Emotional Problems in Childhood and Adolescence

Adolescents — Drug Abuse and Addiction

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Drug taking by young people has been described and debated almost to saturation point by professional and lay people alike. This is not only because of the many connecting professional links in medicine, the law, the social sciences, moral philosophy, psychology, and education, but also because it has a personal impact on every young family in the country. No parent who has the welfare of his children at heart is not concerned at some stage of their development lest one or other of them fall prey to this pervasive threat. It is essentially the adolescent in the flush of his emancipation from adult control who is most at risk.

The Adolescent and the Drug Culture

The idea of drugs fascinates both normal as well as emotionally disturbed young people because drugs offer them very special meanings. They are seen as a direct source of pleasure, excitement, and gratification—more rewarding and more economic than the use of alcohol. They offer an almost perfect vehicle for acting out the "adolescent rebellion" with all the trappings of secrecy and an enemy (the "fuzz") to be overcome, displaced from the home. They are used as part of the virility challenge with the youngster's peers and as a ticket of admission to a privileged group; and they offer the prospect of a magical voyage of discovery into the unchartered territory of the mind. In more sinister fashion drugs promise the young person illusory support in his moments of great personal uncertainty, escape in the face of overwhelming social and psychic pain, and even the prospect of both metaphorically and literally destroying parts of the self, the whole self and others, especially those in the family circle who are of special significance to him.

An adolescent has great difficulty in expressing his turmoil either in logical words or in constant moods, for to do so implies a capacity—which he does not yet possess—to confront his conflicts face to face and suffer the painful reality of them. This is, of course, the capacity to be adult, towards which he is striving. Not surprisingly, therefore, he will try to resolve his difficulties instead by some form of action which attempts both to express these and palliate his suffering while at the same time avoiding an understanding of the underlying issues. Drug taking offers an attractive means to this end.

BEHAVIOURAL TRIAD

So endemic has the use of certain drugs become among young people that it may be seen as one part of a behavioural triad, together with promiscuous sexuality and violence, which penetrates the adolescent world. It does so to an extent which represents more than just the extremes of adolescent behaviour. In increasing numbers young people are caught in a web which this behaviour weaves for them and adults are confused when called upon to make value judgements about it, mindful as they are of their own massive use of alcohol, tranquillizers, and sedatives, as well as of their own moral uncertainties. Conflicting views and theories about such behaviour bewilder not only its subjects and victims but also those who have to salvage the damaged lives that result from it.

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STATISTICS

The statistics available on adolescent drug abuse are restricted and at times misleading. The only direct measure of limited value is that published annually of the numbers of addicts known to the Home Office under the Dangerous Drugs Act. Table I is an abstract of these showing the numbers of opioid addicts with particular relevance to age group distribution.

TABLE I—*Number of Opioid Addicts 1961-71 Coming to the notice of the Home Office**

	1961-66	1967	1968	1969	1970	1971
All addicts	470-1349	1729	2782	2881	2661	2769
Number taking heroin ..	132- 899	1299	2240	1417	914	959
Number taking methadone ..	59- 156	243	486	1687	1820	1927
Number aged under 20 yr ..	2- 329	395	764	637	405	338
Number aged 20-34 yr ..	94- 558	906	1530	1789	1813	2010
Number aged 34-49 yr ..	95- 162	142	146	174	158	156

* Source, Home Office

From the adolescent point of view these figures appear to be encouraging because the peak period would seem to have occurred in 1968, followed by a steady decline in the last three years. This could be a misrepresentation of the real facts as it is recognized that many young addicts today are discouraged from attending official treatment centres by the stringent and lengthy procedures of assessment, together with the understandable—but sometimes unjustifiable—disinclination by licensed doctors to continue adequate maintenance prescribing over long periods.

Thus there is a real danger that the original purpose of these centres could be negated and there is no way of knowing how many youngsters at present rely on the black market. Alternative drug taking patterns are also emerging, and it is by no means an established fact that methadone dependence (for example) is more sinister than the gross, chaotic, and increasing use of barbiturates, LSD and other so called "soft drugs", for which there are no equivalent therapeutic facilities.

