[ADOLESCENT PSYCHOLOGY]

[Information Packet]

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Definition and Introduction to Adolescent Psychology

Psychology Today[1]

Adolescence describes the teenage years between 13 and 19 and can be considered the transitional stage from childhood to adulthood. However, the physical and psychological changes that occur in adolescence can start earlier, during the preteen or "tween" years (ages 9 through 12). Adolescence can be a time of both disorientation and discovery. The transitional period can bring up issues of independence and self-identity; many adolescents and their peers face tough choices regarding schoolwork, sexuality, drugs, alcohol, and their social life. Peer groups, romantic interests and external appearance tend to naturally increase in importance for some time during a teen's journey toward adulthood.

Child and ***adolescent psychology*** involves looking at the issues, stages and various influences that a child experiences throughout their development into functioning adults. Child and adolescent psychology can be divided into two main areas - the actual process of psychological development that the child goes through when growing up and the analysis and treatment of the various problems that a child may face throughout their development.

Adolescence (12 - 18 years old) is a particularly hard time for children. They are experiencing all kinds of new changes in their bodies and in their feelings. As well, they often feel misunderstood as they are struggling to leave behind their *childhood* and become adults. Adolescence has commonly been characterized by issues such as rebellious behavior, lying, cheating, school performance problems, negative attitudes, disobedience and disrespect, sibling rivalry, drug and alcohol abuse, pressures from peers, depression, and issues of sexuality.

All Psychology Careers[2]

Developmental psychology professionals acknowledge that the consequences of bad health habits and extreme behaviors during adolescence have adverse effects on a person's entire life, but they also know that through research and education, they can help teens and their families avoid the most extreme consequences.

Understanding "adolescent-specific" issues helps direct public policy issues related to teens, creates appropriate educational programs and curricula, and helps health care professionals treat adolescents. As in other life stages, adolescent developmentalists focus on the physical, cognitive and emotional aspects of human growth for adolescent individuals ages 12 through 19.

"High Risk Youth" vs. "Youth in High Risk Situations"[3]

The phrase "high risk youth" is a good example to illustrate this point. The order in which the words appear in the term labels the youth as being "high risk" and therefore might convey to the listener that the youth is inadequate, incapable, or incompetent. However, as research and advocacy in the RHY field demonstrates, it is the circumstances of poverty, abuse, and unstable living arrangements experienced by the youth that are inadequate and create a "high risk" environment. This concept is more accurately conveyed to the listener by using the term "youth

in high risk situations", which removes the concept of inadequacy from the youth and prescribes it to the situation. Another term for this type of language selection is "people first language."

Specific Adolescent Developments

Physical Changes

Between the ages of 8 and 14 hormonal changes initiate puberty, which results in sexual maturation, and dramatic internal and external physical changes. Within a year of puberty, a growth spurt causes children to get taller, heavier and increase their muscle mass. All of these physical changes require an increase in calcium, iron and zinc, and a significant increase in calories. However, teens, like adults, often eat poorly - but the consequences for teens can be even more severe.

Bones, for example, grow the fastest during the teen years; by age 17, teens have acquired 90 percent of their adult bone mass. Yet, according to a 2006 report by the National Institutes of Health, fewer than one in ten girls, and only one in four boys, ages 9 to 13, are at or above their adequate intake of calcium. Unfortunately, calcium deficiencies can't be made up for later in life

Identity Crisis[4]

Those who emerge from the adolescent stage of personality development with a strong sense of identity are well equipped to face adulthood with confidence and certainty. This sort of unresolved crisis leaves individuals struggling to "find themselves." They may go on to seek a negative identity, which may involve crime or drugs or the inability to make defining choices about the future. "The basic strength that should develop during adolescence is fidelity, which emerges from a cohesive ego identity".

They often seem to have no idea who or what they are, where they belong or where they want to go. They may withdraw from normal life, not taking action or acting as they usually would at work, in their marriage or at school. They may even turn to negative activities, such as crime or drugs, as a way of dealing with identity crisis. To someone having an identity crisis, it is more acceptable to them to have a negative identity than none at all.

Erikson felt that peers have a strong impact on the development of ego identity during adolescence. He believed that association with negative groups such as cults or fanatics could actually "redistrict" the developing ego during this fragile time. The basic strength that Erikson found should develop during adolescence is fidelity, which only emerges from a cohesive ego identity. Fidelity is known to encompass sincerity, genuineness and a sense of duty in our relationships with other people.

Erikson described identity as "a subjective sense as well as an observable quality of personal sameness and continuity, paired with some belief in the sameness and continuity of some shared world image. As a quality of unself-conscious living, this can be gloriously obvious in a young person who has found himself as he has found his communality. In him we see emerge a unique unification of what is irreversibly given—that is, body type and temperament, giftedness and vulnerability, infantile models and acquired ideals—with the open choices provided in available

roles, occupational possibilities, values offered, mentors met, friendships made, and first sexual encounters."

4 Basic Needs Adolescents Struggle With:

1. to stand out—to develop an identity and pursue autonomy,
2. to fit in—to find comfortable affiliations and gain acceptance from peers,
3. to measure up—to develop competence and find ways to achieve, and
4. to take hold—to make commitments to particular goals, activities, and beliefs

Diagnosing

When diagnosing an Adolescent, there are many different elements to consider at 3 levels:

1. Physical
    a. Peripheral organ symptoms
    b. The immune system
    c. The autonomic nervous system
    d. The sensorimotor systems
2. Psychological
    a. Information processing (orientation, attention, memory, comprehension, judgment)
    b. Learning
    c. Communication
    d. Attitude of self and others
    e. Social competence
    f. Psychological symptoms
    g. Unconscious conflicts and ego defenses
3. Social
    a. Family structure and dynamics
    b. Social relations
    c. School and occupational adjustment

Hospitalization

When to consider hospitalization for Adolescents and young adults:[5]

Though the following signs may be the result of another health condition or other life circumstances, they can assist parents in determining if their child may need further help from a mental heal professional:

- Decline in school performance
- Persistent difficulty with peers
- Poor grades despite strong efforts
- Constant worry or anxiety

- Persistent somatic complaints
- School refusal or loss of interest in usual activities
- Persistent and disruptive hyperactivity
- Inability to focus or concentrate
- Repeated disrupted sleep patters
- Continuous or frequent aggression, “acting out” or oppositional behavior
- Persistent sadness and/or irritability

Symptoms that need immediate attention:

- Suicidal thoughts
- Extreme fright in situations that do not warrant it
- Extreme unreasonable resentments or grudges
- Incoherent speech or writing

Next Steps

So Your Teen Has Been Diagnosed with a Mood Disorder, Now What?[6]

By Judy Shepps Battle

Every parent dreams of having a "perfect" child. One who is smart, attractive, talented, obedient, polite, and healthy in mind and body. Many spend money on preschool and private education to create academic advantage and increase the odds of acceptance into a prestigious college.

