Mission

Y*ellowbrick Journal* is the official publication of Yellowbrick Foundation, a not-for-profit organization, whose mission is to support research, training and community education regarding the emotional, psychological, and developmental challenges of emerging adults, ages 18 to 29. *Yellowbrick Journal* is dedicated to the dissemination of work that informs the Yellowbrick model—a research-based treatment model that combines the most current contributions of developmental psychology, neuroscience, innovative psychotherapies, strength-based strategies, and wellness medicine. *Yellowbrick Journal* highlights cutting-edge theory and research that informs our understanding of emerging adults from a holistic perspective. *Yellowbrick Journal* also publishes articles on applied work that has demonstrated effectiveness and is particularly dedicated to work that emphasizes multi-specialty evaluation, therapeutic residences, research-based strategies, and life-skills interventions. *Yellowbrick Journal* represents the voices and perspectives of those who serve as the catalysts for the evolution of Yellowbrick—emerging adults and all who are dedicated to the optimization of their potentials.

Letter From The Editors

Issue V
The 10th Anniversary Issue

  We are pleased to deliver to you the 5th Issue of *Yellowbrick Journal,* marking the 10-year anniversary of Yellowbrick. Reflecting back on where we were when we launched *Yellowbrick Journal* in 2009, so much has changed. In our original Editorial Introduction in Issue I, there was so much about emerging adulthood we felt the need to explain. Only recently had the concept of "emerging adulthood"—a new life stage in between adolescence and adulthood – gone public. August 2009, *The New York Times Sunday Magazine* article, *What is it about 20-somethings?* went viral online, pre-publication. The article featured Yellowbrick in the context of exploring the question: what's the new normal? The popularity of the piece provided ample evidence that parents, professors, clergymen, and emerging adults themselves were hungry to know—is my 20-something doing okay or is mental health treatment in order? And if so, where do I go to get help for my emerging adult? Only 7 years ago, resources couldn't even be considered scarce. They were nowhere to be found. Until Yellowbrick.

  With the emergence of emerging adulthood in the 21st century comes new opportunity. Spending an additional decade of one's lifespan investing in personal maturation and development is advantageous and even exciting for young people who have access to and are primed to take advantage of these years to invest in themselves and their own personal growth. Emerging adults with serious mental health problems and developmental histories of trauma are at risk for under-achievement and may even lose ground compared to their peers. We, the practitioners and scholars interested in designing and delivering mental health services to emerging adults, were not only eager to adopt the reconceptualization of the transition to adulthood for the 21st century, we snatched-up the opportunity to turn our focus specifically to undertreated, underserved emerging adults with unmet mental health needs.

  Yellowbrick Journal has matured into a home for a wide variety of literature written to enhance our understanding, assessment, diagnosis, and treatment of emerging adults with serious mental health problems and trauma. This 10th Anniversary Issue, first and foremost, represents Yellowbrick's commitment to building a community of professionals who give their minds, hearts, and souls to helping emerging adults recover and achieve during these critical years. In this Issue, each article was selected because it contains, as either a minor or major theme, a focus on change and stability, growth and maturation. It is with excitement that we offer this compilation of excellent resources to our readership. We look forward to growing with you over the next 10 years.
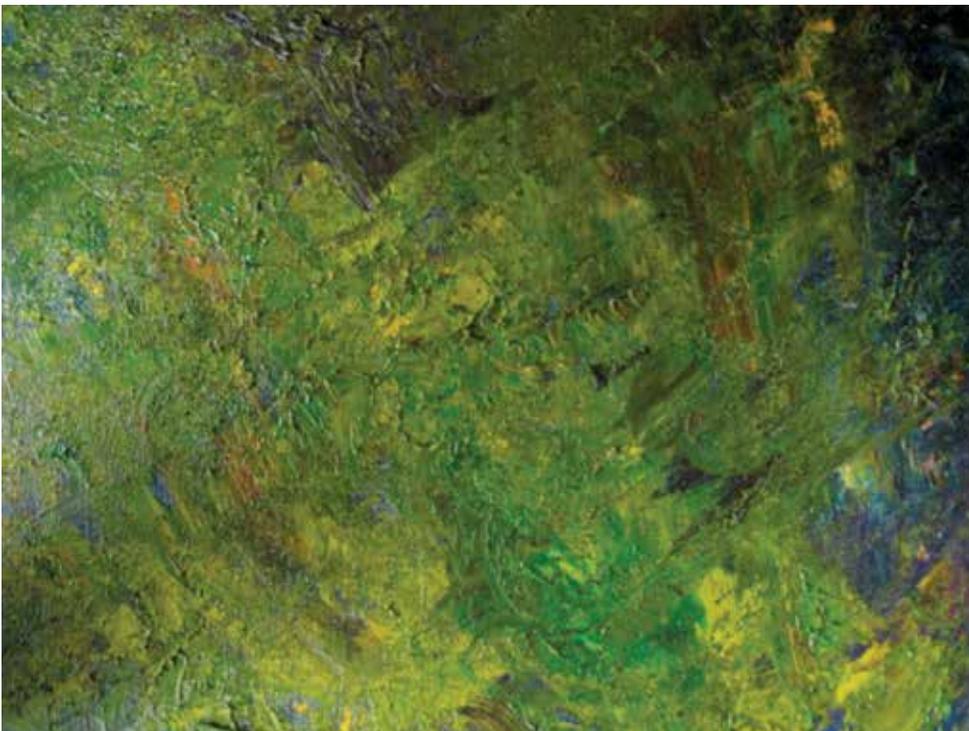
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The Regulation Hypothesis:
A framework for focusing on self in treatment with emerging adults

Harold K. Bendicsen, LCSW, BCD
Winner of the Yellowbrick Emerging Adulthood Paper Prize

Editorial Introduction. Harold Bendicsen has practiced psycho-analytic psychotherapy for over 30 years. He co-authored the *Guide to Psychoanalytic Developmental Theories* (2009) as a resource for current students receiving their training in an era dominated by a cognitive-behavioral lens and biological psychiatry. Throughout his work he emphasizes the value of using the developmental approach in therapeutic work that requires differentiating typical from atypical behavior, feelings, and thoughts. He is particularly known for his specialization in treating children and adolescents. In his 2013 publication, *The Transformational Self: Attachment and the end of the adolescent phase,* Bendicsen articulated a developmentally-informed psychoanalytic model, *Regulation Theory,* which describes a set of interdisciplinary developmental processes that uniquely contribute to the emergence of the critical maturational marker delineating the adolescent phase from young adulthood. Once born, the Transformational Self is used by the emerging adult to establish self-sufficiency. In this current paper, Bendicsen expands his work on Regulation Theory, providing readers with an in-depth analysis of a case study of Myles as he matures, participates in treatment for a range of psychiatric symptoms, and makes progress in his recovery from his complex condition that began in mid-adolescence and continues to the present at age 24.

Case Study: Myles

Treatment with Myles took place in two phases. The first phase lasted two-and-a-half years, beginning when Myles was half way through high school, ending abruptly six months after graduation. The second phase began eleven months later and continues to date. Now in our fifth year of work together, Myles has just celebrated his 24th birthday.

Phase one: Late adolescence

Myles was referred to me in his sophomore year by his high school counselor who believed Myles was experiencing a series of delayed negative reactions to his parents' divorce. The divorce had been finalized several years prior when Myles was 13 and just beginning 7th grade. His older sister by six years was a senior in high school at that time. Myles' developmental history was relatively unremarkable, characterized by average, expected family experiences. His sister was developmentally on track and achievement-oriented. At the time of the divorce, both parents were employed in different fields. Their work had allowed them to establish an upper-middle class family lifestyle. Both parents were free of mental illness. On each side of the extended family there were relatives struggling with Axis I mental disorders.

The shared family event that defined Myles' parents divorce was not the legal finalization of divorce, but rather the day his father suddenly moved out of the family home. By all accounts, Myles took the news of the separation and divorce harder than his sister did. Myles remembers his father gathering the children on a holiday weekend saying he had an important announcement to make. The children, sensing something ominous, sat on the stairs connecting the second floor bedrooms to the ground floor of the house. Myles' father and mother were in the adjacent living room. Myles's father explained that he was growing increasingly unhappy and he was tired of being married. He shared his plans with the children, telling them that he was going to move out, live alone, and sort things out. Myles' mother seemed resigned to the news, sadly saying, "I can't change your father's mind." Prior to this announcement, Myles had no awareness of any difficulties between his parents. He felt shocked and recalls being stunned into silence. His sister reacted quite differently. She peppered her father with questions. Soon after his announcement, Myles's father moved out. Myles didn't have any additional discussions with his father or any family member about his parents' divorce.

Two years after the initiation of the divorce, Myles entered high school. He felt adrift during this transitional year. His interest in school waned and he began experimenting with marijuana. He played on the basketball team, but then dropped out. Throughout these years he maintained his long-term interest in music. Specifically, he played drums in a band. By now, his sister was off to college, leaving Myles and his mother in the family home during the months when the divorce was finalized. To Myles, at that time, it seemed to him that his father made choices to engage in his new life and to avoid his former family. The music scene offered Myles a place to belong. There he experimented not only with music, but also with drugs.

Toward the end of his freshman year, one of his teachers noticed a certain sadness in Myles' demeanor. Myles had lost interest in getting good grades and changes in his peer group were noticeable. This precipitated a referral to therapy but not an immediate start. Late into his sophomore year (at age 15 years, 10 months) Myles and I began weekly therapy. Myles' depression was obvious. He formed a solid therapeutic alliance and used the relationship in a substantial way to come to terms with the divorce.

I met with Myles and his parents once a month. The parents remained cordial and dealt with each other in an amicable manner, both placing the welfare of Myles first. With his sister off to college and work, she did not attend any of the family therapy sessions. In family therapy, Myles found his voice and specifically reached out to his father and experienced an improvement in their relationship. Myles' father upheld his financial obligations to his family and gradually became a dependable figure to Myles. Myles achieved expected developmental milestones and took on increasing responsibility. He obtained his driver's license and demonstrated that he was a careful driver.

Myles' band grew to central importance in his life, giving him a sense of belonging and defining him within his peer group. Even though Myles was the youngest member of the band he was one of its strongest leaders. He helped arrange gigs, composed songs, and played the drums. Myles proudly described his role in his band, *"I keep the rhythm."* This was the first self-referencing metaphor he used. With this metaphor, he referenced both his contribution as the one who maintained the musical rhythm and also as the one who served as the glue that held the band together.

Consistent with his age and developmental stage, Myles made bids for and negotiated increasing autonomy. A few moths after passing his driver's test, Myles wanted to take the family car to haul band members and equipment to a gig some 100 miles away. Both parents balked. One reason for his parents' hesitation to allow Myles to drive himself and his band-mates to the concert was—in addition to his new driver status—his parents' anticipation that Myles and his friends might use drugs at the event. In working toward a solution, Myles' father offered to drive the group. Myles defiantly declined his father's offer to drive them, worried about the perception of needing to have a babysitter. After extensive discussion a compromise was reached. Myles' father drove the group, but did not attend the performance. He agreed not to and did not supervise the group, nor did he observe them while they were at the event. This solution was judged successful by all involved. Myles and his father had the opportunity to recognize this as a turning point and a strength of their relationship. They learned they could find common ground. Myles, in particular, recognized his father's willingness and ability to support his son's autonomy strivings.

Six months after graduation from high school a complete surprise occurred. Myles abruptly, and without explanation, stopped attending therapy. The reason for this discontinuation of therapy was not revealed until we began a second phase of therapeutic work.

Phase two: Post high school

After 11 months had passed, Myles (at age 19 years, 2 months) called and asked to resume therapy. Upon his return, I learned that Myles had withdrawn suddenly from treatment because Myles' father believed Myles had experienced enough help and that he should have, by that time, been able to "stand on his own two feet." When Myles stopped attending therapy, he believed his father was instructing him to stop attending immediately. According to Myles' father, he had wanted Myles to (1) begin a discussion with me about what further gains could be expected from therapy, and (2) initiate a conversation about what the termination process might look like.

When Myles re-established therapy, he was depressed and his functioning was severely impaired. During the first year after high school graduation, Myles had taken a course at a local junior college. He struggled to learn in that course. He found it difficult to read and absorb the material. He enrolled in an online course. But he found that particularly difficult. During this same year, he also experienced significant frustration searching for a job. After what felt like an exhaustive search, he was offered a job as a sales clerk in a large home improvement chain store. Feelings of competence at work eluded him. He worried that he would be terminated if he failed to perform up to the level expected of him.

In addition to managing school and work-related stressors during this transitional year, Myles revealed that he had difficulties with his vision.

Furthermore, he disclosed that he had been experiencing severe, disruptive visual problems since sixth grade and that the visual symptoms had gradually worsened. This admission meant that he had concealed a significant, debilitating symptom from me and his family throughout the entirety of the first phase of treatment. His explanation for not telling anyone about his vision problems was that he did not want to burden anyone.

When asked for additional information about his history of visual problems, Myles explained that by his freshman year of high school, before he and I started our work together, the visual symptoms had noticeably progressed and then had stabilized to a constant level that persisted throughout his high school years. According to Myles, his visual symptoms consisted of a fixed set of horizontal wavy lines, in an amplitude configuration, parallel to each other. The pattern never abated, but it was broken when looking at a face or a moving object such as automobiles in traffic. Without apparent trigger the pattern of visual snow, as he had come to know it, could intensify to an opaque blur of static. He experienced fear and terror when these visual disturbances emerged. To Myles, this condition was terrifying. Dealing with his visual symptoms and managing his depressive symptoms every day contributed to him feeling depleted and exhausted.

After Myles disclosed his visual symptoms, he engaged in a series of consultations with various medical doctors and underwent numerous tests including, but not limited to: eye examinations, an EEG to rule-out seizure activity, a brain scan, a sleep study, neuropsychological testing, and an evaluation by a neuro-ophthalmologist. Testing indicated that Myles was suffering from a number of atypicalities that may have been contributing to his visual symptoms. Results from his sleep study indicated that Myles would significantly benefit from a tonsillectomy to improve a restless sleep pattern. That procedure was successful. Testing showed that Myles met criteria for depression. Therefore, antidepressant medication was prescribed. However, after starting antidepressants, Myles' depression deepened. Meanwhile the visual problems persisted without a known cause. Despite taking responsibility for scheduling his own appointments and following through on recommendations, Myles grew frustrated and disappointed while an explanation of his symptoms remained elusive.

