Treating Adolescents

Second Edition

Hans Steiner with Rebecca Hall

WILEY

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Dedication

Fuer Anny Steiner, deren Liebe zum Leben und zu Kindern
eine persistente Inspiration fuer mich waren. Mit ihr hat alles begonnen.

13.Juni 2014

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Introduction

Hans Steiner and Rebecca Hall

You have to have chaos within you to give birth to a dancing star.
—Friedrich Nietzsche

We are happy to present the second edition of *Treating Adolescents*. As in the first edition, this book covers mental health problems as they emerge during adolescence. The book retains its commitment to a theoretical base in development, psychology, and psychiatry. It is written for the frontline clinician, the young professional, and the educated lay person in an effort to reach as many people as possible in order to help our youth traverse this complicated stage of development, reduce suffering, and restore growth. The format of this book follows the current model of teaching in the Stanford University School of Medicine: All the information offered is empirically based as much as is possible, drawing on two streams of information: (1) evidence-based medicine, and (2) practice-based evidence. The information is presented in representative cases, which allow for the combination of empirical evidence and clinical wisdom. The reader is invited to follow the reasoning and practice of these experts as they prepare to handle their own cases.

In the 20 years since the first edition was published, there have been many gratifying developments in the field of Developmental Psychiatry. We now have at our disposal an ever growing body of empirical knowledge, which allows us to delineate, define, and treat problems in much more effective ways. Progress has been made in all basic sciences that contribute to developmental psychiatry: biology, especially neuroscience; psychology;

and sociology. In 2015, the practitioner is in a better position than ever to draw on these diverse strands of information and tailor them to suit a particular patient's needs. There are still pockets where we wish we had more information, but even then we are better able now than ever to draw on practice-based evidence in the form of systematic approaches to patients, case reports, case series, distilled clinical wisdom, practice guidelines, and meta-analyses.

Along with this expanded database also comes a new responsibility for clinicians to avail themselves of these materials, stay current, and acquire the art of skillful integration of information as they approach the patients, their families, and their social environment. It is in this spirit that our authors, who are mostly at Stanford University School of Medicine, have graduated from our training program or are professionally linked to our professoriate, approach the updated chapters in this book. We have given a detailed summary of our approach in previous publications, as listed in our suggested reading at the end of this introduction (Steiner, 2004, 2011).

Compared to when I (Hans Steiner) began my training in psychiatry some 30 years ago, many more people today have a much better understanding of psychiatric practice and avail themselves with much greater ease of the services it can offer. This most likely is a result of the maturation of our profession, as reflected in its increasing reliance on the principles of evidence-based medicine, and along with it the ongoing destigmatization of psychiatric disorders and their care. In the past 30-some years, we have indeed come a long way.

When I began my studies, training, and clinical practice in the 1960s and 1970s, psychiatry was limited almost exclusively to two forms of practice: On one hand, there were many of us practicing in state hospitals with the severely disturbed individuals who needed to be confined, committed, and deprived of their freedom. There was a frequent and heavy use of potent biological (electroconvulsive therapy, insulin shock, physical restraints, heavy sedatives) interventions with a limited use of psychotherapy and psychosocial interventions. At the same time, in private practice there was a heavy emphasis on the exclusivity of psychoanalytic theories and understanding of patients, and lengthy intensive analyses were the order of the day. Putting people on the couch as a curative agent for

anything from bedwetting to agoraphobia, from obsessive thinking to panic attacks and fear of heights, was inadequately backed up by empirical data. Psychiatry was an anachronistic mixture of practitioners practicing in competing, but idiosyncratic clusters. These subgroups were labeled by the school of thought they adhered to (Freudian, Kleinian, Jungian, Adlerian, etc.). Few, if any, attempts were made to base the practices on facts generated by independent research and clinical trials.

Fortunately for all of us, this state of affairs did not persist. Partially driven by the revolution brought about by social psychiatry, which sought to strengthen individual rights, set patients free from state hospital warehousing, and provide community-based structures to reintegrate them in society, psychiatry was almost forced to come up with more effective and less problematic medications to complement the setting free of individuals who previously had easily been deprived of their freedom and civil rights. Spawned by a surge in our biological understanding of the mind/brain system, our profession expanded the array of increasingly effective and specific medications that facilitated recovery and permitted patients to function in environments with normal daily demands and supports.