It comes as a shock when our youngster has difficulty navigating this traditional path. An elementary school report card may contain "C"s and learning disabilities discovered. Or he or she may simply dislike academic courses.

A healthy parent learns to love and accept their child as he or she is and relinquishes personal and social expectations. Family resources - emotional and financial - are allocated to maximize strengths and remove obstacles to the full development of a youngster's potential.

At no time is this parental resolve more tested than when their teen is diagnosed with a mood disorder.

Adolescent Angst

Under normal circumstances, hormonal and social changes may turn the most compliant and even-tempered pre-adolescent into a defiant, moody, chronically irritated, angry, scared teen. One hour he may be sobbing that no one loves him and the next be excitedly talking on the phone about a date. One minute she may want a hug and the next scream not to be touched.

For a small percentage of teens these normal moods become extremely intense, debilitating and require professional care. They become suicidal when depressed and out-of-control when manic. Eventually, a diagnosis of "mood disorder" - major depression or bipolar disorder - may be made and a combination of medicine and therapy prescribed. Gradually, their whirlwind of emotional changes begins to subside.

It is not as easy for parents of newly diagnosed mood-disordered teens to find inner peace.

You Are Not Alone

Haunting questions of "why did this happen," "what could I have done to prevent it," and "how can I help my mood-disordered teen" often generate parental feelings of shame, guilt, and inadequacy. If you are in such a situation, know first that you are not alone. Statistics indicate that 7 to 14 percent of children will experience an episode of major depression before the age of fifteen. Out of 100,000 adolescents, two to three thousand will have severe mood disorders.

Know also that science is far from clear about the relative effect of environment, genes, and brain chemistry on producing severe adolescent mood disorders. While it is true that both depression and bipolar disease tend to run in families, it is not certain why some genetically-prone individuals remain mentally healthy and others do not. Simply said, you did not cause your child's mental disorder. Neither can you cure it. But you can help your teen cope with his or her disease. And you can keep your own physical and mental health in the process.

Making a Distinction

All the love in the world cannot instantly cure chronic depression or bipolar disease. Our power as parents is to help our kids develop coping mechanisms for effectively dealing with their life circumstances. This means we must not confuse our child with his or her mood disorder. A depressed or bipolar teen is first and foremost a teen. All the hormonal and social factors facing a non-mentally ill adolescent are still present as is the need to separate from parents. We deal with the adolescent part of our children by offering love, enforcing rules and boundaries, allowing them to experience the natural consequences of (non-life-threatening) behavior, and being available to listen in a nonjudgmental fashion. The "disease" part of our teen may require more direct intervention.

Coping With the Disease

Mood-disordered teens do not have the same luxury of experimenting with alcohol and other drugs as their non-diagnosed peers. Legal stimulants such as caffeine and illegal substances such as cocaine may trigger a manic episode for a bipolar youth. Alcohol, which is a depressant, can trigger a depressive episode for any mood-disordered individual. If your child cannot maintain abstinence from these substances it is important to get professional help.

Medicine compliance cannot be left to chance. Many teens lead hectic lives and have difficulty honoring schedules. Although there may be grumbling, it is important that you ensure that prescribed dosages be consistently taken.

Getting a proper amount of sleep is critical to maintain emotional balance. This is difficult for many teens who live on the telephone or computer both day and night. You may need to strictly enforce a bedtime and, if necessary, remove any distractions from the bedroom.

It is important for an individual with mood swings to develop a means to find an emotional center. You can help your child in this process by encouraging relaxation exercises such as yoga or meditation.

Finally, you can "Feng Shui" your home to reduce stress and promote serenity. By decluttering, increasing natural light, having sources of running water, and using certain colors, the general environment can become peaceful for all family members.

Finding Support

Riding the mood swings of a not-yet-diagnosed bipolar teen, or being terrified that your depressed child will commit suicide, takes an intense physical and emotional toll on a parent. As your child begins to get well emotionally, you must take time out for your own recovery. Make sure you get enough sleep, eat healthy foods, exercise, and find a balance between interacting with friends and being alone. Do at least one "special thing" for yourself daily, even if it is taking a bath or playing a round of miniature golf.

Find time to join a support group composed of parents with emotionally disturbed teens. Whether it is facilitated by a therapist or based on a self-help model, it is important to share and listen to the experience, strength and hope of others in your situation. This network can be invaluable during the inevitable bumps in the normal parent-child road and when your child's mood disorder flares up.

Disorders

Teen Depression[7]

Depression in adolescence comes at a time of great personal change: when boys and girls are forming an identity distinct from their parents, grappling with gender issues and emerging sexuality, and making decisions for the first time in their lives. Depression in adolescence frequently co-occurs with other disorders such as anxiety, disruptive behavior, eating disorders, or substance abuse. It can also lead to increased risk for suicide.

Why do adolescents get depression?

There are multiple reasons why a teenager might become depressed. For example, teens can develop feelings of worthlessness and inadequacy over their grades. School performance, social status with peers, sexual orientation, or family life can each have a major effect on how a teen feels. Sometimes, teen depression may result from environmental stress. But whatever the cause,

when friends or family -- or things that the teen usually enjoys -- don't help to improve his or her sadness or sense of isolation, there's a good chance that he or she has teen depression.

