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Response: Adolescent Substance Abuse Patients: Resilience and Complexity

Patricia A. Chandler, M.D., Franklin Ingram, M.Div., and Joseph J. Richard, Jr., Ed.D.

Franklin Ingram: It's awfully hard to convince teenagers that they can suffer any adverse effects from using alcohol or other drugs. Adolescents all think they are bulletproof. They think injury and death can happen to other kids, but not themselves.

Joe Richard: One thing I have noticed about adolescents is that they are very resilient, especially their bodies; they can bounce back from overdoses and traumas. I also think they are a lot more accessible than adults. Not all of them, but as a group they seem to be more amenable to exploring the possibility that they have a problem. And they have a lot more connections than adults. A lot of adults have burned their bridges and they don't have as much support.

Patricia Chandler: One obvious thing about adolescents is that we have their parents to contend with. They are usually a huge factor in the exacerbation of the illness. And often that is a big roadblock.

Ingram: I have noticed that a very high percentage of the adolescents we work with, at age 14 or so, have a parent or guardian who also has a drug problem.

Chandler: That brings up an issue: A huge number of these kids, especially the girls, have been sexually abused. Abuse is common, and right now there is not much effective help available for these individuals.

Ingram: For some kids we ought to come up with something other than family treatment, because the family is what has wounded them so badly.

Treating comorbid disorders

Ingram: What is most important to me about this subject and this article is the increased efficacy we would get if we actually treated patients' comorbid conditions along with their substance abuse disorders. That is locally lacking in most adolescent substance abuse outpatient programs I know about.

Several years ago I became involved with a private, nonprofit adolescent residential program in Greensboro, North Carolina, whose funding was mainly a community effort. The program ran very successfully for a while, serving 28 adolescents, but then the census dropped to 4 and the Board became alarmed, and I was brought in on an interim basis.

My analysis—and of course I consulted experts—was that we needed to do a much better job of addressing all of these comorbid conditions and strengthening our family program. Once we employed a psychiatrist who diagnosed and medicated the comorbid conditions, we realized a significant improvement in the adolescents' staying in treatment and benefiting from treatment. When I left a year and a half later, the facility had a census of 24.

Richard: I liked Dr. Riggs' suggestion to develop two history timelines, one for the development of the adolescent patient's psychiatric symptoms and a separate one for his or her drug use. That is definitely useful.

These patients will just overwhelm you diagnostically. How do you diagnose bipolar disorder when someone has been bingeing on crank 2 weeks every month for the past 3 years? This is one red flag I think we need to throw up for clinicians: It is very difficult to use history and even behaviors to make an accurate diagnosis. For example, consider someone who's been snorting 12 to 15 anxiolytics every day and washing them back with alcohol. He or she is definitely going to have some withdrawal coming off the anxiolytics and also going to have some secondary withdrawal. It is almost impossible, even in 45 days, to make an accurate diagnosis of attention-deficit disorder for this person. There is a host of substances that will interfere with an accurate diagnosis.

Chandler: Dr. Riggs mentions the lack of training among substance use providers concerning medication management for the comorbid psychiatric disorders. My experience has been that there is a lack of education among child psychiatrists in the area of addiction medicine. They tend to have preconceived notions about what substance abuse treatment should be, totally disregarding the few evidence-based treatments we have available.

Richard: We have an attending physician who is an addictionologist, who also does a lot of prescribing of psychotropic medications with our clients who are having psychiatric problems and also reevaluating clients who are on numerous medications. It is not unusual; maybe 50 percent of clients are on two or more medications when they come to us.

Ingram: At SouthLight, we have two psychiatrists working with our staff, neither of whom wants to prescribe medications directly. They want to refer patients with comorbid conditions to outside psychiatrists to follow them on their medication. They don't want to be on call if there is an adverse effect. They don't think our staff is sufficiently trained to spot signs of trouble.

Chandler: As a medical person, I would say that if you have staff members capable of achieving a master's degree in substance abuse counseling, it won't take much to teach them the side effects of medication. Most of them get some of this information along the way anyhow. I think you need people who are smart, and you could do it in a 2- or 3-day workshop.

Richard: I wonder if you have thought of the possibility of having a nurse or a physician's assistant coordinate between the psychiatrist and the counselors. We have a number of psychiatric nurses on our staff who do a really nice job of monitoring target symptoms and educating for side effects as well.

Chandler: That would be ideal.

Ingram: The problem for me is, on the outpatient basis, who can afford that? It's financially impossible.

