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Transformations in Attachment Relationships in Adolescence: Adaptation Versus Need for Psychotherapy[1]

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Adolescence is a period of dramatic change in attachment relationships. These changes enable attached children to become attachment figures for their spouses and children and to live safely in a world characterized by both safety and danger. Furthermore, adolescence culminates a developmental process in which interaction with parents has shaped children's minds and behavior in ways that may or may not prepare them for life outside their families. When family members have been exposed to danger, particularly recurrent or deceptive danger, children may have learned skewed interpersonal strategies that will make life outside their families of origin, particularly marriage and child-rearing, more difficult. On the other hand, the neurological maturation occurring in adolescence creates the first opportunity for individuals to consider and change, independently from their parents, the heritage they take from their childhood families. This article first places attachment in a developmental framework and then focuses on the process of change for those adolescents who require professional intervention to make the transition from a distorted childhood to an adaptive adulthood.

Attachment as a Developmental Construct: A Dynamic-Maturational Model

Prior to adolescence, attachment refers only to the self-protective strategies that children use, primarily with their parents, when they feel threatened or uncomfortable. After puberty, attachment also includes sexual relationships and strategies that are directed to peers. Nevertheless, all attachment relationships can be described in terms of patterns of (a) relationship, (b) processing information, and (c) self-protective strategy. All three perspectives are addressed in terms of how the mental and physical changes associated with adolescence affect attachment relationships. These notions are then applied to the psychological treatment of adolescents who face difficulties managing this transition.

Attachment relationships are the outcome of an interaction between genetically-based, innate processes and experience. Because both change over time, patterns of attachment change as well. That is, the relationships that older people form are more complex than those of infants, the patterns of processing information used by older people are more complex than those of infants, and the self-protective strategies of older people are more complex than those of infants.

Adolescence, particularly late adolescence extending into the early 20s, is the final period[2] in which brain and physical maturation affect patterns of attachment. During the period from about 15 to 25 years of age, prior learning about relationships is integrated with new mental and physical competencies to yield adult patterns of self-protection and reproduction. The new competencies include abstract reasoning, sexual arousal, and reproductive behavior. The integrative process and its significance to human adaptation are the focus of this discussion.

Patterns of relationship

From birth on, humans turn to other humans who can protect and comfort them. By about 9 months of age, most infants have identified one or two specific caregivers, usually their parents, to whom they turn when threatened or uncomfortable (Bowlby, 1969/1982). These people are their attachment figures and they function to protect the child from danger and to comfort the child's distress. In interaction with their attachment figures, growing children slowly learn to manage aspects of these functions for themselves. However, the boundary between personal competence and interpersonal dependancy keeps changing, such that protective attachment figures are needed throughout the life-span. In other words, attachment figures function in our ever-changing zone of proximal development (Crittenden, 1995).

In infancy, the relationship between attached person and attachment figure is non-symmetrical and non-reciprocal. That is, infants and parents have vastly different power and infants do not take care of their parents. Infants explore the world away from their attachments figures when they feel safe and return to them when they feel threatened or uncomfortable. In the preschool years, children begin to challenge parental status, but they still perceive parents to be all-knowing and all-powerful. In the school years, children seek alternate attachment figures who are similar to themselves in status. These are their 'best friends', with whom they explore the physical and social world and to whom they turn for protection and comfort in situations that carry only low to moderate threat. Exploration is also the domain of children's affiliative peer group but, under intense threat, children still run home to mommy for protection and comfort. At the same time, school-age children are learning that parents are not all-knowing and that they can even be deceived. These changes create complexity among relationships and success in managing multiple types relationship that serve overlapping functions is predictive of success with romantic relationships in adolescence (Collins & Sroufe, 1999). The best friend relationship is symmetrical, but non-reciprocal, that is, each child seeks care from the other, but neither thinks of themselves as a caregiver.

Over the course of adolescence, the relationship to parents is attenuated. Not only are parents clearly recognized as imperfect, they are discovered to be vulnerable. This recognition that parents cannot completely fulfill their protective function can undercut adolescent-parent attachment, thus, both making way for new peer attachments and generating misleading expectations that these will have the same limitations. In adolescence, these best friend relationships are transformed in three ways. First, in middle

to late adolescence, the best friend becomes someone of the opposite gender, a romantic partner, with whom adolescents experience sexual desire (Savin-Willians & Berndt, 1990). Sexual desire with its predictable outcome of reproduction is the central distinguishing feature of adolescence, particularly late adolescence. It creates a new means of experiencing intimacy and expressing affection and offers new incentives to maintaining relationships through periods of stress. In addition, sexual desire offers a new means of achieving comfort and reducing arousal. Whenever multiple motivations converge on a single form of expression, it will be enacted preferentially. Moreover, by being so highly motivated and largely reflexive, at its most basic level, sexual intercourse requires almost no social skills, verbal skills, or interpersonal reciprocity to be consummated. Sexual activity, in other words, is so over-determined that almost everyone will engage in it. Managing it in ways that promote intimacy and protection of future progeny becomes a central issue in adolescence.

Second, romantic relationships serve many functions. In modern societies, those that have largely solved the issue of survival, romantic relationships are the forerunners to spousal relationships. Both are expected to fulfill an array of psychological, emotional, and social functions in addition to the essential functions of survival and reproduction. This puts greater pressure on the choice of partner and management of the relationship than was experienced in traditional societies with arranged marriages in which protection and reproduction were the only functions and love was almost never considered.

Third, adolescents' romantic relationships become progressively more reciprocal as each partner recognizes his or her importance to the other and accepts responsibility for caring for the other (Burhmester, 1996; Windle, 1994). In a mature adult attachment relationship, each person is both the attached person and the attachment figure for the partner. In addition, the exploration away from the attachment figure that typified infancy and childhood becomes exploration of shared interests with the attachment partner. When these changes occur, young adults complete the transfer of their primary attachment relationship from their parents to their partner, usually their spouse.

During adolescence, adolescents learn how to select such a partner, one with whom they can be safe, comfortable, and raise their own children. Clearly, selecting a partner is not an easy task: half of adults decide that they selected the wrong person (Bumpass & Raley, 1995), actually an unusually terrible person, and they divorce that person - at substantial physical, emotional, and social cost to us all. The problem appears to be based on two errors of judgment, one having to do with prediction from first appearances to later realities and the other based on the childish assumption that there are perfect people, if not parents, then surely partners. Learning to manage symmetrical and reciprocal attachment relationships in which each partner is accepted as less than perfect is a central task, both for each of us individually and also for society in general. The culmination of the integrative process that promotes this outcome usually occurs in late adolescence. For most older adolescents, this transition generates increased self-esteem, self-efficacy, and social support (Schulenberg, O'Malley, Bachman, & Johnston, 2000). For others, however, the process

highlights their lack of preparation for coping with change. Problems can ensue if the transition to a peer attachment figure occurs too soon, too abruptly, to an unsuitable partner, or incompletely. It is telling that this central outcome of adolescence, the selection of a life partner, is both the least recognized by adolescents as an immediately relevant challenge (Arnett, 2001) and also the most valued as a foundation for future happiness (Arnett, 2000).

