Chapter 7

THE CHEMICALLY DEPENDENT "CHILD" SCRIPT: WILL PETER PAN EVER GROW UP?

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We all know the "happily ever after" script—we fall in love, *forever*. We get married and have children. We parent successfully. Our children become independent, happy adults who leave home and fall in love *forever*.

Although the origin of the above-mentioned script may appear to have its roots in the "happily-ever-afterness" of fairy tales, it has derived its empirical validation from the entire spectrum of systems of thought that collectively comprise the field of mental health. In discussing the pathologizing effects of psychotherapy upon the American psyche, psychologist James Hillman and journalist Michael Ventura (1992) believed that most people think of themselves as dysfunctional essentially as a result of their inability to "fit" into the ideal family. ". . . to tout the ideal family is a way of *making* ourselves dysfunctional, because that ideal makes anything outside it, by definition, not ideal, i.e., dysfunctional. . . . the ideal family makes us feel crazy" (p. 16). In a society where the rate of divorce has approximated 50%, the remaining 50% of families are left clinging to the ideal, in spite of their fair share of infidelity, abuse, and alcoholism to name but a few of the more common familial skeletons. If even half, i.e., only

25%, of the "intact" families in society are considered "functional" as defined by the anachronistic standards of mental health, it stands to reason that the remaining 75% of Americans now are fueling the talk show circuits and the Recovery Movement.

What happens to chemically dependent families as they digress from this "ideal" script? How do they incorporate the deviation without feeling deviant? One way to cope is simply to deny the existence of a problem. In fact, denial is the defense mechanism most closely associated with the chemically dependent person and his or her family. Paradoxically, it is often the case that as the chemical dependency worsens, the denial on the part of the addict and significant others intensifies. This denial results in the rigid implementation of coping strategies that the family relentlessly and unsuccessfully employs in an effort to return to "normal" (i.e., ideal).

There emerges a subtle interplay between the ever-changing reality presented by the progression of chemical dependency and the resultant individual and familial response to changes in self-definition that constantly revise the family's script. In this chapter, case material, formulated from a composite picture of virtually hundreds of families presenting for treatment in an outpatient substance abuse clinic, is presented to track the changes in script as changes occur over the progression of the family's life cycle transitions. We will meet Bob and Jane Pan and their 15-year-old son Peter at the emergence of Peter's problem with chemicals. We will revisit the family at several key interval points as Peter matures into "adulthood." Although the impact of the problem is experienced on a familial as well as individual level, it is important to recognize first the sociocultural context that lies as the backdrop to the internalized meaning system of the family.

SOCIOCULTURAL CONTEXT

According to social construction theory, how individuals and families interpret the world is not in an exact duplicative form, but rather in a subjective confirmation of the reality they construct and subsequently seek to confirm (Gergen, 1985, 1989). In much the same way, the myopic view of therapy, with its focus upon the individual and the family, excludes the social context of the symptom, in this case chemical dependency, by localizing the problem within the psyche. Hillman and Ventura (1992) argued that the therapeurizing of the individual creates a passive acceptance of cultural ills.

Stein (1985), in exploring the societal meaning of addiction, viewed alcoholism as a cultural disorder and the drinking behavior itself an attempt to remedy culturally based ailments. Barrett (1992) expanded upon the use of substance as a metaphor of exhaustion, disconnectedness, and spiritual isolation in response to demands for perfectionism and excessive material consumption in society. Similarly, Peele, (1985) in a more radical view of chemical dependency, argued that addiction itself can be understood best as an adaptation to the social environment.

In a very real sense, the messages that abound within society around chemical usage are at best ambiguous. Consequently, the very society that condemns the addict spends billions of dollars annually in fostering the use of "legal" chemicals such as alcohol, nicotine, caffeine, and prescription tranquilizers. In a society that has come to view alcohol as a prescriptive for stress management (e.g., "This Bud's for you, for all you do."), it becomes difficult to differentiate when the use of a substance is unacceptable, not to mention problematic. The marketing correlation of beer and sports/concerts to young audiences seeks to inextricably link and elevate alcohol consumption to the equivalent pairing of America and apple pie. We are taught to cope with pain through pills—"why suffer?"—and transform our personalities in the era "Beyond Prozac" (Begley, 1994, February 7).