After approximately eight months of seeking expert opinions and undergoing extensive testing, Myles' symptoms progressed and intensified resulting in a new, qualitative state of disruptive panic and terrifying, out-of-control behavior. Myles experienced serious suicidal thoughts, a mixture of severe depression, crippling anxiety, frank hallucinations, and eventually, a devastating collapse. At one point, Myles believed he was being followed and that people were calling out his name behind his back. This first severe episode led to his hospitalization that lasted three days. At that admission, he was diagnosed with schizophrenia and suicidal depression. Myles found this intervention to be intolerably unpleasant and he insisted that he be discharged. He vowed to never enter another psychiatric unit.

This initial episode prompted me to refer Myles to a biological psychiatrist. This consult resulted in confirmation of his diagnoses, schizophrenia and suicidal depression, and added to the diagnosis, 'with possible bipolar features.' At a later date, Myles' diagnosis was changed to schizoaffective disorder with bipolar involvement. After his diagnoses were confirmed and refined, the biological psychiatrist began trial exposure to a wide variety of psychotropic medications. Different chemical

combinations were tried in an attempt to stabilize his condition. At this point, Myles was severely dysregulated. He found it extremely difficult to concentrate. He struggled to continue to drive. Previously proud of his good driving record, within a relatively brief window of time, Myles had three accidents in which he hit the curb, requiring replacement wheels, but managed not to hurt himself or anyone else. He took these accidents seriously and worried about his ability to return to the autonomous life-style he had previously attained. Others in his life grew anxious as well during this period of time when his functioning was compromised.

As he was attempting to gain control and manage his symptoms, he cycled through a range of highs and lows. He experienced improvement followed by deterioration. At his worst, he experienced intense episodes of depression, anxiety and auditory hallucinatory activity, and powerful suicidal thoughts. During his daily activities he encountered unanticipated triggers. For example, while uncrating inventory, Myles became fearful he would cut himself with a box cutter. He left work when this happened. Subsequently, attempts to return to work were unsuccessful. Due to interference of his symptoms at work, he secured a paid, four-month, short-term disability leave.

During this time, Myles moved in with his mother. Soon, however, he began to feel unsafe and vulnerable. Fearful he would overdose or cut himself, he went to his father's home for protection from himself. His father reassured Myles and slept in the same room with him. This arrangement provided Myles with a much-needed opportunity to restore himself. Yet his fluctuating condition and concern for his safety prompted two additional consultations for psychiatric re-hospitalization; both were found to be unnecessary by the admitting doctors. The attending physicians concluded that the support system Myles had in place, given his present circumstances, was sufficient to help him manage his recovery.

Therapeutically, Myles' treatment goals were structured and informed by a five-part wellness plan that assigned specific responsibilities to Myles, his mother and father, and his treatment team (i.e., his therapist, psychiatrist, and various medical practitioners). The overarching goal of the wellness plan was to help Myles self-regulate. Specific objectives of this plan expected Myles to comply with a safety agreement; make efforts to set and attain job and educational goals; focus on building and maintaining relationships; identify and participate in recreational activities; and improve his self-care (e.g., exercise, healthy diet, self-groom, and regulate his sleep/wake cycle). Family sessions proved vital during this period, as did twice-weekly psychotherapy sessions. Myles' father accompanied him to his medication management appointments and monitored the consultations to ensure that the psychiatrist had a full and accurate account of the effects of the medication. Both parents communicated and cooperated well during this difficult period.

At about the 15-month mark, two significant events occurred. Myles received a final interpretation of his visual problems. His eye condition was determined to be an unusual feature of a schizophrenia-spectrum disorder. Myles' reports that area rugs and hanging pictures in my office could rotate, combined with the optic, wavy lines suggested a rare visual neurological/hallucinatory process that eventually was labeled "chronic, atypical visual distortion." Second, the medication cocktail Myles was trying at that time resulted in a significant reduction and stabilization of his symptoms. Myles was prescribed Lithium for bipolar symptoms, Zoloft for depression, Fanapt for psychosis, Busperidon for anxiety, Klonopin for sleeping, and Cogentin for neurological side-effects (e.g., body tremors). Since, Myles has been able to work actively and collaboratively with his psychiatrist to monitor the effects of the medications

and adjust accordingly. Myles' mother supervises the administration of the medication and assures that supplies are adequate.

Myles' condition has remained stable for the past four months. He has made significant progress with respect to the goals of his wellness plan. He has become more self-regulated. While still very tired, he has resumed a more normal sleep pattern. Auditory hallucinations and the rotating objects have abated. On a self-rating scale from 1 to 10, with 10 being the worst, depression has remained between 3 and 4, with no suicidal thoughts; visual distortion has remained a steady 5, with no hyper-static intrusions. Auditory hallucinations have retreated and have remained between 0 and 1. He has found recreational activities he enjoys. Myles plays tennis and golf with his father and goes on occasional outings to major sporting events with him.

How has Myles found the resilience to persevere and improve his quality of life? He has accepted that he will need to develop compensatory mechanisms to balance-out or offset a triple handicap: (1) the full impact of his complex condition, (2) visual impairments, and (3) side effects of his psychotropic medications. Recognizing he cannot accommodate the classroom situation and the academic demands for studying and reading, he has invested his focus and energy in work. In this highly competitive environment, Myles frequently met or exceeded his weekly sales goals or metrics. He was committed to engaging with customers and took satisfaction in surpassing the productivity of his fellow sales associates.

In month sixteen, with considerable relish, a second self-referencing metaphor materialized; he labeled himself the "*top dog on the floor.*" Myles achieved notable success at his job and was recognized as the lead for a promotion to a management-level position. This higher-level job would require him to circulate through all departments, giving suggestions and encouraging floor personnel in an effort to enhance sales. While slumping sales have delayed his company from officially making a promotion to this position, Myles remains optimistic about his prospects. In his annual review he received a rating of A-. He has maintained a regulatory type of relationship with his girlfriend, Cindy, who is pursuing a university degree and is a reliable, calming self-object. Cindy also monitors Myles' cigarette and alcohol consumption and helps to keep him at the level of smoking a half-pack-a-day and drinking a few beers on the weekend, respectively.

Reflections on Myles' treatment

At this writing, we are in the fifth year of Myles' treatment. I see Myles twice a week for individual therapy. The vicissitudes of the treatment process have been highly varied, intense, and unpredictable. Myles has managed numerous challenges through two phases of treatment. He has done well through the challenges he has faced. It is a pleasure to know he now considers himself *"top dog in the store."*

Reflecting back, the first phase of treatment, with the exception of the abrupt ending and concealment of the visual distortion, could essentially be considered successful along traditional lines of goal attainment. Myles became fascinated with his dream life and used his dreams to understand better his internal life with considerable satisfaction. Myles reconciled his parents' divorce, worked through the loss of a romantic relationship, developed an internal motive for learning, restricted his peer relationships to healthy friendships, invested in a band with some success and graduated with a determination to engage the next phase in his life.

When Myles abruptly terminated therapy, this was unexpected and inconsistent with Myles' rather consistent character. I recognized that I was not only puzzled, but also dissatisfied with the abrupt ending. I wondered: *should his unilateral termination be interpreted as an expression of an autonomy striving, fear of withdrawal of support from the father, an unconscious repetition of his father's withdrawal from the family during the divorce, an acting-out of ambivalence toward the treatment, or something else altogether?*

In the second phase, treatment goals shifted to enhancing and facilitating increased self-regulation. External supports were put in place along with a suicide prevention and intervention plan. Myles was made aware of supportive treatment elements; specific responsibilities were assigned to both Myles and his parents and his treatment team. Within the first fifteen months of the second phase, the disease process erupted. Treatment circumstances during these times were exceptionally fluid and turbulent. Profound sadness overtook me, his therapist, due to feelings of uselessness and inadequacy. The suffering Myles was experiencing could not be articulated and I felt unable to actively help.

As we grew to know the nature of his disorder and it stabilized, it seemed to me, Myles, and his parents that his condition could be managed. Sprouts of hopefulness began to emerge. Issues that received the most attention were: 1) the need to stay self-regulated (i.e., keep medical and therapy appointments, get to work on time, take responsibility for self-grooming, etc.) and 2) manage anxiety associated with work. Continuing his education, at that point in his life, was interpreted and respected as an unrealistic goal that had significant potential to put his health in jeopardy. He was, however, able to commit to his job and build his core identity around his work. Myles' self-esteem and self-confidence increased commensurate with his job success. He established relationships with reliable others who helped him to stay regulated. These persons served as vital self-object experiences that helped modulate intense, fluctuating affect states; cushion his frustration; bolster his battered self-esteem; and demonstrate that he was lovable and cherished. The limits of his improved coping strategies and skills were tested, but remained in place as his condition fluctuated.

Resistance to twice-weekly treatment grew and we negotiated reducing the frequency of individual therapy from twice to once per week. This lasted for, perhaps, three months when twice-weekly sessions resumed. At that point, Myles reported that he was feeling better and felt more confident that he could successfully manage his life more independently. After we again agreed to weekly sessions, Myles' participation in treatment improved. His dedication and felt competence related to his awareness of being up for promotion was interpreted as a sign of remarkable progress, a powerful testament to his initiative, his relationship skills, and confirmation of his resilience. *Might this be a repetition associated with the autonomy strivings Myles successfully tested during his negotiations with his parents about driving himself and his band-mates to the concert?*

Interpretation of Myles' case using Regulation Theory

Regulation Theory is an overarching framework specifically useful for interpreting cases, such as Myles', using a developmental lens. One strength of Regulation Theory is that it unities multiple, interlocking theoretical systems. Each model makes a unique contribution to understanding how developmental history informs the developmental work of an individual as he or she progresses from adolescence through the transition to adulthood in an effort to give birth to the Transformational Self (Bendicsen, 2013, p. 196). This developmental algorithm is constructed from seven overlapping and complimentary domains of knowledge: 1) modern, embodied metaphor theory; 2) attachment theory; 3) self psychology; 4) cognitive psychology; 5) contemporary, psychoanalytic developmental psychology; 6) complexity theory; and 7) neurobiology with narrative theory. In the final section of this paper, I describe these seven elements and discuss how each guided my interpretation of Myles' treatment needs and informed Myles' treatment.

Regulation Theory: A guide to case formulation

1) Modern, embodied metaphor theory

The spontaneous emergence of the self-referencing metaphor, "*top dog on the floor*" is a significant event in both Myles' development and treatment. Classical metaphor theory locates metaphor in words and language. Modern metaphor theory, in contrast, draws on neurobiological research findings, pointing us to interpret metaphors in the context of brain-body connections (Lakoff & Johnson, 1980; 2003). Modern metaphor theory views self-referencing metaphors as reflections of an embodied process that informs personality tonus (Blos, 1962, p. 129). Specifically, with respect to the adolescent, these metaphors describe the individual's view of himself on the horizon, in the context of the potentials and possibilities of adulthood.

Different from classic conceptualizations of personality development during this developmental era (e.g., Blos), modern metaphor theory does not assume that healthy adolescents rely on intrapsychic angst to propel the reconfiguration of personality. Rather, modern metaphor theory introduces the concept of "transformational readiness" as the pre-requisite for reconfiguration of the self. Transformational readiness appears when self-doubt and inaction is replaced by a sense of possibility and confidence in one's action potential (Bendicsen, 2013). In Myles' case, his secure attachment heralded the arrival of a self-referencing metaphor that, in thematic content alone, indicated he had made advances and that more growth and progress could be expected.

2) Attachment theory

Freud and his ego psychology followers looked upon an adolescent's independence as a maturational goal. This traditional notion—that the end of adolescence ushers in a state of autonomy—is no longer accepted. Processes such as separation-individuation (Mahler et al., 1975) or the second-individuation (Blos, 1967) imply a need for independence from one's family-of-origin. These working assumptions are now generally considered biased, reflecting Western culture's emphasis on individualism over collectivism.

An updated view of the underlying process that shapes conversion of the dependent self into the adult self is captured by the concept, "attachment-individuation." That is, late adolescents and emerging adults thrive when they remain connected to family and establish intimate peer relationships calibrated to enhance individuation strivings. Myles, having the ability to draw on secure attachment, has the capability of making progress toward connected individuation and a nuclear self. His recovery was fueled by his deep involvement in a mutually supportive network of functional family relationships, others that are there for him in crisis.

3) Self psychology

Kohut (1959, 1966, 1971, 1977) and colleagues rejected specific elements of ego psychology and introduced an alternative theoretical framework for describing the way self-other relationships transform in healthy individuals during the transition to adulthood. A self-object is any narcissistic experience in the which the other (e.g., a caregiver) exists in the service of a developing self (e.g., the child). Self psychology specifies three sets of developmental needs self-objects serve: affirming and admiring; safety, regulation and soothing; and commonality. Each set of needs corresponds with a separate developmental mechanism that enhances or detracts from an individual getting his or her developmental needs met via transference, respectively: mirroring, idealizing, and twinning (or alter ego). These three processes contribute to the three dimensions of the tripolar self.

Theories of self-object transformations focus on the salient role of caregivers at all stages of the lifespan. In general, self-objects are never outgrown but optimally change in accord with developmental needs (Palombo, Bendicsen, & Koch, 2009, pp. 257-281). Self-object experiences cradle an individual's subjective experiences in the world via embodied processing, categorizing, and meaning-making of experience. Myles' "condition," as he labeled it, is managed through the continuous construction and reconstruction or stabilization and restabilization of his self as his condition fluctuates. When his condition intensifies, the threat of fragmentation of the self leads to a desperate search for dependable self-objects. This search is experienced as a counterweight to possible behavioral enfeeblement and terrifying disintegration anxiety. Modulation and regulation of this anxiety becomes the essential therapeutic task.

4) Cognitive psychology

The level of cognitive development typically associated with late adolescence, formal operational thought, has been replaced by a new stage of development now associated with emerging adulthood, post-formal operational thought (Piaget, 1962, in Bendicsen, 2013, pp. 133-147). Piaget's original conceptualization of his stage model of cognitive development described differences between age groups based on averages. Advances in theory of cognitive development focus on intraindividual maturation, more clearly demonstrated through single case study design. In this way, the multiple dimensions of cognitive ability can be considered in the context of the individual's functioning. For example, when Myles' condition is stable and non-refractory, it is clear he has above average intelligence that he can harness in the service of optimal functioning in the competitive world of retail sales. Because this skill set is organized around verbal relationship interaction, he can experience success. However, his visual disturbance is so significant that it compromises traditional learning which relies on reading comprehension.