Patterns of processing information

Why do so many people select a partner whom they think will be better than anyone else, maybe even perfect, only to divorce him or her later - because they think the person is among the worst possible partners? How do we delude ourselves so greatly? The answer lies, in part, in how we have learned to transform sensory stimulation into meaningful information with which to organize our behavior.

The process begins at birth and continues throughout life, but critical steps are made in adolescence. An infant perceives only a portion of the sensory stimulation that is available; the most salient is that about his or her own physical state and the effect of others' actions on that state. This sensory stimulation is transformed into information about how things are. Infants make very direct transformations, that is, information is taken at face value and treated as true information. With experience, however, infants learn that some information is meaningless or even dangerous. Some learn that negative affect, for example crying, leads to angry parents. These infants learn to inhibit their crying, that is, they learn to omit negative affect from the organization of their behavior. This creates certain risks because affect, particularly negative affect, functions to motivate self-protective behavior. Individuals who omit negative affect from processing may fail to identify occasions when they should protect themselves.

Other infants learn that there are no predictable outcomes from their behavior, that their parents respond very differently to the same behavior from day to day. These infants learn to omit temporal/causal information from their mental processing. Failure to identify the causal sequences that lead to danger will prevent children from learning to change those sequences. In addition, associations may be made that are spurious. Such superstitious learning is based on <u>erroneous</u> information. By the end of infancy, three transformations can be made. Sensory stimulation can be treated as <u>truly predictive</u>, be <u>omitted</u> from further processing as though it had no meaning (when it does have meaning), or it can be erroneously included in processing as though it had meaning (when it has no meaning).

In the preschool years, children learn to <u>falsify</u> positive affect (because it pleases some adults), whereas others learn to <u>distort</u> negative affect (because it causes some adults to pay attention and respond). In other words, two new transformations of information are generated: falsified and distorted affect. In the school years, children learn to deceive others about their intentions, especially their intention to misbehave. This is <u>false</u> cognition, a false presentation regarding the temporal/causal order of events. These, I think, are the five possible transformations of information. Only by engaging in cortical integration can the

inaccuracies of distorted attributions be identified and corrected.

Adolescents must learn both to use and integrate all five transformations and also to identify their use by others. This brings us back to the issue of choosing a partner. How can you tell, early on in a relationship, what a person will be like later? The problem is one of prediction. Which information is most important to attend to and what does it mean? Answering this is complex because not everything is as it appears to be, especially among adolescents.

Adolescents spend a great deal of time trying to present themselves attractively - in ways that will attract others, particularly a partner of the opposite-sex. How can one tell whether the attractive appearance is truly predictive, distorted, or even false? Two skills are needed, both of which should have been developing from infancy. First, one's perspective must be de-centered. That is, by adolescence, individuals should be able to take in information about other people without exclusive reference to themselves. Second, individuals should expect that some of what is initially apparent in a new acquaintance will be misleading. Important information may be omitted (for example, the jock may hide his intellectual interests to impress his athletic friends or, alternatively, an angry boy may hide his resentment of females in order to attract a sexy girl). Other information may be distorted, for example, a girl may appear sweet and attentive when really she is sometimes frustrated and bored with the boy. Erroneous information includes some personal feelings that are not relevant at all, but which are treated as powerfully predictive (based on an erroneous belief that one's feelings or intuitions cannot be mistaken). False information, on the other hand, is highly deceptive. Adolescents need to differentiate superficial appearances from the usually more complex reality. Hypocrisy becomes a cardinal sin in adolescence when discerning truth is so difficult and yet so very important to future safety, comfort, and reproductive success. To summarize, all transformations of information are used by younger children, but only adolescents with their ability to think abstractly have the potential to identify these explicitly. Only they are able to use that knowledge to think about the differences between appearance and reality and to protect themselves from both their own and others' distortions. When past experience or current conditions interfere with this process, assistance may be needed.

Self-protective strategies

The central thrust of my work in attachment has been to develop a model of the strategies that individuals use to organize self-protective and reproductive behavior (Crittenden, 1997). This model is developmental and begins with very simple strategies - that are based only on true and omitted information. As a function of development, the strategies are elaborated with the inclusion of distorted, erroneous, and false information, until, by early adulthood, a wide array of deceptive and non-deceptive strategies is available. Based on Ainsworth's observations of infants, three basic groups of strategies, labeled A, B, and C, have been identified (Ainsworth, Blehar, Waters, & Wall, 1978.)

The Type A strategies use true or distorted temporal predictions, i.e., true or distorted cognition, and sometimes false positive affect, but consistently omit negative affect from

mental processing and behavior. Type A people seem inhibited emotionally and quite predictable. In general, they are rule-bound individuals who view the world from the perspective of other people. There are many forms of the Type A pattern.

Insert Figure 1 about here.

Some are just cool and businesslike (A1-2, Figure 1), whereas others are compulsive caregivers who rescue or care for others, especially those who appear weak and needy (A3). Some are compulsively compliant or obedient, especially toward angry and threatening people (A4). Others become compulsively self-reliant (A6). Usually this develops in adolescence after the individual has discovered that they cannot regulate the behavior of important, but dangerous or non-protective, caregivers. They withdraw from close relationships as soon as they are old enough to care for themselves. Among these, a few will become compulsively promiscuous (A5). Again this develops in adolescence when intimate relationships have been treacherous and strangers appear to offer the only hope of closeness and sexual satisfaction. The two most distorted subpatterns (that develop only in early adulthood) are delusional idealization of imaginary protective figures (A7) and an externally assembled self (A8). The latter is usually associated with pervasive and extreme early abuse and neglect that has left the individual without the developmental capacity to represent the self.

The Type C strategies use affect as the central source of information and omit cognition, because others' responses have proved unpredictable. Their use of affect is coercive in that mixed negative feelings are split, exaggerated, and alternated to create a powerful strategy for attracting attention and then manipulating the feelings and responses of others. The alternation is between presentation of a strong, angry invulnerable self (C1,3,5, Figure 1) with the appearance of being fearful, weak, and vulnerable (C2,4,6). The angry presentation elicits compliance and guilt in others, whereas the vulnerable self elicits sympathy and caregiving. This alternating pattern, in its extreme (C5-6), is often seen in violent couples where the hidden half of the pattern is usually forgotten or forgiven - until the presentation reverses. At the extreme, this pattern, too, becomes delusional with delusions of infinite revenge over ubiquitous enemies (a menacing strategy, C7) or the reverse, paranoia regarding the enemies (C8). These last two do not become organized before early adulthood.

