Clinical challenges in juvenile de-addiction: a case study

Amrita Pain[1] & Mayuri Buragohain[2]

[1] Assistant Professor, Human Behaviour Department, IHBAS, Delhi
[2] Senior Medical Officer (Psychiatry) and In-charge (Department of Psychiatry), Ambedkar Nagar Hospital, Delhi
Address for correspondence: a.pain.psyd@gmail.com

Abstract

Objectives: The prevalence of juveniles, children and adolescents below 18 years of age, are on the rise. This case study aimed at understanding the risks of developing substance use disorder in a child and the role of parent counselling and training as an important mediating factor in treatment to build readiness for change and supporting abstinence. **Method:** The case study method allowed for in-depth observations of the child in the context of a family with chronic economic hardships, reasons for gradually choosing substances as a way of coping despite an awareness of its potential risks and parental roles in effecting adjustment in the child. The challenges of engaging a child in treatment, explaining the systemic anxieties to the parents and their importance in navigating therapy with the child have been highlighted. **Results and conclusion.** Identifying and addressing parenting dysfunction, initiating realistic changes within their given context, promoting protective factors in both the parent and the child along with re-introducing a stable secure base for the child via the Mother helped reach the short-term therapy goal of teaching the child to abstain from using substances and empower the Mother to assert herself in the corrosive backdrop of poverty.

Keywords: juvenile de-addiction, parent distress, parent training

Introduction

The earlier an individual is introduced to a substance, the greater the risk of developing harmful use or dependence over time. A nationwide survey by the Ministry of Social Justice and Empowerment reported an estimated 1 crore or more juveniles between the age group of 10-17 years using substances (PIB Delhi, 2022). The prevalence of juveniles, children and adolescents below 18 years of age, using substances is on the rise. A national study on the extent of substance use in India by Ambekar et al. (2019) highlighted that alcohol may have users as young as 10 years of age, children and adolescents use inhalants at greater frequencies than adults with an estimated 4.58 lakh children requiring help. 13% of India's population using substances is below 20 years of age with 9 out of 10 users being below 18 years of age on their first use (UNODC, 2022). The 5% of adolescents who are brought in for treatment are usually those who begin to show emotional or behavioural disturbances rather than for treatment for when substance use began (Kinjawadekar, 2023).

The factors influencing use can range from availability and accessibility of substances, regular exposure and proximity to models who use the substance as well as the appeal of such models, an intrapersonal sense of autonomy and self-esteem, levels of intellectual functioning, scholastic

functioning and positive reinforcements at school and home, awareness of skills to garner acceptance among peers and adults along with parenting styles and secure emotional attachments with caregivers and peers. Data on the prevalence and incidence of juveniles using substances reflect a significantly larger number of male juveniles using substances in comparison to females in India. The relatively low incidence in females may reflect the source and method of data collection. Young girls (aged 8-22 years) with poor self-esteem, a history of bullying and depression are more prone to using substances and becoming dependent quicker and facing the consequences sooner than their male counterparts (Columbia University, National Center on Addiction and Substance Abuse, 2003). Possible internalization of emotions leading to a delayed scope in recognition of problem behaviours along with a larger number of agencies catering to male juveniles with behaviour problems, male juveniles in contact with the law and admission facilities may reflect skewed data for genders in juvenile substance use cases in India (Gupta, Gupta, Darswal, 2018). The Juvenile Justice (Care and Protection of Children) Act, 2015 categorised children in contact with the law as either in conflict with the law or in need of care and protection. The latter section helped address the growing concerns of juveniles who would use substances and come into conflict with the law owing to offences, crimes or repeated offences/ crimes (Sharma, Sharma and Barkataki, 2016). The current case study aims to explore the clinical challenges in intervention for a child with a history of substance use.

Method

In a government secondary-level hospital with facilities for in-patient management of male juveniles with substance use, the age range of in-patient referrals was for ages 8 years to 18 years. Out-patient services were available for all genders and ages of patients with substance use. A majority of the male juveniles admitted had co-morbidities ranging from intellectual disability, scholastic backwardness, emotional/behavioural disturbances, conduct issues and emerging emotionally unstable erratic behaviours. This case study aims to highlight the challenges of integrating the child and family into treatment within the legal system.

