UNIT-11

Problems in Adolescence

Learning Outcomes

By the end of this unit the learner will be able to:

- ✓ Discuss the problems of middle childhood.
- ✓ Identify the causes and development of fears and anxieties in childhood.

Unit 11

Problems in Adolescence

Drug Abuse

Regular drug use in adolescence is of special worry to clinical psychologists because it may result in negative long-term consequences for the adolescents and negative consequences for their children. For adolescents, regular drug abuse may negatively affect mental and physical wellbeing; criminal records; studies; the creation of autonomy from the origin of the family; and the creation of long-term intimate relationships (Newcomb and Bentler, 1988). The children of regular teenage drug users may have drug-related problems. These cases of drug use differed in results. Obviously, drug abuse is not always an issue and it may occur as a part of a larger pattern of life problems. The meaning and grouping of drug use is, therefore, a complicated task.

In the long-term, excessive drug use, in many cases, leads to difficult cognitive working. Additionally, the setting, duration, and reversibility of these complicated conditions also changes according to the pattern of drug abuse. With teenagers, the complex cognitive working is mostly a result of continuous drug abuse. This may lead to a decrease in academic performance.

Drug abuse may have an effect on interpersonal relationships. Within the family, drug use typically leads to conflicts or a separation between adolescents and their parents. At school, drug use may lead to conflicts between the adolescent and teachers due to poor academic performance and unacceptable behaviour, which includes robbery or aggression, linked with drug abuse. Adolescents that frequently take drugs within a peer-group setting may become seriously involved in a drug-addicted life and stop socialising with friends who do not take drugs.

Some adolescents develop a single drug-using pattern and become more and more socially isolated as their drug use continues. Within the bigger picture, drug associated antisocial behaviour may bring adolescents into the legal system with the police over their crime. Drug associated health issues and drug addiction may bring them into contact with hospitals and surgeries. Problems between drug users and healthcare professionals may occur in settings where adolescents are given prescribed drugs (such as methadone) as a replacement for illegal drugs (such as heroin).

Predisposing Risk Factors

Both personal and contextual factors may predispose adolescents to develop drug abuse problems.
Personal predisposing factors include pre-existing conduct problems or emotional problems; specific learning difficulties, attention problems, and academic difficulties; a propensity for risk taking; and positive attitudes, and values concerning drug use. Difficult temperament, low self-esteem, and an

external locus of control may also predispose adolescents to engage in drug abuse. Early onset drug abuse is a personal risk factor for later persistent drug abuse.

Environmental factors requiring special attention include a poor relationship with parents, typically regarding bonding issues or a bad parenting methods; a lack of supervision from parents and a lack of discipline; and parental drug use. This also includes disorganised family management, with ambiguous rules, duties and patterns. Parental law breaking or psychological issues, marital problems, or the presence of bad siblings within the family home are other environmental risk factors.

Precipitating Factors

Adolescent drug use, in the western world, tends to follow after an early use of cigarettes and alcohol, through issues with consuming alcohol and the taking of illusion drugs to multiple drug abuse. Not every adult moves from one stage to the next. Moving to the next stage, depends on the presence of precipitating factors and predisposing risks. Nevertheless, at all stages, the availability of drugs is an accelerating factor when paired with some personal desire, like the will to test ways to satisfy thoughts; the need to conform to peer pressure; or the need to avoid bad moods. These bad moods may appear as a response to recent life problems. Membership in a peer group, parental cigarette usage, alcohol use, and other such minor activities are the major risk factors which go with first cigarette and alcohol use. Progression to problem drinking is more likely to occur if the adolescent develops beliefs and values favouring excessive alcohol use. A further transition to the use of illusion drugs requires the availability of those drugs and exposure to peer use of drugs.

Treatment

In a review of methodologically robust studies, Liddle and Dakof (1995a, 1995b) concluded that a multi-systemic approach to drug abuse, involving family-based intervention and individual therapy, is the most effective available treatment for adolescent drug abusers. Multi-systemic family-based approaches have been shown to be effective for engaging abusers and their networks in therapy; for reducing drug abuse; for improving associated behaviour problems; for improving the overall family functioning; and for preventing relapse.

