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RISKS AND OPPORTUNITIES IN ADOLESCENCE: UNDERSTANDING ADOLESCENT MENTAL HEALTH DIFFICULTIES

Widespread concerns about adolescent mental health difficulties have generated intense debate and resulted in adolescence being high on the policy agenda. Recent government investments aim to ameliorate widely criticised services for adolescence, and redress the negative images of young people. In order to explore the current state of knowledge regarding adolescent mental health, and relate this knowledge to practice, this paper explores three key questions: are adolescent mental health problems increasing, are adolescents dislocated by new and different contexts, and what are the levels of mental health difficulties in adolescence? The paper suggests that evidence that adolescents are 'getting worse' is not convincing, but it is clear that the contexts for adolescence have changed radically and this affects adolescent developmental processes. Adolescent mental health difficulties require a current, developmentally relevant and oriented approach to enhance effective understanding and intervention. Adults in general and professionals in particular need to be able to engage with and not take flight from the impact of adolescent emotionality.

Keywords adolescent mental health; puberty; transition to adulthood; suicidality; self-harm; depression; conduct problems

Introduction

In recent years, the problems of adolescence have been broadcast in a particularly insistent way. Adolescent mental health difficulties — including anxiety and depression, 'conduct' problems including individual and group — or gang — violence, alcohol and drug misuse, eating disorders, and so on — insist on being heard. Two particular aspects of this discourse can be recognised; firstly, there is the notion that adolescents 'are awful', which appears in undiluted form in tabloids, and is echoed ironically in the 'broadsheets':

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> You only ever hear a nice thing about a teenager from a charity worker. Otherwise, parents, teachers, the police, the criminal justice system, all are united, just for this instance: adolescents are awful.
>
> (Zoe Williams, *The Guardian*, Wednesday, 1 October 2008)

The second aspect is that a minority is giving the majority a bad name. This is now the official position in UK social policy:

> There is an unrelentingly negative view of young people in this country, where the problems of the few eclipse the achievements of the many … With this strategy we are determined to rebalance the public debate about our young people.
>
> (Beverley Hughes[1])

The increased emphasis on participation and access to services underpins the Government's 'Aiming High' initiative (DCSF, 2007), which aims to redress the 'unrelenting' negative images of young people.[2] This overlaps with the CAMHS agenda to develop comprehensive services for children and young people, in which recognition and assessment of mental health is central. The CAMHS review (DCSF, 2008) suggests a 'bleak' picture for mental health services offset by some more positive features; among the bleak features is the evidence

> that children and young people say that services are not as well known, accessible, responsive or child-centred as they should be. Those who access specialist services do not always have the opportunity to develop trusting relationships with staff for the length of time they need.
>
> (DCSF, 2008, p. 9)

Thus there are trends towards attempting to make services more accessible and responsive to the needs of young people, to reduce problems such as:

> Administrative and legal processes, unhelpful thresholds for access to services and some entrenched professional views can 'parcel up' children into individual services and prevent their needs being met in a holistic, flexible and responsive way or leave their needs unaddressed.
>
> (DCSF, 2008, p. 9)

As investment in these services aims to reduce the reported world-wide crisis in adolescent mental health services (Patel *et al.*, 2007), it is important to assess whether these approaches are likely to be effective. This means looking closely at the current state of knowledge regarding adolescent mental health and relating this knowledge to practice issues faced by professionals working with young people with mental health difficulties. To explore these issues, I will discuss sequentially three key, and to some extent interrelated questions, namely:

1. Are adolescent mental health problems increasing?
2. Are adolescents dislocated by new and different contexts (particularly in the extended phase of transition to adulthood?
3. What are the levels of mental health difficulties in adolescence?

Are adolescent mental health problems increasing?