Case history: Patient X., an 11-year-old, wandering under intoxication, was brought in by a nominated legal guardian from a legal referral system to the OPD of a government juvenile centre for treatment. His parents were yet to be traced at the time of referral. He had a 2-year history of multiple substance use that began with tobacco (smokeless form), smoking, taking inhalants regularly over time and occasionally experimenting with alcohol. The eldest of two siblings, his Mother was semi-literate and a homemaker and his Father, secondary educated, was an unskilled worker at a local factory within urban Delhi. The Father had a history of nicotine and alcohol use, for as long as the Child could recall.

The Child was admitted to school but difficulties with the medium of communication, the structured environment at school in contrast to the lack of regulation at home and possible academic difficulties put him at risk for peer influence to fulfil his needs for affiliation. By class 3 he was using tobacco with his friends. Punishments for use by school authorities made him want to avoid school leading to frequent incidents of truancy till he finally dropped out of school aged 11 years, in class 5.

He spent his time roaming the city with his friends, visiting known haunts of substance use during school hours and then began staying away from home to avoid the consequences of his truancy from his parents for increasingly longer intervals of time. He was last home 6 months ago. His time with his peers involved irregular sleep-wake cycles. Activities after waking had a structure: smoke, freshen up for the day, eat food if it was available or inhale a portion of a substance, whichever was easily available first. After an hour of intoxication, he and his group of 4 would look out for work: rag picking, petty law-breaking and running errands within the neighbourhood in exchange for money. Group membership and networking within peer groups within and across localities were essential for survival. Afternoons signalled the second round of inhalants, alone or with his peers. Evenings were marked by the hunt for shelter and food for the night and the third dose of inhalants. Peer membership ensured the sharing of resources.

The Child, during an episode of intoxication in the morning, was noticed by vigilant authorities who initiated management in terms of recording a missing child, tracing parents and parallelly processing rehabilitation for de-addiction for juveniles.

Issues in management: The Child was initially kept in an observation home for 2 days before being admitted to the health care facility for detoxification and further intervention as needed. During the initial days of the hospital stay, the case history was explored; his cognitive functioning was assessed and he was screened for signs of abuse and physical and psychiatric comorbidities. Corroboration of information was limited to medical records of tests conducted till his Parents engaged in the treatment within a week of his admission. In the days that his parents were being traced by the needful authorities, the Child needed consistent reassurances about his safety. He remained wary of the treating team, his fears around treatment being likened to 'being jailed' for taking substances and receiving punishment. He made frequent requests to be reunited with either his family or friends, whichever was permissible. He worried about life after discharge, especially returning to his peer group and their acceptance of him after his days coming into contact with the law and rehabilitation. He remained resistant, fluctuating in his openness towards the treating team depending on news from his family, and friends or the possibility of a quick discharge from the hospital for the first few days after admission. Management began once visits from his parents were regularized as the Child felt safer under their guidance.

Discussion

Psychotherapeutic Challenges:

- *The psychosocial context of the Child:* Some of the observed psychosocial characteristics that were recurrent were emotional deprivation, the threat to physical safety and an inadequate sense of age-appropriate autonomy for the Child. There were unfulfilled physiological needs, participation in problematic peer groups, and the influence of role models and places and situations that permitted and tolerated substance use in this age group. The juvenile in the context of myriad environmental threats often used substances as a coping or escape strategy despite awareness of the short-term and long-term health and social disadvantages (e.g.: rejection by family members who do not use substances) of substance use. The Child's helplessness at school was never addressed nor was there

protection from the violence he witnessed in his father abusing his Mother or them under intoxication. No effective skills for emotional regulation were displayed in the parental models around him. With age, his awareness of the world and language skills developed parallel to the physiological changes of growth, however, there was a dissonance between this natural acquisition of autonomy owing to ageing and lack of effective expression and assertion of his opinions and feelings that would work towards his identity formation.

Over time, helplessness to threat versus lack of control to protect himself /asking for reliable help may limit attempts to cope and promote impulsive behaviours for instant relief from apprehension and anticipation such as running away from school because of poor scholastic performance and criticism from teachers. There was an awareness, despite the Father's history of substance use, that substance use is not permitted in society. With his use, however, the conflicts centred around permission increased.

Lack of a secure base and problematic peer influence provided repeated reinforcements of problem-solving that were focused on distracting/avoiding or escaping unpleasant feelings instead of generating solutions to the problem. Staying away from home without a guardian and the constant fight for survival left him vulnerable to the group leader and learning new expressions of power, such as lack of consequences for undesirable behaviours like stealing and asserting himself. The new-found sense of autonomy was dependent on several static and dynamic factors that, without identification and intervention, developed into interpersonal dysfunction such as violence.

