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Clinical Practices

Part 2 - Treating Adolescents with Substance Use Disorders

Adolescence is a period of rapid change. . Between the ages of 12 and 17, for example, a parent ages as much as 20 years.
~Author Unknown ~

Adolescents are fundamentally different from adults and they generally do not benefit from adult substance abuse treatment approaches that are merely "youthed up". From pre-adolescence (11-12 years) and on through the early adult phase (18-24 years) adolescents encounter numerous developmental challenges including physical, emotional and neurological growth and adaptation. Youth also begin to form and solidify their values and beliefs, their perspectives on relationships and sexuality, and their own interests and talents. Each of these issues and development experiences is also influenced by the degree to which the adolescent is system-dependent (home, school, etc.) and both socially and economically supported. Within this myriad of issues, it is not surprising that experimentation and regular use of substances may surface and it may present quite differently from difficulties that appear with adults abusing substances.

Given the aforementioned factors, effective adolescent treatment programs must incorporate specific techniques, activities, and settings tailored to an adolescent's emotional, physical, and psychosocial context. Counselors working with adolescents must have training specific to working with youth and young adults so they can develop their treatment skills in this environment (Moseley, 2007). This article and the following issue of the *Addiction Messenger* will examine the very challenging field of adolescent addiction treatment.

Adolescence, in modern industrial societies, is the transition from childhood to adulthood. It typically lasts from age 11 or 12 until the late teens or early to mid twenties. Adolescence is full of opportunities for physical, cognitive, and psychosocial growth, but it's also a time full of risks to barriers for healthy development. Risky behavior patterns, such as drinking alcohol, drug abuse, sexual activity, gang affiliation and use of firearms, tend to be established early in adolescence. The good news is that roughly 4 out of 5 young people experience no major problems in adolescence. (Papalia et al, 2006)

What type of treatment works best for adolescents? Simply, treatment that is developed with and tested on adolescents, rather than adult treatment that is merely adapted in some form or fashion. Effective adolescent treatment specifically addresses their developmental needs and is provided by a specially trained counselor who enjoys working with this challenging population and who possesses qualities that resonate with adolescents. For example, adolescent counselors should be comfortable with their youthful clients' potential emotional lability, the strong influence of their peers, and their discontent with and often rejection of adults.

In adolescent substance abuse treatment, EBPs range widely in their design and application, from individual forms of counseling to family therapy. Achieving the best outcomes for adolescents requires some combination of EBP and "practice-based evidence" (UNCG, 2008). Cognitive behavioral therapy, motivational interviewing, and multisystemic therapy are a few of the modalities that have shown effectiveness and will be discussed in the second issue of this two-part series.

Why is it important to pay more attention to treating adolescents? First, there is a pressing need. We are entering a renaissance of new knowledge in this area, but are only reaching 1 of 10 adolescents in

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Next Issue:

Evidence-based Practices for Screening, Assessment and Treating Adolescents with Substance Use Disorders.

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need of treatment (Dennis, 2006). Clearly, preventing consequences such as accidents, involvement with the corrections system and family disruption is vital. Substance use can also hamper an adolescent's emotional and intellectual growth and prevent them from completing the maturational tasks of adolescence: personal relationships, identity formation, individuation, education, employment and family role and responsibilities (Townsend, n.d.). Interestingly, those who receive treatment as adolescents are less likely to become chronic substance users as adults, even if their initial experience with treatment is not successful (Moseley, 2006).

Differences Between Adolescents and Adults: Treatment Implications

Adolescence is neither childhood nor adulthood—rather it is the time of transition from one stage to the other. Developmentally, adolescence is a time of:

- skill acquisition and practice
- experimentation, risk taking and novelty seeking
- intense fluctuations on all levels: emotionally, behaviorally, and physically
- changes in diet, sleep, mood, weight, attitude, decreased pleasure from daily activities
- increases in peer relationships and a decrease in time spent with family
- increases in conflicts with authority
- gradual improvements in the ability to link causes and consequences (particularly strings of events over time) and development of impulse control and coping skills
- concerns about avoiding emotional or physical violence (Dennis, 2002)

Adolescents also process information and, indeed, think differently than adults. Cognition is characterized by a shift from concrete to abstract, more hypothetical thinking, more introspection and self-consciousness, a tendency to focus on the here and now, more idealism, feelings of invulnerability. The single quality of invulnerability provides a classic example of how adult treatment methods don't work with adolescents—counselors attempting to reason with an adolescent about long-term health effects of substance abuse often do so futilely because the adolescent is literally unable to appreciate such long-term consequences. This lack of connection or understanding may be misunderstood as hostility or belligerence, creating an unnecessary conflict or rejection of the treatment message or materials.

