

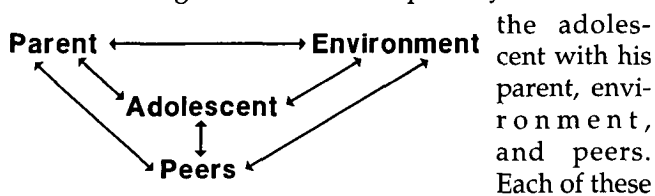
Parenting the adolescent

William F. Waggoner, DDS, MS, Workshop Leader
Allan Bougere, MS, Resource Person

Adolescence marks the period in which a young person attains adult stature and sexual maturity, and begins abstract thinking. These changes present both the adolescent and his parents with new challenges, new problems, and new circumstances that have not been encountered in any previous childhood developmental stage.

The primary goal of parenting during this stage is to have the child develop into a functioning, independent adult. In order to achieve this goal, probably the most critical aspect to the successful parenting of the adolescent is developing an awareness of the changes the child is undergoing and dealing with and the ambivalence that the adolescent often has toward these changes.

There is a multiplicity of factors interacting on the adolescent (Fig 1). There are three primary interactions:



the adolescent with his parent, environment, and peers. Each of these

factors also interacts with the others, multiplying the interacting variables. Additionally, each variable brings its own characteristics which compounds the dynamics even further. For instance, the personalities of each parent, their marital interactions, and socioeconomic status all can act as modifiers of the parent-adolescent interaction. The environment, made up of the school, the home, the city, and even the country, all potentially interact with and modify the adolescent. Even the adolescent himself has modifying variables such as birth orders or genetic predispositions which will come into play in his interaction with those primary variables surrounding him.

As noted previously, adolescence is a time of physical and intellectual change. Adolescents must deal with the changes their bodies are undergoing. The sudden growth during puberty may make a child feel very awkward or ill at ease with his body. He may become

preoccupied with his appearance, constantly looking in mirrors, worrying about the appearance of any small facial blemish. Adolescents often carry with them an "imaginary audience", that is, they feel that everyone is noticing everything that they do or wear. This period is also a time of identity development, when teenagers are attempting to find out who they are and what values they want to adopt.

The sexual changes and hormonal changes must also be dealt with as the adolescent begins to handle sexual urges. Sexuality may bring many mixed feelings. Parents may be voicing strong feelings and attitudes about not engaging in sexual behavior while peers and other environmental factors may be encouraging or condoning active sexual behavior. Adolescents often have a great deal of ambivalence with regard to all these changes. They may be torn between the desire to take on the responsibilities of an adult and yet recognize and want to avoid the consequences which accompany failed adult responsibility. They may express ambivalence about getting old. While overjoyed at the thought of reaching young adult age, they at the same time are realizing that they are giving up the prerogative of being a child, "of being someone special." There is ambivalence about being independent, that is, they may want their own automobile or to set their own curfews; yet they want Mom to continue to do all their laundry and cooking or Dad to supply the gasoline money. All the issues can make life very complex for both the adolescent and his parents.

There are some myths about adolescence which parents should recognize.

Myth 1. Contemporary adolescents are more rebellious and antisocial than ever before.

There are reports from as early as the eighth century about the "unruly spirit" of teenagers and these descriptions have continued through the centuries. In reality, adolescents are probably no more rebellious than in past generations. They may have just found new and different ways of expressing their rebellion.

Myth 2. There is a generation gap.

The "generation gap" has been blamed for the breakdown in parent-child communications, for rebellion, and for other parent-child difficulties. However, a recent study found that 78% of adolescents surveyed said they feel their parents listen to them; 76% believe that adolescents should pay more attention to their parents; and only 4% did not enjoy spending time with their parents. Thus, it appears that the "generation gap" is not nearly as significant as some would claim it to be.

A list of development tasks for adolescents, developed by Havighurst, is shown in Table 1. These 10 tasks represent goals that ought to be achieved by the end of the adolescent period. Parenting skills should be directed toward helping the adolescent achieve these tasks. Additionally, there are several principles for parenting which can be quite useful during the adolescent period.

1. Listen to and acknowledge the thoughts of a child. Be patient and nonjudgmental. Use active listening and acknowledge that the parent hears what the child is saying.

2. Structure situations to help the child experience feelings of success. Devise situations in which the child can utilize his strengths to accomplish goals. Avoid placing the child in circumstances which demand or expect skills or talents which the child does not possess.

3. Structure situations so that the child can feel that he has some reasonable control of his life. Allow the child to make his own choices, within certain well-established limits or boundaries. Opportunities should be given which require the child to think through the situation before developing his decision.

4. Reinforce that the child is lovable and capable. Love should not be tied to behavior, that is, the child should know that he is loved unconditionally. He should feel appreciated and approved as a person. Their behaviors need not necessarily be approved, but their personhood should.