Likewise, as the use of marijuana and alcohol rises among teenagers (Treaster, 1993, April 14), we have constructed a new social reality in which "experimental" drug use among adolescents is accepted as a normative rite of passage (Treadway, 1989). According to a National Institute of Alcoholism and Alcohol Abuse (NIAAA) 1987 report, in this country, the mean age of an adolescent's first drink is 12 years and 3 months. The mean age of the first use of marijuana is 13 years and 4 months. Alcohol continues to be the most popular drug among adolescents (MacDonald, 1987; Bell, 1990). These statistics reflect the "normal" population, not adolescents in treatment (Bell, 1990).

One in six teenagers in the United States suffers from a severe addiction problem (Thorne & DeBlassie, 1985). Unfortunately, it is difficult to distinguish use from abuse and to intervene in a timely manner. Even if one is certain about the need for intervention,

> . . . our attempts to cure, eradicate, prevent, and heal the problems of drug and alcohol abuse involve many different methods and philosophies, often with radical differences between them. We seek solutions through genetics and biology;

> with law enforcement and criminal prosecution; by attempts to teach our children to resist temptation, experimentation, and peer pressure; through inpatient and outpatient treatment programs with varying methodologies; and with academic and "popular" investigations of addicts and the families that they come from and live in. (Barrett, 1992, p. 33)

In this manner, chemical dependency and its concomitant denial system is easily mirrored and reinforced by the larger social context. In treating the chemically dependent family, we must be mindful of this awareness if we are to successfully challenge the social meaning system that fuels the addiction formation. When the family retrospectively wonders why the person uses chemicals in the first place, they often finish the story with a negative script, e.g., problems with low self-esteem or parenting style or the family's skeletons. It is the therapist's task to amplify the context if the family is to understand that in this society, their child is expected to use substances. He or she is acting in an all-American way.

The recovery process then requires the co-creation of a new script: how to be sober in American society. The addict and family must be taught to find and utilize the supporting structure for abstinence. Shifting focus to new role models and heightening awareness of nonchemical forms of recreation such as sober clubs, retreats, exercise, and meditation, to name a few, are steps in the process. Of course this goal is facilitated by participation in 12-step recovery such as Alcoholics Anonymous (AA), AL-Anon, Narcotics Anonymous (NA), Nar-Anon, or alternatives such as Rational Recovery or Woman for Sobriety.

EARLY ADOLESCENT YEARS SCRIPT: "IS HE OR SHE OR ISN'T HE OR SHE?"

There are known risk factors that can predispose and/or exacerbate chemical dependency such as genetic predisposition, early age of onset of chemical usage, negative parenting style (inconsistent and/or too rigid), change in peer relationship, and downward school performance (Archambault, 1989). In addition to those indicators already cited, other known predictors include onset of antisocial behavior in early adolescence and being reared by an alcoholic parent (Zarek, Hawkins, & Rogers, 1987). According to Mooney, Eisenberg, and Eisenberg (1992), some of the clues

to substance use in the adolescent are rather subtle while some are more obvious. These are listed as follows:

1. increasing hours spent alone in room, particularly in a child that was not previously a loner;
2. increased secretiveness;
3. negative change in attitude at school, with friends, in hygiene, in dress;
4. changing peer group;
5. pronounced mood swings;
6. lying, shoplifting, stealing (money from home);
7. abandonment of extracurricular activities: sports, clubs, religious services, etc.;
8. unpredictable rebellious behavior;
9. curfew breaking;
10. alcohol on breath;
11. discovery of drug paraphernalia; and
12. obvious hangovers, blackouts, drugged behavior.

However, most families tend to negate these early signs and symptoms in favor of a more normative view. Parents frequently frame their child's changed behavior as emanating from the disease of "adolescence" rather than from the disease of addiction.

