Adolescent Separation-Individuation and the Court

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Psychiatric hospital staffs have long been wary of involvement with court proceedings. Issues such as civil commitment and conservatorship all too often result in bitter struggles pitting patient against therapeutic team, with the court as final arbiter. The patient perceives himself fighting for his freedom, while the staff is in the uncomfortable position of having to defend its legitimacy as a treating agent. Frequently the experience of testifying at a mental health hearing is uncomfortable for the therapist, as he or she may be cross-examined in the presence of the patient. The risks of a legal battle are evident: if the patient is released, treatment is abruptly terminated; if the patient is ordered confined to the hospital, repercussions arise in the therapeutic alliance.

Sacks *et al.*[1] speculate that the patient's exercise of the legal right of due process can be symptomatic of regression or can function as a resistance to treatment. They present the case of a thirty-year-old psychotic man who externalized his ambivalence over attachment to his female therapist by repeated requests for discharge. This behavior was interpreted as the "principal means of expressing his autonomy and individuality" and as a test of whether his "therapeutic family" cared enough to go to court to effect his commitment.

Haller *et al.*[2] address the tension that exists in the therapist whose adolescent inpatient petitions for a release from the hospital as a substitute for running away. The psychiatrist should encourage neither regression nor rebellion. Rather, the adolescent must be helped to withdraw his petition and acknowledge his need for treatment without suffering a concomitant loss of self-esteem. A therapeutic outcome wil occur only if the adolescent's departure is averted.

The consequences of a 1975 North Carolina statute requiring judicial approval for all admissions of minors to psychiatric hospitals are explored by Amay and Burlingame. Based on their review of all relevant cases, the authors warn, "Even under the best of circumstances, a contested hearing may constitute a traumatic experience and may have a variety of potentially destructive outcomes for the child, family, treatment personnel, and the milieu of the treatment unit." Included in their list of harmful results are psychotic episodes, regression, withdrawal, or aggressive acting out precipitated by the stress of the hearing; rupture of the relationship between patient and therapist; and "the considerable possibility that a seriously

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This paper received the 1982 J. Franklin Robinson Memorial Award of the American Acadmy of Child Psychiatry.

troubled youth may be unexpectedly and abruptly released without a plan or placement, through accident, judicial ignorance or whimsy, a technicality, or the unpreparedness of inexperience on the part of treatment personnel."[3]

It is with these misgivings that the author became enmeshed in applications for ongoing involuntary hospitalization for two adolescent patients. In both cases the court upheld the patients' challenges, and immediate discharge was effected; but, unexpectedly, both adolescents returned to treatment voluntarily. This article will explore the vicissitudes of adolescent separation-individuation in order to understand the patients' apparently paradoxical motivation for continued psychiatric treatment after obtaining the legal victories guaranteeing their release.

Case Reports

Case 1 B is a 17-year-old, white, single female who was admitted to the psychiatric service the morning after her ingestion of three bottles of proprietary sleeping pills. The patient agreed to voluntary hospitalization, stating that she was confused about her apparent suicide attempt and wanted to "straighten out my head." Mental status examination demonstrated an attractive young woman who was sleepy but fully oriented. Her performance on cognitive testing was excellent, and she denied any history of hallucinations or paranoid symptoms. Her affect was labile; her mood depressed. She admitted to chronic alcohol and marijuana abuse. During the second day of hospitalization alcohol withdrawal was treated with chlordiazepoxide. She received the diagnoses of alcohol dependence and borderline personality disorder.

Despite her precarious mental state and her need for medication, B demanded to be released from the hospital. Both an application for a 72-hour detention for evaluation and treatment and a 14-day certification were completed. B did not request judicial review because she was convinced that "No judge would even listen to me." On the twelfth day of hospitalization a recommendation for conservatorship was filed. If approved by the court, the patient would lose her right to refuse treatment and could be hospitalized for a period of time as long as one year. When this fact was explained, she demanded a court appearance.

B's parents are both school teachers; she has one sibling, a brother two years her senior. B's early developmental landmarks were within normal limits. When the patient was four years old, her father joined Alcoholics Anonymous after many years of alcohol abuse and bizarre behavior. Father's alcoholism worsened, and severe marital discord ensued. B's parents divorced when she was ten years old. At that time she began experimenting with marijuana and alcohol. In high school she developed a pattern of truancy, resulting in academic failure. Instead of going to school she would spend her days at the beach drinking beer, smoking marijuana, and having sex with her boyfriends. B sought outpatient psychotherapy on

four separate occasions, but each time failed to return for her scheduled appointment.

