

Adolescent Mental Health

*A guide for teenagers
and their parents*

from Project LIFE

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Introduction

Note to Readers

Whether you say “teenagers,” “teens,” “adolescents” or “youth” (you’ll find the terms used interchangeably), these are the years that last from puberty to adulthood. For parents, professionals and teens, this is an exciting—and often exasperating—time.

Psychologist Anthony Wolf observes that “The only stage of life comparable to adolescence is pregnancy, when the body undergoes radical growth and is flooded with hormonal changes. Luckily, both pregnancy and adolescence are stages that, with a little understanding and compassion, have good outcomes.”

Adolescent Mental Health is designed to provide insight into adolescent development and social factors, as well as adolescent brain disorders, medication and therapy. It is a companion to Project LIFE’s *Understanding Mental Illness* and *The ABCs of Children’s Mental Health*, where you will find additional information.

This booklet is not intended to provide medical or psychiatric advice, and should not be used as a substitute for professional care.

Note to Parents

Throughout this booklet, you will see “Note to Parents” indicating special information for parents. Remember to keep the lines of communication open with your teenager, using the suggestions that follow:

- Don’t lecture, have a conversation. Conversation involves at least two people.
- KISS: Keep It Short and Simple.
- Don’t attack.
- Give the respect that you want given to you.
- Seize the moment. Your message will have a better chance of being heard when your teenager is in a receptive mood.
- **Don’t take it personally.**

Parental Stress Helpline

The **Parental Stress Helpline** is available 24/7 for parents who feel overwhelmed with parental pressures and responsibilities. The Helpline offers on-line crisis counseling to parents and provides referral information about local agencies, which may offer additional or more intensive services. You may call the toll-free **Helpline** at 1-800-367-2543.

Calls to the Parental Stress Helpline may be anonymous. However, if information is given indicating that a child has been or is being abused or neglected, and identifying information is provided, the information *must be referred* to the child abuse and neglect hotline for investigation.

— Mo. Dept. of Social Services, Children’s Division

**IF YOU NEED
IMMEDIATE HELP
call the 24-Hour
CRISIS HOTLINE
for your area.
See Page 36.**

What is the DSM-IV?

In *Adolescent Mental Health*, you will find a summary of important clinical and social aspects of brain disorders.

Much of this information comes from the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders IV*, also called the DSM-IV. This manual [the DSM-IV] is used to describe symptoms of brain disorders; professionals use it to make a diagnosis.

What is a Brain Disorder?

“Open Your Mind: Mental Illnesses are Brain Disorders.”

— National Alliance for the Mentally Ill (NAMI)

In recent years, science has taken unprecedented leap in understanding the nature and cause of “mental illnesses.” With few exceptions (notably schizophrenia), these are neurological disorders of the brain. Many brain disorders are linked to chemical imbalances, and (like diabetes) respond well to medication and therapy. Most individuals can expect to recover from brain disorders, and the outcome for those with severe brain disorders is brighter than ever before. People with chronic brain disorders can maintain good health and enjoy their lives.

Missouri Department of Mental Health

The Department of Mental Health improves the lives of Missourians in the areas of mental illness, substance addiction and developmental disabilities. For information, call the department Toll-Free at 1-800-364-9687, or see the web site at www.dmh.missouri.gov.

Project LIFE

Project LIFE (Leisure Is For Everyone) is making a difference in the lives of Missourians who have mental illnesses. A cooperative program supported by the Missouri Department of Mental Health and the University of Missouri, our mission is to increase public awareness of mental health issues, and to advocate for the quality of life of persons with brain disorders. Project LIFE programs assist children, youth and adults throughout the state.

If you would like to learn more about Project LIFE, call the LIFE Line at 1-800-392-7348; write to us at 623 Clark Hall, Columbia, MO 65211; or visit our web site at <http://web.missouri.edu/~projlife>.

—*Kristen Heitkamp, Director of Information, Project LIFE*

Adolescent Development

During adolescence, children will experience unprecedented changes in mind and body. These changes can be characterized in several areas, as follows.

Physical Changes and Sexuality

As children enter puberty, they experience a growth spurt and the start of “true” sexuality—girls begin menstruating, boys produce sperm. Girls develop breasts. Boys develop a deeper voice and facial hair. Naturally, both genders begin to have sexual feelings. Suddenly they are obsessed with their appearance—how can a “bad hair day” become a crisis? It’s helpful to understand how sexuality and sexual feelings affect teenage behavior. Hormone imbalances can produce tears, tantrums, fears and elation; teens are subject to roller-coaster moods. The effect of reproductive hormones influences male behavior, as boys become intensely aware of sexual feelings:

The emergence of physical sexual feelings is at times so overpowering that a teenage boy cannot look at a female without having sexual feelings. They do not want to have these feelings about their mothers, sisters or aunts, so they physically withdraw. (Wolf)

Reproductive hormone levels rise and fall according to a girl’s evolving menstrual patterns, and will affect her moods and behavior. Girls “want to be seen as sexual beings,” yet resent being sex objects. They’ll bare their midriffs but cringe at wolf whistles. In these years, a girl may see her mother as competitive, overbearing or critical. In order to distance herself from her mother, a girl will “argue, challenge and criticize.” Girls tend to verbalize their emotions, so “the battle is constant and unremitting.” (Wolf)

The first and foremost man in a girl’s life is her father. If her father is absent (physically, emotionally, or through alcoholism or substance abuse), the girl may have difficulty with intimate relationships, and may use sex as a substitute for emotional interaction.

Intellectual Development

Thinking processes are rapidly maturing. “Rapidly maturing” indicates that the brain is still developing. Recent brain research suggests that brain neurochemistry is “vulnerable” to the influence of factors such as head injury and panic attacks, which “short circuit” brain activity, as psychologist Laurence Steinberg notes.

While the interpretation of research is “still speculative,” Steinberg cites “evidence of structural change in the prefrontal cortex, which is the area that governs what we call executive function,” in other words, the brain area that controls skills like planning, scheduling, etc.

As teenagers develop intellectually, they begin to understand that the world isn't black and white, and may tend to see truth as relative. Wolf writes that adolescents tend to lie by "omission" or fabrication:

They are doing a certain amount of experimenting with adult behaviors such as drinking, smoking and having sex, and either do not want to "get caught" in the act, or do not want to hear lectures about these behaviors.

During adolescence, youth develop advances in reasoning. "They are more able to think about things abstractly and logically. Adolescents become interested in concepts such as justice, fairness, and rights." (Galotti et al, 1991)

Adolescent Behavior

Individuality – Being Yourself, just like everyone else.

Commonly adolescence has been seen as a time of rebellion, which is a manifestation of separating from the family, and is in most cases a necessary developmental phase. Caught between childhood and maturity, teenagers naturally exhibit contradictory behavior. Typically, they strive to separate from their parents; they swap allegiance from parents to peer group.

Friends replace family. Teenagers gravitate to clubs, cliques, gangs, teams and youth groups. They form relationships with mentors (a coach, teacher or employer), especially if a parent is emotionally or physically absent.

But establishing an identity is hard work. It takes a lot of introspection ... It takes some breaking away from the family to become an independent person, and an increased interest in what your peers, not your family, think.

(Borowitz)

NOTE TO PARENTS: "Fitting in" is difficult for teens in general, but intensely so for teens with behavioral or brain disorders, who may be shunned or bullied, and often will be misunderstood. Parents, who have been their foremost advocates, are suddenly unwelcome defenders. Group therapy and support is very helpful for these teenagers. They discover that they are not the only ones dealing with the challenges of these disorders, and find common ground with peers.

Physical Fitness

Mental Health Effects of Obesity

Weight gain and lethargy may indicate underlying depression, while an obsession with weight may contribute to eating disorders. But the most immediate consequence of being overweight (as perceived by youth themselves) is social discrimination and low-self-esteem. In a recent study by Schwimmer, et al. (2003), “obese children rated their quality of life with scores as low as those of young cancer patients on chemotherapy.”

In the study, 106 youth aged 5 to 18 filled out a questionnaire used to evaluate quality of life issues: their ability to walk more than one block, play sports, sleep well, get along with others and keep up in school. The results indicated that teasing at school, difficulties playing sports, fatigue, sleep apnea and other obesity-linked problems severely affected obese children’s well-being.

If an adolescent doesn’t seem depressed, but complains of fatigue and is overweight, a blood test can rule out hypothyroidism (low thyroid hormonal level).

Also see Binge-Eating Disorder, page 15.

Active Life-style

Exercise relieves tension, increases energy and improves mood. Studies have shown that active involvement in sports improves mental and physical health, reduces risky behaviors, and increases self-confidence.

Ways to stay fit include physical household chores such as yard work, washing the car, cleaning house and snow shoveling; and physically active jobs like mowing lawns and delivering newspapers.

Teenagers thrive on a variety of experiences. Encourage teens to try water skiing, skateboarding, rock-climbing, canoeing, kayaking, horseback riding, ice and roller skating, motorcycling, mountain biking, yoga, skiing, hiking, camping, martial arts, rugby, synchronized swimming, theatre or filmmaking. Music and dance are natural ways to express emotions.

Reward participation, not competition. The goal is to identify and to enjoy active leisure interests that will be integrated in a healthy life-style.

Never underestimate the power of nature. Teenagers may find comfort and spiritual resonance in a natural setting, and define their lives in relationship to the great outdoors, which is more complex and interesting than video games or reality TV.