Still, to this day many misconceptions and confusions persist. If I had a dollar for every time someone at a party, after finding out what I do for a living, said something like "Oh, you must be analyzing me right now, I'd better watch what I say," I would be a rich man. To this day people still confuse the practice of psychiatry, psychology, and psychoanalysis, to the point where they do not know the difference between the three professions and what drives them. Usually I clarify this by pointing out that psychiatrists are medical doctors who are trained in pharmacotherapy, psychotherapy, and the use of social structures, such as schools, for treatment. They are bio-psycho-social doctors, like many other medical specialists who interview and rally families to support their patients and prescribe and adjust medications. Psychiatrists are the only specialists in the field of mental health that can deliver these many different treatments in integrated packages tailored to the individual needs of the patient, having been trained in all these modalities and having the licenses to practice them.

Paradoxically, there is another threat to psychiatry's integrity, this time driven by the enormous success and progress in the biological basic

sciences, made possible due to a concentration of research resources during the decade of the brain. This has led to the misconception among many of my colleagues and the lay public that psychiatry is a medical discipline based solely on biological data. These reductionist colleagues honestly believe that we are just biological machines, or maybe computers, and they are ready to sacrifice all that I consider quintessentially human: free will, choice, self-determination and meaning, and psychotherapy. In many cases that I am called to consult on these days, I find that interpersonal, social problems and difficulties with intrapsychic conflict are attempted to be solved by giving medications, increasing the doses of existing medications, or adding additional compounds to the existing array.

Case Study

An 11-year-old boy was referred for a second opinion regarding deterioration in treatment. He was diagnosed with attention-deficit/hyperactivity disorder (ADHD), bipolar disorder, oppositional defiant disorder, and separation anxiety disorder. He was on seven medications. On the verge of being ejected from his public school, he continued his disruptive behavior. His parents were desperate: As they reported continuing problems, their psychiatrist either adjusted medications, added another diagnosis, or added another compound.

During our consultation the boy revealed that several older peers bullied him mercilessly. He had not disclosed this at home, because his father expected him "to stand up for yourself." Wanting to please father, he tried to prevail. He indeed exhibited core symptoms of ADHD, but most of his other problems (moodiness, irritability, and oppositional behavior) began during the bullying.

In this case (and all of us have encountered too many like this one) we are witnessing the expansion of reductionism from a methodological tool of science into an ideology resulting in "psychopharmaco-mythology." Our increasing understanding of the details of how the brain works, how medications are helpful in controlling symptoms, and how new tests such as computerized imaging are contributing to our understanding of the

function of the brain have carried these colleagues away: Because there are so many exciting data in these areas, these psychiatrists propose that our field should be entirely limited to the practice of the biological dimensions of human mental functioning. Some of our most enthusiastic colleagues propose that it is just a matter of time before we have reduced all of the mind to neurons. One of my very famous Stanford colleagues pronounced this wish with great confidence about 33 years ago, having studied the science of neurotransmitters and regulators intensively. He was not the only one at Stanford or at other elite institutions across the nation to do so.

But as of this date we still are nowhere near having achieved this type of understanding of the mind and brain. In fact the exact relationship between the brain and mind is as mysterious as ever, and many voices in the field question whether we will ever fully understand how precisely subjectivity arises and is causally effective. Most scientists working in the area of consciousness and brain/mind development expect that we will essentially be in the dark for the next 50 to 200 years. And then there are those like David Chalmers or Colin McGinn who think that given our current theories and methods of inquiries, all limited by us being humans, we shall never understand this connection. I do not necessarily share these scholars' pessimism, but I do think that any reductionist model of practice is premature orthodoxy and ill advised.