Effective family-based treatment programmes for adolescent drug abuse involve the following processes, which, while overlapping, may be conceptualised as stages of therapy (Stanton and Heath, 1995):

- engagement, problem definition, and contracting
- becoming drug free
- facing denial and creating a context for a drug-free lifestyle
- family reorganisation
- disengagement

Becoming Street-Drug Free

Once the family decides to participate in the treatment, the psychologist will advise the family that, in order for the treatment to work, drug use must stop first, and once that has taken place, a drug associated lifestyle may be discussed, not the other way around. If the alterations to a drug associated lifestyle and changes in family relationships are discussed first with the thought that this will lead to drug use ending, then the treatment will most likely work.

If the adolescent is not physically dependent on drugs, then a date for stopping should be set for the near future and a drug-free period of 10 days after that date set, during which the parents take responsibility for round-the-clock surveillance of the adolescent, both to comfort them from any withdraws they may encounter and to prevent drug use, should occur. If the adolescent is physically dependent on drugs, plans for detoxification should be made. Home-based detoxification with medical back-up may be possible in some cases. Home-based detoxification requires the family to agree a 24-hour rotation to monitor the adolescent and administer medication periodically under medical direction.

Alternatively, hospital-based detoxification may be arranged. However, home-based detoxification has the advantage of giving the family a central role in the recovery process. Following home-based detoxification, family members will be less likely to become involved in patterns of behaviour that maintain drug abuse in the future. They will also be less likely to blame the treatment team when relapses occur during the recovery process, and more likely to take some responsibility for dealing with these relapses.

In some instances, where opiate-dependent drug abusers are unwilling to become drug free, participation in a methadone maintenance programme is an alternative to detoxification.

Methadone is typically prescribed to people addicted to heroin as an alternative to either detoxification or continued use of street drugs. Family-based treatment in conjunction with methadone maintenance has been shown to lead to a significant reduction in the use of street drugs in comparison with methadone maintenance alone (Stanton and Todd, 1982). However, a problem with methadone maintenance is that drug dependence (albeit prescribed-drug dependence) continues to be central to the adolescent's lifestyle and to the organisation of the family.

Mood Problems

Depression in childhood or adolescence may be a particularly distressing experience for both the young person and other family members, particularly parents. Unfortunately, the outcome for depression in childhood and adolescence is not favourable. Available evidence suggests that while the majority of adolescents recover from a depressive episode within a year, they do not *outgrow* their mood disorder.

Major depression is a recurrent condition and depressed adolescents are more likely than their non-depressed counterparts to develop episodes of depression as adults although they are no more likely to develop other types of psychological problem. Double depression - that is, an ongoing persistent mood disorder (dysthymia) and an episodic major depressive condition; severe depressive symptoms; maternal depression; and the absence of co-morbid conduct problems have all been shown in longitudinal studies to be predictive of poor outcomes. While depressed adolescents, with conduct difficulties have been found to be less at risk for recurrent episodes of depression, they are at greater risk for the development of relationship problems in adulthood.

Young adults who are depressed attribute themselves, the universe, and the future in negative ways. They look at themselves as nothing and are hard on themselves regarding their intelligence, sport, musical, and other achievements. Typically, this poor self-image is viewed as self-blaming for not achieving specific goals. They view their universe, including family, peers, and learning environment, as harsh and hostile. They explain the future in negative terms and express little hope that things will get better.

When they provide information about extreme hopelessness and this is accompanied with guilt for which they think they should be given consequences. Suicidal thoughts or ideas may be reported. A poor self-image, the universe, and the future may be combined in negative situations leading the young adult into depressive, unstable mindset. Furthermore, regarding depressed adolescent's view of a bleak future, they also show errors in their thought processes and concentration issues. Mistakes in reasoning are characterised by a habit of focusing on problems and ignoring good situations. Attention and concentration issues lead to problems dealing with school work or leisure activity requiring constant concentration.

With respect to effect, feeling low is a major symptom of depression. Depressed feelings are typically identified as an emotion of sadness, being by themselves or fear, and a feeling of not enjoying life.

