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become frustrated, alienated, and demoralized. Clinicians and parents seeking a window into an adolescent's viewpoint should be sensitive to their self-perceptions. A range of emotional maturity exists in teens of the same chronological age. Issues characteristic of adolescence are related to new evolving identities, the development of sexual activity, and developing plans to meet future life goals.

DIAGNOSIS Adolescents can be assessed with a focus on general progress in accomplishing the tasks of individuating and developing a sense of autonomy. For many adolescents in today's culture, school performance and peer relationship successes are the primary barometers of healthy functioning. Adolescents with normative intellectual function who are deteriorating academically, or teens who become isolated from peers, are typically experiencing significant psychological disturbance, which merits investigation. Questions to be asked regarding adolescents' stage-specific tasks are the following: What degree of separation from their parents have they achieved? What sort of identities are evolving? How do they perceive their past? Do they perceive themselves as responsible for their own development or only the passive recipients of their parents' influences? How do they perceive themselves with regard to the future, and how do they anticipate their future responsibilities for themselves and others? Can they think about the varying consequences of different ways of living? How do they express their sexual and affectionate interests? These tasks occupy the lives of all adolescents and normally are performed at different times. Adolescents' family and peer relationships must be evaluated. Do they perceive and accept both "good and bad" qualities in their parents? Do they feel comfortable with their peers and romantic partners as "separate persons" with needs that may not completely match their own? Respect and acceptance of an adolescent's subcultural and ethnic background are essential. INTERVIEWS Adolescent patients and their parents should be interviewed separately in a comprehensive psychiatric evaluation. Other family members also may be included, depending on their involvement in the teenager's life and difficulties. Clinicians often prefer to see the adolescent first, however; in order to develop a rapport with the adolescent and promote being an advocate for the adolescent and avoid the appearance of being the parents' agent. In psychotherapy with an older adolescent, the therapist and the parents usually have little contact after the initial part of the therapy, because ongoing contact inhibits the adolescent's desire to open up. Interview Techniques Adolescents may feel pressured by their parents to receive psychiatric treatment and may at first be defensive, or appear guarded. Clinicians must establish themselves as trustworthy and helpful adults to promote a therapeutic alliance. They should encourage adolescents to tell their own stories, without interrupting to check discrepancies; such a tactic may make the therapist seem correcting and disbelieving. Clinicians should ask patients for explanations and theories about what happened. Why did these behaviors or feelings occur? When did things change? What caused the identified problems to

begin when they did? Sessions with adolescents generally follow the adult model; the therapist sits across from the patient. In early adolescence, however, board games may help to stimulate conversation in an otherwise quiet, anxious patient. Language is crucial. Even when a teenager and a clinician come from the same socioeconomic group, their language use is seldom the same. Psychiatrists should use their own language, explain any specialized terms or concepts, and ask for an explanation of unfamiliar in-group jargon or slang. Many adolescents do not talk spontaneously about illicit substances and suicidal tendencies but do respond honestly to a therapist's questions. A therapist may need to ask specifically about each substance and the amount and frequency of its

use. The sexual histories and current sexual activities of adolescents are increasingly important pieces of information for adequate evaluation. The nature of adolescents' sexual behavior often is a vignette of their whole personality structures and ego development, but a long time may elapse in therapy before adolescents begin to talk about their sexual behavior. A 15-year-old adolescent male was referred for a psychiatric evaluation by his high school counselor when he disclosed that he was late to school each day because it took him 3 hours to get ready in the mornings. Even after he finally got to school, he often missed classes and was found in the bathroom. In speaking to his counselor, he further disclosed that he had developed a number of bedtime and morning rituals that took longer and longer to complete because if he did them incorrectly, he had to repeat them. They included checking the locks on the windows and doors, placing objects in the "right" places on his dresser, and repeating a prayer 16 times. He also revealed that when in the bathroom, he had to wash his hands a certain way and dry them "just so," or he feared something terrible would happen. He had not wanted his parents to know about his difficulties, and he often told them that he had headaches or stomachaches, which made him late. However, he did explain some of his difficulties to his parents during the course of his psychiatric evaluation. His evaluation revealed significant OCD and social phobia. Treatment was initiated, including use of fluoxetine, an SSRI; CBT; and problem-solving family therapy. Over the course of 6 months, his OCD responded well to the combination of medications and CBT, and he was relieved that his family learned ways of helping him both at home and in school. (Adapted from case material courtesy of Eugene V. Beresin, M.D. and Steven C. Schlozman, M.D.) A 14-year-old girl, one of the stars of her high school gymnastic team, began increasing her daily exercise and restricting her diet after her coach indicated that she should lose a few pounds. She became fixated on the size of her thighs and belly, and once she started losing weight, she found that she was not satisfied and wanted to lose a few more pounds. Over the next four months she lost so much weight that her coach and pediatrician no longer allowed her to participate in athletics. Although she was