The media led discourse on the theme that adolescents are 'getting worse' and adolescent mental health is deteriorating, draws on some findings from research which are cited in support of this premise. There are some high profile studies that do show increasing mental health problems. For example, the Time Trends study in the Institute of Psychiatry/Nuffield Foundation reports increasing conduct problems, including aggression, fighting, stealing, in three successive cohorts born in 1958, 1970 and 1983/4 (Collishaw *et al.*, 2004). Fombonne's (1995) study shows rates for depression increasing up to the time of this study. On the other hand, other studies do not support this position. For example, a meta analysis of 26 studies shows no evidence for increase in depression over the past 30 years (Costello *et al.*, 2006). Patel *et al.* (2007) summarise evidence across a number of studies to conclude that 'evidence is mixed for whether rates of mental disorders in young people have increased in the last few decades' (p. 1303). Methodological questions have been raised about studies that claim higher rates of problem in recent times, in that they rely on data from parents' reports or subsequent recall data, both of which may be, to an extent, unreliable. Taking a different perspective, Graham (2004) emphasises that the majority of young people do not have problems, report good relationships with parents and being happy. This accords, to a degree, with the ministerial position, quoted above, that the problems presented to society by adolescents are restricted to the actions of a minority.

Suicide rates amongst young people have been of particular concern but, again, the evidence is 'quite mixed' (Patel *et al.*, 2007). Amongst young people, self-harm and suicide attempts is higher amongst girls (ratio 5:1) and completed suicide higher amongst boys. Biddle *et al.* (2008) found that whilst the suicide rate for females has remained constant, 'since the 1990s, rates of suicide in young men have declined steadily and by 2005 they were at their lowest level for almost 30 years'. The rate for young men fell from 16 per 100,000 in 1998 to 9 per 100,000 in 2005. This finding is echoed by the annual report of the National Strategy for Suicide Prevention (NIMHE, 2008) which finds that the suicide rate for young men is falling:

> There has continued to be an encouraging and sustained fall in the rate of suicide amongst young men under the age of 35. However, the death rate from suicide amongst this high-risk group is still high in comparison with the general population. That is why it is still important for services to develop more effective approaches to engage with young men.
>
> (p. 4)

Overall, we have to conclude that the evidence for adolescents getting worse is equivocal; the 'jury is out'. Further evidence may tilt the balance; meanwhile we need

to find other ways of understanding this discussion. The negative view of adolescents has the feel of what Stan Cohen (2002) called 'Folk Devils and Moral Panics'. From this perspective, discourses about young people surface the threats that they are felt to pose to society's moral decline; thus the issue is not whether the 'problem' exists, but 'how it becomes inflated, stereotyped, to the point of moral panic' (Sharland, 2006, p. 3). Recent coverage of adolescent issues has generated a vast range of folk devils; the moral panic is focused on the discourse that adolescents are 'getting worse'. This shifts the emphasis from a focus on the behaviour of adolescents to an interactional perspective; two parties are involved in setting the agenda and distorting the issues. Thus adolescents are invested with societal and adult attitudes and expectations, in a sense, these are projected on to adolescents, meeting societal (or adult) needs. Cohen pointed out that there is a propensity for 'single solutions' to moral panics. True to form, accounts in the media focus on single causes, and there has been generated a long list of single causes: stress, educational pressure, too many temptations (drugs, alcohol, firearms, the Internet, affluence, consumption opportunities), breakdown of family values and structures, and so on; this is the process through which negative images of adolescence are generated and which distorts interactions between adults and adolescents. A consequence is that as well as critical attitudes towards adolescents, within the moral panic, there is also a social fear of adolescents, and thus of the emotionality which is quintessentially adolescent.

Fear of adolescent emotionality

To illustrate the impact of fear of adolescent emotionality, I will discuss an example, taken from some work in a secondary school (Briggs & Buhagiar, 2008). The school had asked us to help establish policies and practices for preventing suicide and self-harm. They told us that the issue of self-harm made staff anxious and they would appreciate help in dealing with this.

Our preferred method of work in these circumstances is to establish groups in which the staff can discuss their experiences with individual students and class groups in order to help the staff contain the emotional experiences of working with individuals and groups of adolescents. Rustin and Bradley (2008) describe this model of 'work discussion'; developed initially for clinical settings, the model has now been widely applied with beneficial effects. In their evaluation of the application of 'work discussion' in educational settings, Andrea Warman and Emil Jackson (2006) found that as well as experiencing benefits in their work, teachers using the work discussion groups had lower rates of absence through sickness. The process, in the work discussion group method, of exploring the emotional impact of the work, and attending to meaning, appears to support the worker and reduce the risk of 'infection' — enabling the worker to be able to be more 'affected' by emotional experiences, without becoming 'infected' (Heyno, 2008).

