Πρόκειται για εργασία που εκπονήθηκε στα πλαίσια του μεταπτυχιακού προγράμματος Εκπαιδευτικής Ψυχολογίας στο Πανεπιστήμιο του Μάντσεστερ, στην Αγγλία. Εποπτεύουσα καθηγήτρια ήταν η κ. D. Lennox.

DRUG TAKING AND CHILDREN WITH EBD:
REASONS AND TREATMENT

2. EBD IN CHILDREN: A REASON WHICH MAY LEAD TO DRUG MISUSE (OR THE INDICATION OF A HIGH RISK POPULATION)

A number of interrelated factors may consist the causes of emotional and behavioural difficulties. Home environment and the school interact with the child's own genetic predisposition and this complex may result a problem behaviour.

Regarding the factor 'home environment' children with emotional and behavioural difficulties usually come from socially and economically disadvantaged families. Cooper, cited in Farrell (1995), reports that such children are likely to have experienced:

- lack of parental interest in schooling;
- inconsistent and ineffectual parental discipline;
- lack of overtly displayed parental affection;
- parental indifference, hostility or rejection;
- violent displays of temper from the parents;
- parental use of corporal punishment;
- parental cruelty or neglect;
- parental absences;
- rejecting and violent parents.

Schools can play a major role in causing emotional and behavioural difficulties in pupils. Research has shown that schools from similar catchment areas experience different rates of truancy, and behaviour problems. Unsatisfactory standards of behaviour were associated with the following features:

- lessons had staggered beginnings because of late arrivals and unauthorised departures;

- few staff had the skills to defuse potentially difficult situations and on occasion fuelled them by an inappropriate confrontational stance;
- some teachers made threats which they could not carry out;
- many pupils were critical of the capacity of staff to control them;
- standards of achievement were unsatisfactory;
- pupils and staff attendance were poor and morale was at a low ebb.

However, there are some cases of EBD children in which the home environment is supportive and the school is well thought of. These are the most serious forms of emotional disturbance and are associated with a significant inherited or constitutional explanation for their problems. It has to be underlined that one factor alone cannot be held responsible and almost always there is a large interaction between them (Farrell, 1995).

Regarding the drug-taking problem it is worth noticing that among the main causes reported are relief of anxiety and depression. Many adolescents conclude that they find 'better living through chemistry' (Conger and Peterson, 1984).

Dysfunction within the family, antisocial behaviour or delinquency of parents, unsuitable ways of upbringing and abuse from family members are associated with the development of antisocial behaviour in children, including drug misuse (Kokkevi, 1988).

Furthermore, many of the recorded cases of solvent abuse appear to be children who are already in the care of the local authority, which indicates that certain levels of emotional and social deprivation may be determining factors. The practice seems to afford a form of social activity which caters for the needs for acceptance, status and regard for those young persons who feel lonely, rejected or friendless (O' Connor, 1983).

The sniffers and the inhalers are reacting to the absence of a much needed degree of mother and father loving care and attention. Many studies have linked them with sub standard environments. Baker and Adams, cited in O' Connor (1983), found that most glue sniffing boys came from a one parent family, in most cases the mother. Such children search for substitutes and the glue or the diesel may be one. The following result usually is increasing social isolation and withdrawal characterised by truancy and poor educational performance, self destructive behaviour, behaviour disorders and social maladjustment, and delinquency (O' Connor, 1983).

Substance misuse is also associated with low self-esteem, low school performance and low level of future academic progress. Experimentation with substances as well as addiction to them, resulting from feelings of depression, can function as self-treatment behaviour (Kokkevi, 1988).

In their study Stenbanca et al. (1992), have related intravenous drug abuse and cannabis abuse with divorced parents, low emotional control, truancy, run away from home.

Siegel and Ehrlich (1989), have related adolescent drug abuse with depression and anxiety while Luengo et al. (1994), have pointed to impulsivity and antisocial behaviour as risk factors for drug abuse in adolescence.

Subjects often refer to depression when they discuss why they use drugs. Depression seems to result from specific problems, usually family difficulties, and is reported in terms which suggest isolation and pain (Glassner and Loughlin, 1987).

