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Review Article

The Use of Problem Solvıng Therapy in Psychıatrıc Problems in Adolescents

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Abstract

For a healthy development, individuals must have completely completed their own developmental stages in each period. Adolescence, which is one of these developmental periods, is a different and special period, separate from childhood and adulthood, in which many basic developmental characteristics are acquired. It is stated that psychiatric symptoms and disorders seen in adult life begin in early ages and the problem continues over the years. Problem-solving therapy is one of the methods that is increasingly used in the treatment of mental problems in adolescents today. For this reason, it is important in terms of eliminating the negative effects of the problems they encounter in adolescence and facilitating them to cope effectively by increasing their resilience to the problems in question.

Keywords: adolescents; psychiatric nursing; psychiatric problems; problem-solving therapy

Introduction

People go through developmental periods that differ from each other in terms of quality, such as infancy, childhood, adolescence, adulthood and old age, which are successive from birth to the end of life. All these periods are part of a whole. For a healthy development, individuals must have completely completed their own developmental stages in each period. Adolescence, which is one of these developmental periods, is a different and special period, separate from childhood and adulthood, in which many basic developmental characteristics are acquired (Öztop, 2012). In this process, adolescents have many tasks to be accomplished. These; undertaking self-care through physical development; development of a pleasing, realistic body image in response to maturation changes; coping with emerging aggressive and sexual urges; development of individualization and autonomy by separation from parents; identification and reinforcement of professional goals, sexual and ethnic values; developing satisfying peer relationships and developing a romantic relationship with an appropriate partner in late adolescence (Gestsdottir & Lerner, 2008; Öztop 2012; Young et al., 1995). Achieving all these challenging tasks and trying to complete the process can make adolescents more vulnerable to psychiatric disorders (Paus et al., 2008). It is stated that psychiatric symptoms and disorders seen in adult life begin in early ages and the problem persists over the years (Hinshaw, 2013; Kessler et al., 2005). Many psychology theories argue that pathologies seen in adulthood are caused by childhood problems (Hinshaw, 2013). For this reason, it is important to have more information about psychiatric disorders seen in childhood and adolescence in terms of explaining adult psychopathology. In recent years, research on adolescence has begun to develop. In addition to the normal development in adolescence, studies of psychopathology in adolescence are increasing significantly in the literature (Cicchetti & Rogosch, 2002). Problem-solving therapy (CCT) is one of the methods that is increasingly used in the treatment of mental problems in adolescents today (Alpaslan & Erol, 2016). Scientific studies show that inadequacies in individuals' problem-solving skills in the face of problems are causal in both the emergence and maintenance of psychopathologies (Eskin, 2009; Eskin, 2013; Nezu & Nezu, 2009). For this reason, CDT is important in terms of eliminating the negative effects of the problems they encounter in adolescence and facilitating them to cope effectively by increasing their resilience to the problems in question (Eskin, 2011). In this article, common psychiatric problems in adolescence and research examples on the effectiveness of problem-solving therapy on adolescents are discussed, and the results of the research are discussed.

Psychiatric Issues in Adolescents

There are more biological, psychological and social role changes during adolescence than any other phase of life except infancy. Due to the intense changes and developments in adolescence, it can be seen that adaptive behavior turns into maladaptive behavior. Epidemiological studies show that the prevalence and incidence of psychiatric problems in adolescence increase (Hickie et al., 2007). It is stated that approximately 10-25% of adolescent individuals exhibit serious mental disorders and psychiatric disorders in adulthood begin in this period (Kim Cohen et al., 2003; Romano et al., 2001). The onset of substance abuse, social phobia, major depression, eating disorders and panic disorder occurs during adolescence (Costello et al., 2006). In a study conducted by Akdemir and Çuhadaroğlu Çetin (2008), it was stated that female adolescents applied to the child psychiatry outpatient clinic with somatic complaints and suicide attempts, while male adolescents applied to the child psychiatry clinic due to lack of attention and mobility. During adolescence, behavioral problems such as anxiety and depression and problems in social relations are common in girls (Gilbert et al., 2006).

