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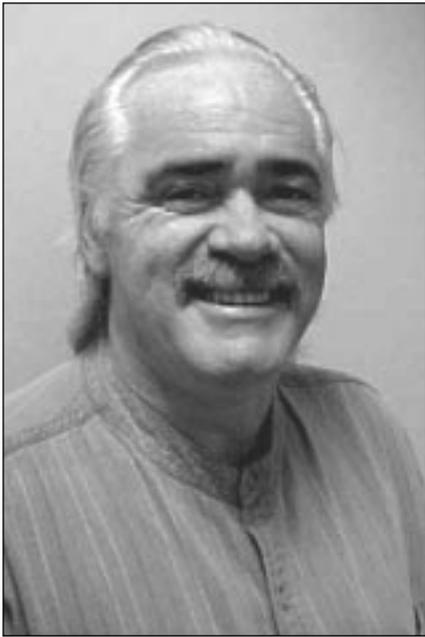
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# Societal Response to Developmental Differences and Adolescent Substance Abuse Treatment Outcomes



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## ABSTRACT

*Recent findings indicate an increased concern that conventional substance abuse treatment models consistently reflect less than satisfactory outcomes when applied to adolescents. This study investigates developmental differences among adolescents and adults as a possible cause of the disparity. The author conducted interviews with substance abuse professionals, developmental psychologists, adolescents in treatment, and adolescents no less than six months out of treatment. Questions focus on assessment agendas, developmental and motivational differences among adolescents and adults, movement along the addiction continuum, developmental tasks of adolescence, and adolescent receptivity. The results of the interviews among each group are compared and consistencies are noted. The implications of any correlation within the noted consistencies are discussed, as well as the implications for social work practice.*

It has been said, “what we, as adults, see in the adolescent culture tells us things we would prefer not to know about ourselves” (Schwartz, 1987, p. 6). As such, that “the special developmental concerns of teenagers are too seldom taken into account in substance abuse research and treatment,” comes as no surprise (Brown University Digest of Addiction Theory and Application, 2000, p. 4). However, the question of why “adolescents are not experiencing the same positive results from treatment that adults do” is an increasing concern within the substance abuse treatment field (Alcohol and Drug Abuse Weekly, 1998, p. 1). Given that the preponderance of adolescent substance abuse treatment programs are based on models designed to accommodate “European adult males” (Johnson, 2002, p.331), this too should come as no surprise. Moreover, it should be noted that according to research conducted by the Center for Substance Abuse Treatment (CSAT, 1995), the term “accommodate” could be understood to mean, to rehabilitate to a previously known level of successful independent functioning. In addition, “success in treatment programs for adults...has been defined as maintenance of abstinence” (CSAT, 1995, p. 3).

While some of these programs may experience adequate results with a small percentage of older adolescents, the majority of alcohol and other drug (AOD) using adolescents do not benefit from these types of programs (Brown, D’Amico, McCarthy, and Tapert, 2001). In addition, and despite the fact that incidence rates are high among European American adolescents, the combined rate of incidence among Hispanics and African Americans is typically greater than 50 percent of all AOD using adolescents, for most substances (Monitoring the Future, 2001). This figure precludes Native Americans and Asians, indicating an



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even greater number of racially and ethnically inappropriate, as well as age inappropriate, treatment modalities being applied with positive outcome expectancies. As a result, adolescents in general have received a negative prognosis – being labeled unresponsive, in denial, not sufficiently motivated, and “treatment – resistant” (Alcoholism and Drug Abuse weekly, 1998, p. 3).

At least one study indicates developmental differences that set adolescents apart from adults may significantly impact the assessment, expectancies for, and adherence to treatment, thereby affecting the adolescent’s response to treatment and ultimately its outcome (Deas, Riggs, Lagenbucher, Goldman, and Brown, 2000). This assumption is based on the belief that adolescent expectancies of AOD consumption change from negative to positive as they make the transition from childhood to early adolescence (Deas et al., 2000). Combined with the concept of the personal fable – a term used to describe a pattern of thinking attributing to adolescents’ delusions that they are unique, very important, and invulnerable (Elkind, 1968) – this shift toward positive expectancies for use represents a barrier specific to adolescence. This paper demonstrates a need to rethink current AOD treatment practices with the intention of developing and implementing assessment tools and treatment strategies that cater to the special developmental differences of adolescents.