heartbroken about being restricted from gymnastics and planned to eat enough to be able to participate again with her team, she was unable to gain weight, and continued to lose more. She became increasingly terrified of getting fat and secretly exercised any chance she could. She was a perfectionist in academics as well as in gymnastics. She had started her menses 6 months previously, but after she lost a significant amount of weight, her menses stopped. She was seen by a therapist and she and her parents agreed to a meal plan that would result in weight gain, but her family was baffled because she continued to lose more weight. Finally, when it became clear that she was not able to be gain weight under the supervision of her family and her outpatient therapist, she was hospitalized, and the diagnosis of anorexia nervosa, was established. After a 30-day hospitalization with a modest weight gain, she was stepped down to a partial hospital program in which she was supervised for all of her meals, and went home at night. She remained in this program for 8 weeks, and was able to gain 1 to 2 pounds per week. As part of this program, her weight was monitored twice weekly, her vital signs were monitored, and she participated in family therapy, individual psychodynamic psychotherapy, and weekly meetings with a nutritionist. In her psychotherapy, over the course of the next year, she was able to understand that her anorexia had served to prevent her from separating from her parents and kept her close to home and isolated from her peers. She learned that she was slower to mature than many of her peers and felt unable to cope with the social pressures of being a high school student. Over time, she was able to maintain her weight and begin to socialize with friends whom she hadn't seen for many months. When she was able to maintain an optimal weight she was thrilled to be able to resume her

athletics, and she began to develop closer friendships. (Adapted from case material courtesy of Eugene V. Beresin, M.D., and Steven C. Schlozman, M.D.) TREATMENT Psychiatric treatment of an adolescent can occur in numerous venues and modalities. Treatment can take place in individual or group settings, and can include interventions that are pharmacological (when indicated), psychosocial, and from an environmental perspective. The best choices for treatment must take into account the characteristics of the individual adolescent and the family or social milieu. Adolescents' striving for autonomy may complicate problems of compliance with therapy and may result in the need for stabilization in inpatient settings, whereas this level of care might not be necessary at a different stage of life. The following discussion is less a set of guidelines than a brief summary of what each treatment modality can or should offer. Individual Psychotherapy Individual psychosocial modalities with an evidence base for efficacy with adolescents include cognitive-behavioral treatments for diagnoses of anxiety disorders, mood disorders, and OCD. Interpersonal therapy is a technique that has been used to treat

