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HOW TO MANAGE ADOLESCENT ADDICTS

The creative chaos in the stage of human development called adolescence is a time of enormous opportunity as well as a time of great vulnerability. The decisions and behaviors during this period of sea change in personality, emotions, physical, cognitive and sexual development may lay the groundwork for future disillusionment, despair, disability or worse; or discovery, achievement, and the establishment of a more solid, dependable self.[1]

The challenge to healthcare workers and other providers during this tumultuous stage needs to take into account the dynamics of rapid change in a critical stage of human development.

What are the primary tasks of psychological development that need to be accomplished?

1. Development of personal autonomy, including the capacity and skills for work, including school-work.
2. Forming romantic relationships and developing the beginnings of a capacity for intimacy.

A brief scan of the two major developmental tasks of adolescence will demonstrate that they are mutually incompatible. Therein lie the conflict, turmoil, and seeds of upheaval that we see and experience (What was he/she thinking?); and the lengthy time it takes (5-10 or even 20 years) to get past it, onto more solid psychological ground.

Can we differentiate between adolescent "experimentation" vs. a "significant problem behavior?" Does it matter when the risky behavior becomes self-destructive, as with drugs and alcohol, reckless driving, unsafe sex, etc.?

In a helpful and informative paper in Psychiatric Annals not long ago, Dr. Lesley Cottrell and others wrote about effective interviewing and counseling of the adolescent patient. The authors outline 10 steps for a successful adolescent-provider encounter:

1. Provide an adolescent-friendly waiting area;
2. Honor requests for same-gender provider whenever feasible;
3. Greet adolescent and parents in a welcoming, respectful manner;
4. Reinforce a strict confidentiality policy, explicitly (while informing that life-threatening situations must be disclosed);
5. Interview adolescent and family together, initially;[2]

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6. Weave social and cultural considerations into assessment and treatment decisions. Also, have awareness of the following factors:
    a. Do any non-parental members have a significant influence on family decisions, i.e. priest, grandparent, truant officer, other official?
    b. What larger support networks are available to the family and patient?
    c. Is there any influence of school, work, ethnicity, or family structure that impacts on health concerns and treatment needs?
    d. Is there a cultural definition of roles and responsibilities that may impact the treatment plan?
7. Plan to incorporate some individual time with the adolescent patient into each visit;
8. Incorporate into your assessment a standard form to address sensitive health topics and risky behavior;
9. Be prepared to openly discuss ethnic, cultural and gender differences between the adolescent and healthcare provider; listen with genuine empathy and interest;[3]
10. If the patient requires referral to a specialist, spend time to process and explain the treatment rational.

It has been suggested in much of the literature that motivational interviewing is the recommended method for counseling adolescents. Motivational interviewing is a client-centered, semi-directive way to mobilize motivation, to change behavior by pointing out discrepancies and exploring and resolving ambivalences within the patient. It is non-adversarial. It is designed to raise the patient's awareness of the risks and consequences of the behavior under scrutiny. In addition, the interviewer assists the adolescent in envisioning a better future and increasing the motivation to achieve it, through change.

Motivational interviewing is based on four principles:

1. Express empathy: the interviewer shares with the patient his understanding of the patient's perspective;
2. Develop discrepancy: the interviewer assists the patient to see how she wants her life to be, as contrasted to how it actually is and what changes may be helpful;
3. Roll with the resistance: accept that patient's resistance and reluctance to change in the face of negative consequences is a part of the illness rather than stubbornness;
4. Support self-efficacy: embrace the patient's autonomy – even when they are choosing not to change successfully and confidently.

To reiterate:[4] It is important to keep in mind that adolescents are a work in progress. They are undergoing dramatic change both physically and psychologically. As they change, their interactions with others will also change, including with the treatment team.

What are some of the annoying, regressive scenarios that you may have to deal with?

1. (Whining) – "It's not fair!"
   Using age appropriate language, explain why he doesn't always get his way. Ask him to start over again and explain his complaint, using less annoying words, such as "I don't agree with this rule." When the patient discovers new ways to express himself, the sense

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of mastery in the relationship will make it more likely for him to abandon the annoying, regressive stances.

2. (Petulant) – "I'll do it my way!" or "Try and make me!"
   The important thing is to keep your cool. Also, have some stock, short and sweet, sound bite to say i.e., "I know this is hard for you" or "Sorry to have to lay this on you," rather than ending up annoyed and saying something you'd regret,
3. (Sarcastic) – "Why should I listen to you?"
   The adolescent is looking for some element of control. The important response is to give the patient a choice. "We can deal with your school chums later and deal with your missing classes first, if you'd like."
4. (Angry) – "I don't like you!"
   Do not take it personally! The patient is frustrated and challenging the issue of trust. The worst thing is to get angry back and let him know that you would be just as happy to get rid of him. Remember that addicted teenagers have a tendency toward "literal thinking," without nuance. Being sarcastic or subtle will only be heard literally, not in the way you may intend.

Also, remember the HALT acronym: whenever the patient is hungry, angry, lonely or tired, he is more likely to regress and the urge to use drugs becomes heightened. Inquiring into these states helps the patient become more aware of his own regressive triggers.

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