You could say it's depressing news. Not only do adolescents experience major depression at the same rates that adults do, three quarters of depressed adolescents experience further psychiatric disorder. By age 24, half of them have had another episode of major depression. And another 25% have experienced alcohol and drug problems.

Only a quarter of those with a history of major depression between ages 14 and 19 remain free of psychiatric problems through age 23. But even they are subject to residual effects of their earlier disorder during young adulthood. They make less money. They are less likely to have graduated from college. They are more likely to have a period of unemployment.

"They show functional scars," reports psychologist Peter M. Lewisohn, Ph.D., of the Oregon Research Institute, who with colleagues is examining the long-term course and consequences of adolescent depression. "We conclude that an episode of depression in adolescents really needs to be taken seriously,"

"These are very clinically important episodes," adds psychologist Paul Rohde, Ph.D. "There are occupational and educational consequences even for those who do not experience another bout of depression."

The trouble is, the vast majority of adolescents who are depressed—around 75%, Rohde reports—do not receive systematic treatment. Their episodes are consigned to resolve just with passage of time.

Yet, some adolescents are at special risk for a protracted course of the disorder, and the studies are able to pinpoint them as:

- Adolescent girls who experience a great deal of conflict with their parents
- Both males and females who have multiple episodes of major depression as teens
- Those with a family history of depression.

Providing the right kind of help early may avert the "depressive scarring" that is generated by multiple episodes. Drs. Lewisohn and Rohde champion psychoeducation rather than psychotherapy or medication.

There's no question that drugs are effective in resolving adult depression, as is cognitive behavioral therapy, although psychotherapy has been shown to be more effective in preventing relapses. "But among young people, it's another story entirely," says Dr. Rohde.

"We're trying to teach the kids better ways of coping with their depression. People can learn how to deal with their depression.

"There's an approach that says 'you have an illness and you need to take a pill,'" Dr. Rohde explains. "Our approach is more, 'you have problems in living. You can help yourself by dealing with those problems better. '"

What they provide is essentially a form of cognitive behavioral psychotherapy, albeit group-based, as it's less stigmatizing. There's a focus on tracking moods; increasing pleasant activities, relaxation skills and social skills; identifying thinking errors and negative thoughts and coming up with more positive and realistic thoughts; and increasing problem-solving skills. The teens learn a variety of skills and then personalize those that prove to be the most helpful to their particular lives.

To a large degree, depression among adolescents is the manifestation of a family disorder, Dr. Lewisohn finds. The rates of mood disturbances, particularly major depression and the mildly depressed mood state known as dysthymia, are significantly elevated among their first degree relatives.

What's more, the pattern of family aggregation of psychopathology is quite specific; teens who suffer major depression have relatives primarily with mood disorders.

"There is a familial transmission of major depression from parents to their children," stresses Dr. Rohde. "It may be genetic or it may be environmental. No one knows."

What the Oregon researchers do know is that in their survey of teens in the community, seven percent had made a suicide attempt. Most such attempts are not medically lethal. But rarely are parents aware of the attempts.

Nevertheless, insists Dr. Rohde, "Suicide attempts in adolescents need to be taken seriously." The reason: The biggest predictor of future suicide completions is past suicidal behavior.

Symptoms

The diagnostic criteria and key defining features of major depressive disorder in children and adolescents are the same as they are for adults. Research has shown that childhood depression often persists, recurs, and continues into adulthood, especially if it goes untreated. The presence of childhood depression also tends to be a predictor of more severe illnesses in adulthood.

However, recognition and diagnosis of the disorder may be more difficult in youth for several reasons. A child with depression may pretend to be sick, refuse to go to school, cling to a parent, or worry that a parent may die. Older children may sulk, get into trouble at school, be negative and irritable, and feel misunderstood. Because these signs may be viewed as normal mood swings typical of children as they move through developmental stages, it may be difficult to accurately diagnose a young person with depression.

Before puberty, boys and girls are equally likely to develop depressive disorders. By age 15, however, girls are twice as likely as boys to have experienced a major depressive episode.

What are the symptoms of teen depression?

Often, kids with teen depression will have a noticeable change in their thinking and behavior. They may have no motivation and even become withdrawn, closing their bedroom door after school and staying in their room for hours.

Kids with teen depression may sleep excessively, have a change in eating habits, and may even exhibit criminal behaviors such as DUI or shoplifting. Here are more signs of depression in adolescents even though they may or may not show all signs:

Symptoms of Major Depressive Disorder Common to Adults, Children and Adolescents:

- Persistent sad, anxious, or "empty" mood
- Feelings of hopelessness or pessimism
- Feelings of guilt, worthlessness, or helplessness
- Loss of interest or pleasure in hobbies and activities that were once enjoyable
- Decreased energy, fatigue or being "slowed down"
- Difficulty concentrating, remembering or making decisions
- Insomnia, early-morning awakening or oversleeping
- Appetite and/or weight loss or overeating and weight gain
- Thoughts of death or suicide; suicide attempts
- Restlessness, irritability
- Persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders, and chronic pain

Five or more of these symptoms must persist for two or more weeks before a diagnosis of major depression is indicated.

Signs That May Be Associated with Depression in Children and Adolescents:

- Frequent vague, nonspecific physical complaints such as headaches, muscle aches, stomachaches, or tiredness
- Frequent absence from school or poor performance in school
- Talk of or efforts to run away from home
- Outbursts of shouting, complaining, unexplained irritability, or crying
- Being bored
- Lack of interest in playing with friends
- Alcohol or substance abuse
- Social isolation, poor communication
- Fear of death
- Extreme sensitivity to rejection or failure
- Increased irritability, anger or hostility
- Reckless behavior
- Difficulty with relationships
- Difficulty concentrating
- Difficulty making decisions

- Excessive or inappropriate guilt
- Irresponsible behavior -- for example, forgetting obligations, being late for classes, skipping school
- Loss of interest in food or compulsive overeating that results in rapid weight loss or gain
- Memory loss
- Preoccupation with death and dying
- Rebellious behavior
- Sadness, anxiety, or a feeling of hopelessness
- Staying awake at night and sleeping during the day
- Sudden drop in grades
- Use of alcohol or drugs and promiscuous sexual activity
- Withdrawal from friend

While the recovery rate from a single episode of major depression in children and adolescents is quite high, episodes are likely to recur. In addition, youth with dysthymic disorder are at risk for developing major depression. Prompt identification and treatment of depression can reduce its duration and severity and associated functional impairment.