mood disorders in adolescents. Few adolescent patients are trusting or open without considerable time and testing of therapists, and it is helpful to anticipate the testing period by letting patients know that it is expected and is natural and healthy. Pointing out the likelihood of therapeutic problems—for instance, impatience and disappointment with the psychiatrist, with the therapy, with the time required, and with the often intangible results—may help keep problems under control. Therapeutic goals should be stated in terms that adolescents understand and value. Although they may not see the point in exercising self-control, enduring dysphoric emotions, or forgoing impulsive gratification, they may value feeling more confident than in the past and gaining more control over their lives and the events that affect them. Typical adolescent patients need a relationship with a therapist they can perceive as a real person, whom they feel respected by and they can trust. The therapist may seem like another parent in some respects, since adolescents still need appropriate guidance, especially in situations of high-risk behaviors. Thus, a professional who is impersonal and anonymous is a less useful model than one who can accept and respond rationally to an angry challenge or confrontation without fear or false conciliation—one that can impose limits and controls when adolescents cannot, can admit mistakes and ignorance, and can openly express the gamut of human emotions. Combined Pharmacotherapy and Psychotherapy Current evidence suggests that for many psychiatric disorders, optimal treatment includes a combination of psychosocial and psychopharmacological interventions. Randomized clinical trials have provided evidence of the superiority of CBT in combination with SSRIs in the treatment of mood disorders, OCD, and anxiety disorders, to name a few. ADHD is often comorbid with additional disorders, thus, although the Multimodal Treatment Study of Children with ADHD (MTA) found that psychosocial interventions did not add to the efficacy of stimulant treatments for the core symptoms of ADHD, it is important to consider that other concurrent disorders that affect overall functioning often require psychosocial treatments. Advances in drug development have widened the choice of medications to treat mood disorders (e.g., SSRIs) and schizophrenia (e.g., SGAs, including risperidone [Risperdal], olanzapine [Zyprexa], and clozapine [Clozaril]). Although these medications have been used to treat psychiatric disorders in adolescents, more research is required to determine their efficacy and safety profiles for treatment of adolescent psychopathology. A 17-year-old girl complained of recurrent episodes of rapid heartbeat, sweating, trembling, and a fear that she was "going crazy." Her first episode had occurred in her high school cafeteria during a "college night" event, when multiple college representatives were displaying their college's information packets. After running out of the cafeteria, she stood outside of her

school and the episode gradually dissipated

over a period of about 15 minutes. Although she was a little nervous about going back to school the next day, she did not have another episode. She had almost forgotten about the episode, when it happened again, and even more intensely, when she was shopping at the mall and talking about college applications with her friends. After this episode, she became fearful of going out alone to the shopping mall. She was at the beginning of her senior year in high school, considering her options for college and was planning to take her SAT for the last time. Her parents wanted her to maintain the family tradition and pressured her to try for the same college from which her mother graduated. She was not opposed to applying to her mother's alma mater, but was very angry and upset about her parents' pressure on her to make a commitment to this school as her first choice. She became irritable and tearful, and she was experiencing several panic attacks per week, all of which indicated that she needed to get some help. She was evaluated by a psychiatrist and started on Lexapro (escitalopram) to alleviate the panic disorder symptoms, as well as weekly psychotherapy. The psychotherapy focused on the patient's conflicts with her parents, highlighting her chronic concern that she could not meet parental expectations and fears of her independence. Medication appeared to reduce symptoms of tachycardia, tremulousness, decreased her irritability, and diminished her preoccupation with lack of competence. Psychotherapy and medication were both maintained for the next 8 months during her last year in high school. (Adapted from case material courtesy of Cynthia R. Pfeffer, M.D.) Group Psychotherapy In many ways, group psychotherapy is a natural setting for adolescents. Most teenagers are more comfortable with peers than with adults. A group diminishes the sense of unequal power between the adult therapist and the adolescent patient. Participation varies, depending on an adolescent's readiness. Not all interpretations and confrontations should come from the parent-figure therapist; group members often are adept at noticing symptomatic behavior in each other, and adolescents may find it easier to hear and consider critical or challenging comments from their peers. Group psychotherapy usually addresses interpersonal and current life issues. Some adolescents, however, are too fragile for group psychotherapy or have symptoms or social traits that are too likely to elicit peer group ridicule; they need individual therapy to attain sufficient ego strength to struggle with peer relationships. Conversely, other adolescents must resolve interpersonal issues in a group before they can tackle intrapsychic issues in the intensity of one-on-one therapy. Family Therapy Family therapy is the primary modality when adolescents' difficulties mainly reflect a dysfunctional family (e.g., teenagers with school refusal, runaways). The same may be true when developmental issues, such as adolescent sexuality and striving for autonomy,

