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Working on Adolescent's Motivation to Improve the Outcome Within a Multimodal Treatment

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Additional information is available at the end of the chapter

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1. Introduction

What is motivation? From a psychological point of view it is a force, of psychic nature, which makes the individual show certain behaviour. Freud said that each behaviour, also the most strange, always responds to a motivation and the motivation's meaning is often unknown not only by people in contact with the subject but also by the subject himself. If we wanted to contextualise motivation within the alliance relationship, we could consider the last one as an interaction between two poles: one is the therapist the other is the patient, each with his own intrapersonal and interpersonal features, in a specific space defined by the setting, motivation is one of the intrapersonal patient's characteristics. Therapeutic alliance is a strong predictor of outcome in individual psychotherapy across diverse treatment orientations and modalities both with adult patients [14], [26] and adolescents [10], [13]. Patient's motivation, within the working alliance, during therapeutic intervention has been much studied [21], [7], [15], [30], [24], [25], [29], whereas the motivation associated with the diagnostic moment has been given less importance in scientific literature [22], [17]. Close to the theory there is clinical experience related to the centre we work in. Longitudinal studies about adolescents' therapeutic compliance and clinical evolution done within our Services [9], [10], [11] showed most of adolescents did not follow therapeutic suggestion about undergoing psychotherapy after the diagnostic process. Compliant and not compliant adolescents were different because of motivation expressed during the diagnostic process: the most of motivated adolescents started therapy, whereas the most of unmotivated adolescents did not. The clinical evolution resulted in association with adolescents' motivation as well: after six months a clinical improvement was statistically more frequent among motivated than among unmotivated adolescents.

These results and other ones from literature, evidencing that an early alliance has been found to be a better predictor of outcome than alliance averaged across sessions or measured in the middle or late phase of treatment [26], [12], stimulated us to think of and to evaluate, during clinical practice, some strategies to favour adolescent's motivation to follow therapeutic suggestion given at the end of the diagnostic process. For this reason we think of a diagnostic protocol which considers, with psychiatric diagnosis (ICD 10) and clinical evaluation (psychopathological investigation), to pay particular attention to motivational aspects. To do that we referred to the experience of interviewing used at the Brent Centre of Young People of London.

Looking at the literature we can deduce that the word "interviewing" has been introduced quite recently. Few authors discussed this process (interviewing) itself. The idea of "Interviewing" with adolescents at the Brent Centre comes from the belief held by M. Laufer that most adolescents were not able to engage in and make use of long term psychoanalytic psychotherapy without some preparatory work, as theorized by Freud (the development of the "observing Ego"). The word "assessment" wasn't used because it reminded to a psychiatric meaning. When the Centre was founded adolescents could come and "walk-in" for any reason. According to the presenting problem, the clinician provided the connection with the general practitioner (GP), the lawyer or the social worker. The aim was to focus on vulnerable adolescents to work on the accessibility, the potentiality for making therapeutic connections. It was considered to work on a long term base and to involve only trained analysts because it takes time and experience to modify the defenses. The results of the first researches showed that the Centre was working with severe neurotic patients and it was considered extremely important to engage the adolescents in order to offer a preventive help. P. Wilson [32] linked intervention in adolescence to the developmental model conceptualized by Laufer and stressed the importance of making an assessment before starting any kind of intervention: "Whatever the extent of intervention, it should be based on an assessment of his feelings about himself, his body and relation to his parents, and designed to contribute towards facilitating progressive movement and so serve to prevent breakdown and the possibility of mental ill-health in adulthood". From his words, it's possible to consider the interviewing as the preliminary work with the adolescent in which there is an assessment about his way of coping with the adolescence tasks. In 'Adolescence and developmental breakdown' [17] it is again stressed that the application of the developmental model to the assessment of psychopathology in adolescence is fundamental to make further decisions about management and treatment of the adolescent. The word "interviewing" appears in the paper written by C. Bronstein and S. Flanders in 1998 [4]. In it, the emphasis is put to another meaning of this process, linked to psychotherapy. The process that develops in this first contact with the adolescents we call *interviewing*, though it could also be described as *psychotherapeutic consultation*. It is stressed that a mere assessment followed by therapy can't give the adolescent the possibility to understand what therapy means, leading to a further drop out. It means that the aims of interviewing are both to assess the extent and the nature of the patient's disease and to give the adolescent the possibility to express his feelings and fears, to come into touch with anxiety, to make the "unknown" less frightening. Another aim of the interviewing process could be to set up the framework for further treatment, if this is considered necessary. It means dealing with "plans, arrangements,

preparation, undertakings" because it can allow the adolescent and his parents to understand better the meaning of further treatment. It is stressed the importance of making the adolescent an active part of the process and of involving him in it. For example the interviewer can use the explanation to make easier the understanding and to involve more the adolescent; the adolescent is made aware of the interviewer's concerns and of severity and implications of his problems in his present and future life. On the other hand the interviewer has to guide the intervention. Any reaction is "within the strict limits set by our specific role" [19] and it is important to avoid collusion, carefully not trying to take sides and allocate blame [18]. It's also part of the process setting up the framework of further treatment, if it's necessary. It means helping the adolescent and the family in understanding the meaning of the therapy but also talking together about practical problems [17].

1.1. The semi-residential adolescent psychopathology service

The study involved patients attending the Daily Service for Adolescents at the Neuropsychiatric Unit for Children and Adolescents in Padua. The main purposes of this service are the care and rehabilitation of adolescents with severe psychopathological disorders (mood disorders, psychotic disorders, antisocial behavior and personality disorders), particularly optimizing their welfare and providing intervention for these young patients through an integrated clinical and pedagogical approach. Various professional figures cooperate on the therapeutic project and this multi-professional team includes a child and adolescent neuropsychiatrist, a psychologist, two educators and a social worker. Adolescents attending the center undergo an initial diagnostic process, leading to a psychiatric diagnosis formulated according to the ICD 10 [33] and the therapeutic project involves attending a day center.

The centre receives adolescents (males and females from 12 to 18 years of age) with various types of psychiatric and behavioral disorder of moderate to severe degree: it has a capacity to treat approximately 25 patients in all and can simultaneously accommodate up to six adolescents, with the ratio of one operator to every two patients.

