ISSN: 2572-4037

Gios et al. Int J Psychol Psychoanal 2018, 4:028
DOI: 10.23937/2572-4037.1510028
Volume 4 | Issue 1
Open Access

International Journal of
Psychology and Psychoanalysis

REVIEW ARTICLE

The Role of the Adult Companion at the Onset of Psychosis in Adolescence

Giulio Gios[1], Claudio Busana[1], Enrico Ceccato[1]*

Department of Mental Health, Hospital of Montecchio Maggiore, Vicenza, Italy

***Corresponding author:** *Enrico Ceccato, Dipartimento di Salute Mentale Az. ULSS 5 "Ovest Vicentino" Via Cà Rotte 9, 36075, Montecchio Maggiore (VI), Italy, Tel: +39-0444-708232; +39-349-2426778, Fax: +39-0444-698869 E-mail: enrico.ceccato@gmail.com*

Abstract

Background: It is widely proved that methods of intervention in cases of adolescent-onset psychosis should be timely and plurifocal, with the application of integrated forms of therapy, including pharmacological treatment and psychological and social rehabilitation, also with an involvement of family members. Research studies moreover indicate that offering adolescents treatment within social contexts besides at facilities which have the specific purpose of providing treatment, on either a hospital or out-patient basis, improves both the outcome and compliance to treatment.

Aim: This work illustrates the function, role and operational methods of the adult companion, a professional figure who supports therapists and operates directly in close contact with adolescents in their habitual life environment.

Methods: This is a narrative review of the Italian literature regarding the use and functions of the adult companion at the onset of psychosis with a specific focus on the experience of the authors.

Conclusions: The intervention seems to be feasible and effective from a clinical point of view. Further RCTs and quantitative studies are needed to provide the effectiveness of this type of intervention.

Keywords

Adolescence, Onset of psychosis, Adult companion, Early intervention

Introduction

The Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV-TR) [1] applies the same diagnostic criteria for psychotic disorders in both children and adolescents and for adults, although various authors express a certain degree of perplexity in this regard [2].

There are relatively few epidemiological studies regarding the onset of psychosis during adolescence but, in general, it is believed that the incidence of psychosis and schizophrenia in particular increases considerably during adolescence, with a preponderant occurrence of the disorder among males [3]. The risk factors for onset of psychosis in adolescence, before 18 years of age, comprise variables linked to both environmental and biological factors and their interaction. Weiden and Buckley [4], for example, suggest that living in an urban area, social adversity and early use of substances-cannabis in particular-are environmental risk factors which may increase the possibility of developing schizophrenia.

Other authors indicate that complications at birth, advanced paternal age, developmental anomalies or problems relating to infections in early childhood are some of the most significant biological factors linked to the possibility of an occurrence of psychosis [5,6].

Diagnostic uncertainty will often arise in a first episode of psychosis with onset occurring during adolescence and psychotic onsets frequently follow a vague and insidious clinical course [7]. In some cases, it may be an extremely arduous task to have to distinguish between the typical behavior and rapidly-changing emotional and physiological manifestations of the adolescent period and traits having a more particular significance in psychopathological terms. Some studies, for example, confirm that the earliest symptoms of a pre-psychotic phase consist in a form of relatively non-specific distress reflecting a state of dysphoria [8]. In a retrospective study of 130 patients, An der Heiden and Hafner [9] indicate how in over 70% of the cases

Citation: Gios G, Busana C, Ceccato E (2018) The Role of the Adult Companion at the Onset of Psychosis in Adolescence. Int J Psychol Psychoanal 4:028. doi.org/10.23937/2572-4037.1510028

Accepted: June 09, 2018: **Published:** June 11, 2018

which they studied onset began with non-specific, negative and affective symptoms.

As indicated by the Child and Adolescent First-Episode Psychosis Study (CAFEPS) [10] the most frequent diagnosis at an onset of psychosis is in fact non-specific. The term psychosis is habitually used in a generic manner and basically includes more specific diagnoses, such as schizophrenia, bipolar disorder or schizoaffective disorder.

Adolescence is a period of life particularly at risk for the occurrence of such disorders as-by definition-it is characterized by the phases of development leading to physical maturity; from the psychological point of view the process of separation and individuation may moreover lead to consequent existential uncertainty and emotional and relational instability. This is the phase when new situations and needs arise which have particular relevance at the emotional level; such situations and conditions include the advent of sexual maturity, choices concerning scholastic options or a career that will be decisive over the following decades, the distancing from models, ideals and forms of behaviour, determined initially and to a large extent by parental figures, with an adherence to new experiences at the social level.