Treatments

Depression, even the most severe cases, is a highly treatable disorder. As with many illnesses, the earlier that treatment can begin, the more effective it is and the greater the likelihood that recurrence can be prevented.

Step 1) get a diagnosis

The first step to getting appropriate treatment is to visit a doctor. Certain medications, and some medical conditions such as viruses or a thyroid disorder, can cause the same symptoms as depression. A doctor can rule out these possibilities by conducting a physical examination, interview, and lab tests. If the doctor can eliminate a medical condition as a cause, he or she should conduct a psychological evaluation or refer the patient to a mental health professional.

The doctor or mental health professional will conduct a complete diagnostic evaluation. He or she should discuss any family history of depression, and get a complete history of symptoms, e.g., when they started, how long they have lasted, their severity, and whether they have occurred before and if so, how they were treated. He or she should also ask if the patient is using alcohol or drugs, and whether the patient is thinking about death or suicide.

There aren't any specific medical tests that can detect depression. Health care professionals determine if a teen has depression by conducting interviews and psychological tests with the teen and his or her family members, teachers, and peers.

The severity of the teen depression and the risk of suicide are determined based on the assessment of these interviews. Treatment recommendations are also made based on the data collected from the interviews.

The doctor will also look for signs of potentially co-existing psychiatric disorders such as anxiety or substance abuse or screen for complex forms of depression such as bipolar disorder (manic depressive illness) or psychosis. . The doctor will also assess the teen for risks of suicidal or homicidal features. Incidences of attempted suicide and self-mutilation is higher in females than males while completed suicide is higher in males. One of the most vulnerable groups for completed suicide is the 18-24 age group.

Once diagnosed, a person with depression can be treated with a number of methods.

The most common treatment for depressive disorders in children and adolescents involves psychotherapy and medication, as well as targeted interventions involving the home or school environment. Family therapy may be helpful if family conflict is contributing to a teen's depression. The teen will also need support from family or teachers to help with any school or peer problems. Occasionally, hospitalization in a psychiatric unit may be required for teenagers with severe depression.

Your mental health care provider will determine the best course of treatment for your teen.

An NIMH-funded clinical trial of 439 adolescents with major depression found that a combination of medication and psychotherapy was the most effective treatment option. Other NIMH-funded researchers are developing and testing ways to prevent suicide in children and adolescents, including early diagnosis and treatment, and a better understanding of suicidal thinking.

Medications:

The FDA warns that antidepressant medications can, rarely, increase the risk of suicidal thinking and behavior in children and adolescents with depression and other psychiatric disorders. Use of antidepressants in younger patients, therefore, requires especially close monitoring and follow-up by the treating doctor. If you have questions or concerns, discuss them with your health care provider.

A large number of research trials have shown the effectiveness of depression medications in relieving the symptoms of teen depression. One key recent study, funded by the National Institute of Mental Health, reviewed three different approaches to treating adolescents with moderate to severe depression:

- One approach was using the antidepressant medication Prozac, which is approved by the FDA for use with pediatric patients ages 8-18.
- The second treatment was using cognitive behavioral therapy, or CBT, to help the teen recognize and change negative patterns of thinking that may increase symptoms of depression.
- The third approach was a combination of medication and CBT.

At the end of the 12-week study, researchers found that nearly three out of every four patients who received the combination treatment -- depression medication and psychotherapy --

significantly improved. More than 60% of the kids who took Prozac alone improved. But the study confirmed that combination treatment was nearly twice as effective in relieving depression as psychotherapy alone.

Antidepressant medications, especially when combined with psychotherapy, can be very effective treatments for depressive disorders in adults. Use of SSRI medications has risen dramatically in the past several years in children and adolescents ages 10 through 19.

Antidepressants work to normalize naturally occurring brain chemicals called neurotransmitters, notably serotonin and norepinephrine. Other antidepressants work on the neurotransmitter dopamine. Scientists studying depression have found that these particular chemicals are involved in regulating mood, but they are unsure of the exact ways in which they work.

The newest and most popular types of antidepressant medications are called selective serotonin reuptake inhibitors (SSRIs). SSRIs include fluoxetine (Prozac®), citalopram (Celexa®), sertraline (Zoloft®) and several others. Serotonin and norepinephrine reuptake inhibitors (SNRIs) are similar to SSRIs and include venlafaxine (Effexor®) and duloxetine (Cymbalta®).

For all classes of antidepressants, patients must take regular doses for at least three to four weeks before they are likely to experience a full therapeutic effect. They should continue taking the medication for the time specified by their doctor, even if they are feeling better, in order to prevent a relapse of the depression. Medication should be stopped only under a doctor's supervision. Some medications need to be gradually stopped to give the body time to adjust. Although antidepressants are not habit-forming or addictive, abruptly ending an antidepressant can cause withdrawal symptoms or lead to a relapse. Some individuals, such as those with chronic or recurrent depression, may need to stay on the medication indefinitely.

In 2005, the FDA adopted a "black box" warning label on all antidepressant medications to alert the public about the potential increased risk of suicidal thinking or attempts in children and adolescents taking antidepressants. In 2007, the FDA proposed that makers of all antidepressant medications extend the warning to include young adults up through age 24. A "black box" warning, the most serious type of warning on prescription drug labeling, emphasizes that patients of all ages taking antidepressants should be closely monitored, especially during the initial weeks of treatment. Possible side effects to look for are worsening depression, suicidal thinking or behavior, or any unusual changes in behavior such as sleeplessness, agitation, or withdrawal from normal social situations. This warning advises additionally that families and caregivers be told of the need for close monitoring and report any changes to the physician.