However, in this school our suggestions that we establish such groups were not accepted; the staff were too busy and could not commit themselves, we were told. Therefore we agreed instead to undertake some focus groups with staff, parents and students to provide a report on how these key groups thought about (and positioned themselves) in relation to self-harm.

Our findings were interesting, but problematic. We encountered a pervading fear of talking about self-harm. The widespread idea was that 'If you talk about self-harm you make it worse or you make it happen'. Staff, students and the members of the research ethics committee (which included members who were parents at the school) all participated in this belief. The Ethics Committee only agreed our application 'on the express understanding that you will not ask school pupils any questions of a personal nature'. There was a pervasive fear of contagion — talking leads to destructive action.

Staff in focus groups oscillated between saying, firstly, that there was no self-harm or suicidal behaviour in the school and, secondly, that they urgently needed experts to come in and work with suicidal students because they felt hopelessly unable to deal with it themselves. Thus we came to the view that staff were anxious and helpless with regard to understanding self-harm because a number of different pressures in the system disabled them from relating to students in ways that would enable understanding of the students, and this heightened anxiety about adolescents, who, it was felt could not be understood. These pressures included, firstly, tensions between academic achievement and pastoral care which led to staff being unsure about their roles and what was expected and how to maintain appropriate boundaries. Secondly, alongside this, the school had the aim of changing its academic profile to improve its Ofsted and league table position. This had the effect of generating a culture in which the aim was to evacuate (rather than address) emotional problems experienced by the students.

We met with two groups of students who also indicated fear of contagion and a fear of talking about difficulties:

> But, sir, it's not that good to talk about it because it might influence other people to have a go as well, because they'll think that if so and so can get their anger out by doing this behaviour, maybe it will work with me.

A small majority of students in our groups (17/31) thought that if someone is self-harming, talking to them about it will only make it worse. Most students felt it inadvisable to talk to teachers or peers; only 4/31 felt talking to teachers could be helpful, and, perhaps more surprising, only 6/31 recommended confiding in a peer.

I emphasise that I am not suggesting this example is typical or representative of schools; in fact what was striking to us was that the local 'culture' (*habitus*) was a powerful factor in determining the qualities of experience and relatedness. However, it does provide an example where the breakdown of communication between adults and adolescents reveals lack of trust, a lack of belief about the capacity to make experiences better through communicating, relating and understanding, and an absence of reflective spaces that enable emotions to be faced thoughtfully.

Fear of adolescent emotionality may be thought of, more generally, as constituting an important aspect in the creation of folk devils and moral panics. Adults find adolescent emotionality disturbing, because it is. When in contact with young people we can be subject to strong feelings, flowing from the post-pubertal drives and impulses in the adolescent process: it is what Hyatt Williams (1978) called the tensions between the creativity that flows 'when the tide of life is running

strongly' and its counter part of a destructive kind, that makes for the intensity of adolescence. And, stirred up by these, we feel maybe provoked or disturbed:

> Sometimes it feels as though all the unwanted feelings, hopelessness, incompetence, and fear on the one hand, and responsibility and worry without the power to go with it on the other, are left with the parents.
>
> (Anderson, 1999, p. 166)

Anderson added, poignantly, that parenting adolescents, like parenting a baby, inevitably leaves a scar — we can't do it without feeling marked and changed in some way; the commitment in terms of emotional labour required is therefore considerable.

Brenman Pick (1988), discussing the emotional impact of work with adolescents in an analytic setting, focused on the intensity of the forces which are mobilised in the adolescent, and their impact on the worker. In adolescence, 'the power of the force by which the post-pubertal adolescent feels carried along by the impulses and defences he (sic) constructs against them' and in turn the adolescent has the potential to have this effect on the therapist. This leads to the adolescent trying to 'sweep the parents along with him, or angrily turn away and be swept along by the adolescent group' (p. 188). The therapist may be 'swept away' into 'colluding with his ideology or trying to sweep him (sic) away with a rival ideology' (p. 188). Brenman Pick compares two adolescents in analysis. The cases complement each other, for whilst 'John was carried away by the adolescent culture, Jane had the power to carry adults away with her through a seductive superiority which aroused adults' envy' (p. 189). John got 'drunk not only with alcohol and drugs but with his power to act out and have a good time'; Jane got the therapist 'drunk' on her seductiveness, and through projecting her sense of her superiority.