But rather than wait for the answers to come in, we as practitioners do not have the luxury of time. We need to act. In the meantime, as I tell my young students and trainees entering our field, one of the most prudent attitudes to take is that free will, self-efficacy, personhood, and so on, are not just figments of our imagination. They are facts of life. This is the position that is so famously espoused by John Searle, one of the most outspoken philosophers of mind in Berkeley, who has proposed his natural emergentism with great pragmatic wisdom. Human beings have a mind, make decisions freely, and can override forces of nature within certain boundaries: This is our daily experience. And if we cannot explain this on the basis of our current models of the mind/brain connection, so be it. But to sacrifice this subjective realm of experience solely because our science is too impotent to explain it is hardly a reason to abandon the quintessential feature of being human. We exercise our free will in accordance with social norms. We are not simply driven by and reacting to neuronal discharges.

From this point of view it is clear that psychiatrists should not limit their practice to just simply dispensing medications and reading MRI reports. It is of the essence that they understand the patient's subjective state, their experience and their account of their experience, their illness narrative. Subjective experience is not just an error term in a clinical trial, it is a core feature of being well and being mentally ill. We are not a simple accumulation of billions of neurons, we operate in a psychosocial context: It is impossible to isolate individuals from their families, friends, and loved ones. When we ignore this social orbit, we lose a tremendous amount of information that helps explain why people do things and that helps us to heal the problems people experience.

When patients as people are viewed as the unit of observation rather than an organ or molecule, one must assume that in addition to their biological characteristics, they have agency that allows them to act on their own behalf; they have a history that has shaped who they are; and they have a psychology that affords them choices despite the biological hand of cards they have been dealt. The limits set by biology and psychosocial contexts are not firm determinants for one's developmental trajectory. The doctor must integrate a body of knowledge generated by science and clinical practice and tailor this information to a particular person based on his or her individual needs.

The ultra-reductionistic stance, which is currently so much in vogue among some researchers and practitioners with a limited view of psychiatry, has also received considerable support from the pharmacological industry, closely followed by support from the U.S. insurance industry. Both of these, for obvious self-interests, would like nothing better than the reductionist model of psychiatry to hold. Dispensing medication is seen as cheaper and more effective than attempting to empathize with patients and their families; administering electric currents to brains is cheaper and more effective than carefully combining pharmaco-, psycho-, and sociotherapy. As I see it, our most important job as physicians of the mind is to preserve and strengthen personhood and agency in the patients by creating in our treatments a private workspace where they can explore their lives, protected by confidentiality. We assist them (and in the case of children—their parents) in recognizing limits and deficiencies, but we also help them

expand their view of possibilities and choices that remain available to them. Although we are experts in how the mind/brain system functions, we are also physicians that operate on the basis of a strong and carefully managed relationship with our patients, not their insurance agent or the drug company representative. And as much as is possible, we will encourage them to make their existential choices on the basis of their preferences, passions, and leanings. This is really what makes us respond with "what do *you* feel, think, like about that" when you ask us—"So what should I do." I usually follow up this interchange by saying that my choices would not necessarily be theirs, and to get them to make their own is of paramount importance. After they have made their choice, I am sometimes willing to disclose what I think about the choice and will discuss the risks and benefits of what they are contemplating. But to preserve their freedom to make that first step is crucial in the treatment process.

In order to have such a discussion in a meaningful way, we need to be experts in building a trusting relationship with patients and their families. This is by no means easy, and requires empathy, and careful management of emotional charges that derive from patients' past experience with doctors, teachers, parents, friends, and siblings. In the context of such a relationship, we can then offer interventions that require homework, learning, practice (as is required in cognitive behavioral therapy), and compliance with medication prescription schedules. And to the extent to which our patients and their parents have developed a deserved trust in our competence and unequivocal advocacy for our patients, we can then make them experts in the management of their own case.