- *The family system:* The hierarchy was strongly defined. Sessions with the Parents revealed a submissive role model in the Mother as a provider. The Father fitted into the conventional responsibilities of a family by working and earning and showed freedom in his choices in the degree of fluctuating familial involvement, substance use and disregard for consequences of his behaviour under intoxication. Although mostly physically absent and emotionally distant, his parental relationship was used by the Mother to instil a sense of fear in the children of being punished by the Father. The Mother would maintain homeostasis by taking the brunt of her spouse's dependence-related dysfunction. The triangulation focused on the index Patient as the eldest son who was doing poorly at school and receiving complaints from teachers. Loyalty conflicts and systemic anxiety reflected the security reasons within the family which were unpredictable and changing.

- *The Child:* The current assessment of the Child suggested an average level of intellectual functioning with a possibility for academic difficulties, especially when the medium of instruction was English. There was an awareness of tensions at home but he could not clearly define if it was stemming from unpredictable communication and affectional exchanges within the family. There was empathy towards the Mother, confusion about his Father and ambivalence about his Father's substance use that contrasted with the guilt, shame and defiance in his use of substances.

He attended a school where he was not performing well or getting nurturance from his teachers. He took to truancy as a mark of freedom from the constricted environment of home and school. His friends provided him an opportunity to escape the distress following interpersonal and

affectional deprivation and academic failures with the added benefit of substances as a coping mechanism.

He learned to express himself through inadequate escape and coping strategies. He acquired the idea that access to resources or money may affirm his identity within the group or family as someone worthy or at par with a male role model.

- *Intervention with the Child was not in isolation:* The initial week following admission was spent on making the child feel safe, he continued to treat us with cautious trust. The reason for admission was explained along with the daily schedule and activities he could expect. There were attendants who would be with him around the clock to ensure safety. Motivational interviewing at this stage was used to help build a working alliance, lower resistance, and set the tone for directional counselling.

The Parents were available to meet the Child and the treating team within the first week of admission. After corroborating the case history, the goals for intervention included parent training and counselling. Parental contribution in nurturing his current cognitive, affective, behavioural and social stage of development, differentiating between signs of defiance and helplessness, and his need for self-expression and control could be achieved through regulating his daily schedule.

The Parents were counselled in engaging in parenthood given their existing socio-demographic risks. Both the exhausted parents needed to assist each other in taking responsibility, improve accessibility through emotional warmth and support towards their children and reintroduce healthy dependency that is consistently responded to by inviting interaction.

The Father was psycho-educated on the need for self-care in the form of rest following physical labour and making changes in his diet including considering modifying his pattern of substance use. The need for improving communication within the family for clarity in boundaries, expressing appreciation and refusals was highlighted. The Father did not follow up after 2 sessions. He requested a reference for a de-addiction centre or treatment facility closer to his residence through his spouse.

The bi-weekly sessions were held with the Mother in the ward. She was encouraged to shadow the Child during her visits to learn steps as well as make suggestions for building his attentional, planning and organizing skills that could be continued after discharge, at home.

Regular interactions that ended with learning a new skill or reinforcing a skill without the threat of devaluation helped the child bond with the Mother as well as improve his self-worth. The Mother was helped to understand that the Child’s anger expressed through truancy was a response to the risk of loss and vulnerability he felt at home and school.

Differentiating the helplessness she felt as a partner was different from the emotions arising from a Child who seemingly challenged her scope of parenting. She was encouraged to identify neutral agencies or social networks beyond the immediate family, such as acquaintances to accompany her for religious activities, speak with her parents and siblings on a regular basis, and establish a routine for herself that would consider the day-time hours when her children would be away at

school and getting her chores done and resting, and having an evening routine that had clear study hours for both the children, teaching the children small responsibilities at home and remaining vigilant about their company.

Her level of literacy was reassessed; she was encouraged to be more involved with her children's schoolwork by asking questions, following up on schoolwork each day and finding tutors for their academic concerns. There was an openness to the possibility of the Child leaving school after attaining sufficient literacy levels and opting for vocational training in the future.

Spousal conflicts were discussed in the light of a partner who had a treatable chronic condition. Despite her helplessness with him, channelling her tensions and expectations on her self-esteem and rebuilding her identity through her perspectives on life as an individual and a parent could be a possibility over time without resorting to triangulation within the family system. The goal was to decide if her reaction or involvement would lead to a change or an escalation; to remain passive, withdraw or ask for help if the latter.

