Box 1. An Hypothesis with Regard to Adolescent Depression, Sexuality, and Cigarettes

Typically, the depressed adult will experience a decrease in libido and a loss of interest in sexual activity or intimacy. Often this is quite the opposite in adolescent depression, in which an increase in libido and sexual activity occurs. Just as adolescents and adults often self-medicate depression and other mental illnesses with legal and illegal substances, so too might adolescents self-medicate depression with increased sexual activity.

A decrease in the neurotransmitter dopamine may be responsible for depression in many individuals. By engaging in sexual activity, the adolescent receives a neuronal release of dopamine, temporarily enhancing mood. Sexual activity creates the self-perception of being more desirable, resulting in enhanced self-esteem. Enhanced self-esteem improves mood.

The role of dopamine may also help explain adolescent use of cigarettes. As the nicotine passes across the alveolar-blood barrier to the blood-brain barrier and into the central nervous system, there is a release of dopamine in the brain. This nicotine-induced dopamine release serves to medicate the depression.

confusion. Throughout the stages of adolescence, the individual tries on different uniforms of thought and dress. In late adolescence the individual has either brought things together to possess a secure sense of self (identity) or has not succeeded in developing a cohesive sense of self or self-awareness, resulting in identity diffusion and confusion.

As mentioned earlier, in early adolescence, peer pressure replaces the superego. By late adolescence, a renewed, matured superego appears. At this stage,

the superego is inflexible and the concept of what is right and wrong is etched in stone. It is not until the late adolescent shifts into adulthood that the superego develops new flexibility. When the young adult needs to make a living, black and white give way to gray. When late adolescents find themselves legally bound by contracts, needing to buy car insurance, paying rent, repaying college loans, and starting their first potentially permanent job, the concept of compromise becomes very real. The late adolescent learns to go along to get along in the daily workforce.

Relationships shed their superficiality (Figure 1). True intimacy ensues and marriage may occur. When asked about future plans, the late adolescent either has fixed realistic plans or is truly unsure and seeks counsel. Adolescents who struggle with the decision-making process and eventually pursue what they want rather than what others want for them are more likely to achieve satisfaction in their lives.

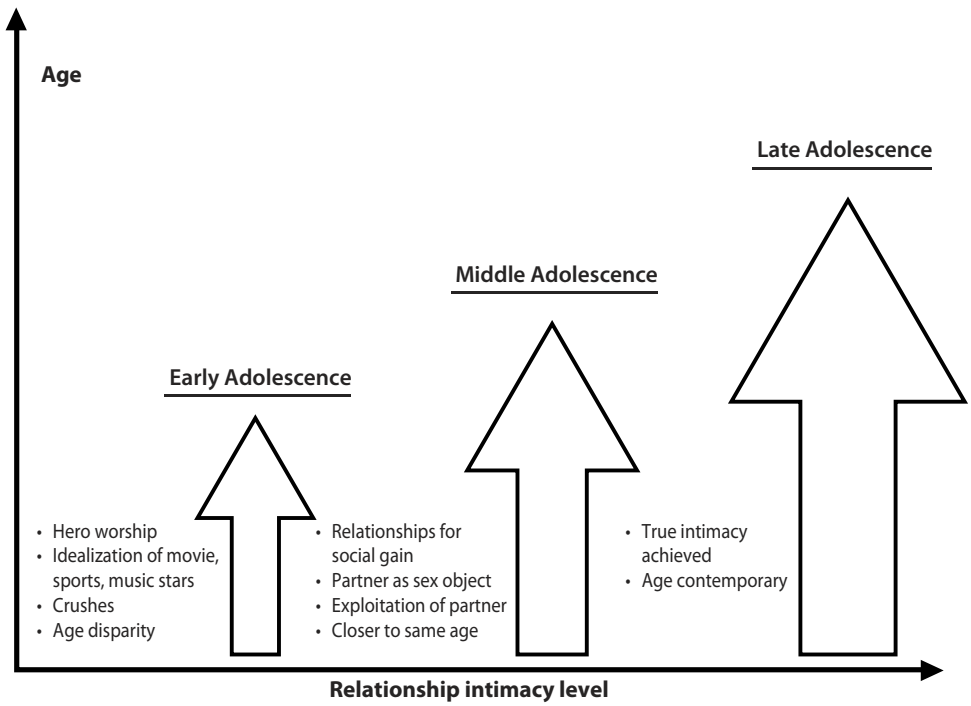


Figure 1. Realistic Intimacy Increases with Increasing Age Throughout Adolescence

DISORDERS OF CHILDHOOD AND ADOLESCENCE

Note: Before initiating any therapy, the clinician should obtain informed consent from the patient, parent, or guardian (see Appendix 1).