With this view, we approach adolescent psychiatric treatment with four "Es": empathy, explication, encouragement, and experience. In order to provide the best care, a physician must understand who the patient is, using accurate *empathy*. This understanding goes beyond tests, labs, and imaging. As in the rest of medicine where the physical examination and touching the patient is still a cornerstone of the assessment of disease, in psychiatry, accurate empathic understanding of a person's subjective state, making mental contact, and being able to put oneself into the patient's shoes, is a sine qua non. The second E is *explication*—the doctor must step into the patient's mind, see the situation from the patient's point of view and

explain what is wrong and what should be done in a language that the patient can follow. The goal is to help patients see, understand, and broaden their choices in life. This process also involves helping the patients to understand what their biological and social limits are, where their individual freedom runs against the boundaries of mother nature and society. This is what the old analytic literature describes as "psycho-synthesis." Third, a doctor must *encourage* patients to move forward, and fourth, *experience* and follow their own path of continued growth and development, not just in theory, but in action.

On the other hand, we must be careful with adolescent patients not to put too much responsibility in their hands. Involving patients in decision making is important, but too often patients are told that treatment decisions are "completely up to them," which should not be true to begin with, but ultimately would render the function of the doctor obsolete. Adolescents in particular can make maladaptive choices when left to their own devices. A doctor must educate the patient on how to accomplish the goal—be it symptom reduction, remission, improved functioning, or something else entirely—and encourage the patient to embark on this path. And at all times, the doctor must work with the patient's family, bring them along into the changing world of their child, and help them support and supervise their child while respecting new boundaries and privacy limits. The doctor is not just the patient's or the family's agent, but balances carefully between these two psychosocial entities.

The fourth E is *experience*. From all of our experience with treatment, it has become abundantly clear that the therapeutic process is approached differently depending on the age and developmental stage of the patient, from infancy to adulthood to senescence. In this volume we focus on adolescence. We can expect that the patients are on the way to form an identity and to have ideas (sometimes very strong ones) about what they want or do not want to do. They need to be given reasons for why we recommend interventions, they need to embrace them, and they will have some power to negotiate with the doctor and/or their families regarding intervention, limits set, desired outcomes, and so on. They are able to reflect on their lives and they are, for the most part, partners with the treatment team as they bring us the pieces of the puzzles of their lives that we then help them fit into a bigger picture.

By criticizing the reductionistic biologism creeping into our practices, I am not advocating that we return to the 1950s and 1960s and prescribe 5 years of psychoanalysis to all comers or lengthy hospitalizations to effect permanent change. In fact, some of the great advances in psychiatry in the past 30 some years have been that (1) treatment length overall has been drastically shortened without loss of efficacy; and (2) treatment in elevated settings of care has become the exception, not the rule; and there is a strong emphasis on retaining patients in their communities, families, and schools while treating even the most difficult problems (an excellent example can be found in the chapter on eating disorders in this volume). There can be no doubt that manualized brief, symptom-focused psychotherapy and psychopharmacology has greatly reduced human suffering. Because of these now individually and family-based therapies and medications, even the most severely ill patients lead lives that approximate normalcy. Some problems, such as severe depressions that have persisted for many years and are complicated by suicidal motives, do need some form of ECT. Some problems, such as reactions to an earthquake, can indeed be prevented from progressing into full-blown posttraumatic stress disorder (PTSD) by giving a short course of very short-acting medications. The point is that we are now in a position where we have all these tools from biology, psychology, and sociology to intervene effectively. Which one and which combinations to use for what length of time has become the difficult task for the psychiatrist to decide. But such decisions cannot be made from a reductionistic platform, they have to be made from a broad spectrum view of how humans function, malfunction, and how we can heal them. This book offers cases and empirical data illustrating psychiatric diagnosis and treatment from the point of view I have just discussed and that I and many others have taught here at Stanford for more than 35 years.

Strengthening my resolve is the fact that while I am writing this book, the most effective intervention in psychiatry, which is based on the meta-analyses of hundreds and thousands of patients, is a psychodynamically based psychotherapy that heavily relies on concepts originally proposed by Freud while employing them in a modern format. The list of diagnoses where psychodynamic treatment is effective is not limitless. It excludes disorders such as mental retardation, schizophrenia, and autism, for instance, disorders that can be classified as neuropsychiatric syndromes. In these, there is a

preponderance of biological factors gone awry. But the list includes diagnoses such as anxiety disorders, reactive depressions, trauma-induced psychopathology, eating disorders, substance and alcohol abuse, and disorders of conduct and disruptive behavior. Such disorders are not devoid of biological factors of import in the pathogenesis and therapy, but it is possible to approach the problems in a top-down way, bringing self-reflection, choice, and effortful self-control into play in the process of healing.