Speaking of TV, a recent long-term study links television watching and ADHD. The researchers “found that early exposure to television was associated with subsequent attentional problems,” independent of “other issues known to cause behavior problems.” (Christakis, D. et al., “Early Television Exposure and Subsequent Attentional Problems in Children,” *Pediatrics* (113,4) April 2004, pp 708-713.)

Mental Health Issues

Mental Health

Teenagers can protect their mental health by eating nutritious meals, getting enough sleep (nine hours each night), and exercising regularly. Teens should be encouraged to practice and master increasingly complex and demanding life skills. Participation in extracurricular activities, such as youth organizations, chess club, school band, drill team, etc., reinforce self-discipline and competence. Work or volunteer experiences also widen a teenager's world view and boost self-worth. An involved teenager is more likely to resist self-destructive acts of addiction, sexuality or aggression.

Participating in activities serves two purposes: it engages a teenager in life outside the home (thus preparing a teen for adulthood); and it limits television/video game time (linked to increased aggression and obesity). Exercise reduces the physiological effects of depression and tension; moreover, research suggests that sports participation curbs substance abuse, and that participation in youth organizations exposes teens to positive role models.

Psychiatric Issues

Statistics showing the prevalence of child and adolescent psychiatric issues indicate:

- Fifteen million (20%) of U.S. children and adolescents ages 9-17 have diagnosable psychiatric disorders (*Cooperative Agreement for Methodologic Research in Child and Adolescent Mental Disorders*, 1996)
- One in ten children and adolescents suffer from a mental illness severe enough to cause some impairment, although fewer than half of them receive needed treatment in any given year. (*Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*, 2001)
- Seven to fourteen percent of all children will experience an episode of major depression before the age of 15. (*National Alliance for Research on Schizophrenia and Depression*, 1996)

Psychiatric Disorders

Listed on the following pages are the most common psychiatric disorders diagnosed in adolescence. A diagnosis describes a pattern of behavior, or set of symptoms. It does not describe the person's home life, feelings, dreams or expectations; rather, a diagnosis is a starting point for intervention and recovery.

Attention Deficit Disorders

Attention-deficit and/or hyperactivity disorders (ADD, ADHD) are the most prevalent brain disorders in children and adolescents, often diagnosed in preschool or early elementary years, and frequently persisting into adulthood.

A growing number of children, especially boys, are diagnosed with attention-deficit or hyperactivity disorders. Not all children (or adults) will exhibit both disorders, although a significant number do. For diagnosis, a person must exhibit characteristics of ADD or ADHD in more than one setting (such as school and home).

Typically, a person diagnosed with **attention-deficit disorder**

- fails to pay attention to details
- has difficulty sustaining interest in tasks or play
- will not listen when spoken to directly
- will not follow through on instructions
- procrastinates
- is easily distracted
- is forgetful

With **hyperactivity disorder**, a person typically

- fidgets or squirms
- cannot remain seated
- often talks excessively
- often interrupts others; is intrusive

RESOURCES

Children with Attention
Deficit Disorders (CHADD)
499 NW 70th Avenue
Suite 308
Plantation, FL 33317
(305) 587-3700
www.chadd.org

Attention Deficit Hyperactivity Disorder
by Russell Barkley
(The Guilford Press, 1990) discusses
various structured psychiatric
interviews
designed to quantify ADHD
specifically in teens:
TOYS (Teenager or Young
Adult Schedule),
DICA, DISC, and K-SADS

ADHD in Adolescence

As they mature, children with attention deficit disorders will feel more comfortable with school and social situations. But puberty raises new challenges. A teenager is expected to master the more complex demands of adult life: to juggle work, school assignments and self-care, along with other interests and relationships. As the executive functions of the brain are still maturing, deficits in this area (caused by ADD or ADHD) hamper the ability to organize and “multitask.”

ADHD Medications

Stimulants, specifically Ritalin and Concerta (methylphenidate), Dexedrine, and Dexedrine Spansules (dextroamphetamine) are prescribed for attention deficit disorders. Adderall XR may be prescribed.

Note:

Sometimes bipolar mood disorders can be mistaken for ADHD; unfortunately, the results of giving stimulants to a child with bipolar disorder can be devastating. Stimulants can trigger a manic reaction as well as increased rapid cycling moods. See **BIPOLAR DISORDERS**.

Anxiety Disorders

Anxiety disorders include obsessive-compulsive disorder (OCD), phobias and panic disorder. The National Institute of Mental Health estimates that about 13 of every 100 children and adolescents, ages 9 to 17, experience some kind of anxiety disorder. About half of children and adolescents with anxiety disorders have a co-occurring brain disorder (e.g., another anxiety disorder, bipolar disorder or depression). Also, anxiety disorders may coexist with physical illnesses or neurological disorders (e.g., migraines, tics or Tourette’s syndrome).

In general, anxiety disorders are caused by neurological changes in response to stress. Just as diabetes is associated with levels of glucose and insulin, anxiety disorders are related to levels of neurochemicals (such as serotonin and dopamine), which influence how the brain reacts to certain events. Adolescents with anxiety disorders typically experience intense and chronic fear, worry, or uneasiness, which significantly affect their lives. Undiagnosed anxiety disorders may cause:

- Repeated school absences or an inability to finish school
- Difficulty making and keeping friends
- Low self-esteem, shame
- Alcohol or other drug use
- Problems adjusting to work situations

ONLINE RESOURCES

Freedom From Fear
www.freedomfromfear.com
(fact sheets and screening in English and Spanish)

National Institute of Mental Health:
Anxiety Disorders
www.nimh.nih.gov/anxiety

Anxiety Disorders Medication and Therapy

Anxiolytics (antianxiety medications) with U.S. Food and Drug Administration (FDA) approval for use in children and adolescents include clomipramine (Anafranil®) and fluvoxamine (Luvox®). **NOTE:** In 2004, the FDA issued a warning to prescribing physicians of suicide or suicidal actions linked to selective serotonin reuptake inhibitors (SSRIs). Bipolar disorder should always be **ruled out** before prescribing antidepressants for anxiety. See **BIPOLAR DISORDERS**, page 16.

Children and adolescents with anxiety disorders can benefit from a variety of therapies. Following an accurate diagnosis, possible treatments include:

- Cognitive-behavioral treatment (CBT), which helps people learn to deal with fears by modifying the ways they think and behave. CBT can be especially helpful for teens who have panic attacks or agoraphobia.
- Relaxation techniques such as controlled breathing
- Biofeedback (to control stress level and muscle tension)
- Family therapy
- Behavioral therapy, specifically Exposure and Response Prevention (ERP), has proven useful for control of agoraphobia or obsessive compulsive disorder. In ERP, a person is exposed to whatever triggers the problem, and then helped to forego the usual ritual—for instance, having a person touch something dirty and refrain from washing hands. ERP is often successful along with cognitive-behavioral therapy.

Information about the most prevalent anxiety disorders follows, in alphabetical order:

Generalized Anxiety Disorder (GAD)

GAD is chronic, exaggerated worry about routine life events and activities. The worry lasts at least six months; a person almost always anticipates the worst, even when there is little reason to expect it. GAD is accompanied by physical symptoms such as stomachaches, fatigue, trembling, muscle tension, Temporo-Mandibular Joint Syndrome (TMJ), headache or nausea.

Obsessive-Compulsive Disorder

Obsessive-Compulsive Disorder (OCD) is characterized by persistent, unwelcome thoughts or images, and by the urgent need to engage in certain rituals such as hand-washing, checking, counting or ordering. The disturbing thoughts or images are called obsessions, and the rituals that are performed to try to prevent or eliminate them are called compulsions. There is no pleasure in carrying out the rituals, but only temporary relief from the discomfort caused by the obsession.

OCD is diagnosed when obsessions and ritual activities consume at least an hour a day, cause anxiety to the person and interfere with his or her daily life.

The occurrence of OCD is approximately one in fifty people. It can appear in childhood, adolescence or adulthood, but on the average it is first diagnosed in teenagers or young adults. The course of the disease is variable—symptoms may come and go, they may ease over time, or they can grow progressively worse. Evidence suggests that OCD has a genetic component.

Depression, tics, eating disorders or other anxiety disorders may accompany OCD. People with OCD may avoid situations in which they might have to confront their obsessions, or they may try unsuccessfully to self-medicate with alcohol or drugs. People with OCD benefit from a combination of medications and behavioral treatments.

Panic Disorder

Repeated panic attacks, without apparent cause, are signs of a panic disorder. Panic attacks are periods of intense fear accompanied by a pounding heartbeat, sweating, dizziness, nausea, or a feeling of imminent death. The disorder includes behavior that avoids the situations that cause the panic attacks.

OCD RESOURCES

Obsessive Compulsive
Foundation, Inc. at
203-401-2070
www.ocfoundation.org

St. Louis Behavioral
Medicines Institute
Anxiety Disorders Center
877-245-2688
www.slbmi.com

St. Louis OCD
Support Group
314-842-7228
www.stlocd.org

NOTE TO PARENTS:

Is it drug use or an anxiety disorder? A physician should rule out drug use, before making the diagnosis and prescribing medication.

Substance-induced Panic Attacks

Panic attacks may result from use of substances such as cocaine, amphetamines or cannabis (marijuana). Cocaine and amphetamine users are commonly anxious, irritated, argumentative or paranoid when in withdrawal. While cannabis is a mild depressant of the central nervous system, some people have a paradoxical reaction with panic attacks. These attacks usually resolve if cannabis use is discontinued.