Criminal statistics related to drug offences provide an indirect measure of the abuse of some other drugs, though the important group of barbiturates and other sedatives are excluded because they are controlled only by the Pharmacy and Poisons Act of 1933. These statistics must give cause for concern. Table II represents a breakdown in age groups of the number of persons found guilty of an offence involving drugs over the last three years. Half the total number are under the age of 21. Table III shows the numbers of persons found guilty of offences involving certain individual groups of drugs. Cannabis and LSD stand out

especially. Table IV gives the number of convictions for offences involving drugs controlled under the two relevant Acts—namely, the Dangerous Drugs Act, 1965 (opioids, cocaine, and cannabis) and the Drugs Prevention of Misuse Act, 1964 (amphetamines and hallucinogens).

TABLE II—*Persons found Guilty of an Offence Involving Drugs, by Age**

	1969	1970	1971
Under 14 yr	11	10	23
14 to under 17 yr	364	451	575
17 to under 21 yr	3,308	4,234	5,237
Total under 21 years	3,683	4,695	5,835
21 years and over	3,228	4,465	5,877
Total all ages	6,911	9,160	11,712

* Source, Home Office

TABLE III—*Persons found Guilty of Offences Involving Certain Drugs**

Type of Drug	1969	1970	1971
All opioids (D.D.A. 1965)	974	860	1,146
Cocaine (D.D.A. 1965)	98	112	107
Cannabis (D.D.A. 1965)	4,606	6,682	8,212
LSD (D.P.M.A. 1964)	161	744	1,537
All other drugs (D.P.M.A. 1964)	2,469	2,181	2,810

* Source, Home Office: D.D.A. = Dangerous Drugs Act D.P.M.A. = Drugs Prevention of Misuse Act

TABLE IV—*Convictions for Offences Involving drugs Controlled under the Dangerous Drugs Act 1965 and the Drugs Prevention of Misuse Act 1964**

Category of Drug	1969	1970	1971
D.D.A. 1965 all drugs	6,095	8,800	10,844
D.D.A. 1965 cannabis alone	4,683	7,520	9,219
D.P.M.A. 1964 all drugs	3,762	3,885	5,516
D.P.M.A. 1964 LSD alone	159	757	1,601

* Source, Home Office

Diagnosis and Assessment

The persistent taking of a drug or drugs by a young person is a symptom-complex which has its roots in both the emotional and personality structure of the individual and the environment in which he evolves. Diagnosis is therefore twofold: first, the detection of drug taking and an assessment of the gravity of the habit; and second, a fuller evaluation of the physical, psychiatric, and social issues involving the drug taker. The latter will usually require the help of a specialized facility.

Certain prerequisites to diagnosis are essential: an understanding of the differences in meaning between such terms as abuse, dependency, and addiction; and a working classification of the drugs commonly abused, together with knowledge of their principal and subsidiary effects.

The essential point about the definition of terms is that the concept of addiction as being primarily an organic event is misleading. The term "dependence" has been introduced to imply that the psychological factors in addiction are far more important than the physical factors. Nevertheless, the word "dependence" removes the essential connotation of a malignant and compulsive force at work and the word "addiction" is relevant to the persistent and compulsive taking of any drug, regardless of organic effects, when such a habit is entrenched in the personality and behaviour of the individual succumbing to it, and when it places that individual or others at risk. So far as the adolescent is concerned, withdrawal symptoms are so variable and so determined by emotional forces derived from the fear of a previous attachment, that the psychological aspects of addiction are the paramount issue which requires understanding and treatment. This issue is of great importance if the dangerous misconception about so called "hard" and "soft" drugs is to be corrected. Many more young people today are at serious risk to the "soft" drugs than they are to the "hard" drugs.

A simple classification of the drugs concerned is given in Table V. Three categories of drugs can be described according to their principal effects on the central nervous system, though some overlapping of subsidiary effects occur, such as the sedating effect of cannabis, the "euphoriant" effect of heroin,

