

SPECIAL PROBLEMS OF THE TEENAGE ALCOHOLIC

By Richard R. Schnurr, M.A.
Director of Talbot Hall
Saint Anthony Hospital, Columbus, Ohio

The Blue Book, Vol. XXXV, 1983
Indianapolis, Indiana

I have been asked to speak to you this evening about the special problems of the teenage alcoholic patient. I have some familiarity in this area because I am the Director of Talbot Hall, the Alcoholism Department of Saint Anthony Hospital in Columbus, Ohio. I believe we have contributed significantly in this almost new area in alcoholism treatment, and we are indeed proud of our results.

Talbot Hall began in 1974 by treating adult alcoholics in a unit especially designed for that purpose. In 1976, we began admitting some adolescent patients along with, and in among, the adult patients to the unit. Although the adolescents liked being in treatment, adult patients did not tolerate the behavior of the adolescents very well. In 1977, we researched the advisability and need of opening a separate unit for the teenage alcoholic/drug addict. In 1978, the unit opened for 30 patients and has been in continuous operation since that date. During the 4-5 weeks treatment period, the patients are insulated from school, TV, and radio, have their clothes and behavior monitored, get up early in the morning, go to bed at a reasonable time and sleep until morning. Most importantly, we have verified that there is such a thing as teenage alcoholism and that if treatment for alcoholism takes priority, at least temporarily over the other problems every teen experiences during this tumultuous period, there is a high degree of success.

My own research into specialized treatment for teenage alcoholism began in 1977 with a teenager who was then in the seventh grade. One day I asked him: "We are thinking of opening a teenage unit for the treatment of alcoholism. What do you think of that idea?"

His response was typical. "Not much. Alcoholics are old people."

I related to him the number of telephone calls we were receiving about the teenage alcohol and drug problem, and the parents' problem with finding a facility to place the patient for treatment. He was very familiar with the symptomology of alcoholism; he had grown up in an alcoholic home — he had done his homework on the disease itself. At that time nothing more was said.

A few weeks later he said to me, "There are six in my homeroom."

"There are six what?"

"Oh, you know, those people."

"No, I don't know."

"Well, druggies."

"Do you mean alcoholics?"

"I don't know, I think so."

"How do you know; what's your data?"

"Well at 8:30 in the morning in homeroom, they smell of alcohol."

Reasonably qualified diagnostician.

I asked him how I would find out about alcohol abuse in school. He became very agitated. The reason is the same now as it was then. No kid will be a "narc." When we ask teenagers to "rat" on or "narc" on or "tell" on other adolescents, we are violating their code of honor. No matter if it is life-threatening, it is still their code of honor.

Now some five and one-half years later, how does the state of the art of treating teenage alcoholism look? We know from our own experience now that there is such a thing as a teenage alcoholic. All the symptoms are there. The disease does progress more rapidly, perhaps because the subject is a teenager, or perhaps because the teenager absorbs narcotics and uppers and downers in such a variety of experiences and dosages, or perhaps for reasons unknown to us. The bottom line is that from the beginning of ingestion of alcohol and drugs, at perhaps nine or ten, within a few short years the teenager does have all the classic symptoms of the adult alcoholic.

We found that Alcoholics Anonymous does in fact work for the teen, but there are rituals in AA which

must be taught to the teenager if the teenager is to survive in that culture. The teenager responds to older members of AA faster than he does to the younger members of AA. Al-Anon does work for the family of the alcoholic teenager as long as it is a special group designed for the parent. The reason for this may be that classic Al-Anon did not know what to do with the parent of the young alcoholic. Alateen does work for the siblings in the alcoholic's family. The Toughlove program works splendidly for the parents of the teenage alcoholic, but most parents who join Toughlove groups do not know that their child has a drug and alcohol dependency. They view their child as a behavioral problem rather than a diseased person.

Patient Profile

Let me share with you a "casual" patient profile and then a more clinical picture of what it is we are seeing in the teenage alcoholic patient.