## **Background**

*Review of literature addressing adolescent AOD abuse treatment outcomes.*

The issues of adolescent AOD use and/or abuse are relatively new concerns. This does not mean, however, that they have only come to be a concern within the last decade. To the contrary, in fact, adolescent AOD use and/or abuse have been societal concerns in this country

for several decades. This is evidenced by the fact that “the extent of...(AOD) abuse among adolescents has been well documented,” as have the acute and chronic “physiologic, behavioral, and social consequences of use, abuse, and addiction” (Center for Substance Abuse Treatment (CSAT), 1995, p. 1). However, the opposite is true of the special developmental concerns of AOD abusing adolescents with regard to treatment in the areas of service delivery and service outcomes (CSAT, 1995). In fact, several studies (Ralph and McMenamy, 1996; Melnick, DeLeon, Hawke, Jainchill, and Kressel, 1997; Brown, D’Amico, McCarthy, and Tapert, 2001; Winters, 1998) indicate concern over the lack of research on adolescent AOD treatment outcomes.

Although research is scarce, it is true that positive results have been found. However, researchers maintain that the implications are skewed since they are based on the “effectiveness of adult substance abuse treatment programs for adolescents” (Brown et al., 2001, p. 382). In reality, research results for treatment outcomes in adolescent-friendly AOD treatment programs are predominantly negative. For example, one study of a social skills activity intervention program for court-ordered adolescents “found that while graduation rates and personal adjustment appeared to be increased by the program, there was no reduction of drug abuse” (Ralph and McMenamy, 1996). In addition, the authors cite Query (1985) who, while following up on 78 percent of 134 American Indians and European American adolescents discharged from a four to six week inpatient treatment program, found that 27 percent of the European Americans and 100 percent of the American Indian adolescents still used alcohol. Results such as these are alarming and serve as the impetus for this study.

*Review of literature addressing adolescent stages of development.*

Understanding why adolescents use AODs is key to understanding why they give the appearance of being resistant to conventional AOD treatment models. In fact, several studies (Peele, 1992; 1998; Sampson and Laub, 1995; Steinberg and Morris, 2001) indicate the term “treatment-resistant” may be inappropriate – suggesting that most adolescents who use AODs typically outgrow the behavior sometime after reaching social maturity. In fact, according to Peele (1992; 1998) this process of ‘aging out’ usually takes place by age 29. As such, adolescent development with regard to motivation for atypical behavior is the focus of this review of the literature addressing adolescent stages of development.

“The empirical study of adolescence barely existed as recently as 25 years ago” (Steinberg and Morris, 2001, p. 83). In fact, according to Steinberg and Morris, popular theories of “normative adolescent development” (e.g. Erikson’s theory of adolescent identity and Piaget’s theory of formal operations) have lost their influence in adolescent research (p. 84). In addition, several studies (Steinberg and Morris, 2001; Henry, Moffitt, Robins, Earls, and Silva, 1993; Rutter, 1989; Farrington, 1995) indicate much of what is understood about normative adolescent development over the last 25 years was learned from studies of atypical adolescent development. Since problems during adolescence and problems of adolescence are not the same thing, and no indisputable means of discriminating between the two has as yet been developed, this approach may result in a radically distorted view of what constitutes normative adolescent development (Steinberg and Morris, 2001).

Interestingly, however, at least one study on adolescent anti-social behavior

borrows from Erikson's theory of adolescent identity in support of an answer to the question, "Why do adolescence-limited delinquents begin delinquency?" (Moffitt, 1993, p.14). To avoid confusion and provide an understanding of Moffitt's response to the above question, those adolescents previously referred to as those who typically experience an 'aging out' process will be referred to as adolescence-limited youths. Those who typically go on to develop persistent AOD problems will be referred to as life-course-persistent youths.

According to Moffitt (1993), adolescence is beset by a socially constructed "maturity gap" characterized by early biological maturation and delayed social maturation (p.14). Moffitt suggests, over the last 100 years, the time at which most adolescents reach social maturity has shifted from a time originally before biological maturity to where it is today – five to ten years after biological maturity. This socially constructed "maturity gap" – a state of being in which social mores prevent adolescents from assuming their ascribed roles as adults – finds adolescents seeking ways to cope with the discomfort and confusion of being trapped in a state of limbo, per se, between childhood and adulthood (Erikson, 1960).