Thus both individual adults, in parental or professional roles, and organisations may develop a 'culture' which coheres around an adolescent ideology (drunk on adolescence). These defensive cultures can include impulsiveness, rather than strategic thinking, individualisation of methods of work, relying on charismatic leaders, having grandiose or manic overestimation of the work. These defences may indicate that the organisation is vulnerable to the power of the forces of adolescence and become swept away with this power. Alternatively, the culture may cohere around an ideology which is an alternative to that of the adolescents. Defences then have the aim of protecting the therapist from the fear of adolescent pain, especially the painfulness of change and separation. These defences aim to control the upsurge of adolescence. The denied, rationalised or 'forgotten' pains and abjection of aspects of our own adolescence (Jacobs, 1990) is felt to be threatening and to stir up fears of losing control of a more rational and balanced approach. Boundaries separating adolescents and adults in these circumstances are usually strictly maintained, so that the pain of adolescence is not felt consciously by the adults.

In current service provision the fear of adolescent emotionality can be seen in a split between, on the one hand, the emphasis on participation and engagement in the voluntary sector, and, on the other hand, prioritisation of severity of difficulties, disturbance, diagnoses and risk assessment in the statutory sector. This split between

'the street and the clinic' pervades policy and reflects the absence of a containing integration of both the rational and the intensely emotional (and often irrational) aspects of adolescence.

How do changing contexts affect adolescent mental health?

Although there is equivocal evidence that adolescent mental health is getting worse, there is strong evidence, on the other hand, that changes in the context for adolescent development, particularly the transition to adulthood, have been extensive and have far reaching effects. These are understood to have been driven by powerful socioeconomic forces, restructuring the routes into employment for young people, increasing the participation in education (including tertiary); new patterns of consumption, and powerful new methods of communication, particularly the Internet, which hosts a virtual world of information, contacts and — through MySpace and FaceBook etc. — new patterns of friendships.

The changing contexts are also deeply divisive for adolescents who have unequal opportunities in the transition to adulthood. Two distinct pathways, reflecting increasing inequalities, lead to two identifiable 'routes' into adulthood. A majority take a 'slow track' (Jones, 2006) route to adulthood, characterised by crossing and re-crossing boundaries in a series of partial transitions. Sustained parental support is necessary for these repeated, partial oscillations between dependence and semi-independence. 'Slow track routes' are characterised by individualised decision making, in which educational attainment plays a central role. Those lacking social and cultural capital are likely to make a 'fast track' transition — with negative consequences. It is increasingly evidenced that adolescents who take a 'fast track' route into adulthood are much more likely to be disadvantaged and at risk of social exclusion (Jones, 2006). Adolescent development is much more governed by which side of the tracks you are on. The defining issue is the distribution of economic, social and cultural capital. The fortunate — on their 'slow track' route — depend on parental support (especially financial) until social and cultural capital is acquired through educational attainments. The costs include being stuck in semi-independence late into the third decade, and needing to find ways of contending with the risks that are faced. Anxiety and frustrations can be high.

Gluckman and Hanson (2006) use a schematic approach to show that, whilst the timing of puberty has remained constant throughout human history, the modern period, since the mid-twentieth century, is unique in separating, in time, two aspects of adolescence; biological (developing mature reproductive capacity) and psychological transitions (taking up 'adult roles'). Though Gluckman and Hanson — and Graham (2004) — lament this 'mismatch', it can be argued that the sequential arrangement facilitates development in contemporary social contexts through offering time to 'work through' the experiences of puberty with social experiences, with trial and error.

