The challenges of adolescence

Adolescence is a crucial stage of biopsychosocial development paving the way for self direction, independence and adulthood. Adjusting to adolescence, however, can be tenuous, with challenges from diverse sources. Peer influence on knowledge, attitudes, values, interests, and action patterns becomes more salient. Indeed, normative preferences of peers, novelty pursuit, risk taking and pleasure seeking are important factors affecting adolescent decision making [1].

Prepared or not, the adolescent confronts starkly with the “real world”, expecting and expected to achieve, at the same time striving to safeguard his/her self esteem, establish social connectedness, and deal with future challenges leading to sustainability and independence. In the process, distorted beliefs about heroism and romanticism may escalate the adolescent’s sense of discontent and frustration. Vulnerability is intensified due to erratic role models, short time perspective, impatience, impulsivity, low perseverance and frustration tolerance. Proper channelling of rapid biological changes and upsurge of energy, as well as coping with intense psychosexual needs often prove daunting.

Compounding the challenges are the stresses of economic concerns, academic pressures, uncertain occupational prospects, sexual maturation and tension, peer conflicts and acceptance, family discord and parental conflicts, psychiatric/psychological problems, and increase focus on materialism and competition against a background of fading traditional Chinese values. The lure of drugs and promise of quick relief thus becomes more salient.

The high risk syndrome

Against the stormy course of adolescent development, the pathway to high risk behaviours has been more clearly mapped out in the recent literature. The classic assertion of Jesser that adolescent problematic behaviours tend to co-vary and cluster into a “risk behavior syndrome” has largely been supported by subsequent research [2]. Stronski et al in their national study noted that amongst other high risk behaviours, cigarette smoking and alcohol use were associated with subsequent marijuana use, supporting the theory of sequences of drug use and involvement, in which a legal drug such as tobacco or alcohol precedes and potentiates the subsequent use of marijuana [3]. In addition, Stronski et al reported escalation in other problem behaviours (such as antisocial acts, injuries, tobacco use, early sexual experiences, depressed mood, and suicide attempts) amongst marijuana users, compared to non-users [3]. A similar pattern of high risk behavioural development had also been noted in our own study on Hong Kong adolescents [4].

The high risk behavioural syndrome may prompt further risks for physical malaise (self harm and accidents), escalating illicit drug use, casual sex (with increased risk of abortions, sexually transmitted diseases, HIV, cervical cancer), mental health problems (depression, anxiety, low self esteem, maladjustments), and social issues (school dropouts, disadvantages, delinquency, second generation problems/issues). Without effective and timely help, the future of the budding adolescent may be destroyed with potential adverse end points, including school failure and dropout, social maladjustment, substance abuse, teenage pregnancies, abortions, unprepared motherhood, family tension and alienation, mood and other psychiatric disorders, prostitution, delinquency and criminality.

Multiple factors associated with the adolescent high risk behavioural syndrome were noted in Lee et al’s study, including: limited personal/support resources; low self esteem; perceived inferior ability, appearance and popularity; low life satisfaction; family conflicts – lack of support and love; poor self rated mental and physical health; and unsatisfactory social relationship [4].
Early detection and intervention

The research so far indicates that no one single factor as being responsible for an adolescent’s drug use. Instead, multiple interlinking and mutually potentiating factors inherent in the person, family, schools, and community/culture are in operation [5].

The available literature, however, points to the importance of early detection and intervention given that a high risk behaviour may potentiate another higher risk behaviour, initiate drug use and further denigration.

The complexities of adolescent drug use problem

Interventions in adolescent drug abuse have generally been difficult and yielded unsatisfactory results. The problem of relapse looms large in any intervention program. Up to 70-80% of adolescents will relapse within 1 year after quitting, and up to two-thirds of this percentage relapse after the first 3 months of treatment.

Multi-modal interventions are required including psychological, medical, community and social interventions. Effective psychological treatment has to be guided by realistic conceptualisation and understanding of the process underlying and maintaining the inception and maintenance of drug abuse.

