New Approaches In Adolescent Treatment.

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ABSTRACT

A detailed discussion as to description and derivation of six innovative techniques for dealing with the in-patient adolescent have been presented, namely:

1. **The use of Annotated Contracts.**
2. **The Early A.M. Group Therapy Experience.**
3. **The Contra Strategy for Adamant Adolescents.**
4. **The Use of Biblical or Literary Stimuli for impasses with adolescents in a group psychotherapy setting.**
5. **Requisite Parental Involvement in the treatment process for in-patient adolescents to enhance treatment outcome.**
6. **Confrontation by Tangential Indirection for litiginous adolescents.**

Socrates — not far from here — some twenty-three hundred years ago issued an admonition stating that the adolescents of the day were hedonistic, resentful of authority, uncouth, and unappreciative of the sagaciousness of the elderly. As Medical Director of the Adolescent Center of the Houston International Hospital in Houston, Texas, I can tell you that we have had to develop certain specialized techniques to deal with the more recalcitrant adolescents, who apparently have not heeded Socrates's admonition. Diagnostically, these adolescents were non-psychotic and labelled Adjustment Reaction of Adolescence. They present essentially with conduct disorders such as truancy, running away, extreme oppositionalism, fabricating, pilfering, significant intra-familial strife, resentment of authoritarian figures, some involvement with illicit drugs and/or depressive traits, diminished self-esteem, and a not-so-well camouflaged global sense of inadequacy. I should like to describe briefly six special techniques which have proven clinically efficacious: (1) The Annotated Contract, (2) Early A.M. Group Therapy, (3) The use of Literary or Biblical Stimuli for adolescent impasses, (4) The Contra Technic for avoidance of escalating hostilities between parent and adolescent, (5) The employment of Concurrent Parent Groups for in-patient adolescents, and (6) Confrontation by Tangential Indirection.

I. The Summit-annotated Contract Technique.

The Summit-annotated Contract Technique was first introduced at the Adolescent Center in 1974 and described the following year in the American Journal of Psychiatry and refers to the compilation of an annotated contract after a meeting with parents, patient, and therapist (the summit) in order to review those specific factors which led to hospitalization and to scrutinize the solutions proposed and then to finalize in writing plans for the first six months after discharge (Rosenstock, 1975). These contracts are time limited. Negotiated points are listed in order of increasing conflict, with emphasis always on areas of agreement. Generally, there are not penalties listed for failure to comply with any area of contention. Throughout, an appeal is made to all parties' sense of autnonomy and fairness. The raison-d'être for each paragraph is rendered by the introductory annotation. Parents, as well as adolescents, are bound by the limitations of the contract. It is understood that new parental demands occuring outside the contract once the patient returns home would in fact be inappropriate and in violation of the understanding. This is especially important, as the Summit and Contract represent the culmination of many hours of therapy both with the parents and adolescent. Preparations for the contract vary and may involve the peer groups, parent groups, and conjoint sessions. Clinically, the principles are reminiscent of Sager's Marriage Contract and Ferber's Family Tasks (Sager **et al.**; Ferber and Ranz, 1972).

The Annotated Contract Technique was recently the subject of a prospective study involving 56 consecutive patients and three primary diagnostic groups: (1) Adjustment Reaction of Adolescence (N=28), (2) Borderline Personality (N=10), (3) Anti-social Personality (N=18) (Rosenstock). The technique proved extremely useful for the borderline group, and of questionable value for the anti-social group. The contract technique was initially accepted by all three groups. It was facilitative in family conferences for 89%, 80% and 55% respectively of the cohorts Adjustment Reaction of Adolescence, Borderline Personality, and Anti-Social Personality. Most patients, regardless of the diagnostic label, were

able to use the contract technique as a barometer of their own progress; the anti-social personality group used the contract largely to ventilate hostilities and/or limit parental demands. Only 18% of the Adjustment Reaction group compared to 50% of the Borderline group and 94% of the Anti-social Personality groups ultimately ignored the contracts altogether.