Results of a comprehensive review of pediatric trials conducted between 1988 and 2006 suggested that the benefits of antidepressant medications likely outweigh their risks to children and adolescents with major depression and anxiety disorders.

Also, the FDA issued a warning that combining an SSRI or SNRI antidepressant with one of the commonly used "triptan" medications for migraine headache could cause a life-threatening "serotonin syndrome," marked by agitation, hallucinations, elevated body temperature, and rapid changes in blood pressure. Although most dramatic in the case of the MAOIs, newer

antidepressants may also be associated with potentially dangerous interactions with other medications.

Medication as a first-line course of treatment should be considered for children and adolescents with severe symptoms that would prevent effective psychotherapy, those who are unable to undergo psychotherapy, those with psychosis, and those with chronic or recurrent episodes. Following remission of symptoms, continuation of treatment with medication and, or, psychotherapy for at least several months may be recommended by the psychiatrist, given the high risk of relapse and recurrence of depression. Discontinuation of medications, as appropriate, should be done gradually over six weeks or more

Psychotherapy:

Psychotherapy is often used as an initial treatment for milder forms of depression. Many times, psychotherapy accompanied by an early follow-up appointment may help to establish the persistence of depression before a decision is made to try antidepressant medications.

Many forms of psychotherapy, including some short-term (10- to 20-week) therapies, can help depressed individuals. Talking therapies help patients gain insight into and resolve their problems through verbal exchange with the therapist, sometimes combined with homework assignments between sessions.

Two main types of psychotherapies—cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT)—have been proven effective in treating depression. CBT helps people change negative styles of thinking and behaving that may contribute to depression. IPT helps people understand and work through troubled personal relationships that may cause their depression or make it worse.

Psychodynamic therapies, which are sometimes used to treat depressed persons, focus on resolving the patient's conflicted feelings.

Continuing psychotherapy for several months after remission of symptoms may help patients and families consolidate the skills learned during the acute phase of depression, cope with the after-effects of the depression, effectively address environmental stressors, and understand how the young person's thoughts and behaviors could contribute to a relapse.

Suicide[8]

What are the warning signs for teen suicide?

Teen suicide is a serious problem. Adolescent suicide is the second leading cause of death, following accidents, among youth and young adults in the U.S. It is estimated that 500,000 teens attempt suicide every year with 5,000 succeeding. These are epidemic numbers.

Family difficulties, the loss of a loved one, or perceived failures at school or in relationships can all lead to negative feelings and depression. And teen depression often makes problems seem

overwhelming and the associated pain unbearable. Suicide is an act of desperation and teen depression is often the root cause.

Warning signs of suicide with teen depression include:

- Expressing hopelessness for the future
- Giving up on one's self, talking as if no one else cares
- Preparing for death, giving away favorite possessions, writing goodbye letters, or making a will
- Starting to use or abuse drugs or alcohol to aid sleep or for relief from their mental anguish
- Threatening to kill one's self

If your teenager displays any of these behaviors, you should seek help from a mental healthcare professional immediately. Or you can call a suicide hotline for help.

Depression carries a high risk of suicide. Anybody who expresses suicidal thoughts or intentions should be taken very, very seriously. Do not hesitate to call your local suicide hotline immediately. Call 1-800-SUICIDE (1-800-784-2433) or 1-800-273-TALK (1-800-273-8255)

Bipolar Disorder[9]

Although rare in young children, bipolar disorder-also known as manic-depressive illness-can appear in both children and adolescents. Bipolar disorder, which involves unusual shifts in mood, energy, and functioning, may begin with either manic, depressive, or mixed manic and depressive symptoms. It is more likely to affect the children of parents who have the disorder. Twenty to 40 percent of adolescents with major depression develop bipolar disorder within 5 years after depression onset

Existing evidence indicates that bipolar disorder beginning in childhood or early adolescence may be a different, possibly more severe form of the illness than older adolescent- and adult-onset bipolar disorder. When the illness begins before or soon after puberty, it is often characterized by a continuous, rapid-cycling, irritable, and mixed symptom state that may co-occur with disruptive behavior disorders, particularly attention deficit hyperactivity disorder (ADHD) or conduct disorder (CD), or may have features of these disorders as initial symptoms. In contrast, later adolescent- or adult-onset bipolar disorder tends to begin suddenly, often with a classic manic episode, and to have a more episodic pattern with relatively stable periods between episodes. There is also less co-occurring ADHD or CD among those with later onset illness.

Manic Symptoms

- Severe changes in mood-either extremely irritable or overly silly and elated
- Overly-inflated self-esteem; grandiosity
- Increased energy
- Decreased need for sleep-able to go with very little or no sleep for days without tiring

- Increased talking-talks too much, too fast; changes topics too quickly; cannot be interrupted
- Distractibility-attention moves constantly from one thing to the next
- Hypersexuality-increased sexual thoughts, feelings, or behaviors; use of explicit sexual language
- Increased goal-directed activity or physical agitation
- Disregard of risk-excessive involvement in risky behaviors or activities

A child or adolescent who appears to be depressed and exhibits ADHD-like symptoms that are very severe, with excessive temper outbursts and mood changes, should be evaluated by a psychiatrist or psychologist with experience in bipolar disorder, particularly if there is a family history of the illness. This evaluation is especially important since psychostimulant medications, often prescribed for ADHD, may worsen manic symptoms. There is also limited evidence suggesting that some of the symptoms of ADHD may be a forerunner of full-blown mania.

The essential treatment of bipolar disorder in adults involves the use of appropriate doses of mood stabilizing medications, typically lithium and/or valproate, which are often very effective for controlling mania and preventing recurrences of manic and depressive episodes. Treatment of children and adolescents diagnosed with bipolar disorder is based mainly on experience with adults, since as yet there is very limited data on the safety and efficacy of mood stabilizing medications in youth. Researchers currently are evaluating both pharmacological and psychosocial interventions for bipolar disorder in young people.