5) Contemporary, psychoanalytic developmental psychology

Contemporary, psychoanalytic developmental theory is heavily indebted to the work of Greenspan and Shanker's (2004) lifespan developmental model. The Greenspan and Shanker framework is grounded in an evolutionary context that is sympathetic to nonlinear developmental dynamics and attachment theory. Philosophically, it is non-teleological and non-deterministic. It is primarily informed by neurobiological research findings, the study of autism in children, and observational studies of infants (e.g., the co-regulation of emotional communication). Of significance, the framework privileges the interactive exchange of affects between caregiver and infant as the origin of communication. The co-regulation of emotional signaling organized through the gradual differentiation of dual coding of experience (e.g., the blanket is both smooth and pleasant) provides the key to understanding how emotions organize symbol formation, intellectual abilities and, indeed, the sense of self (p. 56).

Lichtenberg (and Hadley, 1989, p.372), based on extensive infant observations, postulated that there were five discreet motivational systems that are maintained in memory, mature epigenetically, and must be understood in order to fully understand human behavior. Each of these systems is based on innate needs coupled with associated patterns of response. They are the need for: (1) attachment and affiliation, (2) psychic regulation of early physiological requirements such as hunger, elimination and sleep, (3) assertion and exploration (4) reaction to aversive experiences through withdrawal and/or antagonism, and, (5) sensual enjoyment and ultimately, sexual excitement. Each of the five systems can develop only in the presence of reciprocal responses from caregivers (in Gabbard, 2014, pp. 55-56).

Contemporary, psychoanalytic developmental theories potently ground our interpretations of others' behaviors in universal principles of human needs and motivations, updated to give weight to relationships between the developing individual and caretakers. Myles, now able to access and utilize mature brain and neurophysiological processes, can begin to reflect on his own motivations underlying his behaviors and he can distinguish whether his expressions of self feel within his control or beyond his control. Myles can identify and seek solutions to meeting his needs. The "top dog on the floor" self-referencing metaphor speaks to the drive to dominate through competition, to master feelings of vulnerability through adaptive accommodation, to cultivate resilience, and to maintain narcissistic balance through mutual co-regulation of affect states.

6) Complexity theory

At this point, let us turn to Siegel (1999) and his ideas on dynamic self-systems. Dynamic systems are characterized by three features: 1) self-organizing properties; 2) non-linearity; and 3) emergent patterns with recursive characteristics. *Self-organizing* properties reference the notion that all humans develop from a state of simplicity to increasing states of complexity. Continuous movement toward maximum complexity promotes system stability, understood here as optimal neuronal connectivity. *Non-linearity* refers to the idea that system output is context dependent and, therefore, unpredictable. In other words, a small change in input (such as alterations in one's beliefs, emotions, and perspectives) can lead to disproportionally large behavioral changes. *Recursive* means that a given state influences the re-emergence of that state. Taken all together, this principle describes self-perpetuating, continuous movement toward differentiation and integration. In other words, the self as a dynamic adaptive system is always in a state of construction and reconstruction (pp. 217-222).

When Myles uses the "*top dog on the floor*" self-referencing metaphor, a new self-state, a different state of mind, is created. As different experiences are encountered, the stability of the self-referencing metaphor is challenged. This presents an opportunity for the self to reorganize and refine Myles' understanding of himself in relation to others.

7) Neurobiology with narrative theory

Myles' condition can be understood as a case of biological dysregulation involving hemispheric imbalance. Neurobiological research findings and narrative theory are joined to underscore the profound influence self-narratives have on neural networks. Cozolino (2010) links neural networks and narratives to an innate quest for self-integration. Central to the study of self-integration, two predominant information pathways have been identified: (1) top-down integration (i.e., cortical to subcortical and back again), and (2) left-right integration (i.e., across halves of the cortex). Biopsychosocial regulatory processes can now be organized into a unification of domains of knowledge and theoretical propositions I call the developmental algorithm. The complexities of Myles' condition and circumstances now can be understood through a more coherent perspective creating a more satisfying explanatory synergy.

In sum, Myles, in associating with the "top dog on the floor" metaphor, said, "I'm the best they've got." Myles has understood the reality of the past, measured himself in the present, and has located himself in the possibilities of the future. Myles' capacity for mutual recognition among a host of subjectivities is accompanied with a keen sense of differentiation among the ownership of feelings and those that are shared. If his condition deteriorates, this capacity will certainly worsen. The secure attachment he experienced as a child, linked to the openness of the self-referencing metaphor he has chosen, now serves as a vital underpinning for further growth. Myles will need every measure of his narrative strength as he struggles to stabilize and manage his mental health.

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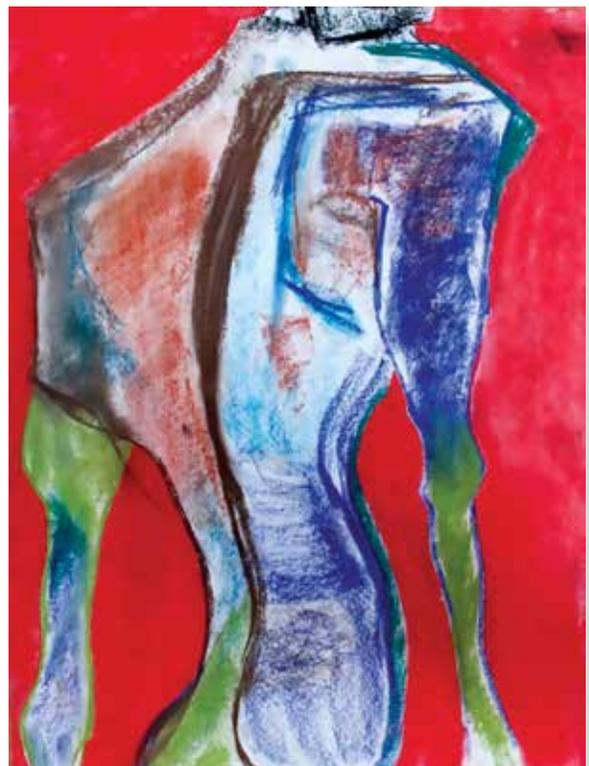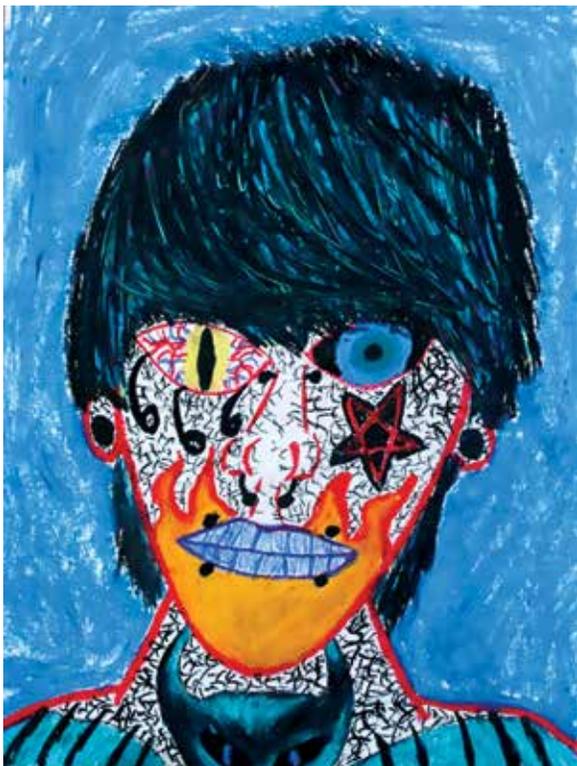
White Coats–Gray Beards: Thoughts on medical education

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The study of "embodied cognition" suggests that we think with our bodies as well as our minds. Decades ago we learned that test subjects reported improved attention and focus when wearing a doctor's lab coat. It's as if the white coat itself holds transformative properties. I reflected on this principle of human behavior when I recently attended my grandson's White Coat Ceremony at Tufts University School of Medicine in Boston, Massachusetts where he, along with his class, was bestowed a white coat to commemorate their initiation into "doctorhood." Over half-a-century prior, in 1954, I graduated from a midwestern medical school, Northwestern University Medical School in Chicago, Illinois. After a rotating internship and a surgical residency, I practiced medicine in a variety of positions at an assortment of hospitals, some private, some public, and some academic. I am now an octogenarian. I practice part-time. I have a gray beard (which I keep closely shaved). While honoring my grandson as he began our shared adventure, I could not help but reflect on the differences and similarities in our medical educations. Let me share some of these impressions with you.

In the first place, I did not have a White Coat Ceremony. There was really no need for one. During my training days, the first two years of medical school were didactic, reflecting the recommendations of the Flexner Report (Duffy, 2011) published over one hundred years ago. These guidelines dictated that we would spend two years training in human anatomy and physiology. Our training consisted of daily lectures and labs. We had many written examinations that, early on, established class standing. Patients were kept at a distance, promised for our third and fourth years that were spent doing clinical work in a teaching hospital.

Current medical education programs, especially at prestigious institutions such as the one my grandson attends, introduce simulated patient contact in the first month and primary care apprenticeship in the second year. To liberate students from anxiety concerning grades, evaluations are pass/fail for the first two years of their medical education. Contemporary pedagogical style is designed for the digital generation. Medical students are challenged to assimilate an outrageous mass of material. Research literature and scientific information is accessible without bounds via the internet where information is exchanged and updated 24 hours a day, 7 days a week. Some topics (e.g., genetics) change as they are taught. Students are expected to connect topics and cross disciplines to find solutions. They attend classes to problem-solve in small groups, sometimes under the guidance of syllabi that collate and condense relevant text via virtual microscope programs, simulations, and other virtual programs. During my matriculation there was, of course, none of this. We did not have models on which to work. We practiced subcutaneous injections on thin-skinned oranges or on ourselves.

There have also been cultural changes. My class of 135 students had six women. Preparing for a career in a male-dominated profession, we were unabashedly politically incorrect, labeling our female peers "hen medics." Women doctors went into anesthesia or pediatrics and seldom, if ever, into the surgical specialties; obstetrics and gynecology on rare occasion. Over half of my grandson's class of 204 students is female and they anticipate their choice of specialties when it comes their time to match. Today's medical schools include international students of every race, religion, and ethnicity. There was not a single person of color in my class.

Both my grandson and I chose to train to become physicians. I felt and he feels a strong vocational imperative to remain human while practicing medicine. To do so, a doctor must focus and be in the moment to access himself. Realizing the importance of this, my grandson's class is formally taught techniques of mindfulness; my colleagues and I had to intuit this, pick-it-up on our own. However, training a balanced, wise, and compassionate doctor is not an easy task, nor is nurturing an inquisitive and creative mind. My grandson is challenged to maintain his humanity in the face of increasing bureaucratization of medical practice which contributes to the fragmentation and depersonalization of patient care.

What I had to learn and what he has to learn is that to fully tend the sick, a physician must know what it is to be sick. This requires drawing upon experiences of pain, fear, and anxiety. What we see in another is just another way of looking at ourselves. Seeing ourselves in the other refines a healer's touch and judgment. The ability to do this transcends empathy. In contemporary medicine, there is a relentless effort to make physicians 'healthcare providers' and patients their 'clients.' Yet my grandson's credo remains the same as mine, our work as physicians is guided by the Hippocratic Oath not The Wealth of Nations (Smith, 1776).

My grandson's class recited a modern version of the Hippocratic Oath at their White Coat Ceremony. There was no mention of "not cutting for the stone reserving that affair entirely to the surgeons," but their recitation admonished the act of failing to call in colleagues when the skills of another are needed for a particular recovery. Both versions noted sharing one's knowledge with those who follow and respecting a patient's privacy. It is reassuring to see that such ethical precepts endure.

The practice of medicine has indeed changed a great deal. I entered medicine at the beginning of the era of antibiotic therapy. Today, physicians are working toward treating disease by genetic manipulation.

And yet things have not changed at all. There are many skills we still cannot teach but instead just have to learn. A patient evaluation is still a procedure requiring no less skill than an operation. A well-conducted examination is therapeutic. The most cogent way to relate to a difficult patient is through the persuasion of compassion. It is even sometimes advisable to take off your white coat, as when examining an anxious child.

Formal medical education, neither then nor now marks an endpoint. Rather, medical school can only get you ready to learn, prepare a physician to strive for excellence, and teach doctors the value of reinventing your authentic self every day of practice.

Every time you put on your white coat.