TABLE V—*Drugs* of Abuse and Addiction Taken by Adolescents*

C.N.S. Depressants	C.N.S. Stimulants	Hallucinogens
Organic Solvents (sniffing) e.g., Toluene, Acetone, etc.	Caffeine (mixed with "Chinese" heroin)	Nutmeg, Morning Glory
ALCOHOL	Ephedrine	CANNABIS
Hypnotics and Sedatives	Anorectics	Mescaline
(a) Barbiturates	(a) Amphetamines	Psilocybin
e.g., TUINAL, NEMBUTAL, AMYTAL, etc.	e.g., DEXEDRINE, METHEDRINE, etc.	Dimethyltryptamine
Mixtures—e.g., DRINAMYL		
(b) Miscellaneous	(b) Miscellaneous	
e.g., MANDRAX, VALIUM, Librium, Doriden, etc.	e.g., RITALIN, Preludin, etc.	
Opioids	Cocaine	LSD (LYSERGIC ACID DIETHYLAMIDE)
(a) Opiates		
e.g., Opium, Morphine, HEROIN, etc.		
(b) Non-opiates		
e.g., METHADONE, Pethidine, etc.		

* Drugs in capitals signify most common usage. Proprietary names where used are for purposes of simplicity.

and the psychotic effects of large doses of amphetamines, in addition to that of hallucinogens. These three groups in common alter the mood and perceptions of the taker. Thus the depressants reduce anxiety (which itself alters the mood), the stimulants lessen the lethargy of depression, and the hallucinogens distort both the internal and external environment. Cannabis is probably the most popular drug of all because, like alcohol, to some extent it achieves all these effects with the minimum of complication and danger. For some isolated individuals however the response to cannabis is inadequate because it requires some degree of social integration in the first place and its action is relatively slow and mild.

SIGNS OF DRUG TAKING

The early signs of drug taking may be hidden by the inconsistent behaviour patterns of this age group and the lengths to which a youngster will go to conceal his thoughts and actions. Significant pointers include: (1) at school.—sudden loss of interest and performance in studies or sports, general evasiveness and truancy, and problems over discipline. (2) At home.—unaccountable changes in habits and moods, loss of appetite and weight, and the sudden development of clandestine friendships, especially with older boys. (3) At work.—late time keeping, frequent changes of occupation, problems with employers, and failure to settle down.

Amphetamines

The features of amphetamine or Ritalin taking are unusual excitability and irritability, restlessness and anxiety, hand tremors, and sleeplessness. While under the influence of the drug this is combined with dilated pupils, nystagmus, and tachycardia, and followed later by dramatic weight loss and the development of facial pallor and acne. On the other hand, incidents of unusual drowsiness, slight ataxia, slurred speech, sluggishness, mild inebriation, and lethargy suggest the taking of sedatives—while cannabis will often cause an inappropriate

affect and hilarity not typical of the youngster's normal spirits, together with reddened eyes, a vacant look, pallor, sweating, and a detached inertia.

Lysergic Acid Diethylamide

There are few such tell-tale patterns with LSD but a youngster who develops a marked interest in esoteric and mystical ideas, together with the use of unfamiliar pseudo scientific and psychological language, may perhaps be experimenting with the drug. Later, he may display more clearly delusional material or transient and intermittent thought disorder. LSD produces little in the way of physical signs.

Heroin

Before turning to the opioid, the heroin (or "Chinese" heroin) and methadone taker may already display many of the above features, but when he starts taking heroin itself he will also progressively lose weight, become neglectful of his person, "lose" valuable possessions and clothes, and become preoccupied and isolated from the family. At times he will be moody, hostile, and very secretive. Under the effects of the drug he has a striking "gaze" caused by pinpoint pupils, and he may be incessantly scratching himself. Watery eyes, a running nose, and yawning herald the withdrawal periods, followed by abdominal cramps, sweating, and shivering. The youngster on the needle may be observed concealing his forearms, and an unaccountable blood stain may occasionally be noticed on his shirt. A detailed account of these drugs and effects in the adolescent is provided by Boyd.[1]

DETECTION

Usually, parents or teachers are the first to become suspicious of the youngster, who will often resist seeing a doctor and may convincingly deny what is said about him. The detection of drug taking therefore depends on a carefully taken social history, the catalogue of behaviour and clinical appearances, the distinctive signs and possibly needle marks (legs and feet in addition to arms and hands), the admission (if possible) by the youngster, and confirmation by analysis of a urine specimen for drugs (other than LSD and cannabis) provided at a relevant time in front of the doctor. Accurate urine analysis does, however, depend on appropriate facilities, which are not always easily available. Moreover, even in expert hands, the results are sometimes unsatisfactory and misleading.