When the clinician assesses children and adolescents for psychiatric disturbance, the usual and customary triad of mood disorder, anxiety disorder, and thought disorder serves as the first component of assessment (Box 2). However, the assessment then broadens to include additional disorders commonly seen in children and adolescents:

- Attention-deficit hyperactivity disorder (and its spectrum of oppositional defiant disorder and conduct disorder)
- Developmental disorders (the autistic spectrum disorders)
- Elimination disorders (enuresis and encopresis)
- Eating disorders (anorexia nervosa, bulimia nervosa)
- Substance abuse and dependence (especially in adolescence and late adolescence)
- Tic disorders (Tourette's Disorder)

Box 2. Guidelines for Interviewing Adolescents

- **Assess transference and countertransference issues**
- **Be nonjudgmental and remain objective**
- **Establish rapport**
- **Explain confidentiality**
- **Facilitate insight formation by the adolescent**
- **Interview the adolescent independent of his or her parents**
- **Obtain data**

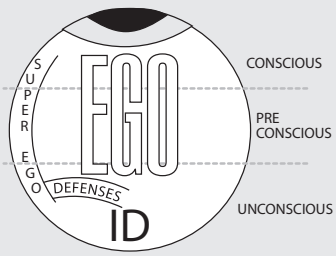
Topics to Assess

- **Family issues**
- **Mood**
- **Past physical and sexual abuse**
- **Peer group**
- **School**
- **Self-esteem**
- **Sexual activity**
- **Substance usage**
- **Suicidal ideations and attempts**

These therapies may be used alone or in combination with other approaches, except for psychoanalysis (Box 2), which has a therapeutic exclusivity because of the intricate balance that is created in its application.

Box 2. The Birth of Psychoanalysis

Psychoanalysis was born out of treating the psychiatrically afflicted with hypnosis. Sigmund Freud and Josef Breuer were physicians treating individuals with hypnotic technique for neurologic disorders that did not conform to classical neurologic symptomatology. The case of *Anna O* [Bertha Pappenheim] is emblematic of the early hypnotherapeutic approach to treating intrapsychic conflict manifesting as somatic symptoms. Freud and Breuer noted that Anna O's symptoms of visual and motor dysfunctions disappeared during and after hypnotic trance, which the physicians postulated resulted from her verbalizations while in trance *(ventilating the intrapsychic conflict)*. The 2 physicians reported their findings in the now classic *Studies in Hysteria*, published in 1895.



The hysteria of which they wrote has since come to be termed *conversion disorder*. They postulated that the condition resulted from a traumatic experience (usually of a sexual nature) that was too painful for the conscious mind; and the resultant unconscious conflict produced one or more physical manifestations. Freud believed the key to resolving the intrapsychic conflict was penetrating the unconscious resistance, which is managed by the unconscious defense mechanisms. Eventually, Freud forsook hypnosis for his newly developed technique of free association. Psychotherapy is based on Freud's structural concept of the mind components of id, ego, and superego and the concomitant topographic mind concepts of conscious, preconscious, and unconscious. Bringing these components together with the defense mechanisms provides an understanding of the process of intrapsychic conflict. Psychoanalysis became Freud's tool for treating the intrapsychic conflict and effecting resolution.

