "good vibes" that make speech unimportant. The interest of

adolescents in protest trips, communes, rock festivals, coffee houses, free pads, and new communities within decaying parts of cities pose crucial problems in adolescent development practices, the nature of psychopathology, and clinical care.

Conclusion

The adolescent period is the first one in which symptoms and behavior can be grouped into well-defined psychiatric categories. Whereas the younger child is seen as a behavior problem, the adolescent, unable to keep his deviant behavior and thoughts under the protection of his family or to successfully continue to inflict such behavior on the society, has one of three roads to travel. He may crystallize non-adaptive behavior into characterological defects, such as acting out and ego restriction, in which case he is either punished or ignored by the society. He may also turn his developmental concerns and thoughts inward in the form of anxiety, expressed as various kinds of neurotic, psychosomatic, or motor symptoms. Finally, symptoms may be expressed through suicidal behavior, depression, and schizophrenic disorganization.

It is of the greatest importance that the clinician dissuade himself from the conventional view that adolescence is a disease in itself, or, at least, that it is only one disease. Too often, clinical writing about adolescence emphasizes

the problems of inhibited or rebellious adolescents, with concomitant suggestions for ways of developing therapeutic relationships and strategies that will foster expression of impulse or offer control. However, there is no single therapeutic alliance, drug treatment, way of speaking with an adolescent, or method of working with parents that can encompass the great number of now well-defined syndromes of the period. It is the responsibility of the clinician working with adolescents to establish a differential diagnosis of the adolescent and his parental and social network and then to offer a specific treatment plan for the disorder uncovered.

This chapter has emphasized the great importance of assessing symptoms over time, seeing them in the context of the developmental periods and challenges of the adolescent and of understanding the social setting in which the behavior occurs. Ensuing chapters will expand greatly on each of the categories described here. They will emphasize the importance of understanding the adolescent as a constantly developing organism who needs support and medical and educational intervention in order to allow him to continue to grow effectively and adaptively. Most of the disorders of adolescence can be seen as the result of unavailability of supportive help during developmental crises. When such help is available, transient disorders can be understood and lived through so that they do not develop into the more serious psychiatric difficulties described throughout the rest of this volume.

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