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The treatment of adolescent alcoholism

Only recently has the abuse of alcohol by young people and its relationship to the family, the schools, and the law become more evident

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Adolescent alcohol abuse has become widely recognized as a serious social problem during the past few years; however, little exists in the way of treatment or prevention resources. In this article the author will discuss the prevalence of the problem, explore reasons that underlie its growth, and outline approaches for its treatment.

Growth of adolescent alcohol abuse

Drinking has always been an accepted part of the American culture and there has always been at least a general awareness of the problems that it can cause. Alcoholics Anonymous (AA), founded in the 1930s, has dramatized some of the problems alcoholism causes and represents what is probably the most successful self-help organization in existence. As a reflection of the social acceptability of drinking among adults, young people, particularly of high school and college age, also experiment with alcohol, and this experimentation is also generally sanctioned by society. Only recently, however, has abuse of alcohol by young people and its relationship to the family, the schools, and the law become much more evident. Studies show that alcohol abuse is widespread among young people. A study done in 1974 for the National Institute on Alcohol Abuse and Alcoholism (NIAAA) indicated that 90 percent of high school seniors and more than 50 percent of seventh graders had experimented with alcohol.[1] Another NIAAA study estimates that 1.3 million Americans between the ages of twelve and seventeen have a serious drinking problem.[2] About one-third of high school students get drunk once a month, and arrests of teenagers for drunken driving have tripled since 1960.[3]

Social acceptability of alcohol

There are many underlying reasons for adolescent alcohol abuse. The main reason for the growth of the problem is the social acceptability of alcohol by the adult culture. Approximately 70 percent of adult Americans drink, and although only about 15 percent of these are considered heavy drinkers,[4] there is no doubt that the major inducement

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[1]National Institute of Alcohol Abuse and Alcoholism, "Young People and Alcohol," *Alcohol Health and Research World,* Experimental Issue (Summer 1975): 2-11.

[2]James Collier, "New Drug Menace: Teen Age Drinking," *Reader's Digest,* April 1975, pp. 109-13.

[3]Ibid.

[4]U.S. Department of Health, Education and Welfare, Office of the Assistant Secretary for Health and Scientific Affairs, *Alcohol and Health,* First Special Report to the U.S. 92nd Congress, 2nd Session, December 1971.

to drinking is its narcotic effect in helping people cope with stressful situations. In the treatment of adult alcoholics, the most common defense encountered is denial of a dependence upon alcohol. In the community at large, where parents, teachers, and counselors drink, it is inevitable that this denial mechanism contributes toward a reluctance to deal with alcoholism in young people.

Also, there are several other interrelated reasons that explain excessive drinking among adolescents and, in particular, its recent increase. As a result of the drug scare of the 1960s, parents today are often relieved that their children are "only drinking" and ignore, or even give indirect approval to, drinking behavior. And because drinking among young people is often associated with rebellion, risk taking, or being "grown-up," there is a great deal of peer pressure to drink. More important than the initial impetus to drink, however, is the effect that continued drinking has on the adolescent, and how alcohol can be quickly adopted to serve as an individual's chief coping mechanism.

The anesthetic effect of alcohol

Alcohol is a sedative, a depressant of the central nervous system.[5] It provides relief from tension and anxiety in much the same way that ether or novocaine removes the painful experience of the dentist's drill. This numbing effect makes alcohol particularly attractive during adolescence, a time when numerous physiological, emotional, and experiential changes give rise to a great deal of anxiety. It is important to bear in mind that adolescence is also a time to begin to prepare in earnest for the tasks and frustrations of adult life. Reliance on alcohol can short-circuit the learning process during this critical period. If this happens, the adolescent will usually find himself or herself without the emotional capacity to deal with adult life. Often, the only escape from this situation is an even greater reliance on alcohol.

[5]Stanley Gitlow, "A Pharmacological Approach to Alcoholism," in *Alcoholism and Family Casework*, ed. Margaret Bailey (New York: Community Council of Greater New York, 1968), pp. 31-42.