The adolescents attend from Monday to Friday from 09.00 to 17.00. Access to the structure is based on individual projects prepared by the team, which establishes the number of weekly visits and their duration. The educators can also implement tailored and/or home-based interventions in situations where an adolescent suffers from significant social isolation, and in acute cases requiring temporary hospital stays, acting as companions and providing support while the patient is in hospital. Patients can also be received in emergency situations (moments of acute crisis, or when a "buffer intervention" is needed while a patient is waiting to join a residential community). These latter interventions do not follow the normal enrolment protocol.

The general goals of the service are:

- to optimize the patient care and education measures for adolescents in situations of particular mental illness and at particularly crucial times;
- to support the families in their educational role;

- to construct an integrated clinical and pedagogical project with the various services on different levels and with different institutional roles;
- to improve the social involvement of adolescent in their living environment.

1.1.1. The multidisciplinary team

The multidisciplinary team consists of: a developmental neuropsychiatrist responsible for the service, a psychologist-psychotherapist, two educators, a social worker, a coordinator, and an administrative assistant.

There are also trainee psychologists, trainees on the degree course for professional educators at the Faculties of Education Sciences and Psychology, and physicians training in developmental neuropsychiatry.

The team holds the following meetings:

- a weekly meeting to coordinate their clinical-pedagogical work and program the educational activities;
- a weekly team meeting to discuss the cases;
- periodical meetings with social-sanitary operators and clinicians to report on the cases being treated in the semi-residential setting to discuss the clinical issues, assess the adolescent's progress, and recommend new patients for the treatment;
- a monthly supervisory team meeting with an outside psychiatrist-psychotherapist.

1.2. Protocol for enrolling new patients at the semi-residential center

The phase for assessing and enrolling an adolescent at the semi-residential center for adolescent psychopathologies is completed according to the following protocol.

1. The case is presented to the team operating at the semi-residential service for adolescent psychopathologies by the psychologist or neuropsychiatrist proposing their enrolment at the Neuropsychiatric Unit for Children and Adolescents and a file is prepared for the patient being recommended.
2. The case is discussed and, where applicable, a preliminary period of observation and assessment of the adolescent is decided.
3. A meeting is held with the patient and family to formalize the proposal to start with a preliminary period for the adolescent to get to know the semi-residential service. In addition to patients and their parents, this meeting is also attended by the clinician referring them and an educator.
4. The observation period starts, normally involving four meetings according to the following schedule:
 - the first meeting is for introductions, observations and free activity (playing, computer, exploring spaces);

- the second meeting is when an observation file is completed (a semistructured interview) by a "third party" educator, i.e. an educator who has had the least to do with the adolescent so far, in order to guarantee the utmost neutrality in the administering the assessment tool. Then activities are proposed in small groups to see how the adolescent functions in group situations;
 - at the third meeting activities are proposed on the basis of the adolescent's interests emerging from the previous interview;
 - the fourth and last meeting is where, in addition to the activities already begun at the third meeting, there is also space for a conversation and exchange of ideas with the adolescent, to provide feedback relating to the previous meetings, the adolescent's mode of participation and greater or lesser willingness to enroll at the semi-residential center.
5. The reference educator completes an initial observation file on the trend of the four meetings.
 6. The team assesses the observation period within two weeks after its completion and decides whether to recommend that the adolescent continue with the semi-residential experience or terminate it.
 7. The patient and family are informed about the child's progress so far and there is an exchange of ideas relating to the adolescent's and the family's experiences and motivations. If all concerned agree to the semi-residential program, this decision is shared and signed jointly by the family and by the physician referring the case to the team, and these parties agree on a first integrated, tailored therapeutic and educational project, and an initial schedule for the adolescent's attendance at the center.

1.3. The path for taking the patient into care

1.3.1. Formulation of the tailored educational project and schedule of attendance at the semi-residential center

This phase is completed by the working team and the object is to prepare a first project in the light of the findings during the preliminary observation period. A record is made of patients' and their families' demographic details, the motives for enrolment on the program, the internal and external activities conducted, the established goals, the general and specific objectives of the course of therapy, a description of the integrated intervention designed for each adolescent and the timing for assessing their progress and the project.

Access is always formulated on the basis of a tailored individual project and the adolescent's weekly attendance is constantly monitored. Punctuality and adherence to the agreed frequency of attendance is an important tool for assessing the adolescents' and their families' compliance with the agreed educational project, as well as being a necessary premise for implementing the semi-residential program. For each patient, a schedule is agreed with the family, the specialist and the adolescent concerned, starting from a minimum of two attendances a week (lasting four hours each).

1.3.2. Periodical clinical interviews and progress monitoring

For each patient, there are periodical clinical meetings with their own doctors to monitor their psycho-developmental trends and personal response to the therapy. The parental couple is also followed up with regular meetings with a clinician (neuropsychiatrist or psychologist), possibly with the support of an educator.

This action on the families needs to be supported and empowered to help parents establish a different image of their child from the one they knew before, and make sense of the changes taking place in the child during the period in semi-residential care, as well as providing input on how the parents themselves need to respond to the child on a daily basis. A course of psychotherapy proper for both the adolescents and their parents is often recommended and implemented.

1.3.3. Completion of a file for recording changes and reviewing the therapy

After the first six months of attendance at the semi-residential centre, the educational project is reviewed, and the goals and/or operating methods are expanded and/or diversified, based on a first structured assessment of the adolescent's progress that involves completing and checklist of specific indicators relating to the various areas of intervention (relational, social, autonomy).

1.3.4. Ongoing assessment

The ongoing assessment of the adolescent's progress is based on various methods:

- periodic team discussions,
- periodic meetings with reference clinicians,
- periodic meetings with family,
- periodic meetings with teachers,
- periodic assessment of files completed by the reference educator,
- observation/assessment charts recorded before and after laboratory activities,
- the periodic administration of standardized tests (YSR 11-18) [1] at the baseline, when the patient is taken into care and subsequently every six months,
- the periodic completion by the team of the Global Assessment of Functioning test [31] (at the time of compiling the therapeutic and educational project and subsequently every six months).
- This assessment and constant monitoring procedure enables the ongoing adjustment of the objectives of the integrated individual projects, which is normally done every 3-6 months. The tests can also be used as a tool for pre-and post-assessment of the effects of the intervention at the start and end of a specific laboratory activity to evaluate its efficacy.