All adolescents who are successful for as long as six months after discharge were able to continue to monitor their behavior autonomously. Hence, there was no need to renegotiate any contract after the six month review. In several instances the contract, along with the family follow-up conferences, helped avert rehospitalization. This was expressly the case where the patient and family members continued to regard the contract as meaningful.

Many adolescents argued for a more detailed contract than initally requested by the parents. Those that did so seemed to experience a special sense of accomplishment and were rather dutiful about keeping their contractual obligations over the 6-20 month study period. Parents were also able to reflect more reasonably on their own expectations, thereby, adding another element of stability to the family system.

Finally, though designed primarily for the termination phase of in-patient treatment, experience has proven that the annotated contract technique can be readily modified for out-patient practice.

The contract technique appeals to the patient's sense of increasing autonomy in that it is binding not only on him but on the parents as well. Finally, not all adolescent patients are candidates for summits and contracts. The technique seems most useful with non-psychotic, non-organic, acting out adolescents, including those who fit Masterson's diagnostic criteria for the "borderline adolescent" (Masterson, 1972). After clinical experience with over 200 annotated contracts, a firm recommendation can be made as to the efficiency of this technique.

II. The Early A.M. Group Therapy Technique.

The Early A.M. Group Therapy Technique, more colloquially termed by the adolescents "the donut group," refers to a psychodynamically oriented group therapy model currently in use at the Adolescent Center. This group meets once approximately every three weeks at 6:00 a.m. for one and a quarter hours. The early time creates a special excitement within the patient population and stands in contrast to the routine schedule. Involved in this experience are the attending psychiatrist, the head nurse, the program director and usually a group membership of approximately ten patients and four staff members.

The purpose of this special model is to increase the cohesiveness of the group as well as provide a technique for reducing patient resistance and denial.

Scheduling of the special A.M. group is usually prompted by observations that many patients are engaging in passive-aggressive behavior, such as, coming late to regularly scheduled group therapy or feigning drowsiness during group. The group as a whole is confronted with its behavior.

What often follows is the election of a special A.M. group to be held within four to seven days. Involved in the decision is the expectation that there will be 100% patient participation. Should this not be achieved, the group is not held.

Special privileges enhance the motivation for attendance at this early A.M. group. (1) Patients are allowed to attend in casual robes unlike the usual daytime dress, (2) Special refreshments such as donuts are available without restriction, (3) The patient has a choice following the group to return to bed and skip breakfast without penalty.

One very important spinoff has been the patient's voice recognition that staff does care about them. Adolescents volunteer that this is de-

monstrated to them by their knowing that the three co-leaders arise hours earlier to be on time for the group and actually purchase refreshments in route. The patients appreciate the interest and the involvement of the night staff, who interact with them to assist in preparation for the group.

Most importantly, experience with this model has shown us that this group modality often provides important insights into the lives of the patients, which otherwise might not be obtained for many weeks. This group facilitates patients' sharing of meaningful fantasies and dreams which they seem less able to share at other times.

Consider the following illustrative vignette: Mr. G. is an older adolescent male with a diagnosis of Borderline Personality Disorder. He left home only months before violently attacking an adolescent peer in what appeared a rather over-determined reaction. Because of a long history of poor adjustment and the need for further diagnostic and therapeutic evaluation, he was hospitalized at the Adolescent Center. Although he had been in treatment for many weeks, it was, heretofore, never really clear, his platitudes notwithstanding, why he left home in the first place. In a recent 6:00 am group therapy experience he revealed, with tears flowing and with strong encouragement from a unified, supportive peer group, that he was in contact with the reason for his departure from home. For the first time he admitted, to himself as well as to others, that he had in fact entertained homicidal thoughts toward his father, which were rather detailed and only short of actual implementation. The dynamics of his so-called unexplainable departure from home, as well as the over-determined aggressive behavior with a peer, suddenly became more lucid. Subsequent to the meeting, the patient's commitment to therapy was clearly increased as was the depth of his psychotherapeutic engagement.

