Preventing Substance Abuse
An Interview Paradigm

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Use and abuse of mood-altering chemicals—whether tobacco, alcohol, or other drugs—is a national health problem. For many, it begins young in life. By the age of 15 years, one in eight adolescents smokes daily; more than one in three drink excessively; and more than one in five use marijuana.[1] *Healthy People 2000*[2] lists "tobacco" and "alcohol and other drugs" as separate priority areas; additionally, they are integral to two of the other 20 major priority areas. Few other health problems are so easily and necessarily linked to health promotion and disease prevention. Health promotion implies encouraging habits to foster improved health status, whereas disease prevention implies helping persons refrain from something that could adversely affect health.[3] Our goal is to review risks that adolescents face regarding substance use and abuse and to suggest approaches for the medical interview that may assist the family physician in preventing or identifying a problem and intervening.

Substance Use and Abuse: A Problem for Youth

With about 57 million Americans classified as smokers, tobacco's overall destructive toll on health is higher than that of all other addictive substances combined. More than one of five deaths are smoking-related; each day there are over 1000 tobacco-related deaths in the United States. Smoking costs our nation at least $68 billion yearly in medical expenses and lost work days.[4] The problem begins early, with youth in their teens, and persists into adulthood. Some 44% of students have already tried cigarettes by the eighth grade. Nearly one in five high school seniors and one in seven college students smoke daily, reflecting little or no change in percentages compared with 10 years ago.[5]

Alcohol is the most widely used and potentially addictive substance in the United States. For many, use of alcohol starts early in life, and for some, it may progress in frequency and intensity. In a large-scale 1991 study, drinking in the preceding year was reported by 54% of eighth graders, 72% of tenth graders, and 78% of twelfth graders. Some 70% of eighth graders had at least tried alcohol at some time, 27% had gotten drunk at least once, and 13% admitted to consuming five or more drinks in a row (binge drinking). Over one half of twelfth graders (54%) had used alcohol the prior month, and 30% admitted to binge drinking; for college students the statistics were 75% and 43%, respectively.[5] Whereas rates of binge drinking have declined by about 10% for high school seniors in the last decade, they have not declined for college students. Neither has any other commonly cited drinking rate declined for college students. Although the moderation message is beginning to affect some sectors of society, it is not affecting college-aged youth.

Regarding illicit drug use among youth (aged 12 to 17 years), prevalence rates for current drug use (used at least once in the past month) have declined since 1985, dropping from 14.9% to 6.8%. Prevalence rates for use within the past year are generally higher (14.8%).[6] Use of illicit drugs in young adults (aged 20 to 34 years) is considerably higher for high school dropouts (16.6%) than for graduates (9.9%). The same is true for the unemployed (21.5%) compared with those employed full time (9.7%).[5]

The Natural History of Addiction

Addiction to tobacco is serious and costly, both for individuals and the nation. However, Americans con-

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sider alcoholism and drug addiction more serious national problems.[7] The natural history of substance use and abuse is a progressive process that results in addiction.[8] Addiction experts generally agree that sex and age, being female and being younger, increase the risk for persons to move to final stages of addiction more quickly. For example, adult men may be social drinkers for 20 to 30 years before demonstrating addictive behaviors. Women, compared with men, tend to have a shorter history of progression. Interestingly, children and adolescents who begin using tobacco products, drinking, or using other drugs may be addicted within 1 to 4 years later.[9] This gives further meaning to previous statistics regarding consumption of alcohol and use of drugs by young persons.

The Physician-Patient Relationship

The family physician usually becomes aware of substance abuse problems in one of the family members when some disruption occurs in a major life area. In the case of the adolescent, these problems can become apparent as brushes with the law, behavioral or academic problems in school, automobile accidents, the discovery of drugs in the home, a drunken incident, an overdose, or radical changes in behavior. The family physician must evaluate the extent and severity of the adolescent's drug use and problems by obtaining data from family members, the patient, and other available sources. In this article we focus on how this is done with the adolescent patient.[10]

The chemical dependency assessment interview is not dissimilar to any other health or medical interview. The family physician needs to facilitate the patient's telling of the story, to help focus on the process so that relevant data are provided, and to terminate the process when sufficient data have been obtained. Perhaps more so in this situation than in others, the physician needs to create an atmosphere that encourages rapport and disclosure. He or she needs to be exquisitely aware of the negative variables that impinge on this atmosphere and make every effort to overcome them. Factors that encourage the patient's perception of the family physician's empathy and acceptance, as well as the perception of privacy (both psychological and actual), need to be encouraged.