1.3.5. Discharge

The end of the course of therapeutic intervention can be decided by various factors. In the most favorable of outcomes, the project may be concluded because the preset goals have been achieved and the adolescents have regained their social contacts and schooling experience, and the course of therapy undertaken can be consolidated.

Attendance at the centre may also be interrupted due to poor compliance on the part of the adolescent and/or the family (with repeated and unjustified failures to attend appointments at the semi-residential centre or meetings with clinicians, or inadequate cooperation). The program may also be stopped by the need to include the patient in a residential community. In each case, the conclusion of the project is confirmed during the course of a final meeting attended by all the parties involved (the adolescent, the family, the reference educator, the psychologist and the neuropsychiatrist).

1.4. Pedagogical activities

The object of the pedagogical activities is to support the adolescents in the course of their development by means of a relationship with the figure of the educator, who serves as an "auxiliary ego" and consequently as a supportive companion. This is achieved by providing a space, which takes practical shape in the rooms at the semi-residential centre, and by designing a project that involves customized objectives and timings.

In experiences of research applied to different educational settings, various functions have been identified on which the educator's action is concentrated. The educator thus has several functions [23], [28]:

- as a mediator between the adolescent and the adult world,
- to provide protection in relation to the adolescent's interior conflicts,
- to accompany the patient on a path towards a normalizing educational context,
- as containment, providing stability and helping the adolescent to manage the dynamics of his/her daily life.

The *general educational goals* of the educational process providing the starting point of an individual educational project tailored to each patient include:

- helping the adolescents to gain awareness of their own sentiments, impulses and behavior;
- helping them to test their abilities in a protected setting and to raise their self-esteem;
- helping them to realistically assess their living environment.

The *activities* in which the psycho-educational process takes shape are designed to achieve the individual objectives of each adolescent's project and rely on fundamental tools, such as providing a setting as a framework in which to enable the experience of meeting, using the operator's capacity for empathy to create a relationship that can help the adolescent to let their emotional experiences resound inside themselves and thereby increasingly gain control over

them, promoting organized behavior patterns, abilities and motivations that can pave the way to satisfactory social relations and an adequate performance in the completion of tasks and the achievement of goals. During their attendance at the center, the adolescents conduct activities designed to develop their personal interests, acquire skills and reinforce their self-esteem. Outings, the preparation of a newspaper, painting, watching films, playing, writing, and dramatizations are activities conducted at the center, individually and in small groups, in the constant presence of the educators. There are also structured laboratories involving pet therapy, horse therapy, art therapy and naturalistic experiences at teaching farms organized in cooperation with other associations, as well as participation in therapeutic winter and summer holiday camps. For many young people, these activities are the only opportunities they have to put themselves to the test away from their usual living environments, to measure themselves against an adventure outside the home, and thereby testing their capacity to manage on their own, to experiment with detachment from the family, to live in groups and share the group's behavioral rules.

Finally, courses are also organized to support the adolescents' formal education in cooperation with their schools. This involves formulating tailored teaching programs and the presence of teachers at the semi-residential centre.

2. Sample

Sample is formed by adolescents who, during a semester, consecutively came to the Neuropsychiatric Unit for Children and Adolescents in Padua, Italy, requesting a psycho diagnostic evaluation and then were suggested to undergo multimodal intervention at the Daily Service for Adolescents. The main purposes of this service are the care and rehabilitation of adolescents with severe psychopathological disorders (mood disorders, psychotic disorders, antisocial behavior and personality disorders), particularly optimizing their welfare and providing intervention for these young patients through an integrated clinical and pedagogical approach. Various professional figures cooperate on the therapeutic project and this multi-professional team includes a child and adolescent neuropsychiatrist, a psychologist, two educators and a social worker. They are 50 individuals, 33 males (66%) and 17 females (34%), aged 13 to 18 years (mean 15,6 y.). The only exclusion criteria were age below 13, chronic rather than acute psychotic state, $QI < 70$ and presence of known organic pathology associated with mental disease.

3. Methodology

Neuropsychiatric consultation was articulated into 5 diagnostic interviews with adolescent and his parents, separately. The last session was deputed to communication of psychiatric diagnosis and therapeutic suggestion. We added to this protocol, which was the usual one, another semistructured meeting finalised to the discussion about therapeutic

indication. This difference with respect to usual diagnostic protocol (where the diagnostic communication and therapeutic suggestion formed the last meeting with the adolescent) was set up with the aim of giving information about semiresidential treatment (what it is, how it works, what it is useful for) (1) and raising adolescent's questions, doubts, fantasies and anxieties about therapy and to talk about them with the specialist (2); the hypothesis was that giving voice to these issues and receiving information could be useful to create motivation towards multimodal intervention.

Adolescent's motivation was evaluated at the beginning and at the end of the diagnostic process, considering these three elements according to Marcelli and Bracconier [23]:

- Awareness of the disease,
- Worry about his/her own psychological state,
- Self observing and describing capacities.

Recognising and admitting an uneasy state is the first step to deal with it. Being preoccupied with it means to be in touch with anxiety caused by one's own condition and to hinge on this to desire to change. Having the capacity to self observe and describe means to be in touch with one's own inner world and to quite tolerate anxiety coming from conflicts.

An anamnesis schedule collecting data about adolescent's identification, his/her family, psychosocial situation and clinical elements was filled in for each subject.

The psychiatric diagnosis was formulated using ICD 10 [33]. Additionally, we grouped subjects into three categories according to the severity of the psychopathology and pathologic personality organisation as described by Kernberg [16]. Neurotic personality organization is characterized by psychostructural conditions that include: 1) intact reality testing, 2) a consistent sense of self and of other people, and 3) generally rely on mature defense mechanisms when stressed. At the opposite end of the personality organization dimension are severely disorganized personalities, the Psychotic one which is characterized by: 1) severely compromised reality testing, 2) an inconsistent sense of self and others, and 3) utilize immature defenses. Along the middle of this dimension are personalities organized at the borderline level: 1) the syndrome of identity diffusion, 2) the predominance of primitive defensive mechanisms centering around splitting, and 3) maintenance of reality testing.