How we account for and consider genetic influences in psychiatry has also become a very important question in psychiatry, as in the rest of medicine. There has been much excitement in the field about some findings, but it is good to remember that so far genetics has a very limited influence on our practice, as will become obvious in all the chapters of this book. It is clear that genes influence the way we act, feel, and think; it is just a matter of how important and how large of an effect these types of factors have. The stage is set such that we are talking about genetics and environment as each having 100% influence, as one of my geneticist researcher friends says with a twinkle in his eye, that effects of genes combine with environmental influences to produce bad outcomes, and that development and age remain contributors to whether things will take a bad, neutral or good turn. Interactions are the order of the day, and that leaves plenty of room for personal decisions contributing to good and bad outcomes.

We are each who we are due to the profound interaction between genes and environment. Just like the seed of the tree pictured above, our biology is the framework of who we are—male or female, tall or short—but it is not the sole determinant of who we are to become. The environment in which a seed is planted has significant effects on how the tree grows. Over time, these external influences—sunshine, water, soil quality—affect the growth of the tree in important ways. A redwood seed will always grow to be a redwood tree (the tree's biology), but a redwood seed planted in the forest will grow to be a very different tree from a seed planted in the desert due to differences in sun exposure, access to water, seasonal changes, and terrain. The tree is vulnerable to the elements; its health is at the mercy of its environment. In the picture, for example, we can see that the tree has sprouted two branches at the very top—evidence that it has been struck by lightning. An environmental trauma changed the course of its development, and the tree adapted in response.

Likewise, our biology provides the structure of our development, but our psychosocial context, such as birthplace, family, and community factors, strongly influences how we develop and who we become. We adapt and change in response to these influences, and our experiences layer on top of our genes to produce our persona. How can we best accommodate all these factors in a theory that embraces complexity and does not seek to eliminate it? I find that a developmental theory of psychiatry best fits this picture.

I usually encourage our young doctors in training as they embark on the difficult journey to get to know and forge an integration of biology, psychology, sociology, and neuroscience. I explain that the psychiatrist is the medical specialist who straddles these sciences and thus is in a very difficult position. However, this position is necessary for now and probably will be for a long time, perhaps forever. As consolation I offer the observation that as they embark on their careers, they have 100% job security for the foreseeable future. They will not be replaced by machines, as the technological understanding of mental functioning will never replace their capacity for empathizing with humans. This is true in the diagnostic and the therapeutic realm. One only needs to remind oneself of all the failed AI experiments in the 1960s and 1970s where scientists were trying to replace psychotherapy with computer-driven scripts. Such scripts are

coming back into the field, in the form of manualized treatments and computer-based exposure scripts. This is an advance, as some simple psychiatric problems do respond to such interventions. It is also good to remember that most of the trials reporting on the efficacy of these interventions take place in very "purified" samples, arrived at by stringent exclusion and inclusion criteria. The fact that many complex cases are excluded from such trials artificially inflates the response rates and effect sizes of interventions. This is also true of clinical trials of medications. Furthermore, we have to remember Shedler's interesting finding from a very large meta-analysis that the elements in cognitive behavioral therapy (CBT) and dialectical behavioral therapy (DBT), which are efficacious, are not necessarily exclusive characteristics of these interventions, and it often seems that if certain interventions are effective they are delivered in a manner or package that bears many characteristics of psychodynamic treatment.

I also tell them that being a psychiatrist brings with it an excitement and an invigorating and demanding knowledge base. I've been a physician, writer, and psychiatrist for more than 40 years, and at no point in my career have I seriously repented my choice. However, the path I chose has not been an easy one. During my entire academic career, I have struggled with the interpretation of these divergent streams of information and have attempted to find ways of integrating them. I've summarized the results of my struggles in many papers and textbooks, but at the end of my career in academia, it is important to me to reach beyond the circle of medical and scientific colleagues. This current volume tries to achieve the same synthesis.

