SPEAKER NOTES

Adolescence and Mental Illness

Summarized by Thomas T. Thomas

It's hard being a teenager—coping with new freedoms and responsibilities, entering social structures that are not always family-oriented, and learning to deal with new freedoms and responsibilities. On top of all this, the teen years are a time when certain brain disorders first manifest themselves. At our March 28 meeting, we heard from two specialists in treating these problems: **Moises Garcia-Lemus,** Therapist-Intern at La Cheim School, Oakland, and our own **Liz Rebensdorf,** School Psychologist at the Diagnostic Center of Oakland Public Schools.

MOISES GARCIA-LEMUS

Rebensdorf said she was pleased to participate in this program "because many people in our group have adolescents living at home—or not—with mental illness.

"Adolescence is the one time in life when the line between normal behavior and mental illness is very thin," she said. "Withdrawing socially, or lashing out, can be either a natural reaction or a symptom." Adolescence is a hard time, she went on, when young people are gaining new mobility and freedoms, when peer approval is an important part of life, when they are urged to be adventurous and try new things, including experimentation with drugs and alcohol. And yet none of these things—especially self-medication—mix well with mental illness. "Adolescence is also a time when hormones are changing their bodies and their central nervous systems. Many behaviors that look like illness can be attributed to hormones."

LIZ REBENSDORF

When mental illness comes in adolescence, it's hard on the parents. Suddenly, a reasonable child that they've known for 15 years becomes possessed. "And you learn about the resources one step at a time," she said. "When your child is taken in on a 5150 [the section of the penal code allowing incarceration as "a danger to self or others"], you are told to call back in forty-eight hours. And only then do you learn that your child will be released."

Another issue is the appropriateness of psychotropic medications, which go through clinical trials on adults, not children, because the adolescent population is small, and pharmaceutical companies are concerned with liability. Doctors must therefore extrapolate from the adult dosage to treat adolescents.

And finally, Rebensdorf said, at age 18—right in the middle the treatment process—the child is no longer a minor. The child has rights; the psychiatrist must

respect the doctor-patient relationship; and the parents are on the outside. The parent still has all the responsibility but no authority to exercise it.

In addition, adolescents are usually part of an educational institution, which has its own set of priorities, responsibilities, and processes. "When the child has a break and goes through psychiatric hospitalization," Rebensdorf said, "the school will do an evaluation if the parent requests it. If the child can be labeled as 'emotionally disturbed,' the school can go to the county under Section 3632 procedures for mental health funding. This will support treatment on an outpatient basis or in a day program or residential program as appropriate. The school's obligation covers the child from age 8 until graduation or age 22.

Garcia-Lemus noted that he has worked for La Cheim for twelve and a half years. He has been a special education assistant and is now an intern working in therapy. He agrees that, when a child turns 18, he or she no longer needs to have the family involved in counseling. This is not only a loss to the parents but also a loss of support for the child. Garcia-Lemus encourages parents to attend these sessions anyway and participate, even if they no longer sign the forms.

"Children have no concept of their rights," he said. "They think it means freedom, and then they realize: 'But what can I do?' "

Garcia-Lemus has found it easier to work with adolescents than with children, but they have tremendous defenses. "Children have defenses, too, but they will open the window. They know you are there to help them. With adolescents, it's harder to develop a trusting relationship, because often they've been betrayed by adults.

"You have to be genuine," he said. "Kids can tell when you're not being real. I tell them stories, and they can sense when I depart from the truth. You have to be open and honest with them."

At this point, Rebensdorf and Garcia-Lemus opened the floor to general discussion and questions.

What population and age group does La Cheim serve?

Garcia-Lemus said the organization has three schools, in Pleasant Hill, Richmond, and Oakland, and two residential facilities, in El Sobrante and Pinole. The students are from age 8 to adolescent, and suffer from simple hyperactivity to schizophrenia. "Generally, our children come from lower socioeconomic situations," he said. "The parents tend to keep to themselves and not go to support groups. But it's important for them to see that they are not alone."

What form does your therapy take? It sounds like talk therapy.

Garcia-Lemus acknowledged this is a common question: "How will you help my child?" He also noted he is not a psychiatrist and cannot prescribe drugs, although he works with the doctors and shares observations with them. Garcia-Lemus said he will observe the child as frequently as necessary for about six months.

"With the kids, I don't talk that much. Children have a switch to turn off adults." Instead, he uses play therapy. He doesn't tell the children what to do, but offers them balls and toys, and lets them do what they want. "I respect their space, don't impose, and wait for them to invite me to join them." By his being an observer, the children are not forced to become oppositional and defiant. So he is

able to see something positive in their interactions, and that is what will help them. "When they start saying my name, it's the beginning of a relationship."

Rebensdorf concurred in this. "It's valuable to be in the school setting, to watch the kids on the playground and in the classroom, to observe their peer relationships."

As a therapist, what's your opinion of putting children on medication?

Parents ask about medications, Garcia-Lemus said, and usually don't want their children to take them. But medication can be helpful, especially with attention deficit hyperactivity disorder (ADHD). "You can see a child who wouldn't sit still for a minute suddenly concentrating for twenty minutes. But personally, I would rather see a child very active than medicated. Activity is healthy if it doesn't prevent needed rest."

When asked about the long-term prognosis for ADHD, he noted that some children outgrow it in two to three years, while some adults suffer from continuing hyperactivity.

How do you respond when inappropriate behavior is due to mental illness?

This question raised the largest amount of comment from the audience. One issue was the thin line between ignoring rude, offensive, or angry behavior—in order not to reward it with attention—and being too permissive. In the home, when parents are the focus of the behavior, they will not have access to the tools used by professionals: special body holds, mechanical restraints, and safe rooms.

One audience member suggested slipping out of the parental role, which is to try to change or reform the child's behavior. Instead, you may have to become his or her friend, "but first you have to feel it within."

Another suggestion was that these behaviors have a course, and you need to separate yourself, mentally or physically, from the full effect. "But the child will follow you around from room to room so you will see it."

A question to ask is what the temper is accomplishing for the child: getting attention? escaping a situation? or achieving sensory release? When the parent knows this, he or she can try to find other ways to accomplish the child's inner goal. But sometimes the behavior is like a seizure—in fact, in some cases it may be triggered by temporal lobe epilepsy—and then nothing can stop the outburst.

It's important, however, for the parent not to get drawn into the behavior, shouting, arguing, or reacting to inconsequentials. "It's as if they're sick and throwing up," one person said. "You can't argue with conjectural rambling," said another.

One strategy may be to observe what in the past has accompanied the downward part of the behavior cycle, such as a teddy bear or favorite activity. It might short-circuit the outburst by introducing the calming effect sooner.

"But when you're working with children," Garcia-Lemus said, "every day is different."

"And eventually," Rebensdorf added, " they do mellow out."