Moffitt (1993) suggests, "social mimicry of the antisocial style of life-course-persistent youths" as the predominant means adopted by adolescence-limited youths as a coping strategy (p.14). Social mimicry, a concept borrowed from ethology, occurs when a species of animal mimics some aspect of another species to gain access to, or acquire, a desired resource enjoyed by the species being mimicked (Moynihan, 1968). According to Moffitt (1993) the same concept applies to adolescence-limited youths who mimic the antisocial behavior, (AOD use/abuse)

of their life-course-persistent peers. These antisocial behaviors are viewed as a highly coveted technique for the acquisition of the desired resource – in this case, "mature status, with its consequent power and privilege" (p. 15). For instance, as young adolescents experience biological maturity there is a concurrent transition into a new social reference group (e.g. high school society) comprised of predominantly older youth. Having had three to four years in which to develop coping strategies – albeit antisocial in nature – these older youth, at least one of which is almost always life-course-persistent antisocial, appear to be minimally affected by the maturity gap. As such, they became the objects of vicarious learning by the adolescence-limited youth (Moffitt, 1993).

An interesting aspect of the concept of social mimicry is that there is no indication for a required exchange of affection between those mimicking and those being mimicked – the participants need not like, or even know each other. All that is required is the presence of one or more life-course-persistents for the behavior to be observed closely enough and long enough to be successfully imitated (Moffitt, 1993). In fact, Cairns, Cairns, Neckerman, Gest, and Gariaepy (1998) indicate high membership turnover rates among delinquent peer groups. The implication here may support the assertion by Peele (1992; 1998) and the other studies mentioned earlier that most adolescents who use AOD's typically outgrow the behavior sometime after reaching social maturity. According to Steinberg and Morris (2001), little is known about how or why individuals experience this process of 'aging out'. However, they indicate as well that a correlation may exist between 'aging out' and "the settling down effects of marriage and full-time work" (p. 3). Furthermore, Moffitt (2001) cites Csikszentmihalyi

and Larson (1984) as having suggested that although adolescents are typically socially, as well as financially, dependent on their "families of origin," they want desperately to "establish intimate bonds with the opposite sex, to accrue material belongings, to make their own decisions, and to be regarded as consequential by adults" (p. 14). However, Moffitt's (1993) application of the concept of social mimicry only offers a plausible explanation for the adolescence-limited youth's involvement in AOD use and the behaviors associated with such use.

But, what about the life-course-persistent youth? It was previously suggested that problems of adolescence and problems during adolescence are not the same thing (Steinberg and Morris, 2001). According to Moffitt (1993), life-course-persistent youth develop a bent for anti-social behavior early in life and that the prognosis for these individuals is "bleak" (p. 679). Furthermore, Garnier and Stein (2002), suggest the propensity to conform to these unconventional values and beliefs is transmitted from parents to their children. In fact, they go on to cite Berg (1985) declaring, "children form their worldview through the value and meanings within the context of the family socializing environment" (2002, p. 46). Children are products of their environment – parents with positive attitudes about AOD use and the behaviors associated with AOD use may instill these attitudes in their children. As such, "development during adolescence cannot be understood without considering development prior to adolescence" (Steinberg and Morris, 2001, p.3), which brings us to the final aspect of development relevant to this study – the moment of transition from one stage, or level of status, to the next.

Social scientists and scholars such as Van Gennep and Mead, agree that nearly every human society either uses, or has

used, certain ceremonial rites to mark significant transitions of an individual's social status (Van Gennep, 1960; Mead, 1928). According to Van Gennep (1960), these rites of passage are intended to acknowledge, or validate, changes in a person's social status. Furthermore, Mead (1928) suggests that all children, regardless of culture or ethnicity, come to a turning point, typically during the teenage years (adolescence), when they start looking beyond themselves in an effort to discover how, and/or where, they fit in their society. In fact, and in agreement with Mead, Steinberg and Morris (2001) refer to adolescence as a period when youth "begin to explore and examine psychological characteristics of the self in order to discover who they really are, and how they fit in the social world in which they live" (p. 5).

With regard to the previously mentioned maturity gap, Mead (1928) makes reference to the delicacy of adolescence – a period when the individual is developmentally excluded from the childhood social group (biological maturity) and unsure about membership in the adult social group (social maturity). Caught in this period of ambiguous transition, the individual is faced with two choices: to join the adult social group (if that really is a choice) or to band together with peers and form their own society (or sub-culture), parallel to, but more often than not, counter to the rest of society. According to Mead, without the proper guidance, or a blueprint per se, the second option often prevails.