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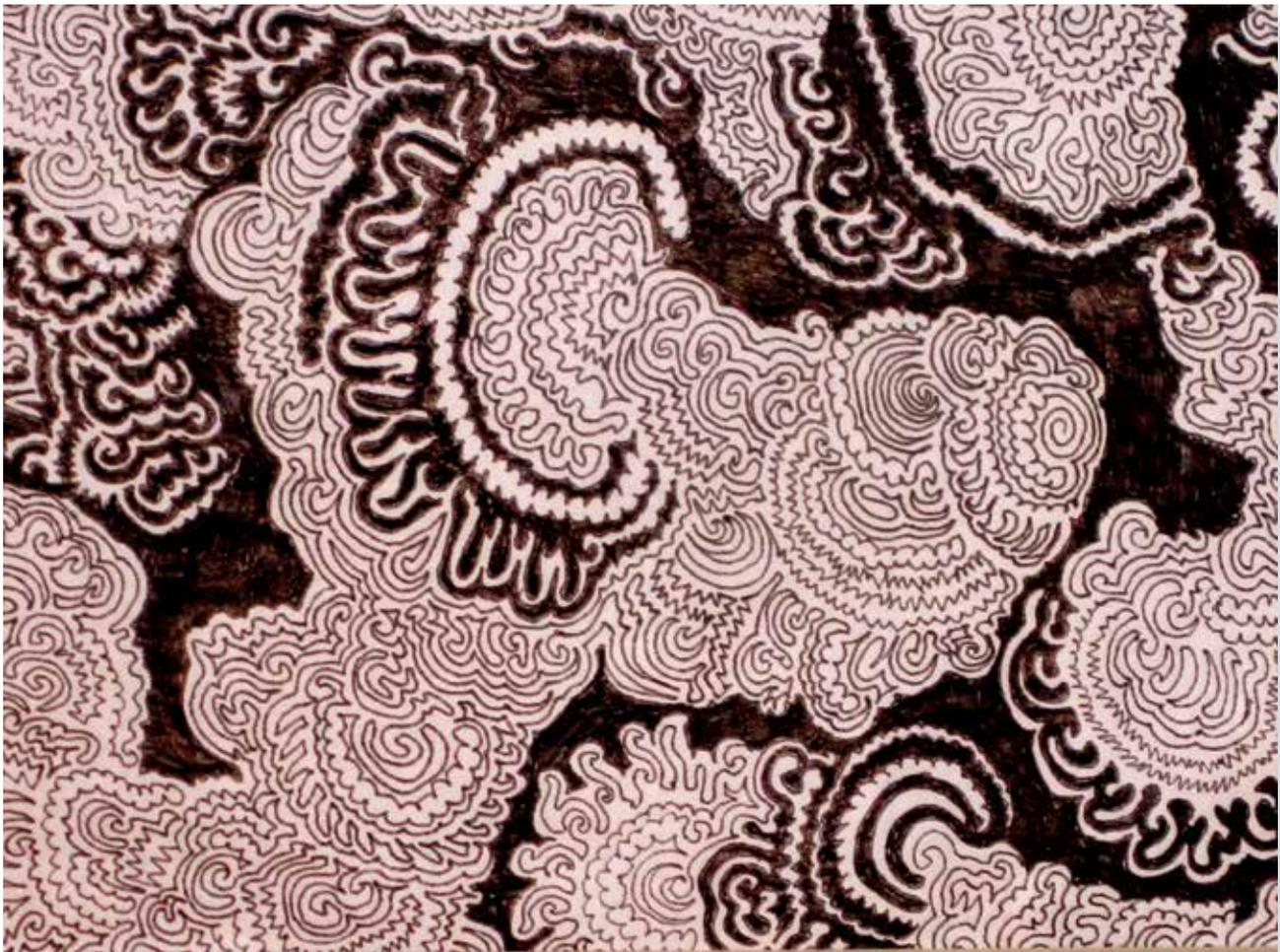
Into The Future: A challenge to lasting change in the treatment of distressed emerging adults

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Anticipating and experiencing an unfolding of self in both the occupational and interpersonal worlds represents a central developmental task of emerging adulthood (Arnett, 2000; Schulenberg & Zarrett, 2006; Tanner & Arnett, 2009). A key feature of this phase is a sense of possibility (Arnett, 2004; Schulenberg et al, 2004), the underlying belief that the roles, tasks and relationships of adulthood will eventually emerge in a reasonably hoped for fashion. For emerging adults who have known a past filled with deep dysfunction and damaging reactions to efforts to express themselves, however, the kind of future where there can be genuine and safe self-expression and self-discovery can seem unimaginable. This difficulty in imagining a hopeful future poses a powerful challenge to the process through which change can be launched via the kind of intensive psychotherapeutic services offered at Yellowbrick.

The treatment course of the severely distressed emerging adults who bring themselves to Yellowbrick follow a basic trajectory toward establishing or re-establishing a hopeful future. This trajectory is similar to one observed by Werbart (1995) in his review of a program with a similar psychodynamic approach. A first phase entails the use of therapeutic structure and support to regulate the experience of self enough to curtail the severely pathological behaviors that had been used as self-expression up to the point of admission. Once regulated enough to entertain observations about behavior patterns, a second phase of treatment for these emerging adults entails developing and refining a therapeutic dialog about the underlying dynamics behind their patterns of relating. In this phase, a basic sense of self-observation and self-understanding is developed, even at times a self-analyzing capacity. The focus of treatment then becomes leveraging the therapeutic gains from the first two phases in the service of creating and sustaining new patterns of interacting with others and of initiating productive activities such as school or work. There are significant challenges inherent in this final phase, for both patients and treatment staff.

We have observed two basic trajectories followed by those patients who bring their treatment into this final phase. The first represents patients who make a reasonably successful transition into and through the phase, utilizing new patterns and self-understandings to reimagine their life trajectories to hold possibilities that they previously had been unable to approach. The second trajectory represents patients for whom this kind of transition stalls stubbornly. At times

the stall is expressed in the form of a determined avoidance of further treatment, frequently to the point that the patient ceases to attend treatment, defying efforts to reach out and sustain the connections that have been established during the earlier two phases of treatment. At other times, the obstacle takes the form of an aggressive, even assaultive attack against the treatment, using behaviors that are not only self-destructive, but that beg rejection in the form of discharge from treatment. In these expressions of resistance to further change we see the difficulties confronting efforts to help emerging adults redirect lives that have become derailed, often dangerously so.

The case of William will help illustrate the challenges and the efforts we have made to help a treatment move past them. William is a composite patient, drawn from the characteristics of actual patients, partly in an effort to protect anonymity and partly to help highlight the issues. William is a twenty-six year old man who, after several failed treatments, was admitted to Yellowbrick after detoxing once again from dangerously heavy and frequent alcohol use. After completing two years of college with poor performance, he worked sporadically at part-time menial jobs that made scant use of his strong intellectual and social capacities. William spent most of his time drinking alcohol in the basement suite of his parents' home, occasionally snorting cocaine. This living situation enabled the continuation of a dynamic in which he was depreciated by his parents as a ne'er-do-well, especially in comparison to his two academically and professionally successful older siblings. William developed a refusal to apply himself in middle school in part as a protest against what he experienced as his father's misattuned expectations, which were often expressed abusively, and in part to demonstrate anger at his father's regular alcohol use.

Although clearly desirous of finding a new path for himself, William entered treatment with debilitating cynicism. He regularly slept through morning programming and resisted with hostility the efforts of Core Competence Staff (CCS)* to help him structure his sleep/wake cycle and morning routines. Even after waking, he often missed later programming, isolating himself in his room. When he was present in groups, he remained silent, except for occasionally lashing out against peers who endorsed the benefits of treatment. He was more participatory in individual therapy, although his general approach was to argue cynically against the utility of a therapeutic alliance to help him through his deep anger, pain and skepticism about a viable future.

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*Core Competence Staff (CCS) at Yellowbrick support patients in a broad array of adaptive living skills as well as assist with distress tolerance and emotion regulation. They are typically master's level professionals who provide the foundational day-to-day treatment structure, staffing open living apartment where two-thirds of our patients live, yet which serves as a touch point for nearly all of our patients.

Drawing on an underlying desire to find productive autonomy that his cynicism had hidden from others and himself, William tentatively began to embrace the support, containment and structure provided by CCS. He began to use group and individual therapy more openly and readily. Therapeutic interventions targeted his use of refusal and isolation as expressions of anger and power. These interventions were at times backed by the setting of administrative boundaries (e.g. attendance expectations) past which his treatment would not be considered viable. The interventions as a whole helped William find the resolve to bring himself to life, even if with some resentment. He became a more regular presence in the peer community; he became more open to the support of his peers and developed a useful voice in group therapy venues, albeit retaining a signature cynical gruffness and intolerance for what he perceived as emotional dishonesty.

Overall, then, William passed through the first phase of treatment, using the therapeutic structure to contain his raging passivity and began to participate as a functioning member of a community. This containment opened the space for William to develop an increasingly honest and sophisticated psychotherapeutic dialog about the underlying dynamics behind his self-destructive approach to life, once expressed through severe alcohol use. He began to articulate the aspect of his disengagement that was directed at his father as an expression of the power he did not feel he was allowed to develop more legitimately as a child and adolescent. Thus, William embraced a second phase of treatment, developing self-understanding and self-compassion, allowing him to engage in more open dialog with both peers and therapeutic staff to express his struggles in words rather than actions.

In the context of thetherapeutic gains from these two phases of treatment, William began to embrace important aspects of overcoming addiction, such as developing a sober friendship group and attending support meetings. Safely off of alcohol, he could experience emotions more directly. He enrolled in a course at a local university, an act of great courage given his history of being devalued and derided by his father for his dismal school performance. With the continued financial support of his parents, he moved into his own apartment, taking a new friend as a roommate. He planned to find part-time work as well. William thus brought himself to the doorstep of deep and lasting change. His treatment at that point hit a roadblock that is important to explore in understanding key challenges to ushering distressed emerging adults toward a more viable life path.

In the psychoanalytic literature, the concept of the "psychic future" has been invoked to conceptualize the process through which change occurs in psychoanalysis (Brusset, 2012; Cooper, 1997; Loewald, 1960; Summers, 2005). Although literature on the concept lays out many subtleties and technicalities, it suggests that, in the change process, there is an interplay between the analyst's vision of a new future for the patient and the development of the patient's own vision of new life possibilities. This interplay between the therapist and the patient's capacity and propensity to develop his or her own vision is the very psychotherapeutic vessel within which the patient alters previously dysfunctional patterns of relating to the world. The action that occurs within the vessel holds the subtleties of the patient-therapist, or at Yellowbrick, the patient-treatment team interaction that determines the path change takes, or the disruptions in the path that block or derail change.

A vital ingredient in this psychotherapeutic vessel is the future vision provided by the therapist or treatment team, as this vision creates a space for the kind of creative potential the patient's psyche needs in order to discover new patterns of relating (Summers, 2005). With emerging adults who carry a stunted or damaged capacity to imagine or to believe in the development of a viable adulthood, the vision of the treatment team must be especially strongly articulated. In the Yellowbrick therapeutic community, this vision is held up to the patient not only by the primary therapist, but by an array of providers, including psychiatrists, clinical administrators, group therapists, counselors, creative arts therapists, mind-body professionals (e.g. yoga, deep body work), occupational therapists and in a vital way, CCS. A central vision is communicated through a common language used community wide: we articulate for patients and help them see and understand their core enactment**, a construct that references how core self-experiences are expressed in patterns of relating to others. In tracking with patients how their core enactment operates in real-time in the treatment community, we hold forth a common vision to suggest and help guide the process of creating a new self-experience. We help patients see how their self-experience is intricately interwoven with their interactions with others, peers and professional staff alike, providing early proxies or objects of practice for new ways of relating to others in the re-creation of self (cf Summers, 2005).

When significant movement toward a lasting change in core enactment can be accomplished, consolidating earlier gains and moving to create new patterns as a foundation for a new self-vision, the more normative developmental trajectory of emerging adulthood can be embraced, perhaps for the very first time. This shift requires the tolerance of anxiety that necessarily arises when consciously giving up old relational patterns and moving into a space that is unknown, where new patterns have to be tested and adjusted and vulnerability is high. When the patient cannot or will not tolerate this anxiety, or when circumstances and relationships in the patient's life outside treatment agitate the anxiety, there is a move to recreate old patterns rather than create new ones. In other words, there is a move to redouble elements of core enactment that drive interactions in a way that old self-experiences are reinforced. William serves as a classic example of this kind of turn. In his later phase of treatment, after he had successfully overcome his immediate drinking urges and opened himself to an indepth and nuanced dialog about his core enactment, he enrolled in a university course. Utilizing the various relationships he developed in treatment to have a newly created self reflected back to him, he was able to push through intense anxiety and make it to the end of the semester with outstanding grades.

**The concept of enactment encapsulatesa deep level process that occurs in the patient-therapist interaction that is understood to be based on how early attachment patterns become deeply embedded at the sub-verbal, sub-conscious level and how this encoding shapes the experience of self that then becomes transmitted into the therapy relationship (Stern, 2004). There is increasing evidence that this encoding occurs at the neurological level and that the process of change in treatment—helping patients develop new interaction patterns—involves a redirecting of how the brain communicates with itself through neuronal pathways (Aron, 1998; Ginot, 2007, 2015; Schore, 2012).*

Tragically at that point in his treatment, William faltered. He did not fully complete his course, passing all exams and completing all assignments, but refusing to take the final exam or even to accept assistance in preparing for it. He returned to a dysfunctional sleep/wake cycle and to isolation. He stopped attending support meetings and began to skip Yellowbrick's Addictions Services Program. He returned to a cynical rejection of the power of deep change and to a fast hold on the futility of continued efforts to drive forward in his life. In short, William was unable or unwilling to allow his hard won real and substantial therapeutic gains to blossom into a more functional pattern of purposeful activity.

The relentless harassment William experienced from his alcoholic father and the easy success of his older siblings left him with a self-experience as a social and occupational misfit and ne'er-do-well. Although William is bright and talented by nature, his father's frustration was based partly on William's academic struggles that were diagnostically related to attentional difficulties. Thus, the genuine anxiety that was connected to these struggles was magnified and distorted in his family environment, in part, by his father's strong negative reactions. William grew to manage this anxiety and his anger at the pressure and criticism of his father by capitalizing on his negative self-experience, increasingly rebelling against school, further frustrating – actually punishing – his father, who valued strict discipline and academic achievement above all else. William's core enactment entailed a destructive dynamic in which his experience of himself as a failing outcast was reinforced by the provocation of his father, who then lashed out at him, which in turn led William to use his own failure to retaliate. This failure then further provoked his father, creating the destructive cycle. In his treatment, an interruption to this cycle started to take hold as the interactions between William and members of the treatment team helped a new self-experience emerge. Key to this new self-experience was the idea of completing a university degree.

The performance anxiety underlying the destructive dynamic between William and his father that had festered throughout his life rushed forward in a pronounced way as William approached his final exam; on the precipice of new success, he felt the threat of "alienating" his father or giving up the power that he gained over his father by failing. William balked, refusing to take the final exam, unable or unwilling to relinquish his cherished self-experience as an outcast and failure. This obstacle was abetted by his father, who did his part to keep William in the role of the helpless, hopeless son. On the verge of being able to envision a more viable course of self-development and thus step onto the normative trajectory of emerging adulthood, William could not overcome the intense anxiety that first surfaced in early elementary school as a genuine part of himself and that re-emerged as he began to allow himself the space to envision new possibilities. As Summers (2005) observes, in order to tolerate enough anxiety to open the space needed to alter relational dynamics and therefore begin to experience self in a different way, there must be a sense that old wounds are sufficiently healed in the course of therapy.

William's inability to experience enough healing was related in part to a plan to terminate his treatment earlier than he would have liked due to a family emergency unrelated to the treatment. William experienced the disappointment of the early termination as another instance of unfairness he was left to endure. The power of the entrenched destructive dynamic with his father that was at the source of this sense of unfairness was encoded in William's self-experience, expressed through his core enactment. The interaction patterns inherent in this core enactment began to play out in his individual therapy, as well as in the larger treatment community.