Typically, adolescents will be hostile or defensive if they have been brought to a physician for assessment because drinking or drug use is suspected. They usually are angry with parents and readily identify the physician as another authority figure. Seldom, however, will they verbalize these feelings, and attempts by the physician to mollify them are generally unsuccessful. Also, the time constraints imposed by the assessment itself mitigate against a constructive confrontation with the adolescent's feelings. Instead, it is more productive to acknowledge those feelings and affirm the adolescent's right to have them. Using such a posture, it is possible to "agree-to-disagree" about how the world works and still proceed with the task at hand.

The Interview Paradigm

Immediately inquiring about drug use or drinking is nonproductive. It readily confirms the adolescent's preconception about the nature of the assessment and can make him or her even more defensive. However, acknowledging that the visit has been provoked by a crisis or disruption in the teenager's life, and that the situation involved has at least two sides, makes it possible to invite the adolescent to tell his or her side of the story and describe from his or her own perspective the events that led up to the crisis. Hence, the description of the specific event lends itself readily to lines of inquiry that allow the teenager to describe how his or her family has reacted to the incident, and how others, including peers, have reacted as well.

Early in the interview process, one should reinforce confidentiality, making it clear that questions asked about friends are for clarification only and that there is no interest in identifying information, such as last names. Open-ended questions are much more productive than closed-ended questions. At each point, ask for clarification and specifics, and, whenever possible, request behavioral examples.

Data are needed to indicate changes that have occurred in the adolescent's life that may relate to drinking or drug use. Since adolescence is a period of such rapid change in development, intervals of 3 to 6 months are appropriate milestone marks. Again, behavioral examples will clarify one's perspective on the young person's situation.

The drinking history and, following that, the drug history should not be separate from other aspects of the adolescent's life. For example, a comfortable lead might be first to inquire about the smoking history. Next, ask for a description of the initial experimentation with alcohol: when it occurred, who was there, how the patient felt about it, and what sensations were experienced. Proceed to inqueries about more recent events and any changes in consumption patterns or tolerance. These data will provide a picture of the adolescent's relationship with alcohol. A typical dialogue might be:

PHYSICIAN: "Do you smoke cigarettes?"
PATIENT: "I guess you could say I do."
PHYSICIAN: "How many packs a day?"
PATIENT: "Somewhere around one."
PHYSICIAN: "Do you use snuff or other spitting tobacco?"
PATIENT: "Only when I play softball, then I grab a can of snuff."
PHYSICIAN: "How do you use alcohol?" (Notice the difference in asking this question as opposed to "How much do you drink?")
PATIENT: "I don't drink."
or:
"A couple of beers sometimes."
or:
"As much as I can afford."

A helpful question to ask oneself often is, "Does drinking interfere recurringly with any aspect of this person's life?" If the cumulative answer is yes, the physician has some evidence that this teenager may be harmfully involved with alcohol.

At this point in the interview, the next natural step is to inquire about drug use, either past or present. Again, at first, tangential questions are more useful than direct ones. Since it is often difficult to detect alcohol or drug use among teenagers, it may be helpful to approach the subject first by inquiring about prescription drugs. Use questions such as: "Has a doctor ever prescribed a pain pill, sleeping pill, or tranquilizer for you?" This type of question may set the stage for more openness by the patient. Then questions posed in generalities about peer activities relevant to drug use become an easy way to broach the patient's own use. Here, too, be sure to approach the issues with a chronological perspective and be especially sensitive to changes in the patient's use pattern.

It is also important to determine the source of the young person's alcohol or drugs to ascertain the use pattern, not to report it to the authorities but to further one's understanding of the level of involvement. For example, the teenager who can buy marijuana is further advanced in a use pattern than the young person who smokes it only when it is provided by a friend.

Alcohol and drug-use history-taking can be learned with a minimum of practice. Patient-reported and related objective data can and must be obtained to help determine where the adolescent patient is on the substance-use continuum. Depending on that determination, prevention measures will vary. If the adolescent is only at risk by reason of exposure to alcohol or other drugs used by peers, then primary prevention would be appropriate and usually would involve education, both of the patient and the family. The adolescent at higher risk, that is, in the seeking phase, should be educated, monitored regularly, and given emotional support. If the adolescent is harmfully involved, prevention involves treatment and management with the intent of returning the patient to a nonuser status. This requires removing the patient from access to alcohol or other drugs and, ideally, entering him or her into a residential treatment program.

Summary

In summary, substance use and abuse is a major health problem in the United States affecting adolescents of both sexes and of every socioeconomic level. Family physicians have numerous opportunities to improve the health of future generations by using specific skills and expertise to prevent, identify, and intervene with adolescents' abuse of alcohol and other chemical substances. The first step is taking an effective alcohol and drug-use history.

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