Stages of motivation for abstinence

The motivation for drug abstinence needs to be ascertained and intensified. Different stages of readiness, from precontemplation to contemplation, action, and maintenance of a drug-free lifestyle should be noted for appropriate treatment planning [6]. Youths who use drugs are motivationally diverse. Precontemplators may pay lip service to the merits of abstaining, but basically still believe that “I have no problem, and there is no need for any change”. Contemplators may be a step closer to initiating genuine change with more willingness to consider the benefits of change despite that no plans or skills are yet present. Those more genuinely prepared are inclined to resolve that “it’s time to do something different”, leading to attempts to abstain for at least a day or more. Those in maintenance strive to stay drug free for at least 6 months or more. Identifying the different stages of the youths’ readiness guides the nature and focus of interventions.

Need to avoid stereotypes

Every youth is different with their unique developmental and family history, having diverse needs and confronting different challenges. Stereotypes must be avoided. To understand is not to categorise. Help is a joint venture, working “with” rather than “on” youths. Optimal therapeutic conditions of trust and collaboration must be established at the start. Differences should be respected and complexities expected. Multi-drug use is not uncommon. Co-existing psychiatric disorders may be present in up to one-third of drug abusing youths, the most frequent of which are mood disorders, antisocial personality disorders, mania, and schizophrenia. Drug abusing youths may also be entangled in a web of complex social, economic, legal and health problems, frequently requiring concurrent tangible help as well.

Psychological conceptualisation

To be effective, psychological interventions are best guided by a realistic conceptualisation of the underlying problem. A framework for understanding drug abuse is presented below as a basis for treatment strategy.

Understanding motivation

As a start, thoughts and beliefs relating to drug use have to be noted. The question of “what motivates you when you use drugs?” needs to be answered, whether it be for relief of dysphoric mood, booster self esteem, thrills, or enhance social acceptance. At a later stage, explorations with the youth about “what goes through your mind when you continue to use drugs in spite of their devastating consequences?” are needed so that drug-use motivating and maintaining factors may be clarified and targeted.
Pre-existing vulnerability

Pre-existing vulnerability comes to play especially during stressful times and paves the way for initial drug use and experimentation. Early negative experiences including parents who model substance use and lack of validation (in contrast to protective factors like secure personal relationships, supportive family, and validation from important others) may continue to plague the vulnerable adolescent, and serve as precursors to low self esteem, misguided values, as well as indiscriminate need for social approval and acceptance.

The youths’ negative beliefs about themselves, their personal world, other individuals, and their future affect their vulnerability. When lovability and adequacy are continually put to doubt, when social acceptance remains precarious despite being much sought after, when emotional distresses are chronically experienced, the lure for quick fixes and relief of negative emotions is heightened.

Beliefs facilitating first time drug use

Conditioned beliefs concerning drugs often come to play during initiation into drug use. For example, in face with social pressure, the adolescent may believe that “If I use drugs, then I’ll be popular”, or “If I don’t use drugs, I will be seen as a wimp”. The danger of drug use may be unwisely minimised with the conviction that “A one-time use has no major consequences”, “I can control myself and would never depend on it”. The youth’s emotional needs also influence choice of drugs. For example, numbing anxiolytic substances are often used to lower fear, as well as distresses relating to low self esteem and social incompetence.

Drug use maintaining factors

Initial drug use provides short-term positive experience that becomes chronically sought. A one-time drug use opens the flood gate to ongoing perpetuating cycles of continual use, relief reinforcement, and cravings followed by lowering inhibitions for further use. The drug use habit can be rather easily established given its rapid and intense impact, subsequent distressing craving, and short of any alternatives providing comparable seemingly effortless good feeling states and/or escape from bad ones.

Various drug related beliefs have been noted to facilitate drug use. In broad terms, two types of drug use beliefs have been noted:

a. Anticipatory beliefs: expectation of gratification, increased personal efficacy, heightened sociability.

    Examples: “I can’t have fun unless I have ‘x substance’ in me”, “go ahead”, “life is short”, “I’m so cool”.

b. Relief-oriented beliefs: relief from unpleasant physical and emotional states.

    Examples: “I can’t stand it anymore”, “only drugs will do, nothing else can make me feel better”.

Continual drug use makes drug-related beliefs more pervasive, salient, and accessible, and enables such beliefs to be activated by an ever increasing range of circumstances, making continual use more preferred and entrenched.