According to a study by Ballageer, Malla, Manchanda, Tackar & Haricharan [11] there is solid evidence indicating that patients with a psychotic onset during adolescence are more likely to present clinical characteristics that would indicate an unfavourable outcome and are more likely to require a different approach for early identification and treatment. This research moreover emphasizes that the prognosis for schizophrenia with onset during childhood or during adolescence is worse than that observed with onset occurring in adult subjects. As adults, these patients will have social relations that are less profound, will have less success in scholastic activities and will encounter problems in finding employment and in achieving a reasonable degree of autonomy in the various spheres of life. Patients with an onset occurring before adolescence and those with an insidious onset would appear to present a worse response to pharmacological therapy.

In consideration of these observations it has now been ascertained that clinical treatment provided at a psychotic onset must be plurifocal and, that is, should include interventions of the psychotherapeutic and pharmacological types, with assistance provided at the psychological and social levels in terms of rehabilitation, both with the patient and also with family members [12,13][a].

Moreover, research emphasizes that to offer a patient treatment in the social context rather than within structures specifically established to provide mental health care services will improve the outcome of interventions and the chance to follow treated subjects over time [20].

In this paper we present the figure and the role of the Adult Companion that provide an intervention that occurs within a treatment design aimed at bringing psychiatric care increasingly closer to the home and personal life environment of patients.

The Adult Companion

At the beginning of a work published in 1998 in the Italian journal "Adolescenza" Enrico de Vito [21] states that empathic understanding, establishing an area of trust and the development of the capacity to reflect can be considered as essential elements in the psychotherapeutic relationship with adolescents. These tenets are apt not only in relation to psychotherapy in the strict sense but are of fundamental importance also within the sphere of relational support provided for problematical adolescents.

In particular, reference will be made to those operators who work in close contact with young people and are generally referred to as "adult companions". Very often, this supporting role is assumed by young psychologists who assist traditional therapists, performing an intermediate role between the adolescent, his/her habitual life environment and the treatment team, thus allowing for an enhancement of traditional interventions by means of this additional function.

In Italy, the first experiences relating to adult companion activities date back to the early 1980s, when a group of researchers at the Institute of Child Neuropsychiatry at the La Sapienza University in Rome began to adopt the approach. This work was continued by a few psychoanalysts in Rome and Milan, the former working with the "Rifornimento in Volo" cooperative [22] and the latter with the "Area-G Association" (Pelanda, personal communication, November 26, 2005).

The role and function of accompaniment occurring on the part of an adult who assists adolescents represent the nucleus of an arrangement featuring various activities characterized by a strong sense of working and doing things together.

The theoretical point of reference provides for a strategy that goes beyond the therapist's office and implies the use of extended treatment settings including places such as the patient's home and/or social venues where the subject would normally spend time with youths of his/her own age; such contexts include for example the premises of religious organizations, sports fields and facilities, local bars etc. It is believed that

[a]The Department of Mental Health of Sub-District 5 of the Local Health-Care and Social Services Department (Veneto Region) participates in the GET-UP (Genetics, Endophenotypes and Treatment: Understanding early Psychosis) targeted national research project. Within the framework of the PIANO (Psychosis early Intervention and Assessment of Needs and Outcome) partner project, this is an RCT which compares effectiveness at 9 months of an intervention of integrated multi-factorial psychosocial treatment based on available guidelines [14-18] for patients at the onset of psychosis and their family's vs routine treatment currently provided by public psychiatric services in Italy [19].

this approach addresses more effectively the particular characteristics of adolescents and in some cases is seen as a more adequate solution given the seriousness of the disorder.

Castellano and Cordiale [22] emphasizes how the relationship with an adult companion is mainly oriented towards the external reality of the patient and is closely linked to his/her habitual environment and social context; the relationship is moreover consolidated through opportunities to share situations and activities forming part of the life experience of the patient.

Adult companions normally accompany youths in their daily activities, such as games and scholastic work. These may also include such activities as simply going for a walk so as to generate a significant affective relationship and narcissistic support and at the same time develop positive identification. An adult companion will also attempt to tune in to the subject's affective dimension, using the non-verbal aspects of a relationship and applying the principles of "doing things together" and "being together", and responding in the here and now to the youth's doubts and questions.