It has been said, "The need youth have for some kind of initiation is so strong that it will happen with or without a healthy blueprint" (Teen Rites Projects, 2000, p. 1). It is when youth turn to their peers for guidance when problems associated with adolescence emerge. Some examples given include "use of guns, use of alcohol and drugs,

displays of toughness, hazing, sexually acting out, or any combination of these behaviors" (Teen Rites Projects, 2000, p. 1).

### **Purpose, Rationale, and Objective**

This research will attempt to answer the following questions:

1. Could these developmental concerns, or differences, account for the fact that adolescents are not experiencing the same positive results from treatment that adults do, as well as explain the apparent resistance to treatment exhibited by adolescent users and/or abusers?
2. Could understanding the relationship between these developmental differences and adolescent substance use and/or abuse serve to quell the conceivable overreaction by society to the adolescent's natural progression through the process of lifespan development?

The rationale for this research is two fold. First, if those adolescents who are indeed chemically dependent are to be successfully treated for their dependency, it is imperative to discover why they give the appearance of being treatment-resistant. If the answer(s) lie(s) within the relationship between these developmental differences and current treatment models, this research could prove to be important in the development of more effective adolescent substance abuse treatment models.

Secondly, societal overreaction to a circumstance considered by many to be part of the natural developmental process can be devastating in many ways. Having cited Peele (1992; 1998), Johnson (2002) reports, many people view drug and alcohol consumption as a "rite of passage" – further suggesting its consumption will decrease with age (pp.

3-7). With this in mind, negatively mislabeling adolescents as addicts at a time typically identified as the stage where individuals develop self-concepts can lead to social ostracisation, as well as invoke the concept of the self-fulfilling prophesy – leading to the development of negative self-concepts. Moreover, according to Steinberg and Morris (2001), "adolescents who engage in false self behavior because they devalue their true self suffer from depression and hopelessness; adolescents who engage in false self behavior to please others or just for experimentation do not" (p. 6).

Based on this rationale, it is the objective of this research to discover characteristics of adolescent development that will lead to the advancement and implementation of adolescent friendly substance abuse treatment models. It is further anticipated that AOD researchers and treatment providers would develop a more realistic response to the issues of adolescent AOD use and/or abuse. This is not to say that society's views are unrealistic – simply overstated.

### **Method**

#### *Participants*

Participants in this study were selected from four separate groups consisting of substance abuse treatment professionals, developmental psychologists, adolescents still in AOD treatment, and adolescents no less than six months after AOD treatment. Prospective participants from the two professional groups (five from each group, located throughout the West Michigan area) were contacted. They were informed of the nature of the study and asked if they would be interested in participating. There were four affirmative responses from each of the two professional groups and three were selected from each group to participate. Selection was based on credentials, knowledge of, and experience with the adolescent population.

Prospective participants from the two adolescent groups were contacted less directly for reasons of confidentiality. Three AOD treatment programs serving adolescents were contacted and informed of the nature of the study being conducted. These agencies were asked to seek volunteers from their current and former clients. Each of the three agencies was provided with the necessary release of information and consent for interview forms. There were five prospective participants from those individuals still in AOD treatment and only three from those at least six months after AOD treatment. Of the five prospective participants still in treatment, three were randomly selected. As a result the study consisted of 12 participants – three substance abuse treatment professionals, three developmental psychologists, three adolescents still in AOD treatment, and three adolescents at least six months after completing an AOD treatment program.

#### *Instrument*

The instruments used consisted of two sets of open-ended questions requiring qualitative responses based on the disease model of addiction with a focus intended to address the concerns expressed in the stated research questions. Those interview questions addressing the stages of developmental tasks of adolescence refer to the following – (a) separation from parents (autonomy), (b) establishment of peer attachments, (c) establishment of sexual identity, (d) formulation of new ideas/ideals about the world they live in, and (e) a blending of the first four to consolidate one's character. Those questions addressing the stages of addiction refer to the four frequently seen stages of adolescent AOD use – (a) experimental use, (b) more regular use, (c) daily preoccupation, and (d) dependency.