Data about patient's therapeutic compliance and clinical evolution were collected during a visit of control after nine months by the last diagnostic session. They are based on both what was referred by the patient about subjective perception of health state and on what the specialist verified about psychosocial functioning changes in a nine months period. Clinical evolution was evaluated throughout the Global Assessment Functioning Scale (GAF) [31], which was filled in before and nine months after the beginning of the semiresidential intervention. The GAF is a scale used by the operators to rate a patient's psychosocial functioning and activities, regardless of the nature of their psychiatric disease. It corresponds to Axis V of the DSM IV [2]. The GAF scale comprises 10 levels (further divided into 10 points) and each patient is assigned to a given level on the strength of a scoring system: the higher the score the better the patient's psycho- social functioning. The patients were retested nine months later:

an improvement was considered when the GAF score changed to an upper level, an unvaried situation when the score remained in the same level and an aggravation when the score decreased to an under level with regard to the initial scoring.

Statistical analysis: data analysis considers the variable motivation in relation with gender (male/female); age (13-15 years old, 16-18 years old); educational level of family - valued on parent's education degree (low, middle, high); arrival status (voluntary, by referral); support by parents - evaluated by empathetic capacities towards adolescent, availability to come to the interviews, collaborative capacities about therapeutic project (supportive family, not supportive family); diagnosis (ICD 10); compliance with therapeutic project (in therapy, drop out, therapy never started); nine months follow up (better, unvaried, worse).

The data are expressed as frequencies and percentages. Variables are expressed using nominal and ordinal scales. Cross-tabulations were analyzed using the chi-square test, considering $P<0.05$ as significant. The analyses were performed using SPSS rel. 14.

4. Result and discussion

The sample is formed by 50 individuals, 33 males (66%) and 17 females (34%), aged 13 to 18 years. They were divided in 2 age groups: 13-15 years old (24 subjects, 48%) and 16-18 years old (26 subjects, 52%). 6% attended primary school, 36% secondary school, 56% college and 2% had abandoned school. Gender/age cross tabulation shows that males are younger (61% in age range 13-15, 39% in age range 16-18) than females (23.5% in age range 13-15, 76.5% in age range 16-18). The family's educational level the adolescents come from, results low in 18%, middle in 62% and high in 20% of cases. Arrival status is by spontaneous request for psychodiagnostic consultation in 40% of cases and by referral in 60% of cases. Diagnosis are summarised in table 1, where comorbidity is referred to depressive mood disorder and personality disorder.

Diagnosis (ICD 10)	Frequency(N)	Percent (%)
anxiety disorders	18	36
mood disorders	3	6
psychotic disorders	3	6
personality disorders	10	20
behaviour disorders	8	16
eating disorders	3	6
mental retardation	2	4
comorbidity (depression and personality disorder)	3	6
Total	50	100

Table 1. Psychiatric diagnosis according to ICD 10

Adolescent's motivation has been evaluated on the basis of three elements: knowledge of a disease, preoccupation about personal psychological state and self observing and describing capacities. Three categories have been individuated on the basis of this evaluation: motivated adolescents –38%-(who recognise the disease, are worried about it and desire to change it), indifferent adolescents –34%-(who admit and describe the disease, but do not seem worried and tend to minimise their psychological condition) and contrary adolescents 28%-(who arrive to the service obliged by parents, do not recognise a disease and say that it is others' fault if they are there) (graphic 1). The difference between indifferent and contrary categories, considering the psycho-relational way of functioning, is the dimension respectively passive and active which characterizes their resistance to meet the clinician.

The motivation, evaluated at the first interview, shows that less than half of the cases (38%) agrees on diagnostic process. This result suggests that adolescent's motivation to be helped is an aim of an intervention rather than an assumption. This is confirmed by literature [23] and agrees with the result about arrival status which shows that more than 50% of subjects came because they were referred by others rather than coming by themselves and also in this last case, the visit was requested by parents and not by the adolescent. We wanted to determine whether the variable initial motivation was significantly different among groups defined by gender, age, educational level of family and diagnosis. Statistical analysis evidences that diagnosis, gender and educational level influence in some way adolescent's initial motivation. Actually, distribution of initial motivation in adolescents grouped for sex, educational level and diagnosis is not casual, while age doesn't seem affect initial motivation like the other factors (tables 2, 3, 4).

			Initial motivation categories			Total
			motivated	indifferent	contrary	
Gender	male	Count	6	17	10	33
		% within gender	18,18	51,51	30,3	100
		% within motivation	40	80,95	71,42	66
		% of Total	12	34	20	66
	female	Count	9	4	4	17
		% within gender	52,94	23,52	23,52	100
		% within motivation	60	19,04	28,57	34
		% of Total	18	8	8	34
Total		Count	15	21	14	50
		% within gender	30	42	28	100
		% within motivation	100	100	100	100
		% of Total	30	42	28	100
Chi-Square Tests						
	Value	df	Asymp. Sig. (2-sided)			
Pearson Chi-Square	6,794	2	0,033			

Table 2. Crosstab: initial motivation in relation with gender

			Initial motivation categories			Total
			motivated	indifferent	contrary	
family's formal education	low	Count	1	6	2	9
		% within education	11,11	66,66	22,22	100
		% within motivation	6,66	28,57	14,28	18
		% of Total	2	12	4	18
	medium	Count	13	12	6	31
		% within education	41,93	38,7	19,35	100
		% within motivation	86,66	57,14	42,85	62
		% of Total	26	24	12	62
	high	Count	1	3	6	10
		% within education	10	30	60	100
		% within motivation	6,66	14,28	42,85	20
		% of Total	2	6	12	20
Total	Count	15	21	14	50	
	% within education	30	42	28	100	
	% within motivation	100	100	100	100	
	% of Total	30	42	28	100	
Chi-Square Tests						
	Value	df	Asymp. Sig. (2-sided)			
Pearson Chi-Square	10,194	4	0,037			

Table 3. Crosstab: initial motivation in relation with family’s cultural level

			Initial motivation categories			Total
			motivated	indifferent	contrary	
psychopathological categories	nevrosis	Count	10	7	2	19
		% within diagnosis	52,63	36,84	10,52	100
		% within motivation	66,66	33,33	14,28	38
		% of Total	20	14	4	38
	psychosis	Count		5		5
		% within diagnosis		100		100
		% within motivation		23,8		10