Re-creating his old self-experience, William presented himself in sessions as irredeemable, beginning to skip sessions. When present, he vocalized intense cynicism and self-loathing and insisted that he could not alter these experiences. He reflexively rebuked efforts to shore him up or to help him see himself as an autonomous agent, not needing his father's affirmation or recognition. Holding private disappointment and frustration about this obstacle after so much treatment progress, I felt a pull of anger as William used his cynicism to express his sense of futility. I registered it subconsciously as an attack against the therapy or against me. William must have felt this anger in my increasingly pointed efforts to hold out to him the future I believed he could attain. I was able to step back from the enactment only after I accepted that William would begin to experience himself differently only when the therapy relationship contained acknowledgement that, as much as I could hold out my image of a future vision, his true autonomy lied in his decisions on how to respond to that vision. The challenge I experienced in individual therapy was shared throughout the treatment community, as nearly all team members reported reactions similar to my own.

The use of interactions within the therapy relationship to arrive at and begin to solidify a new psychic future often proceeds in fits and starts. As Summers (2005) observes, it is vital to work through precisely the kind of patient-therapist dynamic I experienced with William in his faltering: the patient comes to understand and refine a re-created self as the therapist reflects stumbles and failures in a way that is different than previously experienced. William's treatment at Yellowbrick unfortunately terminated before there was a full chance to engage in such an interplay. When the strivings of an emerging adult run up against the kind of powerful anxiety and negative self-experience at the source of deep distress, an important treatment challenge lies in understanding the power of a core enactment to influence treatment relationships in a way that reproduces old dynamics and interferes with the ability to hold steady for the patient a new way to imagine and experience the future. This imagining and experiencing stands as the key developmental task of emerging adulthood.

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Ten Years At Yellowbrick: What I learned

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As I approach retirement and the end of my clinical work at Yellowbrick, I have been asked to reflect on what I have learned during the past ten years of working in this emerging adult treatment program. While much of what I have learned at Yellowbrick has been an enhancement of previous knowledge, some of the most important new knowledge I acquired is a product of the extraordinary experience of working in a unique treatment environment. The philosophy of treatment at Yellowbrick is a complicated blend of evidence-based findings, developments in the world of science, insights about the developmental tasks of emerging adulthood, psychoanalytic models of psychological development, systems theory, nonverbal treatment interventions and skills-based training. The creative application of these elements to psychological work with emerging adults has promoted a rich and ever-evolving context and process for learning for emerging adults, families, the staff, and for me. Albeit a difficult task to select only a few of those things that I have learned, what follows is some of the most significant concepts I have learned as Yellowbrick evolved from a startup program in August, 2006 to become a nationally recognized center of excellence in the treatment of emerging adults in 2016.

What Gets Fired Gets Wired

Hebb's Law, "neurons that fire together wire together", is a decades-old concept that has engendered new applications as our understanding of the brain has evolved. This concept was first introduced in 1949 by Donald Hebb, a Canadian neuropsychologist. He proposed the idea that every experience we have activates thousands of neurons that begin to form a neural network. The more signals sent between two neurons, the stronger the connection grows. As an experience is repeated, the same neural network is activated, forming a stronger and stronger neuropathway.

Understanding the way in which experiences are wired together is particularly important when working to facilitate change in behavioral enactments and emotional expression. From a neuropsychological perspective, effective interventions require memories to be reactivated and reconsolidated in a different form. Dr. Cristina Alberini's (2012, 2013) research suggests that the timing of interventions that are intended to facilitate the development of new neuropathways is critical. Her research demonstrates that when stored memories are recalled or reactivated, they are temporarily fragile. In this vulnerable state, those memories are more subject to interventions that are designed to facilitate change in that memory. In other words, for a memory to be reconsolidated in a different form, it needs to be reactivated first. This understanding is especially important when intervening with traumatic memory.

The nature of the interventions that assist with emotional change is articulated in Dr. Alan Schore's (2003) study of the psychotherapeutic change process. His work furthers the idea that psychotherapy is relational in nature, that emotional empathy is a right brain activity and that effective psychotherapy requires right brain to right brain communication – in other words, a "limbic conversation." This kind of conversation changes more than overt behavior and language. It also changes emotion and subjective experience.

When combined, these two ideas—reactivating memories and limbic conversations--have important implications for the clinician supporting a patient in developing alternatives to pathological emotional processes. In order to facilitate emotional change–that is, fire new neural connections that can then become wired—the clinician has to be willing to facilitate access to emotional memory (reactivation) that is often intensely disruptive to both the patient and the clinician, maintain emotional attunement as the distressing affect is activated (a limbic conversation), and thereby, facilitate human connection about that which has been previously maintained only in the unconscious. This process changes character.

My exposure to these concepts shifted the focus of my psychotherapeutic work. In individual, family and group therapy, I have become less organized around interpretation and analytic understanding and more focused on following the affect and facilitating emotional connection. In the past, I attempted to use cognitive processes to access emotional processes. During the past ten years, my clinical effectiveness has been gradually improved as I learned to exist in the experience of the moment, trust my intuitions, process my own affective experience while I experience that of another, and only then use cognitive processes to better understand an emotional state.

A Place For Paradox

Some of my learning while at Yellowbrick has been a new perspective about leveraging the tensions present during emerging adulthood. Treatment often requires coming to terms with conflicting internal forces. The ability to tolerate ambiguity, the capacity to manage ambivalence, and the acceptance of polarities present in human existence are essential elements of emotional health. Dialectic behavior therapy, DBT, (Linehan, 1993) is a well-established treatment model created to address issues of emotional dysregulation. Linehan's model includes an understanding of the fact that we are often faced with the need to manage conflicting aspects of the same process, for example, tolerating feelings and managing feelings.

Less well known is the process of Polarity Thinking (Johnson, 1992), a conceptual model for the management of the polarities in our lives. Polarities are two interdependent variables that are both indestructible and unresolvable. An example of a polarity we all experience is breathing. To sustain life, we need to both inhale and exhale, breathe in and breath out. These two needs are interdependent and we cannot do both simultaneously. No one would claim that one is more important than the other since both are essential to life. While there is an upside to both

inhaling and exhaling, there is also a downside to both actions. That is, we inhale benefitting from its upside, obtaining oxygen, until we began to experience the downside of inhaling, too much carbon dioxide. We then transition to exhaling, benefitting from the upside of that action, cleaning out carbon dioxide, until we experience its downside, too little oxygen (Figure I). Dr. Johnson's model suggests that when polarities are present in our lives, we can engage in a process similar to breathing.
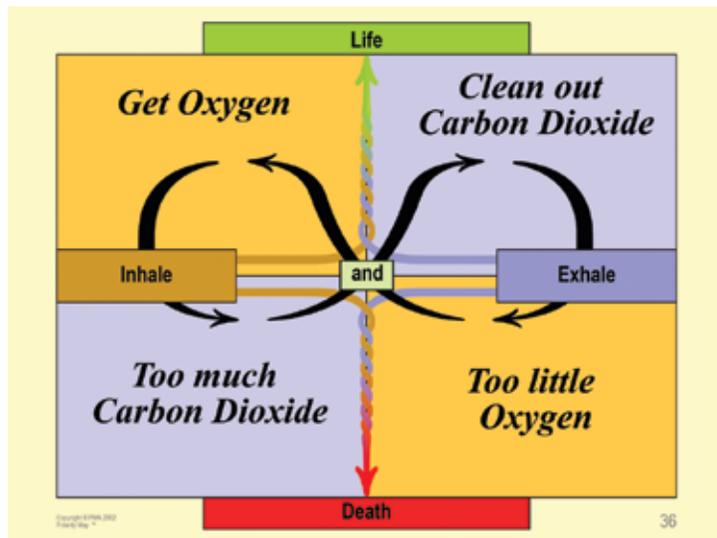

Figure 1: The Inhale-Exhale Polarity. Based on the work of Barry Johnson and Polarity Partnerships, LLC. Reprinted with Permission.

This model is easily applied to the experience of emerging adults. While many polarities exist as part of emerging adulthood, a particularly important one involves the changing nature of relationships within the family, the task of separating from family of origin and establishing a separate existence, that is, autonomy (Tanner, 2006). That idea, however, only focuses on one side of this developmental task. Emerging adults and their families also have the developmental task of reconfiguring and reorganizing the relationships within the family, including transitioning to adult-to-adult engagements, that is, connection. The upsides of autonomy include independence, enhanced self-confidence, and freedom. However, there are also potential downsides – loneliness, isolation, lack of support. At the same time the upsides to connection include emotional support, intimacy and empathy; and potential downsides to connection include overdependence, loss of freedom, and abandonment of self. In Yellowbrick, this polarity of autonomy and connection in the lives of emerging adults and their families has been captured in the expression, "connected autonomy," a term originally used by Dr. Jesse Viner, the founder of Yellowbrick. Understanding this emerging-adult tension as a dynamic process that involves a flow back and forth between the poles of connection and autonomy is important and demonstrates the usefulness of facilitating awareness of the upsides and downsides of a constantly evolving organization unique to each family. Polarity Thinking's dynamic flow between poles contrasts with a more static resolution in which there is an attempt to find an appropriate stopping point between the two poles.

A second important polarity present in emerging adulthood and in treatment at Yellowbrick is that of freedom and accountability. In my work at Yellowbrick, I have come to understand that there is no true freedom without a sense of accountability and that there is no real accountability without freedom. While this polarity is related to that of connected autonomy, the focus here is on a specific dimension of the relationship between self and other, the experience of choice. This polarity is present in both the philosophy and the structure of Yellowbrick.

A fundamental underpinning of Yellowbrick's treatment philosophy is that of "real time" treatment, a research-based understanding that lasting change is most facilitated by supporting emerging adults who are managing actual life experiences. This philosophy leads to an environment in which individuals have the freedom to make choices, experience personal agency, exercise power, and learn from mistakes. These choices, however, are not made in a vacuum. Upon entering Yellowbrick, emerging adults are asked about their willingness to commit to a set of agreements that are understood to support treatment and establish norms for the treatment community. These agreements create a basis for accountability to others in the community. Violations of the agreements are understood to negatively impact one's individual treatment, one's peers and the treatment community.

The persistent but natural tension between individual freedom of choice and interpersonal accountability is thus established in the treatment experience. Accountability to one another engages emerging adults in dynamic relationships with peers, relationships that are not complicated by the perceived authority of parents and staff. Individuals tend to explore the edges of asserting individual power while establishing belonging in the community, migrating back and forth within the poles, gaining awareness of the upsides and downsides of both freedom and accountability. Violations of the agreements provide opportunities in individual, group and family therapy for emerging adults to better understand the meanings and impacts of personal choice, rather than be discharged for problematic behavior. As individuals make choices to engage in educational and vocational pursuits, the experience of accountability becomes active in relationships outside of the treatment community. Understanding the dynamic relationship between freedom and accountability and applying it to treatment in this manner has been a gratifying part of my learning during the past ten years.

I take with me the enhanced awareness that emotional health requires that we embrace paradox and that we breathe, in and out.

What's in a Name

I understood early in my career that individual therapy involves providing a space in which the individual can safely and creatively explore his or her internal world. As I engaged in training in family therapy, it became clear that this interplay of space and creativity could also apply when working with a family system. My exposure to the teachings of Wilfred Bion (1951) further expanded this idea of interplay to the process of group therapy. At Yellowbrick, I have come to understand the many ways in which the provision of a space and the energy of the creative process are fully present in the experience of treatment in a community context.

Two of the rooms that are part of Yellowbrick's physical plant have been given names of particular significance, Makom and Makor. Makom is the Hebrew word denoting the place and the space for Creation. Makor is the Hebrew word for the Source, the fountain or spring, of the energy for Creation within that space. These rooms were given these names as a statement of the importance of both providing a coherent space for self-discovery and acknowledging the source of the powerful

forces that facilitate that self-discovery. While at Yellowbrick I have seen the meanings of these words reflected in many aspects of our program.

D.W. Winnicott (1971) recognized the importance of the creative space of play, something he said took place in the interface between our inner world and external reality. This experience of play is present in many elements of the Yellowbrick program–art therapy, camping trips, community dinners, talent shows, group improvisation, yoga, weekend community outings and even ping pong therapy. These treatment interventions give access to nonverbal processes, allow nonconscious parts of self to be available, facilitate human connection and support competence. I have come to understand that often the most effective treatment involves activities other than talking. With one especially treatment-resistant emerging adult, I agreed, at his request to play ping pong during our scheduled therapy time. As we played together, he began to tell me more about his internal world, one that included a history of mistrust and anger directed at those in authority. Play, in the form of ping pong, provided a space in which the power of his longings for connection could thrive.

The meanings of the words Makom and Makor are also embedded in the philosophy of the program. The entire program provides a space, a living laboratory, for self-discovery. In real time, the opportunity exists in that space to expand understanding by experimenting with new behaviors, to learn from failure, to acknowledge the need for others, to experience support in times of need, to direct anger where it belongs rather than toward self, to experience confrontation that is motivated by caring and to gain strength by acknowledging vulnerability. The collective energy of the community of emerging adults, their families and the staff creates a force much greater than the sum of its parts. The source of that energy comes from deep within the human spirit, and is part of our fundamental need for human connection.

Mind Matters

During the past two decades, we have developed a fuller and more nuanced understanding of the capacity of the brain to sprout and prune neurons throughout the human lifespan. We now know that neuroplasticity (Rakic, 2002) includes the fact that different parts of the brain come online at different times in one's development, and that there is a degree of neuroplasticity present during adolescence and emerging adulthood that is only rivaled by the earliest years of one's development (Taber-Thomas and Pérez-Edgar, 2016). Applying these revelations to the treatment of mental health problems has given rise to several innovative, neurobiological interventions in the world of psychiatry. At Yellowbrick, we have incorporated treatment interventions that take advantage of the high degree of neuroplasticity and the nature of brain development, particularly the frontal cortex, that occurs during emerging adulthood.

Among the examples of innovative interventions for our emerging adults is Transcranial Magnetic Stimulation (TMS), a neurobiological treatment intervention for depression that delivers promising results. TMS is a noninvasive procedure that uses magnetic fields to stimulate nerve cells in the frontal cortex to reduce symptoms of depression. We have also adopted Cranial Electronic Stimulation, such as AlphaStim, as a neurobiological tool for the management of anxiety, panic and sleep management. We have applied Neurofeedback as it has become more refined and targeted, allowing for intervention that assists with the activation of some parts of the brain and the quieting of other parts, all in real time with the use of a qEEG.

In addition, the mapping of the human genome in 2000 and the capacity to test for genetic variants has opened the door to the application of our understanding of gene structures to the practice of psychiatry. Pharmacogenetic testing is now expanding our understanding of individual vulnerabilities and the probable efficacy of specific medications for a given patient. When I started at Yellowbrick, there was no reliable, cost effective means of providing genetic information to assist with medication management. When Yellowbrick began to use genomic testing as an assessment tool, there was testing available for a total of six psychiatrically relevant genetic variants. Now we can test for eighteen relevant genetic variants, with more to come. These are exciting developments in the world of personalized psychiatric care.