Change in the extent and the quality of the transition to adulthood has radically impacted on adolescents and adults. There has been a struggle to realise the extent of the impact, that for many, adolescence continues into what used to be 'early

adulthood'. In the fast track route the risks of exclusion and marginalisation have appropriately become the focus of policies and practices aiming to increase participation and inclusion. During the 'first phase' of modern adolescence a theory was developed that seemed to 'fit'. Adolescence was a time for identity formation, ending with the capacity to make decisions that led to commitments for life — in work and in relationships. In contrast today, the process of developing identity requires a different kind of adaptation, in which the key characteristics are decision-making capacity and the ability to live with uncertainty and manage piecemeal and often reversed changes into independence. Theorisation of this new kind of identity development has inevitably lagged behind experience. Now, we are beginning to match the conceptualisations with the practice, through the idea of a more fluid kind of identity, an elusive kind of subjectivity, gained through a sense of knowing about both the internal and social forces that act upon the individual during adolescent development (Briggs, 2008). Kennedy (2000) usefully contrasts a state of 'being subject to' internal, interpersonal and social forces with being the 'subject of' these. In this latter state there is some ownership of body, drives and thoughts, and a making sense of experience (Ladame, 2008).

We can see emerging elusive subjectivity in the clinical setting, where young people in difficulties illustrate the internal and social aspects of their struggles in the context of relating to a therapist. A brief anecdote illustrates this: I heard a dream presented to her therapist by a 16-year-old who had been taking a precocious route through adolescence — in this dream, she said she was queuing up for a club with her friends when she realised she couldn't go in as she had no make-up on. She ran home to get her make-up but didn't have enough time, and it all went wrong trying to get home. The dream then had the sense of a journey that got longer the further she travelled.

I think this rather beautifully — and simply — encapsulates an emotional predicament. Make-up signifies having the equipment to join the 'grown up' going-out peer group, and it may have the quality of being 'grown-up' or covering up. To get what she needs she has to go back to her childhood home; that is, she experiences dependence on her parents, and recognises the childhood home as the place to get what she needs to be able to be more independent. The anxiety expressed in the dream is that she is too far away to get back, and she feels stuck between the world 'outside' and the family home. This is a 'playful' communication expressed in a symbolic form and told to another.

Gluckman and Hanson (2006) show the striking consistency of the timing of the pubertal transition over time and this foregrounds the link between the two aspects of adolescence, an essential link that is often broken in the way that services are constructed and delivered; adolescence is often split between services, either at 18, excluding essential aspects in 'slow track' transitions, or at 16, which splits off the pubertal phase. Psychoanalytic theories of adolescence capture the immense turbulence of the early adolescent period. Melanie Klein (1922) wrote of the 'great uprush of feelings', the flooding forward of new intensities of feeling which puts the child/adolescent out of balance. Time is 'out of joint'. One 13-year-old I saw for psychotherapy said that though he was growing, it was not a problem for him, but he had two friends who did have problems, because for one of them his bones were

growing faster than his muscles and ligaments and for the other friend it was the other way round, that his muscles were growing faster than his bones. One of them was very stiff and the other was very floppy. This disaster, it can be noted, is located, through projection, in a friend.

In psychoanalytic thinking, the fluidity of internal organisation of the early adolescent period has been thought for some time to provide opportunities for reworking early experiences, providing a 'second chance' to experience key developmental issues. Recently, some unlikely corroboration of these ideas has emerged. Studies of rodents show that the effects of early maternal deprivation can be reversed if there are favourable conditions at puberty. Neuroscientific studies of the brain are providing some exciting new avenues of understanding adolescent development. Though the state of understanding is as yet uncertain in many respects, the current consensus is that changes to the brain occur during puberty and continue for up to another decade into early adulthood. Blakemore's MRI studies (e.g. Choudhury *et al.*, 2006) show that social competency changes and develops throughout adolescence, particularly the capacity to take account of another's perspective. Thus changes in the brain at puberty create a situation of 'neural plasticity' (Patton & Viner, 2007). There is the opportunity for a different set of experiences to have significance and change developmental pathways. There is, as Patton and Viner (2007) suggest, the opportunity to rework developmental experiences:

> where the effects of earlier adversity may be ameliorated and where experience may shape brain development and later emotional functioning.
>
> (p. 1136)

The key to this is that favourable environmental circumstances need to be present to permit this reworking. Favourable experiences include, as Patel *et al.* (2007) summarise from longitudinal research studies, 'a sense of connection, low levels of conflict and an environment in which expression of emotions is encouraged' (p. 1305). Adverse circumstances during the pubertal years such as family conflict, divorce, or peer violence and rejection are likely to have a particularly acute impact on subsequent development (Patton & Viner, 2007, p. 1134). Unfavourable experiences will simply generate a 'second helping' repeating and reinvesting the deprivations of the early years with another dose when it matters in early adolescence. In these circumstances, mental health problems are likely to be severe.