Placing at the patient's disposal his/her own concept and vision of adolescence, an adult companion will be capable of acting as a model, triggering relational mechanisms of empathic resonance which may function as a means of mirroring and promoting healthy identification [23].

Patients should be encouraged to communicate and exchange views and thoughts, referring mainly to day-to-day events and activities, which may lead to a progressive awareness of their "being-in-the-world" through a relationship with a person who can understand them and will meet their expectations. It is thus possible to generate a virtuous circle, moving in the direction of self-care and individual growth, and facilitating the development in the adolescent of a natural and spontaneous tendency to seek out models they can identify with.

In other words, through the relationship, the adult companion will facilitate the development of object-related and also narcissistic investments which the adolescent needs in order to reset in motion the various areas of his/her psychic functioning. Recalling the work of Jeammet [24], we may definitely state that, above all, the difficulty experienced by the adolescent occurs in the form of a malaise which he/she will project onto the environment, i.e. within the family, at school, in peer groups and in those places where social relations occur. In this regard the author uses the term "enlarged psychic space".

We would agree with Castellano and Cordiale [22] and believe that carrying out activities in the presence of the adult companion-who can ensure the continuity of relational experiences, reduced levels of conflictuality and stable affective support-will allow the adolescent to experience a more positive self-image and rediscover the pleasure of using his/her capacity to cope with developmental commitments and tasks. Spending time with adolescents, whether problematical or not, means, on the one hand, being actively present when needs are manifested in a regressive manner and, on the other hand, participating as a neutral observer when adolescent behaviour and functions are aimed at acquiring a sense of autonomy and individuation. The adult companion is involved in providing adolescents in a crisis state with behavioral patterns that may be taken as a response to existential distress. The adult companion remains close to the subject in an understanding and tolerant way, attempting to produce new and healthy emotional experiences, especially when the patient reveals the most severely regressed and disturbed parts of the self.

In the presence of what Cahn [25] refers to as pathological arrests, this modality of relating is found to be particularly useful and indeed necessary to orientate developmental processes in the direction of growth and reduce the risk of dangerous regressions. This is why empathic understanding, the possibility of establishing a sense of trust and the capacity to reflect mentioned earlier may be considered as essential elements in the supportive relationship engendered between the adult companion and the adolescent. Moreover, one has to be aware that it is essential for the adult to deserve the trust of the adolescent with his or her capacity to be loyal, convey a sense of understanding and be respectful when personal matters are revealed [26].

The relationship with the adolescent implies an introspective capacity which may involve a personal willingness on the part of the adult companion to revisit and consider the variability and lack of definition that characterised his/her own adolescent years. A capacity for introspection allows the adult companion to manifest empathy when confronted with the difficult condition of adolescents and this particular dimension may be the appropriate starting-point in any consideration of the potential for growth of a given subject. In agreement with Fowles [27] we believe that adolescence needs to be lived and felt rather than described, studied or categorised.

Intervention at the onset of psychotic symptoms

As mentioned in the introduction, intervention involving an adult companion occurs within a treatment design aimed at bringing psychiatric care increasingly closer to the home and personal life environment of patients.

When we encounter adolescents at the onset of psychosis, we realise how these youths are emotionally fragile and inevitably incapable of coping with such a dramatic experience that causes the disarray of all

former parameters relating to their identity, the emotions and the sphere of social relations: we are agree with Laura Bislenghi that said "the experience of psychosis disturbs the patient's perception with respect to relations formerly conceived as protective and safe, creating intense and often stable persecutory ideation and sensations of violation, desperation and a sense of imminent catastrophe" (personal communication, October, 2010).

Raphael [12] refers to an onset of psychosis as a personal catastrophe, in which not only the patient but the entire family suffers a serious trauma and consequent losses.

In such situations, in which words are few and far between or are uttered in outbursts of delirious, fragmented speech, the adult companion offers a possibility at the relational level, providing practical support by means of the "doing things together" principle and, with his/her presence, provides a possible functional model for identification. Adult companions perform an important therapeutic function as they help adolescents make sense of what's happening, accept their illness and control their sense of anguish. The relationship allows the adolescent to reduce the feeling of profound narcissistic humiliation he/she experiences and detect a way out of the great distress that is felt. To facilitate progress the AC must be capable of accepting the pain of the patient, which may be concealed beneath drastic, tragic and omnipotent forms of acting out and self-destructive or hetero-destructive impulses23 and his/her task is that of being a silent presence, capable of tolerating a dimension of emptiness, besides feeling, understanding and containing pain. He/she attempts to promote what may be described as a form of resonance which may generate a virtuous response with respect to fears and anxiety related to feelings of emptiness and derealisation, thereby facilitating the chance to build an adequate referential system external to the self.