To establish a foundation for the interviews based on the disease model of addiction, each of the participants from the professional groups were asked about their views concerning adolescent AOD use from a disease perspective; the adolescent participants, from both groups, were simply asked if they believe they have a disease. Having established a foundation based on the disease model, the respondents from the professional groups were informed of the recent research findings indicating adolescent resistance to conventional AOD treatment programs and asked to express their beliefs for the cause of such findings. In addition, participants from the professional groups were asked to express their views as to whether the concept of "hitting bottom" is a realistic expectation for adolescents who use mind or mood altering substances. With regard to the concept of "aging out," the participants were asked if they believed, as adolescents make the transition to young adulthood and experience new freedoms and responsibilities, their attitudes about drugs changed – and if so, how? The final interview question for the professional groups required much more dialogue than the others, with the focus addressing any correlation between the stages of addiction and the stages, or tasks, of adolescent development.

Of the adolescent participants – each of the respondents, those currently in treatment and those having completed at least one treatment program, were asked if, at any time during treatment, they were told where they were believed to be on the addiction scale. The respondents were then asked where they thought themselves to be on the addiction scale. The next two questions were directed toward expectations, both for treatment and for AOD consumption. Similarly, motivation was the impetus for the next two questions – motivation for use, as well as motivation

to seek treatment. The final question asked of both adolescent groups addressed the impact, if any, of the original assessment at the onset of treatment, and those adolescents having already completed treatment were asked what, if anything, about treatment had the greatest impact on them.

#### *Results*

As previously stated, the first question asked of all the participants was to establish a foundation based on the disease model of addiction. Of the six professional participants, five favor the disease model, even with regard to adolescents. However, although they stated their belief in the disease model of addiction, their responses contained at least one disclaimer. For instance, one SA treatment professional stated her belief in the disease model, yet went on to indicate an inclination to struggle with a 16-year old being an addict. In fact, that was typically the concern of the others as well. The participant that did not favor the disease model was from the developmental psychologist's group. It was his contention that AOD use is a cognitive behavioral concern – further stating that AOD use and the behaviors associated with such use are learned behaviors and as such can be unlearned.

As for the adolescent participants, all appeared to have attitudes of indifference, and their responses were brief. When asked if they believed they had a disease, five said "no" and one said "yes." The participant who believed he had a disease was from the group having already completed an AOD treatment program.

Because there are significant contextual differences in the remainder of the interview questions asked of the participants in the professional groups and those asked of the participants in the adolescent groups the remainder of this section will be addressed separately,

beginning with the professional groups and following up with the adolescent groups. This is based strictly on the contextual differences of the interview questions and to avoid confusion.

#### *SA professionals and developmental psychologists*

With regard to recent research findings indicating a resistance to AOD treatment by adolescents, all three SA professionals and two developmental psychologists indicated their disagreement with such findings. Although one developmental psychologist did agree that adolescents do appear to be resistant to conventional AOD treatment programs, all six participants agreed that if there was a problem it was in the method of treatment, not the adolescent.

The developmental psychologist who was in agreement with the literature on adolescent AOD treatment outcomes went on to suggest, that most people, if they do not see themselves as a significant abuser tend to initially react with resistance. In addition two of the SA professionals and two developmental psychologists spoke of the tendency for the concept of the personal fable to compound denial, or resistance to treatment. Furthermore, one of the developmental psychologists emphasized the importance of peer opinion and its effect on an individual's compliance with AOD treatment.

With regard to the concept of "hitting bottom," there was a general consensus among the professionals that adolescents do indeed hit bottom. However, exactly what constitutes bottom is not easily discernable and varied from one participant to the next. Again, reference was made to the invincibility factor (personal fable) by 50 percent of the respondents. One SA professional and one developmental psychologist made reference to the adolescent's ability to recognize terrible things happening in their lives, but being unable to, or

simply refusing to, attribute them to their AOD use. Furthermore, all of the respondents emphasized the importance of recognizing, based on developmental differences, that hitting bottom for an adolescent is significantly different than hitting bottom for an adult.

Concerning the process of "aging out," again the general consensus among the professionals is, for most adolescents, positive changes in attitudes concerning AOD use do take place as they mature. Exactly how, or why, is difficult to say. However, one developmental psychologist suggested career choices, religious experience, and association with a spouse or partner as possible motivating factors. In addition, one SA professional went on to say there is really no obvious and clear way of tracking changes in the adolescent's attitude concerning AOD use since they typically move on before making the transition to young adulthood.