The Type B strategy involves a balanced integration of cognitive, temporal prediction with affect. In childhood, the information used is true, but, as children are exposed to the range of strategies used by others outside the family, Type B children have the opportunity to learn to recognize and use a wide range of distorted strategies. Failure to recognize distortion and deception and an unwillingness to ever use these strategies oneself makes an honest person at best naive and at worst a fool, the potential victim of another person's deception.

A central notion underlying this model is that exposure to danger, particularly inescapable

and unpredictable danger, and lack of comfort lead to the development of the most distorted transformations and the most complex strategies (Crittenden, 1999). These become organized only in late adolescence and early adulthood. After puberty, achievement of sexual satisfaction and reproductive success become integrated with the protective function of attachment. This means that the highly distorted strategies will usually include some form of sexual dysfunction.

On the other hand, by late adolescence, it becomes possible for threatened individuals to think productively about their own experience and the way it has affected their behavior. They become able to consider the possibility of other life situations in which safety and comfort are possible and predictable. The challenge becomes restructuring their adult life, particularly their choice of spouse and manner of raising children, so that they and their future families can experience security. Adolescents whose childhoods were secure face the opposite challenge: to develop an array of strategies that will enable them to live in reasonable safety in a world in which there is danger, treachery, and suffering. This, too, relies on competencies that first become available in adolescence.

Integration

The central task of adolescence is integration: physical, emotional, and intellectual integration (Masten & Coastworth, 1998). Physically, integration requires that we balance strength with gentleness and sexual behavior with discretion. Emotionally, integration requires that we balance the motivations of our feelings, including the new feeling of sexual desire, both with other feelings, including our understanding of others' feelings, and also with our intellectual understanding of situations. Without this balance, we become dependent upon chance to select our behavior and possibly even our partner. Mental integration requires the ability to think consciously and abstractly about the reasons for one's own behavior as well as for the behavior of others. It permits one to discern both self-deception and the deception of others. Without integration, we are poorly prepared to regulate our own behavior and poorly prepared to make the transition from parental attachment figures to the selection of a spousal attachment figure. Failing to accomplish these forms of integration interferes with our ability to maintain a marriage and to raise and protect our children.

Integration versus fragmentation. If we are distorted in our own processing of information and our own strategies, chances are that we will attract and select an unsuitable partner. Similarly, if we are unaware of others' potential to distort, we may fall victim to their deception. In either case, we jeopardize our own safety and comfort and that of our spouse and children. Even more ominously, if we cannot manage an adult relationship that provides, in a less than perfect manner, both protection and comfort and also reproduction and sexual satisfaction, we may fragment these functions by seeking to fulfill them in different relationships. Often this necessitates use of incompatible strategies in which satisfaction of one need conflicts directly with satisfaction of another. For example, seeking protection and comfort with one's spouse while seeking sexual satisfaction in other ways can destroy a marriage. Alternatively, offering protection and comfort to someone other than

one's spouse (and children) may deny the spouse his or her primary role and its associated comfort. Further, dissatisfaction with a spouse's imperfection may elicit the same sorts of distorted self-protective strategies that were used with parents in childhood.

Fragmentation of functions usually weakens relationships. In addition, however, splitting protection from comfort and sexual satisfaction creates the risk that we will incur danger while seeking comfort or sex. Similarly, splitting reproduction from sexual satisfaction creates the risk that only sexual satisfaction will be achieved and reproduction will fail. On the other hand, inability to accept imperfection in self or partner can lead to withdrawal or coercive retribution; this, too, weakens a marriage. These failures, that often are first perceived when adolescent love relationships break up, can become the impetus to change. Such change can lead to reorganization of childhood relationships, patterns of attributing meaning to information, and strategies for achieving safety and comfort, and reproduction and sexual satisfaction.

Integration and discrepancy. Even in the more fortunate circumstances of Type B adolescents, discrepancy is the key to integration. There are several ways in which an adolescent who was raised in the security of safety and comfort can become aware of the range of dangers and distortions inherent in life. One is by being exposed directly to untoward events. Often it is the experience of being duped or hurt that elicits reconsideration of self and others. At other times, comparison of their own felicitous experience with others' more difficult circumstances is the impetus. Sometimes these other people are not even known personally: they live in disadvantaged parts of town, in the news, or in books. Unfortunately, without some basis in personal experience, this offers a limited foundation upon which to understand the complexity of life and, all too often, leads to naive idealism, to 'save the earth', 'save the poor', bleeding-heart foolishness. It helps to have experienced suffering, at least a little. If adolescents experience problems first-hand, they will perceive directly some of the complexity of life. Without recognition of complexity, there can be no balanced integration. The process of integration is dependent upon recognition of discrepancy, and discrepancy, in turn, is best elicited by experiencing unrealized expectations and unexpected negative affect.

Although selecting an appropriate person with whom to have a relationship is a difficult and informative task that can promote integration, it is still easier than maintaining the relationship over time and in the face of the problems that will certainly crop up. During early love relationships, adolescents practice applying their own strategies to relationship problems in ways that promote mutual satisfaction and learn how to work with partners' strategies to maintain relationships.

Integration of multiple relationships. The task, however, is more complex than simply learning to manage one love relationship. Adolescents and adults must also manage concurrently an array of attachment and affiliative relationships, all of which are changing all of the time. This is very complex. With our parents, we must slowly transform the asymmetrical, non-reciprocal relationship of childhood in the direction of greater symmetry

and reciprocity. With our partner, we need both symmetry and reciprocity. If we cannot both care for the partner and be cared for by our partner, the relationship will fail to yield maximum protection and comfort and it may founder and dissolve in the face of serious threat. This harms both us and our progeny. In our relationships with our children, we must accept the role of caregiver in a non-symmetrical, non-reciprocal relationship that itself will change as our children grow. Finally, affiliative relationships overlap some of the functions of attachment relationships, including exploration and comfort; this reduces the pressure on spouses to be everything to each other. On the other hand, when they overlap essential functions of the spousal relationship, specifically sexual satisfaction and support of progeny, affiliative relationships threaten the spousal relationship. Managing the set of relationships is very complex, very challenging. And yet management of this complexity is essential to our survival and happiness. And to that of our children.