Towards the end of a 28-day admission, the Mother was guiding the Child's decision, echoing his need for protection and openly addressing the factors at home that would not change, the alternatives at hand and how to tolerate safely those situations they could not escape. They were encouraged to immediately seek help, should the Child take substances; to report a relapse even if the child was unwilling to come or was truant and to find ways of re-engaging in treatment and rehabilitation again. The Mother appeared motivated to continue positively reinforcing her relationship with both her children to ensure the prevention of the index patient falling back on the earlier patterns of use and monitoring her younger son from attempting any use. The Child, having learned to trust the treating team through their interaction with his Mother, spoke spontaneously of his days away from home and fears about going back to school. Realistic goals regarding education and his Mother's support for his well-being made him motivated to look at his Mother as a role model.

Follow-up: There was a request for a follow-up every 2 weeks post-discharge. The Child and Mother returned in a month. The family system had not changed much but the Mother, while not reactive or challenging towards her Spouse, had clarity about her role in the children's lives. She was aware that re-establishing the parent-child bond would take time and effort on her part. She had taken help from her parents to engage the children in positive socialization, remained vigilant about their whereabouts, had realistic expectations about their academic abilities and was able to maintain the activity schedule that was started during hospitalization with changes for school hours or any other factors. She was encouraged to follow up every two weeks.

There were no follow-ups thereafter in the months following discharge. The absence of follow-ups over the year may imply complete hopelessness for recovery and giving up on treatment after a short period of abstinence. Perhaps the Child was sent to a different Centre. Or perhaps, the Mother, with the slightest guidance, had responded to her role in mitigating the role of hardships within the family to protect her children from using substances, at least for the moment.

Implication

The presence of marital discord, parental illness, multiple adversities and poverty on its own may not affect dysfunction in children but if two or more of these variables co-exist, it may affect developing children negatively (Rutter,1979). These form the backdrop of the current family system. Poverty has a corrosive effect on well-being, as individuals or within a family system (Luthar, 1999).

In the current family system, the Parents have reached their stage-appropriate task of being a young evolving family. Financial constraints, lack of education and related vulnerabilities and the uncertainty of basic physical and safety needs being met may be seen reflected in the personal and socio-occupational functioning of the parents. The Father's role remained unclear; a history of substance use does not rule out his ability or the quality of his parenting roles and skills.

Poor adjustment and coping levels in the caregivers were reflected in the Child's socio-emotional development. Interventions involving the parents need to rule out underlying psychopathology in them (in this case, substance use and adjustment), personal attributes (learning to blame self or others) and exposure to life stressors as they are important indicators for planning intervention and rehabilitation and initiating change.

Constant exposure to chronic stress such as daily hassles of life and the threat to safety that increases the pressure of survival can lead to parents becoming less attentive towards their children suggested in an oscillation between disengagement and intrusiveness in their relationships, less reciprocity and synchronicity with their demands. Low support for children and an aversion to parenting roles and responsibilities may be a sign of emotional distress in parents rather than uncaring ambivalence.

The need for parental, especially the Mother's empowerment was to help her recognize factors that interfered with her role as a parent and identify boundaries in the multiple roles she had to fulfil. Removing ambiguity in instruction and teaching ways to monitor her children within the resources available to her helped incorporate a closely related skill: disciplining her children by setting limits and responding to rule adherence along a continuum of support, warmth and warning instead of rejection. The latter ultimately had the purpose of protecting both her children against maltreatment, at home and in social situations outside. The intervention aimed to counsel and train the parent to help mediate the effects of economic hardships while on the path to the Child's rehabilitation.

Conclusion

The current case study may be seen as an instrumental case study of the typical cases in a juvenile de-addiction centre. The Juvenile Justice (Care and Protection of Children) Act 2015 provides provisions for protecting, providing treatment and mandating rehabilitation of juveniles with substance use disorders and related dysfunction. There are regular capacity-building programmes for professionals involved in the treatment of substance use disorders. The overwhelming numbers suffering from substance use disorders across all genders and ages with complex co-morbidities following onset, duration and severity of use contrasts sharply in the resources available for

treatment. Legal systems and NGOs working with juveniles who come into contact with the law because of substance use-related concerns may remain a strong source of referral for such cases to continue providing opportunities for treatment and rehabilitation. Working with the juvenile population by training the parents to improve their sense of efficacy and engagement with their child may have better outcomes in developing the protective factors of regulation in the child rather than working individually with the child in an environment where substances are easily available and expecting readiness to change and lowered chances of relapse.

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