In response to the question concerning any correlation between the stages of addiction and the stages, or tasks, of adolescent development the respondents were very nearly in agreement on much of what was discussed. Nearly all the participants began their response with the concept of arrested development – delayed progression through the developmental stages due to AOD use. However, other correlations began to emerge as we talked. For instance, two SA professionals and two developmental psychologists alluded to the powerful influence of peers, especially during the formation of peer attachments. One SA professional and two developmental psychologists also referred to separation from parents – challenging the parents' lifestyle; the parents' authority; and establishing autonomy.

Furthermore, two SA professionals and one developmental psychologist included some discussion of delay of onset of first use. It was suggested by

the three aforementioned professionals that if an individual can make it to age 25 without having experimented with, or developed any significant patterns of AOD use, the probability of ever doing so is reduced to almost zero. This data appears to contradict the literature, in which Peele (1992; 1998) suggests age 29 as the time typically established for the "aging out" process to occur. However, it should be noted that the respondents to this interview question are speaking in regard to delay of onset of first use, whereas Peele (1992; 1998) is referring to those individuals who have already achieved various levels of AOD use. So as not to lose the impact of the participant's response concerning delay of onset, it should also be noted that this might prove to be significant in that it seems to suggest that AOD problems are conditions born of adolescence, which will be discussed further in the next section.

#### *Adolescents*

With regard to the adolescent interviews, in response to whether or not they were told at any time during treatment where they were believed to be on the addiction scale, four of the respondents indicated they were told they were addicted (the fourth stage mentioned in the instrument section), but did not agree. Of those four, one stated he later came to agree with the assessment. The other two indicated they were never told, but at the time of the interview saw themselves at the second stage (more regular use). The others, when asked where they saw themselves on the scale (with the exception of the individual who later came to agree with the assessment), indicated they were not on it at all – stating they had no problems. It should be noted that the two who believed themselves to be at the second stage were from the group having already completed treatment and the individual

who later came to agree with his assessment was of the group still in treatment.

In response to the question addressing expectations for treatment the respondents from both groups indicated treatment was simply a means to become educated about the effects of AOD use. In fact, two participants from the group still in treatment and two from the group having completed treatment indicated what they had learned, or had yet to learn, would better equip them in controlling their consumption. The next question then addresses the issue of expectancies for future use. All of the respondents indicate they have every intention to continue using as soon as they are finished with whatever legal circumstances they happen to be involved with. Although all of the participants from both groups state their intentions to continue using, one from each group states he will only use alcohol because it is a legal substance.

With regard to motivation for treatment, the participants from both groups are, or were, in treatment as the result of judicial mandates or at the recommendation of their probation officers. None of the participants voluntarily sought treatment. In response to the inquiry concerning motivation for use all of the participants indicated they did it to fit in – stating everyone was doing it. In fact, one of the individuals from the group still in treatment said it gave him a sense of belonging.

In response to the question addressing any impact that may have been experienced as a result of the original assessment the general consensus among all the participants was one of indifference. In fact, all the participants indicated a lack of concern about what the people doing the assessment thought about them. However, two of the respondents from the group still in

treatment further indicated their lack of concern was based on the assurance of confidentiality, expressing their concern about being treated differently should people find out they were addicts.

Finally, with regard to what, if anything, actually worked or helped those individuals having completed a treatment program, all the participants indicated the didactic aspect of treatment had the greatest impact. The delivery of the instruction took multiple forms as well – videos, lectures, reading material and the sharing of personal stories. In addition, one of the participants also indicated support networks – emphasizing, however, it did not include his friends, since they no longer wanted to be his friends if he was actually going to stop using.

#### **Discussion**

In as much as the sample size used in this study is by no means large enough to establish conclusively the significance of developmental differences among adolescents and adults with regard to AOD treatment outcomes, the data presented appears to support the current literature. In addition, a serendipitous aspect of AOD use concerning the delay of onset in reference to an individual's first encounter with AODs is presented as well. Although this aspect of AOD consumption is not supported by the current literature, the significance of this discovery may have a direct impact on the development of alternative AOD treatment models – not just for adolescents, but also for AOD users in general.

The research indicates a high likelihood that if an individual can make it to age 25 without experimenting with, or developing any significant patterns of AOD use, the chances are almost zero that he/she ever will. This is substantiated by 50 percent of the professional participants interviewed for this study. However, in order to fully

understand its implication, this concept must be put together from its single component parts. Therefore, the full formation of this concept cannot appear at the beginning of this discussion; rather, it must stand at its conclusion.