The most important single factor is the truthful admission of what he is doing by the adolescent himself, and this is achieved only by courtesy, interest, and empathy offered on more than one occasion.

DEPTH OF DRUG INVOLVEMENT

At the same time the depth of drug involvement has to be judged. This is not easy because a false claim may be made in either direction depending on the youngster's hopes and fears. Some young people will actually present themselves to doctors requesting drugs. If an adolescent is seeking to obtain an unwarranted prescription he may deny taking drugs, yet beg for sedatives to help him sleep, or, if he claims to be addicted, he may grossly exaggerate the dose he claims to be taking. If he fears parental or legal repercussions he will totally deny drug taking when the evidence is stacked against him. On the other hand, he may pretend to be an addict, even to falsifying injection marks, to obtain drugs for illicit purposes.

The stories and manipulations are legion, but a shrewd observer will not allow himself to be led astray. It is vital that the doctor should not make rapid decisions either way or be seduced into offering some alternative drug in the hope of avoiding the clinical dilemma which he is facing. There is, of course, no biochemical way of assessing the amount of drug taken and the matter is entirely one of cautious clinical judgement.

Management and Treatment

The overall features of the case will make it clear whether or not the symptom of drug taking is an expression of serious psychosocial disturbance. If it is not then it will be the general practitioner's task to take the appropriate steps with the family and others to motivate the adolescent in the right direction. In these circumstances it is seldom wise to use drugs of any kind, for to do so quickly involves the doctor in the youngster's endless drug manipulations. If it is, then, depending on the age of the adolescent and the nature of his drug taking, the practitioner will require the assistance of either the local child guidance or adolescent clinic, or the ordinary psychiatric outpatient clinic. These may in turn refer the patient to a drug dependence clinic, though this should not be a matter of course as such referrals could easily be overwhelming. Unfortunately, many local psychiatric outpatient facilities are inadequate to deal with this problem.

With regard to the whole question of adolescent psychosocial disturbance many general practitioners today are often out of touch with young people, unaware of their difficulties and vulnerability, and ill-equipped in training and experience to provide the appropriate form of assistance. The school leaver or late adolescent particularly suffers from neglect and lack of support. As Miller[2] pointed out, the peak of delinquent behaviour in Britain occurs in the six months before the optional school leaving age. He suggests two possible reasons for this: the impending departure from a well-known and secure environment, and the loss of the only significant adults other than parents in the life of the young person. The same pattern can be related to drug taking.

In particular, the family doctor needs to be familiar with the dynamics of adolescent emotional development and social adjustment, as well as his patterns of behaviour and communication. He needs to know and gain the confidence of the teenager in his family setting, and the parents should feel that they can approach him for sound counselling and advice about and to their child. In addition the medical profession generally must recognize the nature of its role as a broker of drugs (it must not be forgotten that the present epidemic of heroin addiction was initiated iatrogenically). Today, under the twin pressures of a sales-conscious pharmaceutical industry and the pill-conscious patient the doctor is increasingly exposed to the dangers of indiscriminate prescribing. The ease with which young people can obtain all sorts of sedative and other drugs directly from doctors —as well as indirectly from others, including members of the family—illustrates the tremendous laxity attached to the whole procedure of providing drugs to the public. This has led in large measure to a prevailing climate of drug taking of all kinds.

INDICATIONS FOR PSYCHOACTIVE DRUGS

There are few occasions for prescribing psychoactive drugs to young people. The adolescent only rarely displays adult postures of psychiatric illness known to respond to drug therapy and in consequence his response to these drugs is often variable and uncertain. There are virtually no indications for using amphetamines alone or, especially, in combination with sedatives (they are totally undesirable in treating overweight or depressive episodes in youngsters). Sedatives should be considered only at times of physical illness or in exceptional cases of crisis anxiety such as pronounced pre-examination phobia. Any request for sleeping tablets by an unknown teenager should be viewed with

great suspicion. If there is a longer term underlying anxiety state the major tranquillizers may be used as they do not seem to be addictive as are the minor tranquillizers.