Only the process of on-going mental integration can enable humans to achieve sufficiently differentiated behavior to behave adaptively in the wide range of situations that life offers. For some individuals, particularly those developing in safe and comfortable families, the process of mental integration is generated naturally as maturation and change in contexts make new thoughts, feelings and integrations of these possible. For others, the process of integration is more elusive. Particularly if the individual has been exposed to recurrent and deceptive forms of danger and the absence of comfort, external help may be needed before the capacity to integrate can be accessed fully and applied to the problems of daily life. In that case, mental health treatment may be needed.

Treatment

Psychotherapy can promote troubled adolescents' potential to reorganize their existing strategies so as to live in greater safety and comfort in adulthood. An understanding of the process for accomplishing this requires a theory of human adaptation and conceptualization of its relation to treatment. From these, a set of modalities and techniques for the treatment itself can be derived. The preceding section presented a Dynamic-Maturational theory of human adaptation at three levels of functioning:

1. The *relationship* level, in terms of multiple attachment relationships that vary in symmetry and reciprocity;
2. The *mental* level, in terms of five transformations of sensory stimulation into meanings that dispose one to behave in particular ways;
3. The *strategic* level, in terms of Type A, B, and C strategies that combine, in various patterns, the dispositions to behave that are experienced in different relationships.

In the sections below, the Dynamic-Maturational model of attachment is applied to the conceptualization of treatment in terms of (a) defining treatment and its objectives and (b) outlining a set of principles upon which to base treatment modalities and techniques. The final topic, the modalities and techniques themselves, exceeds the limits of this article. It awaits explication in the future (for a discussion relevant to children, see Crittenden, Landini, & Claussen, 2001).

What is treatment in a Dynamic-Maturational framework?

What is being treated in psychotherapy? An advantage of the Dynamic-Maturation model of adaptation is that it focuses on three distinct levels of human functioning, any and all of which could be the focus of treatment. One can treat distortions of thought and feeling that render adolescents' behavior maladaptive in one or more life settings, including family, school, peer relationships, and subjective mental state. Alternatively, the focus can be one or more distorted relationships. Finally, one can focus on strategies that both serve adolescents in moments of threat, but also obstruct or hinder their developmental progress at other times. These three levels are, of course, connected, almost to the point of being three facets of the same thing. That is, distortions of information processing underlie individuals' strategic attempt to cope with physical or psychological danger or the lack of being comforted, usually in their family. The outcomes are (1) behavior that is (or was) adaptive in the family context, but is now misfitting and maladaptive elsewhere and (2) negative feelings that are either inhibited or exaggerated manipulatively or both. Organized as strategies, these function self-protectively, albeit with distress and some error, in the family home, but lead to maladaptation when applied to the world outside the family. When alone, with peers, or in school, these adolescents' behavior is dysfunctional. Even in their families, some previously tolerated behavior may have become intolerable.

Correction of the distortion would, therefore, need to affect both adolescents and the environments in which they function. But families with disturbed adolescents have usually been disturbed for a long time and may not be willing or able to change. The extra-familial environment can rarely be accessed or changed by the therapist (but see Call & Mortimer, 2001). Only the adolescents, if they choose to participate in therapy, are fully accessible to the therapist. On the other hand, adolescents select some aspects of their environment, for example peer groups, best friends, and romantic partners; these could be changed. Most important, the family environment will soon change. Protecting adolescents' opportunity to improve their adult lives may depend upon enabling them to make choices, particularly the choice of partner, that will not replicate (nor reverse with the opposite distortion) the patterns learned in their families of origin. Instead successful psychotherapy should both reduce the immediate problems of adolescents, especially in their interactions with family, peers, and schools, and also prepare adolescents to make growth-promoting choices for the future.

Principles upon which to structure an attachment-based treatment in the transition to adulthood

Four sorts of principles will be discussed: those relevant at all ages, those specific to adolescents, those relevant to the role of the therapist, and those tied to assessment.

1. Perspectives relevant to all developmental periods:

(a) Strengths approach. Most important is taking a strength's approach to understanding behavior. That is, rather than assuming that troubled adolescents' minds have malfunctioned, the opposite assumption is made: troubled adolescents are presumed to have found ways to minimize the problems that have threatened them in the past. The focus

on strategies presumes that most behavior that appears maladaptive now has in the past served a self-protective function. Moreover, it may do so now as well, at least under some circumstances. On the other hand, it is also understood that some past learning may be erroneous, that is, some consistently maladaptive learning may have occurred along with self-protective learning. This creates superstitious behavior that may range from innocuous to severely maladaptive. Identifying the past and present circumstances that elicit problematic behavior, differentiating behavior that is adaptive under some conditions from behavior that is consistently maladaptive, and discovering how an adolescent's behavior affects other people is central to successful change.

(b) Safety and comfort. Achieving safety and comfort are central motivations to behavior throughout the life-span. Exposure to danger and lack of comfort lead to the most distorted patterns of interpersonal behavior, those considered psychopathological. Further, because safety and comfort are tied to human relationships as both the source and resolution of problems, a Dynamic-Maturational approach to treatment suggests that identifying the sources of threat and discomfort is very important, as is finding strategies for reducing the threat and achieving comfort (Simmons & Blyth, 1987). This is best done in the context of relationships with the goal of changing individuals' contribution to relationships as well as the adaptiveness of interpersonal processes. That is, both dysfunction and resolution of dysfunction are tied to relationships.

(c) Functional patterns of behavior. Understanding the relation between past and present and discerning the strategic meaning of behavior is not a simple task. Three assumptions underlie the perspective offered here. First, we can never know exactly what happened in the past. To the contrary, we can only know what various people say about it now, given the knowledge of how things turned out. Second, historical events, even if they were known to have occurred, do not themselves determine strategy. Different people, including siblings, respond to the same circumstances differently. Consequently, knowing about the past is helpful, but insufficient, to understanding current behavior. Third, the same behavior can function in different ways. That is, there is no specific behavior that can reliably inform us about an individual's self-protective strategy. These notions reflect the basic premises of systems theory. Their application to the conceptualization of interpersonal dysfunction leads to very different diagnostic statements as compared to symptom-based approaches to diagnosis, such as DSM-IV or ICD-10. That is, in the functional approach offered here, a symptom-based diagnosis (e.g., depression, eating disorder, ADHD) is not assumed to have direct implications for treatment. To the contrary, the therapist needs person-specific knowledge of the strategic function of the symptom and patterns of interpersonal behavior used by the individual.