5. Parents must provide a positive role for children to observe. Parents who desire some action or value from their children should exhibit the behavior for modeling. For instance, a child is less likely to listen to a parent who has a two-pack a day habit and admonishes against smoking than if the parent were a non-smoker.

The tasks of parenting an adolescent are varied, complex, and ever changing because that is the nature of adolescents. The parents' awareness of the child's emotional, physical, and sexual state during this developmental stage will help develop parenting skills.

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TABLE 1. Developmental Tasks of Adolescents

1. Accept one's own body.
2. Accept one's sex role.
3. Develop relations with peers.
4. Develop emotional independence from parents.
5. Partial attainment of economic independence.
6. Make vocational choices.
7. Acquire intellectual competency.
8. Acquire socially responsible behavior.
9. Prepare for marriage and family.
10. Build values and harmony with the world to which they belong.

Psychosocial pathology and developmental tasks in the adolescent

Melvyn N. Oppenheim, DMD Robert H. Spedding, DDS, Workshop Leaders
Chin Chin Ho and Steven York, Resource Persons

Adolescence is considered by many as a time of turmoil linking childhood to adulthood. It is also thought of as a period characterized by self-assertiveness, aggression, and experimental sexuality all leading to healthy separation from one's parents toward independent autonomous behavior. Many of the studies describing adolescent behavior emanated from interviews and observations of inpatient adolescents during the late 1960s. A body of knowledge was accumulated using a skewed population sample which inaccurately represented the behavior patterns of most adolescents. In fact, today it is believed that only 15-20% of adolescents experience significant turmoil sometimes known as "storm and stress." Recognizing that adolescence is a time for separation from one's parents it is reasonable to expect some stress associated with the aforementioned search for independence, self-reliance, and autonomy; however, it is important to distinguish between true behavioral pathology and developmental disturbances that are within normal limits. Some of the major problems occurring during the adolescent period include eating disorders, identity crisis, rebellion, drug or alcohol abuse, and sexual activity.

Eating Disorders

Parental anxiety is not unusual when a daughter is perceived to be dieting unnecessarily. The eating disorder feared in these cases is anorexia nervosa seen in females to males at a 250:1 ratio. As there are many normal and reasonably healthy factors related to the desire for weight loss, an interview with a trained health professional is crucial when such cases are suspected. If the reasons seem nonobsessive—related more to grooming and self image and the child's life is essentially normal with an active social life—nutritional counseling is probably more appropriate than psychotherapy. On the other hand, a child with anorexia nervosa may have the same desire to lose weight but the reasons for doing so and the manner in which the weight is lost are entirely different. The disturbed child also will think that she is

too heavy but will have a more distorted perception of reality; e.g., she may have peculiar dietary habits such as consuming single foods as a substitute for balanced meals. Some anorexics may exercise vigorously, using calories that aren't being replaced by normal food intake. Amenorrhea may be a concomitant finding. These children do not have an active social life and can be defiant or angry when confronted with their problem.

Two of the underlying psychological factors in these girls are denial of one's femininity by reduction of body curves and manipulation of one's family. They become the center of attention and contribute to a general tenseness at home. This psychological need to be the center of attention is a common thread seen in many psychosocial pathologies. Understandably, parents of anorexics are very concerned about their offspring's self-destructive habits and often have difficulty coping with the problem. Family therapy may be very helpful in these cases. Death can occur in 2-3% of those afflicted, and even those who recover still may have eating problems throughout life.

A correlative eating disorder called bulimia is characterized by gorging and then vomiting. This often occurs before anorexia disappears, but it can be a problem in itself. These children may feel emotionally deprived and will substitute food for love. Similarly, food may also be a substitute for taking action. Therapy tries to determine what food means to the child; is it pleasure or compulsion? A related food-associated disorder is overeating. This represents a symptom expressing anxiety or depression and is understood less than anorexia nervosa.

Identity Crisis

Another common developmental problem in adolescents is the identity crisis. It may be the underlying problem within a number of the other specific disturbance entities such as conduct disorder, personality disorder, and depression. There is always some identity crisis in normal adolescence as the teenager appraises

and then mimics his role models. Some of the characteristics of the adolescent in identity crises include: feelings of emptiness, lack of goals, pessimism, hopelessness, and general uncertainty of who he is. He may seem disinterested in school with average to poor grades, and may complain of not being able to concentrate and being easily distracted. There appears to be confrontation between himself and the outside world leading to anxiety attacks of varying magnitude. Cynicism, bitterness, pain, and disgust at the world may also be part of the composite. In the extreme, these children are in pain, but they're not out of touch with reality and psychotherapy should help them refocus and develop their sense of self.