We are also happy to report that in these past 20 years there has been a sustained interest in treating adolescents, reflected in the strong sales of the first volume. We do realize that treating adolescents is a very complex task, or as some of my own supervisors said at the time—the true calculus of psychiatry. Adolescence is a time of unparalleled threat, change, challenge, and opportunity. Nowhere else in human development do we encounter such a major transformation in such a short time in so many domains: our bodies, minds, abilities, and interpersonal relationships. And for those among us with a stronger humanistic bend, we can offer literature and film to bring about knowledge that is needed in dealing with adolescents. The

theme of adolescence and the changes it brings has intrigued artists and writers for centuries. One of the earliest versions of it is the medieval epic of Parsifal by the German knight Wolfram von Eschenbach (1170–1220), which was set to magical music by Richard Wagner. Modern-day versions are depicted in the trials and tribulations of Holden Caulfield in *The Catcher in the Rye,* and Hans Castorp in Thomas Mann's *Magic Mountain. Girl, Interrupted*, *The Virgin Suicides*, and *The Perks of Being a Wallflower* are all other examples of coming of age fiction. We invite you to explore these works as excellent interpretations of the turmoil and power of adolescence.

In addition to the books mentioned earlier, I always recommend that our trainees see certain movies: *Fanny and Alexander* (lngmar Bergman, director), where the dawn of adolescence is described in two very different family milieus; *My Life as a Dog* (Lasse Halstrom, director), from which we regain a precious understanding of the reactions and explorations of early adolescence; *Stand by Me* (Rob Reiner, director), where we see feats of heroism, idealism, friendship, and selfishness performed altogether in a very short span of time; and *Amarcord* (Federico Fellini, director), which so beautifully portrays the full spectrum of life's complexities through the eyes of a mid-adolescent teenager. Also, spend some time looking at photographs and films from your own adolescence. Listen to the music that speaks to the youth of today. Such a comprehensive approach to the subject is most helpful, we find, in allowing us to blend fact with empathy and preparing us properly to enter the world of adolescence, where time and energy are boundless, and opportunity for growth and change is the order of the day.

It is not surprising that the rates of psychopathology increase dramatically during adolescence. There are biological, psychological, and social reasons for that. New syndromes appear as never before in development, and old ones persist, assuming new shapes and forms. Many of these changes are dramatic in character but surprisingly inaccessible to the clinician, as they are present for only brief periods of time. Also, bad habits that may develop in this period have not had time to crystallize into a way of life quite yet. Thus, through timely intervention, a clinician has a unique opportunity to eliminate suffering, future disorders, and such

habits they might cause, thereby preventing chronic impairment. Interventions can also have a major impact with younger children, but there is an essential difference with adolescents that soon becomes apparent: the ways and means of communication and understanding used with and by adolescents are as powerful and have as much impact as those associated with adults. This fact makes the task of addressing problems faster, easier, and sometimes more enjoyable than when working with children. It is not uncommon to find quantum leaps of change taking place in very short periods of time with these young people. Again, threat and opportunity are closely knit together.

Most clinicians find it difficult to engage with adolescents. The reasons for this are complex. In order to engage with this population it is especially important to integrate biological, psychological, and social dimensions of development and psychopathology. The databases for each are still uneven, as is evident in the chapters to follow, but as previously mentioned we now have significantly more empirical evidence compared to 1994 when the first edition of this book was written.

Additionally, the successful blending of experience and technique is a difficult task because we are required to track so much information simultaneously and make sense of it by recognizing patterns. We have to integrate all the information into a broader social context. We need to keep in mind the physical limitations, the biological givens of each patient that limit potential and call for adaptation. This process in adults is quite complex, but is even more challenging in the adolescent age group because of the speed with which events develop and change occurs in these young people.