Substance-induced Anxiety Disorder

The DSM-IV notes that anxiety disorder can occur “in association with intoxication with the following...alcohol, amphetamine and related substances, caffeine, cannabis, cocaine, hallucinogens, inhalant, phencyclidine and related substances...” Anxiety disorders also occur in withdrawal from alcohol, cocaine, sedatives, hypnotics and anxiolytics. Also noted to induce anxiety symptoms are bronchodilators, oral contraceptives, antihistamines, antidepressants and antipsychotics.

Social Phobia (Social Anxiety Disorder)

Overwhelming anxiety and excessive self-consciousness in everyday social situations are symptoms of social anxiety disorder. Youth with social phobia have an intense, chronic fear of being watched and judged by others, and of being humiliated by their own actions. Their fear may be so severe that it interferes with their lives. While many people with social phobia recognize that their fear of being around people may be excessive or unreasonable, they are unable to overcome it without therapy. They often worry for days or weeks in advance of a dreaded situation. Physical symptoms often accompany the intense anxiety of social phobia and include blushing, profuse sweating, trembling, nausea, and difficulty talking.

Social phobia occurs in females twice as often as in males, although a higher proportion of men seeks help for this disorder. Typically, the disorder begins in childhood or early adolescence.

Phobias

Phobias are unrealistic and excessive fears of certain situations or objects. Many phobias center on animals, storms, water, heights or situations, such as being in an enclosed space (claustrophobia). Youth with phobias will try to avoid the objects and situations they fear, so the disorder can greatly restrict their lives.

Agoraphobia

This phobia is caused by anxiety related to being in places where a person feels vulnerable to having a panic attack. Often, people with agoraphobia feel they cannot leave the house.

Oppositional Defiant Disorder

Oppositional defiant disorder (ODD) and conduct disorder, while presenting related behaviors, have specific differences. Following are behaviors associated with each disorder.

RESOURCES

Oppositional Defiant Disorder: Help for the Angry, Troubled Child, John F. Taylor and Jamie Miller, Prima Communications, 2001.

Winning Cooperation from Your Child: A Comprehensive Method to Stop Defiant and Aggressive Behavior in Children, Kenneth Wenning, Jason Aronson Publishers, 1996.

Oppositional Defiant Disorder

(behaviors exhibited since childhood)

- Loses temper
- Argues with adults
- Defies requests and rules
- Deliberately annoys others
- Blames others for mistakes
- Touchy and easily annoyed
- Angry and resentful
- Spiteful and vindictive
- Swears and uses obscenities

Conduct Disorder

- Initiates fights
- Cruelty to people
- Cruelty to animals
- Uses weapons in a fight
- Stealing
- Lying
- Fire-setting
- School truancy
- Forced sex (rape)
- Breaking and entering
- Destruction of property

Oppositional defiant disorder is usually diagnosed in childhood, and may be present with ADHD. Of those diagnosed with ODD, approximately 25% will also develop mood or anxiety disorders.

Oppositional Defiant Disorder Therapy

Psychotherapy must be intensive and consistent, focused on changing cognitive patterns, and teaching and reinforcing behavior management skills. Some of these changes may include:

- Learning to accurately evaluate whether peers (or others) are acting with hostile intent. Identifying a range of emotions besides anger.
- Changing perspective, especially seeing another person's point of view in a conflict situation.
- Learning to trust others and to be trustworthy.
- Consequences. Reinforcing the cause/effect cycle, understanding consequences of actions.
- Problem solving.
- Learning interpersonal skills; recognizing boundaries.

Recognizing the urgency of treating this disorder, professionals have designed options and interventions such as recreational therapy, equine therapy, alternative schools, boot camps and residential facilities. An innovative program in Florida teamed up teenagers and therapy dogs; the teens successfully learned how to care for and train the dogs, and gained social skills in the process.

NOTE TO PARENTS:

Some communities have initiated "parent accountability" laws or programs to help parents learn positive parenting interventions. "Parent accountability" means that parents must answer for the conduct of their children; if a youth is arrested for fighting, for vandalism, or for drug or alcohol use, the courts may order parents to attend parenting classes.

Conduct Disorder

RESOURCE

Parent discussion forum:
"A Place for Us" at
www.conductdisorders.com

The “essential feature of conduct disorder is a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated. The disturbance in behavior causes *clinically significant* impairment in social, academic, or occupational functioning.” (DSM-IV) Approximately 6-10% of boys and 2-9% of girls are diagnosed with conduct disorder. Many will develop substance abuse problems, while some will “grow out of it” or will develop other psychiatric disorders.

“Conduct disorder” describes a serious emotional disturbance, usually seen in a variety of settings. Typically, a person with this disorder is aggressive, deceitful, and lacks empathy for the feelings of others.

The diagnosis also ranges in severity, from “Mild” (conduct problems cause only minor harm to others) to “Moderate,” to “Severe” (many problems, or those causing considerable harm to others).

Conduct disorder diagnosed before the age of 10 represents serious outcomes such as adult antisocial behaviors, juvenile justice intervention, etc.

Lack of positive parental feedback, early childhood abuse and related traumatic experiences may contribute to conduct disorder, but this is difficult to determine, since conduct disorder severely disrupts family life. Children with conduct disorder apparently misunderstand the intentions of others, “many times believing that people are threatening them or putting them down, when this is not really the case. They tend to react to these supposed threats or put-downs in an aggressive manner with little show of feeling or remorse.” (*Merck Manual*)

Many adolescents with a conduct disorder also have anxiety or mood disorders, PTSD, ADHD, or learning disorders. Substance abuse is often a factor.

Conduct Disorder Therapy

Early intervention and comprehensive treatment are essential. Comprehensive means that everyone involved with the youth is on the same page: parents, teachers, counselors, physicians and parole officers must communicate with each other; they must have consensus on treatment plans; and they must be consistent in enforcing consequences.

A youth with conduct disorder may benefit from behavioral and family counseling, an individualized education plan, and recreation therapy. “Eliminate or reduce television and video games (sexual, violent and aggressive content encourage these behaviors).” (*Jim Chandler, MD*)

Medication to treat co-occurring disorders (ADHD, depression, Tourette’s syndrome) may be prescribed.

Eating Disorders

Along with the advent of sexuality, teens become very concerned with body image. As they are acutely aware of their looks and unimpressed by nutritional needs, teens may look for a quick fix to weight issues: starving, bingeing or purging. Anyone can develop eating disorders, although underlying issues include low self-esteem, depression, identity concerns, family communication problems, and inability to cope with emotions.

Signs of Eating Disorders

- eating alone
- preoccupation with food and weight
- continuous drinking of water and diet soda
- frequent trips to the rest room during and after meals
- using laxatives
- presence of laguna (fine, soft hair that grows on the body)
- eroded (worn away) tooth enamel (from frequent vomiting)
- anemia (fewer red blood cells in the blood than normal)
- sensitivity to cold
- heart irregularities and chest pain

RESOURCES

American Anorexia/
Bulimia Association, Inc.
239 Central Park West,
Suite 1R
New York, NY 10024
(212)501-8351

ANRED: Anorexia Nervosa
and Related Eating Disorders
www.anred.com

Eating Disorders Medications

Fluoxetine (Prozac™) is often prescribed for eating disorders.

Eating Disorders Therapy

Building self-esteem, behavioral modification, nutritional therapy and group therapy are factors in recovery.

Anorexia Nervosa

“Lose Weight. Feel Great. Be Happy.” You could say that this sums up the thought pattern of a person with anorexia. While the average age of onset is 17, anorexia has been diagnosed in individuals (90% females) as young as 13. Research suggests that about one out of every 100 young women, between 10 and 20 years of age, is starving herself, sometimes to death.

A teen with anorexia “refuses to maintain minimal body weight [for age and height], is intensely afraid of gaining weight,” (DSM-IV) and will typically think that she’s too fat. Often she strives for perfection and accomplishments, yet never feels rewarded. Underlying stress, depression or anxiety, in addition to weight gain, may have caused the initial negative body image. Control is a major issue. Dieting is a way to gain a feeling of control, thus the emphasis on diet and exercise.

NOTE: Males, particularly male athletes, may develop eating disorders in response to weight control (e.g., wrestling or gymnastics).

Bulimia Nervosa

This eating disorder is characterized by binge eating and subsequent purging (vomiting), use of laxatives, diuretics, diet pills, ipecac, strict diets, fasts, “chew-spitting,” vigorous exercise, or other “compensatory” behaviors to prevent weight gain. Bulimia generally appears in late adolescence. A teen with bulimia is usually within normal body weight, yet has a negative body image.

A person may deny the bulimia; she (or he) may feel guilty and fear humiliation. The pattern of eating forbidden food, then feeling guilty, erodes a positive self-image. Bulimia has been linked to sexual abuse, risky behavior (e.g. shoplifting), difficulty regulating moods, substance abuse and dysfunctional family of origin.

Research suggests that about four percent of college-aged women have bulimia. About 50 % of people who have been anorexic develop bulimia or bulimic patterns. Medical problems include osteoporosis, anemia, gum disease and erosion of teeth enamel.

Binge-Eating Disorder

Binge-eating (also known as compulsive overeating) is described as “a vicious cycle” of overeating and depression. Teens with this disorder use food for comfort, or as a coping mechanism. Anxiety creates stress, which is relieved by bingeing, yet this is followed by feelings of guilt and shame, followed inevitably by depression. And so the cycle continues. Like bulimia, binge-eating often occurs in private. A person may eat normally in public, binge in private, or “graze” on food all day long. Medical complications of this disorder can be severe. (*National Association of Anorexia and Associated Disorders*)

Female Athlete Triad

Female athlete triad is a combination of three conditions: an eating disorder, amenorrhea (loss of menstrual period), and osteoporosis (weakening of the bones). A female athlete may have one, two, or all three parts of the triad, as she loses weight in order to improve athletic performance. Like teens with eating disorders, girls with female athlete triad may be dieting, purging, and exercising to lose weight.