A Warning About Antidepressants and Psychostimulants

Using antidepressant medication to treat depression in a person who has bipolar disorder may induce manic symptoms if it is taken without a mood stabilizer, such as lithium or valproate. In addition, using psychostimulant medications to treat ADHD or ADHD-like symptoms in a child or adolescent with bipolar disorder may worsen manic symptoms. While it can be hard to determine which young patients will become manic, there is a greater likelihood among children and adolescents who have a family history of bipolar disorder. If manic symptoms develop or markedly worsen during antidepressant or stimulant use, a child psychiatrist should be consulted, and treatment for bipolar disorder should be considered. Physicians should be aware of the signs and symptoms of mania so that they can educate families on how to recognize these and report them immediately.

Valproate Use

According to studies conducted in Finland in patients with epilepsy, valproate may increase testosterone levels in teenage girls and produce polycystic ovary syndrome in women who began taking the medication before age 20. Increased testosterone can lead to polycystic ovary syndrome with irregular or absent menses, obesity, and abnormal growth of hair. Therefore, young female patients prescribed valproate should be monitored carefully.

Dysthymic disorder (or dysthymia)

This less severe yet typically more chronic form of depression is diagnosed when depressed mood persists for at least one year in children or adolescents and is accompanied by at least two other symptoms of major depression. Dysthymia is associated with an increased risk for developing major depressive disorder, bipolar disorder, and substance abuse. Treatment of dysthmia may prevent the deterioration to more severe illness. If dysthymia is suspected in a young patient, referral to a mental health specialist is indicated for a comprehensive diagnostic evaluation and appropriate treatment.

Eating Disorders[10]

What are Eating Disorders?

Disordered eating often (but not always) occurs in affluent cultures, especially in America, where anorexia nervosa (voluntary starvation) and bulimia nervosa (binge-eating followed by purging) now afflict one in ten people.

Most of the diagnosed are young women in their teens and 20s, but the prevalence is increasing among young men each year.

Among the most baffling of conditions, eating disorders take on a life of their own so that eating, or not eating, becomes the point of everyday existence. Both anorexia and bulimia are powered by a desire for control.

But in another eating disorder, binge-eating, in which people gorge on large amounts of food and generally gain weight, sufferers feel that eating is out of their control during such bouts.

Both culturally mediated body-image concerns and personality traits like perfectionism and obsessiveness play a large role in creating eating disorders, which are also often accompanied by depression and/or anxiety.

There is no magic cure for these conditions, which are often resistant to treatment, and many cases can be acutely life-threatening, requiring hospitalization and forced nourishment.

Self-Esteem[11]

What is Self-Esteem?

Possessing little self-regard can lead people to become depressed, to fall short of their potential, or to tolerate abusive situations and relationships. Too much self-love, on the other hand, results in an off-putting sense of entitlement and an inability to learn from failures. (It can also be a sign of clinical narcissism.) Perhaps no other self-help topic has spawned so much advice and so many (often conflicting) theories. Here are our best insights on how to strike a balance between accurate self-knowledge and respect for who you are.

Anxiety[12]

What Is Anxiety?

Anxiety is a normal reaction to stressful situations. But in some cases, it becomes excessive and can cause sufferers to dread everyday situations.

This type of steady, all-over anxiety is called Generalized Anxiety Disorder. Other anxiety-related disorders include panic attacks—severe episodes of anxiety which happen in response to specific triggers—and obsessive-compulsive disorder, which is marked by persistent invasive thoughts or compulsions to carry out specific behaviors (such as hand-washing).

Anxiety so frequently co-occurs with depression that the two are thought to be twin faces of one disorder. Like depression, it strikes twice as many females as males.

Generally, anxiety arises first, often during childhood. Evidence suggests that both biology and environment can contribute to the disorder. Some people may have a genetic predisposition to anxiety; however, this does not make development of the condition inevitable. Early traumatic experiences can also reset the body's normal fear-processing system so that it is hyper-reactive to stress.

The exaggerated worries and expectations of negative outcomes in unknown situations that typify anxiety are often accompanied by physical symptoms. These include muscle tension, headaches, stomach cramps, and frequent urination. Behavioral therapies, with or without medication to control symptoms, have proved highly effective against anxiety, especially in children.

Bullying[13]

Understanding Bullying

Bullying is a distinctive pattern of deliberately harming and humiliating others. It's a very durable behavioral style, largely because bullies get what they want—at least at first. Bullies are made, not born, and it happens at an early age, if the normal aggression of two-year-olds isn't handled well.

Bullies couldn't exist without victims, and they don't pick on just anyone; those singled out lack assertiveness and radiate fear long before they ever encounter a bully. No one likes a bully, but no one likes a victim either. Grown-up bullies wreak havoc in their relationships and in the workplace.

Many experts believe that bullying behavior is on the rise because children increasingly grow up without the kinds of experiences that lead to the development of social skills. It has been well-documented that free play is on the decline, but it is in playing with peers, without adult

monitoring, that children develop the skills that make them well-liked by agemates and learn how to solve social problems

Oppositional Defiant Disorder (ODD)[14]

Even the best-behaved children can be difficult and challenging at times. But if your child or teen has a frequent and persistent pattern of anger, irritability, arguing, defiance or vindictiveness toward you and other authority figures, he or she may have oppositional defiant disorder (ODD).

As a parent, you don't have to go it alone in trying to manage a child with ODD. Doctors, counselors and child development experts can help.

Treatment of ODD involves therapy, training to help build positive family interactions and skills to manage behaviors, and possibly medications to treat related mental health conditions.

Sometimes it's difficult to recognize the difference between a strong-willed or emotional child and one with oppositional defiant disorder. It's normal to exhibit oppositional behavior at certain stages of a child's development.

Signs of ODD generally begin during preschool years. Sometimes ODD may develop later, but almost always before the early teen years. These behaviors cause significant impairment with family, social activities, school and work.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5), published by the American Psychiatric Association, lists criteria for diagnosing ODD. This manual is used by mental health providers to diagnose mental conditions and by insurance companies to reimburse for treatment.