		Initial motivation categories			Total
		motivated	indifferent	contrary	
% of Total			10		10
borderline	Count	5	9	12	26
	% within diagnosis	19,23	34,61	46,15	100
	% within motivation	33,33	42,85	85,71	52
% of Total		10	18	24	52
Total	Count	15	21	14	50
	% within diagnosis	30	42	28	100
	% within motivation	100	100	100	100
% of Total		30	42	28	100
Chi-Square Tests					
	Value	df	Asymp. Sig. (2-sided)		
Pearson Chi-Square	16,743	4	0,002		

Table 4. Crosstab: initial motivation in relation with diagnostic categories

With respect to gender (table 2 a), motivated are prevalently females, while indifferent and contrary are prevalently males; these differences are statistically significant ($p=0.033$). This could be explained by the general tendency of females to be more reflexive and capable of insight than males teenagers, added to the fact that in our sample females are older than males and then more mature.

With regard to the educational level of family (table 2b), the most of motivated adolescents come from family with a middle educational level, the most of indifferent come from family with a low educational level, and contrary prevalently come from family with high educational level ($p=0.033$). Considering initial motivation in relation with nosographic categories, anxiety disorders and eating disorders are the most frequent diagnosis among motivated; acute psychosis, mood disorders and borderline mental retardation ($70 < QI < 85$) are more frequent among indifferent; conduct disorders and personality disorders are prevalent among contrary adolescents ($p=0.007$).

We considered motivation categories in relation to Kernberg's personality organisation categories too. It is interesting to note that the association between motivation categories and personality organisation categories (motivated -nevrosis, indifferent- psychosis and contrary-borderline), as showed in table 2c, reminds about the kind of bond that usually characterises the clinical relationship with the patient according to different psychofunctional level: the neurotic one (patients motivated to get better given their good reality test and a differentiated sense of social tact and sensitivity), borderline one (patients ambivalent and often oppositive towards therapist, given their lack of capacity for a mature empathy with others, and a lack of mature evaluation of other people, who are seen either as idealized, persecutory or devalued

persons), psychotic one (patients often not conscious of their diseases, with a rigid relational modalities and then mainly indifferent towards therapy).

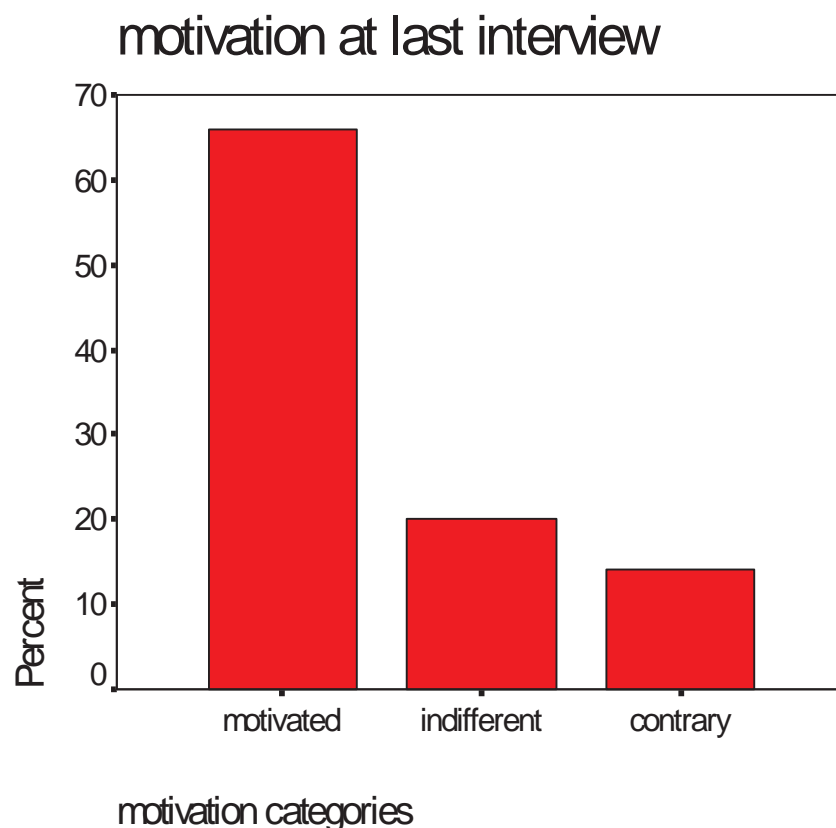
The aim of the diagnostic process, and overall aim of the last interview, was to create a relationship with the patient whose objective was to become aware of the disease and to want to change. So we tried to change the situation where the specialist evaluates the patient and at the end delivers a verdict - instead we tried to build a collaborative relation with adolescent where the main objective is to give a sense to the symptoms, to verify where the adolescent had stopped and to make the therapy to be perceived as something useful.



Scheme 1. Motivation at the beginning of the psychodiagnostic process

Adolescent’s motivation was evaluated again at the end of the diagnosis process (basing on the same elements). The result was an increase of motivated and a decrease of indifferent and contrary adolescents (scheme 2), without relevant difference regarding gender within the three categories ($p=0.19$). The relation between motivation and diagnosis loses statistical significance too ($p=0.09$), whereas educational level remains significant in regard to adolescent’s motivation ($\chi^2=11.38$ (DF4), $p=0.023$). This result suggests that sociocultural aspects (like educational background) influences thinking capacity more than other more constitutional factors (like gender or psychiatric disorder); moreover, it could make operators inclined to differentiate the way of approaching psychopathology in case of particular cultural conditions,

like the realization of more supportive rather than expressive intervention with people coming from a low socio-cultural background. It is interesting to note that the change to a motivated category is bigger among contrary than among indifferent adolescents: actually first halved during the diagnostic process, showing major capacities of mobilization (compare scheme 1 and 2). This could be linked to what was said before about the psychopathological features of these subjects: indifferent who are mainly psychotic organised are characterised by a defending setting and a psychorelational functioning which are less flexible and changeable than the one of contraries who enter mainly the borderline and neurotic psycho structural organisations.