Jeammet [24] suggests that, in order to be effective, operators should relate to patients in a manner free of any trace of narcissistic omnipotence and have the capacity to accept, without surrendering to feelings of impotence inevitably aroused by the pathological condition in question.

The action of the AC is integrated with other forms of treatment and is thus oriented towards generally facilitating the achievement of the Individualized Therapeutic Project (ITP). One should note for example the importance of obtaining a good degree of compliance with pharmacological treatment, which is sometimes viewed as a negative imposition and rejected by adolescents but which remains a determining factor in the attempt to abate psychotic symptoms; a carefully nurtured relationship which the adult companion develops with the adolescent initially makes it possible to draw the patient closer to the prospect of participating in the therapeutic process and will allow the AC to help the patient cope with the intervention and remain in a position of compliance over time.

Psychotherapeutic interventions aimed more specifically at facilitating a return to normality and development may be undertaken later if and when the patient has achieved a sufficient rebalancing of fragmented functions of the self. The intervention of the adult companion may then facilitate on the part of the adolescent an increasing closeness to or reintegration with the external environment, for example with a group of youths of the same age, so as to promote positive narcissistic confirmation.

At the onset of psychosis, with both productive or negative symptoms, a central purpose of the intervention is also to create a relationship of trust, where the element of trust becomes the point of departure for the construction of a treatment plan and to determine the therapeutic objective itself ("*Here I am; you are important to me; I want to listen to what you have to say and spend time with you. I recognize your right to exist, and to exist in the way you want to at this very moment …*").

An evaluation occurring mainly in qualitative terms led us to believe that the adult companion can indeed perform a variety of functions such as acceptance, validation, and 'amplification' (recognition of the patient's mental states and mirroring), positive reinforcement, and also a motivational function, assisting the adolescent during a period when several important questions may arise ("*What am I doing?" "Why am I doing this?" "Where am I going?" "With whom will I be going there?*") and helping the patient establish tangible and achievable objectives within the therapeutic process.

Very often the adult companion has made it possible to implement certain behavioral techniques that are sometimes difficult to apply in public treatment contexts, such as graduated exposure *in vivo*, behavioral modelling and problem solving.

Involvement of the family

The parents are involved in therapy from the very first phases of the therapeutic intervention given the importance of their affective and educational role [28]. Generally speaking, at a preliminary stage the therapist assigned to a particular case will meet the parents together with the adult companion in order to share with them the aims of the ITP. During the course of two or three interviews the function of the adult companion and the manner of intervening are presented, relating the same to the overall intervention implemented by the treatment team.

This initial phase is necessary to ensure a favorable course of treatment and, as far as possible, has the further aim of avoiding a situation where the therapeutic project and the adult companion (AC) are experienced as intrusive interventions or with indifference or, worse

still, with hostility, this latter being an attitude which might generate a rift in the relationship with the treatment team.

The adult companion will subsequently initiate the course of intervention, entering the habitual life environment of the adolescent, whose home will be a privileged meeting place; the youth's home will always be identified as a place of safety and support, also when other sites of social activity are visited. It should be specified that the ITP may provide for the involvement of other important family members such as grandparents, siblings, and aunts and uncles, who may live at the patient's home and are therefore already present in the house during meetings with the adult companion or who live elsewhere and are invited to participate, thereby providing support for parents who are absent or who may present an excessively pathological condition.

By venturing beyond the traditional, institutional structures of the mental-health clinic and entering the daily life of the patient, the adult companion inevitably modifies the equilibrium of the family, generating reactions which may be positive, reflect a sense of collaboration, a willingness to change, closeness, understanding or, on the contrary, may be quite negative and even veer towards the point of open opposition and rejection. In some families, for example, feelings of jealousy or envy may arise accompanied by reactions whereby the therapeutic process is discredited or denigrated; it is thus important for the AC to operate with the aim of obtaining the trust of the parents so that they may support him/her and provide their assistance in his/her therapeutic role.