Drinking parent

One aspect of the problem of adolescent alcohol abuse which is often overlooked is the situation of the nondrinking adolescent with one or two drinking parents. Families with a drinking parent are usually under a great deal of stress. Home life is uncomfortable for an adolescent in this situation, and he or she is often physically abused and given a disproportionate amount of family responsibility. The stresses that develop in this position will often result in poor school performance and an unsatisfactory social life. If the tensions are too great, chances are that he or she will turn to the coping method learned from the parent's drinking.[6] In fact, the risk of a child of an alcoholic parent becoming alcoholic is 50 percent.[7]

Definition of alcoholism in adolescents

Treating the drinking adolescent presents a variety of problems. First, the worker must deal with the question of definition. There is a great deal of debate regarding definition of an adult alcoholic and the issue becomes even more complicated with an adolescent alcoholic. An adult alcoholic is characterized as a person whose normal functioning has been disrupted by alcohol. Adolescents, however, have not yet achieved a stable mode of functioning, so, with the exception of the school environment, it is difficult to see where alcohol presents a disruptive influence. This situation is similarly true of the physiological aspects of alcoholism.

Many physical indicators of alcoholism—such as liver, bone, and nutritional problems—manifest themselves over a period of many years. In light of this criteria, some argue that an adolescent cannot really be considered alcoholic. Recent research, however, suggests that because of the more critical nutritional needs during body growth, disorders which would take ten years to form in an adult

[6]Margaret Hindeman, "Children of Alcoholic Parents," *Alcohol Health and Research World*, Experimental Issue (Winter 1975-76): 2-7.

[7]Howard T. Blane, *The Personality of the Alcoholic* (New York: Harper and Row, 1968), p. 157.

might take only two or three years to develop in an adolescent.[8] Finally, because experimentation with alcohol is so prevalent among young people, it is difficult to distinguish experimentation and problem drinking.

Dynamics of alcohol addiction

In order to understand the kind of transference relationship most likely to form between the adolescent and therapist, it is helpful to understand some of the dynamics of alcohol addiction. *The Psychiatric Dictionary* states:

> . . . it is believed that most chronic alcoholics are characterized by a (? constitutional) increase in orality and that the attitudes of their parents are typically such as to frustrate these oral needs. Resultant disappointment and rage must be turned away from those on whom the individual is dependent, leading to tense depression, guilt, and masochism, with a turning to alcohol which (1) physiologically reduces the strength of the drives, particularly the aggressive drives, (2) minimizes the effects of stress, and (3) affords a symbolic substitute for the desired gratification, thus giving temporary pleasure and elation and allowing a retreat into infantile megalomania. Eventually, a pattern is established: frustration brings anxiety and rage, alcohol brings relief, but this is temporary and does not bring a solution and more alcohol is required. . . .[9]

Transferentially, then, the therapist might be seen initially as one who is bent upon depriving and frustrating the adolescent. In this light, the therapist must be careful not to act out this projected role by making immediate demands on the adolescent to stop drinking. Similarly, the therapist must strive to create an environment in which the adolescent will feel safe to come and talk without pressure to deal directly with his or her drinking behavior.

In the author's practice, if the patient is referred specifically for drinking behavior, the author explains that he is not interested in finding out if the client is an alcoholic, but that some people are more constitutionally susceptible to the effects of alcohol and that it is sometimes helpful to find out if the person is prone to developing a *drinking problem* (the word "alcoholic" is itself very frightening to most adolescents, who usually associate it with Bowery-type alcoholics).

In the author's experience, there are very few adolescents who will admit to having a drinking problem, much less to being an alcoholic. Most adolescents come into treatment involuntarily, primarily through the court system or as a result of a great deal of coercion, and usually because of pressure applied by family, school, or residential home. In these situations, the drinking has usually come to light in connection with some undesirable behavior—such as theft, fighting, poor school performance, or some other acting-out behavior.

Denial

Moreover, the adolescent does not usually want to associate drinking with his or her behavior. Excessive drinking that results in involuntary actions indicates being out of control, and it is most important for the adolescent to give the impression, especially to his or her peers, that he or she is "in control." Also, alcohol, because it helps release inhibitions to the expression of unconscious wishes and feelings, can be responsible for displays of anger and hostility that are normally repressed. Many adolescents, particularly those who come from severely troubled homes, harbor a great deal of resentment toward the adult world and have not been taught how to release this resentment in constructive ways. To admit the connection between alcohol and their behavior is to admit that these feelings exist. Thus, the mechanism of denial, which is a characteristic defense of adult alcoholics, is particularly strong in adolescents with drinking problems.