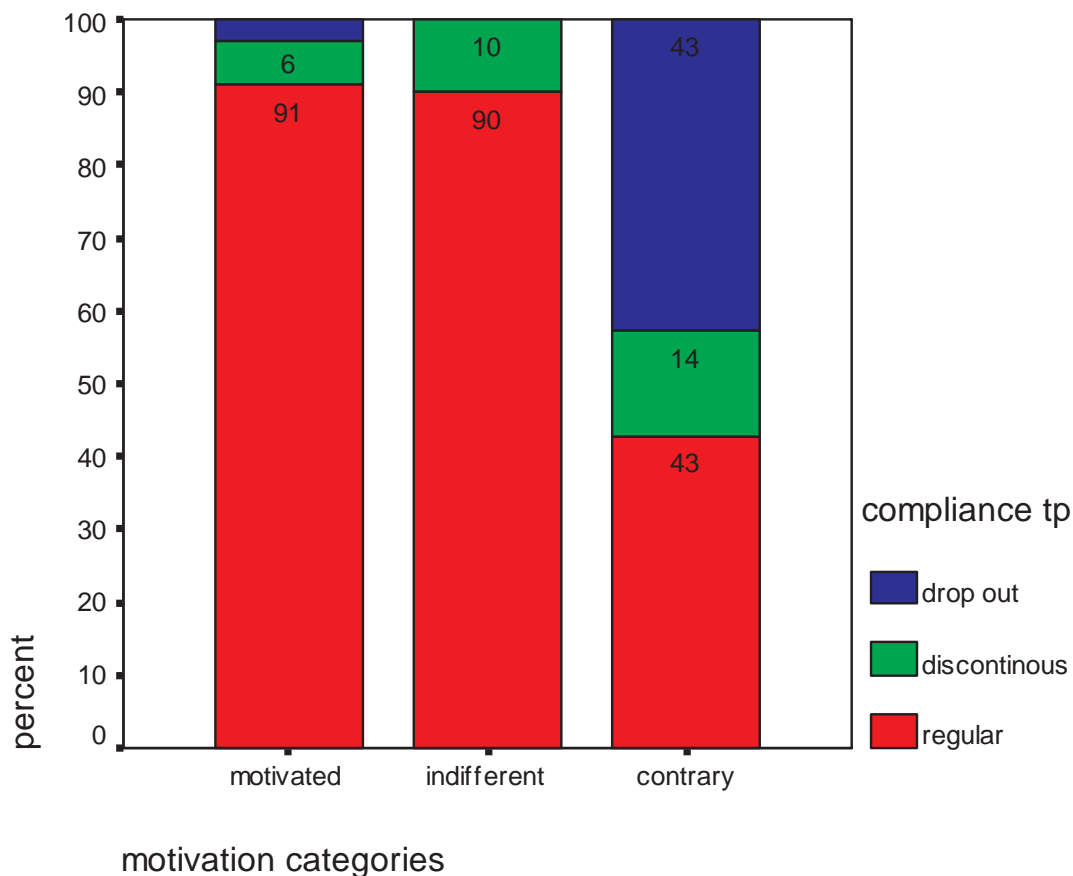


Scheme 2. Motivation at the end of the psychodiagnostic process

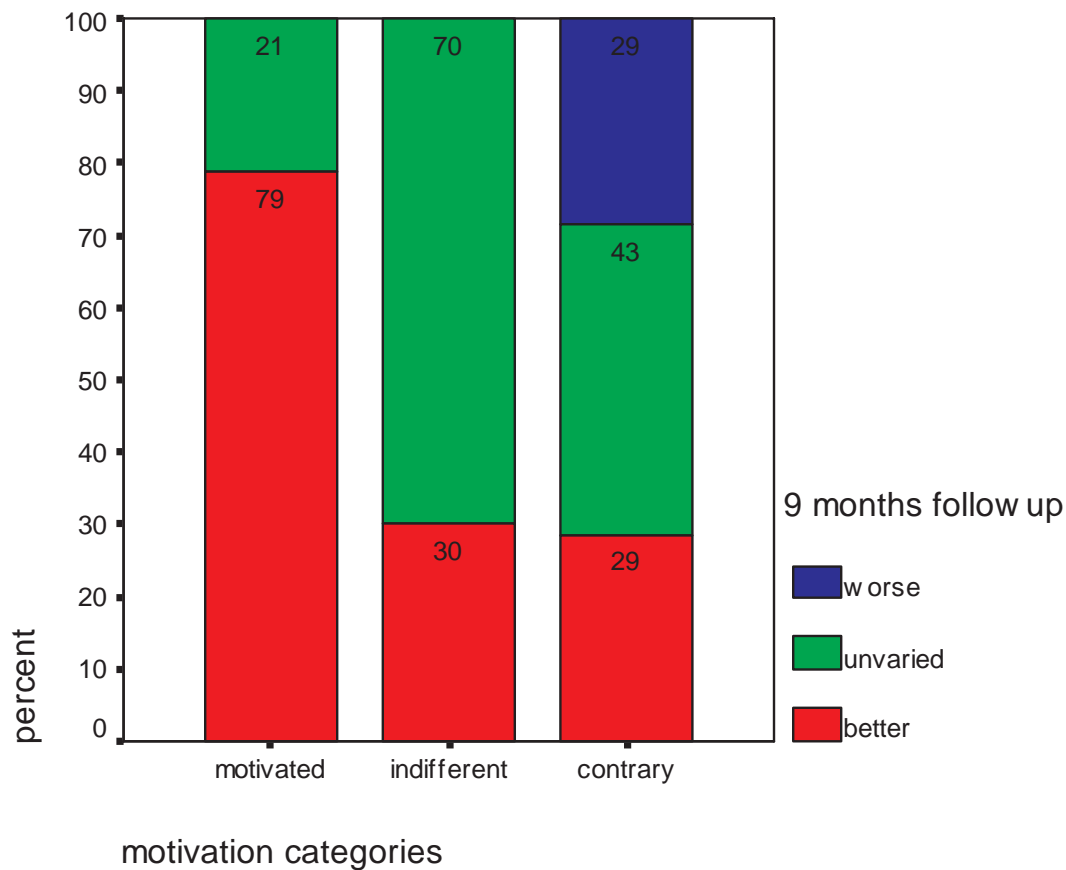
Evaluation of adolescents and their family showed, among contrary subjects, high frequency of difficult relationships and conflict with parents. This aspect seems preponderant in influencing the adolescent's feeling towards the specialist and psychological space. It is as if the difficulty with the parents is expressed by the difficulty and refusal in regards to psychiatric consultation, to which the adolescent has been lead by parents rather than coming by him self. In these cases, focusing on problematic relations and working on the relationship with the parental couple in terms of separation/ individuation, seems to favour the use of psychodiagnostic space as one's own rather than as something to be used to attack parents. This was shown by contrary adolescents as major capacity to thinking for them selves, to recognise personal

difficulties and to accept help to sort them out. Contrary adolescents, even if more oppositional evidently, are more “malleable” than indifferent adolescents whose defences are rigid and whose emotive distance makes it difficult to establish an emphatic relationship.