In a 1984 Johnson Institute survey of Minnesota teenagers (Zarek et al., 1987, p. 484), it was found that parents underestimated the proportion of children who drank regularly by the staggering ratio of 10 to 1. In this same study, parents thought that only 2.5% of the teens drank every 2 weeks, while in reality, 29% were drinking every 2 weeks. Likewise, the teenagers who were abusing alcohol heavily also were found to be abusing other drugs. This helps to dispel the myth that adolescents who are drinkers are not drug users. Even if families do seek treatment at this time, it often will be for other problems such as conduct disorders or attention deficit disorders. Families often believe that the child is primarily depressed—not secondary to the use of chemicals that might be creating the mood disorder. Morrison and Smith (1987) discussed the ramifications of misdiagnosis particularly as a failure to recognize pathology as emanating from intoxication. Misdiagnosis, unfortunately, can lead to inappropriate treatment for psychiatric disorders that generally clear up as the intoxication subsides.

Case Illustration

Let us now meet Bob, Jane, and Peter Pan at the outset of their encounter with substance abuse in their family.

Bob and Jane are the parents of 15-year-old Peter who recently was caught smoking marijuana on school grounds. Over the course of the past year, Bob and Jane have observed an increased moodiness on the part of their son and a tendency for him to isolate himself from family events. They believe this behavior to be "normal for a kid his age." Although they no longer approve of Peter's friends, some of whom they barely know, Bob and Jane believe Peter's claim that "these kids are just more fun." Bob and Jane are aware that Peter has been drinking beer on weekends, but "so does everyone his age." Peter maintains he would "never use any hard drugs." His grades have begun to deteriorate, and his parents have responded by providing him with tutors. Bob and Jane continue to give Peter his weekly allowance "for lunch money." In response to this latest event, they believe that Peter is becoming scapegoated at school and have begun to investigate placing him in a prestigious private school. Bob and Jane, having both grown up in the 1960s, do not believe there is any significance to Peter's use of marijuana.

One way to reconstruct the interpretation of the familial denial, so salient to the progression of chemical dependency, is to understand the desperate attempt on the part of the addict and his or her family to cling to the original "happily ever after" script even at the expense of reality. Clearly, Bob and Jane both believe that they are doing their best to keep Peter on track towards adulthood. Though their actions obviously are understood as enabling, the therapist must remain attuned to not prematurely labeling their behavior as dysfunctional and, thus, part of the inevitable disease process of codependency. To join effectively with Bob and Jane is to understand that their quest to meet the successive challenges of parenting Peter places them in direct opposition to some of their core beliefs. One can assume that many of these beliefs have been formulated in their own respective adolescent experiences and have been adhered to stubbornly despite these beliefs' inappropriateness to the current situation of caretaking an adolescent son in the 1990s.

On a societal level, parents of the 60s, currently parenting the adolescents of the 90s, need to be helped to recognize the changing cultural context for drug usage. The "love" generation has dissipated to a society

riddled with high risks of random violence, AIDS, and addiction. As the number of HIV carriers increases, the lifestyle practices of adolescents and their concomitant drug usage patterns will place them at significantly higher risk. Already, approximately 21% of AIDS cases occur in the 20- through 29-year-old population, with the age of contraction believed to be often during adolescence (Petosa, 1992).

Parents who have failed to update their scripts to accommodate the changing context of substance use may inadvertently tolerate the very behavior they hope their child will outgrow. Age of onset is increasingly becoming earlier, thereby resetting the norm despite its negative consequences. Earlier onset is not only known to be a prime indicator of addictive disorder (Archambault, 1989; Zarek et al., 1987), but it also is correlated with poorer prognosis. Parents frequently are naive to the developmental implications of earlier age of substance use when comparing their child's to their own experiences. Parents may be equally naive to the knowledge that the potency of marijuana is now 20 times stronger than it was 20 years ago (*The New York Times*, 1994, February 6). Parents' messages regarding substance use may be fraught with ambivalence and inconsistency with respect to their own former and/or current patterns of usage. Yet it is known that parental permissiveness toward drinking and drug use is positively correlated with adolescent substance abuse (Johnson, Shontz, & Locke, 1984). Adolescent substance abuse not only results from the imitation of parental substance use but also from the modeling of attitudes toward use, established norms, and standards of behavior (Howard, 1992).