trigger family conflicts or when family pathology is severe, as in cases of incest and child abuse. In these instances, adolescents usually need individual therapy as well, but family therapy is mandatory if an adolescent is to remain in the home or return to it. Serious character pathology, such as that underlying antisocial and borderline personality disorders, often develops from highly pathogenic early parenting. Family therapy is strongly indicated whenever possible for such disorders, but most authorities consider it adjunctive to intensive individual psychotherapy when individual psychopathology has become so internalized that it persists regardless of the current family status. Inpatient Treatment Residential treatment schools often are preferable for long-term therapy, but hospitals are more suitable for emergencies, although some adolescent inpatient hospital units also provide educational, recreational, and occupational facilities for long-term patients. Adolescents whose families are too disturbed or incompetent, who are dangerous to

themselves or others, who are out of control in ways that preclude further healthy development, or who are seriously disorganized require, at least temporarily, the external controls of a structured environment. Long-term inpatient therapy is the treatment of choice for severe disorders that are considered wholly or largely psychogenic in origin, such as major ego deficits that are caused by early massive deprivation and that respond poorly or not at all to medication. Severe borderline personality disorder, for example, regardless of the behavioral symptoms, requires a full-time corrective environment in which regression is possible and safe and in which ego development can take place. Psychotic disorders in adolescence often require hospitalization; however, psychotic adolescents often respond to appropriate medication well enough that therapy is feasible in an outpatient setting, except during exacerbations. Adolescent patients with schizophrenia who exhibit a longterm deteriorating course may require hospitalization periodically. Day Hospitals In day hospitals, which have become increasingly popular, adolescents spend the day in class, individual and group psychotherapy, and other programs, but they go home in the evenings. Day hospitals are less expensive than full hospitalization and usually are preferred by patients. CLINICAL PROBLEMS Atypical Puberty Pubertal changes that occur 2.5 years earlier or later than the average age are within the normal range. Body image is so important to adolescents, however, that extremes of the norm may be distressing to some, either because markedly early maturation subjects

them to social and sexual pressures for which they are unready or because late maturation makes them feel inferior and excludes them from some peer activities. Medical reassurance, even if based on examination and testing to rule out pathophysiology, may not suffice. An adolescent’s distress may show as sexual or delinquent acting out, withdrawal, or problems at school that are sufficiently serious to warrant therapeutic intervention. Therapy also may be prompted by similar disturbances in some adolescents who fail to achieve peer-valued stereotypes of physical development despite normal pubertal physiology. Substance-Related Disorders Some experimentation with psychoactive substances is almost ubiquitous among adolescents, especially if this category of behavior includes alcohol use. Most adolescents, however, do not become abusers, particularly of prescription drugs and illegal substances. Any regular substance abuse represents disturbance. Substance abuse sometimes is self-medication against depression or schizophrenic deterioration and sometimes it signals a character disorder in teenagers whose ego deficits render them unequal to the stresses of puberty and the tasks of adolescence. Some substances, including cocaine, have a physiologically reinforcing action that acts independent of preexisting psychopathology. When substance abuse covers an underlying illness or is a maladaptive response to current stresses or disturbed family dynamics, treatment of the underlying cause may diminish the substance use; in most cases of significant abuse, however, the drug-taking behavior typically requires intervention. Substance abuse treatments typically include a 12-step program with behavioral monitoring to accomplish sobriety as well as the ability to verbalize regarding the motivations for substance use. These philosophies are adapted to inpatient, intensive outpatient, and once-a-week outpatient treatment. Suicide Suicide is the third leading cause of death among adolescents. Many hospital admissions of adolescents result from suicidal ideation or behavior. Among adolescents who are not psychotic, the highest suicidal risks occur in those who have a history of parental suicide, who are unable to form stable attachments, who display impulsive behavior, and who abuse alcohol or other substances. Many adolescents who complete suicide have backgrounds that include long-standing family conflict and social problems since early childhood and the escalation of subjective distress under the pressure of a sudden

perceived conflict or loss. Early childhood loss of parents also can increase the risk of depression in adolescence. Adolescents who are susceptible to rapid and extreme mood swings and a history of impulsive behavior are at greater risk of responding to despair with impulsive suicide attempts. Abuse of alcohol and other substances are known added risks for suicidal behavior in adolescents with suicidal ideations. The developmentally predictable “omnipotent” attitudes of adolescents may cloud the immediate sense of permanence of death and result in impulsive self-destructive behavior in adolescents.