The early A.M. Group Therapy engages adolescents, characteristically, at a moment of weakened defenses and in a setting where regressive behavior is fostered. Experience has repeatedly shown that even the most

hostile adolescent can engage in meaningful dialogue with this specially structured change in setting and set.

III. The Contra Technique.

The contra strategy of technique is simply a deliverate substitution of neutral non-sequiturs for the escalating epithets, heretofore, freely hurled between adolescents and their parents (Rosenstock, 1978). The word substitution is intentionally non-related to any of the ongoing conversation or to the precipitating antecedents. Carefully introduced non-sequiturs literally provide nothing for the adolescent to logically refute. Avoided are the familiar scenarios which invite escalating power struggles where each party's integrity in an existential sense depends on being victorious. This technique further avoids the need to retract the acrimonious statements made during the quintessence of mutual discontrol.

Parents report that the adolescent usually gives up his well-rehearsed cache of expletives and simply walks away or retires to his room without obvious need to continue debate. In fact, both parents and adolescents, typically, frequently feel a sense of relief. In some instances, all parties have broken into spontaneous smiles. As one adolescent volunteered, "How can you fight it?" More recalcitrant adolescents, especially those with anti-social personality traits, have reported that when they too try retort with non-sequiturs, there was still no perpetuation of the debate. The Contra Technique generally seems to provide an element of novelty and contrast that precludes the maintenance of an implacable angry stance. In the operant conditioning sense, when the adolescent recognizes that as a result of a defused argument that the aftermath is not only less painful but more pleasing, his behavior hopefully tends to be modified in the more positive direction (Wyatt, 1974; Crowley, 1975; Wilson and Ross, 1972; Biklen, 1976; Lehrer, 1971; Shaffer and Hansen, 1973; Abrams **et al.**, 1974; Dickson **et al.**, 1975).

There are limitations which need enumeration. It is important to realize that this technique is by definition only an ancillary therapeutic

tool and clearly not a solution to any problem. It is designed only to facilitate therapy, that is, to act as a catalyst. A certain amount of essential rapport is presupposed. Furthermore, the technique is contra-indicated in the presence of frank psychosis.

IV. Biblical or Literary Stimuli for Adolescent Impasses.

This technique involves the judicious utilization of selected Biblical or other Literary references for specific adolescents who during the course of group therapy reach what is desscribed as an impasse. An impasse occurs when the group as a whole, or one of its members, developes a marked reluctance to analyze its' or his own behavior or move beyond an interim obstacle. When the usual methods for dealing with such crises seem feeble, experience has shown that the introduction of Biblical stimuli, for example, very much lends itself to projective interpretation and can be an effective strategem for getting beyond an impasse. Introduction of such selected material by the leader seems to protend the following: (1) The attention of the group is immediately enhanced as materials are extemporaneously introduced, (2) There is instant speculation as to whom the material is supposed to apply, (3) In cases where the therapist targets one particular member by selection of pertinent material, the group predictable organizes itself around facilitating participation by that member, (4) Typically, the targeted member finds it much easier to discuss the material in the third person motif before ultimately allowing first person exposure.

Clinically, experience has shown that the following adolescents seem to benefit most: (1) The depressed patient who may be harboring suicidal ruminations and prefers to remain totally reticent or to make rather tangential inferences about his decision, simultaneously, defying further personal discussion, (2) The shy, basically withdrawn patient who has little or no previous group experience and who finds the group process particularly threatening to the point of elective mutism, (3) The oppositional adolescent who has attempted to close all of the usual avenues of ingress. Here the careful introduction of special material in a non-

targeted fashion can be especially facilitative. By the time the patient realizes he has become involved in an active conversation, the momentum of his engagement will usually prevent his well-rehearsed reflexive withdrawal, (4) The highly defended patient in a felt crisis. This is the patient who frequently announces "You are all against me and I refuse to hear another word."