It’s estimated that 15 % to 62 % of female college athletes have eating disorders, and as many as 66 % of female athletes have amenorrhea.

Because a girl with female athlete triad is exercising intensely and reducing weight, she may experience decreases in estrogen, which helps to regulate the menstrual cycle. As a result, a girl’s periods may become irregular or stop altogether. Low estrogen levels and poor nutrition can also lead to osteoporosis, which is a weakening of the bones due to the loss of bone density and improper bone formation.

For some competitive female athletes, low self-esteem, a tendency toward perfectionism, and family problems place them at risk for disordered eating.

RESOURCE

KidsHealth at
www.kidshealth.org

Mood Disorders

Teenagers are, by definition, moody. With reproductive hormones on hyperdrive, it's difficult to draw the line between *normal* erratic moods, thoughts or behavior, and a mood disorder. Key diagnostic factors are intensity, chronic nature, and extent of disability. Is this youth a suicide risk? Has the mood endured for a long time? And to what extent does it interfere with relationships, school and work?

Bipolar Disorders

A diagnosis of bipolar disorder means the child has a significant health impairment [not unlike diabetes, epilepsy, or leukemia] that requires ongoing medical management. The youth needs and is entitled to accommodations in school to benefit from his or her education. Bipolar disorder and the medications used to treat it can affect a child's school attendance, alertness and concentration, sensitivity to light, noise and stress, motivation, and energy available for learning. The child's functioning can vary greatly at different times throughout the day, season, and school year.

www.bipolarkids.org

Bipolar disorders indicate a *major* change in mood—from depression to elation (mania). Mania means an elevated, expansive or irritable mood, lasting at least one week. This mood is also accompanied by at least three (four if the mood is only irritable) of the following:

- Inflated self-esteem or grandiosity
- Decreased need for sleep
- Increased talkativeness or pressure to keep talking
- Racing thoughts or flight of ideas
- Distractibility
- Increased activity or psychomotor agitation
- Excessive involvement in pleasurable activities that have a high potential for painful consequences.

The other side of the bipolar cycle is depression. As a parent explained, “Depression in a kid may be misinterpreted as a bad attitude and uncooperative behavior. It can also be observed as low energy, inability to concentrate and low self-esteem. Even small assignments can be overwhelming. Everything seems difficult.”

Warren A. Weinberg, MD and others note that bipolar disorder covers a wide range of symptoms:

Some teens “cycle” back and forth from depression to mania. Still others seem to be both manic and depressed at the same time. Over the course of a year, some people with bipolar disorders may have a few cycles of depression and mania. Others have many cycles in a year, a week or even in a day. Some people may start out the day in tears and feel on top of the world by nightfall, or vice versa.

RESOURCES

Child & Adolescent
Bipolar Foundation
(847) 256-8525
www.bpkids.org

Depression and Related
Affective Disorders
Association (DRADA)
www.drada.org

NDMDA
National Depressive
and Manic-Depressive
Association
1-800-82-NDMDA

*The Bipolar Child: The Definitive
and Reassuring Guide to
Childhood's Most Misunderstood
Disorder*, Demetri F., MD and
Janice Papoulas, Broadway
Books, 1997.
www.bipolarchild.com

Bipolar disorder may be misdiagnosed—commonly as ADHD, depression or oppositional defiant disorder. The medications prescribed for ADHD (stimulants) or depression (antidepressants) may incite a manic episode, so carefully monitor reactions to medications, and report these to healthcare providers. Researchers have noted, also, a “kindling effect,” when medication or environmental effects apparently produce hypersensitivity to stimuli, and greater risk of ultradian (rapid) mood cycling.

By adolescence, the task of maintenance is as important as an accurate diagnosis. A youth with bipolar disorder faces increased school and peer pressure. Note that some teens who have bipolar disorder will self-medicate with street drugs, primarily alcohol and cannabis.

HYPOMANIA describes mania that is not severe enough to cause a marked disability; it can last only a few days, and does not require hospitalization. Or it can be present most of the time, depending on the person. In children and adolescents, hypomania may be interpreted as irritability.

CYCLOTHYMIA is chronic hypomania with moments per day of both depressive moods and “mini” moments of significant anger. Most of the days are “mixed days” with an occasional all “bad” day, but rarely an “all good day.” The cyclothymic disorder begins in the toddler or preschool years; this may progress during late childhood and early adolescent years to major depression or a bipolar disorder.

JUVENILE RAPID CYCLING BIPOLAR DISORDER.

This term is applied to children and youth who have moment-to-moment, day-to-day (“all mixed days”) depressive moods, actions and feelings interspersed with hostile anger, ranting or rages. Juvenile rapid cycling bipolar disorder most often is evident during preschool years, changing to classic bipolar symptoms during adolescence. (*Weinberg, et al.*)

Bipolar Disorders Medication

Any combination of mood stabilizer, antidepressant and/or antipsychotic may be prescribed.

Bipolar Disorders Therapy

Depending on circumstances, teens with bipolar disorder may benefit from counseling, family counseling, group therapy, school intervention (or alternative schooling), social skills training or behavioral therapy.

Depression

Population studies show that 10 to 15 percent of children and adolescents have some symptoms of depression. Having a family history of depression, particularly a parent who had depression at an early age, also increases the chance that an adolescent may develop depression. (NIMH) Girls are at greater risk, estimated at as many as 20 percent, or twice the percentage of boys. (*Report of the President's Council on Physical Fitness and Sports*, 1997)

Clinical depression in adolescence is similar to depression in adults—with a few exceptions. “Rather than having a depressed mood, teens are much more likely to have an irritable mood. Adults often will not enjoy anything ... but there are usually some activities children and adolescents will enjoy doing no matter how depressed they get.” (*Jim Chandler, MD*)

Clinically significant depression (MAJOR DEPRESSIVE DISORDER or MDD) is diagnosed when at least five of nine symptoms are observed to significantly interfere with daily functions, for at least a year.

- depressed or irritable mood most of the day
- lacking interest or pleasure in all (or almost all) activities, most of the day
- significant weight loss when not dieting, or failure to make appropriate weight gains
- trouble sleeping or too much sleeping
- restlessness or lethargy that is obvious to others
- fatigue or loss of energy
- feelings of worthlessness or excessive guilt
- lowered ability to think or concentrate, or indecisiveness
- recurrent thoughts of death, suicidal thoughts or suicide attempts

Physical symptoms (stomachaches, back pain or severe headaches) are very common.

Dysthymia

This describes a mild depression characterized by irritation, a “lowered expectation of outcomes, and lack of real enjoyment. Children and adolescents with dysthymia often have been depressed so long that they cannot recall what not being depressed is like. People think it is part of their personality. Typically they are irritable, hard to please, unhappy with nearly everything and very trying to be around.” (*Chandler*)

Intervention consists of helping the youth participate in activities that are enjoyable *and* social.

Dr. Chandler recommends activities that “incorporate one or two of the following: exercise, social contacts and accomplishments. Usually there is some element of this type of intervention in every treatment plan. Often it is combined with the other types of treatment such as medication.”

RESOURCES

Depression & Bipolar
Support Alliance (DBSA)
1-800-826-3632
www.DBSAAlliance.org

Dr. Ivan Goldberg's
Depression Central
[www.psycom.net/
depression.central.html](http://www.psycom.net/depression.central.html)

*Depression is the Pits,
But I'm Getting Better:
A Guide for Adolescents,*
E. Jane Garland. American
Psychological Association, 1997.

Activities based on exercise, socializing and/or accomplishments:

- recreational swimming or boating with family or friends
- go to a park, skate park or roller rink with a friend
- go to a movie with a friend
- make a craft or model together
- go fishing, hunting, or biking with family or friends
- go to a concert or join a garage band
- go camping or floating
- have friends over to play cards or ping pong, or to shoot baskets
- volunteer with friends
- join youth groups, Scouts or 4-H Club, sports teams, dance, theatre or music groups

Depression Medication and Therapy

Antidepressants may be prescribed, but should be carefully monitored for the risk of suicidal effects. Interpersonal Therapy (IPT) helps adolescents sort out relationship problems that may have precipitated the episode of depression. IPT **plus** medication are more effective in the long run, than either IPT or medication alone.

Depression and Accutane™ (isotretinoin)

Teenagers who are seeking treatment for acne should consider reports of depression, suicide and psychosis associated with the acne medication isotretinoin (Accutane™). Reports of depression include some cases in which symptoms resolved and reemerged when the medication was stopped and restarted.

Revised FDA labeling for Accutane™ warns of potential serious and persistent depressive side effects, and the possibility of suicide. Discontinuation of Accutane™ may not alleviate the symptoms of depression; further psychiatric evaluation and therapy may be necessary. (*Bender*)

Seasonal Affective Disorder

This is also called the “Winter Blues,” when a lack of light causes the brain to increase levels of melatonin, related to depressed mood, overeating (especially carbohydrates), lethargy, social isolation and oversleeping.

Seasonal Affective Disorder can be alleviated by “phototherapy,” or bright light therapy, which has been shown to suppress the brain’s secretion of melatonin. Therapies include sitting in front of special full-spectrum lights for several hours each day, wearing a light visor, or using a bedroom light that is programmed to simulate the early dawn light. Exercise also reduces craving for carbohydrates, and improves mood.

