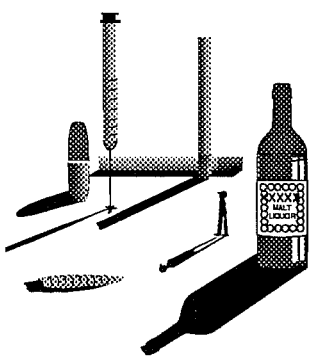
New Jersey Alcohol/Drug Resource Center & Clearinghouse

Center of Alcohol Studies
Smithers Hall-Busch Campus
Rutgers University
Piscataway NJ 08855-0969
Phone: (908) 932-0792
FAX : (908) 932-0790

Fact Sheet No. 26



The New Jersey Alcohol/Drug Resource Center and Clearinghouse serves institutions of higher education, state agencies, communities, and school districts throughout the state of New Jersey by providing technical assistance, training, and resources in alcohol and other drug abuse education and prevention.

For further information, call or write to the Clearinghouse at the address shown above.

THE STATE UNIVERSITY OF NEW JERSEY
RUTGERS

FACTS ON:
Adolescent Substance Abuse

Judy Shepps Battle, M.A.

After more than a decade of gradual decline in the overall use of alcohol, tobacco, and other drugs (ATOD) by adolescents, researchers are reporting signs that this encouraging trend is reversing. There has been a sharp rise in marijuana use and an increase in the use of stimulants, LSD, inhalants, and cigarettes. These patterns of increasing ATOD use and abuse are occurring across most of America, and are not simply a phenomenon of the large urban areas or particular regions of the country.

Nearly 9 out of 10 high school seniors report experimenting with alcohol, and almost 3 out of 10 from this group have abused alcohol (defined as the consumption of five or more drinks in a row at least once during the past two weeks). In addition, adolescents are reporting increased skepticism about the dangers associated with ATOD use and a decreased level of personal disapproval by their peers.

In light of this trend of increasing substance use by adolescents, it is important to look carefully at use and abuse patterns, stages of use, at-risk factors, treatment issues, and prevention strategies for this population.

Who Uses: Three out of four adolescents report a pattern of regular drinking, and nearly 100,000 children aged 10 or 11 report getting drunk once a week. Between 2 and 6 percent of adolescents are problem drinkers, 8 to 13 percent have an alcohol abuse problem, and 6 to 9 percent have other drug abuse problems. Fifty percent of all adolescents admitted to psychiatric wards self-report moderate to heavy substance abuse. Significant alcohol, inhalant, and cigarette use is reported as early as fourth grade, and alcohol experimentation increases from 6 to 17 percent between fourth and sixth grades.

Does this pattern of substance abuse carry over into adulthood, or is there a discernible adolescent use phenomenon? The evidence supports the latter view. While 10 percent of all adolescents will emerge as alcoholic/addicted in adulthood, statistics show a 75 percent decline in substance use/abuse by the ages of 21 to 23 and a nearly 90 percent non-problematic use of substances by age 30.

What is not clear is whether the 10 percent of adolescents who become alcoholic/addicted adults were ATOD abusers, moderate users, experimenters, or abstainers in their youth. Adolescence as a developmental stage involves an aggressive search for identity—physical, intellectual, emotional, spiritual, and sexual—through an active process of experimentation. In the American culture this quest often involves experimentation with substances, resulting in adolescence being characterized as a "high-risk" stage for all youth, whether the risk is with alcohol, tobacco, drugs, or sex. The implications for teachers, counselors, and related professionals is that they cannot accurately predict an adolescent's future addiction issues by observing current substance abuse patterns. This inability must be factored in when determining school and community prevention, intervention, and treatment strategies: all adolescents need to have addiction and co-dependency addressed.

Patterns of substance abuse with regard to racial and ethnic lines also emerge, with Black eighth-through-twelfth grade students, as compared with Hispanic and White students, reporting the lowest rates of use for nearly all substances. In addition, Black twelfth graders show a long-term decline in smoking, have less of an increase in inhalant use than their White and Hispanic peers, and have not shown the increase in LSD use observed in the other ethnic groups.

Stages of Use: Researchers have identified five sequential steps in the progression of substance use and abuse. Initial use is most likely to be with beer or wine, followed by cigarettes or hard liquor, then marijuana use, followed by problem drinking and, lastly, other illicit drugs. The actual stages of drug use also generally progress from initiation to experimentation to casual use and abuse and, finally, to light or regular use or abuse.

What determines initial alcohol use? Research indicates that youth learn drinking patterns from their parents. A majority of youth report that their first drinking experiences are at home with parents and/or relatives present, that they see drinking as adult behavior, and that alcoholic beverages are readily available at home. Does every adolescent who uses ATOD go on to the next step of substance abuse? No, the evidence is that only a subgroup is at risk for progressing. Many teenagers advance to a stage and go no further. The at-risk factors that contribute to substance abuse are discussed below.

At-Risk Factors: Some of the factors that place an adolescent at risk for substance abuse relate to general adolescent issues while others are specific to future alcohol or drug use. General factors that increase the probability that a youth will abuse substances include: being home alone after school, having friends who approve of alcohol or other drug use, having friends who use alcohol or other drugs, perceived pressure to use alcohol or other drugs, a history of alcohol or other drug use, a history of cigarette use, a high level of delinquent behavior, expectations of getting in trouble with police, and expectation of using alcohol or other drugs.