Frustration, worry, and aggression may be the core factors, with sadness causing difficulty in enjoying good times being lesser factors. This is expected, as typical grief is marked by sadness as the missing factor, frustration as the missing factor for abandoning the grieving person, and worry that more losses may occur.

Depressed children and young adults may show some signs of all three main feelings, for example depressed feelings, aggravated feelings, and worry. In behaviour, depressed adolescents may express either reduced and slowed activity levels or higher but pointless activity. They may express a failure to concentrate on items that would provide them a sense of pleasure or bond to family or peers. When adolescents rarely want to participate in anything, this is known as a depressive stupor. This is not a common syndrome.

Somatic or vegetative factors, such as a loss of energy, interruptions of sleep and eating, a loss of weight or failure to make an age-suitable weight gain, abdominal aches or headaches, and an unusual combination of feelings are all indicative of more severe syndromes. Teenagers may also state that they have lost an interest in sex. These factors of depression are consistent with results that a lack of regulation of neurophysiologic, endocrine, and immune functions are linked with depression.

At a different level, depressed children sever their bonds with family, peers, teachers, and other important people in their lives. They see themselves as being alone and not able to take, or undeservedly taking stages to communicate with other individuals.

Precipitating Factors

Losses that come from the interruption of important relationships and loss related to failures to achieve goals may contribute to a feeling of depression in children and young adults. Relationships may be severed for many reasons. Feelings of failure and threats of self-harm may occur with a failure of exams or health problems that prevent them from reaching goals in sports or leisure activities.

Maintaining Factors

Both personal and situational factors may contribute towards depression. A depressive approach, where mentally, global, unstable factors are created as a result of bad experiences and outside, certain and crazy factors are created for greatness, can also continue depression. A bad mood may be sustained by often thinking poorly of themselves. Other important mental factors that prolong depression include choosing to monitor negative features of a person's actions, concentrating on negative self-evaluation or consequence, and focusing on only small parts of positive self-evaluation.

Punishing behavioural patterns that come from social-ability problems, especially when involving others in depressive dialogues regarding depression which lead them to stop future communication, may maintain depressed attitudes. Depression may be extended by utilising unusual coping mechanisms, especially drug abuse and self-harming actions. Unusual defences for coping with such threats like denial making may also extend a depressed mood. From a biological standpoint, depression may be prolonged by an inefficient amine system providing rewards and consequences; a slow endocrine system, the immune system fighting illness, and the negative effects of the sleep-waking patterns.

Within the adolescent's family or school context, a variety of factors that create mood issues, this can include the following: continuous abuse, being bullied, feeling the effects of the loss of good care, or being in an uncaring education environment. Continuous contact with parents or caregivers who give constant negative feedback may prolong depression, as many family situations where the adolescent is prevented from achieving developmental milestones like growing autonomy.

These parenting patterns may be created by unusual family contact, disorganised family planning, and triangulation, where the depressed adolescent is pulled between the different parental requests. These difficult factors may arise from in family settings where parents have stress levels that are high, along with social problems, low levels of social care, marital problems, a lack of parent involvement, physical infliction, or psychological issues, including depression. When parents have poor, internal working models for relationships, low levels of confidence, a poor work-ethic, a loss of control, poor defences, and poor coping mechanisms, their ability to manage their children's depression may be confirmed.

In the treatment sector, a lack of teamwork or good relationships with involved professionals may prolong adults' depression. It is not uncommon for members of the professional team to provide different views and advice on the nature and treatment of adult depression. These may go from seeing the child as mentally ill and needing patient support, anti-depressants and attentive discipline, to seeing the child as inefficient and requiring tough discipline. When teamwork issues between families and support providers arise and families do not agree on the reality of the diagnosis or the suitability of the treatment plan, then the problems may persist. Parents' inexperience in coping with similar issues in the past is another factor that needs to be addressed with the treatment group and so they may move forward in managing the adult's problems.

Protective Factors

The likelihood that a treatment plan will work is determined by a mix of personal and environmental factors. It is vital that these are examined and used in the plan creation, as it is these factors that typically are the basis for mental compromise. Adolescents displaying not so obvious mood swings and negative behaviour are less at risk than those with double depression and no conduct issues. From a biological viewpoint, wellbeing and a drive to succeed in constant physical exercise are good factors. A high level of intelligence and a hopeful mind-set are vital personal protective factors.