DSM-5 criteria for diagnosis of ODD show a pattern of behavior that:

- Includes at least four symptoms from any of these categories — angry and irritable mood; argumentative and defiant behavior; or vindictiveness
- Occurs with at least one individual who is not a sibling
- Causes significant problems at work, school or home
- Occurs on its own, rather than as part of the course of another mental health problem, such as a substance use disorder, depression or bipolar disorder
- Lasts at least six months

DSM-5 criteria for diagnosis of ODD include both emotional and behavioral symptoms.

Angry and irritable mood:

- Often loses temper
- Is often touchy or easily annoyed by others
- Is often angry and resentful

Argumentative and defiant behavior:

- Often argues with adults or people in authority
- Often actively defies or refuses to comply with adults' requests or rules
- Often deliberately annoys people
- Often blames others for his or her mistakes or misbehavior

Vindictiveness:

- Is often spiteful or vindictive
- Has shown spiteful or vindictive behavior at least twice in the past six months

These behaviors must be displayed more often than is typical for your child's peers. For children younger than 5 years, the behavior must occur on most days for a period of at least six months. For individuals 5 years or older, the behavior must occur at least once a week for at least six months.

ODD can vary in severity:

- **Mild.** Symptoms occur only in one setting, such as only at home, school, work or with peers.
- **Moderate.** Some symptoms occur in at least two settings.
- **Severe.** Some symptoms occur in three or more settings.

For some children, symptoms may first be seen only at home, but with time extend to other settings, such as school and with friends.

When to see a doctor

Your child isn't likely to see his or her behavior as a problem. Instead, your child will probably believe that unreasonable demands are being placed on him or her. But if your child has signs and symptoms common to ODD that are more frequent than is typical for his or her peers, make an appointment with your child's doctor.

If you're concerned about your child's behavior or your own ability to parent a challenging child, seek help from your doctor, a child psychologist or a child behavioral expert. Your primary care doctor or your child's pediatrician can refer you to the appropriate professional.

There's no known clear cause of oppositional defiant disorder. Contributing causes may be a combination of inherited and environmental factors, including:

- **Genetics** — a child's natural disposition or temperament and possibly neurobiological differences in the way nerves and the brain function
- **Environment** — problems with parenting that may involve a lack of supervision, inconsistent or harsh discipline, or abuse or neglect

Oppositional defiant disorder is a complex problem. Possible risk factors for ODD include:

- **Temperament —** a child who has a temperament that includes difficulty regulating emotions, such as being highly emotionally reactive to situations or having trouble tolerating frustration
- **Parenting issues —** a child who experiences abuse or neglect, harsh or inconsistent discipline, or a lack of parental supervision
- **Other family issues —** a child who lives with parent or family discord or has a parent with a mental health or substance use disorder

Children with oppositional defiant disorder may have trouble at home with parents and siblings, in school with teachers, at work with supervisors and other authority figures, and may struggle to make and keep friends and relationships.

ODD may lead to problems such as:

- Poor school and work performance
- Antisocial behavior
- Impulse control problems
- Substance use disorder
- Suicide

Many children with ODD also have other mental health conditions, such as:

- Attention-deficit/hyperactivity disorder (ADHD)
- Depression
- Anxiety
- Conduct disorder
- Learning and communication disorders

Treating these other mental health conditions may help improve ODD symptoms. And it may be difficult to treat ODD if these other conditions are not evaluated and treated appropriately.

You may start by seeing your child's doctor. After an initial evaluation, your doctor may refer you to a mental health professional who can help make a diagnosis and create the appropriate treatment plan for your child.

What you can do

When possible, both parents should be present with the child. Or, take a trusted family member or friend along. Someone who accompanies you may remember something that you missed or forgot.

Questions to ask the doctor at your child's initial appointment include:

- What do you believe is causing my child's symptoms?
- Are there any other possible causes?
- How will you determine the diagnosis?

- Should my child see a mental health provider?

Questions to ask if your child is referred to a mental health provider include:

- Does my child have oppositional defiant disorder?
- Is this condition likely temporary or long lasting?
- What factors do you think might be contributing to my child's problem?
- What treatment approach do you recommend?
- Is it possible for my child to grow out of this condition?
- Does my child need to be screened for any other mental health problems?
- Is my child at increased risk of any long-term complications from this condition?
- Do you recommend any changes at home or school to encourage my child's recovery?
- Should I tell my child's teachers about this diagnosis?
- What else can my family and I do to help my child?
- Do you recommend family therapy?
- What can we, the parents, do to cope and sustain our ability to help our child?

Don't hesitate to ask additional questions during your appointment.

What to expect from your doctor

Be ready to answer your doctor's questions. That way you'll have more time to go over any points you want to talk about in-depth. Your doctor may ask:

- What are your concerns about your child's behavior?
- When did you first notice these problems?
- Have your child's teachers or other caregivers reported similar behaviors in your child?
- How often over the last six months has your child been spiteful or vindictive, or blamed others for his or her own mistakes?
- How often over the last six months has your child been easily annoyed or deliberately annoying to others?
- How often over the last six months has your child argued with adults or defied or refused adults' requests?
- How often over the last six months has your child been visibly angry or lost his or her temper?
- In what settings does your child demonstrate these behaviors?
- Do any particular situations seem to trigger negative or defiant behavior in your child?
- How have you been handling your child's disruptive behavior?
- How do you typically discipline your child?
- How would you describe your child's home and family life?
- What stresses has the family been dealing with?
- Has your child been diagnosed with any other medical conditions, including mental health conditions?

To determine whether your child has oppositional defiant disorder, the mental health provider can do a comprehensive psychological evaluation. This evaluation will likely include an assessment of:

- Your child's overall health
- The frequency and intensity of your child's behaviors
- Your child's behavior across multiple settings and relationships
- The presence of other mental health, learning or communication disorders

Related mental health issues

Because ODD often occurs along with other behavioral or mental health problems, symptoms of ODD may be difficult to distinguish from those related to other problems. It's important to diagnose and treat any co-occurring problems because they can create or worsen ODD symptoms if left untreated.

Treating oppositional defiant disorder generally involves several types of psychotherapy and training for your child — as well as for parents. Treatment often lasts several months or longer.