Are there high levels of mental health difficulties in adolescence?

The third question I will address is whether there are high levels of mental health problems in adolescence. Most evidence points out that the level is unacceptably high. Patel *et al.* (2007) conclude that the 'burden' of mental disorder (worldwide) in adolescence is high: between 1 in 4 and 1 in 5 adolescents in any one year are likely to experience a mental health problem. Young Minds has collated the extent of the problem in the following summary of statistics and evidence:

- 1 in 10 children and young people aged 5–16 suffer from a diagnosable mental health disorder — that is around three in every class (Green *et al.*, 2005);
- between 1 in 12 and 1 in 15 children and young people deliberately self-harm (Mental Health Foundation, 2006) and around 25,000 are admitted to hospital every year due to the severity of their injuries (Fox & Hawton, 2004);
- over half of all adults with mental health problems were diagnosed in childhood. Less than half were treated appropriately at the time (Kim-Cohen *et al.*, 2003);
- nearly 80,000 children and young people suffer from severe depression (Office for National Statistics, 2004);
- over 8,000 children under 10-years-old suffer from severe depression (Office for National Statistics, 2004);
- 45% of children in care have a mental health disorder — these are some of the most vulnerable people in our society (Meltzer *et al.*, 2003);
- 95% of imprisoned young offenders have a mental health disorder. Many of them are struggling with more than one type (Office for National Statistics, 1997).

Anyone working in front-line child and adolescent mental health services will probably recognise this picture; high rates of self-harm, depression and offending behaviour. Services often feel flooded by 'difficult' cases, and that work is 'getting more difficult'. It is important, though, to look at what these statistics might be conveying.

Firstly, we can note that the list here consists of a number of different kinds of identifiers, including *diagnoses* (depression), *behaviours* (self-harm and offending) and *social categories* (e.g. looked after children and offenders). These are therefore different ways of recording mental health difficulties; behavioural, social and medical (or psychiatric).

In recent years we have witnessed — and I do not think this is an exaggeration — a 'psychiatric deluge'; diagnoses such as 'conduct disorders' are prominent, outcomes of intervention are measured in 'symptom change' and assessment of interventions based on risk assessment and management. The (psychiatric) diagnostic and risk assessment focused approaches flatten and concretise the experiences that lie behind diagnoses such as conduct disorders, depression and self-harm. These are the outcome of complex internal organisations, and each 'symptom' or 'syndrome' contains a range of different relational constellations. For example, in a study of underlying relational patterns and suicidal risks, we (Wright *et al.*, 2005) found some distinctive patterns.

Some suicidal adolescents stir up terrific anxiety in others, whilst others can leave one unaffected, or unworried, and surprised that the adolescent was suicidal. ('I never knew s/he was thinking like that': Briggs, 2002). In the therapeutic setting, the experience is that the worker experiences different kinds of emotional reactions, or counter-transference. This indicates that though the concern is similar — suicidality — this is driven by different internal patterns of relatedness.

We compared the internal relationship patterns of suicidal and non-suicidal adolescents. We interviewed the adolescents using a semi-projective interview schedule that generated narrative accounts of the adolescents' responses to different situations that involved a separation. The interviews were analysed quantitatively and qualitatively. We found that the suicidal adolescents were more insecure (less

emotionally open, more pessimistic, more self-blaming, less coherent in their narratives) — but they used different attachment strategies for dealing with emotional difficulties. One group, highly preoccupied or enmeshed, tended to talk anxiously and at great length about their difficulties, seeming to worry about everything (without prioritising what should be most worrying). For example, one participant spoke for several minutes — with varying qualities of coherence — building up an account with a great sense of worry, until she provided a picture of being trapped within her body, her lack of capacity to control it, and her fear of negative peer judgements.