Treating the adolescent alcoholic

The beginning stages of treatment are very difficult. The adolescent will usually be in treatment against his will, and powerful

[8] Joel A. Bennett et al., "Who Will Help the Teenage Alcohol Abusers?" *Patient Care* 9, no. 16 (September 1975): 88-117.

[9] Robert Campbell and Leland Hinsie, *The Psychiatric Dictionary* (New York: Oxford University Press, 1970), p. 26.

forces will be working to deny the existence of a drinking problem. An important issue of technique arises here. It is generally held that in treating the alcoholic it is important to confront him or her with the drinking behavior directly—especially its consequences and the need for abstention. The widespread view is that the alcoholic must "surrender" to his problem.

The author has found that this approach is not generally successful with adolescents. The defenses which the adolescent has established to deny the possibility of alcohol dependence are vital to maintaining a precarious balance in the world of peer, family, and institutional demands. Any attempt to remove these defenses immediately can result in the weakening of an already struggling ego. Hyman Spotnitz and Phyllis Meadow note:

> . . . the withdrawn person's tendency to experience the mere impact of another personality as a constraining force . . . the narcissistic patient requires a constant and tension-free environment, one in which he feels safe in forming a relationship with another human being.[10]

Thus, it is clear that the therapist must then be extremely sensitive to the adolescent's ability to tolerate any pressure or demands the therapist might be inclined to make.

Treatment partnership

The initial phase of therapy, where the treatment partnership is formed, is the most critical. Even with those adolescents who have accepted their drinking problem to some degree and are motivated to resolve it, therapy will usually prove to be a disappointing experience. Most adolescents are geared to a world of action and quick changes, and the slow arduous task of therapy, with its emphasis on talking, will prove to be very frustrating. This is particularly true with drinking adolescents who, after using alcohol as a source of immediate gratification, have very low frustration tolerances.

The immediate task for the therapist is to find things to talk about which provide enough gratification to keep the adolescent interested in returning. In the author's experience, this involves discovering subjects which most interest the adolescent and sticking to them, regardless of their nature or scope. The author, in beginning therapy, informs the adolescent that he or she is free to talk about anything he or she wishes to discuss in their sessions. The goal is to develop a relationship in which the adolescent feels comfortable talking. This comfortable relationship is necessary if the drinking is to be eventually and thoroughly handled.

Determining therapist participation

It is also important to determine how much talking the therapist should do. Some adolescents feel more comfortable if the therapist does a great deal of talking, and others are happy if the therapist's input is quite minimal. A good rule to follow is that of contact functioning—that is, talking to the adolescent when he or she addresses you directly. This method gives the adolescent the feeling that he or she can control the degree of the therapist's participation, and it helps to reduce their anxiety. This would not be applicable in situations in which the therapist senses that the adolescent's anxiety is increasing, but that he or she is afraid to talk directly to the therapist. In this situation, some nonthreatening intervention is needed.[11]

The therapist must also note the quality of the adolescent's communications. For example, if a patient talks abstractly or intellectually, the therapist should try to keep comments on the same level, rather than ask for meaning or underlying feelings. This process gives the adolescent the feeling that he or she can control the degree of closeness with the therapist and it enhances the feeling that the therapist respects his or her own defense structure. This approach helps the adolescent to feel accepted for the person he or she is and works toward improving self-esteem.

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[10]Hyman Spotnitz and Phyllis Meadow, *Treatment of the Narcissistic Neurosis* (New York: Manhattan Center for Modern Psychoanalytic Studies, 1976), p. 139.

[11]Hyman Spotnitz, *Psychotherapy of Preoedipal Conditions* (New York: Jason Aronson, 1976), p. 130.

