Psyke & Logos, 2005, *26,* 27-31

ADDICTION IN ADOLESCENCE:
Why don't adolescent addicts turn up for treatment?

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It has been well established that prevalence rates of addiction are reportedly higher among youth than adults. It is also widely reported that very few adolescent addicts turn up for treatment. This paper outlines some of the possible reasons as to why this is the case. These are that (i) adolescents don't seek treatment in general, (ii) treating other underlying problems may help adolescent addiction problems, (iii) attending treatment programs may be stigmatizing for adolescents, (iv) adolescents may have committed suicide before getting treatment, (v) addicts may be lying or distorting the truth when they fill out survey questionnaires, (vi) adolescents may not understand what they are asked in questionnaires, (vii) screening instruments for adolescent addicts may be being used incorrectly, (viii) adolescent addiction may be socially constructed to be non-problematic and (ix) adolescent excesses may change too quickly to warrant treatment.

It has been well established that prevalence rates of addiction are reportedly higher among youth than adults (e.g., Jacobs 1993; Shaffer, Hall, & Vander Bilt, 1997). It is also widely reported that very few adolescent addicts turn up for treatment (Griffiths, 2001). Griffiths (2001) outlined ten speculative reasons as to why adolescent gamblers may not seek out help for their gambling addiction. Some of these are applicable to adolescent addiction more generally including:

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- denial by adolescents of having a problem
- adolescents not wanting to seek treatment even if they admit to themselves that they have a problem
- the general lack of adolescent treatment programs available for adolescents
- treatment programs not being appropriate and/or suitable for adolescents
- the occurrence of spontaneous remission and/or maturing out of adolescent addiction problems
- lying or distortion by adolescents on self-report measures when being researched
- the possibility of invalid screening instruments for measuring addiction in adolescents
- the possibility that some researchers may be exaggerating the adolescent addiction problem to serve their own career needs

Griffiths (2001) concluded that there was no single reason that provided a definitive answer to the question of why adolescents don't seek treatment. In this paper further reasons and observations relating to this issue are brought forward.

Adolescents don't seek treatment in general – It perhaps could be argued that apart from life threatening traumas and extremely severe acne, young males rarely contemplate seeking treatment for anything. Young females are a little more likely than young males to consult health professionals (especially for gynecological reasons). The reasons why adolescents in general do not consult health professionals is their perceived invincibility, invulnerability, and immortality. In addition, adolescents are constantly learning and want to resolve their own problems rather than seek help from a third party. If adolescents rarely present themselves for any kind of treatment, it would therefore be surprising to see them turning up for very specific treatments such as treatment for addiction.

Treating other underlying problems may help adolescent addiction problems – Addiction problems could be (and quite often are) symptomatic of some underlying problem (e.g., depression, dysfunctional family life, physical disability, lack of direction or purpose of life) (e.g., Griffiths, 1995; Darbyshire, Oster & Carrig, 2001). Therefore, if these other problems are treated, the symptomatic behaviour (i.e. addiction) should disappear negating the need for addiction specific treatment.

Attending treatment programs may be stigmatizing for adolescents – Adolescents might not seek treatment because of the stigma attached to such a course of action. Seeking treatment may signify that they can no longer participate in the activities by which they and their peer group define themselves. Furthermore, it may also point to a failure.

Adolescents may have committed suicide before getting treatment – Suicide rates among adolescents are comparatively high (Duchesne, 2002;

World Health Organization, 2002). Suicide is often attributed to adolescence itself (i.e., a host of reasons not always well define by medical examiners) (Gould, 2003). Addiction may be one of the reasons associated with suicide without anyone ever realizing the true cause.

Adolescent addicts may be lying or distorting the truth when they fill out survey questionnaires – It has been asserted by Stinchfield (1999) that the prevalence rates for adolescent problem gambling are not real and are due to youth exaggerating their involvement in gambling. This may also be the case for adolescent addicts more generally. Furthermore, truths are multiple. It could be that, while answering truthfully from their standpoint, they are giving researchers answers that we would not think suitable.

Adolescents may not understand what they are asked in questionnaires – Another reason that the prevalence rates of adolescent addiction are elevated may be due to measurement error. By administering adult instruments to youth they may endorse items they should not, doing so because they do not understand the item. For instance, among adolescent gamblers, Ladouceur, Bouchard, Rhéaume, et al. (1999) showed that many items on a highly used problem gambling scale were misunderstood with only 31% of students understanding all of the items correctly.

Screening instruments for adolescent addicts are being used incorrectly – With measures developed for adolescents, as with those for adults, there may be incorrect use of screening instruments. Stinchfield (1999) asserts that this is one possibility for elevated prevalence rates among adolescent gamblers. He further claims there may be a lack of consistency in methodology, definitions, measurement, cut scores, and diagnostic criteria across studies and particularly, the use of lenient diagnostic criteria for youth in some studies.

Adolescent addiction problems may be socially constructed to be non-problematic – Problems – whether they are medical or otherwise – are socially constructed (Castellani, 2000). In the case of denial, there might not be denial because there isn't a problem. For instance, if the peer group, school class, and/or the family of the adolescent is pro-drinking, smoking and gambling, actively engage in drinking, smoking and gambling, and show signs of problems, it may appear to the adolescent that it goes with the territory. Playing guitar is hard on the fingers, playing football is hard on the shins, and drinking, smoking, and gambling would be hard on cash flow, nerves, sleep, digestion, friends, mood, family, school, job and everything else that it is hard on. Therefore, it is not perceived as a medical, psychological and/or personal problem, but merely a fact of life.

Adolescent excesses may change too quickly to warrant treatment – Adolescence is sometimes about excess and many addictions peak in youth (Griffiths, 1996). It could be that transfer of excess is a simpler matter for adolescent. They might have excess "flavour of the month" syndrome where one month it is binge alcohol drinking, one month it is joyriding, and one

month it is gambling. Adolescents may not seek treatment because of spontaneous remission in the classical sense but because of some sort of transfer of excess.

Concluding comments

Many of the possibilities outlined here are speculative. However, there are clearly some research questions that need answering. For instance, why do youths appear to be reluctant to seek help for addiction problems? What is the true prevalence of addictions among youth? Are the available statistics inflated by a lack of understanding of the survey questionnaire items, too liberal cut-offs etc.? Where does addiction fit among the many difficulties young people face during the developmental process? Are the heightened rates of addiction among youth the result of having grown up during times of such extensive availability (i.e., a cohort effect)? Or is it merely a reflection of adolescent experimentation that they will grow out of (or a combination of the two)?

Research needs to address directions and magnitudes of causality among addiction and other health and social problems, such as cardiovascular disease, psychiatric disorders and social problems (e.g., divorce, domestic violence, bankruptcy, etc). The question of where addiction comes in the chain of negative events in the life of each case, such as before or after the onset of depression. The evidence is overwhelming that most cases of addiction have their origins in the developmental period. One study asked patients to specify when their gambling and drug-taking began, and it emerged that gambling follows some forms of drug abuse and appears to emerge simultaneously with others (Hall, Carriero, Takushi, Montoya, Preston & Gorlick, 2000). Hall and his colleagues reported that gambling problems precede addiction to cocaine but seem to emerge simultaneously with opiate dependence. As can be seen, there is large scope for future research in this area. Hopefully, papers such as this may provide the impetus for such research.

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