A second group dismissed, downplayed, negated or denied emotional experiences, so that an emotional issue was introduced by a negative: 'I wouldn't say I was bothered about it'. Alongside this, adolescents in this group spoke about 'not thinking' about emotions, or relationships. Interestingly, these narrative patterns were 'applied to the adolescents' relationships to their own body as well as to relationships with others. Suicidal adolescents — in both insecure attachment groups — related to their bodies as out of their control, and that the attempt to exert control was overwhelming. In the face of this difficulty, submission and despair occurred.

The preoccupied group 'hyperactivate' the emotional and relational links with others, and the dismissing group aim to 'deactivate' these links. This leads to two distinctive kinds of narrative for suicidal adolescents: the preoccupied group generate 'narratives of enactment' pursuing their pattern of relatedness with others, engaging them in the replication and repetition of these conflicts. The dismissing group create 'narratives of elimination', aiming to shut down contact with others and escape from or obliterate relatedness. For this group being engaged in emotional discussion is in itself intolerable.

These findings map on to and make sense of clinical experiences of being emotionally affected in different ways, and they provide a route into identifying relational patterns leading to suicidal risks. Thus taking a developmental approach helps to distinguish different developmental pathways for individuals with specific problems and thus revitalise the connections between different kinds of individual experience, development and mental health problems. This approach can be applied to the 'diagnoses' that show high levels of mental health problems in adolescence.

As we have seen, time trends in adolescence show that conduct disorders are increasing (Collishaw *et al.*, 2004). This fits with media views of adolescence that highlight violence and crime, stealing, lying and disobedience. We know that many adult mental health problems in this area begin in adolescence. Conduct disorders that persist through life, sometimes referred to as Life-Course Persistent, affect 1/20 of the age group, whereas it is more common (1 in 4 of the age group) for 'conduct disorders' to begin and end in adolescence (Graham, 2004). 'Conduct disorder' used to be called 'delinquency'. Keeping this now — apparently — anachronistic term, delinquency, in mind as adolescent and 'developmental' behaviour, offers the capacity to link experiences and behaviour in psychosocial contexts with the possibility of understanding the meaning behind particular acts. Moreover, this also provides the opportunity for more accurately and earlier identifying the Life-Course Persistent group, and offering different and more effective and earlier interventions.

Depression can be discussed in similar terms. Depression is a summary term which accounts for a range of feelings — sadness, misery, disappointment through to

self-blaming, despair and hopelessness, and an intense sense of aggression directed against the self (or a part of the self). It is experienced in varying degrees of severity, and duration, through the life course. At the extreme (in terms of degree) is clinical depression. The incidence of depression increases in adolescence. It is important to distinguish degree of depression, its persistence and the propensity for this to develop into self-harm and suicidal behaviour. However, it is also important to distinguish between different *qualities* of depression; on the one hand 'depression' (which here needs to be in inverted commas) means depressive, and includes sadness, the pain of loss and concern about another; on the other hand it is a more agitated or in reality an internally persecuted state in which self-criticisms, recriminations and blame feature; this is paranoid-schizoid, and not depress*ive*.

Diagnoses of depression inappropriately labels all depression as a 'bad thing', and something to be got rid of. Sometimes, in fact, some depression can be an interim outcome especially for young people prone to act destructively. The crucial factor is whether the individual, supported by adults, can bear and make sense of depressed feelings. Depression in adolescence is not new. Thirty years ago, Hyatt Williams wrote

> During adolescence it is common to encounter depression. What happens during its course depends on a bewildering variety of factors. If the depression can be borne, sustained and worked through, there often follows an efflorescence of emotional growth.
>
> (Williams, 1978, p. 309)

One of the aims of therapeutic work is to help adolescents sustain feelings — even those not particularly pleasant ones like depression — and help tolerate the difficulties in bearing and thinking about these. The therapeutic value of this can be seen in the following clinical vignette:

> Howard, was 21 when he came for his first assessment session three weeks before Christmas — he turned up nearly 30 minutes late wrapped in a large coat; he held his appointment letter tightly in his hand as if he feared losing it. He made apologies for being late quipping rather lamely about his geography degree not helping much with map reading. He then gave an account of his family history, describing an entanglement with his mother and his contempt for his father who was, he said, 'about as useless as a hole in the head'. Then he told me of his propensity to find all kinds of ways of putting himself into risky situations — jumping out of moving taxis, walking alone drunk around central London in the early hours, (acting one might say as though *he* had a hole in his head) and then threatening to make suicide attempts. The incidents intensified as Christmas drew nearer, and as we approached a break in sessions over the holiday period my anxieties also intensified. I felt I was helpless and useless — like he described his father in fact. The risky and suicidal behaviour always occurred when he was drunk, and in my state of some desperation I suggested one thing to try would be not to drink. In response he went ballistic — how stupid I was; he comes all the way here to this esteemed (the word emphasized with total contempt) institution,

and that is all I have to say — how pathetic. Despite the onslaught I stuck to my guns and said that nevertheless, although he considers me to be absolutely stupid, I did think that this could be important. I was left with a great deal of anxiety about him over the Christmas break but found on my return the suicidal behaviour had reduced.

This did not prevent Howard continuing to rage at me. Even though week by week there were considerable improvements, he complained with rage and contempt, that before coming here he had been all right. If there was a problem he would get drunk and 'do something'. Now, he can't do that because I 'make him think', and then he 'gets *depressed*'.

This therapeutic process demonstrates a shift from acting out to depression, accompanied by pains that were felt to be unbearable, and the therapist is called upon to withstand the force of these emotions, the rage and the complaints through which inner distress is communicated.

Conclusion

In order to explore contemporary themes of adolescent mental health, in this paper I have addressed three key, overlapping questions. The discourse that there is an increase in adolescent mental health difficulties is not substantiated by available research knowledge and appears, rather, to be a media-led example in the genre of 'folk devils and moral panics'. This resituates the discussion as interactional, driven as much by adult attitudes to young people as by the behaviour of young people; I suggest this is partly driven by fear of adolescent emotionality.

Current policy initiatives, based on the notion that a minority of adolescents are to blame, underestimates the extent to which changing contexts for adolescent development have impacted on young people. The extent of these changes leads to the need to reconceptualise adolescent development and, though inevitably lagging behind experience, new theorisations are beginning to emerge, recognising the diversity of the routes through adolescence into adulthood. The emphasis is currently on the distinction between fast and slow track routes into adulthood, the impact of these on identity and subjectivity and the different kinds of identity formation that are taking place now, compared with previous generations of modern adolescence. Conceptualising identity as being formed through relatedness to others to constitute a fluid, elusive subjectivity has potential for developing theoretical accounts of a psychosocial subject, that takes into account internal as well as social aspects of subjectivity.

There is strong evidence for the existence of high levels of mental health difficulties in adolescence, evidence that comes as no surprise to front line practitioners. The current predominance of a diagnostic approach has the effect of collapsing distinctions within categories such as depression and 'conduct problems' and undervaluing the importance of psychosocial descriptions of individual problems. Thus the diagnostic approach is detrimental to understanding important facets of development. Restoring and reasserting a developmental approach to adolescence

increases sensitivity to adolescent difficulties and makes it possible to relate to the needs of young people and provide effective interventions. Relating to adolescence as a developmental unity — beginning with the transformations of puberty and continually working through these until the transition to adulthood is achieved — and being prepared through reflective emotional involvement to face and work with issues of relatedness and emotionality between adolescents and adults, are the key conditions for working with and making policies for young people. There is, therefore, a strong possibility that current initiatives to develop services will fall short unless these are configured in ways that take these factors into account. Particularly, it is necessary to prioritise assessments that differentiate developmental pathways rather than being diagnosis-led. Services need to be constructed across the entire range of adolescence, including, rather than excluding the pubertal (under 16) or the young adult (over 18) periods.

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Notes

1 Beverley Hughes, MP, is Minister of State for Children, Young People and Families.

2 The six objectives of 'Aiming High' are: (1) rebalancing the public narrative about young people; (2) empowering young people to increase their influence over the design and delivery of services for them; (3) increasing the number of local places for young people to go; (4) removing barriers and supporting young people to access local opportunities and services for them; (5) improving the capacity and quality of services for young people; and (6) supporting and developing the youth workforce to employ the very best practice in working with young people.

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