Let me give you an example of a 15-year-old male who came into the teenage unit as a patient. He was semi-high, or as we would say in the adult world, "feeling no pain." He was wearing a pork-pie hat when he came to the desk at the nurses' station. He was helped physically by those who were admitting him to the hospital. He warned all of us that he has a black belt in karate and that his hands are registered weapons. He is kind enough to warn us so that we will not get in the way of his willpower. I said to a nurse, "When the pork-pie hat disappears, we'll know he is beginning some recovery." Three days later he is now detoxed and a wimp. The hat and the black belt have been forgotten. His willpower has now been reduced to sneak power. We have noticed that the percentage of females coming into the teenage unit is much higher than the percentage of females entering the adult unit. The percentage of male□female patients on the teenage unit is approximately 50-50%; in the adult unit the percentage is seldom over 20%.

If we could test the teenage alcoholic patient we would find an extremely high tolerance for drugs and alcohol. Essentially, that is the definition of any alcoholic patient. As an example of this, a 14-year-old patient who has never had any kind of mood-changing chemicals and who has not been addicted to any drug or alcohol, came into the hospital for a tonsillectomy. Because both of his parents were recovered alcoholics, they were interested in his tolerance for drugs. We gathered together a team, including the anesthesiologist and the surgeon and the nurses and those who would prepare the patient for surgery in order that we might lower the anxiety of the patient, the 14-year-old, about his surgery so as to prevent a false interpretation of tolerance. Pre-operation drugs were administered to the patient. According to his body weight and height, etc., the patient should have been at least drowsy. He was not. He was very hyper, clicking his fingers, asking when he was going to fall asleep, when he was going to go to surgery. The anesthesiologist reported that the patient required more anesthesia than was normal for his weight and height. In the recovery room the patient was combative as he was coming out of the anesthesia. None of these behaviors were remembered by the patient subsequent to the instances described. Later on, the parents sat with the child and explained to him what drug tolerance means and its relevance to his life. He understands that because of his tolerance, complete abstinence is required of him. Now, some three years later, the family reports that the child is still chemically clean and uses his data as a defense, a healthy defense, so that he will not "have to" use drugs when his peers do.

It has been my observation that the adult patient considers himself drunk only when he is passed out. Anything less than being passed out is called "making the scene." The patient will say, "I got to work, didn't I. I got home, didn't I. I drove the car, didn't I." He will proclaim quite loudly, and I believe quite correctly, that he was not drunk. To others he is drunk, but according to his individual tolerance for chemicals, he is not chemically drunk. This is why the alcoholic who does not know anything about the disease of alcoholism has a difficult time understanding the blackout syndrome. One of the most foolish questions that we ask the alcoholic is: "How many blackouts have you had?" It is impossible for the alcoholic to answer correctly. The same phenomenon is true in the teenage alcoholic. "High" for the teen is not the same as "drunk" for the adult. "Wiped out" to the teen or "wasted" to the teen is synonymous with "drunk." "High" is simply a stage on the way to passing out or being wasted. "High" to the teen then is being sober and if adults tell the teenage alcoholic that when he is high he is drunk, he does not believe it. I believe he is chemically correct. "High" then is not intoxication. "Wiped out" or "wasted" is the same as intoxication. Anything less than that is "making the scene." The child got to school, got to work, drove the car, rode the bicycle, got home, did his homework, and played football.

The teenage alcoholic views the family as very rejecting, controlling, and demanding. The teenage alcoholic has an enormous capacity for alcohol and other drugs in wild combinations. Once, in more than 2,000 patients, we have had a pure alcoholic in the sense that the patient used only alcohol. The teenage alcoholic is a friend to blackouts and a friend to blackout behavior. He is very sophisticated about “good stuff” and “bad stuff,” much the same as the adult is about “top shelf” and “bottom shelf.” They do not like “Thunderbird.” He has an average or above average IQ. He has a relevant mental age testing, a normal abstract function, a highly believable set of denial tools, uses threats very effectively, whether that threat be of a hurt little child, abused child, or physical power threats. Those threats work. He does feel guilty and is quite knowledgeable about the natural law and the consequences of breaking that law. He has a very rigid adolescent personality, loves devil worship because it offers an absolute with appropriate rituals and because the devil is the representation of evil. He is very given to bulimic and anorexic behavior.