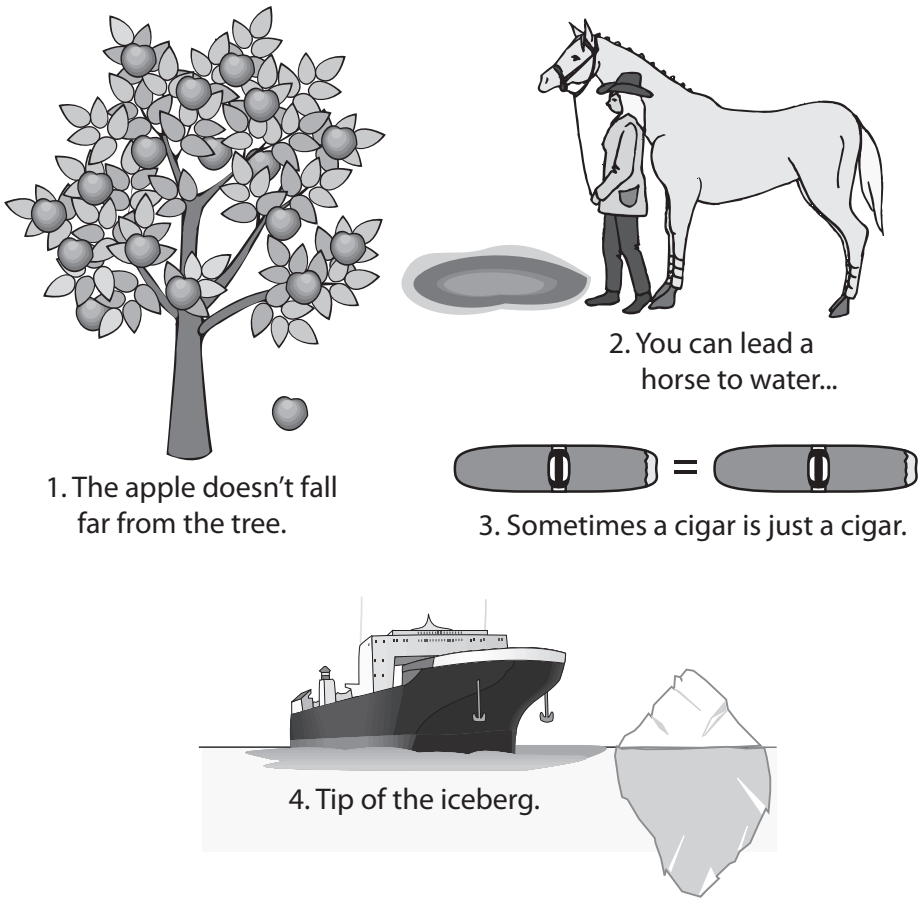


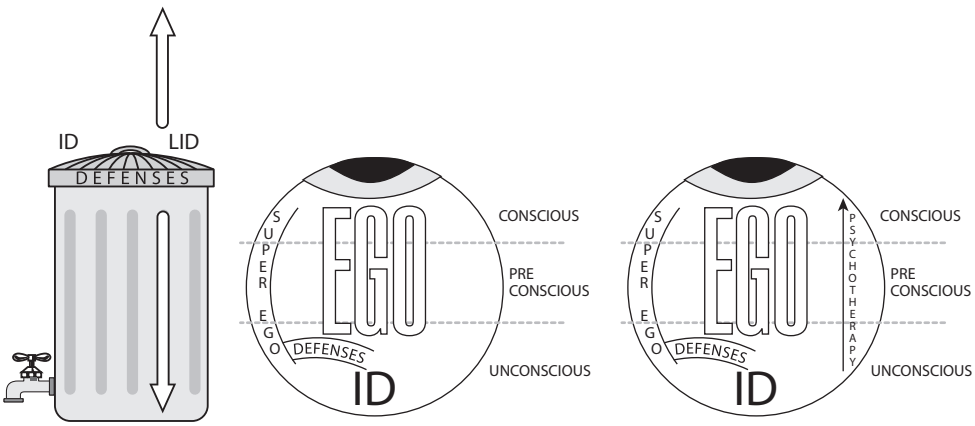
Figure 1. Goldman's 4 Pictographs of Psychiatry

GOLDMAN ON FREUD

Goldman's 4 Pictographs of Psychiatry (Figure 1) present psychiatry in a nutshell. Pictograph 1 shows an apple tree with an apple falling to the ground, a depiction of the concept ***The apple does not fall far from the tree***. We are all a product of both our nature and our nurture; we are guided by both our genetic make-up and the home in which we are raised. The genetic make-up is metaphorically the cards we are dealt, while our home of origin metaphorically determines how we will play that hand.

Pictograph 2 shows a woman holding the reigns of a horse near a stream, depicting ***You can lead a horse to water; you cannot make him/her drink***. Our role as

improvement in the neurovegetative functioning inventory indices of sleep, appetite, memory, concentration, energy, and libido.