In the family, tight parent-child bonds and disciplined parenting are vital securing factors, especially if they occur within the environment of a good family organisation in which there is good connection and strong marital satisfaction, and both parents share the essential tasks of dealing with home life.

Good parental is also an important behaviour changing factor. Where adults have a good sense of management then they are highly equipped to deal with their children's issues well. A good knowledge about the character of psychological factors for overcoming depression is also a self-defence mechanism.

In the wider social network, high amounts of care, low amounts of stress, and an involvement of a high socioeconomic group are all self-defence mechanisms for depressed adults. When families are in social networks that provide good care and put less stressful requests on family members, then, it is less common that parents' and children's needs for coping with health-associated issues will be used. A well-equipped educational institution may also be viewed as a self-defence mechanism. Educational

environments, where teachers have enough time and have flexibility in their schedule to attend necessary home-school meetings, lead to positive results for depressed young adults.

In the treatment sector, teamwork between the treatment group and the family and the coordination of many teams are self-defence mechanisms.

Families are most likely to benefit from help when they accept the development of the plan provided by the treatment group and are willing to cooperate with the team to resolve the issue. When families have previously successfully addressed similar difficulties, they are most likely to benefit from treatment, and in this implication, past experience with similar difficulties is a self-defence mechanisms.

Treatment

These factors are held in this way of treatment:

- Psychological-education
- Self-evaluation
- Interventions regarding participation
- Interventions regarding family connections
- Interventions regarding the mind
- Social ability and social problem education
- School intervention
- Medications
- Managing parental mood issues
- Absent or broken control

Prevention

School-based plans to stop depression in children should aid adolescents in creating the mental and social abilities needed to decrease their vulnerability to depression.

Particularly, these methods include:

- A plan for addressing the concept of depression, which define psychological, social and biological factors
- Skilled training to aid adolescents create learned hope
- Social problem education
- Organising pleasurable activities
- Relaxation training

Anorexia and Bulimia Nervosa

Anorexia

Anorexia nervosa is an eating disorder in which a person is afraid of putting on weight or has a lack of muscle because they extremely limit their food intake. Typically, anorexics will also exercise more than necessary to burn the calories consumed to avoid weight gain. Even when they are getting ill physically and others label them as being unhealthily thin, anorexics will still think that their physique is too large and they continue to deprive themselves of adequate nutrition. Sadly, with the absence of a sufficient amount of nutrients to keep them healthy, an anorexic's internal organs may fail and this may lead to death.

A Fear of Gaining Weight

The most well-known of the eating disorders is anorexia nervosa. It is typically characterised by a person's slenderness due to their fearful emotions of putting on weight and their resulting desire not to eat. They will decline food and go for long periods without eating to lose weight. They will continue to do so despite a decline in health due to malnutrition. They are then labelled anorexic.

Distorted Body Image

Even when they are harmfully slender, anorexic people may still think of themselves to be overweight due to distorted vision of their body. They are often surprised to learn that they are underweight. The lack of food consumption is typically combined with a compulsion to exercise. Anorexics will exercise more than necessary, putting further stress on their bodies. Anorexic may also purge (vomit).

Health Risks of Anorexia

If weight falls to dangerously low levels, there is the chance of vital organ failure. Of all the eating disorders, and certainly of every psychological condition, anorexia nervosa has the highest death rate. Long-term health concerns that arise from anorexia include osteoporosis, a weakened immune system, fertility issues, damage to bodily organs, and mental health issues.

Two conditions of anorexia nervosa are: the restricting condition and the binge-eating/purging condition.

Restricting Type

In the current description of anorexia nervosa, there is no constant bingeing or purging action.

Binge-Eating Type or Purging Type

In the relevant time of anorexia nervosa, there is a persistent development of binge-consuming or purging actions.

Signs of Anorexia Nervosa

Symptoms of anorexia nervosa can be physical, psychological, and behavioural.