Clinically, the profile of a teenage alcoholic looks like this: overactive, over-achiever, rather vague about goals, resentful, feels alienated from the world, suspicious, very sensitive to the thoughts and words of others, over-sensitive to criticism, believes firmly in magic, grandiose, insecure, manipulative of others with a significant background of family problems, sulky, pouty, compliant, alternately responding to tender loving care, or rejecting of it.

Parent Profile

One day I was standing in the waiting room of our hospital, and I saw a mother and father who were waiting for their teen to come out of our Evaluation Office. The parents’ eyes were dazed; they looked disheveled and bedraggled. Both were in the middle of what should have been for them a working day; they were and looked tired — sick and tired. Out of the Counselor’s Office came a young man, fingers clicking, eyes raised to the ceiling, in tune with the world, walking three feet off the carpeting on the floor. He did not know me, but he included me in telling his parents, “They want me to stay here for 35 days. I’m okay with that as long as they meet my conditions. I think it would be a good thing.”

The point is, the child was happy, no matter where he was, no matter what happened to him. The parents, to all intents and purposes, were the sick ones. The child did not look “high” or “drunk.” He just looked like a happy, eager teenage young man. The parent of the teenage alcoholic is often himself or herself alcoholic; sometimes recovered, sometimes not. That fact can itself sometimes, and frequently does, get in the way of the child’s right to treatment because the parent is told that “if you sober up and ‘fly right’ the problems in your family will go away, including your teenager’s supposed alcoholism.” But the parents are now at wit’s end and look it. The patient looks “terrific.”

Ever noticed someone who is insulated against advice? When you speak with them they kind of nod back at you as though they were absorbing every last syllable, but nothing is really going into their computer. That is a good picture of the parents of a teenage alcoholic.

They feel rejected, and they often are rejected by their friends, by the school, by society, by their church, by their own families. They are stunned by what has happened to them. They are also angry at what has happened to them, that the world should gift them with this teenage alcoholic. They wonder what they have done to deserve this. They have an almost overpowering sense of guilt and do everything possible to have the child not be alcoholic. They will buy, cajole, plead. They were, for awhile, unwelcome in Al-Anon because Al-Anon knew not what to do with them.

They have misused the love of their children to a tragic degree, or out of desperation they have abused their child. They desperately have a need to be told that they are sane, their child has a disease, is ill, and they also need to be told that every teenager in the world is not “high” and on drugs.

In a word, teenage alcoholism has destroyed them and they look at us with longing eyes that say, “Please take this thing out of our hands so we can have a night’s good sleep .” One parent once really bawled me out in anger because we did not advertise in the newspapers and on TV. He said, “We have looked for you, for an answer for two years and no one knows that you exist. Why do you not make your existence known to the people in this state?”

Ten Problems of the Teenage Alcoholic

One: Right of the Teen to be Alcoholic

We do not want our adolescent population to have diabetes, cancer, retardation, or alcoholism. We would rather have them healthy, going through a phase perhaps, suffering from adolescent adjustment reaction, the victim of unloving parents, suffering from wimp syndrome with the need to grow a bit of backbone, the victim of incest, or of battering parents, but not victims of fatal diseases. When a teenager dies as a result of overdose or an automobile accident, a scapegoat is found. For example, he is the victim of a soft "society." Teens are expected to grow magically out of a drug problem.