In the hospital B was often verbally abusive. She openly spoke of the ward as a prison and berated the staff in front of other patients. She insisted that she was not "crazy" and castigated her therapist as a "rapist trying to fuck my mind." She threatened to use force to escape if she were not released. A temporary conservatorship, for the purpose of investigation by the public guardian, was granted. During this period the patient attempted to establish that she was not insane or self-destructive. As she became convinced that she could win the court battle, her attitude in sessions evolved from fury to superficial compliance, and she agreed to begin treatment with disulfiram. Disregarding the documented history of alcoholism and suicidal behavior, the court ordered B released from the hospital. B readily agreed to the discharge plan of three sessions per week, but her underlying angry defiance implied that the promise of cooperation was merely a ruse to ensure that the court would not reconsider its decision to free her.

Much to her therapist's surprise, B attended regularly her thrice-weekly outpatient sessions. Acceptance of daily disulfiram ensured sobriety, and she began to attend school consistently. Conjoint sessions with father revealed his active alcoholism and his tendency to engage in sexually provocative behavior toward his daughter. B recognized that he had always been a terrible disappointment to her. In contrast, sessions with mother were characterized by stony silence, punctuated by angry outbursts by mother when her rigidity was challenged. In individual sessions B would lament sadly: "I want the empty part of me filled, but I don't want to become vulnerable." Despite many stormy sessions, B continued in treatment and the following year was graduated from high school.

Case 2 C is a 17-year-old single, Hispanic female, who was admitted to the psychiatric service after her behavior at home became intolerable. She was brought to the hospital by her parents and detained for evaluation and treatment on a 72-hour hold as a danger to herself and others. Her involuntary status was necessitated when C insisted there was nothing wrong with her and that she wanted to go home. Her present illness began one month prior to admission with a noticeable change in her behavior. She became agitated, screamed frequently, and required less than four hours sleep each night. C would wander from home and return with strange men, whom she claimed were her boyfriends. On the day of admission, during an argument over her activities, C grabbed a butcher knife and made a threatening gesture toward her mother.

C's mental status examination disclosed an overweight, excitable, young woman who was hypervigilant and oriented in all spheres. Memory was grossly intact, but her decreased attention span and distractability rendered formal cognitive testing difficult. Speech was pressured with flight of ideas. Her affect was labile and her mood was elevated. Many of C's statements were false. For example, she claimed that she had given birth to

a daughter when she was 9 years old. The patient denied visual and auditory hallucinations. C was diagnosed as having a schizoaffective disorder, manic type.

During her first day in the hospital C was observed to take other patients' possessions and to disrobe in public areas. She was prescribed chlorpromazine and lithium carbonate. Despite her grossly inappropriate behavior, C demanded immediate discharge from the ward. A 14-day certification for involuntary hospitalization was completed and at her request a court appearance was scheduled.

C is the youngest of three children, all born in the Dominican Republic. No difficulties or abnormalities were reported during infancy. When the patient was 8 months old, her father left his country after a brief imprisonment for subversive political activities. He immigrated to the United States while the rest of the family remained in the Dominican Republic for an additional four years. After the family's reunion in California, the patient described herself as never feeling close to her father. C states her problems began in junior high school when she was teased for wearing eyeglasses and complained of having few friends. She preferred to spend time with younger children in the neighborhood, verbalizing her wish to be little again.

C was very unhappy in high school and began a pattern of frequent truancy. Eventually she discontinued school in her junior year. She would spend most of her day at home sleeping and complaining of feeling sad and tired. She became increasingly disorganized and nonfunctional, leading to her first psychiatric admission at age fifteen. C was hospitalized for two months and responded favorably to treatment with chlorpromazine. At the time of her present admission, C was living with her parents and older sister, who herself had suffered from depression and had made one suicide attempt.