Posttraumatic Stress Disorder

Adolescents may develop posttraumatic stress disorder from experiencing a very stressful event (e.g., rape or war) or natural disaster (e.g., tornado); or experiencing (or witnessing) ongoing domestic violence or sexual abuse. This disorder may occur when a person has been “in association with an interpersonal *stressor*,” such as bullying, battering, or domestic or sexual abuse, over a period of time. (DSM-IV)

An estimated one out of ten girls will acquire posttraumatic stress disorder at some time in her life, and women are about twice as likely as men to develop the disorder. Children of alcoholics or substance abusers also may develop PTSD.

PTSD behaviors include persistent anxiety, rage, excessive aggression, depression, emotional numbing (“blunting” or denial of feelings), risky behavior, hypervigilance, self-injury, dissociation (feeling “out of body”), “magical thinking,” short or long-term memory loss, panic attacks, flashbacks, sleep disturbances, and eating or elimination disorders.

Long-term effects of PTSD may include excessive risk-taking, codependent behaviors and need for perfection. A teen with PTSD may adopt an “Us/them” attitude or a “save the world” life-style.

PTSD may co-occur with substance abuse, anxiety disorders, depression or dysthymia. Posttraumatic stress disorder may be misdiagnosed as ADHD, ADD, conduct disorder or oppositional defiant disorder.

Additionally, PTSD may produce *symptoms* that may be mistaken for other disorders: panic attacks (Panic Disorder), visual hallucinations (Schizophrenia), compulsive behaviors (Obsessive-Compulsive Disorder), “sexualized” or suicidal behaviors (Borderline Personality Disorder).

ACUTE STRESS DISORDER is similar to PTSD but occurs and *resolves* within four weeks of the traumatic event.

Posttraumatic Stress Disorder Medications

Medications prescribed for PTSD include sertraline, SSRI antidepressants and benzodiazepines. Sleeping medications also may be prescribed.

Posttraumatic Stress Disorder Therapy

Therapeutic interventions help people with PTSD confront and resolve traumatic memories, through some form of desensitization and resolution. Therapeutic Incident Reduction, Eye Movement Desensitization and Reprocessing are two examples.

Before a person with PTSD can confront memories of the trauma, however, they benefit from learning appropriate “tools” or skills to remedy dysfunctional cognitive and behavioral patterns; these include behavior modification, problem-solving, cognitive therapy and making interpersonal connections.

RESOURCES

National Center for
Post-Traumatic
Stress Disorder
www.ncptsd.org

Sidran Institute
(PTSD education)
www.sidran.org

Schizophrenia

Although it's unclear whether schizophrenia has a single or multiple underlying causes, evidence suggests that it is a neurodevelopmental disease likely involving a genetic predisposition, a prenatal insult to the developing brain and stressful life events. The role of genetics has long been established; the risk of schizophrenia rises from 1 percent with no family history of the illness, to 10 percent if a first degree relative has it, to 50 percent if an identical twin has it.
[NIMH]

Schizophrenia is a severe and disabling brain disease that affects a person's thoughts and behavior. Untreated, schizophrenia causes distortions of reality; a person may have auditory or olfactory (smell) hallucinations, be fearful and withdrawn, a "flat affect" (lack of facial expression), or behave inappropriately for the circumstances.

Usually schizophrenia first appears in late adolescence. The disease is most often diagnosed following an acute psychotic episode (after ruling out a manic phase of bipolar disorder, or abuse of amphetamines, cocaine or hallucinogens).

It is CRUCIAL to get immediate psychiatric treatment, because early intervention increases the likelihood of stabilizing symptoms, and recovering an active, independent life. Ignoring or denying symptoms increases the risk of disability and need for hospitalization.

The characteristic aspects of schizophrenia always include disturbances in several of the following areas:

Content and form of thought

Schizophrenia is noted by delusions that are often multiple, fragmented, or bizarre. Examples include paranoid and persecutory delusions or beliefs about others; delusions of *reference* in which events, objects, or other people are given particular and unusual significance; the belief that one's thoughts and feelings are not one's own, or are imposed by some external force. Ideas shift from one subject to a completely unrelated topic, without the speaker showing any awareness that the topics are unconnected.

Perception

Commonly, a person will experience auditory hallucinations, frequently involving voices. Tactile hallucinations may be present; these typically involve electrical, tingling, or burning sensations. Hallucinations of sight, smell or taste **do** occur, but with less frequency (and may indicate a disorder associated with a medical condition, such as a brain tumor).

Schizophrenia (continued)

Affect

“Affect” means how a person appears to others. With schizophrenia, the “sense of self,” which normally gives a person the feeling of individuality, uniqueness, and self-direction, is frequently disturbed. A person who has schizophrenia may ignore or lack social involvement.

Relationship to the external world

Frequently, people who have schizophrenia will be physically or emotionally withdrawn, paranoid, or preoccupied with egocentric and illogical ideas and fantasies.

Schizophrenia Therapy

Medication is prescribed to stabilize and manage symptoms.

Antipsychotic medications are especially helpful in reducing hallucinations and delusions. The newer generation “atypical” antipsychotics, such as olanzapine and clozapine, improve motivation and emotional expressiveness, and significantly improve the likelihood of recovery. Research overwhelmingly supports the use of these antipsychotics. (*NIMH*)

Adolescents who develop schizophrenia, and their families, benefit from supportive counseling, psychotherapy and social skills training.

Tourette Syndrome (TS)

Tourette Syndrome is an inherited neurological disorder characterized by repeated and involuntary body movements (tics) and uncontrollable vocal sounds. Like epilepsy, TS produces involuntary nervous movements, or “tics,” which are repeated, uncontrollable movements or involuntary vocal sounds.

People with TS may grimace, blink their eyes rapidly, jerk their heads, or stamp their feet, without being able to control it. These kinds of tics are called motor tics. Others may express verbal tics, like clearing their throats constantly, yelping or shouting.

These and other symptoms typically appear before the age of 18. The condition occurs in all ethnic groups with males affected 3 to 4 times more often than females. Although the symptoms of TS vary from person to person and range from very mild to severe, the majority of cases fall into the mild category. Associated conditions can include attentional problems, impulsiveness and learning disabilities.

Tourette syndrome may co-occur with other neurological disorders, such as migraines or obsessive-compulsive disorder. (Note that tics may also present in some disorders, such as ASPERGER SYNDROME.)

REFERENCE

Tourette Syndrome Assoc.
42-40 Bell Boulevard
Bayside NY 11361
718-224-2999
www.tsa-usa.org

Asperger Syndrome

Asperger Syndrome (AS) [or Asperger Disorder, DSM-IV] is an autism spectrum pervasive developmental disability, which is characterized by “an inability to understand how to interact socially.” (NINDS)

“Researchers say autism spectrum disorders are a result of a combination of perhaps 10 to 20 genes, plus environmental factors, that seem to cause the brain to exhibit less activity in its social and emotional centers. Unlike people with classic autism, which is often accompanied by mental retardation, those with Asperger's have normal language development and intelligence. ” (*New York Times*)

Asperger Syndrome is determined by the presence of the majority of following traits:

- Unusual responses to stimulation and environment. A person with AS may be extremely sensitive to noise, smell or taste, and will respond to sensory overload with a meltdown or withdrawal.
- Limited interests or unusual preoccupations. People with AS tend to specialize on whatever they find interesting; they tend to “spout off” information. (They’re great at Trivia but cannot play Charades.)
- Repetitive routines or rituals. For a person with AS, ritual and routines provide comfort and predictability in a world that threatens his or her sense of control. If the routine is broken, typically, the person with AS may respond by crying or having a meltdown.
- Speech and language peculiarities, such as tics or repetitive words or phrases.
- Uncoordinated or repetitive physical movements: walking on toes, flapping hands, fidgeting or facial tics.
- Impaired social and communication skills, such as the inability to “read” the facial expressions or body language of others; or the inability to intuit the rules (“give and take”) of conversation.
- Lack of flexibility. People with Asperger Syndrome interpret life literally. For instance, they will not bend the rules or tell “social lies,” and do not recognize metaphors (such as, “raining cats and dogs”).

Upon entering school, a child with Asperger Syndrome may be misdiagnosed as having ADHD, oppositional defiant disorder, bipolar disorder, or a learning or hearing disorder. In some instances, teachers are unaware of the syndrome or its characteristics.

A person with Asperger Syndrome faces a new set of problems during adolescence, when peer pressure and “fitting in” take precedence over individuality. It can be difficult for people with AS to form relationships, often resulting in feelings of loneliness and frustration. It’s not unusual for a person with AS to have concurrent depression or anxiety.

A person with Asperger Syndrome can learn and practice social rules, and hone social skills with parents, mentors or therapists. Treatment may include psychotherapy, parent education and training, behavioral modification, educational interventions, and medications for specific behavioral symptoms. (*NINDS*)

RESOURCES

O.A.S.I.S.

On-line Asperger Syndrome Information and Support at www.udel.edu/bkirby/asperger/

Asperger Syndrome and Your Child, Michael D. Powers with Janet Poland (2002). New York: Skylight Press.