(d) Relationships and patterns of interpersonal behavior. The sequential patterning of behavior between people provides the only reliable information about individuals' strategies. Put another way, it is only when a functional sequence is repeated that we can infer the attributions of meaning made by each person and the intent of their behavior with regard to the other. This makes understanding another person's behavior very complex. On the other

hand, the more often a pattern is repeated and the less variation there is in the pattern, the more easily and confidently we can identify the strategy. It is characteristic of individuals in psychotherapy that interpersonal sequences are repeated with unusual regularity and frequency as compared to those of less troubled people. This increases the probability that the strategy will be identified correctly. This very stability, however, is also the problem. The failure of individuals to modify their strategy in the face of changed conditions both causes maladaptation and, at heart, is the maladaptation. One goal of psychotherapy is to initiate, in those who have not developed it themselves, a life-long process of reorganization of self to fit life's ever-changing circumstances. Therapists need information regarding not only adolescents' strategies, but also the models of spousal and parental functioning that they have extracted from their experience in their childhood families.

(e) Information to predict the future. Strategies use information from the past to make predictions about the future - for the purpose of organizing self-protective and reproductive behavior. The Dynamic-Maturational model assumes that the evolved brain and the developing mind function to make hypotheses regarding the future and to organize behavior that will promote safety, comfort, and reproductive success. That is, the only information that we have is information about the past whereas the only information that we need is information about the future. The brain functions to gather information and the mind functions to give it meaning. When the meanings are either too loosely or too closely tied to the past, i.e., to the circumstances under which the information was obtained, behavior in the present and future may be maladaptive.

In the transition from childhood (with its requirement of protection) to adulthood (with its requirement that one protect others), the tie between past and future is most likely to be misleading. When prior development has generated flexible mental processes, changed experience will instigate changed mental processing. The emerging adult will experience discrepancy when acting on the basis of childhood models and this will stimulate integration. For example, threatened young husbands or wives sometimes run back to their parents only to be treated coolly, even told directly to work it out with their spouses. Slowly, they discover that their comfort lies with their spouse and they learn protect its source. In this process, childhood models are reorganized to yield new adult models of self-and-other-protection, in new relationships that are structured reciprocally.

Adolescents who have been endangered are less likely to have awareness of discrepancy and flexibility of organization. They need a more flexible, less rigid relation of past to present and future. Misfits of past to present and future are most likely when individuals have been threatened in childhood in ways that will not, or need not, affect adulthood[3]. Therapists can assist adolescents to notice and analyze the dissynchrony which then can then be used to organize new and potentially more adaptive patterns of behavior. The issue is knowing what to carry forward into adulthood and what to leave firmly rooted in the past.

It is the absence of the process of on-going reorganization that is the central problem in psychological dysfunction and not the specific behavior or strategy that is used. Put more

directly, the Dynamic-Maturation perspective focuses less on disorder and more on dysfunction. Because function always implies a context, usually an interpersonal context, mental dysfunction becomes a relative concept, one that is tied to individuals' life circumstances. On the other hand, life circumstances change. The most robust individuals are those who can most easily adapt their strategies to new circumstances. Thus, the goal of psychotherapy is not ridding the individual of maladaptive thoughts, feelings or behavior, nor of substituting 'better' strategies for maladaptive ones. To the contrary, psychotherapy should be directed toward establishing in the individual a process by which misfitting strategies can be identified and transformed into more successful strategic behavior in a recursive and on-going manner. This process of reflective functioning (Fonagy, Steele, Steele, & Target, 1997) first becomes a viable possibility in late adolescence.

(f) Fragmented and fused processing, fragmented and fused relationships. When information is not integrated, behavior at any given moment will be regulated by only part of what is known. Alternatively, when information is fused, one sequence of events or one feeling state becomes blurred with another. With temporal sequences, this can lead to an expanding array of compulsive repetitions. Ambiguous feeling states occur when arousal is the glue that both holds feelings together and also obscures their discrete meanings. Both fragmentation and fusion can lead to inconsistent, incongruent, and/or maladaptive behavior.

When fragmentation or fusion of information becomes great enough or the skills for fulfilling motivations few enough, basic life functions may be distributed across many relationships, each of which is likely to be incomplete and not fully satisfying. This weakens each relationship and also, by associating problems with different people, obscures the problem of fragmentation in the individual. Alternatively, relationships established on the basis of fused information may be expected to fulfill multiple inexplicit functions. Again, the least prepared individuals find themselves in the most complex interpersonal contexts. The issue becomes making the components of thought and feeling available for integrative processing and identifying the function of each relationship. That is, hidden and distorted motivations must be made apparent before they can be integrated and applied to clarifying and managing specific relationships.

(g) Opposites strategies may call for opposite treatments. A corollary of the theory offered here is that the Type A and Type C organizations are psychological opposites. This implies that interventions that function to correct one sort of distortion might augment the opposite distortion. There are no data yet that test this proposition, but it is a crucial proposition because it suggests that choosing inappropriate intervention techniques might increase psychopathology.

The relevance of this conceptualization to symptom-based diagnosis can be demonstrated with a few examples. Two types of adolescent suicide have been identified, those carried out by studious, withdrawn, and solitary adolescents who feel that they have failed to meet the standards of others and those by individuals displaying anti-social, acting out tendencies

(Lehnert, Overholser, & Spirito, 1994). These types correspond closely to the A4 and C3,5 strategies in the Dynamic-Maturational model. Recognition of these two opposite forms of strategic patterning might help in early detection and prevention of suicide. Similarly, girls with anorexia can be divided into those with high achievement orientation and little awareness of self and those who passively resist intense maternal expectations, control, and overprotectiveness (Pike & Rodin, 1991). Again, this may reflect the two opposite attachment patterns and, indeed, there are now attachment-derived data support the distinction (Ringer, 2001). The critical test, however, is whether different forms of treatment or prevention are needed for different functional uses of a symptom.

Elsewhere my colleagues and I have outlined this perspective more fully (Crittenden, Landini, & Claussen, 2001). Here I prefer simply to point to that work and to highlight the importance of focusing psychotherapy on the goal of initiating integrative processes that can be maintained throughout the life-span.

2. Perspectives tied specifically to adolescence:
(a) Adolescence as a period of reorganization. All periods of developmental change and reorganization involve disruption of the behavioral organizations constructed in previous developmental periods. Moreover, the greater the change, the greater the disruption and, correspondingly, the greater the opportunity for change in the subsequent reorganization. The biological and contextual changes in adolescence are so sweeping that the behavior patterns of childhood simply cannot be maintained without change either in the behavior itself or in the response of others to it. That is, even those adolescents who make the least accommodation to puberty will find that others respond differently to them. As a consequence, the function of their childhood strategies will necessarily change. Adolescence, especially late adolescence, offers possibly the greatest potential for reorganization in the life-span.[4]