The tap (the therapeutic spigot), placed into the bottom of the container via therapy, is very gently opened at each therapy session, allowing the conflict to be slowly and steadily viewed by the individual in a very structured, safe, and guided manner. The spigot is the metaphor for talking therapy. The therapist is trained in knowing just how much to open the valve at each session; knowing just how evocative, supportive, and interventional to be. Remember that the conflict is occurring at the unconscious level. The process of psychotherapy allows the individual to gain conscious insight, allowing the unconscious conflict to leave the dark recesses of the unconscious mind, and come into the light of the conscious mind bringing healing and repair.

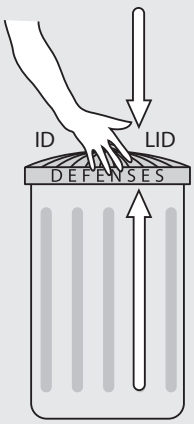
Freud's Original 7 Defense Mechanisms

As discussed above, Freud recognized that the interaction of the id, the ego, and the superego often creates an inner dissonance he called intrapsychic conflict. He identified the technique used by the mind at the unconscious level to calm this psychological upheaval as the defense mechanism. Freud detailed 7 defense mechanisms, which were later expanded by his daughter, Anna Freud, and categorized into a hierarchy by George Vaillant. Below is a thumbnail sketch of Sigmund Freud's original 7 defense mechanisms, all of which occur at an unconscious level.

Denial. The conflict between id, ego, and superego is resolved by the erasure of the awareness of the problem altogether. The conscious mind proceeds as if nothing ever happened. The external stimuli are actually blotted out from awareness (as in the example of Jimmy and the cookie).

Repression. This defense mechanism is a subtle variation of denial. In denial, the conscious awareness of the conflict is negated. In repression, the thought or conflict is either curbed before it reaches the conscious level (primary repression), or the idea, feeling, or conflict is excluded from awareness once it has reached the conscious level (secondary repression) (Box 3).

Box 3. Goldman's Theory of Somatic Consequences of Repression



When the mind implements repression, a dramatic amount of energy is used to keep a lid on the unconscious. This effort is truly exhausting and requires real energy, the same energy needed to climb a long flight of stairs, to run several miles, or to work hard all day. This use of mind energy is energy-depleting and can cause a disruption in the sleep schedule, disturbance of appetite, disruption of memory and concentration, lack of energy (fatigue), and loss of libido. All of these complaints are heard when individuals describe the somatic side effects of depression and anxiety disorders. Somatization disorder and conversion disorder are key examples of this phenomenon. For so long as a lid is kept on the intrapsychic conflict, it does not become resolved. Repression prevents this conflict from rising into conscious awareness. Some of these conflicts, in pursuit of being "heard" will convert the body into their messenger and become a conversion disorder.

The Dream Trilogy

There are 3 types of dreams:

Patent dreams **are dreams with clear meaning associated with a readily identifiable stimulus. Eg: during the day you step down from the sidewalk into the crosswalk and are almost struck by an oncoming car. That night you dream about the exact episode.**

Latent dreams **are dreams with garbled and confused meaning; they are the product of intrapsychic conflict. It is this type of dream that releases the intrapsychic energy.**

Electrical discharge **indicates dreams that are the result of the random firing of brain neurons during the sleep without meaning: similar to the flutter of an eyelid or the twitch of a finger.**

Latent Dreams: The Royal Road to the Unconscious

Unlike the conscious and preconscious minds, the unconscious mind does not readily come onto the screen of awareness. When it does come into awareness via latent dreams, it does so in an unrecognizable code—the analog to computer programming languages such as COBOL and FORTRAN—so that it does not become readily understandable to the conscious mind. The unconscious is always functioning, even during sleep. Thus, in Freud's words, latent dreams are the "royal road to the unconscious." Latent dreams are disorganized screenplays that run in a person's mind during sleep. When a person is able to remember some of these dream sequences, they seem disjointed and unintelligible because they are coded in the language of the unconscious. Latent dreams serve as an outlet for energy generated at the unconscious level. The energy is the by-product of the intrapsychic conflict that needs to be released. Because elements of the inner conflict are too painful were they to be seen in the light of day of the conscious mind, the unconscious brings the elements to awareness in code via latent dreams.