The following is a list of common symptoms:

Physical Symptoms of Anorexia Nervosa

- Weight loss
- Weight which is below 85% of the recommended weight based on height and age
- Poor heart rate and low blood pressure
- Cold hands and feet and lower than usual body temperature
- Poor circulation
- Digestive issues, such as, constipation and bloating
- The absence of the menstrual cycle in women
- Lanugo, a layer of thin hairs all-over the body to provide insulation
- Brittle hair and nails, dry skin, a loss of hair from the scalp
- Hollow-looking eyes and pasty skin colour
- A lack of strength and exhaustion, dizziness, and breathing issues
- Dehydration
- Stunted growth - if anorexia occurs before or in adolescence
- A compromised immune system
- Anaemia
- Swollen joints
- Osteoporosis
- Fertility issues

Psychological Symptoms of Anorexia Nervosa

- Frequent mood swings
- Depression and annoyance
- Difficulty focusing and a loss of memory
- Ignoring feelings of hunger
- Concern about being over the recommended weight
- An obsession with food and nutritional guidelines

- Persistently striving for perfection
- Denial about being underweight
- Low amounts of confidence
- An obsession with tidiness
- An addiction for exercise
- Worry when consuming food in front of others
- Feelings that joy is undeserved
- Strong urge to be in control

Behavioural Symptoms of Anorexia Nervosa

- Wearing baggy clothes to hide a thin physique
- Rarely consuming food
- Consuming only certain types of foods and counting calories
- Frequently looking in the mirror and monitoring weight
- Excessive exercise to lose weight
- Binge consuming
- Fainting and dizzy spells
- Preparing meals for other individuals, while declining food consumption with them
- Secretly eating or exercising
- Self-harm
- Exhibiting controlling behaviour

Causes of Anorexia Nervosa

The cause of anorexia nervosa have a high number of associated physiological, psychological, and social factors, which can increase the odds of a person acquiring the disorder.

Physiological/Biological Causes of Anorexia

A genetic factor to developing anorexia may be somewhat responsible. If another family member has been diagnosed with anorexia nervosa, the chances of getting it may be increased.

Psychological/Emotional Causes of Anorexia

- Anorexia nervosa is concerned with specific personality factors.
- Examining food and weight loss provides a detour from the main psychological issues that may be too hard to address or manage.

Social/Behavioural Causes of Anorexia

- Western culture encourages extreme thinness as an example of body perfection.
- This leads to people growing unhappy with their own bodies, their confidence falls, and they turn to dieting as they feel the stress to be slender. Anorexia nervosa can begin from the need to achieve over-ambitious goals.
- Hard, difficult relationships in the family that makes an individual view themselves negatively may lead to the condition, as can other stresses from school or work.

Therapy

The type of therapy, that is most appropriate. will depend on the patient's individual preferences and the particular eating disorder they have.

Psychotherapy: There are alternative forms of psychotherapy which can be good in determining the main psychological causes of an eating disorder. Psychotherapy helps create good thought patterns, changes attitudes, and helps interpersonal relationships. Specific psychotherapy can aid an anorexia patient to change their body image and improve self-esteem, as well as guiding them to a sensible relationship with food and healthy eating plans.

Family Therapy: Family therapy is beneficial if the person is staying at home; the whole family can go to therapy sessions with each other. It can help to spot the main causes of the person's anorexia, like problematic relationships with one another. An example would be a parent, without realising, putting too much pressure on their child to achieve, leaving the child feeling underachievement. Family therapy will encourage the child and parents to cope with the issue as one and aid in recovery from anorexia.

Group Therapy: Group therapy sessions may or may not be run by qualified health professionals, and are attended by individuals with varying degrees of anorexia. Some people find great comfort and support from attending therapy sessions with other anorexics and are encouraged to overcome the disorder

Bulimia Nervosa

Bulimia nervosa also known as 'bulimia' is an eating disorder identified by binges and then purges. During a binge, a bulimic will consume a large amount of food in one sitting, then vomit, which is known as purging. For bulimics, binging and purging become a habit but they may not lose or gain a sufficient amount weight to make it clear that they have an eating disorder.

Health Risks of Bulimia Nervosa

Long-term health problems, which are caused by bulimia, are changes in body chemistry and, ultimately, death. People with bulimia will not necessarily be thin and may even be overweight. Excessive weight causes different health issues which lead to further risks. People who are bulimic are typically of a

normal weight so it may go unnoticed for many years, with those closest to them typically having no idea they are bulimic or their health is declining.