Establishing treatment goals

Once the treatment relationship gains some security, treatment goals can be established. It is important to note that the form the treatment takes is largely dictated by the therapist's view of alcoholism as being either a disease or a symptom. This subject has been heavily debated. Generally, those who accept alcoholism as a disease feel that the primary goal of treatment is to stop the drinking behavior, and those who view drinking as a symptom focus more on the underlying problems. With adolescents, it is important to consider both points of view. Although drinking is both a symptom and a cause of deeper problems, the drinking behavior itself serves to block the possibility of working these problems through. Because alcohol acts to anesthetize one against painful and uncomfortable feelings, the drinking adolescent does not have the opportunity to experience and integrate the full range of emotions necessary for survival in the adult world. While drinking, he cannot work through the feelings that underlie the drinking behavior because they are not actually experienced. Thus, the potential of therapy is extremely limited.

Gradual reduction in drinking

It is, however, precisely because of the intensity of these feelings and the defenses against them that the therapist must be extremely careful in attempting to influence the adolescent to relinquish the drinking behavior. If the drinking is being used to protect the adolescent from powerful suicidal or homicidal impulses, premature removal of the drinking defense can result in the adolescent acting on these impulses, or developing a psychosis as a substitute protection. The issue must be explored with the adolescent to the point where he or she feels comfortable in reducing or ceasing drinking. One approach with heavily drinking adolescents is to explore the possibility of abstaining for a day or two before the therapy session. Although discomfort is usually heightened during this period because of the withdrawal mechanism, it gives the adolescent and therapist the opportunity to deal with these feelings in the therapeutic environment. As the adolescent becomes more comfortable with his feelings in sobriety, longer periods of abstinence can be attempted.

Abstinence

Another issue which often arises is the question of total abstinence. Although the predominant therapeutic view is that an alcoholic can never drink again, this idea is usually threatening to an adolescent and might result in the rejection of treatment. If this question arises, communicate to the adolescent that it is of primary importance to maintain some period of total abstinence to be certain that the drinking is by choice rather than by compulsion. Then, through the process of therapy, a mutual decision can be reached regarding drinking in the future.

Hospital detoxification

If the adolescent has developed a physiological dependence to the degree that drinking cannot be halted without serious withdrawal symptoms—delirium tremens, shakes, and so forth—hospital detoxification might be necessary. This hospitalization, however, should be very carefully considered. A young person can feel very alienated in a ward full of adult alcoholics. Also, an alcoholic adolescent may experience a hospital stay as basically positive because most of his or her needs are met and he or she usually receives a great deal of attention. This is particularly true if the adolescent has a problematic home life. The hospital stay can then be experienced as a reward for drinking, and continued drinking might be the result.

Situations for direct intervention

These approaches will not work where the adolescent's drinking occurs in a manner which can jeopardize treatment. If drinking results in trouble with the law, a worsening home situation, or any other activity which might result in removal from treatment, the therapist must intervene in a more direct manner. The therapist must assess the situation accurately and not react to a personal need to intervene in a specific manner.

Alcoholics, because of their strong feelings of guilt and worthlessness, often provoke a desire to punish in the persons around them. The therapist must be careful not to act on this countertransference feeling by unduly punishing or disciplining the adolescent, because this most likely would be a repetition of the adolescent's family situation. Similarly, the therapist should not be too kind or supportive. Neutrality, with mild interest, is best.

Because one of the goals of treatment is to help the adolescent learn to structure his or her life and discipline himself or herself, the treatment situation should be a model for this. The adolescent should be encouraged to attend appointments regularly and on time. Deviations should be explored in a nonpunitive manner. Impulse control is a problem for all adolescents, particularly those with drinking problems, and the therapist's own demonstration of self-control is the best example for the adolescent. This includes not responding to the adolescent's frustrations and anxieties with the therapist's need to relieve the adolescent of his discomfort. If he or she is to mature, the adolescent must learn to tolerate frustration and anxiety and to verbalize these feelings rather than to annihilate them with alcohol.

Enlisting other supports

During the initial stages of therapy, the short time the adolescent spends with the therapist will not provide enough influence to counteract the forces, particularly those of the peer group and family, which directly or indirectly encourage drinking. It is, therefore, advisable to enlist the aid of supports outside of the therapeutic relationship to help the adolescent gain and maintain sobriety.