Another reason why clinicians can find adolescents challenging to work with is probably one that usually ranks high among them: Therapists often want to forget their own most difficult period of development. Most of us are happy to have escaped into an adult world, where life is stable and predictable. We have no desire to revisit the maelstrom of uncertainties that the adolescent period of development presented to all of us. For better or worse, we have forged our identities and have consciously forgotten the days when it was possible to feel like Alexander the Great in the morning and to be on the dark edge of chaos by the afternoon, when we felt that a

bright future as a film star was certain as we looked at ourselves in the mirror prior to the prom date, but knew by the end of the evening that we would be spinsters for life.

We are required to take on these age-old dilemmas once again as we engage with adolescent patients. To be able to provide sustained and effective help, we have to remember the pain and exhilaration of the moment, without belittling or patronizing the patient. There is an immediacy to this work that is usually not found in working with adult patients. Consequently, it is common to get caught by surprise and rediscover unfinished business within ourselves. If you wish to be effective in making contact with this age group, you must enjoy paradox. You must also have a good sense of humor and be flexible. You must be willing to stand with one foot in your own past without being consumed by it, not be afraid to be parental when that is needed, and yet be quick enough to step back into the role of the professional when necessary. This is a tall order. No wonder most of us prefer the tranquil world of adult interaction and easily pay the price of slow change for the reassurance that the world is orderly after all.

We hope that many of you find excitement in working with this age group. As with anything in life, there are risks and rewards. All of us who have spent the better part of our lives working with adolescents and their families obviously think the latter outweigh the former. It will take some time to acquire the necessary skill, but in our eyes, the investment is well worth the result. This book is meant to give you some guidance, but ultimately it is our patients who truly make experts of us all.

The mental health professional working with adolescents also needs to be prepared to be part of a team. More often than not, the treatment of adolescents requires the close collaboration of several people, and without such collaboration treatment will usually stall. Parents, teachers, pediatricians, and the mental health team need to compare notes frequently so they can change course or renegotiate contracts as needed. This is not an area of medicine where "lone wolves" do particularly well as therapists. Again, the reasons for this are complex, but are mostly rooted in adolescent psychology: internal structures are unstable, as are relationships; divide and conquer is a favorite pastime of the teenager. Which of us does not

remember the intricate schemes we engaged in to spend time with a friend who was off limits? Some of those dynamics rapidly become apparent in treatment, as the patient attempts to neutralize a certain painful awareness in a conflicted domain. Some of the emergent discrepancies of the patient's situation are not brought about consciously by the teenager. Others, however, are cleverly engineered and require a full-court press by everyone concerned to avert negative consequences. This immediate response is possible only if all concerned are prepared to coordinate their efforts to the fullest.

We all hope that our book gives the novice a jump start in working with adolescents. We believe that additional benefits accrue to clinicians who become involved with this age group: Work with children and adolescents generally leads to a deeper understanding and appreciation of the principles of development, and this knowledge in turn enriches a therapist's understanding of adult cases. Once we directly observe an individual's process of becoming a person, we are better able to help those who merely tell us about this process in retrospect. By expanding our skills to new areas, we can gain a new understanding of well-traveled paths. Everybody wins: our patients, because we will be better therapists; their parents, because they get back their children whom they think they've lost; and we ourselves, because we find new professional fulfillment.

This book is organized to follow the emergence of specific syndromes in adolescents between the ages of 11 and 18. Most of the authors of the chapters are associated with Stanford University School of Medicine. We do not suggest by these selections that our division has a monopoly on expertise in the field, as there are many other excellent academic centers in child and adolescent psychiatry in the nation. However, our division, although small, usually ranks among the top four or five most prolific academic settings, and we thought it useful to present "the Stanford approach" to give the clinician a more cohesive picture of a kaleidoscopic and complex situation. All our authors have many years of experience treating adolescents.

Chapters are organized by grouping diagnoses into three categories: externalizing disorders, internalizing disorders, and psychosomatic and neuropsychiatric disorders. Since the first edition was published, it has

become clear that the disorders within these domains are somewhat distinct, though they do overlap and have commonalities in terms of origin, treatments, and underlying neuroscience. Adolescents with externalizing disorders are most often brought in to the clinic by their parents due to complaints about their behavior. The teens' symptoms cause those around them distress, rather than causing the teens distress. These patients can be more difficult to engage in treatment, as they often do not see the point of it. Conversely, adolescents with internalizing disorders report symptoms that cause them internal suffering and are often easier to engage in treatment. Psychosomatic and neuropsychiatric disorders involve complex psychopathology, and their treatment requires an extended team of specialists to collaborate, such as medical specialists, pediatricians, and nutritionists.