In order to proceed to a statutory assessment of children who may have EBD, LEAs are urged by the Code of Practice on the Identification and Assessment of Special Educational Needs, to seek to establish among others whether there is substance misuse (Farrell, 1995).

The antisocial behaviour during early ages and the proneness to problematic and troubled behaviour increase the likelihood of drug and volatile abuse. Substance misuse is part of problematic behaviour within a general feature of deviant behaviour (Kokkevi, 1988).

3. RECOGNISING YOUNG DRUG USERS

The first step to help children and adolescents who misuse drugs is to find them. In this task the school staff can play a key role if they learn the signs and the symptoms of use. Especially the teacher who is involved with the pupils every day for long time can easier identify the signs and suspect the children who begin to abuse substances.

Early detection can lead to prevention of further misuse. Many signs can be identified in activities which take groups of young persons away from the school premises. First experiments with drugs almost always involve a substance provided by a member of the peer group. Therefore it is important for teachers to be observative at all times, inside and outside school (DFE, 1995).

Some general symptoms that a teacher must keep in mind are: changes in behaviour and personality, for example being unwilling to attend the classes and to take part in school activities; poor physical appearance and dress; borrowing or stealing money and goods; reports from parents that more time is being spent away from home or staying out very late or never bringing friends home; loss of appetite or excessive tiredness without obvious cause; unusual outbreaks of temper, withdrawn or aggressive behaviour, unusually quiet and reticent; wearing sunglasses at inappropriate time, to hide sides of intoxication (DFE, 1995).

There are also some signs in groups which might be a trigger for alert between the school staff: regular absence on certain days; being the subject of rumours about drug taking; use of drug takers slang; talking to strangers; keeping at a distance from other pupils away from supervision points; associating briefly with one person who is much older and not normally part of the peer group enhancing money or other objects in unusual circumstances (DFE, 1995).

Concrete substances have different effects on the appearance and behaviour of abusers. Glue sniffing and volatile substance use- which is more often among young persons- is easy to be identified by spots and sores especially around the mouth and nose, bloodshot eyes, having illusions, disturbed behaviour- similar to alcohol intoxication- odour of solvents in clothes or breath. Users suffer of sore eyes, nose bleeds, dizziness headaches. Presence of empty containers such as freezer bags or glue tins another sign of solvent misuse (O’ Connor, 1983).

Adolescents who have drinking problems appeared to place a high value on independence, to engage heavily in social activities (such as parties), to be impulsive and engage in deviant behaviour (such as cutting classes), and to be dominant and outgoing (Conger and Petersen, 1984).

Pupils who misuse amphetamines have dilated, staring and prominent eyes, are hyperactive and irritable. Barbiturate misusers are characterised by drowsiness and staggering.

Marijuana users are difficult to be recognised unless they are being observed under the substance's influence. They have changes in visual perceptions, acting in an hallucinated manner, become excitable or laugh uncontrollably. As personalities they appear to be blunt, dull, mildly confused with diminished attention span, passive and lacking in goal-directed activity, emotionally as impulsive, sensation-seeking, narcissistic or as calm, relaxed and open to experience (Conger and Petersen, 1984).

Narcotic misusers are characterised by redness and rawness, injection scars, loss of appetite, constricted looking.

The presence of some objects indicates possible substance use. Such objects may be metal tins, pill boxes, sugar lumps, spoons discoloured by heat, straws, cardboard or other tubes, syringes and needles.

It must be noticed that the above signs do not ensure drug or volatile misuse. The presence of several signs together can be proof of the problem. Teachers must be careful in order to avoid confusion and misunderstanding (DFE, 1995).

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5. CONCLUDING COMMENTS

From the above study one becomes aware of the overlap that exists between the causes of drug misuse in young persons and the causes of emotional and behavioural disorders in children. In some cases there are similarities in behavioural reactions between the two groups.