In adolescents, the incidence of depressive symptoms is higher in girls, but the incidence is up to 20% (Hoffman et al., 2003). Restlessness, introversion, boredom, loss of interest in friends and activities, overeating and sleeping, falling in school success, loneliness, psychomotor slowdown, decreased attention, feeling of being disliked, suicidal thoughts or attempts can be seen (Ağaoğlu, 2008; Yorgun, 2021). In the study of Gould et al. (2003), it is stated that 90% of adolescents who attempt suicide have psychiatric problems, and depression, conduct disorder and substance use are the three most common disorders in completed suicides, respectively. Even if most of them do not attempt suicide, a mental problem is almost accompanied by self-mutilation (Miller, 2007). Another psychiatric problem that usually begins in adolescence is eating disorders. Eating disorders show a significant gender difference and are 6-10 times more common in girls (APA, 2006). Eating disorders are a diagnosis that includes the atypical forms of these two syndromes, especially bulimia nervosa and anorexia nervosa, and binge eating disorder (Gürdal Küey, 2008). In bulimia nervosa, inappropriate behaviors such as using diuretics and laxatives, self-induced vomiting and excessive exercise are observed in order to avoid weight gain after binge eating. Anorexia nervosa, on the other hand, is characterized by a distorted desire to have a weak body, fear of gaining weight, and having a distorted body image. In individuals, these conditions should be distinguishable from dietary habits and organic conditions (APA, 2006; Gürdal Küey, 2008; Moser & Bober, 2011).

Considering the mental problems in male adolescents, problems in school and work life, antisocial and violent externalizing behavior problems (oppositional disorder, conduct disorder, attention deficit-hyperactivity disorder) are more common (Laukkanen et al., 2010). Oppositional Defiant Disorder (OCD) is reported to vary between 2% and 16% in adolescents and is more common in boys than girls (Akyol Ardıç et al., 2016; Karatoprak & Özcan, 2019; Öztop 2012). ODD is a chronic disorder. Although many developmental, psychological, biological and social factors play a role in its etiology, a definite factor cannot be shown. It is stated that genetic factors are responsible for 40-60% (Karatoprak & Özcan, 2019; Moser & Bober, 2011; Öztop, 2012). ODD is characterized by behavioral problems in which there are conflicts with parents, teachers, siblings and friends (Akyol Ardıç et al., 2016; Karatoprak & Özcan, 2019; Öztop 2012). Another psychiatric disorder in adolescents is conduct disorder. Conduct disorder is a disorder in which behaviors such as physical aggression, damage to property, lying or theft, and serious violation of rules are seen (Akyol Ardıç et al., 2016; İşeri & Şener, 2014). Its prevalence varies between 6-16% in boys under the age of 18, and 2-9% in girls (Öztop, 2012). Behaviors such as lying, damaging behaviors, stealing, running away from home and school can result in deterioration in academic achievement, inappropriate sexual acts, unplanned pregnancy and sexually transmitted diseases, delinquency, and suicide (Akyol Ardıç et al., 2016; İşeri & Şener, 2014; Öztop, 2012; Tired, 2021). Other problems that can be seen in adolescence; exam anxiety, traumatic life experiences and sleep problems. Delayed sleep phase syndrome and sleep deprivation are common sleep disorders in adolescents. Smoking and caffeine use, environmental stimuli, and changing biological circadian rhythm in adolescents may prevent falling asleep (Moser & Bober, 2011).

Problem Solving Therapy

Problem solving therapy (CCT) is a treatment method that can be used to solve some mental states that arise as a result of people's difficulties or problems in their daily lives (Eskin, 2011). The main purpose of therapy is to teach individuals how to approach the problems they encounter and the ways and strategies to be followed in order to solve the problems (Eskin, 2013). CDT aims to both prevent the emergence of psychological distress in the face of problems and to treat the mental distress caused by the problems (Eskin et al., 2008).