A nine months follow up have permitted verification of therapeutic compliance and clinical evolution. 84% of the adolescents are compliant, 8% have dropped out and 8% have never started psychotherapy. 62% of the adolescents have improved, 34% have not varied and 4% have got worse. There are significant statistical differences both in regard to therapeutic compliance and clinical evolution: motivated and indifferent adolescents mainly follow the therapeutic suggestion at the end of the diagnostic procedure, whereas contrary do not even start therapy ($p=0.006$) (scheme 3). In parallel after nine months motivated get better, indifferent do not vary and contrary adolescents do not vary or get worse ($p=0.000$) (scheme 4). The evidence of a missed clinical improvement nine months later even if indifferent are compliant for 90%, suggests - and confirms what said before about that - the presence of stronger rigidity of personality structure and defence mechanisms and/or necessity of a longer period to get better in these subjects.



Scheme 3. Motivation in relation with therapeutic compliance after nine months by the beginning of the semiresidential treatment.



Scheme 4. Motivation in relation with outcome nine month by the beginning of the semiresidential treatment.

This result is relevant because it indicates that adolescent's motivation is linked not only to therapeutic compliance but also to therapeutic efficacy. In fact the elements we considered to define motivation are significant ingredients to build an alliance relationship; this one is an important factor in regard to efficacy of therapeutic process [20], [14], [5], [8],[3].

Significant, statistically only in the latter case, the result about parents' collaboration in regard to therapeutic compliance and clinical evolution: 10% of adolescents do not start multimodal treatment or drop out among supportive families, whereas the percentage becomes 30% among not supportive families. With respect to clinical evolution: nine months later there was a clinical improvement in 73% of cases with supportive families, while the improvement regarding 31% of subjects with not supportive families ($p=0.005$).

This data seems to indicate that parental support for adolescents is more important to the efficacy of intervention than to compliance, as if adolescent's motivation was fundamental to start treatment, but then the family's support becomes significant as well to get clinically better.

5. Romeo (R), 18 years old: Reports diagnostic interviews by interviewer's words

5.1. First diagnostic session

Yesterday R's mother (Mrs A) phoned to confirm the appointment and asked if it would be possible to speak to me before his son would. Today Mrs A arrived at the Institute on time and the secretary found her screaming asking for someone, from the balcony upstairs on the first floor. Mrs A said she couldn't find anyone immediately upon entering the building and she didn't know where to go. Mrs A asked the secretary if she could speak to me before I saw R (R was waiting into the car). The secretary said she could spend the first 10 minutes with me whilst R was present – then she went to get R.

After I had introduced myself, we entered the room together and R's mother started to speak to me about R. "R has been suffering panic attacks for 4 months, he has got very nervous, he can't sleep, he has a lot of difficulties with his exams, he needs help in facing going to university, panic attacks, girls..." Furthermore she asked for medication to help him to sleep. She was very agitated and I felt R's anxiety rising while she was speaking. After a while I asked her to leave and wait for R. Then I asked R what he thought and he replied that what his mother had said was true, and he started to tell me about his panic attacks. They started since February when he had to do his first exam. He was at home, having a shower; his heart started to beat faster, he couldn't understand what was going on and he went to his mum (who was in the kitchen) to ask for help. I wondered within myself what he was doing or thinking while having a shower. His mum suggested he drink a glass of water but it didn't work. His legs and arms started to tremble and he was not able to control them. So his mum took him to the hospital where he had a lot of tests; everything was all right medically.

The second panic attack came a month later, at home too, nobody was in. R called his dad who went home and took R to the hospital again. Then panic attacks became more frequent: until two weeks ago they were every day. During these two last weeks R has been feeling a bit better (the exams have finished). His General Practitioner (GP) did not prescribe any medication, instead he suggested R come to the Service. I asked him what he thought about that and he answered he preferred not to take medication at that moment. I asked him about University and he told me the choice to go on to study was a very important one. Before he had been working at his stepfather's shop for nearly one year. Now he has to study a lot, he has no more time for friends and recreation. His life consists of going to university then coming back home and so on again, every day. He did not look worried or sad saying this. He doesn't want to give university up "even if it causes my panic at-

tacks". His words made me remember that his mum had said that 'there are guys who are able to study and guys who aren't able to bear the burden and R should understand if he's able or not; he could eventually leave university...'

After about 20 minutes someone knocked on the door, twice. I went to open it and it was R's mum who wanted to tell me she'd wait for R outside, in the car. In the meantime she was trying to look behind me to see R, at the same time, looking at me making a lot of signs with her face and her hands as if to say "is it all right with him?" I closed the door with a gentle smile and went back to my seat feeling annoyed; I looked at R with a questioning glance. He did not say anything about his mum, he did not seem ashamed or embarrassed or annoyed. He seemed to me a bit relieved instead. I asked him more about his parents: R's mum is from South Italy while his father is North Italian. They divorced when R was 6 because his father had an affair. His mum, who now is a housewife, has been living with another man for 10 years. He told me about the first time he'd met his mother's partner, saying that he'd liked him from the start.

R said he gets on very well with both his dad and his stepfather. It seemed to me it was very important for R to tell me that everything is all right with his family. This picture (intrusive and anxious mum, close family, worry about school, not many friends) gave me the image of a little boy, even though I was listening to a tall, broad, handsome man of 18 years. I felt a sort of big gap between his physical appearance and the way in which his mum treated him plus the way in which his symptoms seemed to ask for care. R was very keen to go on with interviews (what struck me was that he spoke about finding a way to face panic attacks rather than a way to rid himself of them). We agreed to see each other next week at the same time.