Richard: Dr. Riggs raises a very interesting issue concerning the practice of getting patients abstinent from their drugs of abuse before starting them on medications for comorbid disorders. I would say 25 percent of our clients come from another facility where they have undergone psychiatric evaluation. We automatically keep them on those medications.

On the other hand, some physicians will take kids off the medications before they get here because they are afraid of interactions with substances the kid

may be abusing. They might have been on an antidepressant or some regimen for bipolar disorder, and all their medications are discontinued. Then we start them again on those medications. There are many different scenarios with different outcomes. There are no black and white answers.

Chandler: Dr. Richard, what if a kid comes in with a strong family history of depression and depressive symptoms that predate the use of substances? I would be more inclined to start that patient on an antidepressant immediately, rather than waiting to sort out whether or not the depression is substance-induced.

Richard: If the patient has recently been suicidal, we don't wait. That is our rule of thumb.

Chandler: And if there is no suicidality, would you consider it in these kids who you are pretty certain have an underlying depressive disorder? I worry about withholding treatment from kids who might do better in programs if they were medicated from the get-go.

Richard: We don't wait much longer than a week. Our attending physician joins our staff meetings every Thursday.

Chandler: Dr. Riggs emphasizes lithium as a mood stabilizer. I'm concerned as a primary care physician who takes care of people later on in life and sees enormous problems with this medication. We have many years of experience with other medications, such as Depakote, that do not have the same renal toxicity, for when a kid needs a mood stabilizer.

Richard: Dr. Riggs characterizes pemoline [Cylert] as having lower abuse potential than other stimulants for ADHD. That may be true, but kids snort it, they sell it, they trade it for illicit drugs. Is anyone familiar with atomoxetine [Strattera]? It's a very new nonaddictive, nonstimulant medication for ADHD. We have one client on it, and he's doing very well.

Around 25 percent of our kids have sleep problems coming in, and had them before they ever used drugs. As an inpatient facility, we have the luxury of observing whether they are medication-seeking when they report sleep problems. If they really are sleeping fitfully or not at all, there is a recommendation for sleep medication, usually trazodone [Desyrel]. When individuals sleep they are able to function at a much higher level and participate in therapy much better.

12-step responses and funding

Chandler: I'm in the thick of the Bible Belt. I find that some of these adolescent patients hold on to fundamental Christian beliefs, and for them AA is very good.

Ingram: In my experience, if you are going to rely on 12-step programs and groups, make sure the adolescent gets involved with a group that has some long-term recovery. I have seen kids and adults get in NA and AA groups where there is no long-term recovery, and it just turns into a disaster.

Chandler: I have a question. Almost all of these kids have family members who are also abusing substances. How much emphasis do you put on the codependency model, which a lot of psychiatrists say is just pop psychology? Sometimes people have had a lot of success with that.

Ingram: Both my father and my stepfather were alcoholic. In my own experience, even though I didn't use alcohol or drugs, I found AA more helpful than Alateen. I don't know if Alateen is particularly helpful for somebody who is dealing with their own alcohol or drug issues. From my personal experience, I was much more inspired by the recovery stories in AA. Just my opinion.

Richard: We use Al-Anon here. A lot of our kids have alcoholic or drug-addicted close family members. Some of these kids just seem to come from Mars into these families. It's devastating for them and they don't have a clue about what these kids are going through when they are in treatment. Al-Anon really helps.

Ingram: I have tried to set up self-sustaining adolescent treatment programs. I think it is virtually impossible to sustain a really good adolescent substance abuse treatment program, to say nothing of one that also treats comorbid disorders, without a big influx of money from grants, fund-raising efforts,

If you have staff members capable of achieving a master's degree in substance abuse, it won't take much to teach them the side effects of medication.

United Way, and so on. There is no way families can pay for this out of pocket. The amount of third-party payments available for this purpose is minuscule.

Around 25% of our kids have sleep problems coming in, and had them before they ever used drugs.

Chandler: The only bright point is that I think it is easier to advocate for funds for adolescent treatment than adults. Legislatures, policymakers in general are more willing to provide money for adolescents than for adults.

Ingram: I agree, particularly if you have a family program.

Richard: Every time I go to a conference, clinicians tell me, 'You're not going to have a program there next year.' I have been here 9 years now and people have told me that every year. But there is a Federal mandate that States be able to provide residential treatment for adolescent substance abuse-dependent individuals. From what I'm told, a lot of States, and a lot of programs in a lot of States, have monies available that they may not be using. &