Again, most families do not present for treatment at this early phase. The cognitively dissonant information (Festinger, 1957) that suggests "all is not well" is relegated to the background. What we have are the early traces of the pattern of parental rescuing—a pattern that becomes firmly entrenched over time as the script subtly begins to alter to accommodate chemical dependency. We begin to see changes in the family's ability to process contradictory information through the use of secondary defenses such as rationalization, ("The behavior is normal for a kid."), minimization ("Everyone is doing it."), and externalization of the blame ("It is the school's fault."). An almost imperceptible shift in the collective familial resources to defend against the awareness of a substance abuse problem occurs. Even in moments of confrontation, it becomes reassuring to surrender to false protestations ("No, I do not have a problem." or "Those drugs are not mine; I am holding them for a friend.") than to maintain a reality-based focus that would lead to heightened anxiety. We have the emergence of the dichotomy in individual family members absorbing the blame for the

problem, e.g., "Maybe we are just overreacting." Ironically, the family invites the betrayal and then becomes enraged with the addict for being dishonest.

Family Intervention with the Early Adolescent

The dilemma for the family becomes one in which the very act of seeking help becomes a confirmation of a problem. If they do present for therapy, it is often at the strong suggestion/mandate of a secondary party such as the school-based guidance counselor. Peter has begun to show several of the warning signs associated with substance use. Yet, based on the above information, it would be most difficult and arguably inappropriate to label him as having a disease called addiction at this juncture. Early labeling often creates panic and increases the likelihood of the family fleeing treatment. This can further reinforce the denial of the substance user.

On the other hand, the therapist must absolutely never enter into collusion with the denial system of the family. It is important not to negate the significance of the substance usage or to treat it as a secondary symptom of a larger problem. This is a frequent error easily fallen into when both the therapist and family align in discussions around the "larger issues," hoping that the substance usage will subside merely as a result. This is magical thinking on the part of the therapist and it arguably could be stated that the therapist is utilizing a mental health script to deal with a substance abuse drama.

Through the use of ***therapeutic languaging*** (Atwood & Zebertsky, 1993; Gergen, 1985), intervention at this juncture requires redefining the frame from one of problem to that of prevention. A further distinction must be made between primary and secondary prevention. Primary prevention is intended to stop the disorder before its onset and can take the from of information dissemination or therapy. Primary prevention also can include parenting skills training, education, and media programming. It is an attempt to alter the script before it has been written. On the other hand, secondary prevention is the attempt to disrupt a process that has already begun, (an early revision of the script). Carroll (Archambault, 1989) believed secondary prevention to be the more realistic alternative since primary prevention strategies designed to stop adolescents from experimenting with usage have thus far been unrealistic.

The strategy of secondary prevention, revising the script to effect a more positive future outcome, becomes the goal of intervention at this time. The therapist can help the family recognize that in the case above, Peter is beginning to have difficulty in the process of meeting his age-appropriate developmental tasks. The family can be helped substantially to be motivated for change through their participation in psychoeducational support groups designed essentially to teach the family what the completion of the script will look like if they fail to intervene at this time. This is concretized through the participation of other group members coping with substance abuse at often more advanced stages. The family is exposed to the realities of the impaired development created and fostered by the progression of chemical dependency. Likewise, they can heed the admonishments of other parents who regretfully feel they failed to intervene sooner, usually as a result of their own denial.

The essential task becomes one of joining with the family to reduce as many of the risk factors (as delineated above) as possible. The intention is to offset the inevitability of family members becoming further entrapped in the stereotypical roles (which will be described at length in the remainder of the chapter) of the chemical dependency script.

To this end, the therapist must seek to become allied with the family in negotiating the significant systems that impact upon the problem. Downhill school performance can be seen as a harbinger of an emergent chemical dependency problem. As such, the interaction between the family and the school must take on significance in the treatment of the family. The therapist must be cautious, however, not to connect to the resistance of the family regarding the outside systems (e.g., Peter's family's view of the school as "scapegoating" Peter), particularly if those systems can be used to maintain leverage for treatment. Instead, the therapist can assist in brokering a co-operative relationship between the family and the school that is needed to facilitate improved school performance. Improved school performance can enhance self-esteem, which can mediate against the use of chemicals to make oneself feel better artificially.