The best film I know of regarding teenage alcoholism is "The Other Side of the Mountain," which has nothing to do with drinking or with alcoholism. It has a lot to do with denial of the problem facing a young person and of the parents' need to deny that problem. If we admit the existence of a problem, we need to look for a solution. If alcoholism exists among the teenage population, then the teenager needs treatment. If I deny existence of the problem, then treatment is not needed because there is no problem. There is a problem.

Two: Few Schools have an "Employee" Assistance Program

The "employer" of the teenager is the school. Very few school systems have programs designed to intervene into the life of a child in order to help. The schools have backed away from such policies because they are afraid of being sued; they are afraid of parents; they are not backed up by school administrators. The end result is that if the employer does not enforce his clout in order to get the patient to treatment, we are dependent upon the patient's internal desire for motivation for treatment. We know how flimsy that motivation is.

Three: Parents do not have an EAP Program or Policy

Parents are frightened by children, particularly teenage children. Parents are impressed by articles about harming children emotionally; they are terrorized and frightened that if they do this or that the child will be harmed as a result, and so they are paralyzed into not acting, and slowly the child begins to run the home and the parent of the house is a teenage alcoholic. The best EAP programs for parents are Toughlove and Al-Anon.

Four: Teens have few Legal Rights

The teenage alcoholic is "condemned" to return to the source that referred the child to treatment. As a teenager, he has very few rights. Whereas an adult can choose within certain limits where he will spend the future, the teenager is "owned" by an adult or in the charge of an adult, or parent, or an agency, and does not have those choices. The teen then is not a free agent. When the child is returned to an agency, an adult, a parent, or a family where alcoholism is viewed as something other than a disease, the likelihood of a successful sober product is extremely slim. When the child is returned to a school that has referred him to treatment and the school views the drinking or drug addiction as a moral problem, the child will be treated as a leper, ostracized, and punished as a result of his addiction. If a child is returned to school after having suffered a broken limb, the child is given special consideration in the school. When a drug addict is returned after treatment, additional punishment is handed to him by the school in order to help him "see the light."

Five: Lack of Normal Growth and Development

Because so many of our patients have begun to use alcohol when they are 10, 11, or 12 years old, they have missed a great deal of the fantasy and play-life associated with the normal child. As they become more addicted to chemicals, fun and play are equated to chemical usage. On our unit, although we can and do show films relevant to alcoholism and drug addiction to the teenage patient, the most genuinely liked films are those produced by Walt Disney. Our patients have seldom seen cartoons or silly fantasy comedies. Bugs Bunny is quite a favorite.

Six: Relationships with Adults

Some adults, sometimes staff, attempt to engage the teenage alcoholic in a popularity contest in order to win the confidence of the patient. Intentions are good and the results disastrous. No 40-year-old chooses a 15-year-old as an intimate friend and no 15-year-old chooses a 40-year-old as an intimate friend. Staff people or volunteers who operate out of this stance harm the teenage alcoholic. Because of his addiction, the teenage alcoholic has missed appropriate parenting and needs necessary lessons in appropriate parenting now

that he is in treatment. Appropriate parenting is not based on the buddy system.

Seven: Self-Help Group Friction

When we first opened the teenage unit, we sent groups of teenage patients to AA groups. We still do. Because the patients did not know the AA ground rules or rituals, AA members called us asking that we do not send the children to their AA group. Now a few years later, most AA groups will accept the teenage alcoholic because the patients now understand the adult rituals. Individual AA members welcome the teenage alcoholic by telling them of their genuine happiness in seeing someone arrest their addiction at such a young age. Interestingly, most teenage alcoholics hear those remarks as discounts. Their fantasy is that they are already adults and want to be treated like adults. In 1979, in our city, there were two Narcotic Anonymous meetings. Now there are 27 in 1983. The growth of this movement has been phenomenal. Most of the graduates of our unit feel more comfortable and feel more accepted by members of NA than they do by members of AA.