For example : Anna, a 15 year old white adolescent girl, of middle class, and upward striving parents, became rather intimately involved with a young man. The patient, soon after admission, presented with the problem of being pregnant. Where logically it seemed abundantly clear that this patient could not possibly provide adequately for the baby she might deliver, initally she refused to discuss with anyone either the possibility of termination of pregnancy or adoption. She would constantly scream "No one hears me, nobody believes me. Our marriage can work." At that point she put both hands over her ears and indicated that she had literally checked out of the group.

During the next group session, the patient was told by the leader before a panel of peers that indeed the marriage could work."In fact,there is a Biblical precedent for it." The patient was both alerted and startled by the information and indicated that she was very much in tune with what the speaker was saying. With the encouragement of peers, this otherwise silent girl sprang forth with a number of questions, such as, "You mean there is a chance it can work ?"

The attending psychiatrist indicated that it could work according to the Prophet Isaiah (11:4); the only problem was a matter of reframing and timing. The patient was invited to turn to the 11th chapter of Isaiah in order to determine the probability of when such a marriage would work. Paraphrasing this would occur only at such a time as when the leopard would lie down with the lamb — highly unlikely in the livable future of this adolescent.

What was most important is that this technique provided a method

of engagement for an adolescent who was, heretofore, unreachable by the usual techniques in the psychotherapeutic armamentarium. Once Anna was able to truly make contact with the group members, she was able to participate in a meaningful discussion about matters of adoption, termination of pregnancy, and issues of identity.

Even patients who seem to exude toughness and implacability and who court revenge as a solution for frustrations can benefit at times from the utilization of this special technique. With such patients one impasse-breaking strategem has been the careful introduction of the meaning of lex talionis. With a lively discussion of the eye-for-an-eye, tooth-for-a-tooth equation of justice, there is a predictable interruption of what was non-polarized bravado.

V. Parental Involvement as a Requisite for Successful Adolescent Therapy.

In one recent study at the Adolescent Center of 63 consecutive patients, an assessment was made as to the impact of parental involvement with respect to treatment outcome. (Lacker et al., 1973) Each patient was following approximately two months of in-patient care and six months of out-patient treatment and again from 8 months to 12 months after the formal termination of therapy. The presenting problems were used as assessment baseline criteria for success, the results would be weighted toward failures. Assessment of outcome was by attending psychiatrist, consulting psychologist, the patient, and important family members.

Three different cohorts were delineated; namely, (1) those whose parents participated in a parents' psychotherapy group concurrently (N=21), (2) those participating in individual parental consultation and therapy (N=21), and (3) those parents who throughout the treatment course refused to participate (N=21).

The results showed a 67% success rate in those cohorts where the

parents were involved in the treatment process on a regular basis. In fact, there was no significant difference in results between the involved parent cohorts. Most importantly, a highly significant difference was found between the parents who participated in either the therapy groups or in the individual sessions and those who did not participate at all (at the $P<.001$ level). In fact, clinically where there was no parental involvement none of the adolescents were classified as success.

The data strongly supports the contention that the prognosis for the seriously disturbed adolescent is greatly enhanced by the active participation of his parents in the treatment process. That there were virtually no successes in the patient sub group where the parents refused to become involved only emphasizes the critical need for parental participation. The parent group itself seemed to manifest clinically certain intangible advantages : (1) Parents can evaluate their own effectiveness and tolerance with peers, (2) Parents in a group feel less isolated with their problems. To some extent, the cathartic process of the group helps them to avoid pathological ventilatory defenses elsewhere. (3) The group experience is also time and cost effective, and (4) The group also represents a vast pool of collective experience from which the parents not only sample other alternatives, but at the same time contribute to the amelioration of the problems of others — thereby, enhancing their own self-worth. They may subsequently feel less abused by their children and show more self-control.