5.2. Second diagnostic session

R arrived on time, brought by his stepfather who waited for him outside. R had had his hair cut and he was wearing a cap that he did not take off. He started to tell me about his last panic attack that had happened while he was reading an article about a 12 y.o. girl's death. R told me that horror films made him have panic attacks as well. I asked him what he'd felt about the girl's death and he was able to say only that he'd felt strange "how can things like that happen?" Then he told me yesterday he went to his GP who prescribed R some medication (paroxetine) for his shaking. He went on to speak about his panic attacks, how they happen, how he feels and so on, talking very fast and repeating the same things. R links them to the fear of exams, stubbornly, as if he had to convince himself about that.

R said he gets very anxious thinking about his exams. I asked him what he's scared of. He's scared of failing. What could happen if you failed an exam? R answered he wouldn't know what to do. I asked him if it's something to do with him only and he said that he's worried what others could say about him too. He was getting very anxious so I asked him what he was going to do after his graduation. He seemed relieved to change the topic and said he'd like to get a job and a house. I asked him if he would like to live with anyone; he answered it doesn't matter. I asked him about girlfriends: he has never had one and he doesn't care...now he has no time to think of this. He told me he used to speak with his mother about these things, also

because she asks him a lot...even if it is not so easy and a bit embarrassing too, he added. I wondered whether he wouldn't find easier to talk to his father about things like this, "between men" ...R looked a bit thoughtful then said that yes, probably it'd be easier.

What about friends? He has a few good friends, but now he has no time anymore to go out with them. I asked R what his mum would think about him going to live on his own. R said that it would be difficult for her to accept, but she knows it'll happen one day. He told me he gets on very well with his mum, she's very supportive and that's been very important for R. I asked R if anyone else in his family was suffering panic attacks. He, looking as if he had been discovered of some secret, answered that his mum had had panic attacks too, when she was the same age as R. According to this she used to tell him not to worry because "panic attacks are going to stop spontaneously". He did not look very sure about this. His voice and way of talking made me ask him whether he's worried about his mum. "Yes" he said "because she's worried about me". I took up it looks like a sort of vicious circle and R agreed but he did not add anything else.

R likes music very much; he can play the piano (he had studied in a music school for some years). His dream is to become a musician...I took up he had chosen quite a different subject (computers) and R said it was because after you qualify you can get a job easier.

Towards the end of the session I asked him how he felt and he said with a smile he's feeling much better, he needs to talk to somebody about himself and what's happening "I should have come before". I thought he had been saying only a little of the whole and the way in which he used to speak about his panic attacks (using the most of our sessions talking about them) seemed to me a sort of defense for avoiding different topics or for not telling me something deeper.

R's mother phoned to the service saying that R wasn't very well so he could not come today. He'd phone when he was better. The secretary who answered the phone, told her we would send a new appointment anyway and R's mum said not to do that because R would phone when he felt ready to ask for another appointment.

It was phoned for another appointment.

5.3. Third diagnostic session

R arrived on time, he looked anxious as usual, but smiling. As soon as he sat down he started to say that he feels much better. I asked him what had happened (I was referring to last missed interview) and R told me he had managed to confide in his father about something he had been keeping to himself and that had been really hard to bear. He added it had been easier to speak between men and his father had supported and reassured him, so now he feels really well. Furthermore the day after he had spoken with his dad he managed to speak to his mum as well "so now it's all sorted out". He told me when the first panic attack came he was masturbating under the shower. He felt he had damaged his body, he felt really ashamed and scared at the same time. Until now he has been feeling that something wrong had happened to him, he's been fearing he couldn't masturbate anymore, he's been fearing about what might happen with girls.... Now the truth has come out he feels really better. It's all over. He has no

fear anymore; he has not had panic attacks since he managed to talk about it. I asked what his mum had said. She had told R he shouldn't have worried, that's normal, besides the same had happened to his father years ago (!). The mother told him she thought it might be something to do with sex and now he has told her she feels better. R told me he should have spoken before. I commented he'd probably needed a period in order to understand and to face a lot of feelings that had been coming out, not always easy to deal with. He agreed and repeated he had felt really ashamed and guilty. In particular, he had been scared of what his mum could have thought about him. I took up that it was difficult to say such personal things to his mum, especially now that he's growing up, and that growing up could be also be something to feel guilty about. He agreed and said it had been very important to speak to his dad before... because he's a man.

We spoke a bit about girls; R got a bit anxious and it seemed to me he wanted to censor the topic. He repeated he's very well, he wants to go on with University, he's able to go out again and so on. I felt he was censoring interviewing as well so I asked him openly what he had thought about continuing to come here. He seemed relieved by my question and answered that he felt he had received the help he needed and that he was very grateful. I proposed to him to take some time to think about that and to see each other next week again...he seemed more agitated and in trouble, then he repeated his thanks for the help he has received and that he preferred to stop there, because he was really OK and he did not need help anymore.

I took up his anxiety (probably linked to sexuality and body) and his fear in facing it: I told him I thought it would be important for him to have a deeper look inside; I also said that, looking at his anxious state, I could feel that perhaps it was too much for him at that moment and that it was important and right to respect his feelings of being scared by those thoughts and emotions. So I reassured R about the possibility of finding someone to help him here, if and when he decides to ask for further help.

We said goodbye each other.

Six months later, R came and ask for psychotherapy. He was chosen a male therapist for him. The compliance has been good from the beginning.

6. Conclusions

Results of this study suggest that it is possible to work on adolescent's motivation using relational instruments. Data from follow up indicates the importance of preparing the adolescent and his family, since during the diagnosis process, for treatment with the object of fair compliance and clinical evolution. With regard to that this paper suggests that an improvement of interviews, specifically used to discuss therapeutic referral, could be methodologically useful to improve motivation. In conclusion the motivation influences both compliance and clinical evolution, so it is important to pay attention to motivation since the start of the diagnosis process. This study moreover suggests that it is important to work with

adolescent's parents too to obtain effective results from the treatment. If we consider that a missed therapy opportunity for psychological disease during the developmental age could become a psychiatric disease in adult age [6], [27], then what mentioned before gains the meaning of prevention too.

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