As time goes by, situations likely to trigger such beliefs and lead on to drug use increase in breath and diversity. High risk situations prompting easy triggering of such drug use beliefs have been noted as follows:

| Internal: negative emotions (anxiety, depression, boredom, anger, frustration, loneliness), positive emotions (fun times and celebration), physical sensations (pain, hunger, fatigue, withdrawal symptoms); |
| External: interpersonal conflicts, availability of substance, peer usage, task accomplishments. |

Harbouring a strong conviction of the efficacy of drugs in achieving personally desired states, together with an equally strong conviction that other things will “not do”, inhibition and resistance to drug use dwindles further over time. Even after successful abstinence, three
of the most common situations conducive to relapse have been noted, including negative emotional states, social pressure, and interpersonal conflicts accounting for 35%, 20% and 16% of the relapse [6]. It should thus be noted that even after a short period of abstinence, drug use is likely to rebound under adverse mood and social situations.

Urges and cravings are intensified as drugs provide immediate regulation of mood states and where non-use leads to distressing withdrawal effects. Different drugs cater to different needs, e.g. some provide anti-anxiety effects, while others have stimulating, anti-boredom effects. Some youths use drugs to turn a good mood into an even better mood as part of a celebration ritual. Unfortunately, alongside the rapid and intense impact of drug use, healthy pursuits and simple gratifications of everyday life gradually fade into insignificance.

Cravings and urges reinforce and perpetuate reliance on drugs. Urges can become highly distressing, sometimes even described as being “very physical” in nature. Increasingly, falling prey to drugs, trapped into strong cravings during withdrawal, coupled with high risk settings, youths often find themselves being obsessed and thinking about drugs all the time, with lukewarm efforts to resist, which finally leads to chronic use. With habitual use, as the conviction that “I cannot survive without it” is fortified, abstinence becomes increasingly remote.

**Psychological interventions – goals and focus**

Understanding the initiating and maintaining factors of drug use as detailed previously opens up new avenues and targeted areas of psychological interventions, namely, change drug use cognitions and beliefs, promote tolerance of negative emotions, build better self esteem, develop skills to resist conformity and social pressures, foster long-term aspirations in life to combat fixation on short-term relief of negative moods and unsatisfactory life circumstances.

However, for such interventions to be effective, the priority is that a genuine, open, mutually respectful therapeutic relationship be established. Youths may find it initially awkward to come forth given embarrassment, shame, sense of alienation, and distrust leading to underreporting of problems. Sometimes, they may even be convinced that “Non-users simply do not understand”. Barriers have to be broken down. Our stereotypes and biases against drug using youths have to be constantly held in check. Instead, to be effective, the helper must be prepared to take on an open-minded exploration of the problem and be truly empathic towards the drug abuser’s plight.

When setbacks and relapses are encountered, instead of portending that “these people are hopeless”, “they can never be trusted”, or that “this is a waste of time”, it may be more useful to consider that “he is still struggling to overcome his problem”, “his relapse is not a reflection of my inadequacies”, “when he was dishonest, it’s likely that he was feeling ashamed of the truth”, “a relapse is not the end of the world”, or “we can really learn from the relapse” [6, 7].

Having established a secure therapeutic relationship, the youth’s problems need to be carefully conceptualised.

Everybody is different. For those akin to using psychiatric formulations, be aware that there is no simple psychiatric diagnosis which can adequately capture the youth’s problems. Instead, the best approach is to be able to develop a genuine “feel” into the youth’s life, problems and living circumstances. Background information needs to be explored, and updated every now and then. Presenting problems need to be exhausted and clarified, including drugs used, pattern of use, effects, other chronic problems and difficulties, e.g. job, relationship, mood, self esteem issues. Current and/or impending crisis needs to be anticipated. Co-existing psychiatric problems need to be addressed. An understanding needs to be established together with the youth addressing “how drugs might help with, and at the same time contribute to his emotional concerns and life problems?” Motivation needs to be
fortified, identifying and strengthening aspirations rather than be fixated on running away from pains and distresses.