Although C was clearly in need of hospitalization, the hospital staff realized that recent court actions releasing very disturbed patients did not bode well for their petition for C. Despite the fact that C jogged around the courtroom, sang aloud, and was otherwise inappropriate, C was released by the judge. C's parting words were: "I just want to go home to see my boyfriend, my husband, and my daughter." C was encouraged to return to the hospital for voluntary admission.

Unexpectedly, C arrived the next morning at the hospital's admitting office. Upon seeing her therapist, she shouted: "It's good to be back. Now that I'm voluntary, I'll stay longer." C was never able to articulate more clearly why she chose to return. C's behavior continued to be disruptive, bizarre, and impulsive throughout the remainder of her three-month hospitalization. C never accepted the fact that she was ill and in need of treatment, although she did passively cooperate with her therapist's recommendations for intensive chemotherapy and vocational rehabilitation. She was discharged to her parents' care with arrangements for daily attendance at a partial hospitalization program. She agreed to the plan because, "You say I need it."

Discussion

The developmental history of each of these patients is remarkable for early parent-child interactional disruptions. For patient B, mother's availability during infancy was compromised by the presence of an older brother and by father's frequent episodes of alcoholic intoxication. Patient C's relationship with her mother was hampered by competition with siblings and the depression her mother experienced following father's incarceration and his escape to the United States.

For both patients the interruptions and deprivations were relative, as neither child suffered severe infantile trauma; however, the material supports the speculation that each mother's libidinal availability was insufficient to promote normal psychological development in their daughters. Each child emerged from the differentiation subphase of the separation-individuation process with less than optimal ego capacities and an overly dependent attachment to their deficient mother. Consequently, ego maturation was impaired in childhood, predisposing these girls to specific difficulties in adolescence. The crucial issue here is the manner in which the disturbance was expressed in the treatment situation. The contention is that these adolescent patients' conflicts with their respective therapists represent an externalization of pathology in the intrapsychic process of separation-individuation.

The first extensive use of the term separation-individuation was by Margaret Mahler, who described the toddler's developing capacity to function apart from his/her mother.[4] Blos[5] referred to the second individuation process of adolescence, elaborating Anna Freud's[6] belief that the primary task of adolescence is separation from the incestuous object ties. The second process also involves the struggle to relinquish emotional attachments to the maternal object, and thereby reawakens the adolescent's contact with primitive drives and ego positions. In this framework, regression during adolescence is viewed as constituting an obligatory component of normal development. However, the stress of adolescent regression and affective disengagement on a defective ego could result in the emergence of psychiatric symptomatology.

Schafer has contributed to our understanding of this complicated phenomenon.[7] He recognizes that the outstanding manifestation of separation-individuation difficulties is the adolescent's tireless effort to eradicate parental influence. While struggling to disengage emotionally, some adolescents will force a geographic separation in order to experience a sense of triumph and independence, but these are the very adolescents for whom the ambivalent tie to the infantile object and the corresponding regressive pull are the most powerful. For them, freedom won through violent and reckless action is but a pyrrhic victory. As Schafer noted: "In the attempt to expel the unconscious feelings, identifications, and relationships, the adolescent expels/destroys them with real and imagined separations, and then comes to think of himself as empty and dead, and of the

world as desolate."[7] The remedy for this desperately lonely predicament is to gratify the wish for fusion by regressing to a dependent, infantile attachment.

Masterson[8] and Esman[9] have described borderline psychopathology in adolescents, which they postulate arose from disturbed mother-child interactions during the critical rapprochement subphase of the childhood separation-individuation process. Masterson stresses the importance of curbing the adolescent's acting-out behaviors on an inpatient ward, in order to render more accessible the abandonment depression caused by a mother who punished or withdrew in response to her child's efforts to gain autonomy.[8] Esman presents two outpatients whose conflicts stemmed from their ambivalence over object ties. For his patients closeness evoked fears of regressive engulfment, while distance led to the anxiety of objectlessness and self-depletion.[9]