Psychotherapy in adolescence should take advantage of this moment in development when change is already under way to nudge the process in an adaptive direction. It also has the advantage of using adolescents' new capacities, specifically abstract reasoning and sexual functioning, to accomplish this change while these capacities are maturing and before they have been incorporated into the pattern of pre-existing distortions. Finally, the timing of therapy is just as adolescents are approaching a change of physical and social/psychological environment. That is, adolescents will soon live away from their parents, with a spouse and in work and social environments that they select. The challenge for psychotherapists is to reduce the immediate problems that brought the adolescents to psychotherapy while, more importantly, preparing a base from which the transition to adulthood can be made in ways that will promote well-being. In other words, psychotherapy in late adolescence has the combined advantages of shaping a developmental process that is already reorganizing spontaneously, giving adaptive meaning to new capacities as they emerge, and occurring during a hiatus between the close ties to families of origin and the self-defining commitments to future families of reproduction. Therapy at this moment has a greater potential than therapy at other ages to break intergenerational transmission of dysfunction

and to create the possibility of a productive, reasonably safe and comfortable future.[5]

(b) Risk of dysfunction and opportunity for reorganization. Given the extent of change, it is not surprising that adolescence is marked by the highest rate of dysfunction, particularly of depression (Cicchetti & Toth, 1998), of any period in the life-span (Loeber & Stouthamer-Loeber, 1998). Approximately 20% of adolescents have diagnosable disorders, which is higher than in childhood but the same as in adulthood (Costello & Angold, 1995; Dilling, Weyerer, & Castell, 1984; Hagnell, Öjesjö, Otterbeck, & Rorsman, 1994; Kessler, 1994; Powers, Hauser, & Kilner, 1989; Roberts, Attkisson, & Rosenblatt, 1998; Rutter & Rutter, 1993; Schepank, 1987). In addition, however, adolescents experience high frequencies of other forms of maladaptive behavior. These include risk-taking (U.S. Department of Health and Human Services [DHHS], 1997c)[6], injuries (U.S. DHHS, 1977a), eating disorders (Wilson, Hefferna, & Black, 1996), suicide (U.S. DHHS, 1997d), drug use (U.S. DHHS, 1977b), delinquency (U.S. Department of Justice, 1997), and sexual behavior (U.S. Centers for Disease Control, 1997), including early pregnancy (United Nations, 1991). Together these suggest an array of additional forms of vulnerability. Existing strategies for self-protection and comfort are being reorganized, new strategies for sexual behavior will be constructed, and the two sorts of strategies need to be integrated in ways that will permit a variety of attachment relationships to co-exist and enhance one another. Accomplishing this in the period of about a decade is very challenging. It is not surprising that many adolescents founder along the way and that others reach adulthood without being able to function adequately in one or more adult roles, e.g., personal autonomy, marriage, parenthood, employment.

(c) Reproduction and sexual desire. Sexual maturity changes children's identity to that of men or women and propels them to seek opposite sex partners. This creates both opportunity and risk. For some disturbed adolescents, desire for a sexual relationship with a member of the opposite gender provides strong motivation to evaluate themselves, learn new skills, and begin the process of adaptive reorganization. For others, the same desires lead to distortions of sexuality. Many confuse sexual satisfaction with comfort and engage in frequent and unsafe sex in order to reduce chronic anxiety. Others find that being sexually precocious or promiscuous enables them to break out of the isolation of their childhood. Some comply with others' demands, in accord with their childhood strategy and, at the same time, experience sexual pleasure. In addition, just as sexual satisfaction and comfort can be confused such that sex is sought when comfort is desired, sexual desire and aggression can be confused, particularly by males. Intense anger expressed as sexual desire can be labeled "love" by both the aggressor and its recipient. Anger and fighting may become intertwined with love and sex. On the other hand, because males desire sex so intensely, some girls find they can use sexual favors manipulatively, thus, by-passing more direct ways of achieving personal goals. Not surprisingly, these two distortions often work in concert, hooking couples together in confusing and self-maintaining love/hate relationships. Finally, among those who have no access to the opposite sex (because none are available, or advances are refused, or opposite sex partners are not desired), sexual desire and activity may be directed elsewhere, toward members of one's own sex or exclusively toward

oneself.

The point is that by mid-adolescence sexual desire is such a strong motivator of behavior and overlaps so greatly with other behavioral systems, that its expression can easily be hijacked by other pressing psychological needs. Few adolescents are prepared to recognize or regulate this. Needless to say, it is those with the least satisfaction in other spheres of life who are most at risk for employing sexuality in distorted ways. From the evolutionary perspective of promoting reproduction, the outcome will be the birth of progeny. Indeed, more children are likely to be born earlier under these conditions (Moffitt, Caspi, Belsky, & Silva, 1992). From the perspective of safety, both physical and psychological, substantial risks will be incurred. The sexual act is dangerous, especially for adolescents. Finding a safe place and a safe partner is not always easy. One physical danger is the risk of attack during sexual contact. Sexually transmitted diseases are another. Psychologically, there is the risk of confusion of affective states and the risk that one's self-identity will become defined too narrowly to what one takes or gives sexually. Both distortions stunt the development of self and reduce greatly the potential of sex to give pleasure, express affection, and strengthen relationships. In the longer term, the protection of progeny is negatively correlated with early pregnancy and, not surprisingly, early pregnancy is correlated with everything that typifies disturbed adolescents. Treatment should at least assess sexual functioning and its relation to other areas of functioning. At present, however, both theory and assessment of sexual functioning are insufficiently developed.

3. The role of the therapist:
A central principle underlying attachment-based psychotherapy is that the therapist functions as a transitional attachment figure in the adolescent's zone of proximal development. As such, the therapist fulfills, or partially fulfills, the traditional functions of attachment figures. That is, he or she is available for protection and comfort, specifically around problems in the adolescent's zone of proximate development. Consequently, the adolescent influences, explicitly or implicitly, both the focus and the means of the therapy. Those things that the adolescent manages competently are left to the adolescent and those things that are beyond the reach of the adolescent are handled for the adolescent by a protective adult. It is in the adolescent's zone of proximal development, i.e., the area of emerging competencies, that the therapy should take place.

For adolescents in general, this zone includes learning to think abstractly about their own and others' behavior and to use this process to regulate their behavior. In addition, adolescents must learn to manage their own sexuality and to use interpersonal sexual behavior appropriately and in ways that are mutually satisfying to self and partner. Finally, adolescents should be in the process of transforming a few peer relationships into symmetrical and reciprocal attachments, the forerunners of the spousal relationship that will be central to their adulthood. Accomplishing these tasks will enable most adolescents to enter adulthood prepared to establish a protective and sexually satisfying adult attachment that will promote the development of the couples' children. Of course, each adolescent differs in when and how these tasks are managed.