Alcoholics Anonymous

The most successful support for the adult alcoholic has been Alcoholics Anonymous (AA). It is, however, difficult to get an adolescent involved in AA because adolescents are very reluctant to identify themselves as, or with, alcoholics; consequently, attendance at an AA meeting is very threatening. Also, most AA groups are made up of members considerably older than adolescents, and, as a result, the adolescent often feels very isolated at AA meetings. Membership in AA, however, is becoming younger and in many larger communities there are groups which cater specifically to the young alcoholic. It is wise, therefore, to contact the central AA office to see which groups are oriented toward younger members.

Other activities

Other supports are useful in helping the adolescent maintain sobriety. Drinking leaves little time to engage in other activities and a pattern of "drinking and hanging out" often predominates the drinking adolescent's life. Abstinence often creates a feeling of boredom and being lost, which is difficult to tolerate and encourages a return to drinking. It is very important for the adolescent to find some other way to occupy his or her time during this period, preferably in the company of nondrinking peers. Sports, crafts, or other activities which are not too frustrating or demanding will suffice. Most communities have adequate resources in these areas. It is important not to push the adolescent into these activities, but to explore possibilities until he or she is ready to become involved.

It is especially important that the therapist not require the adolescent to give up current peer relationships, even if they are destructive. Clearly, the adolescent has a need for these relationships, and to relinquish them will only create resentment toward the therapist. It is generally more helpful to teach the adolescent how to persuade friends to cooperate with his or her new efforts at sobriety. If the treatment experience is positive, he or she either will do this, or will voluntarily give up such friendships.

There is another important dimension to the use of external support systems. People with drinking problems are in a dependency conflict, with the dependency on alcohol functioning as a symbol of the greater dependency problem. The conflict usually manifests itself in two extremes: either totally dependent behavior or, as is most often the case with adolescents, a denial of any dependency needs at all. The therapist, by admitting a need for help outside of the treatment relationship, sets a model for the adolescent

to deal more realistically with dependency needs.[12]

The family

The family is probably the most important adjunct to the treatment of the drinking adolescent. Alcoholism is generally considered a family problem, the drinking of one or more of its members being a coping mechanism, as well as a symptom of deeper family problems. Seeking relief from family tensions might have motivated the adolescent to drink initially, and the therapist must arrest the drinking behavior, as well as train the adolescent to function within the family which motivated him to drink. If, in fact, the drinking is serving as a symptom of a family problem, removal of it can be threatening to the equilibrium of the family. Because of this, the family will often unconsciously sabotage treatment, although it ostensibly appears to support it. The presentation of an adolescent for treatment, however, can also serve as a testing ground for parents who would like help themselves. Sidney Love and Yonata Feldman describe several situations in which children were presented for treatment by mothers who ultimately came to the agency for help themselves. The mothers were unable to reveal their own needs for treatment until they saw that their children were being helped.[13]

Because of all these factors, the therapist must work carefully with respect to the family. It is important to get the family to cooperate with the treatment; however, if this is done without the desire and consent of the adolescent (who will often feel that any communication with the family will destroy his own confidential bond with the therapist), the treatment can also be impaired. Thus, it is best to get the adolescent's approval before any contact is made with the family and to work together to determine the best way in which to approach family members. If the situation is critical, it might be necessary to inform the adolescent that the family must be involved. The manner in which the family is involved will vary with each case, but it is important to emphasize that the therapist needs the family's help to proceed with treatment successfully.

Often the family, in the process of denying the existence of a drinking problem with the adolescent, or denying any responsibility for an already acknowledged problem, will refuse to participate in the treatment. Occasionally, the adolescent's drinking problem will be so threatening that the parents will refuse to issue the consent for treatment required by most clinics. A noncooperative family is a serious impairment, because the indirect message to the adolescent is reinforcement for maintenance of the drinking behavior. In these situations there are a few possible alternatives. Some agencies require parental involvement as a precondition to treating the adolescent. This may be used if it is felt that there is no chance for successful treatment without family participation. If the adolescent is a court or school referral, these agencies can be asked to apply pressure to the family to become involved. If parental consent is the issue, an adolescent can get an older sibling or other adult family member, such as an aunt or uncle, to sign release forms.