CDT is a cognitive-behavioral psychotherapy method. Cognitive behavioral psychotherapy approaches are among the empirically supported psychotherapies (Borkovec & Castonguay, 1998). CDT is seen as a psychological treatment approach that is empirically supported (Eskin, 2011; Nezu & Nezu, 2001). Problem-solving therapy is very flexible to use. This flexibility in its use enables CDT to address many problems in different ways. CDT can be applied in three different ways. These application methods can be in the form of individual, group or telephone and internet applications (Eskin 2011; Eskin, 2013; Nezu, 2004). As a cognitive behavioral intervention, problem-solving therapy or training (D'Zurilla et al., 1971; Nezu & Nezu, 2001) is often used to reduce levels of psychological distress (Allen et al., 2002; Eskin et al., 2008; Nezu). & Perri, 1989; Mynors Wallis et al., 2000; Sahler et al., 2002). Problem-solving training also includes studies on suicide (Eskin et al., 2008; Salkovskis et al., 1990), depression (Bell & D'Zurilla, 2009; Alexopoulos et al., 2011), and schizophrenia (Falloon, 2000, Falloon et al.)., 2007) in severe mental health problems, individuals with psychological problems who apply to primary health care services with somatic complaints, and patients with mental problems that develop as well as medical disorders (Eskin 2011; Eskin, 2013; Nezu, 2004).

CDT is used in two ways in general. The first of these is for the purpose of treatment. In this form of usage, it is used to eliminate the problem that individuals encounter in life, and to eliminate the mental distress that the situation gives to the person. In the second type of use, the problem encountered has not yet given any trouble to the individual. In this case, the purpose of use is to prevent the possible negative psychological effects of the problems faced by the individual. At the same time, this form of use also aims to increase the endurance of individuals (Eskin et al., 2008; Eskin 2011). The main treatment goals of CDT include the adoption of an adaptive worldview or the effective implementation of certain problem-solving behaviors (e.g., planned problem solving, emotional regulation and management) (Eskin, 2013). CDT has been conceptualized and implemented both as a psychotherapy system and as a short, skill-oriented training program (problem solving skills training) (Nezu & Nezu, 2009). Reviewing the literature, many researchers and clinicians have adapted this model to treat a wide variety of psychological problems and patient populations. Notable examples

include adults with various medical conditions requiring care (eg, traumatic brain injury) (Bucher et al., 2001; Rivera et al., 2008; Wade et al., 2011); geriatric depression (Areán et al, 1993; Areán et al, 2010); depressed adults (Ell et al., 2008; Ell et al., 2010); persons with mental retardation (Nezu et al., 1991); adults with personality disorders (Huband et al., 2007; McMurran et al., 2008); generalized anxiety disorder (Dugas et al, 2003; Provencher et al., 2004); primary care patients (Barrett et al., 2001; MynorsWallis et al., 2000); There are adults who suffer from a variety of chronic diseases, including cancer (Allen et al., 2002; Nezu et al., 2003) and diabetes (Hill-Briggs & Gemmell, 2007; Glasgow et al., 2004). The primary basis for such adaptations includes the hypothesis that the targeted problem is significantly associated with ineffective problem solving in real life (Nezu et al., 2004; Nezu & Nezu, 2010).

Problem Solving Therapy and Studies Related to Adolescents

When the literature is examined, it is seen that CDT is applied as problem solving therapy or problem solving skills training in adolescents (D'Zurilla et al., 1971; Nezu & Nezu, 2001). When the literature is examined, it is generally used to reduce psychological distress levels (Allen et al., 2002; Eskin et al., 2008; Mynors Wallis et al., 2000; Nezu & Perri, 1989; Sahler et al., 2002) as well as suicide (Eskin et al., 2002). et al., 2008; Salkovskis et al., 1990), depression (Alexopoulos et al., 2011; Bell & D'Zurilla, 2009) and schizophrenia (Falloon, 2000; Falloon et al., 2007). is used.