National Institute of Neurological Disorders and Stroke. www.ninds.nih.gov

Yale Child Study Institute info.med.yale.edu/chldstddy/autism/asdiagnosis.html

Personality Disorders

Personality traits are patterns of thinking, perceiving, reacting, and relating that are relatively stable over time and in various situations. Personality disorders occur when these traits are “so rigid and mal-adaptive that they impair interpersonal or vocational functioning.” (*Merck Manual*)

Personality disorders are distinct from other brain disorders in a number of ways, primarily in disturbances in self-image; inability to have successful interpersonal relationships; inappropriateness of range of emotion, ways of perceiving oneself, others and the world; and difficulty controlling impulses.

Personality disorders are “a significant cause of chronic behavioral and emotional distress,” may be associated with PTSD, depression, compulsive or addictive disorders, and are a risk factor for “other serious life and medical problems.” (*Lester*)

Personality disorders are divided among three clusters: A) odd/eccentric, B) dramatic/erratic, and C) anxious/inhibited. (DSM-IV)

While personality disorders are not diagnosed in childhood, three that may be diagnosed in adolescence are:

ON-LINE RESOURCES

Personality Disorders Foundation at
pdf.uchc.edu

mentalhealth.com

www.mhsanctuary.com

www.bpdcentral.com

Avoidant Personality Disorder

This disorder is characterized by a “long-standing and complex pattern of feelings of inadequacy, extreme sensitivity to what other people think about them, and social inhibition.” (DSM-IV) Typically it is diagnosed by early adulthood, and includes most of the following behaviors, carried to an extreme:

- Avoids activities that involve significant interpersonal contact, because of fears of criticism, disapproval or rejection;
- Is unwilling to get involved with people, unless certain of being liked;
- Shows restraint within intimate relationships, and fears being shamed or ridiculed;
- Is preoccupied with being criticized or rejected in social situations;
- Is inhibited in new interpersonal situations because of feelings of inadequacy
- Sees oneself as socially inept, personally unappealing, or inferior to others;
- Is unusually reluctant to take personal risks or to engage in any new activities because they may prove embarrassing.

Antisocial Personality Disorder

Antisocial personality disorder is diagnosed in persons who “callously disregard the rights and feelings of others. They exploit others for materialistic gain or personal gratification.” Diagnosis depends on evidence of an antisocial behavioral pattern, consistent with a diagnosis of Conduct Disorder, since the age of 15.

People with an antisocial personality will act impulsively and irresponsibly, sometimes with hostility and serious violence. Often they do not anticipate the negative consequences of their behaviors, and typically do not feel remorse or guilt. Rationalizing their behavior or blaming it on others is common, as well as low tolerance for frustration. Manipulation and dishonesty are typical features of their relationships. Intensive psychotherapy targets learned behaviors such as anger and impulse control. Learning to identify emotions, and to express them, is a key aspect of treatment.

Borderline Personality Disorder (BPD)

The DSM-IV reports that physical and sexual abuse, neglect, hostile conflict and early parental loss or separation are common themes in the childhood histories of people with Borderline Personality Disorder.

“Individuals with Borderline Personality Disorder make frantic efforts to avoid real or imagined abandonment.” (DSM-IV) Additionally, a person with the disorder typically is afraid of success, has low self-esteem, drinks heavily, is impulsive, and has difficulty forming relationships. This person may worship a caregiver or friend, yet suddenly “switch from idealizing other people to devaluing them, feeling that the other person does not care enough, does not give enough, is not ‘there’ enough.” (DSM-IV)

While some teenagers will change their minds about their goals, values, careers and friends, BPD is characterized by persistent, extremely erratic behavior. Someone with BPD may quit school just before graduation, or withdraw from therapy just as they are showing improvement.

Typically, people with Borderline Personality Disorder are impulsive and engage in risky behavior such as gambling, overspending, binge eating, and promiscuity. There is a strong desire to self-mutilate or commit suicide, with a high rate of completed suicide (8% to 10%).

Personality Disorders Therapy

Therapy for personality disorders may include medication and psychotherapy. Medication may be prescribed for concurrent psychiatric disorders such as depression, or for impulse control or sleep problems. There is no acknowledged *medical* cure for a personality disorder.

The primary form of treatment is psychotherapy, such as cognitive-behavioral therapy, which targets beliefs in order to change behaviors, or dialectical behavior therapy (DBT), which targets emotions and beliefs associated with borderline personality disorder. Group therapy and peer support may also be helpful.

Self-Injury

Depression has many manifestations. It makes some young women sluggish and apathetic, others angry and hate-filled. Some girls manifest their depression by starving themselves or carving on their bodies. (Lerner)

Some adolescents may only experiment with self-injury, while others may be acting on a compulsion to self-injure. People who self-injure describe it as a way to distract themselves from emotional pain.

RESOURCE

S.A.F.E. Alternatives
I-800-DONTCUT
I-800-366-8288
www.selfinjury.com

Self-injurious behavior is deliberate, repetitive, impulsive, *nonlethal* harming of one's body. This includes cutting; scratching; picking scabs or interfering with wound healing; burning; punching self or objects; infecting oneself; inserting objects into body openings; bruising or breaking bones; as well as other forms of bodily harm.

The typical onset of self-harming behavior occurs at puberty, and often lasts for five to ten years, depending on intervention and therapy. Self-injury has a “biological component which drives the person toward the behavior if enough psychological stressors are present.” Studies link self-injury to the limbic system involved in mood regulation, but other factors also apply; when the body is injured, it releases endorphins—hormones which relieve pain. A self-injury cycle of stress, injury and pain is completed by feeling better.

Self-injury is linked to PTSD, anxiety disorders, eating disorders, personality disorders and depression.

Self-Injury Therapy

Medication may be prescribed to manage associated depression or anxiety.

Therapy addresses the motivation for self-injury, and teaches behavioral strategies for overcoming the urge to self-injure. Cognitive behavioral therapy uses contracts, journals, and behavioral logs as tools for regaining self-control. Interpersonal therapy helps people gain skills for developing and maintaining relationships, and insight into their destructive thoughts and behaviors. (*Wendy Lader, Ph.D.*) Dialectic Behavioral Therapy, developed by Marsha Linehan, helps people learn to tolerate emotional stress and redefine behaviors based on circumstances, rather than on habitual responses.

Alternatives to Self-Injury

The following strategies cause pain but do not mutilate the body:

- Hold some ice cubes in your closed mouth for as long as you can.
- Wrap a rubber band (loosely) around your wrist and “snap” it against your skin.
- Squeeze your ear lobe between your finger and thumb.
- Squeeze the inside of your nose between the two nostrils with your finger and thumb.
- Hold your arms in front of you for as long as you can.

Substance Dependence/Abuse

Teenagers will typically experiment with substance use (e.g., nicotine, alcohol, drugs). Substance use is related to peer pressure and social norms, as well as parental values and behaviors. Research also suggests a genetic component to addiction—children of alcoholics are susceptible to alcoholism, for instance.

Adolescents may use drugs to “self medicate” undiagnosed mood disorders, PTSD or anxiety. As the adolescent brain is still maturing, it can be negatively affected by substance use. (See SUBSTANCE-INDUCED PANIC ATTACKS and SUBSTANCE-INDUCED ANXIETY DISORDERS on page 11.)

SUBSTANCE DEPENDENCE involves a “cluster of cognitive, behavioral and physiological symptoms” that may or may not co-occur with a brain disorder. (DSM-IV) A prime example is tobacco use.

SUBSTANCE ABUSE is noted by an addictive behavioral pattern: the addiction, like a compulsion, rules the person’s life. “Copping a high” or getting drunk becomes more important than anything or anyone else. Signs of substance abuse include drop in school activities, attendance or grades; negative attitude; problems with relationships; withdrawal from friends who do not use substances; wild mood swings; behavioral and emotional outbursts; overreacting or “numbing” behavior; weight loss; physical complaints or accidents.

RESOURCES

Teen-Anon on-line
www.teen-anon.com

National Clearinghouse
for Alcohol and Drug Information
(NCADI)
P.O. Box 2345
Rockville, MD 20847
800-729-6686

DRUG FACTS

Mo. Dept. of Mental Health
1-800-364-9687

DMH-ADA
www.dmh.mo.gov/ada

BEWARE OF “ROOFIES”

Ten times more powerful than Valium, the illegal drug Rohypnol has been used in “date rapes” because it causes temporary amnesia. Other date rape drugs are Revitol, GHB and Ketamine.

For safety, open a drink container yourself; never accept a drink from someone you don’t know and trust; do not drink out of a punch bowl; keep your drink with you at all times.

Common Drugs of Abuse

- Caffeine, nicotine, alcohol, cannabis
- Depressant class of substances: tranquilizers, barbiturates
- Inhalants: nail polish remover, gasoline, aerosol propellant, lighter and cleaning fluids, asthma inhalers
- Stimulants: cocaine or crack; ecstasy (MDMA); amphetamines
- Hallucinogens: LSD, mescaline, psilocybin mushrooms
- Narcotics: Morphine, codeine, heroin, oxycontin
- Prescription drugs of abuse: Ritalin, dexamphetamine, Valium and other benzodiazepines, Soma and other muscle relaxants

Signs of substance use include staggering or poor coordination; smell of alcohol, slurred speech; seeming to be “spaced out” or distracted; dilated pupils, red eyes; smell of gas or household products; smell of urine (methedrine use).

Therapy

Psychotherapy addresses underlying causes for substance use, helps adolescents identify and cope with their emotions, and teaches positive behaviors. Alcoholics Anonymous (AA) and twelve-step programs succeed in helping people overcome addictions. These programs are based on peer education and support, which have been shown to be an important factor in recovery.