Each of these neurobiological interventions help move our understanding of mental health problems away from an emphasis on the characterological and toward the world of the biological, a relief for many individuals who have been self-condemning, and condemned by others, in the face of their psychological challenges. None of these interventions, however, can replace human connection as part of an effective treatment program. How TMS is used at Yellowbrick provides an excellent example of the synergistic relationship between neurobiological intervention and programmatic treatment involvement. At Yellowbrick, we see TMS treatment improvements in depression, as measured by the Beck Depression Inventory, that are significantly greater than in the published research with similar age groups. We hypothesize that these greater levels of improvements are a product of the combination of the opening up of the brain to new learning during TMS treatment, followed by experiential, didactic and other learning in treatment activities. We have called this process *directed neurogenesis*.

In my professional experience, awareness of each of these neurobiological interventions has only occurred in the past few years. I believe that in the not too distant future, as we learn even more about our individual genetic makeup and the processes of the brain, we will see many newer neurobiological applications of that knowledge, applications that will vastly improve the efficacy of psychiatric care as long as the human connection or relational work is also seen as an essential part of all psychiatric care.

Engage the Rage, Claim the Shame

During the past ten years, I have developed a more complete understanding of the concept of enactment in treatment. Ginot (2007) describes enactments as "powerful manifestations of the intersubjective process and as inevitable expressions of complex, though largely unconscious self-states and relational patterns." An ongoing focus of treatment at Yellowbrick is to deepen understanding of the core enactment for each emerging adult. In this process both therapist and emerging adult strive to understand the evolution of core self-experience and the organization of emotions, needs and attachment patterns as shown in relationships. Core enactments emerge in individual therapy, a product of both parties participating in the previously mentioned "limbic conversation." McLaughlin (1991) described enactments as "events occurring within the dyad that both parties experience as being the consequence of behavior in the other".

It is important to know that the underlying emotional motivation of a core enactment is typically unconscious. Although core enactments include a wide range of emotional states, enactments of nonconscious anger and associated shame have been especially prominent in

the treatment of emerging adults at Yellowbrick. Looking at the symptomatic behaviors of many people in treatment at Yellowbrick through a psychodynamic lens, one can identify significant underlying anger, and at times rage. More than two-thirds of the emerging adults admitted to Yellowbrick have made at least one serious suicide attempt prior to admission. For many, their suicide attempt was an act of murderous rage (Plakun, 2001). Khantzian and Halliday's (1990) study of substance use preferences found that opiate abusers were often attempting to medicate away anger and rage. The act of vomiting for those with bulimia nervosa is often associated with disavowed anger. Depression is often understood as anger turned against self. The self-destructive aggression present in an act of self-injury also belies an angry underlying motivation. When anger is experienced as evidence of defectiveness, shame is often an associated affect. Shame promotes the desire to hide and patterns of avoidance and withdrawal ensue, further compromising emotional health.

However difficult, engaging denied and dissociated affect is an essential task in psychodynamic psychotherapy. In the midst of intense anger, especially anger experienced by the patient toward the therapist or experienced by the therapist toward the patient, a tendency exists for either the patient or the therapist, or both, to disengage from the emerging or potential conflict. The disengagement is an attempt to minimize the discomfort of the intrapersonal and interpersonal tension and, thereby, preserve the relationship. In fact, however, the disengagement jeopardizes both the relationship and the treatment through mutual participation in a destructive enactment. The active willingness of a therapist to approach anger and conflict in a treatment relationship ultimately helps preserve and strengthen both the treatment and the relationship. The therapist's willingness to approach affect that was previously unacceptable to the patient allows that affect to be accepted in the relationship, and thus promotes self-acceptance by the individual in therapy. It is an act of genuine caring.

A therapist cannot effectively engage in this process without the courage to face his or her own anger and shame. Verbal assaults directed at the therapist are often intuitively targeted toward the most vulnerable parts of the therapist's own identity, provoking anger and shame. Engaging in treatment relationships with emerging adults has challenged me to know the breadth and depth of my anger, to accept my limitations, to have compassion for my vulnerabilities, to acknowledge my shame, and to embrace my need for the support of others.

It Takes A Community

The concept of a therapeutic community has been around since the 1950's (Sacks and Sacks, 2010). These types of communities were originally established to support abstinence and recovery from substance abuse disorders. They existed in the context of both institutions and open settings. My first exposure to the use of an open community model in a mental health settings was in 1989 when I began working in an open psychiatric hospital (Muller, 2014). That experience set the stage for my desire to work at Yellowbrick, an open community model that provided a supportive, not supervisory, resource for emerging adults.

The Yellowbrick community is unique in that all patient members are emerging adults, struggling to find their way through that particular stage of individual development. The treatment community is understood to be the combination of all the emerging adults in the program, their families and all staff. Membership in the community is understood to be both a responsibility and a privilege. Each community member agrees to function within the parameters of agreements that outline those responsibilities for all involved, responsibilities to self and to one another. The agreements are guidelines for participation in treatment, guidelines that maximize the likelihood that treatment will be beneficial.

This construction of community provides another context for enactments, the unconscious expression of dissociated parts of self. All behavior is understood to be a communication. Understanding the meaning of that communication is the difficult task of treatment, a task made especially challenging because the meaning resides in the unconscious, the same behavior is likely to have entirely different meanings for different individuals, and the same behavior often has different meanings for the same individual on different occasions. Rather than discharge individuals who violate the agreements, they are asked to discuss with the community the underlying motivations for their behavioral choices, the effects on their treatment, the effects on the community, and alternative behavioral options. This kind of engagement with the community effectively brings those dissociated parts of self into relationships in the community and into treatment.

Focusing on community relationships and agreements also encourages the acknowledgement of the individual's responsibility to the wellbeing of the community with a special emphasis on their peers. We have found that the emerging adults in the program are willing to say things, and hear things, from one another that would not be said or heard in relationships with those in positions of perceived authority, such as staff members and parents. This open communication with their fellow emerging adults is consistent with the appropriate developmental step of creating stronger attachments to peers as they separate from their families of origin.

Finally, this construction of community affirms the relationships established among staff members. This is not work one can do alone. Given the personal investment required to manage the emotional intensity of the day-to-day work, the support of colleagues is essential. Working within the framework of "real time" treatment in an open community requires a high tolerance for ambiguity, courage to take risks, a willingness to be vulnerable and openness to acknowledging imperfection and shame. In my relationships with colleagues, I have learned about the synergistic result of working as a team, the comfort of depending on colleagues in times of need, the importance of knowing and acknowledging my limitations, and the power of the collective commitment to the same mission.

Teachers Come In All Shapes and Sizes

When all is said and done, I believe that I have learned the most from the emerging adults and the families who have been a part of the Yellowbrick community. On a daily basis, they have been the teachers and I have been the student. The intimacy of right-brain to right-brain communications affects both parties involved; thus, my brain has also changed as a result of those interactions. I have been privileged to experience being trusted with the darkest of secrets, to experience the resilience of the human spirit, to know the true meaning of courage in the midst of fear and danger, and to participate in the creative process of life changing self-discovery. The individual and collective willingness of emerging adults to be open, vulnerable, and rigorously honest has given me a deeper understanding of my own tolerance, my capacity to care, my vulnerabilities and the need for flexibility and humility.

These insights have altered my personal life as well as my professional life. To be with people as they heal is to experience healing.

The learning that was most unexpected, however, occurred in relationships with those emerging adults who resisted treatment, often attempting to destroy the treatment or themselves. They are the individuals who challenged my limitations, required me to be most creative, exposed my intolerance and forced me to access the extremes of my emotional life. These experiences broadened my willingness to rely on others for support and guidance, changed my attitude toward my own dependency needs and facilitated deeper connection with my colleagues. All of these experiences enriched my own journey of self-discovery.

And Now As An Emerging Senior Citizen

The last decade of my professional career has been at Yellowbrick. In this paper, I have humbly offered some highlights of my learning, but must admit it is only a small portion of what I have learned in ten very full years. I have been privileged to be a part of the development and implementation of such a unique and comprehensive treatment model and I am immensely grateful to all of my teachers – emerging adults, families, colleagues and supervisors and my family. May each and every person I have worked with experience the same abundance of growth and connection I have had the privilege of knowing during my ten years at Yellowbrick.

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Turn Off the Spotlight:
The case for "community" theatre.

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Yellowbrick recently integrated therapeutic theatrical practices into its treatment program and by doing so now offers emerging adults a new way to articulate their emotions in the company of others. Bringing therapeutic theatrical practices to Yellowbrick offers emerging adults a new way to articulate their emotions in the company of others. For example, in the Trauma Recovery Program young men and women bring their personal stories forward on a weekly basis. Through theatre, personal dramas become discovery spaces not only for young people exploring their own traumas, but also for their peers taking on the roles of director and actors. Theatre is a communal event. Whether one is an actor, director, audience member, or concessionist, everyone is in it together. Theatre provides emerging adults with an opportunity to hone their perspective-taking and recognize that reality is not absolute, but rather constructed.

William Shakespeare wrote plays for a company of actors to perform in the light of day. Modern versions of Hamlet in which audience members witness Hamlet sitting alone on a dark stage, silhouetted by a spotlight, pontificating the question "To be or not to be?" in isolation and disconnection reinterprets that epic moment. The advent of electricity and its ability to harness the impact of the spotlight made possible the seclusion of Hamlet's introspections. Shakespeare did not intend, however, for young Hamlet to contemplate his fate alone, with only the darkness as his witness. Modern versions of this scene concentrate direct lighting on Hamlet, under which he delivers his so-called soliloquy into the abyss of darkness.

In contrast, imagine the conditions under which Shakespeare first conjured this work. Imagine instead a bright sunny afternoon, a huge audience, and five musicians sitting on stage with Hamlet. How might it feel to a member of the audience when Hamlet, one amongst many, asks "To be or not to be?" In this moment, Hamlet recognizes that you are there with him. He is asking you just as he is asking others, what are your thoughts on this subject? He doesn't protect the boundaries of his struggle. He projects an assumption that his dilemma has universal elements. He shares with others the pain of not knowing where he belongs. He also recognizes that he is not unique in wondering, do I have a place in this world?

At Yellowbrick, therapeutic experiences using theatrical exercises offer patients different ways to express feelings, memories, and patterns of relating. Some exercises involve an emerging adult describing a memory or event that occurred in the past, in real life. Peers then act-out the memory or event as described. The memory holder then has the opportunity to re-direct the scene, change the ending, say something different, or receive a different level of support from another character. These theatrical exercises offer emerging adults a new way of processing old memories. Acting out the past is different from talking about the past. Oftentimes the themes presented in one person's struggles resemble or match others' experiences. When similarities between stories and patterns of experience emerge, these shared experiences generate a web of trust and mutual support. One benefit of these re-enactments is that

a sense of isolation associated with traumatic memories begins to dissolve. The spotlight gets switched off, and everyone is there together, seeing faces, creating community.

Returning to Hamlet's self-imposed question, "To be or not to be?" we can conclude that the question is a deeply painful one. His question takes on a specific meaning when he wrestles with it in isolation and it takes on a different meaning when he grapples with it in a forum, sharing it with others. Perhaps theatre's most amazing quality is its ability to serve as a fishbowl, allowing actors to express and explore depths of human emotion, action, and hope while stimulating audience members to vicariously experience emotions and reactions. Yellowbrick is similar; its boundaries hold deeply painful questions and its community members desire to explore them. The parallel reveals the value for continued theatrical expression in therapeutic practice at Yellowbrick. Like Shakespeare would have wanted, keep the spotlight off and the sun up on all the faces at once.

Transparency and the treatment process

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To some degree, I favor therapist transparency in relationship to the psychotherapy process for personal reasons. My dad was a gifted mechanic who didn't say, "Here's how you do that." My mother had a tendency to speak *ex cathedra*, rendering opinions but not saying how she had arrived at them. Their ways of being, in combination with my own natural shyness and eldest son tendency to respect his elders, led to a sense of awe toward my parents, but also left me feeling diminished and in the dark. How things were accomplished, the processes whereby things were fixed or learned were shrouded in mystery.

This is often the case for many of the emerging adults whom we treat at Yellowbrick: What causes the tension in this house? Why does mom stay with dad when they always seem so angry at each other? What could I do so that dad won't be so sad? The answers to these kinds of questions have also been shrouded, leaving children and then adults, wondering about the processes that lead, for instance, to resolution of conflict or to the ability to stay connected to someone and also to be one's own person. This suggests to me that one thing psychotherapy can offer as an antidote to these mystifications, would be to lay bare, as much as possible, the processes of the therapeutic relationship.

Transparency about the treatment process is useful: because it promotes autonomy in the patient, rather than mystifying ones' technique/intentions, which promotes idealization and dependence. It also models the value of thinking about thinking. Transparency emphasizes the mutuality of all human relationships and a sense of a shared responsibility for what happens in the therapy relationship.

Also, Fonagy (2002) writes that it is through the "markedness" of experience that children develop an awareness of their own minds as their own, as separate and distinct. The sense of self develops when the parent can both mirror the child's affect and also mark the mirroring as pretend, i.e., as a mirror, by exaggerating the perceived affect and also contrasting it with a display that is the parent's own. Clearly, there can be difficulties in either direction: If the parent's response doesn't mirror, the child doesn't receive the advantages of a reflected image of self, doesn't feel known or understood. On the other hand, if the parent's affective mirroring isn't marked, it can leave the child feeling "My upset is contagious and overwhelming, it's too much for you and for me to handle."

This suggests that marking the differences between your mind and mine would be a critical part of the therapeutic experience. While therapists tend to emphasize empathy, this implies that it is equally important to distinguish our separateness.

The concept of markedness has a parallel in the attachment literature: Secure attachment allows a child (and later the adult) both to feel he has a safe and trustworthy home base in relationship and also that he is free to explore the world. This is achieved by a balanced kind of attunement to the child's needs- not too much hovering and not too little, sensitivity to when the child needs to be picked up or protected and when s/he needs space to explore or experiment.

Again, there can be difficulties in either direction: premature expectation of autonomy leaves the child feeling overwhelmed by a responsibility he can't possibly handle, also neglected, sad and resentful. Over protection leaves a child doubtful about the safety of the world out there and also doubtful about his/her own capacity to manage.