Pathological behavior is seen in the schizophrenic child who has psychotic episodes, losing touch with reality. These adolescents demonstrate irrational thinking, disturbed ideas of reference, a life-threatening degree of withdrawal, and distortion. They may also have insomnia, paranoia, and illusions of grandeur. Depending on the severity of the disturbance, treatment includes medication, hospitalization, and psychotherapy. The prognosis is unpredictable. Developmental problems such as identity crisis and rebellion may be subgrouped under an umbrella phrase called conduct disorders. Sometimes the two problems, rebellion and identity crisis, exist side by side.

Adolescent rebellion is another example of a normal developmental stage that, in the extreme, can become pathological. As part of the separation process, adolescents sometimes reject parental values and family responsibilities, especially as perceived by the parents. The key factor seems to be the degree of the rebellion. Children who exhibit extreme antisocial behavior and are blatantly disobedient to parents in matters of importance, such as going to school, have gone beyond normal rebellion. Their problems may extend to brushes with the law, and in general they have little or no remorse for their actions. These children don't go through the process of identification with parents and models in the normal way.

Within this pathology, adolescents who are unable to obey society's rules may be considered either socialized or nonsocialized. The socialized ones can make attachments to parents or gangs while the nonsocialized person is unable to bond with anyone. Their pathology probably goes far back in childhood development. In addition, the two subgroups can each be broken into two more groups, that of aggressive and nonaggressive. The nonaggressive offender may steal or lie while exhibiting nonaggressive pathological behavior. They may give up their conduct disorder eventually, but if retained it may evolve in adulthood as so-called white collar crime. The aggressive pathological extreme may see the same stealing and lying but is coupled with

altercation. The future for these aggressive sociopaths is frequently incarceration or worse. Parents of the more disturbed, rebellious adolescents feel impotent because their children are unable to accept reality.

Substance Abuse

Drug or alcohol use is one of the "hot" topics in modern adolescent behavior. Experimentation is common during the adolescent years and use of these substances may at first represent an attempt to gain peer acceptance or to act out hostility to authority. When use becomes repeated, leading to substance abuse, arrest, or violent behavior, experimentation has evolved into pathology. Mental health professionals treating such adolescents may choose not to make a moral issue about infrequent drug or alcohol use, but it is imperative that the children assume personal responsibility for their activities. When adolescents ask parents or therapists about their views on the issue there should be no implied ambivalence. The adult must take a clear stand on the recreational use of drugs or alcohol, as the adolescent is ill-served by silence. The mixed message given by a parent or teacher who may smoke marijuana or drink and in the same breath make value judgments about the adolescent's use of these substances represents a double standard to the adolescent.

Sexual Activity

Problems concerning sexual awareness and activity are normal and expected during the adolescent years, but like other problems already discussed, pathology only exists when the behavior is extreme. Boys may worry about stirrings of homosexuality, not comprehending the universality of these feelings in adolescent males. They may misinterpret their lack of interest in girls or lack of success when interested; this is usually a matter of the individual's psychosexual timetable and not a developmental disturbance. The adolescent believes that one is either heterosexual or homosexual, and if problems arise with the first heterosexual experience, anxiety results. If the adolescent is in treatment or the subject matter is broached, reassurance that universal homosexual tendencies exist is helpful to the child. Anxiety and depression are associated with repression of homosexual fear and may be detrimental to healthy growth and development of the individual.

Adolescents who are promiscuous may have an underlying combination of rage, anxiety, depression, and insecurity. Pregnancy may be associated with the need to prove one's masculinity or femininity. Girls may be lonely and exhibit neurotic acting out behavior or become pregnant either to gain companionship or to shame a parent. Adolescent girls also may have ambivalence about the act of intercourse itself. In spite of the so-

called new morality, vestiges of the old morality remain; girls frequently do not anticipate sexual activity, leaving protection decisions to a time when both partners are already stimulated.

The normal psychological development of the adolescent may be problematic as the completion of their developmental tasks may not follow an exact time and sequence. Normal development, characterized by egocentricity and a sense of grandiosity or even narcissism, may be appropriate at an early stage but is inappropriate when exaggerated or exhibited at a later stage. Adolescents who have any of the pathological disturbances discussed may in fact incorporate several at the same time. An anorexic child is likely to be depressed and in extreme cases when death occurs, a psychotic episode may have been superimposed on the basic disturbance.

In a brief discussion of childhood suicide it was recognized that the incidence is rising and now includes an increase in children under nine years of age. The very young child does not understand the concept of permanence and their threats of suicide must be taken seriously.

The participants of the workshop all shared a frustration regarding their ability to make referrals to a mental health professional. Although, as pediatric dentists they felt competent to identify deviant behavior in the dental milieu that was strongly suggestive of underlying emotional difficulties, most parents were reluctant

to act on their recommendation. In fact many of these patients left the practices when so advised. It was suggested that time be spent with the parent clearly identifying the unusual behavior before a referral is made. An additional strategy would be to bring the child's physician into the referral process although it is understood that many have already tried these strategies with little success.