The current literature clearly indicates that the majority of conventional AOD treatment programs were designed, or conceived of, many years before the empirical study of adolescence even began. As such, the inclusion of the special developmental concerns of adolescence could not have been incorporated in their design. Furthermore, the research clearly indicates, based on the agreement of all the professional participants, if there was a problem of receptivity to conventional AOD treatment methods by adolescents, the problem was to be found in the method of treatment, not the adolescent. This can only serve to confirm the inappropriateness of applying treatment models designed to accommodate “European adult males” (Johnson, 2002) for the treatment of adolescent AOD users.

Since it has also been established that the goal of conventional AOD treatment programs is to rehabilitate European adult males to a previously known level of independent functioning, it is now necessary to address this concern with regard to adolescent AOD users. The question, “How do you rehabilitate someone to a previously known level of independent functioning if they have never known one?” cannot be avoided and must be answered. Perhaps the answer lies in the removal of the prefix in the term rehabilitate, with regard to the objective of adolescent AOD treatment. To habilitate an individual to a level of independent functioning seems to be a more realistic treatment objective for an individual who has never known any level of independent functioning. Of course, to do this would call for a complete rethinking of conventional AOD treatment models.

Before returning to the concept concerning the delay of onset introduced at the beginning of this discussion it is necessary to address one final issue – the issue of the adolescence-limited youth and the life-course-persistent youth. According to the literature, there is an “aging out” process that occurs around the age of 29 (Peele, 1992; 1998) for the adolescence-limited youth. Unfortunately it is the life-course-persistent youth who carries his/her AOD problems beyond the “aging out” period. Since it is the life-course-persistent youths who serve as the models for the adolescence-limited youths it stands to reason that these individuals should be the focus for the development and implementation of alternative adolescent AOD treatment models.

Having presented the component parts necessary for the understanding of the concept concerning the delay of onset of first AOD use, it can now be adequately addressed. If, according to the research, an individual can make it to age 25 without having experimented with, or developed any significant patterns of AOD use, the probability of ever doing so are reduced to almost zero, then it would appear that problems of AOD use are conditions born of adolescence. If problems of AOD use are conditions born of adolescence then the question arises, “Has anyone in treatment, regardless of age, ever experienced a previously known level of independent functioning?” It is this writer’s opinion that any response to this question can only be negative, and the goal of rehabilitation to a previously known level of independent functioning is nothing more than what CSAT refers to as “maintenance of abstinence” (1995, p.3). This may be fine for the adolescence-limited youth who is going to experience the “aging out” process.

What about the life-course-persistent youth whose problems originated in

childhood and became manifest during adolescence? There is a saying in Alcoholics Anonymous and it carries over into Narcotics Anonymous as well – if you sober up a horse thief, all you have is a sober horse thief. AOD treatment programs for adolescents need a much deeper and comprehensive definition of success than the mere maintenance of abstinence. The issues of adolescence-limited youths and life-course-persistent youths will be addressed more completely in the discussion of the second research question.

Now with regard to the second research question, since, according to Steinberg and Morris (2001), much of what we understand about normative adolescent development was learned through the study of atypical development perhaps this discussion should employ the same approach. Over the years, we as a society have decided to take the power and privilege typically characteristic of social maturity and distribute it in portions over an unspecified time known as adolescence. The result of this is the socially constructed maturity gap mentioned earlier in this article. There is, or are, no clear-cut point(s) of entry into adulthood in our society. However, there are symbols, determined through the attitudes and beliefs of the society in question, representative of the various levels of social status. Unfortunately, in our society we have allowed the use of beverage alcohol, certain drugs, and certain behaviors associated with their use to become symbols of social maturity.

Faced with the ensuing frustration, as well as the perceived insignificance inherent in this period of extreme role confusion, adolescence-limited antisocial youth learn to mimic the behaviors (AOD use) of their life-course-persistent peers. These life-course-persistent youths, through the expression of their

antisocial behaviors, appear not to experience the discomfort of the socially constructed maturity gap. Although the concept of life-course-persistence is significant to the objective of this study, to explain it in detail constitutes a study in and of itself since the understanding of life-course-persistent behavior must begin long before the onset of adolescence.