Substance-specific, at-risk factors include: **self-image** (the better the adolescent's self-image the more likely he/she is to drink and become intoxicated, but the less likely to use drugs), **exposure to parents who are ATOD users** (increases probability of alcohol but not marijuana use), **and peer influence** (important for increased marijuana use but not alcohol consumption).

Treatment Issues: Treatment professionals have only recently recognized that substance abuse treatment programs for adolescents cannot simply be scaled-down versions of adult programs. Unlike their adult counterparts, adolescents in treatment have more family difficulties, are more likely to have psychological problems, and are more likely to have attempted suicide. They have different alcohol and other drug use patterns than adults, they are interested in different treatment approaches such as group therapy, they need to have their family included in treatment, and they need to have an educational component. Their outward signs of being substance abusers are also different. For adults, loss of job and family and chronic medical problems are red flags. The "bottom" for most adolescent users is more subtly revealed in school performance, peer relationships, family of origin dynamics, and involvements with the law. Also, most adult treatment programs are not set up to deal with the oppositional or acting-out behaviors characteristic of adolescent substance abusers.

For those adolescents who have begun to actively use and abuse substances, a "second chance" model has been tried in many alternative education programs within traditional middle and high schools. The guiding characteristic of such an approach is the formation of a trusting and supportive relationship between adult and adolescent within the context of a consistently enforced set of rules and consequences and a peer-governed community. Such programs for at-risk adolescents focus directly on behavioral, family, and personality issues and have a high degree of success.

Prevention Strategies: Traditional prevention programs that have success with preadolescents, such as information programs (using persuasion), individual deficiency programs (focusing on self-esteem and building social skills), and social cognitive models (teaching decision-making skills) do not have a high degree of effectiveness with adolescents. Adolescents are present-oriented, and information on long-term consequences does not always guide their behavior. Also, many substance-using adolescents already have a high degree of self-esteem and social skills.

Although there is little research evidence, the consensus of prevention specialists is that comprehensive community programs with consistent messages that include a peer group pressure component have the strongest effect on deterring the alcohol and drug use of younger adolescents (ages 11-15). Many professionals also suggest that, for the older adolescent (ages 15-18), peer group influence declines and is replaced by an identification with a media hero figure.

Adolescents present a unique challenge to prevention and treatment professionals. The positive dimension of their search for identity and their concurrent need to separate from their family of origin and to define future societal roles for themselves must be honored and supported. When dysfunctional and life-threatening behavior, such as substance use and abuse, accompanies this process, then adult intervention is required. We cannot predict, and adolescents cannot tell us, who among them will develop the disease of alcoholism/addiction. Therefore, all adolescent use of alcohol, tobacco, and other drugs needs to be addressed with peer-group, media, and adult assistance.

Judy Shepps Battle, M.A. is the Coordinator of Alcohol/Drug Education & Training Programs for the New Jersey Alcohol/Drug Resource Center and Clearinghouse at the Center of Alcohol Studies, Rutgers Universtiy

References:

Beschner, G.M., & Friedman, A.S. (1985). Treatment of adolescent drug abusers. *The International Journal of the Addictions*, 20(6 & 7)), 971-993.

Braught, G.N., Brakarsh, D., Follingstal, D., & Berry, K.L. (1978). Deviant drug use in adolescence: A review of psychosocial correlates. *Psychological Bulletin*, 79(2), 92-106.

Farrell, A., Anchors, D., Danish, S., & Howard, C. (1992). Risk factors for drug use in rural adolescents. *Journal of Drug Education*, 22(2), 313-328.

Feldman, A.S., & Glickman, N. (1986). Program characteristics for successful treatment of adolescent drug abuse. *The Journal of Nervous and Mental Disease*, 174(11), 669-679.

Fleish, B. (1991). *Approaches in the treatment of adolescents with emotional and substance abuse problems.* (Technical Assistance Publication Series #1. DHHS Publication No. 91-1744). Rockville, MD: U.S. Department of Health and Human Services.

Johnston, L.D., O'Malley, P.M., & Bachman, J.G. (in press). *National Survey Results on Drug Use from the Monitoring the Future Study, 1975-1993: Volume 1: Secondary school students.* Rockville, MD: National Institute on Drug Abuse.

Kandel, D.B. (1982). Epidemiological and psychosocial perspectives on adolescent drug use. *Journal of American Academic Clinical Psychiatry*, 21(4), 328-347.

Oei, T.P., & Baldwin, A.R. (1992). Smoking education and prevention: A developmental model. *Journal of Drug Education*, 22 (2), 155-181.

Pransky, J. (1991). *Prevention: The Critical Need.* Vermont: Burrell Foundation and Paradigm Press.

U.S. Congress, Joint Economic Committee, Subcommittee on Economic Growth, Trade and Taxes. (1991). Doing Drugs and Dropping Out: Report 102 Congress, 1st Session. Washington: Government Printing Office.

Suggestions for Further Reading:

Goplerud, E.N. (Ed.) (1991). *Preventing adolescent drug use: From theory to practice.* (OSAP Monograph-8; DHHS Publication No. (ADM) 91-1725). Rockville, MD: Office of Substance Abuse Prevention.

Slade, J. (1993). Adolescent nicotine use and dependence. *Adolescent medicine: State of the art reviews*, 4 (2), 305-320.

Snow, D.L., Tebes, J.K., Arthur, M., & Tapasat, R. (1992). Two-year follow-up of a social cognitive intervention to prevent substance abuse. *Journal of Drug Education*, 22(2), 101-114.