Chapter 1, General Principles, discusses the general philosophies behind this book and explains the principles of treatment that are common to all adolescent psychiatric disorders. I also touch on emerging adulthood, the developmental phase between adolescence and adulthood, and how the discussions in the following chapters apply to this stage of life.

Chapter 2 begins our discussion of externalizing disorders with disruptive behavior disorders, which are some of the most frequent complaints to mental health providers and can be a challenge to address. We provide an overview of the recommendations for treatment of disorders such as oppositional defiant disorder (ODD) and conduct disorder (CD).

Chapter 3 focuses on the treatment options for adolescents with attention-deficit/hyperactivity disorder (ADHD), another externalizing disorder and one that has been the topic of much criticism and controversy. We approach this chapter from the perspective that this is a real diagnosis and discuss the substantial evidence base that supports its treatment.

Chapter 4, Learning and Executive Cognitive Functions, discusses the current knowledge base surrounding learning disorders (externalizing disorders), which can change the trajectory of a young person's life and have significant negative effects on quality of life. We discuss the different treatment options that can help these teens.

Our discussion of externalizing disorders concludes with Chapter 5, in which we address substance use disorders, a major public health concern in

the United States. Substance use disorders contribute to a range of serious outcomes, including incarceration and fatalities. We outline the current knowledge base on how to best help these youth.

In Chapter 6, Anxiety Disorders, Tics, and Trichotillomania, we begin our discussion of internalizing disorders. The diagnosis and treatment for disorders such as generalized anxiety disorder, specific phobia, school refusal, social anxiety disorder, panic disorder, and obsessive compulsive disorder (OCD), in addition to tics and trichotillomania, are outlined.

Chapter 7 moves into a discussion about adolescent depressive disorders (internalizing disorders), such as major depressive disorder and persistent depressive disorder, and their psychosocial and pharmacological treatment options.

Chapter 8 discusses adolescent bipolar and mood disorders, which have gained public and clinical interest since the 1990s, leading to advancements in psychotherapeutic and pharmacologic treatments. Bipolar and mood disorders are considered primarily internalizing disorders.

In Chapter 9, Psychiatric Trauma and Related Psychopathologies (internalizing disorders), the discussion centers on adolescents who are experiencing psychiatric symptoms as a results of trauma, such as PTSD. We review the currently available treatments and knowledge base for these disorders.

Suicide, which is the third leading cause of death among adolescents each year in the United States, is reviewed in Chapter 10, Self-Harm and Suicidal Behavior. In addition to discussing the treatment recommendations for suicidal thoughts and behaviors, we also review self-harm disorders, such as non-suicidal self-injury (NSSI).

Our discussion of psychosomatic and neuropsychiatric disorders begins with Chapter 11, Somatic Symptom and Related Disorders. This chapter focuses on the treatment of adolescents who experience physical symptoms with no known medical cause or whose physical symptoms are exacerbated by their psychiatric symptoms.

In Chapter 12 we continue our discussion of psychosomatic and neuropsychiatric disorders with eating disorders, which are one of the most common psychiatric issues in adolescents. We outline the epidemiology, diagnosis, and treatment options for anorexia nervosa and bulimia nervosa.

Chapter 13 details the knowledge base and treatment options for the devastating diagnosis of schizophrenia in adolescence. We also briefly discuss common clinical concerns that arise when an adolescent presents with a pervasive developmental disorder, and how this can be confused with psychosis.

Finally, Chapter 14 focuses on sleep disorders in adolescence, such as sleep disordered breathing (SDB), narcolepsy, delayed sleep phase syndrome (DSPS), restless legs syndrome (RLS), and parasomnias. We review the available treatment options and provide clinical recommendations.

Throughout the book, we alternate between referring to patients as males and females.

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