The adolescent brain is a work in progress and, unfortunately many of its physical/developmental characteristics provide fertile ground for addiction. Put overly simply, the pleasure center in the adolescent brain is readily activated, whereas higher judgment circuits are not as thoroughly "wired". The ability of a drug to generate an addiction is more powerful when a person experiments during adolescence than when they use in adulthood.

Behaviorally, adolescents will tend to test limits, take risks, act out, experiment with extremes, quickly shift mood, dramatize and exaggerate. Despite these rather assertive and overt behaviors, emotionally they often feel powerless, alienated, rebellious, anxious and moody. The addictions treatment counselor must be able to work within these disparate experiences, recognizing their need for both testing limits and being emotionally "held" and supported.

There are other contextual and environmental considerations in adolescent treatment as well. Most adolescents are not autonomous or self-directed, rather they are part of other systems over which they may have little or no control or choice—family, school, work, etc. These environments can impact treatment engagement and success. For example, adolescents living in stressed family systems may be delayed in acquiring abstract thinking or may lack some family or other supports during and after treatment. Adults may also lack those support systems, but they generally have more power and freedom of choice regarding alternative environments as compared with adolescents seeking social services. All of these issues must be taken into account when counseling adolescents.

The clinical presentation of adolescent substance use disorders differ significantly from adults despite common biopsychosocial and etiological influences. Most adolescents don't develop classic physical dependence or well-defined withdrawal symptoms. They do not exhibit the physiological deterioration seen in many adults because of the shorter duration of exposure to substances. Yet adolescents remain vulnerable to the full range of emotional, behavioral, familial and cognitive manifestations of addiction. Further, the progression from casual use to dependence can be more rapid in adolescents than in adults. For some youth, signs of abuse and dependence may include:

- changes in school performance, peer group (hanging out with drug-using, antisocial, older friends), physical appearance (weight loss, lack of cleanliness), eating or sleeping habits, activity levels (sudden increase or decrease);
- extreme mood swings, depression, irritability, anger;
- behaviors such as lying, stealing, breaking rules, withdrawing from the family;
- physical manifestations such as red, watery, glassy eyes or runny nose not due to allergies or cold; and
- using street or drug language or possession of drug paraphernalia/items.

A higher degree of co-occurring psychopathology is typically evidenced by adolescents. Trauma can be a significant underlying issue with many youth and without careful attention to those issues, chances of successful recovery are diminished.

The table on page 3 lists other important contrasts between adolescents and adults, each with implications for effective treatment.

Equally important, research is revealing what doesn't work in adolescent treatment, including:

- passive referrals
- educational units
- probation services
- unstandardized outpatient services
- treatment of adolescents in "groups including one or more highly deviant individuals" (but NOT all groups)
- treatment of adolescents in adult units and/or with adult models/materials (particularly outpatient) (Dennis, 2002)

Here are a few more examples of how "treatment as usual" needs to be adjusted for adolescents:

- Examples given in counseling need to reflect the substances, situations, and triggers that are relevant to youth
- Consequences discussed in counseling should reflect issues of concern to adolescents
- Materials should converted from abstract to concrete

- Comorbid problems (mental, trauma, legal) are the norm and often predate substance use
- Treatment has to take into account the multiple systems (family, school, welfare, criminal justice) in which adolescents operate
- Adolescents have less control of their life and recovery environment, less aftercare and social support (Dennis, 2002)

A recent review of "what works" in adolescent treatment revealed the following (Dennis, 2002):