Inducing family members to collaborate not only facilitates the relationship between the AC and an adolescent; it is also useful to avoid situations where the AC is perceived as a scrutinizing, judgmental individual conveying a sense of blame and may nurture within the family fantasies of a persecutory intrusion, possibly conducive to defensive reactions rather than a desire to collaborate in the treatment process. Such persecutory fantasies, where present, would put the youth in a position where he/she would be driven to conform with respect to regressive and pathological forces present in the family, drawing the adolescent away from the adult companion and treatment and thus compromising his/her developmental skills.

Another outcome to be feared is the possibility that parents incapable of coping with their child's severe pathological condition may develop a form of rejection, abandoning their role and delegating parental functions to the therapist, to the adult companion or to the treatment team. The risk is that a rather dangerous relational and affective void may be produced, resulting in a need to provide treatment also for the parents or the extended family. Such family treatment must occur in a context of close collaboration with the AC so as to avoid the occurrence of overlapping interventions or, worse still, misunderstandings.

In brief, the commitment of the adult companion is mainly that of contributing towards implementation of the therapeutic project, contending with the rigid defensive reactions present in the family - persecution and disinvestment on the one hand and delegation on the other - offering a willingness to listen, and providing information concerning the development of treatment and support for the parents. The AC is the component of the treatment team closest to the adolescent and his/her family and the person who is the easiest to approach when a need arises to communicate worries and distress. The adult companion acts as the patient's most easily-accessible point of liaison with the health-care team and facilitates an awareness of the sense and necessity of the therapeutic intervention in general. In other words, the AC directly implements that part of the ITP which is carried out in the setting of the patient's life environment and at the same time creates a bridge between the adolescent with his/her family on the one hand and the treatment team on the other.

The context: The Interservice Unit for the Treatment of Adolescents with Psychopathology (IUTAP)

The IUTAP is formed by psychiatrists and psychologists assigned to Mental Health Department, Pathological Dependence Department and various services within the local Maternal and Child Health Department, such as Child Neuropsychiatry, the service for the protection of Minors and Family-Care Unit. The IUTAP is active since the year 2000 within Sub-District 5 of the Local Health-Care and Social Services Department in Vicenza (Italy).

This unit aimed at providing an adequate response to the complex psychopathological symptoms of adolescents who, as often occurs in cases of multiple diagnosis and in adolescents, not being considered subject to the specific competence of any specific Department or service.

The Unit had the specific task of treating the more complex clinical cases of psychopathology in adolescents. Its aim was and remains twofold, starting from the moment a report is submitted by an operator or the particular service that has seen an adolescent for the first time. More precisely, first of all it has to identify and present the clinical case in a timely manner to the competent specialized service in order to immediately initiate therapeutic interventions and, secondly, organize the scientific and technical support system necessary to provide adequate treatment for these patients.

A form of collaboration was thus begun between territorial services on the basis of the following model of organization: 1) The taking into care and admission to a treatment plan is the responsibility of the competent service, which will assign a case manager and specific

operator(s); 2) The programme may, if necessary, also involve other services available in the IUTAP; 3) The IUTAP itself provides for supervision of the most serious clinical cases and any modifications of the ITP.

The role of the adult companion was introduced and implemented by the IUTAP to make it possible to work with those youths with whom it was difficult or impossible to develop a therapeutic relationship in the traditional setting, moreover introducing a treatment strategy within the Therapeutic Project which might be implemented in an environment that would be more 'open' and different from that found within the sphere of traditional out-patient services [29].

Conclusions

The AC intervention has been proven to be feasible at the onset of psychosis and provide some benefits in the treatment of psychosis.

The Authors believes that the AC, working integrated with other professionals, could facilitate the achievement of the Individualized Therapeutic Project (ITP) implementing that part of the ITP which is carried out in the setting of the patient's life environment and the same time creates a bridge between the adolescent with his/her family on the one hand and the treatment team on the other.

The AC also facilitate an increasing closeness to or reintegration with the external environment, for example with a group of youths of the same age, so as to promote positive narcissistic confirmation.

An evaluation occurring mainly in qualitative terms led us to believe that the adult companion can indeed perform a variety of therapeutic functions such as acceptance, validation, and 'amplification' (recognition of the patient's mental states and mirroring), positive reinforcement and also a motivational function, assisting the adolescent during a period when several important questions may arise and helping the patient establish tangible and achievable objectives within the therapeutic process.

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We hope that in the future we will able to further investigate and verify the effectiveness of this type of intervention with quantitative methods.

Acknowledgements

We should mention Prof. Eugenia Pelanda who, as supervisor of our workgroup, provided us theoretical and clinical knowledge which we needed to comprehend and introduce this figure in our activities.

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