During a psychiatric evaluation of an adolescent with suicidal thoughts, plans and past attempts must be discussed directly when the concern arises and information is not volunteered. Recurring suicidal thoughts should be taken seriously, and a clinician must evaluate the imminent clinical danger requiring inpatient hospitalization versus an adolescent’s ability to engage in an agreement or contract mandating that the adolescent will seek help before engaging in self-destructive behavior. Adolescents typically are honest in their refusal of such agreements, and, in such cases, hospitalization is indicated. Hospitalization of a suicidal adolescent by a clinician is an act of serious, protective concern. REFERENCES Beresin EV, Schlozman SC. The treatment of adolescents. In: Sadock BJ, Sadock VA, Ruiz, P, eds. Kaplan & Sadock’s Comprehensive Textbook of Psychiatry. 9th ed. Vol. 2. Philadelphia: Lippincott Williams & Wilkins; 2009:3777. Biegel GM, Brown KW, Shapiro SL, Schubert CM. Mindfulness-based stress reduction for the treatment of adolescent psychiatric outpatients: A randomized clinical trial. J Consult Clin Psychol. 2009;5:855–866. Connor DF, McLaughlin TJ, Jeffers-Terry M, O’Brien WH, Stille CJ, Young LM, Antonelli RC. Targeted child psychiatric services: A new model of pediatric primary clinician–child psychiatry collaborative care. Clin Pediatr (Phila). 2006;45:423. Laugeson EA, Frankel F, Gantman A, Dillon AR, Mogil C. Evidence-based social skills training for adolescents with autism spectrum disorders: The UCLA PEERS Program. J Autism Dev Disord. 2012;42:1025–1036. Leckman JF. The risks and benefits of antidepressants to treat pediatric-onset depression and anxiety disorders: A developmental perspective. Psychother Psychosom. 2013;82(3):129–131. Lundh A, Forsman M, Serlachius E, Lichtenstein P, Landen M. Outcomes of child psychiatric treatment. Acta Psychiatr Scand. Jul 2013;128(1):34–44. Mathyssek CM, Olino TM, Hartman CA, Ormel J, Verhulst FC, Van Oort FV. Does the Revised Child Anxiety and Depression Scale (RCADS) measure anxiety symptoms consistently across adolescence? The TRAILS study. Int J Methods Psychiatric Res. Mar 2013;22(1):27–35. Mufson L, Dorta KP, Wickramaratne P, Nomura Y, Olfson M, Weissman MM. A randomized effectiveness trial of interpersonal psychotherapy for depressed adolescents. Arch Gen Psychiatry. 2004;61(6):577. Nevels RM, Dehon EE, Gontkovsky ST, Alexander K. Psychopharmacology of aggression in children and adolescents with primary neuropsychiatric disorders: A review of current and potentially promising treatment options. Exp Clin Psychopharmacol. 2010;8:184–201. Olfson M, Marcus SC, Shaffer D. Antidepressant drug therapy and suicide in severely depressed children and adolescents: A case-control study. Arch Gen Psychiatry. 2006;63:865. Richardson T, Stallard P, Velleman S. Computerised cognitive behavioural therapy for the prevention and treatment of depression and anxiety in children and adolescents: A systematic review. Clin Child Fam Psychol Rev. 2010;13:275–290. Romano E, Zoccolillo M, Paquette D. Histories of child maltreatment and psychiatric disorder in pregnant adolescents. J Am Acad Child Adolesc Psychiatry. 2006;45:329. Seidman LJ. Neuropsychological functioning in people with ADHD across the lifespan. Clin Psychol Rev. 2006;26:466. Stallard P, Sayal K, Phillips R, Taylor JA, Spears M, Araya R. Classroom based cognitive behavioral therapy in reducing symptoms of depression in high risk adolescents: pragmatic cluster randomised controlled trial. BMJ. 2012;345:e6058.

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