

"The Age of Feeling in-Between": Addressing Challenges in the Treatment of Emerging Adults With Substance Use Disorders [☆]

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Substance use and substance-related disorders are among the most prodigious public health problems in the United States. Emerging adults (ages 18–25) appear to carry a disproportionately large share of this societal burden, as they are more than twice as likely as adolescents and older adults to be diagnosed with substance use disorders (SUDs), and comprise more than 20% of SUD treatment seekers. Described as the "age of feeling in-between," emerging adulthood is associated with a biopsychosocial profile distinct from both adolescence and older adulthood, making members of this age group unique and challenging clinical cases. Data suggest that although emerging adults can benefit from cognitive-behavioral (CB) and other psychosocial treatments for SUD, they are likely to have poorer treatment response than their younger and older counterparts. Therefore, we propose several theoretically and empirically-grounded treatment modifications for this vulnerable group, such as parent counseling (or "coaching") to facilitate better treatment engagement and benefit via contingency management. A case example is used to illustrate challenges typical in SUD treatment for emerging adults and how a CB practitioner might choose to modify his/her approach based on the proposed modifications. We also offer several recommendations for practitioners who wish to address their patients' SUD or harmful substance use when it is not the primary focus of treatment.

EMERGING adulthood (approximately ages 18 to 25) is a unique stage in the human life course (Arnett, 2000), characterized by myriad opportunities for greater autonomy and independent living that comes with reaching the age of majority. Failure to meet and adjust successfully to this newfound freedom can result in life-impacting problems. Chief among these problems are those associated with alcohol and other drug use, the top public health concern in the United States according to multiple research reports (Robert Wood Johnson Foundation, 2001; The National Center on Addiction and Substance Use at Columbia University, 2011). Among 15- to 24-year-olds, alcohol and other drug use account for nearly all of the disability-adjusted life years (DALYs) lost for males, and a large proportion of DALYs lost for females (Gore et al., 2011). Emerging adults, in particular, constitute a disproportionately large share of the overall health and economic burdens conferred by harmful substance use and substance use disorders (SUDs; Bouchery, Harwood, Sacks, Simon, & Brewer, 2011; Rehm et al., 2014; Substance Abuse and Mental

Health Services Administration [SAMHSA], 2013b; SAMHSA, 2014b; United States Department of Intelligence, 2011). SUDs are comprised of alcohol and other drug use disorders (excluding nicotine and caffeine), defined as continued use of alcohol, illicit drugs (e.g., cocaine), and/or prescription drugs used for nonmedical purposes (e.g., pharmaceutical opioids) despite associated negative consequences and often functional impairment (American Psychiatric Association, 2013).

Relative to the other life stages, emerging adulthood has only recently been delineated as a distinct phase of psychosocial adjustment and neurobiological development, and as such comparatively less is known about SUDs during this critical life stage. From a clinical perspective, providers might benefit from greater sensitivity to the biopsychosocial idiosyncrasies of this life stage in order to effectively address SUD in their emerging adult patients and to help increase the likelihood of remission and recovery. In this paper, (a) we describe prevalence rates of SUD across the life course and discuss developmentally-specific risk factors related to SUD onset, (b) review a widely used cognitive-behavioral model of SUD treatment, (c) discuss clinical challenges in applying traditional adult and adolescent treatment models to emerging adult patients, (d) review what is known empirically about the specificity and effectiveness of emerging adult SUD treatment, (e) suggest modifications to standard models of care that might improve treatment

Keywords: emerging adulthood; substance use disorders; addiction treatment; mutual-help organizations

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engagement and outcomes, (f) present a case example to illustrate more concretely these broader points, and (g) offer an approach to address emerging adults' harmful substance use when it is not the chief treatment focus.