The youth’s beliefs related to drug use have to be thoroughly discussed and clinically addressed. A number of areas need to be routinely explored and dealt with including:

- High risk situations
- Beliefs about drugs’ efficacy and functions
- Circumstances conducive to permitting oneself to use drugs
- Beliefs held which may contribute or facilitate drug use
- Negative (undesired) and positive (desired) consequences of drug use – cost/return analyses
- Build up of more realistic understanding and cost-benefit analyses of functions of drugs.

Information gathered would be used to formulate action and change plans. Motivation for change needs to be continually monitored and fortified [1]. The following areas are routinely addressed and dealt with in therapeutic sessions:

- How does drug use serve as a coping strategy? Is there any alternative and less costly strategy available?
- What motivates you to change addictive behaviours and adhere to a non-drug use lifestyle? What are the barriers?
- How do drug use and self-esteem impact on each other?
- What change strategies would be most effective? In the short-run… in the longer-term?

Interventions and the nature of the work to be conducted with the youth are best clearly set out, agreed upon and with no surprises. Periodically, the youth’s mood state needs to be monitored and dealt with when needed. In terms of approach, guided discovery over preaching or lecturing is preferred. Given the youths’ characteristic narrow perspectives, summaries and feedbacks are required so that useful points gained would not be easily forgotten. In between sessions, positive actions are fostered, with small goals and limited successes are targeted. Low demand homework may be built in between sessions where activity scheduling and time with drug-free peers may be introduced. Episodic relapses, particularly during intense stress must be expected and dealt with. Relapse management and prevention of snowballing effect is an integral part of any drug treatment programme [8].

Critical incidents are reviewed. A cognitive behavioural approach is useful in guiding the youth to understand that events themselves would not lead on to initiation or recurrence of drug use. Rather, a better sense of efficacy is fostered when the youth is guided to see that their cognitions and reactions to the situation may be more instrumental in leading to emotional distress and thereby weakening their resolve to stay drug free. Alternative and more adaptive beliefs and cognitions as well as assertion skills may be enhanced as when needed. In promoting skills of the youth in combating drugs, it is a useful exercise to consider the following when appropriate:

- What concrete, factual evidence supports or refutes your automatic thoughts/beliefs about drug use?
- Are there other ways you could view the situation? Could it be a blessing in disguise to stimulate you to learn more adaptive ways of handling your problems?
- In distressing and high-stress situations, what is the worst thing that could happen? What is the best thing? What is most likely to realistically happen? So are your fears too extreme and you might be reacting too impulsively?
- What constructive action can you take to deal with the situation?
- What are the pros and cons of changing the way you view the situation?
- What advice would you give your best friend in this situation?
Communication skills training has sometimes been profitably incorporated into therapeutic sessions. Targeted interventions on specific personality weaknesses had been reported to be useful [9]. Various other procedures have been found to be useful, including group sessions and support, developing a drug-free buddy system, developing a mind to seeking help when relapse is imminent, identifying with a higher power, seeking religious faith, learning to face life difficulties and accepting some things cannot be changed.

**Role of positive prevention**

Not all youths are susceptible to the lure of drugs. Drugs only find their leeway into vulnerable and disadvantaged youths. As a longer-term prevention strategy, character development as a lifelong enterprise would hold great promise as a useful prevention and life enhancing process. Peterson and Seligman advocated development of lifelong character strengths from childhood [10], including:

- Courage
- Interpersonal skills
- Rationality
- Insight
- Optimism
- Honesty
- Perseverance
- Realism
- Capacity for pleasure
- Altruism
- Putting troubles into perspective
- Future-mindedness
- Happiness
- Tolerance of ambiguity and negative emotions
- Finding purpose.

Likewise, Zimbardo emphasises life-long training to enhance awareness and possibilities of every youth's potential to become “ordinary” or “everyday life heroes” [11]. Armed with strengths of character and the mission to become ordinary heroes, drugs would have much less freeway into the youth's budding life.

In the richness and great depths of Chinese culture, it is also easy to find prescriptions for a good and thereby drug-free life. Confucius talks about:

In conclusion, while we have established a better grasp of the inherent pathological processes underlying a youth's drug use, prevention, ultimately, is a more cost-effective and rewarding strategy. Our modern day youths would benefit greatly starting from very early days onwards being helped to develop a sense of purpose, service, meaning, and happiness in their lives.
References