Eight: Self-Monitoring

The teenage alcoholic has difficulty accepting that in order to survive in sobriety he will be required to monitor his behavior, thinking, and feeling life. This mechanism of self-monitoring is necessary for all ages but for the teenage patient, the mechanism has to be reinforced daily. Successful graduates of the teenage unit report to us that they attend a phenomenally large number of NA and AA meetings in order to stay sober. Those who are casual about their attendance at AA and NA meetings reduce themselves to casual sobriety and slips. We believe, as a result of these behaviors on their part, that self-monitoring is more difficult for the adolescent than it is for the adult.

Nine: Re-Entry Difficulties

Emotionally, the teenager needs a sufficient amount of ego strength to survive adolescence and move into adulthood. Because of all his conflicting emotional forces, added pressures to a tender ego strength are not welcome. The teenage alcoholic leaves treatment and returns to a school where he is neither needed nor wanted, is looked upon as an evil influence, not accepted by the "straights" or the "hoods," by the faculty or administration of the school, is an embarrassment to them. He needs a generous overdose of ego strength to survive. In the city of Minneapolis there are support groups in all the schools so that teenage alcoholics leaving treatment can report to a group and receive academic credit. In our City of Columbus, Ohio, as we began our treatment of adolescents, there were no support groups of any kind in the schools. That means in the beginning we had to depend exclusively upon the charity of people in Alcoholics Anonymous.

Support groups in schools are necessary before the teenage recovered person can survive. Understanding that the school is the "work place" for the teenager, that there are no halfway houses for adolescents that have abstinence as a part of their policy and alcoholism treatment as part of their therapy, helps us understand the difficulty facing the recovering teenage alcoholic. When the child returns to school he faces drug usage from the lavatory to the parking lot to the teachers' lounge and a school where drugs are a way of life. Fighting this permissive philosophy is beyond the teen's power. Although I understand that the drug problem in the world is essentially not the schools' problem, I believe that the child sitting in school in a drugged state is a school problem. For the school to abandon its responsibility and not ask for help from agencies delivering drug treatment is a mistake. Industry that has a strong policy and implements that policy in a strong fashion, including a strong followup program, has a very high rate of success with sober alcoholics. The opposite is true. Dioceses which have strong policies implemented in a strong way with a strong followup therapy have successfully combated their alcohol problem among their clergy. The patient lists at Guest House can support that theory. When school systems have strong policies implemented in a strong way with a strong followup therapy for sober graduates from their school, success follows.

In Columbus, Ohio, the school system in the past year finally has begun to awaken after five years of cajoling and needling. Although there are signs of life in the school system as a result of a change in administration, we do not yet know how strong that life will be for the future. The difference is important.

Ten: Fantasy Edition of Sobriety

Those who offer the recovering addict a set of false promises by saying that life without chemicals will be beautiful, are offering an unrealistic picture of recovery. A teenaged addict associates important areas of his

life with chemicals. Relief from physical and emotional pain has come from addictive chemicals; the teen's religious life, often devil worship, is associated with chemicals; his entertainment life is associated with chemicals; his social life, his sex life, his fun life is clearly associated with chemicals. The problem is that the teen cannot relearn or return to a value system or behavior system if he is now sixteen and his chemical usage began at ten or eleven. The answers to his normal physical, emotional, spiritual, sexual, and religious human desires must be learned from the ground up. To offer him a "rose garden" is a mistake. Recovery for the adolescent is not easy. It is twice as painful and difficult as it is for an adult.

Finally, it is an absolute miracle that the child can survive into adulthood in a world which views chemistry as part of life. That the addicted teenager survives and then maintains sobriety and gains a measure of maturity is a modern major miracle. I used to believe, and I still really do, that a greater and deeper measure of maturity is demanded from the recovering alcoholic than is required from the ordinary human being. An even greater supply of strength and help and maturity is demanded of the recovering teen alcoholic. I see them doing it; I see the successes. I know it can be done, and I am profoundly grateful that I am part of that success.

© Copyright 2003 National Catholic Council on Alcoholism and Related Drug Problems, Inc.