Two types of bulimia nervosa are recognised: the purging type and the non-purging type.

Purging Type

While suffering from bulimia nervosa, there has been a persistent pattern of self-induced vomiting.

Non-Purging Type

While suffering from bulimia nervosa, there has been no persistent pattern of self-induced vomiting.

Causes of Bulimia Nervosa

Causes of bulimia nervosa have a lot of bad physiological effect, which can increase the possibility of a person acquiring the disorder.

Physiological/Biological Causes of Bulimia Nervosa

Some people may have genetic factors which predispose them to getting bulimia. Therefore the chance they will acquire the disorder is increased.

Unusual levels of serotonin in the brain are at times detected in patients with bulimia nervosa.

Psychological/Emotional Causes of Bulimia Nervosa

Bulimia nervosa can occur as result of major emotional issues that are hard to express or manage. Bulimia provides the person an outlet for their mental issues and helps them to feel that life is manageable, although in the real world they are not in control.
Sadness with weight and body shape can lead to dieting, , if the person is still unhappy and does not believe the diet is working they may turn to bulimia.

Social/Behavioural Causes of Bulimia Nervosa

Western culture encourages thinness as the picture of success and happiness. This stress to be thin can promote people to begin dieting, as they think it will provide them the results they require to make them happy and successful. If dietary addictions get out of control in trying to achieve the perfect body, bulimia nervosa can begin.

Abnormal relationships in the family or a marriage can be a cause of bulimia nervosa, as the disorder can stem from challenging life events.

Psychological Symptoms of Bulimia Nervosa

- Frequent mood swings
- Low confidence
- Depression
- Anxiety
- Feelings of loss of control
- Overly conscious about appearance
- Obsession with food, dieting, and exercise
- Withdrawal symptoms

Behavioural Symptoms of Bulimia Nervosa

- Leaving the table right after a meal to vomit
- Running water in the bathroom to cover the sound of vomiting
- Binge eating, frequently and at odd times, such as, in the middle of the night
- Excessive exercise
- Frequently desire to be alone and requesting privacy
- Obsessing about body weight
- Avoiding social events

Main Treatments for Bulimia Nervosa:

Cognitive Behaviour Therapy: Cognitive Behavioural Therapy is a type of psychotherapy, in which a bulimia patient has frequent discussions with a therapist about their behaviour issues. The discussions will address the negative thoughts the person has about their weight and body shape, with other explanations for eating excessive amounts and vomiting. They will then learn to see, understand and take control of the environments that cause these attitudes, and take on more positive methods of thinking. Cognitive Behavioural Therapy will help a person get back to a normal lifestyle by breaking the cycle of excessive eating and vomiting and promoting healthier eating regimens.

Interpersonal Therapy: Rather than focusing on the bulimic behaviours themselves, interpersonal therapy deals with a person's relationships with other people in order to spot and change interpersonal issues that have led to and continue the bulimia. The objective is to help create relationships that are supportive rather than turning to excessive consumption and vomiting for emotional comfort.

Self-help Programme: A self-help program uses the same methods therapists use in cognitive behavioural therapy, but is conducted by the person in their free time. Additional care and help should be given as they work through the plan. As with cognitive behavioural therapy, the objective of the plan is to change negative ideas into better ideas with the hope of changing difficult behaviours.

Family Therapy: The bulimic person attends therapy session with their family. The family can help the person gain confidence in oneself and aid in recovery from the eating disorder.

Group Therapy: Group therapy classes are typically run by a therapist and are attended by other people with bulimia. Some individuals find comfort and support from going to therapy classes with other bulimics and are driven to conquer their eating disorder. It is vital that group therapy sessions help recovery rather than add to the bulimic behaviours.

Further Reading:

- ✓ ***Alcohol Problems in Adolescents and Young Adults: Epidemiology. Neurobiology, (1983), edited by Marc Galanter***
- ✓ ***Adolescence: Biological and Psychosocial Perspectives, (1998), By Benjamin B. Wolman***