In extreme cases, the question of removal of the adolescent from the home might arise. There are several reasons not to choose this course, except as a last resort. Even if there are obvious destructive patterns within the family system, these patterns are usually accompanied by an equally strong secondary gain system, that is, the destructive patterns provide some kind of sustenance and gratification for all family members, including the drinking adolescent. If the adolescent is removed from the home before these patterns are worked through or replaced with more constructive ones, it might actually be more difficult for him to function or respond to treatment. Simply stated, there is usually ambivalence about giving up a familiar relationship, even if it is a destructive one. Also, because alcohol is often used as a substitute for relationships, premature removal from the

[12]Adrienne Fischer, personal communication, May 1977.

[13]Sidney Love and Yonata Feldman, "The Disguised Cry for Help: Narcissistic Mothers and Their Children," *The Psychoanalytic Review* 48 (Summer 1961): 51-79.

home might reinforce the idea of ending or avoiding all relationships rather them working them through. Finally, most institutions or foster homes available to a drinking adolescent would not provide a significantly improved environment over the natural home.

School

Because schools have a close and lengthy involvement with most adolescents, their role in dealing with adolescent alcoholism is an important one. Until recently, schools have done little in a systematic way to deal with adolescent drinking, but, as the problem becomes more widely recognized, steps are being taken to provide more education about alcoholism for grammar and high school students. For example, New York State is preparing an alcoholism curriculum which will be used in health education classes from the primary grades through high school.[14]

How should schools deal with youngsters who are already problem drinkers? The question that often arises is whether the school should be the provider of treatment or whether it should serve primarily to locate problem drinkers and refer them to appropriate professional treatment agencies. Some schools are using previously established drug programs, or creating new programs within their counseling systems, to deal with problem drinkers. Some argue against this, stating that the primary role of the school is to educate, not to provide treatment for emotional problems. They also question the ability of most school counseling personnel to provide specialized psychotherapeutic treatment. The author's experience suggests that treatment programs should work closely with schools to help school personnel recognize actual and potential problem drinkers, perhaps including workshops for teachers and counselors. Ideally, youngsters would then be referred to appropriate treatment agencies where they could receive treatment in a setting specifically designed to deal with drinking and its related problems.

Group therapy

The use of group therapy to treat adolescent alcoholics can be seen as a supportive as well as a therapeutic technique. The adolescent often feels threatened by the intimacy of a one-to-one relationship with the therapist. A group situation can dilute this reaction. Group treatment also provides the adolescent with an opportunity to share experiences with peers, thus overcoming some of the isolation characteristic of the young drinker. The ideal composition of these groups is open to debate. One view posits a group solely of adolescent alcoholics as most beneficial because the members can identify fully with each other and feel more comfortable relating to others with problems similar to their own. Another view suggests that groups composed of members with similar problems or levels of development have difficulty progressing because the members are blind to each other's resistances. Groups overloaded with depressed or self-involved members may not survive the initial stage.[15] Both viewpoints should be considered when composing a group.

Conclusion

The use of family, groups, and other support systems might be necessary to help the adolescent stop drinking and stay in treatment, but resolution of the underlying problems through use of the transference relationship is necessary to prevent a recurrence of drinking without external supports.[16] Through the therapeutic relationship, the adolescent can be helped to reexperience the feelings which gave rise to the impulsive behavior and be taught to express

[14]For further information, contact: Office of Education and Training, Division of Alcoholism, New York State Department of Mental Hygiene, 44 Holland Avenue, Albany, New York.

[15]Phyllis Meadow, "The Treatment of Marital Problems," *Modern Psychoanalysis* 2 (Summer 1977): 15–34.

[16]Hyman Spotnitz, personal communication, 9 May 1977.

them in words, rather than attack his or her body with alcohol or other self-destructive activities.

In this article the author has discussed the scope, causes, and some treatment approaches to the problem of adolescent alcoholism. Although becoming more visible, the seriousness of the problem is not widely recognized, as evidenced by the fact that few treatment facilities exist and little is being done to train professionals to diagnose and treat drinking adolescents. It must be remembered that adolescent alcoholics will become adult alcoholics if they are not helped. Therefore, treatment of drinking youngsters is the best form of prevention.