Getting back to the concept of social mimicry, adolescents desperately seeking to demonstrate their maturity are engaging in these activities and discovering these symbols of maturity sooth the discomfort associated with existing in the maturity gap created by their parents and the society in which they hope to define themselves. It is through testing these boundaries and challenging social prohibitions that young people learn to develop internal control over their behavior. As they participate in this concept of social mimicry, they begin to experience the illusion of adult status and will typically continue to mimic the antisocial styles of their life-course-persistent peers until such time as the settling-down effects of certain conditions, such as marriage and full-time work, symbolize societies acknowledgement of them as consequential adults.

Based on this interpretation of the research data it would seem that for most adolescents their involvement in AOD use is likely just a part of their natural progression through the stages of life-span development. This writer suggests that it is the life-course-persistent youth, and the research seems to support this as well, whose AOD use is maladaptive, or problematic in that their motivation for use far exceeds an expression of social maturity. Therefore, it would behoove us to focus our attention on the development of AOD treatment models designed to cater to the needs of these life-course-persistent youth. The problem, it seems, is how do we distinguish between life-course-persistent youth and adolescence-

limited youth. The answer lies in the need for further research.

There are, however, certain steps that can be taken in the interim. You will recall that the research indicates the didactic aspect of treatment was the most beneficial. Since the development of life-course-persistent antisocial behavior, such as AOD use, occurs prior to adolescence this writer suggests that perhaps treatment should begin in the primary years of school. It should become a mandatory part of the primary school curriculum – a required class, the same as math, English, and science. It should be taught by trained professionals, teaching such topics as the possible dangers associated with AOD use, alternative socialization skills, peer norms adjustments, and perhaps the establishment of more positive icons representative of the various levels of social maturity. Furthermore, this writer suggests the development of AOD treatment policies requiring parental involvement with mandatory sanctions for non-compliance.

### **Implications for Social Work Practice**

When considering the purpose of social work in conjunction with the multiple roles assumed by its practitioners, these findings have important implications for social work practice at the micro, mezzo, and macro levels. The social worker's ability to function at multiple levels and areas of ecological systems, a model that views individuals and groups in their capacities to function and interact with, as well as within, the various complex systems that constitute society, requires their involvement as agents of change in the process of education and reform expressed in this study. In fact, it was the "increased influence of the 'ecological perspective on human development' (Bronfenbrenner, 1979) during the late 1980's "that gave rise to a heightened interest in adolescent development – particularly atypical (or antisocial)

development (Steinberg and Morris, 2001, p. 83).

Facilitating change in attitudes, processes, procedures, and policies are integral factors necessary to bring about the restructuring of AOD treatment models and prevention programs suggested in this study. To develop an awareness of the potential risks of AOD use, as well as the development of alternative socialization practices designed to accommodate diverse populations, these actions must be undertaken as part of well-thought-out plans developed with the assistance of, and on behalf of, AOD users themselves. To do this, however, we must first educate ourselves about the dynamics of AOD use from an adolescent perspective.

The social worker must then provide widespread education about the possible changes in the acute and chronic effects of AOD use when approached from an adolescent perspective. This can be done in many ways, for example, publishing a newsletter, being a guest speaker at classes or seminars, designing a website, or starting discussion groups to educate the community. In addition, the social worker must work with individuals at the various levels (micro, mezzo, and macro) to aid in the development of more positive icons representative of having achieved adult status.

At the mezzo level the social worker must work with others to develop ways in which to distinguish between adolescence-limited youth and life-course-persistent youth. This is perhaps the most important undertaking set forth in this study, since it is the life-course-persistent youth that go on to develop lasting AOD problems, as well as become models for social mimicry by the adolescence-limited youth. The ability to make this distinction would then lead to yet another task incumbent on the social worker's eclectic knowledge base – the development and

implementation of a mandatory class in the primary school curriculum. The scare tactics employed by such programs as D.A.R.E. merely give the illusion of success in the overall reduction of AOD use in adolescence (Levinthal, 2002). As such, a major effort on the part of social workers, educators, psychologists, researchers and policy makers is called for.

Finally, for any or all of the proposed changes to take place, research must be a paramount factor in all of the undertakings set forth in this study. Research that purposefully targets and supports the development and implementation of the practices, procedures, and policies necessary to achieve success in the elimination or significant reduction of AOD use among the adolescent population. Furthermore, the implementation of well-designed research studies to monitor the progress and effectiveness of our efforts for the purpose of informing practice and policy is called for as well.

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