Family Issues

For Teens: When a Parent Abuses Substances

RESOURCE

www.al-anon.alateen.org

Having been abused is not a life sentence of pain and agony. The world can be yours for the taking once you get help. A wonderful man once helped keep me alive with this hopeful bit of wisdom: "I want you to know that all you have to do is grow up and your life will be your own." (from Teen Trip)

Substance abuse causes damage to many families—with emotional, physical and financial problems. Substance abusers behave unpredictably, like Dr. Jekyll and Mr. Hyde. Although each family is different, the children of substance abusers almost always report feeling alone, unloved, depressed, or burdened by the secret life they lead at home. Older siblings may perform “damage control” on a regular basis, and become responsible for the household and for younger siblings. The pressure can leave them exhausted and resentful. It’s not uncommon to hide the parent’s problem, invariably with “social” lies, nor to attempt to “fix” the parents.

As much as a person would like to run away from the problem, it doesn’t go away. It cannot be hidden. It’s important to find help, often by confiding in a trusted adult: a family member, a school counselor, a teacher or coach. A teenager is not betraying a parent by seeking help. Teens can continue to be supportive of parents, even as they try to make things better for themselves and the rest of the family.

Codependence

Codependence is destructive behavior that seeks “dysfunctional” (not normal functioning) patterns and relationships in life. The family develops patterns of codependent behavior in response to problems created by alcoholism, substance abuse and/or mental illness. Generally, the “problem” (or family member with the problem) causes pain and shame. Because of the stigma associated with this “secret,” family members often will go to great lengths to minimize or deny the problem.

Within the family, attitudes and behaviors commonly associated with codependence include:

- “enabling” behaviors like lying, denying, covering for others;
- self-destructive behaviors like fear of success, self-sabotage, assuming the worst, and distrust;
- unwillingness to seek outside help;
- be strong, good, right, perfect;
- alcohol or substance abuse is normal;
- don’t be selfish; don’t rock the boat;
- it’s not okay to play or to be playful (to be happy).

These attitudes interfere with the development of healthy coping skills and self-esteem. Consequently, many will grow up seeking love and security in codependent relationships. Codependence is a contributing factor to both domestic violence and intimate partner violence (IPV). Victims of IPV may be exposed to sexually transmitted diseases; mental health issues, depression, suicidal thoughts and/or attempts are likely outcomes.

Sexual Violence

While adolescent and young adult women report the highest rates of violence from an intimate partner, sexual assault is a threat to both young women and men—with devastating results. Rape in any form—including “date rape”—produces lifelong consequences. The original trauma is compounded by the trauma of reporting the rape to police and medical professionals. All too often, victims are blamed for the rape, stigmatized or ignored. Many victims feel such shame that they hesitate to confide in anyone; instead, they suffer in silence. If a teenager *suddenly* seems extremely silent, depressed or aggressive, a sexual assault may have occurred. Professional counseling offers victims the opportunity to talk, and to eventually resolve the trauma.

Suicide

Teenagers experience stress, confusion, self-doubt, pressure to succeed, financial uncertainty, and other fears while growing up. (AACAP) Since they are still developing coping skills, some teenagers may feel so desperate that they *think* suicide is the only way out of their pain or situation.

According to the American Academy of Child and Adolescent Psychiatry, “Children with a diagnosable mental health disorder such as ADHD, depression, sleep difficulties or bipolar disorder,” as well as teens of minority groups (race, gender preference or class) are more likely to be suicidal. Additionally, drug use alters mood regulation, and is often a factor in teen suicide.

A person may be considering suicide when talking about it, withdrawing from friends and family, suddenly giving away personal possessions, or increasing use of drugs or alcohol.

ALWAYS take a suicide threat seriously. Don’t assume the teen is trying to manipulate you. Seek professional help. DO NOT keep weapons, alcohol or lethal drugs in the house.

IN CRISIS: Don’t argue about suicide. Let the person talk. Be calm; do not leave them. Call 1-800-SUICIDE, a national suicide hotline, or a local Crisis Hotline (page 36), where you can get professional assistance. WHEN IN DOUBT, CALL 911.

RESOURCE

National Hopeline Network
<http://www.hopeline.com>

(800) 784-2433

National number that automatically routes caller to a local crisis center.

Divorce

Although an adolescent may appear to be mature, he or she may react to divorce with childlike responses. The divorce signifies loss of security (even if a parent was absent), loss of stability (even if the household was chaotic), and loss of identity (even if the family was dysfunctional). When parents divorce, a teenager may have some of the following feelings or beliefs:

Fear of Abandonment. The belief that the parents may abandon the child physically or emotionally.

Peer Ridicule and Avoidance. The belief that parental divorce will stigmatize the child in the eyes of his peers.

Hopes of Reconciliation. The belief that the parents may reunite, and that getting sick or in trouble may hasten the reconciliation.

Self Blame. The belief that the child's misbehavior led to the divorce.

Parental Blame. The belief that either one of the parents was entirely responsible for the divorce and is a "bad" person.

Typical reactions to divorce include aggressive or depressed behaviors. Prolonged negative behaviors may indicate trauma that should be addressed by family counseling.

Grief

People grieve when they have lost a loving relationship. Grief is a natural reaction to losses: losing relationships, divorce (and a parent's remarriage), moving to a new home or school, losing a job. Stages of grief follow a path from shock to acceptance: shock, anger, guilt, loneliness, sorrow and acceptance. If a person seems "stuck" in one of these stages, seek counseling.

Tough Love

Inevitably, when one family member has a serious problem, it affects the whole family. "Often the 'recovery' of the rest of the family has much to do with—and even serves as—the catalyst in the healing of the teen or preteen." A combination of support groups, individual counseling and family therapy address the emotional needs of the entire family.

When all else fails, parents turn to some form of "tough love."

The TOUGHLOVE® Program works on a set of beliefs:

1. Family problems have their roots and supports in the culture.
2. Parents are people too.
3. Parents' material and emotional resources are limited.
4. Parents and kids are not equal.
5. Blaming keeps people helpless.
6. Kids' behavior affects parents. Parents' behavior affects kids.
7. Taking a stand precipitates a crisis.
8. From a controlled crisis comes the possibility of positive change.
9. In order to change, families need to give and get support in their own community.
10. The essence of family life is cooperation, not togetherness.

NOTE TO PARENTS:

Remember that the second part of "tough love" is love.
(Child Net)

RESOURCES

www.child.net/toughlove.htm

TOUGHLOVE® International
www.toughlove.org

Custody

There are circumstances when custody of a youth may be awarded to the courts. In some cases, especially those in which a youth is a threat to others or has committed a crime, institutional care is not only appropriate, but also mandated by law.

The “Comprehensive Children’s Mental Health Law of Missouri (2004)” legislates a safety net for families of youth who have mental illnesses. The law allows parents to retain custody, and to obtain Medicaid coverage of children who receive mental health treatment.

The law requires “judicial review or family support meetings,” in which the Children's Division determines which child custody cases need only mental health services. Further, the law requires that a treatment plan be made within sixty days, and submitted to the court for approval.

Psychiatric Hospitalization

Eleven questions to ask before psychiatric hospitalization of your child or adolescent

Hospital treatment is a serious matter for parents ... and adolescents. Parents are naturally concerned and may be frightened and confused when inpatient treatment is recommended for their child. Parents should raise these questions before their child or adolescent is admitted to the hospital. If after asking the above questions, parents still have serious questions or doubts, they should feel free to ask for a second opinion. :

1. Why is psychiatric inpatient treatment being recommended, and how will it help our child?
2. What are treatment alternatives to hospitalization, and how do they compare?
3. Is a child and adolescent psychiatrist admitting our child to the hospital?
4. What does the inpatient treatment include, and how will our child be able to keep up with school work?
5. What are the responsibilities of the child and adolescent psychiatrist and other people on the treatment team?
6. How long will our child be in the hospital, how much will it cost, and how do we pay for these services?
7. What will happen if we can no longer afford to keep our child in this hospital or if the insurance company denies coverage and inpatient treatment is still necessary?
8. Will our child be on a unit specifically designed for the treatment of children and adolescents, and is this hospital accredited by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) as a treatment facility for youngsters of our child's age?
9. How will we as parents be involved in our child's hospital treatment, including the decision for discharge and after-care treatment?
10. How will the decision be made to discharge our child from the hospital?
11. Once our child is discharged, what are the plans for continuing or follow-up treatment?

REFERENCE

American Academy of Pediatrics,
“Facts for Families,”
(No. 32, 1/2000)

See www.aacap.org/
for information.

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School

Problems first surfacing at home are often amplified in the school setting; by law, schools provide the critical link between a child in crisis and referral for evaluation.

(Joyce Burland)

ON-LINE RESOURCES

SAMHSA 1-800-789-2647
www.mentalhealth.samhsa.gov

US Dept. Health & Human Svcs.
www.hhs.gov

Mo Dept. Education &
Secondary Education
www.dese.mo.gov

READ

*Helping Adolescents
With Adhd & Learning Disabilities:
Ready-to-Use
Tips, Techniques and
Checklists for School Success.* Judith
Greenbaum, PH.D.
and Geraldine Markel, PH.D.
John Wiley & Sons, 2001

Individualized Education Plan

School systems are required by law to file an “individualized education plan” (IEP) for students who have disabilities that interfere with their ability to learn. An IEP can specify accommodations, such as alternate testing, tutoring or speech therapy. The IEP is updated every year by a committee of the student’s parent(s), teachers and therapists. Individuals with ADD or ADHD may be eligible for accommodations through Section 504 of the 1973 Federal Rehabilitation Act. From the time students are 14 years of age, schools must work with a student to design a statement of “needed transitional services” from school to workplace.