Prevalence of Substance Use Disorders Across the Life Course and Risk Among Emerging Adults

Approximately 8.2% of Americans, or 21.6 million individuals, meet criteria for SUD (SAMHSA, 2014a), while the transition to the 5th edition of the diagnostic and statistical manual of mental disorders (DSM) is likely to result in greater diagnostic precision and correspondingly higher rates of SUD diagnosis (Grant et al., 2015; Peer et al., 2013). There are marked prevalence differences by age group, however, as 17% of emerging adults have an SUD, compared to roughly 7% for adults 26 and older and 5% for adolescents (SAMHSA, 2014a). Emerging adults also have the highest rates of any illicit drug use (including nonmedical use of prescription medications; 22%), binge drinking (five or more drinks on one occasion during the past month; 38%), and heavy drinking (five or more drinks on five occasions during the past month; 11%) (SAMHSA, 2014a). Given their greater rates of risky and/or life-impacting substance use, it follows that emerging adults constitute more than 20% of SUD treatment seekers—almost twice what would be expected given the age composition of the general population (SAMHSA, 2014b).

Several interrelated and dynamic factors likely contribute to these epidemiological trends. As outlined by Arnett (2000, 2005, 2015), emerging adulthood is characterized by several transitions that could be both exciting and stressful, including separation and individuation from parents/caretakers that becomes manifest via independent living, admission to college or entrance into the workforce, increased time and emotional connection with peers, and engaging in one's first long-term, intimate romantic relationship. While social controls and their corresponding contingencies are commonplace for adolescents (e.g., rules and regulations for high school students), these decline sharply and suddenly after an individual reaches 18 years old. Relaxed parental monitoring and substantially increased exposure to alcohol and other drugs makes emerging adulthood a time of intensive experimentation. The predictable, potent, and immediate physiological and psychological effects from substances like alcohol, cannabis, cocaine, and opioids are alluring and compelling reinforcers perceived to enhance the good times and mitigate the bad.

Also notable is that dissymmetry between the more developed subcortical limbic brain regions implicated in affect, motivation, memory, and reward, and still-developing prefrontal cortex implicated in behavioral inhibition, planning, and higher-order cognitive tasks can persist through adolescence and well into the third decade of life

(Casey & Caudle, 2013; Casey & Jones, 2010; Wilens & Rosenbaum, 2013). In tandem with their higher levels of psychological distress relative to other age groups (SAMHSA, 2009), emerging adults' general lack of experience with alcohol and other drugs, as well as underdeveloped frontal, cortical areas increase the risk of harmful substance use. Also, while genetics play an important role in the development of SUD (Urbanoski & Kelly, 2012), its influence on SUD risk increases substantially, while the influence of family environment decreases, as individuals enter into this life stage (Bevilacqua & Goldman, 2009; Kendler, Schmitt, Aggen, & Prescott, 2008). Thus, as with other health outcomes, we know there are certain critical developmental periods wherein risk for disease onset is particularly high. Regarding SUD, specifically, emerging adulthood appears to be chief among those critical periods.

A Brief Review of Cognitive-Behavioral Approaches for Substance Use Disorders

Before outlining emerging adult SUD treatment, it may be helpful to review a cognitive-behavioral (CB) approach for SUD more generally (see Figures 1a and 1b). CB theory combines classical and operant behavioral conditioning models and Beck's cognitive model of substance use (Beck, Wright, Newman, & Liese, 1993). Regarding classical conditioning, for individuals with SUD, substance use (the unconditioned stimulus) is paired with several environmental characteristics (the conditioned stimuli), including not only people (e.g., person with whom the individual drinks or uses drugs), places (e.g., bars, liquor stores, drug dealer's neighborhood), and objects (e.g., alcohol advertisements and drug paraphernalia), but also smells (e.g., alcohol and butane-based lighter fluid), times of day (e.g., evenings), and situations (e.g., "pay-day"). Exposure to these cues can elicit powerful memories and increase expectations about the pleasant (or reduced unpleasant) feelings associated with the drink or drug, leading to thoughts of substance use, which, in turn, may result in strong urges and cravings. Regarding operant conditioning, individuals with SUD have been reinforced very rapidly and powerfully following substance use, both positively, through the experience of pleasant sensations and feelings, and negatively, through the amelioration of negative sensations and feelings, such as stress, depression, anxiety, and physiological withdrawal symptoms. For those with SUD, however, substance use also results in negative consequences, which may onset shortly after initiation of use but can also take several weeks, months, or years to develop (e.g., deleterious impact on health and relationships). Because individuals with SUD come to derive emotional reward and cope with positive and negative stressors primarily through substance use, they generally lack alternative, adaptive, healthy coping skills (Bandura, 1977; Kaplan, 1996; Lazarus, 1966; Moos, 2007).

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