Disturbed adolescents differ even more greatly than others in their zones of proximal development. It is not that they are delayed as compared to their more normative peers. Some are, but the more important differences are the unevenness of their competencies and the often distorted ways in which they manage the transitions of adolescence. In general, one could say that their zone of proximal development falls between the distorted relationships with their parents and the more balanced relationships that they could develop with partners in the future. The function of the therapist is to promote the transition from distorted relationships to the selection and maintenance of more balanced relationships. Doing this requires enabling adolescents to change their own contribution to these relationships. Therapy, in other words, should not only address problems of which adolescents are aware, but possibly more importantly, it should begin an integrative process that will enable troubled adolescents to reorganize their attachment relationships.

Three aspects of the transitional attachment relationship with the therapist warrant special attention: the central role of discrepancy in guiding the therapeutic process, the inclusion of sexuality in the relationship with the therapist, and the engagement of the family.

(a) Using discrepancy to guide reorganization. Recognition of discrepancy is central to the process of reorganization. Two sorts of discrepancy are of interest. One functions within the world as the adolescent construed it in the past, i.e., the world in which his or her strategy was the best solution for past problems. Older adolescents in particular have the possibility to apply integrative processes in examination of the past. This can be less threatening, less arousing than examination of the present. Its outcome can be both practice of the emerging skill of reflective thought and, in some cases, preparation for improving those past relationships that continue into the present. The success of latter, of course, implies cooperation from the other person. Individuals of any age can only control their own contributions, but examination of the past can be a basis upon which to formulate changes in the present.

The other type of discrepancy differentiates the world of childhood from that which the rest of us perceive, i.e., the world that finds the adolescent's behavior maladaptive. Identifying discrepancy and ambiguity in the here and now of on-going action is very difficult, especially when one's past strategies preclude such perception. Examination of the past permits practice of essential perceptual and integrative processes with the luxury of time. The issue becomes reducing the lag from looking back some years with the therapist's help, to looking back a week or two, to recognizing discrepancies in oneself after only some days or hours, to recognizing them as they occur. At this point, recognition of discrepancy and ambiguity can become a procedural function, one that automatically signals an occasion for integration in advance of action. When ambiguities and discrepancies function to alert the mind, to initiate more complete forms of processing, clarification of motivation and adjustment of behavior can be expected. Therapists can offer a protected relationship in which adolescents can practice new response patterns and become familiar with using the process of mental integration to generate change in behavior.

(b) Sexuality in the relationship with the therapist. Therapists working with adolescents will almost always need to deal with sexuality, both the adolescent's and their own. Regardless of whether the therapist is the same or the opposite sex as the adolescent, sexuality as an interpersonal process will be universally relevant, if only because it is central in all adolescents' zone of proximal development. In addition, however, the therapist's role as an intermediate attachment figure places them between the non-sexual parental role and the sexual spousal role. It would be an unusual circumstance in which the adolescent's emerging sexuality did not affect the relationship between adolescent and therapist.

Direct discussion of sexual behavior may or may not be relevant in a given case and rarely causes the confusion and discomfort that non-verbal expressions of sexuality can generate. Most therapists are sufficiently knowledgeable to handle this easily. On the other hand, because it is non-verbal, expressed sexuality is more difficult to manage. Nevertheless, it will almost certainly need to be negotiated between adolescents and their therapists.

(c) The role of the family. Almost all of the long-term problems that bring adolescents to psychotherapy are interpersonal in nature and have roots in adolescents' relationship with their parents. It becomes important, therefore, to consider what role the family should play in the therapy. The adolescent's age (or functional disability) is one important factor. The longer the adolescent will continue to live with and depend upon the parents, the more they must be accounted for in the treatment. Older adolescents, therefore, are more likely candidates for treatment with an individual focus[7] than younger ones.

The extent, duration, and intractability of family problems is another factor. Extreme family dysfunction could easily derail a family approach. In general, however, family-focused treatment is usually indicated, especially for young adolescents. Moreover, because it affects more members of the family, it holds the potential for greater and more enduring change than individual work. Nevertheless, it is far more complex to implement because the needs and functioning of each family member, together with their interactive contributions, must be considered. Consequently, family-focused approaches require far greater expertise on the part of the therapist than individual treatment.

On the other hand, family-focused treatment is less vulnerable to reinforcing the skewed perspective of the adolescent and for failing to account adequately for the complex realities of the adolescent's life outside of the psychotherapist's office. Put another way, in individual treatment, therapists are at risk of colluding with adolescents' distortions because no other information is available. By accessing multiple perspectives as they are enacted in the room, therapists can assess the entire family system. Therapists can then formulate the pattern of family interaction from a broader base. This is likely to be useful to adolescents, even if the treatment is primarily with the adolescent. In conclusion, because families always exist and always influence adolescents' functioning, all courses of psychotherapy, whether family- or individual-focused, should account for their contribution.

Finally, it should be noted that, although it is easy to define the family as a problem that

limits the success of an adolescent's treatment, in fact, families are the central reality of life. Further, all of us, even those who live alone, are constrained by our relationships with others. Indeed, it could be argued that only those of us who learn to live comfortably in families can experience fully the benefits of intimate relationships. In other words, families, whether or not they are present, visible, and actively contributing to the therapy, are always an implicit part of treatment and always function as both constraints and opportunities. The challenge to therapists is to engage family members productively in adolescents' transition to adulthood.

4. Functional assessment of relationships, transformations of information, and self-protective strategy.

Knowing what a particular adolescent needs is critical to structuring a course of psychotherapy. Unfortunately, traditional diagnoses and psychological assessments do not indicate how an adolescent's mind functions, nor why he or she behaves in a particular way. Further, because parents and adolescents, particularly in cases needing psychotherapy, rarely have an unbiased perspective on their problems, direct questions (either orally or through self-report assessments) cannot yield unambiguous information. What is needed is an efficient means of observing and interpreting the process of self-protection and comfort. Several such assessments have now been developed by attachment theorists for various ages, but all need further validation before they can be applied with full confidence to treatment planning.

(a) Assessing attachment. For older adolescents, those who no longer depend upon parents for essential needs, the *Adult Attachment Interview* (*AAI*, George, Kaplan, & Main, 1996) is particularly useful for discovering both the circumstances that led to an adolescent's current strategies and also the strategies themselves. The hour-long interview is structured as a series of probes about childhood relationships with caregivers. The probes increase in threat, thus, slowly increasing the need for respondents to use strategic behavior. By its conclusion, the interview will have brought together information that is relevant to the adolescent's situation, thus, promoting the adolescent's ability to find meaningful connections between past and present.