Medications alone generally aren't used for ODD unless another disorder co-exists. If your child has co-existing conditions, particularly ADHD, medications may help significantly improve symptoms.

The cornerstones of treatment for ODD usually include:

- **Parent training.** A mental health provider with experience treating ODD may help you develop parenting skills that are more positive and less frustrating for you and your child. In some cases, your child may participate in this type of training with you, so that everyone in your family develops shared goals for how to handle problems.
- **Parent-child interaction therapy (PCIT).** During PCIT, therapists coach parents while they interact with their children. In one approach, the therapist sits behind a one-way mirror and, using an "ear bug" audio device, guides parents through strategies that reinforce their children's positive behavior. As a result, parents learn more-effective parenting techniques, the quality of the parent-child relationship improves and problem behaviors decrease.
- **Individual and family therapy.** Individual counseling for your child may help him or her learn to manage anger and express feelings in a healthier way. Family counseling may help improve your communication and relationships, and help members of your family learn how to work together.
- **Cognitive problem-solving training.** This type of therapy is aimed at helping your child identify and change thought patterns that lead to behavior problems. Collaborative problem-solving — in which you and your child work together to come up with solutions that work for both of you — can help improve ODD-related problems.
- **Social skills training.** Your child also might benefit from therapy that will help him or her learn how to interact more positively and effectively with peers.

As part of parent training, you may learn how to manage your child's behavior by:

- Giving clear instructions and following through with appropriate consequences when needed
- Recognizing and praising your child's good behaviors and positive characteristics to promote desired behaviors

Although some parenting techniques may seem like common sense, learning to use them in the face of opposition isn't easy, especially if there are other stressors at home. Learning these skills will require consistent practice and patience.

Most important in treatment is for you to show consistent, unconditional love and acceptance of your child — even during difficult and disruptive situations. Don't be too hard on yourself. This process can be tough for even the most patient parents.

At home, you can begin chipping away at problem behaviors of oppositional defiant disorder by practicing these strategies:

- **Recognize and praise** your child's positive behaviors. Be as specific as possible, such as, "I really liked the way you helped pick up your toys tonight."
- **Model the behavior** you want your child to have.
- **Pick your battles** and avoid power struggles. Almost everything can turn into a power struggle, if you let it.
- **Set limits** and enforce consistent reasonable consequences.
- **Set up a routine** by developing a consistent daily schedule for your child. Asking your child to help develop that routine may be beneficial.
- **Build in time together** by developing a consistent weekly schedule that involves you and your child spending time together.
- **Work with your partner** or others in your household to ensure consistent and appropriate discipline procedures. Enlist support from teachers, coaches and other adults who spend time with your child.
- **Assign a household chore** that's essential and that won't get done unless the child does it. Initially, it's important to set your child up for success with tasks that are relatively easy to achieve and gradually blend in more important and challenging expectations. Give clear, easy-to-follow instructions.
- **Be prepared for challenges early on.** At first, your child probably won't be cooperative or appreciate your changed response to his or her behavior. Expect behavior to temporarily worsen in the face of new expectations. This is called an "extinction burst" by behavior therapists. Remaining consistent in the face of increasingly challenging behavior is the key to success at this early stage.

With perseverance and consistency, the initial hard work often pays off with improved behavior and relationships.

Being the parent of a child with oppositional defiant disorder isn't easy. Counseling for you can provide you with an outlet for your frustrations and concerns. In turn, this can lead to better outcomes for your child because you'll be more prepared to deal with problem behaviors.

Maintaining your health through relaxation, supportive relationships, and effective communication of your concerns and needs are important elements during treatment of ODD.

There's no guaranteed way to prevent oppositional defiant disorder. However, positive parenting and early treatment can help improve behavior and prevent the situation from getting worse. The earlier that ODD can be managed, the better.

Treatment can help restore your child's self-esteem and rebuild a positive relationship between you and your child. Your child's relationships with other important adults in his or her life — such as teachers, community supports and care providers — also will benefit from early treatment.

TR Implications

Designing a goal-directed treatment plan[15]

The steps of goal-directed treatment planning are as follows:

1. Identify pivotal problems and potentials
2. Rewrite the problems/potentials as goals
3. Estimate the time required to reach each goal
4. For each goal identify at least two objectives
5. For each goal decide a treatment or treatments in accordance with the evidence base, sociocultural appropriateness, and the resources available
6. For each goal/objective identify a monitor to determine if treatment is progressing or if the goal has been attained

Other Program Options[16]

Small animal therapy

Small animal therapy uses smaller animals, such as guinea pigs and rabbits, to help youth learn:

- Empathy
- Self-awareness
- Nurturing capabilities
- Appropriate touch
- Appropriate social skills

- Self-esteem

Horse therapy

Horse therapy is designed for experiential learning by setting up activities involving horses that enables the group to learn skills such as:

- Non-verbal communication
- Assertiveness
- Creative thinking
- Problem solving
- Leadership
- Teamwork
- Building Relationships
- Confidence
- Positive attitude
- Responsibility

Therapeutic Play

Therapeutic play is an opportunity for children to engage in play within a group setting. Play helps children:

- Become responsible for their behavior
- Learn to express emotion
- Develop creative solutions
- Learn new social and relational skills

Care Facilities

Private

- Residential treatment programs
- Outpatient treatment programs
- Outdoor wilderness

State

- State Hospital
- Juvenile Detention Centers

Community

- Recreation centers
- After school programs
- Parks and Recreation Departments
- Boys and Girls Club

Resources

Encyclopedia of Psychology: Environment Behavior Relationships of Adolescents
http://www.psychology.org/links/Environment_Behavior_Relationships/Adolescent/

American Psychology Association: Developing Adolescents
http://www.apa.org/pi/families/resources/develop.pdf
http://apa.org/topics/teens/index.aspx

American Academy of Child & Adolescent Psychiatry
http://www.aacap.org/

Society of Clinical Child & Adolescent Psychology
http://effectivechildtherapy.fiu.edu

Troubled Teen Programs by States
http://www.troubledteenprograms.org/

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