Siegel and Ehrlich (1989) reported that personality problems and deviant behaviour appear to precede rather than follow excessive drug use. There appears to

exist a strong association between low emotional control and drug and volatile misuse. It is likely that drug use can cause decreased emotional control. Low emotional control apart from being a risk factor for the development of drug misuse may be aggravated by increased drug use. Deviant behaviour such as running away from home or truancy is also a strong indicator for ensuing drug misuse and therefore vigilance is needed for intervention on time (Stenbacka et al., 1992).

In order to solve the causes relying only on brief classroom - based curricula to alter complex socially derived patterns of behaviour is not enough. Young people already disaffected with schooling can not change their ways and behaviour because they have learnt to say “no” from the teachers. Apart from the acquisition of social skills and a sense of self-competency which are essential for the success of a training program young drug-abusers also need a comprehensive package of health, mental health and social support services. Schools cannot provide all this. Agencies better equipped can make it much better and bring such services into the school and at the same time protect pupils’ confidentiality (Dryfoos, 1993).

According to a new approach to drug use, concentrating on harm-reduction, if it is impossible to persuade drug-users to stop immediately, at least keep them as healthy as possible until such time as they decide to do so (Davies and Coggans, 1991).

The role of the teacher is always important and multiple. He/she can give advice and solutions through discussion, refer a troubled and confused pupil to other relative agencies and services, inform and make parents aware and finally work in partnership for pupils’ treatment.

REFERENCES

Bagnall, G. (1991). Educating Young Drinkers. London: Routledge.

Conger, J. J. & Peterson, A. C. (1984). Adolescence and Youth: Psychological Development in A Changing World. New York: Harper & Row.

Davies, J. & Coggans, N. (1991). The Facts about Adolescent Drug Abuse. London: Cassel.

DFE. (!995). Drug Prevention and Schools, Circular 4/95. London.

Dryfoos, J. G. (1993). Preventing substance use: Rethinking strategies. American Journal of Public Health, 83 (6), 793-795.

Farrell, P. (1995). Emotional and Behavioural Difficulties: Causes, Definition and Assessment. In Farrell, P. (Eds.), Children with Emotional and Behavioural Difficulties: Strategies for Assessment and Intervention. London: Falmer Press.

Farrell, P. (1995). Guidelines for Helping Children with Emotional and Behavioural Difficulties. In Farrell, P. (Eds.), Children with Emotional and Behavioural Difficulties: Strategies for Assessment and Intervention. London: Falmer Press.

Glassner, B. & Loughlin, J. (1987). Drugs in Adolescent Worlds. Burnouts to Straights. London: Macmillan.

Kokkevi, A. (1988). The Use of Legal and Illegal Toxic Substances in Adolescence. In Tsiantis, G. & Manolopoulos, S. (Eds.), Contemporary Issues of Child Psychiatry II. Athens: Kastaniotis.

Luengo, M. A. et al. (1994). A Short Term Longitudinal Study of Impulsivity and Antisocial Behavior. Journal of Personality and Social Psychology, 66, 542-548.

McCall, L. & Farrell, P. (1993). Methods used by educational psychologists to assess children with emotional and behavioural difficulties. Educational Psychology in Practice, 9 (3), 164-169.

O' Connor, D. (1983). Glue Sniffing and Volatile Substance Abuse. Case Studies of Children and Young Adults. Hampshire: Gower.

Queen, K. W. (1994). Meeting affective needs of at-risk adolescents. Psychological Reports, 74, 753-754.

Siegel, R. A. & Ehrlich, A. (1989). A comparison of personality characteristics, family relationships, and drug taking behaviour in low and high socioeconomic status adolescents who are drug abusers. Adolescence, 24, 925-936.

Smith, C. J. (1990). The Management of Children with Emotional and Behavioural Difficulties in Ordinary and Special Schools. In Varma V. P. (Eds.), The Management of Children with Emotional and Behavioural Difficulties. London: Routledge.

Stenbacka, M. et al. (1992). Do cannabis drug abusers differ from intravenous drug abusers? The role of social and behavioural risk factors. British Journal of Addiction, 87, 259-266.

Watson, J. (1986). Solvent Abuse: the Adolescent Epidemic? Kent: Croom Helm.