- Assessment needs to be very concrete
- Multiple co-occurring problems are the norm in clinical samples of SUD adolescents (60-80% external disorders, 25-60% mood disorders, 16-45% anxiety disorders, 70-90% 3 or more diagnoses)
- Adolescents are involved in multiple systems competing to control their behavior (e.g, family, peers, school, work, criminal justice)
- Relapse is common in the first 3-12 months
- Recovery often takes multiple attempts and episodes of care that may take years
- Family therapies were associated with less initial change but more change post active treatment (and the same in long-term effects)
- Effectiveness was associated with therapies that:
  - were manual-guided and had developmentally appropriate materials
  - involved more quality assurance and clinical supervision
  - achieved therapeutic alliance and early positive outcomes
  - successfully engaged adolescents in continuing care, support groups, positive peer reference groups, more supportive recovery environments
- It is essential to conduct aftercare monitoring with all adolescents
- The effectiveness of therapy was dependent on changes in the recovery environment and social risk
- Effectiveness was not consistently associated with the amount of therapy over 6-12 weeks or type of therapy

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Counselor Qualities

Counseling adolescents can be extremely rewarding, and also poses big challenges. Successful adolescent counselors often possess certain personal qualities, including: good self-knowledge; personal vision and passion for working with this group; uses insight and demonstrates courage; creative and thinks "outside the box"; establishes structure; can identify and praise strengths in adolescent clients; stays vigilant and doesn't quit; understands and employs motivational approaches; understands youth culture (Hargett, n.d.).

Adolescents, when asked about qualities they prefer in "helping" adults, say the following are important to them: being

Contrasts Between Adults and Adolescents In the Progression of Chemical Dependency (Gust and Smith, 1994)

Adolescent	Adult
6 – 18 month progression	5 – 10 year progression
Mostly psychological dependence	Tolerance/withdrawal
Glorification of use	Minimization of use
"Garbage can" syndrome	May have a single chemical of choice
Social activities often are chemical use	Social activities may include chemical use
Developmental issues can delay identification of C/D	Social/professional standing obscures identification of C/D
Early arrest of emotional development	Minimal arrest of emotional development
Morning use not indicative of chemical dependency	Morning use often indicates chemical dependency

respectful, sharing time, being open, offering recognition, offering trust, and supporting their freedoms as appropriate. Further, the therapeutic alliance with an adolescent is assisted by: trust, being helpful, offering support rather than advice in honoring their movement towards autonomy, being nonjudgmental, respecting their perspective, allowing them to make choices, being direct and honest, and helping them to see the value of therapy to their own individual needs, goals and hopes (Harget, n.d.).

Adolescent counseling is not for everyone. David Jefferson, MSW, CDP, is a Research Associate with Northwest Frontier Addiction Technology Transfer Center and experienced counselor of adolescents. He offers the following tips:

1. Spend time volunteering or working with youth before you make the investment in your education in this area of expertise.

2. Take as many adolescent-specific courses as you can before you start working with youth. Courses in human development, family systems and theory, models of teaching and latest youth EBP are all worth the time and effort. Knowing about adolescents is as important or maybe more important than knowing how to treat addiction.

3. Find a mentor; it is steep learning curve and guidance goes a long way.

4. The field of adolescent services is always changing; if you like change, you will like this service domain, if you want stability and consistency, try a different population.

5. If you decide to take a job with a youth serving agency, look closely at their model of care and services. Pick programs that are innovating and staying relevant with new treatment protocols.

David also shares that he likes counseling adolescents, because among other things it offers: "a chance to address a substance use disorder at the start, before it has progressed. Youth need our specialized help to find a path to wellness. I like that the hope and possibilities are high…. and that I could help somebody avoid the years of suffering that addiction is guaranteed to bring."

Engagement

As with adult treatment, building a trusting relationship with adolescents is critical. A counselor who doesn't genuinely like and understand this population is likely to have trouble creating engaging interactions. Additionally, engaging youth differs from adults in several other ways:

- how quickly a trusting relationship is likely to develop (youth will take longer to trust most adult counselors),
- the timing of when to introduce concepts such as abstinence (introduce it too soon and you may get compliance, but not long term recovery),
- the importance of engagement with family and other systems upon which youth are dependent and in which they will recover (leave these other "systems" out and recovery is hampered at best).

Adolescents need support, guidance and some degree of independence, which can be a tricky combination to provide.

In the next issue of this series we will explore current evidence-based practices for screening, assessment and treating adolescents with substance use disorders.

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