At the same time, the process of the interview uses the interviewer-therapist's relationship with the adolescent as the means for directly exploring relationships. When delivered well, the *AAI* establishes a tone of thoughtful exploration in which there are no right or wrong answers. The questions, however, are highly relevant to the issues that bring adolescents to psychotherapy. Conclusions are sought only after relevant information has been presented and, even then, only slowly and tentatively. Further, the adolescent him- or herself takes charge of the process, with the interviewer-therapist following that lead. Unlike multiple choice measures that impose both topic and form of response upon the respondent, the *AAI* gives the interviewed person partial control over the topics and full control over the form and content of responses. Similarly, unlike projective procedures that leave the respondent helpless to influence the meanings attributed by the interpreter, the *AAI* asks the respondent to state and explain their own meanings. Most important, the *AAI* places

adolescents in the role of having the information that is needed and offers them the opportunity to take a perspective on it. In addition, the process of the interview promotes the establishment of a symmetrical relationship between adolescent and interviewer-therapist. In sum, the *AAI* initiates the process of integrative thought in the adolescent and does so in a respectful and collaborative manner.

When the *AAI* is analyzed using the Dynamic-Maturational method, it yields several important types of information that can guide the therapist: (1) the speaker's predominant strategy for achieving safety and comfort, (2) aspects of the history that may have led to the strategy, (3) whether that strategy is incoherent (i.e., disorganized), believed to be futile (i.e., depressed), or in the process of change (i.e., reorganizing), and (4) whether there are any specific experiences that strongly affect the speaker's thoughts, feelings, and behavior (i.e., unresolved trauma or loss).[8] It also provides a very limited exploration of sexuality and the interpersonal use of sexuality. The content of the history also suggests the notion of parental and spousal roles that the interviewed person carries forward from his or her childhood family. Together, these can guide the therapist in constructing an initial plan for the conduct of the therapy.

(b) <u>Differentiating adolescence-specific problems from chronic problems carried forward from childhood</u>. Because adolescence is a period of substantial change, many of the problems that adolescents face are age-specific. That is, children who functioned well in earlier age periods may stumble when facing the new conditions of adolescence. For example, they may face discomfort adapting to their newly sexual bodies, to the responses of others to their sexuality, or to delay of puberty as compared to that of their peers. Such problems are tied to changes that first occur in adolescence and, although they may affect the course of later development, they usually are less severe and less ominous than dysfunction that has its roots in previous unrelieved dysfunction. The latter sort of problem carries greater risk that the strategies used in childhood will become reorganized in the direction of more distorted functioning, including distorted sexual functioning. In addition, some chronically troubled adolescents will become very severely disturbed adults who will become either incompetent to manage adulthood independently or dangerous to themselves and others or both. These adolescents need to be identified as early as possible and their treatment undertaken with care.

5. The expected outcomes of attachment-based psychotherapy:
Leaving the actual conduct of psychotherapy as a mysterious black box, one might ask, what changes after treatment? The adolescent is not created anew. The events of the past are unchanged. One's personal characteristics remain one's characteristics. One's family remains itself and continues to have influence on one's life. One's usual way of seeing the world and one's reflexive strategies for solving problems are largely as they were. Nothing, in other words, is taken away.

What changes after successful treatment? The speed with which the adolescent can see that this view, these strategies aren't working, not at this moment, in this situation. The pain and

confusion that used to accompany discovery of such errors. The ability to predict, in advance of action, that the old errors are present. The ability to reflect on this, using integrative thought processes, to correct the errors of thought and generate new and creative solutions to life's problems. The ability to use relationships mutually and reciprocally to meet life's basic needs: for safety and comfort, and for reproduction and sexual satisfaction. The ability to seek and offer forgiveness.

In the best of outcomes, the characteristics that were once liabilities become limited to and focused on those situations and contexts where they function best, where they are advantages. Adults exert some choice over their life contexts, choosing their partners, peers, and occupations. Choosing a niche where one fits is as important as modifying oneself to fit the context in which one finds oneself. The wise adult, one who knows him- or herself well, does both. It's adaptive, and it changes everything.

Opportunity for Change

Adolescence is a critical period, a period marked by integration, complexity, and, most of all, opportunity. The onset of sexual maturity broadens the function of relationships beyond promotion of protection and comfort. Sexual pleasure and reproductive success become integrated with the protective function. This increases the complexity of relationships while concurrently creating new forms of relating and additional means of holding relationships together.

Adolescents' competence at meeting their daily needs for food, shelter, and social engagement creates the possibility for them to move away from their childhood relationships with their parents, particularly if these created constraints or dysfunction. Adolescents, in other words, can choose the environments in which they will develop as adults, rather than having to adapt to the environment of their parents. This creates the opportunity for self-directed change. Abstract thought makes this a viable possibility. For the first time in their lives, adolescents have the potential to think about relationships, about their own and others' behavior in relationships, and about how they might want to change these. These changes that occur in late adolescence create the first real opportunity for individuals to take charge of their lives, to actively maintain the benefits of a safe and secure childhood or, conversely, to extricate themselves from the suffering of an unfortunate childhood. Without doubt, the task of generating change is complex, but late adolescence, when individuals have new mental and behavioral competencies and before they are settled into their adulthood families, is the ideal time to take charge of the on-going life process of self-transformation.

Few of us at any age think deeply about how our experience in the past might affect our current way of thinking about and responding to life's problems. Usually, we are far too involved with solving the immediate problems of daily life to reflect in this manner. Neither do we consider at length how the solutions we employ today might influence our choices in the future. Nevertheless, the past does influence us and our actions in the present will affect our future. One of the functions of therapists is to keep this larger perspective in mind. For

the most disturbed adolescents, those whose course of change will encompass many years' effort, becoming explicitly aware of the process of seeking discrepancy and resolving it recursively through reflection can be helpful, maybe even essential. Late adolescence is a suitable time to initiate this.

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Endnotes

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2. This excludes the decline in intellectual competence that sometimes accompanies old age.

3. Some threats, however, are ongoing. For example, an anxious, even paranoid, strategy might be self-protective across the life-span in places where the government is despotic.

4. This statement is specific to westernized cultures that permit young people an extended period of role exploration (Arnett, 2000). Further, it varies from one culture to the next depending upon the role of the extended family in adults' lives, on the roles women can take, and the relative emphasis on individual functioning versus family obligations. That is, the biological aspects of maturation are universal, but the cultural display of them varies.

5. Intervention with mothers in infancy is the most effective treatment, but, from the perspective of the infant, it is prevention, not psychotherapy.

6. Most of these data are American; among Americans cultural minorities (Hispanics, African-Americans, and Native Americans) tended to have higher rates of risk. The pattern of high risk behavior is consistent across cultures although both the absolute and relative proportions for risk condition vary from one culture to another.

7. The terms "individual-focused" and "family-focused" treatment are used instead of the more usual individual or family systems treatment in order to leave open the modality or combination of modalities that might implement the focus.

8. These outcomes are specific to the Dynamic-Maturational method of analyzing the *Adult Attachment Interview* (Crittenden, 1999-2001).