In summary, most children manage adolescence well enough to make the healthy transition to adulthood. Extreme behavior in otherwise normal stages of development may indicate a psychosocial pathology. Psychotherapeutic intervention is essential in these cases, but a complete cure is often elusive.

Conclusions

1. Only 15-20% of adolescent children experience significant turmoil.
2. Psychosocial problems around such issues as eating disorders, identity crisis, rebellion, substance abuse, and sexual activity represent the major difficulties for the adolescent.
3. The need to be the center of attention is a common thread in most adolescent behavioral pathologies.
4. Families are disrupted and parents often feel impatient when an adolescent exhibits extreme antisocial behavior.

Adolescents and the health care professional

John Mink, DDS, MS, Workshop Leader

Gayle R. Baer and Lynn H. Parker, Resource Persons*

One of the most important things to remember in working with adolescents, according to Dr. Lynn H. Parker, is that adolescents are very healthy, but it is also a time when they may be engaging in unhealthy behavior which can lead to devastating life styles. It is important for us as health professionals to intervene early in these unhealthy behaviors. These areas include: the ordinary health problems of adolescents, their increased sexual capacity, smoking habits, and substance abuse. But, there are problems associated with early intervention; if we educate them about the problems related to smoking early in life, i.e., third and fourth grade, will they rebel as adolescents and choose to smoke as a reaction against authority?

*A paper was presented by Dr. Parker which highlighted some of the current concerns and statistics about the adolescent.

It is important to look at the entire patient and not just focus on the confines of our own specialty. While health behavior is an individual responsibility, we should try to help adolescents with all of their health concerns. As we deal with the adolescent we must be aware of the pressures placed on them by society and their peers. At the same time, we must be aware that the doctor/patient relationship is still very powerful in today's society.

Stereotyping the adolescent is a common pitfall in dealing with the adolescent — it is important to deal with their realities. We tend to avoid talking with them about difficult problems such as drugs, sex, and birth control. By not recognizing these problems, however, we can give the adolescent unspoken messages: be good, don't be ambivalent, don't be rebellious, don't

mention drugs, be nonsexual, and don't ask hard questions. We also must be careful to be a good model for our adolescent patients in order to reinforce positive values in them.

Another pitfall to avoid is thinking that adolescents are vulnerable and that as a pediatric dentist you can "rescue" an adolescent. You may not be able to rescue them, but you can listen to their problems. When an adolescent comes to your office, ask what is important to him; have your questions geared toward him. You must both listen and encourage the adolescent to open up.

Dr. Gayle R. Baer reviewed current behavior techniques the pediatric dentist uses in the office such as positive reinforcement, communication, modeling, and other management approaches we use currently with pre-adolescents. Many of these interventions also can be effective with the adolescent. Dr. Baer emphasized areas that are more specific to the adolescent — such as confidentiality; the adolescent is very concerned about confidentiality and privacy. Dr. Baer also discussed laws concerning confidentiality in working with the adolescent. This led to a group discussion of open bay versus private rooms. The consensus was that the teen prefers privacy. It was suggested we have certain hours only for the adolescent so they aren't seen at the same times as small children. Suggestions also were made about having appropriate music and reading material available for the adolescent.

The question was asked, "How do you deal with the difficult adolescent with whom you have tried everything, but without success?" Dr. Baer commented that with the difficult adolescent the best solution is time. One approach suggested by the consultants in dealing with the difficult adolescent was the use of contracts. An example used was a 15-year-old boy who has been in the

practice a long time, but who still has caries and periodontal problems. The patient has significant dental problems and you are attempting to prevent his losing teeth.

In contracting, you make a deal with the patient that might impact favorably on his oral health. In his history you find he plays guitar, likes heavy metal music, and is in a band. He is the eldest of six children, his father is laid off, and the adolescent has home problems. He missed band practice to come for his appointment. Since you know his background and likes, you can use this information in your interaction by setting up a contract. The contract might say, "I, John, agree to brush my teeth every night and floss two times a week and come to my next appointment." In return you say, "I, Dr. Smith, will have a heavy metal group tape for John to listen to in the dental chair at the next appointment."

This concept involves praise for improvement and not being overly critical of areas that haven't dramatically improved. Even though this concept uses an artificial external motivator, it can work because the patient has some control of the situation. For contracting to be successful you must be specific, have reasonable expectations, reward after desired behavior, have balance, and not use coercion. At no time should you "put down" the patient or be overly critical.

The adolescent age group can be a difficult age group for the health professional to work with and the success rate for the difficult, uncooperative patient may be low. However, as health professionals we must strive to communicate with this age group to be successful. Also, if we as dental health professionals detect problems beyond our scope, we should have a referral system to send these patients to competent mental health professionals.

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