The clinical situations described in this paper confronted the therapist with the pathological exercise of legal rights. The stated desire to leave the hospital is a manifestation of the complex interplay of many conscious and unconscious factors, including symptomatology (C's delusional wish to find her child), ego function (defense mechanisms of denial and avoidance), and developmental processes (separation-individuation). Surely any patient's refusal of further hospitalization and its necessary loss of personal freedom does not alone signify psychopathology. But in the contexts of B's suicide attempt and alcohol withdrawal and C's homicidal behavior and florid psychosis, their writs of habeas corpus are products of decision-making ability grossly impaired by mental illness. Both B and C were able to manipulate the court to terminate prematurely their inpatient treatment. Unlike the experienced psychiatrist who can recognize ambivalence and acting out behavior, the judicial system cannot deviate from the rule of law in order to satisfy the patient's need for appropriate psychosocial limits. These two patients' areas of symptomatology and corresponding diagnoses differed considerably, but both were required to meet identical criteria for civil commitment. This stringent standard, as determined by the judge, must reflect severe behavioral disturbance that extends across many diagnostic categories. Often the adolescent patient discovers a surprising ally in her defensive efforts to flee from the therapeutic relationship. Suddenly the intensely regressive pull of the transference is obliterated, and the patient is propelled away from the hospital.

The adolescent patient's conflict with her therapist is an external representation of disruption in the universal second separation-individuation process. The closeness and intensity of the transference during an acute decompensation predispose the adolescent to a fearful loss of ego boundaries. The patient's unmodulated, acting-out response is to escape. This impulse is conveniently facilitated by the initiation of a writ of habeas corpus. However, the resolution of the power struggle by the court provides a unique opportunity for the therapist to assume a neutral, detached stance. The therapist consistently recommends the needed treatment, while

acknowledging the patient's desire for independence — a wish that will be supported at the appropriate time. Unlike battles within the adolescent's family, the psychiatrist has no personal interest in the outcome of the hearing. The therapist will neither be damaged by the patient's release nor enhanced by his/her retention. Rather, the therapist remains available for psychotherapy irrespective of the judicial decision. In this situation, the patient can either experience noncritical acceptance in treatment or a nonpunitive termination.

Similar ambivalence over the issue of contesting involuntary psychiatric hospitalization occurs in patients of all ages. However, adolescence is peculiar for the intensification of separation-individuation, and this dynamic should receive prime consideration in understanding patients in this age group. For B and C, their exacerbated separation-individuation conflicts were inadvertently relieved by the court's action. The court validated the patients' thrusts for premature separation, but by so doing enabled the patients to recognize that the therapist would not react angrily to their desertion. The therapist remained available for a rapprochement at the patients' discretion. The subsequent return of each patient under her own control confirmed that the therapy was a potent source of emotional refueling. In addition, the patients dramatic reentry into treatment was evidence of the existence of the other side of their ambivalence over object ties. Ultimately for these particular patients the legal outcome had little objective bearing on their progress, since both B and C were willing to continue psychiatric treatment voluntarily. Such, however, may not always be the case.

Clearly, B and C had other dynamic and clinical issues arise in their treatments. B's painfully ambivalent and sexualized relationship with her father reappeared as a prominent feature in her transference to her male therapist. Her escape from treatment can be interpreted as a flight from her forbidden incestuous urges. This formulation casts in oedipal terms what has already been discussed as a separation-individuation derivative. The phenomenon of an adolescent leaving and then returning to treatment is overdetermined on many developmental levels. Similarly, C's psychosis implied more serious psychopathology. Her illness included the delusion that she had given birth to a daughter with whom she wished to be reunited. Perhaps her daugher symbolized her own lost symbiotic part object. Having physically searched for her nonexistent child, she was able to tolerate further hospitalization. Her schizoaffective condition largely defied pharmacologic intervention, though she was cooperative in the ongoing therapeutic relationship. And for both B and C hospitalization had the additional meanings of providing the feared yet desired structure of an external control agent, while also conferring the socially stigmatizing status of psychiatric patient (crazy person) on these self-conscious adolescents.

Conclusion

The question of how to explain the unexpected return to treatment of

adolescents adamantly demanding and successfully winning their discharge is answerable by reframing the overt behavior. The patient's oscillation is reexamined at the level of its intrapsychic meaning. The goal of the patient's action is not discharge from the hospital per se but freedom from the pain of archaic internal objects. Although argued in terms of due process in a courtroom, the transcendent struggle occurs in the patient's unconscious. The psychiatrist may have gracefully lost the cases in court but by so doing emerged victorious when the patients resumed treatment. In this sense, the adolescent's separation-individuation process was assisted by the court enforced differentiation, followed by the patient-initiated rapprochement with the therapist.

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