Insecure attachments detach the child/the person from their selves, parts of the self are disallowed, disavowed, dissociated, and that which is dissociated is, in Wallin's (2007) shorthand, either evoked (i.e., projectively identified), embodied (i.e., expressed somatically) or enacted (i.e., replayed over and over again in our relational world).

Enactments are co-created. As Stern (2009) puts it, "Each participant's dissociation emerges instead from the interaction of her own private motives with the unconscious influence of the other." Enactment is a mutual process that may require the therapist to take the lead in self-disclosure.

The case of Chelsea

(This psychotherapy was conducted in the context of Yellowbrick's intensive outpatient program. In addition to a three times weekly individual psychotherapy, the patient participated in a full day of psychotherapeutic and psycho-educational groups including programming targeting addiction and trauma issues.)

Chelsea is a 30ish young woman from Des Moines, youngest sister by 7 years with 3 older brothers, all of whom were out of the house by the time she was in high school. Her parents both came from neglectful, sometimes abusive, alcoholic families and joined an Evangelical church after they were married, in the hope of providing their children a more stable, faith-based home-life than they had experienced themselves.

Her father has epilepsy that he neglected, leading to repeated and likely unnecessary seizures. Chelsea herself witnessed many of these. He also has chronic back trouble that left him mostly unemployed. Despite his avowed position on sobriety, he has secretly abused alcohol for many years and is removed emotionally from the family. Her mother is the primary breadwinner, the caretaker of the children and of her husband. She confided her unhappiness and her anxiety to Chelsea from the time she was a young girl and called her daughter "my best friend."

In her teens, Chelsea began drinking to excess and putting herself in dangerous situations, often with men she didn't know. She was sexually assaulted at least once while she was blacked out. Chelsea became chronically suicidal, nihilistic, anhedonic, hopeless that things could change. She managed to graduate from a local college and worked a series of dead-end jobs in retail after graduation. Prior to her admission to Yellowbrick, she had made a serious suicide attempt via overdose and was rescued by roommates, despite her attempt to conceal her action. She woke up angry to be alive.

At the outset of treatment, Chelsea was passive, couldn't or wouldn't lead the discussion. "I don't have anything to say," or "I don't know what to talk about." would be typical session starters. She complained that our first sessions were uncomfortable because of the awkward silences. Her previous therapist had always asked questions to get things started. "It's more comfortable to talk with him. He never let me get anxious."

I thought that she was inviting a relationship in which she would be the passive partner and I would set the agenda and be responsible for not allowing her/our anxiety to build. I also recognized that her idealization of her previous therapist stirred up my own competitive feelings: I wanted to be the preferred, more helpful one.

I wondered: Should I jump in to relieve the tension or remain silent and allow her to struggle and to be anxious? Both had advantages, both also seemed "wrong." I recognized that this situation was likely paradigmatic for her (i.e., a core enactment), so it was probably not best just to "solve" it.

Rather than choosing sides, I was transparent about the spot I thought we were in. I described the dilemma from my side: I didn't want her to suffer unnecessarily, but I thought that if I set the agenda by asking questions it would rob her of the opportunity to start to identify her own priorities.

Also, I suggested that it seemed likely that we were engaged in an enactment that had significance for her and that a major role of the treatment was for us to learn something about the meaning of this moment and also discover a way to work ourselves out of the dilemma.

Chelsea said, " I'm embarrassed to admit it, but I get attracted to guys who really take charge. I want a guy who will make the decisions and who will pay for things." We considered whether having had an emotionally absent father, and also having a mother who asked her to take adult responsibility at too early an age had left her wishing for others, and especially a man, to take charge. She began to see that enacting this wish had significant downsides. Feeling dependent on a man to fill this bill made her doubt her own autonomous capacities.

We negotiated our way out of the dilemma: Chelsea said that she'd work at thinking about her treatment priorities and at bringing these into our sessions, but if she wasn't able to come up with something in the moment, she'd ask for guidance. This seemed a step in a better direction.

In mid-treatment, the enactment appeared in a different form: Chelsea did things to evoke anxious-preoccupation in others, e.g., disappeared for a week, drank in an uncontrolled fashion, failed to respond to texts or calls inquiring about her safety, leaving us to call the police to perform a safety check. This made her angry and reconfirmed in her the idea that if she trusted others and asked for help, they would attempt to control her and restrict her freedom.

She said, "Why should I talk about this? You just judge me! When I get stoned or blackout drunk then I'm not responsible for my own actions…"

She believed that the antidote to her parents' fundamentalism was to have no faith and no values. "I'll make decisions based on what feels good in the moment." and, " I don't want to have limits, even my own, because then I wouldn't feel free to do as I please." When I suggested discussing how she herself might know if her alcohol use was problematic, she accused me of trying to impose my values on her.

At this stage I thought: I'm anxious about the risks she is taking and resentful that she puts me in the position of being her judge and jury and also leaves the responsibility for her safety to me. Earlier, I felt unfairly burdened by the responsibility of choosing an agenda, now I began to feel angry.

I was also becoming increasingly aware of another dimension of my own feelings. While I cared about Chelsea, it was also true that I wanted this treatment to end well for my own sake. I wanted my colleagues to think well of me and my work. I wanted to feel competent, but was feeling like Chelsea rendered me powerless to help her. I felt some shame over these more "selfish" aspects of my own feelings.

I felt pulled to rush into the void to protect Chelsea and at the same time reluctant to step in, aware that this reenacted the drama with her mother (who stepped in repeatedly out of her own anxiety and guilt) that left her feeling intruded upon and controlled and responsible for the other's feelings. Her anger about the intrusion also seemed to deny another part of her experience: she has complained bitterly that her parents neglected her, that she struggled right under their nose and they never noticed or attended to her crippling anxiety, depression or her drinking. ("We didn't know. You seemed able to handle it yourself.")

I tried to express the enactment between us, and particularly my end of it. It would feel neglectful to let her do something dangerous right under my nose and not to say or do anything about it, though I could see clearly that she ended up feeling judged and controlled by my asserting my concern. On the other hand, it seemed to me that, by refusing to state her own limits, she invited me to participate in a process that enabled her to avoid defining and declaring her own self.

I also said that I was angry. Abdicating responsibility for her own safety left me holding the bag and at the same time, by disappearing and not answering her phone, she rendered others powerless to help her. Chelsea insisted that I was speaking out of my own fears, or worse, my own bourgeois values.

Now what do I do? In fact, there was an element of truth in what she was saying. I was afraid for her and I *did* have a self-interest in her treatment. So I told her, that at least in part, she was right, but that acting in a self interested way wasn't incompatible with genuinely caring about another person. In her world, judging by her mother's example and her own experience, caring for another person meant sacrificing oneself.

This discussion led to further understandings and integration: We realized together that her saying "I'm not responsible for what I do when I'm drunk," was in part an identification with her father who repeatedly said "I didn't know you were struggling," by means of denying his responsibility as her dad. In this enactment Chelsea was both the child daring the parents to rescue her, while angrily proving their incompetence to do so and she was also playing the part of her own negligent father and paying attention to how I responded.

This discussion helped Chelsea to acknowledge her angry withholding. She said that she knew that agreeing to set a limit on her drinking would

reassure me, and she hadn't want to do that. This was her angry protest for years of feeling responsible for her parents' health, anxiety and depression. She didn't want any of that on her shoulders and so wouldn't lift a finger to reassure me, even if it meant not defining her own self by beginning to identify her own limits and values around alcohol.

Through most of her life, Chelsea had thought of herself as not wanting a relationship or not capable of having one. Now she began to be aware of her yearning, met a fellow whom she liked and began a relationship, though she was reluctant to call it that.

I began to use the framework of attachment theory (Fraley and Shaver, 2000) to offer her some perspective on her typical interpersonal stance and also to help her track the way this is changing: She shifted from a primarily avoidant-dismissive stance to an anxious pre-occupied one. Mostly she had said: Other people want relationships, I don't seem capable and I'm not that interested." But, as she let down her guard and began to recognize her longings for connection, she became anxious about the state of the relationship. She moved from "If he doesn't ask me out, then the hell with him. I don't need that," to, "Why hasn't he called? Maybe I'm just not good enough."

After a succession of episodes in which Chelsea got drunk in order to feel comfortable enough to sleep with her boyfriend and another in which she drunk-texted him in anger, he stopped calling her. She was depressed and stayed in bed for a day, but then got up and went to work and class. We noticed that, unlike in the past, she had no suicidal ideas or intentions.

I was actually more on the fence at this stage. She was delighting in being herself and in starting to risk stepping out in the world and I experienced a genuine pleasure in seeing her flower. At the same time, when she drank or engaged sexually with someone she barely knew I was anxious and fearful for her safety.

When I spoke to her about my concerns about her drinking and about the way she chose to engage with men, she oscillated between recognizing my genuine concern and, on the other hand, believing that I just was trying to impose my values. I felt allowed in to her decision making process and then excluded.

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Chelsea thought briefly after being dumped, as she had in the past: "I'll never have a relationship," but then was able to put this in perspective and began to talk about what she had learned from the experience:

- It was ok to have desires and to let them be known. "At least I got into the game that way, instead of always sitting on the outside looking in."
- "I could be less sarcastic and more direct with my wishes and with my hurts and anger."
- "I got too concerned with fear of rejection and trying not to lose the relationship so I wasn't able to say 'No,' " and "I didn't know my own limits so I didn't assert them."
- "I think alcohol contributed to my depression and also to the downfall of this relationship."

Chelsea's statements testified to significant changes she had made, at least in part, through the give and take of the therapy relationship. A greater awareness of her sadness and anger, of her passivity and it's consequences, of the functions alcohol served for her, the acknowledgement of her dependent longings and her need for others, the budding sense that she had the right to set limits in relationships, all emerged first in the therapeutic interchange before she bravely took the understandings out into the world.

Identity develops in relationship- engaging in the give and take, the testing my values against yours. The treatment is the result of a whole host of transparencies and negotiations, of both mirroring ("I see you.") and distinguishing ("You see me.").

Enactments are most alive, affectively charged and accessible to change when they can be identified and addressed in the therapy relationship. Transparency around what is enacted in the therapy relationship, a transparency that often is led by the therapist's willingness to reveal his own internal processes, can allow for both a deeper understanding of the origins of the enactment and also open the door to the possibility of something new.

LITERATURE REVIEW:
EMERGING ADULT MENTAL HEALTH

Jennifer L. Tanner, Ph.D.

Co-editor, *Yellowbrick Journal*

The purpose of the LITERATURE REVIEW is to provide readers with a sampling of scholarship that has been conducted since the prior issue. The LITERATURE REVIEW draws attention to and summarizes research and writing that has relevance to the rapidly progressive specialization in designing interventions that support development, facilitate healthy adjustment, and reduce mental health problems among emerging adults, ages 18 to 29. In this issue, we celebrate the 10th anniversary of Yellowbrick. This 5th LITERATURE REVIEW reflects great progress and significant momentum in research and practice dedicated specifically to meeting the mental health needs of emerging adults and their families.

Dr. Jesse Viner, CEO & Chief Medical Officer of Yellowbrick deserves credit for the concept and having the vision to include the LITERATURE REVIEW in each issue. With the same level of enthusiasm I had when I wrote the first LITERATURE REVIEW, it is my honor to offer you this 10th anniversary review. Cheers to future decades watching Yellowbrick make contributions to clients, their families, and the community-at-large. And cheers to all of us for making progress to fill-in a service gap for an age group defined by pure promise.

LITERATURE REVIEW

Working with emerging adults offers the unique opportunity to say, "I see you, I see your past, I see you now, and I am confident you're entitled to a healthy future." Over two decades ago when I took the first steps of my research career, I wondered, *where is the literature on young people—ages 18 to 29? Where are they represented?* I could have accepted that adolescent services or adult services were adequately designed to meet their needs, except that they weren't. I observed, over and over again, late adolescents and 20-somethings reaching-out for and failing to find help they desperately wanted, needed, and deserved. Emerging adults, both then and now, turn to siblings, friends, dorm-mates, girlfriends and boyfriends to be their therapists. Generally speaking, they remain significantly under-served.

What has changed over the years is that now I can say— *we've come a long way baby.* It is my pleasure to announce the publication of the first APA Handbook Chapter on Specialty Practice in Emerging Adult Mental Health. This is a sure sign that the call for attention to recognize emerging adults with mental health problems has been heard. We can also interpret from the inclusion of this chapter in *The Handbook,* we've been granted a greenlight to proceed with our efforts. And proceed we will.

In this 5th issue of *Yellowbrick Journal,* marking the 10th anniversary of Yellowbrick, I have taken a different approach to organizing the LITERA-TURE REVIEW. Please consider this a review within a review. The LITERATURE REVIEW first references the aforementioned handbook chapter. Following, readers will find the LITERATURE REVIEW organized by the main points of the chapter. After each main point readers will find citations to thought-provoking, informative research reflecting the fast progress we're making to conceptualize and bring tailored services to young people ages 18 to 29. From one member of our dedicated community to another, may you find this information helpful and may it validate us all in our belief that we are fortunate to have good work to do.

> Tanner, J. L., & Arnett, J. J. (2016). Chapter 7: Emerging Adult Clinical Psychology, pp. 127-138. In John C. Norcross, Gary R. VandenBos, & Donald K. Freedheim (Editors-in-Chief) *APA Handbook of Clinical Psychology: Volume I, Roots and Branches.* Washington, DC: APA.

We are beginning to see government agencies, at the state and federal levels in the U.S. and in other countries, prioritize the health, mental health, and well-being of emerging adults. As a result, independent scholars and working groups have made efforts to outline new goals and objectives related to distinguishing the 18 to 29 year-old age period as a distinct life stage with unique risks, vulnerabilities, and opportunities for resilience and recovery. Over the next decade, it will be interesting to follow refinements of our understanding of this critical juncture in lifespan human development.

> Tanner, J. L. (2015). Mental Health in Emerging Adulthood, chapter 31, pages 499-520. In J. J. Arnett (Ed), *The Oxford Handbook of Emerging Adulthood.* NY: Oxford University Press.

> Bonnie, R. J., Stroud, C., Breiner, H. (Eds.) (2015). *Investing in the health and well-being of young adults.* Washington, DC: National Academies Press.

> Haber, M. G., LaPorte, T. M. & Knight, N. M. (2014). Young adult services. *The Handbook of Adolescent Behavior Problems,* 649-669.