Eskin et al. (2008) studied the effectiveness of problem-solving therapy in the treatment of depression and suicidal potential in adolescents and young adults in a randomized controlled study with 46 individuals diagnosed with major depression. Individual CDT was applied to the intervention group (27 individuals), consisting of a total of 6 sessions, with an average of 38 minutes, once a week. No intervention was made in the control group (19 individuals). In their study, Hamilton Depression Rating Scale, Beck Depression Inventory, Suicide Probability Scale, Problem Solving Inventory, Interpersonal Behavior Scale, Rosenberg Self-Esteem Scale and Therapeutic Alliance (Agreement) Scale designed by the author were used. According to the results of the study, according to the Beck Depression Inventory, 77.8% of individuals who received CDT at the level of depression after treatment achieved full or partial recovery, while only 15.8% of individuals in the control group achieved only partial recovery. According to the Hamilton Depression Rating Scale scores, 96.3% of the participants who received CDT achieved full or partial recovery, while only 21.1% of the control group achieved this. Findings from the study show that improvements in depression persisted over a 12-month follow-up period. While it was found that the participants in the CDT had a decrease in their suicide risk scores after treatment, there was no change in the suicide risk scores of the participants in the control group. In addition, it was found that the group receiving problem-solving therapy increased their self-esteem, self-confidence, and interpersonal relationships after therapy compared to before therapy. In a meta-analysis by Bell and D'Zurilla (2009) examining the effectiveness of problem-solving therapy for depression, the results of approximately 20 studies were evaluated. It has been determined that problem-solving therapy in depression has the same effect as other psychosocial therapies and medical treatments, and is more effective than the control group in which no intervention was made.

Yildiz and Eşkisu (2011) conducted their experimental studies with 20 adolescent individuals with pretest-posttest control group in order to examine the effectiveness of the training program designed to develop problem solving skills. In their study, they used the Problem Solving Inventory as a measurement tool. In the study, while the experimental group (10 individuals) was given a program to improve problem solving skills, which lasted for 6 weeks and for 90 minutes per week, no intervention was made for the control group (10 individuals). As a result of the study, it was found that there was an increase in the problem-solving skills of the individuals who participated in the training.

Problem solving training in male adolescents conducted by Öztaban and Adana (2015); The quasi-experimental study with a control group, in which the effect on problem solving skills, interpersonal relationship style and anger control was examined, consisted of the study group (34 individuals), the control group with intervention (50 individuals) and the control group without intervention (63 individuals). Problem Solving Inventory, Multidimensional Anger Scale and Interpersonal Relationship Style Scale were used as measurement tools in their study. The students in the study group were given an eight-session psychoeducational problem solving skills training created by the author; The applied control group was given a training consisting of 8 sessions on the characteristics of adolescence that would have a placebo effect, and no intervention was applied to the control group. At the end of the 8-week training, post-test measurements were taken by applying the Problem Solving Inventory, Multidimensional Anger Scale and Interpersonal Relationship Style Scale, which were given to the students in the study, interventional control and non-interventional control groups at the start. All three groups were followed up after 3 months and 6 months, and the scales were applied again. As a result of the research, it is stated that the problem-solving education group program applied to male adolescents is effective in the development of students' problem-solving skills, contributes to the development of anger control and positive development of interpersonal relations, and this effect continues and increases for a long time.

Conclusion

Adolescence can be defined as a very important period for detecting psychological disorders. Psychiatric problems experienced during adolescence also affect the later life of individuals. Overcoming the problems that have not been achieved in this period is usually more difficult to achieve in the later periods. Therefore, psychiatric disorders seen in adolescence should be taken into consideration and necessary interventions should be made in a timely manner. CDT is a very flexible therapy method that can be used in the form of individual and group therapy in adolescents. In conclusion, the results obtained from the literature and all the studies examined show that problem-solving therapy is an effective and acceptable treatment method for emotional and psychiatric problems in adolescents.

Although the number of studies in the scientific literature on adolescence has increased considerably, it is seen that the number of published studies on development and psychopathology in adolescence is low. For this reason, it can be suggested that nurses, who are effective in all areas of society, give more place to problem-solving therapy in their scientific studies and that problem-solving skills training should be included in the educational life of adolescents.

References

1. Ağaoğlu, B. (2008). Depresif bozukluklar. In: Çocuk ve Ergen Psikiyatrisi Temel Kitabı. Eds: Çuhadaroğlu Çetin F ve ark. Ankara, *Hekimler Yayın* Birliği;373-382.
2. Akdemir D, Çuhadaroğlu Çetin F. (2008). Çocuk ve ergen psikiyatrisi bölümüne başvuran ergenlerin klinik özellikleri. *Çocuk ve Gençlik Ruh Sağlığı Dergisi* 15;5-13.