When it comes to the question of drug-treatment of drug abusing adolescents neither the drugs abused nor alternative forms should be prescribed except in the case of the true addict to opioid drugs, and such a case should be referred to the drug dependence centres and their specially licensed doctors. Individual general practitioners would be unwise to attempt to treat these cases, as they lack both the proper facilities and the necessary support and protection offered by the organized centres to staff working in this difficult field. Teenagers who grossly misuse barbiturates do not often reach a point of organic addiction with them. There is therefore rarely any indication for the withdrawal prescribing of barbiturates to this age group of drug takers. This does not however imply that barbiturate abuse (including intravenous use) is not a serious problem among adolescents and a difficult one to manage.

Finally, any adolescent who persists in the abuse of drugs in spite of medical intervention and assistance from others is almost invariably someone who needs ongoing psychiatric help and supervision. He may, however, refuse this until he is flat on his back or brought to his senses by some critical event such as a serious legal charge.

References

[1] Boyd, Philip, in *Modern Perspectives in Adolescent Psychiatry*, ed. J. G. Howells, p. 290-328. Edinburgh, Oliver and Boyd, 1971.
[2] Miller, Derek, *The Age Between*, p. 29. London, Cornmarket and Hutchinson Ltd., 1969.

Impressions of Cogwheel

Cogwheel and the Medical Social Worker

FROM A SPECIAL CORRESPONDENT

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Since 1895, when the first lady almoner was appointed at the Royal Free Hospital (in the first place to prevent abuse of the hospital's facilities by those in a position to pay for treatment), the contribution of medical social workers has been consistently underestimated. One reason is that there are not many of them—in 1969 there were only 1,077 (906 whole-time equivalents) of whom 30% worked in teaching hospitals, 59% for regional hospital boards, and 11% for local authorities. Their relevance to Cogwheel[1 2] emerged only because they are going through a crisis of their own and have also been reported upon—both by the Butterworth report[3] and in the second report of the Health and Social Services Subcommittee of the D.H.S.S. Working Party on Collaboration.[4] The former considers the discrepancies in pay and career prospects between the N.H.S. and local authority employment; the latter recommends that the responsibility for providing social work in hospitals should be formally transferred to local authority social services' departments at the time of N.H.S. reorganization in 1974.[5]

Alarm over Reorganization

Some members of Cogwheel divisions have also found this recommendation very alarming. Many consultants regard their medical social worker as an integral part of their team and fear that if the hospital, or even the integrated health service, is no longer her employer, they will have no control over her work or even whether she comes at all. The medical social workers themselves have been deeply divided about the recommendation that they should be transferred to the local authority, but at a recent meeting of the British Association of Social Workers the majority showed by their votes that they agreed with it.

I spoke to Miss Huntercombe,* who reminded me that medical social workers had to have a degree with postgraduate training or a certificate in social work from an approved polytechnic. She said that many local authorities would take staff at the degree stage and second them for postgraduate training. Hospitals were empowered to do so but rarely did, probably because of the shortage of staff in small hospital departments. Until October 1972 a senior social worker could have earned up to £1,000 more with the local authority but the Butterworth recommendations, if implemented, could largely correct this. On the other hand, many medical social workers had spent many years in hospital and not only valued their own contacts and methods for helping sick people but were afraid that in the local authority case work would be swamped by impersonal welfare work and red tape, and that the special needs of the sick and physically handicapped would be insufficiently understood. They had seen the application of the Seebohm recommendations[8] with local authority social workers, mental health workers, and children's service workers all brought together into one department, sometimes without regard for their hard-earned specialist experience. They also doubted whether existing social service departments could absorb another large field of social work.

Bridging the Gap

Miss Huntercombe then quoted the case of an unmarried woman admitted with multiple fractures sustained while jumping from a burning house. Her medical problems were soon much less important than the fact that she now had no house, no income, and her neighbours could no longer look after her children. Pre-Seebohm, Miss Huntercombe pointed out, she would have had to liaise with the housing, welfare, and children's departments. Now she could deal with one social worker concerned with all aspects of the patient's care viewing her problem as a whole, if necessary liaising with the housing department. Miss Huntercombe herself would have preferred to make and implement her own assessments working in the hospital but employed by the local authority. This would lead to quicker alleviation of the patient's anxieties by one relationship rather than several and might lead to earlier discharge from hospital.

*the name is fictional.