Developmental history of psychopathology must be front and center in work with emerging adults. Childhood psychiatric disorders persist and recur in emerging adulthood, and there are also spillover effects from subclinical and undiagnosed conditions. In addition, by emerging adulthood, psychiatric disorders and symptom patterns are best conceptualized as complex cases, reflecting high rates of comorbidity not only with respect to psychiatric disorders, but also between learning disorders, psychiatric disorders, and physical health problems.

Bao, L., Brownlie, E. B., & Beitchman, J. H. (2016). Mental health trajectories from adolescence to adulthood: Language disorder and other childhood and adolescent risk factors. *Development and Psychopathology, 28(*2), 489-504.

Copeland, W. E., Shanahan, L. Davis, M., Burns, B., Angold, A., & Costello, E. J. (2015). Untreated psychiatric cases increase during the transition to adulthood. *Psychiatric Services, 66*(4), 397-403.

Copeland, W. E., Wolke, D., Shanahan, L., & Costello, E. J. (2015). Adult functional outcomes of common childhood psychiatric problems: A prospective, longitudinal study. *JAMA Psychiatry, 72*(9), 892–899.

Pakasarian, D., Cui, L., & Angst, J. (2016). Latent trajectories of common mental health disorder risk across 3 decades of adulthood in a population-based cohort study. *JAMA Psychiatry, 73*(10), doi: 10.1001/jamapsychiatry.2016.1921

Untreated neurodevelopmental disorders that are first discovered or remain undiscovered in emerging adulthood can account for a significant proportion of functional impairment. All mental health professionals working with this age group, if they have not spent time considering the high rate of undiagnosed neurodevelopmental disorders in this age group, may benefit from knowing that the majority of these disorders that onset early in the lifespan often do go undetected. The sequelae of not having self-understanding of one's own atypicalities can be wide-ranging and, specifically, may undermine an emerging adult developing an accurate sense of self.

Hartman, C. A., Guerts, H. M., Franke, B., Buitelear, J. K., & Rommelse, N. N. J. (2016). Changing ASD-ADHD symptom co-occurrence across the lifespan with adolescence as a crucial time window: Illustrating the need to go beyond childhood. *Neuroscience & Biobehavioral Reviews, 71,* 529-541.

Hechtman, L. (2016). *Attention deficit hyperactivity disorder: Adult outcome and its predictors.* NY: Oxford University Press.

Uchida, M., Spencer, T. J., Faraone, S. V., & Beiderman, J. (2015). Adult outcome of ADHD: An overview of results from the MGH Longitudinal Family Studies of pediatrically and psychiatrically referred youth with and without ADHD of both sexes. *Journal of Attention Disorders.* doi: 10.1177/1087054715604360

As scientific literature that examines mental health, psychopathology, and functioning in the late teens and twenties continues to mount, it is becoming impossible to disregard the role that developmental histories of adverse childhood experiences and trauma play in the accurate assessment, diagnosis, and treatment of emerging adults. Several studies, primarily the CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study, offer insightful research findings that will shape the future of health care for transition-aged young people.

CLASSIC: Schilling, E. A., Aseltine, R. H. Jr., & Gore, S. (2007). Adverse childhood experiences and mental health in young adults: A longitudinal survey. *BMC Public Health, 7*(1), 7-30.

Ballard, E. D., Eck, K. V., Musci, R. J., & Hart, S. R. (2015). Latent classes of childhood trauma exposure predict the development of behavioral health outcomes in adolescence and young adulthood. *Psychological Medicine, 45*(15), 3305-3316.

Korotana, L. M., Dobson, K. S., Pusch, D., & Josephson, T. (2016). A review of primary care interventions to improve health outcomes in adult survivors of adverse childhood experiences. *Clinical Psychology Review, 46,* 59-90.

Nurius, P. S., Green, S., Logan-Greene, & Borja, S. (2015). Life course pathways of adverse childhood experiences toward adult psychological well-being: A stress process analysis. *Child Abuse & Neglect, 45,* 143-153.

Work with emerging adults requires mental health professionals to be well-versed in theories of personality; and, especially, self development. Distinguishing typical from atypical thought, behavior, and emotional patterns is equally important, if not more important than understanding categorical disorders of personality. Digging into literatures on attachment theory, neurobiology of self and self-development, and family interaction patterns offer us frameworks for reconceptualizing symptoms we observe in emerging adults as adaptations to less than ideal need-meeting experiences in their developmental histories.

Knox, J. (2016). Epistemic mistrust: A crucial aspect of mentalization in people with a history of abuse? *British Journal of Psychotherapy, 32*(2), 226-236.

Lyons-Ruth, K., Brumariu, L. E., Bureau, J-F., Henninghausen, K., & Holmes, B. (2014). Role confusion and disorientation in young adult-parent interaction among individuals with borderline symptomology. *Journal of Personality Disorders, 28,* 641-682.

Perez, N. M., Jennings, W. G., Piquero, A. R., & Baglivio, M. T. (2016). Adverse childhood experiences and suicide attempts: The mediating influence of personality development and problem behaviors. *Journal of Youth & Adolescence, 45(8),* 1527-1545.

Schore, A. N. (2015). *Affect regulation and the origin of the self: the neurobiology of emotional development.* NY: Routledge.

If we adopt the goal of moving away from treatment that focuses only on classic diagnosis, assessment, and symptom reduction treatments, we risk failing to provide emerging adults with the structure and support needed to make normative developmental progress. Advances in theoretical conceptualizations of typical emerging adult development and measurement tools for assessing heath-enhancing behaviors, attitudes, and values (i.e., contributing to self-regulation) provide mental health professionals with a framework for designing developmentally-informed, research-based treatment plans for emerging adult clients.

Chandler, G. E., Roberts, S. J., & Chido, L. (2015). Resilience intervention for young adults with adverse childhood experiences. *Journal of the American Psychiatric Nurses Association, 21*(6), 406-416.

Madewell, A. N., & Ponce-Garcia, E. (2016). Assessing resilience in emerging adulthood: The resilience scale (RS), Connor-Davidson Resilience Scale (CD-RISC), and Scale of Protective Factors (SPF). *Personality and Individual Differences, 97,* 249-255.

Sieff, D. F. (2015). *Understanding and healing emotional trauma: Conversations with pioneering clinicians and researchers.* NY: Routledge.

Siegel, D. J. (2015). Interpersonal neurobiology as a lens into the development of wellbeing and resilience. *Children Australia, 40*(2), 160-164.

Author Bios

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Harold K. Bendicsen, LCSW, BCD, is a clinical social worker who maintains a private practice in Elmhurst, Illinois. He holds certificate in Child and Adolescent Psychoanalytic Psychotherapy from the Chicago Institute for Psychoanalysis. He has held clinical, supervisory, and administrative positions in child welfare agencies, residential treatment centers, and social service agencies. He is an Adjunct Professor at Loyola University Chicago School of Social Work and a member of the faculty of the Child and Adolescent Psychoanalytic Psychotherapy Training Program at the Chicago Institute for Psychoanalysis.

Dale Monroe–Cook, Ph.D.

Dr. Monroe-Cook is Vice President for Clinical Operations at Yellowbrick. Dr. Monroe-Cook earned his Ph.D. in Counseling Psychology from Michigan State University in 1979, completing specialized training in family therapy through the Family Life Clinic there. He has extensive clinical and administrative experience in the treatment of substance abuse and dual diagnosis disorders, including functioning as Chief of Family Services for the substance abuse program at Martha Washington Hospital and as the Director of Substance Abuse Services at Four Winds Chicago. Throughout his career, he has maintained a commitment to the development and implementation of integrative models of treatment for individuals and families with concerns regarding addictive behaviors. As VP of Clinical Operations at Yellowbrick since the opening of Yellowbrick in 2006, Dr. Monroe-Cook functions as Chief Clinical Officer and is responsible for development and implementation of the comprehensive Family Model and the Parents as Partners Program.

Dr. Monroe-Cook is the father of an emerging adult son and daughter.

David Daskovsky, Ph.D.

Dr. David Daskovsky is Senior Staff Psychologist and Director of Training at Yellowbrick. Dr. Daskovsky earned his Ph.D. in Clinical Psychology from Northwestern University's School of Medicine in 1988. He completed his internship at Northwestern Memorial Hospital's Institute of Psychiatry and also served as Chief Intern there in 1987-8. For the next nine years, Dr. Daskovsky provided individual and group psychotherapy as a staff member of NMH's Extended Partial Hospitalization Program, which offered intensive, long term treatment for adults with severe mental illnesses including many who had suffered chronic trauma. In 1998, he became Director of Psycho-Social Rehabilitation at Trilogy, Inc. and in 2003 became that agency's Clinical Director, a position he held until coming to Yellowbrick in 2009. While at Trilogy, Dr. Daskovsky was instrumental in the development of a highly respected practicum training program and has long been committed to teaching graduate students about the treatment of mental illness in community settings. He is an Assistant Professor in the Division of Psychology at Northwestern's Feinberg School of Medicine.

Dr. Daskovsky is the father of three emerging adults.

Eliza Hofman, MFA

Eliza Hoffman is a Creative Arts Specialist at Yellowbrick. Originally from Philadelphia, Eliza took her first yoga class over 15 years ago and became a certified yoga teacher in 2005. Her studies have included many styles of yoga, from vigorous practices to therapeutic trainings under the Kripalu and Parayoga traditions. Her teaching style links appropriately-modified physical practice with a commitment to mindful body awareness. She believes that the student should receive practical skills to access the body, mind, and spirit. Her yoga teaching motivates practitioners to gain self-compassion and positively impact themselves and the world around them. When not teaching yoga, Eliza can be found acting in plays throughout the thriving Chicago theatre community. Eliza holds an MFA in Shakespeare from Mary Baldwin College and a BFA in Drama from NYU.

Michael Losoff, Ph.D.

Dr. Michael Losoff is a Staff Psychologist and Coordinator of the Men's Trauma recovery program at Yellowbrick. Dr. Michael Losoff is a graduate of Loyola University of Chicago, subsequently earning a Masters in Human Development from the Pennsylvania State University and a PhD in Psychology from the University of Texas at Austin. He completed a two-year NIMH Post-Doctoral Fellowship in Research and Clinical Work in Adolescence, jointly sponsored by Northwestern University Medical School and The University of Chicago. Across his career, he has held leadership positions in the provision of high quality psychological services for both the public and private sectors, including as President (2012-2014) of the Chicago Association for Psychoanalytic Psychology. He has spoken frequently on the skills and art of psychoanalytically informed treatment across a range of ages, particularly adolescence and emerging adulthood. Dr. Losoff brings a deep understanding of development during adolescence and young adulthood and to utilizing this understanding within the kinds of rich clinical settings that are relevant and resonant to Yellowbrick's intensive community immersion model of treatment.

He is the father of an emerging adult daughter and son.

Irwin Siegel, M.D.

Irwin Siegel, M.D., is a specialist in neurology, has been practicing in the field of medicine for over 60 years. He is currently Associate Professor at Rush University Medical Center hospital in Chicago, Department of Neurological Sciences. He was awarded his medical degree from Northwestern University in 1954. He has received numerous awards in his field and by the state of Illinois. His clinical expertise focuses on neuromuscular disorders, postpolio syndrome, and the orthopaedic complications of neurological disease, diagnosis, and treatment. His research interests include orthotic design and gait in movement disorders.

Jennifer L. Tanner, Ph.D.

Dr. Jennifer Tanner received her doctorate in Human Development and Family Studies from The Pennsylvania State University. Dr. Tanner is an applied developmental psychologist whose work focuses on developmental and clinical issues of emerging adulthood (ages 18 to 29). She is co-founder of the Society for the Study of Emerging Adulthood (www.ssea.org) and has authored numerous publications on emerging adult development and adaptation including the co-edited book, *Emerging Adults in America: Coming of Age in the 21st Century* (APA Books). She serves on executive boards and provides consultations to organizations whose missions are to design and develop programs to benefit emerging adults. She has taught and supervised emerging adults at Boston College, Tufts University, The Pennsylvania State University, Farleigh Dickenson, and Drew University. In addition, Dr. Tanner delivers programs on emerging adulthood and writes a blog on these issues for Psychology Today, Becoming Adult. www.jenniferltanner.com

Jesse Viner, M.D.

Dr. Jesse Viner created Yellowbrick in recognition of the specialized needs of emerging adults and their families, and the necessity for a treatment system that addressed the unique challenges of the transition into adulthood. A recognized expert in the treatment of eating disorders, difficulties resulting from trauma and bipolar disorder Dr. Viner has three decades of experience applying the knowledge of psychiatry and psychoanalysis to the challenge of creating meaningful and pragmatically effective treatment programs.

Following his education at Yale, The Chicago Medical School, Northwestern University Medical School Psychiatry Residency and The Chicago Institute for Psychoanalysis, Dr. Viner has served as Director of Adult Psychiatry Inpatient Services for Northwestern University Medical School; Medical Director of Four Winds Chicago, a private psychiatric healthcare system; and Director of University Behavioral Health, a group practice on the North Shore of Chicago. He is on the faculty of the Chicago Institute for Psychoanalysis, and an Assistant Professor of Clinical Psychiatry at Northwestern Feinberg School of Medicine (1980-2012). Dr. Viner is a Distinguished Life Fellow of the American Psychiatric Association. Dr. Viner is the recipient of the Illinois Psychiatric Society 2015 award for *Excellence in Patient Services*.

Dr. Viner is parent to six emerging adult and young adult sons (2) and daughters (4).

Laura Viner, Ph.D.

Dr. Laura Viner is the Director of The Emerging Adult Assessment Center and the Director of Research at Yellowbrick. Dr. Laura Viner is a Clinical Psychologist and tenured Associate Professor of Psychiatry and Behavioral Sciences and Northwestern University Medical School. For over 30 years, Dr. Viner has done clinical research, teaching of Psychology and Psychiatry students, assessment and clinical treatment of individuals, families and groups with adults, adolescents, and children. She has published over 50 scholarly articles in scientific journals and books, including her recent popular psychology book on psychoneuroimmunology, *The Joy Formula for Health and Beauty*. Dr. Viner also gives scientific presentations to professional audiences around the country.

Prior to Yellowbrick, Dr. Viner was Senior Staff Psychologist at The Family Institute at Northwestern University where she also developed and directed a program for inner city children and their families to prevent violence and antisocial behavior. Earlier at Northwestern, Dr. Viner was Director of the Outpatient Eating Disorders Program.

Dr. Viner is parent to six emerging adult and young adult sons (2) and daughters (4).