3. Akyol Ardıç Ü, Ercan ES, Durak S, (2016). Karşıt olma karşı gelme bozukluğu. In: Çocuk ve Ergen Ruh Sağlığı ve Hastalıkları. Eds: Pekcanlar Akay A, Ercan ES. Ankara, *HYB Basın Yayın*: 81-84.
4. Alexopoulos GS, Raue PJ, Kiosses DN, Mackin RS, Kanellopoulos D.et al. (2011). Problem solving therapy and supportive therapy in older adults with major depression and executive dysfunction: Effect on disability. *Archives of General Psychiatry*,68: 33-41.
5. Alpaslan AH, Erol Y.(2016). Çocuk ve ergenlerde depresif bozukluk non-farmakolojik tedavisi. *Türkiye Klinikleri J Child Psychiatry-Special Topics*, 2;1,62-67.
6. American Psychiatric Association. (2006). Work Group on eating disorders. Practice guidelines for the treatment of patients with eating disorders. *Washington DC.*
7. Ardıç, E., Ünsal, G. & Bayram S. (2020). Resimli psikososyal ve davranış sorunları kontrol listesi'nin geçerlik ve güvenirlik çalışması. *Psikiyatri Hemşireliği Dergisi,* 11(1);20-27.
8. Bell AC, D'Zurilla TJ.(2009). Problem-solving therapy for depression: a meta-analysis. *Clin Psychol Rev*,29;4,348-353.
9. Borkovec TD, Castonguay LG, (1998). What is the scientific meaning of empirically supported therapy? *Journal of Consulting and Clinical Psychology*,66;1;136-42.
10. Cicchetti D, Rogosch FA, (2002). A develop mental psychopathology perspective on adolescence. *Journal of Consulting and Clinical Psychology*,70;1:6–20.
11. Costello EJ, Foley DL, Angold A, (2006). 10-year research update review:the epidemiology of child and adolescent psychiatry disorders: II. developmental epidemiology. *J Am Acad Child Adolesc Psychiatry*, 45;8-25.
12. D'Zurilla TJ, Goldfried MR, (1971). Problem solving and behavior modification. *Journal of Abnormal Psychology*, 78;107-1026.
13. Eskin M, 2011. Sorun çözme terapisi. 2nd ed. Ankara, HYB Basın Yayım, s.1-345.
14. Eskin, M. (2013). *Problem solving therapy in the clinical practice*. Elsevier.
15. Eskin M, Ertekin K, Demir H, (2008). Efficacy of a problem-solving therapy for depression and suicide potential in adolescents and young adults. *Cognitive Therapy and Research*,32;227-245.
16. Falloon, IRH,(2000). Problem solving as a core strategy in the prevention of schizophrenia and other mental disorders. *Australian and New Zealand Journal Of Psychiatry*, 34;185-190.
17. Falloon IRH, Barbieri L, Boggian I, Lamonaca D, (2007). Problem solving training for schizophrenia: Rationale and review. *Journal of Mental Health*, 16;553-568.
18. Gilbert A, Maheux B, Frappier JY, Haley N, (2006). Adolescent care part 1: are family physicians caring for adolescents' mental health? *Can Fam Physician*,52;1440-1441.
19. Gould MS, Greenberg T, Velting DM, Shaffer D, (2003). Youth suicide risk and preventive interventions: a review of the past 10 years. *J Am Acad Child Adolesc Psychiatr*,42;386-405.
20. Gürdal Küey A. (2008). Ergenlerde yeme bozuklukları. Çocuk ve Ergen Psikiyatrisi Temel Kitabı. Eds: Çuhadaroğlu Çetin F ve ark. Ankara, *Çocuk ve Gençlik Ruh Sağlığı Derneği Yayınları,* 373-382.
21. Hickie Ib, Fogarty AS, Davenport TA, Luscombe GM, Burns J, (2007). Responding to experiences of young people with common mental health problems attending Australian general practice. *Med J Aust*,187;7;47-52.
22. Hinshaw SP, (2013). Develop mental psycopathology as a scientific disipline. In: Child and adolescent psychopathology. Eds: Beauchaine TP, Hinshaw SP. *John Wiley&Sons.*