Admittedly, the absence of parental involvement often clinically signals more serious psychopathology in the family and in the adolescent. The more dismal prognosis protended by parental non-participation should be considered reflective of many psychosocial stressors rather then the mere lack of violition.

Our experiences at the Adolescent Center in Houston have in a compelling way convinced us of the necessity for parental involvement in the treatment process. Present policy, therefore, requires parental participation.

VI. Confrontation by Tangential Indirection.

The Technique of Confrontation by Tangential Indirection. This is expressly a special group therapy technique for acting-out adolescents. This technique provides a way to introduce sensitive material in a group setting of peers without causing immediate confrontation with the targeted patient. Not only is there competition among peers to show that they understand the topic at hand, but there is also the additional spin-off of projective comments by the entire group membership. The targeted adolescent is very quickly engaged with peers as opposed to being left to his usual pattern of dealing with authoritarian figures; namely, direct confrontation in an antler-to-antler fashion with sequelae of impasses and therapeutic losses.

Consider the following illustrative vignette: A 17½ year old white adolescent male, who had a history of a volatile temperament, anti-social as to his virility and power, violated the in-patient rules one evening by clandestinely piercing his left earlobe. Whereas, this information instantly seemed to become community knowledge it, nevertheless, needed to be dealt with in therapy. During the course of the next regularly scheduled group session, the attending psychiatrist opted to introduce the topic through the Technique of Tangential Indirection and thus the patient was asked whether he intended in the post-discharge period to pursue his previously announced plans of customizing vans or whether, in fact, he was contemplating going into the jewelry business. Whereas, initially the patient expressed confusion as to what the group leader was asking him, the immediate effect was an obvious competitiveness among peers to explain succintly to the targeted patient what the superficial issues were. All of this served as a springboard for more indepth discussion of the psychodynamic factors which were active — all without direct confrontation with the patient and without his of precedented loss of control.

Experience with this particular technique has to date been found to be most successful with those litiginous adolescents who have a particular antipathy for authoritarian figures and who are so much more exquisitely sensitive to constructive criticism by adults than peers.

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الموجز

طرق جديدة لعلاج المشاكل النفسية للمراهقين

يناقش هذا البحث ستة أنواع مستحدثة لعلاج المشاكل النفسية للمراهقين والتى طبقت بالأقسام الداخلية ، وهى :

١ – استعمال التعاقد المفسر .

٢ – خبرة العلاج النفسى الجمعى فى الصباح الباكر .

٣ – الاستراتيجية المعاكسة للمراهقين المتشددين .

٤ – استعمال البواعث الانجيلية والأدبية فى المآذق التى تحدث أثناء جلسات العلاج النفسى الجمعى للمراهقين .

٥ – ضرورة اشتراك الأهل فى عملية علاج المرضى فى الأقسام الداخلية حتى يمكن الارتفاع بعائد العلاج .

٦ – المواجهة عن طريق ما يسمى « باللاجهة المماسية » للمراهقين المشاكسين .

ABSTRAIT

De nouvelles méthodes pour le traitement des adolescents.

Une discussion détaillée relative à la description et à la dérivation de 6 techniques neuves pour traiter des malades adolescents internés, **a été soumise, notamment :**

1. L'emploi de contracts annotés.
2. L'expérience de therapie de groupe A.M. de bonne heure.
3. La contre-stratégie pour les adolescents inflexibles.
4. L'utilisation de stimulants bibliques ou littéraires, durant les impasses, avec les adolescents dans une session de psychothérapie de groupe.
5. La nécessité de l'implication parentèle dans le processus de traitement pour les adolescents internée pour rehausser le résultat du traitement.
6. Confrontation par indirection tangentielle pour les adolescents litigieux.