Referrals

Teachers consider referral to a school counselor if a student:

- Is disoriented (unable to give own name, town and the date)
- Complains of significant memory gaps
- Is despondent and shows agitation, restlessness and pacing
- Is severely depressed and withdrawn
- Mutilates self
- Displays drug or alcohol use
- Is unable to care for self, e.g., doesn’t eat, drink, bath or change clothes
- Repeats ritualistic acts (excessive hand washing, etc.)
- Hallucinates, hears voices, sees visions
- Is excessively preoccupied with one idea or thought
- Is unable to make simple decisions or carry out everyday functions
- Shows extreme pressure of speech, talk overflows [signs of mania]

(SAMHSA)

The school counselor keeps information confidential unless “disclosure is required to prevent clear and imminent danger to the counselee or others, or when legal requirements demand that confidential information be revealed.” (*American School Counselors Assn.*) Mandates for disclosure include information about child abuse or neglect.

NOTE TO PARENTS: Missouri School Violence Hotline

The School Violence Hotline is a reporting and referral “mechanism to assist local schools and law enforcement agencies.” Its goal is to help prevent, or minimize, actual or potential violence in schools.

The Hotline accepts calls, gathers information concerning an incident of school violence, and enters the report into a database. The information is then phoned and faxed to local law enforcement and to school officials. Local law enforcement and school district officials determine how to most appropriately handle hotline reports.

For details, see the web site at www.schoolviolencehotline.com.

Juvenile Justice

The Mo. Division of Youth Services (DYS) is “charged with the care and treatment of youth committed to its custody by one of the 45 Missouri juvenile courts. DYS operates treatment programs ranging from non-residential day treatment centers through secure residential institutions. Additionally, DYS ... operates an accredited school program, and maintains a statewide statistical database of juvenile court referrals.”

READ

“Judgment at Hookyville,” Jeannette Batz. *St. Louis Riverfront Times* (Mar. 27, 2002). Archived with other articles in this series at: www.riverfronttimes.com

Rehabilitative Services/Drug Court

In many Missouri counties, some form of rehabilitation (or drug court) is mandated if a person is arrested for DWI or drug possession.

A drug court is “a special court given the responsibility to handle cases involving drug-addicted offenders through an extensive supervision and treatment program.” (*National Association of Drug Court Professionals, 2001*) Drug court participants undergo long-term treatment and counseling, sanctions, incentives, and frequent court appearances. Successful completion of the treatment program results in dismissal of the charges, reduced or set-aside sentences, lesser penalties, or a combination of these. Most importantly, graduating participants gain the necessary tools to rebuild their lives.

(*Defining Drug Courts: The Key Components, 1997*)

Teen Court

Teen Court is a community-based alternative to the traditional juvenile justice system, offering a “second chance” for teens “to learn from their mistakes.” It is seen as an effective intervention where enforcement of misdemeanor charges are sometimes given low priority because of heavy caseloads in the traditional system and the need to focus on more serious offenders. “In Missouri, the recidivism rate was shown by comparison to be 9 percent for teen court youth and 27 percent for the traditional process.” (*The Urban Institute, report of April 15, 2002*)

Currently, there are 16 Teen Court programs operating in Missouri. Most programs require defendants to plead guilty prior to participating in the program; however, those in Jackson and Lafayette Counties are structured to determine guilt or innocence.

(*Missouri Juvenile and Adult Courts Programs Division*
see www.osca.state.mo.us/osca/index.nsf)

Mental Health Court

Based on the success of Drug Courts, Mental Health Courts are designed “1) to break the cycle of worsening mental illness and criminal behavior that begins with the failure of the community health system and is accelerated by the inadequacy of treatment in prisons and jails and 2) to provide effective treatment options instead of the usual criminal sanctions for offenders with mental illnesses.” (*Bazelon Center for Mental Health Law*)

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Additional Resources

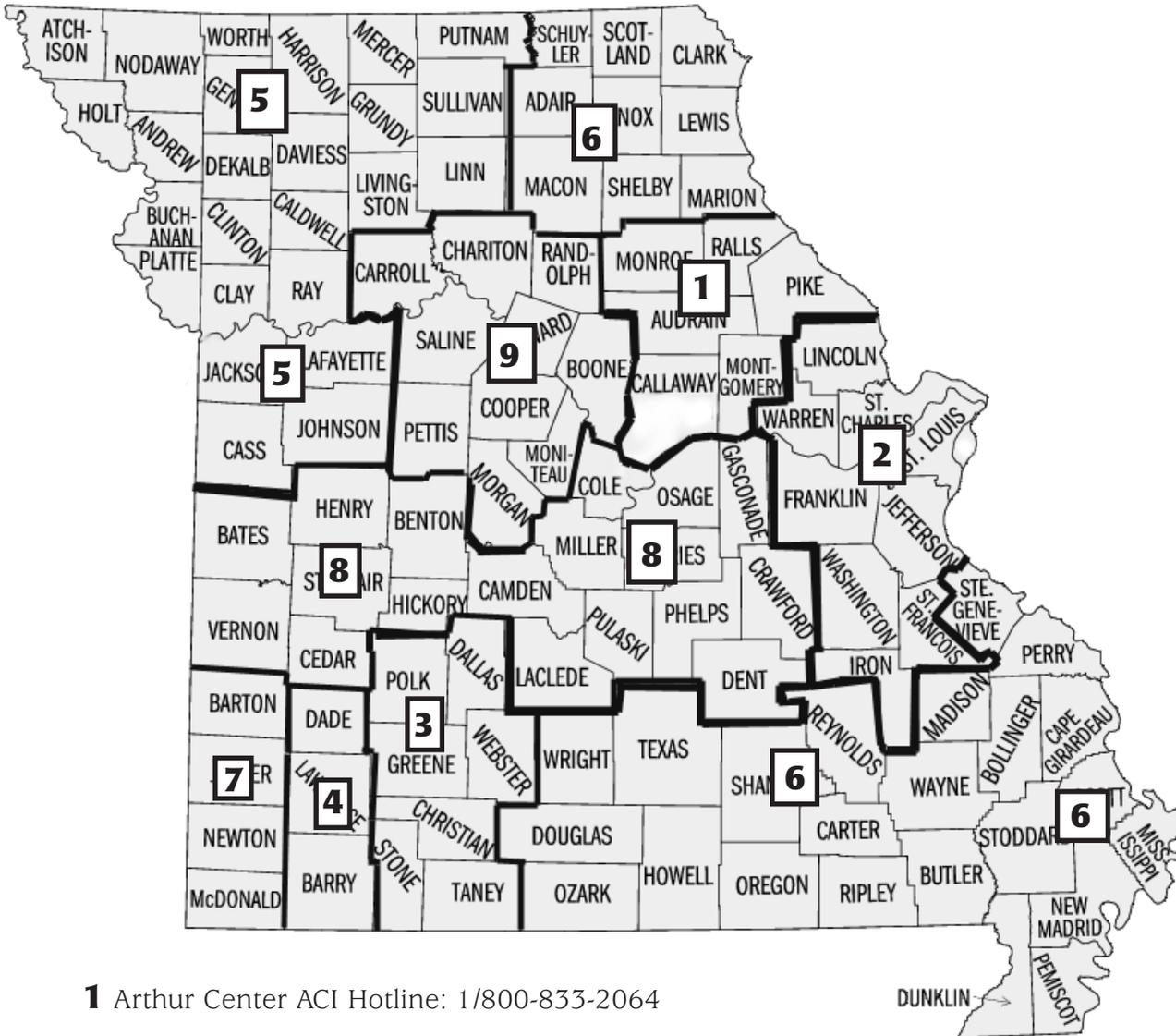
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On-line Resources

- Adolescent Directory On-Line: <http://education.indiana.edu/cas/adol/adol>
- American Academy of Child & Adolescent Psychiatry: www.aacap.org
- Because I Love You Parent Support Group: www.becauseiloveyou.org
- Citizens for Missouri's Children: www.mokids.org
- Child Psychiatrist Jim Chandler, M.D. is the author of enlightening booklets that discuss brain disorders diagnosed in childhood. Read these booklets on-line at www.klis.com/chandler
- GirlPower! www.girlpower.gov
- Institute for Research on Poverty: www.ssc.wisc.edu/irp/faqs/faq6.htm
- "Love Is Not Abuse" on relationship violence, with a special section on teen dating violence: <http://www.loveisnotabuse.com>
- Mental Health Net: mentalhelp.net
- Missouri Department of Mental Health: www.dmh.missouri.gov
- National Alliance for the Mentally Ill: nami.org
- NAMI of Missouri: mo.nami.org
- National Institute of Mental Health: www.nimh.nih.gov/home.cfm
- New York University Child Study Center: www.aboutourkids.org

Statewide 24-Hour Crisis Hotlines

from the Mo. Department of Mental Health



1 Arthur Center ACI Hotline: 1/800-833-2064

2 Behavioral Health Response ACI Hotline: 1/800-811-4760

3 Burrell ACI System: 1/800-494-7355

4 Clark Center ACI Hotline: 1/800-801-4405

5 Comm Care ACI Hotline: 1/888-279-8188

6 MOCARS ACI Hotline: 1/800-356-5395

7 Ozark ACI Hotline: 1/800-247-0661

8 Pathways ACI Hotline: 1/800-833-3915

9 University Behavioral Health: 1/800-395-2132

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Project LIFE 1-800-392-7348
www.missouri.edu/~projlif