23. Karatoprak S, Özel Özcan Ö, (2019). Ergenlik döneminde bilişsel, duygusal ve sosyal gelişim. In: Çocuk ve ergen ruh sağlığı ve hastalıkları. Ed: Özel Özcan Ö, 2nd ed. Malatya, *İnönü Üniversitesi Yayınevi,* p. 21-27.
24. Kessler RC, Berglund P, Demler O, Jin R, Walters EE, (2005). Lifetime prevalence and age of-onset distributions of DSM-IV disorders in the national comorbidity survey replication. *Archives of General Psychiatry*, 62; 593–602.
25. Kim-Cohen J, Caspi A, Moffitt TE, Harrington H, Milne BJ, et al. (2003). Prior juvenile diagnoses in adults with mental disorders: developmental follow- back of a prospective longitudinal cohort. *Arch Gen Psychiat*, 60; 709-801.
26. Laukkanen E, Hintikka JJ, Kylma J, Kekkonen V, Marttunen M, (2010). A brief intervention is sufficient for many adolescents seeking help from low threshold adolescent psychiatric services. *BMC Health Serv Res*,261;1-10.
27. Miller JW, (2007). Screening children for developmental behavioral problems: principles for the practitioner. *Primar Care Clin Office Pract*, 34;177-201.
28. Moser SE, Bober JF, (2011). Behavioral problems in children and adolescents. In: Textbook of Family Medicine. Eds: Rakel RE, Rakel DP. 8th ed. China, *Elsevier-Saunders.*442-54.
29. Mynors-Wallis L, Gath D, Day A, Baker F, (2000). Randomized controlled trial of problem solving treatment, antidepressant medication, and combined treatment for major depression in primary care. *British Medical Journal*, 320;26-30.
30. Nezu AM, (2004). Problem solving and behavior therapy revisited. *Behavior Therapy*, 35;1-33.
31. Nezu AM, Nezu MN, (2001). Problem solving therapy. *Journal of Psychotherapy Integration,* 11;187-205.
32. Nezu AM, Perri MG, (1989). Social problem solving therapy for unipolar depression: An initial dismantling investigation. *Journal of Consulting and Clinical Psychology*, 57;408-413.
33. Öztaban Ş, Adana F, (2015). Lise öğrencisi erkek ergenlerde problem çözme eğitiminin; problem çözme becerisi, kişilerarası ilişki tarzı ve öfke kontrolü üzerine etkisi. *Hemşirelikte Araştırma Geliştirme Dergisi,* 17,1;21-36.
34. Öztop DB, 2012. Adolesanda ruhsal sorunlar. Türk Aile Hek Dergisi, 16, 14-8.
35. Paus T, Keshavan M, Giedd JN, (2008). Why do many psychiatric disorders emerge during adolescence? *Nat Rev Neurosc*, 9;947-57.
36. Romano E, Tremblay RE, Vitaro F, Zoccolillo M, Pagani L, (2001). Prevalence of psychiatric diagnoses and the role of perceived impairment: findings from an adolescent community sample. *J Child Psychol Psychiatr*, 42, 451-61.
37. Sahler OJ, Varni JW, Fairclough DL, Butler RW, Noll RB, et al. (2002). Problem-solving skills training for mothers of children with newly diagnosed cancer: a randomized trial.

Journal of Development and Behavioral Pediatrics, 23;77-86.
38. Salkovskis PM, Atha C, Storer D, (1990). Cognitive-behavioural problem solving in the treatment of patients who repeatedly attempt suicide: a controlled trial. *British Journal of Psychiatry*, 157; 871-76.
39. Yıldız SA, Ekşisu M, (2011). Problem çözme becerisini geliştirme programının 9. sınıf öğrencilerinin problem çözme becerisi üzerindeki etkisi. *Erzincan Eğitim Fakültesi Dergisi*, 13; 1; 189-206.
40. Yorgun V, (2021). Kriz yaratan durumlar. In: Ergenlik ve Ergen Bireye Yaklaşım. Eds: Akdoğan R, Çimşir E. 1st ed. Ankara, *Anı Yayıncılık.* p. 120-39.
41. Young JG, Kaplan D, Pascualvaca D, Brasic JR, (1995). Psychiatric examination of the infant, child, and adolescent. In: Comprehensive Textbook of Psychiatry. Eds: Sadock BJ, Sadock VA. 6th ed. Baltimore, *Williams & Wilkins.* p. 2169-2176.

DOI:10.31579/2690-8794/160