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The Phenomenon of Adolescent Addiction

In 1969 the office of the Chief Medical Examiner of New York City released statistics which provided blunt quantitative confirmation to a matter of growing concern to both the lay and professional communities. Two hundred twenty-four deaths from heroin were attributed to persons between the ages of 12 and 18, representing 25 percent of the total number of deaths in that city due to heroin. This startling statistic represented a fantastic increase from the preceding year and was greater than 5 percent for the first time in the fifty-year period that this information was compiled.

At the same time a marked increase in the number of adolescents seeking treatment at Odyssey House occurred and the need for separate facilities for the treatment of adolescent drug abuse was recognized. The reasons for distinguishing the adolescent problem as a separate entity and an evaluation of the first 800 in-patients are presented here.

The great majority of the first 800 consecutive admissions to the Adolescent Treatment Unit of the Odyssey House program were from the Greater New York Metropolitan area comprising several strata of economic neighborhoods, with ghetto and non-ghetto populations represented almost equally. Fifty percent of these patients were black, 30 percent white, and 20 percent Puerto Rican. Sources of referral were varied, but approximately 60 percent were through the juvenile, criminal, or family courts. All of these patients were considered voluntary admissions and they were not maintained in treatment involuntarily. All patients received a complete medical evaluation within the first 48 hours and a determination of mental status was performed separately, again, on each patient. In addition, information was obtained pertaining to type and amount of drugs used, duration of abuse, the order in which drugs were abused, and frequency and conditions under which this particular behavior occurred. Information about education, criminal activity, family (including substance abuse of parents, relatives, and siblings), and employment was also obtained.

From the moment of induction each adolescent was carefully observed for development of the abstinence syndrome. If the most recent drug abused was of the sedative type, namely, barbiturate or glutethimide, the adolescent was routinely given anticonvulsant medication. Otherwise no chemotherapy was attempted. In not one individual, 80 percent of whom had recently used heroin, was the overt development of withdrawal symptoms, so familiar to those experienced with adult heroin addicts, noted by either a physician

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or trained ex-addict professional who was responsible for "round-the-clock" supervision. On one occasion severe gastric distress associated with vomiting occurred in a 16-year-old male with a history of six months of intravenous heroin abuse who had not eaten recently. This period of "discomfort" lasted 24 hours, but the physician in attendance could not conclude that this represented withdrawal. Insomnia was a frequent problem with the great majority of patients during their initial days in the program but, again, this could not be directly related to abstinence. No seizures occurred in any of the patients.

A lack of basic physical or mental pathology characterized this group. To be sure, there were a great number of minor medical problems common to any adolescent population. Seven patients, all intravenous heroin users, were hospitalized for hepatitis, an incidence of slightly less than 1 percent. Sixteen patients were diagnosed as schizophrenics and seven required medication in the form of thorazine or thioridazine. This is far below the estimated 10 to 20 percent incidence rate of schizophrenia among adult drug addicts. No other types of major mental pathology were observed and patterns of bizarre behavior were likewise unusual. It was interesting that the results from psychological testing indicated a very normal population, at least on the intelligence scale. The average IQ among our patients was 105, which is consistent with the average for the adolescent population as a whole. This contrasts with the average IQ of 118 for the adults in our program who were tested in the same manner. It has been known for several years that adult drug addicts have a higher average level of intelligence than the general population. These data have led us to conclude that adolescent drug abusers, even those whose life style has in one way or another caused them to enter a long-term in-patient treatment program, have no significant physical or mental problems which distinguish them from their non-drug abusing peers.

As was previously pointed out, 80 percent of these patients have used heroin, of whom 60 percent have used it intravenously at least once. There was a wide variation in frequency and amount from only a single experience of "snorting" to "mainlining" daily for over two years. What was significant was the fact that few of the "daily mainliners" used more than 2 or 3 "bags" a day—a very small amount when compared to their adult counterparts who not uncommonly used 15 to 30 bags daily. Also significant was the fact that no individual used one drug to the exclusion of others. Rather, the general pattern seemed to reflect an indiscriminate use of *any* drug, with availability determining the choice. To be sure, those who used heroin frequently preferred that particular experience, but they still would readily use other drugs along with heroin. All patients used at least two drugs with equal frequency and most used more than two. No specific drug combinations were apparent, regardless of the way in which this population was evaluated.

The first drug used was, overwhelmingly, marihuana. However, if drug abuse commenced before the age of 12, the first experience was just as likely to be inhalation of organic solvents, especially "glue" and "carbona." Approximately 5 percent named heroin as the first drug that was tried and this was always snorted. The reasons given for initially using drugs were apt to be as varied as the individuals themselves. However, answers such as "it was the thing to do" and "I didn't want to be left out" accurately summarize this particular aspect. All patients were introduced to drugs by either a sibling (15 percent) or a close friend at the peer level (85 percent). The ratio of male to female was drastically reduced from the 6:1 to 10:1 ratio reported for adults to approximately 2:1 in this program. This ratio, incidentally, continues to decline. It was unusual for the first experience to be within the school setting but most patients later used drugs during school hours. As expected, there was a significant correlation between poor academic performance, truancy, dropping-out, and drug abuse. Likewise, 75 percent had criminal

records for a variety of offenses associated with drug use, although it was not unusual for a patient to have a criminal or arrest record prior to his first drug experience.

Tentative conclusions based upon data pertaining to these 800 admissions are as follows:

1. This is a vastly different problem from that of adult addiction and it cannot be properly approached and treated if there is only reliance upon information and clinical methods that have been developed over several decades for the motivation and rehabilitation of adults. The adolescent problem is actually a phenomenon of the last five years and, it is believed, this is the first report which attempts to deal specifically with this group.

2. It is difficult to consider adolescent drug abuse in terms of deviant behavior on the part of an individual. There seems to be nothing that sets him apart from his peers physically, mentally, or emotionally, nor does he appear to be different from his counterparts of previous generations in these respects. Rather, he appears to be a normal adolescent that is relating in a normal manner to a group that exhibits deviant behavior. This is exactly the opposite of the position of the adult addict who operates outside of the commonly accepted behavior patterns of his peer group. This, then, is properly a problem of group pathology and an adequate treatment modality must concentrate on the group in order to help the individual.

3. With this in mind, it must be understood that a "healthy" adolescent has no immunity from drugs and is, in fact, uniquely susceptible to drug experimentation, abuse, and addiction. As is normal at this stage of life the adolescent seeks the requisite security and acceptance of his peers. In the 1970's use of drugs is a rapidly expanding requirement for entrance into this group.

4. It is important not to try to classify patients according to the type of drug they use. There is very little difference, if any, between the barbiturate user, the amphetamine user, the opiate user, and the hallucinogen user. He will abuse whatever is available. Basic to the adolescent problem is a multidrug pattern.

5. The total lack of withdrawal symptomatology among adolescent heroin users suggests that our entire attitude towards detoxification must be re-evaluated. The detoxification approach is based on the assumption that avoidance of the abstinence syndrome is necessary and important for adequate treatment of heroin addiction. It appears that methadone has no place in the proper treatment of adolescents because (a) there is no abstinence syndrome, and (b) its proposed efficacy requires that a patient be using only one drug. Furthermore, it would seem extremely detrimental to provide a highly addictive potent narcotic to a patient who has no demonstrable need for it. This is of vital importance because the medical profession, the lay public, elected officials, and active community groups have all readily accepted methadone as an appropriate agent for this particular problem. In some quarters it is even accepted as a panacea.

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