The Adolescent

The adolescent must be engaged in the process of co-creating a new definition of self. To that end, a commitment to abstinence is essential and must be contracted for the entire duration of treatment. Of course the goal would be to extend this commitment into the future. In fact, focusing upon

the future is one way to assist in the visualization of a future without the problem (Atwood & Zebertsky, 1993). Projecting into the future allows the adolescent to envision and plan a life without the use of drugs. At a minimum, however, the adolescent must be made aware of the need to reestablish a new sober baseline against which he or she later can measure his or her own respective behavior. Should the adolescent return to substance usage at another stage in life, he or she has a reference point of comparison upon which any behavioral changes can reflect.

Clearly, commitment to abstinence is not always easily accomplished, and the operationalization of this goal often forms the central task of the initial phase of family treatment (Usher, 1991). In their discussion of neurolinguistic programming of belief change, Davis and Davis (1991) felt that the "truths" as we see them are the result of conscious or unconscious imprinting experiences. The task is to re-imprint new beliefs by challenging the former process of understanding the universe through the confirmation of the old belief system. The adolescent must be helped in changing the emergent and increasingly pervasive construction of the negative self script. A competing re-imprint of a positive self must be reintroduced to challenge the formation of the destructive belief system. As Baab (1992) noted, the therapist's first step is to help the adolescent distinguish between the self-destructive part (the drug using self, "scapegoat," "patient," or "addict") and the self-nurturing part ("natural child," "inquisitive student," "brother," "sister," or "friend"). If the adolescent can be re-armed with a new script, even if time-limited, for how to interact in the world without chemical alteration, he or she stands a better chance of consolidating developmental gains that bring him or her closer towards maturational goals.

The Parents

There are known correlates between parental style and increased risk of chemical dependency. Again, if the therapist is to join with the family in a cooperative venture of eradicating as many risk factors as possible with the goal of "problem prevention," it is important to engage the parents in an exploration of the possible scenarios that exacerbate substance abuse. Lawson, Peterson, and Lawson (1983) have described four parental types most closely associated with increased risk of substance abuse in an adolescent. These are as follows:

1. "alcoholic parent" script
   The correlation between alcoholism in a parent and the high risk

of alcoholism in the offspring has been well documented over the years through adoption studies (Cotton, 1979; Goodwin, 1983) and longitudinal studies (Chafetz, Blane, & Hill, 1977; Miller & Jang; 1978) that have directed attention to genetic predisposition. A multitude of other studies have sought to examine the interrelationship between family dynamics and the creation of substance abuse in the offspring. These studies range from the impact of parental chemical dependency upon the children (Woititz, 1983; Black, 1982), to the association between the disruption of family rituals and increased substance use in offspring (Wolin & Bennet, 1984), to the significance of cultural patterning (Ablon, 1980; Kaufman & Borders 1984).

In attempting to create an alternative script in which the family is able to address the alcoholic parent, it is necessary to shift the focus of the problem from the adolescent while being careful not to disempower the parent. This is a complex act that requires joining with the parent in the first place, learning and entering his or her respective meaning system regarding chemical usage, and attempting to engage him or her in the possibility of co-creating a new script. This is a complicated process and not without its own set of treatment risks. As Treadway (1989) so clearly pointed out regarding the shift in focus, "The drinker may not be ready to address the alcohol abuse in a motivated manner; the family members may be unable or unwilling to confront the drinking; and the child may 'rescue' the family by creating a distracting crisis" (p. 124). Obviously the task of assisting the parent toward his or her own recovery is quite complex. If successfully achieved, it is profoundly destabilizing; in a sense it renders the individual and the family temporarily "scriptless."

2. "teetotaler parent" script
   This scenario is marked by parents who adopt an excessively rigid, moralistic, intolerant stance towards substance abuse, not only with regard to themselves but to others as well. Teetotaling parents attempt to instill a dualistic approach to life (right/wrong, good/evil, black/white), leaving their child ill-equipped to deal with all the shades of gray. The child cannot adaptively utilize the rules that are inconsistent with human need. The child therefore can respond contemptuously through the use of substances as a statement of defiance and a means of coping.
3. "overly demanding parent" script
   In this script, the parent clearly sets forth his or her expectations for the child. Unfortunately, the expectation level itself is not com-

mensurate with the realistic abilities of the child, and as a result the child's self-esteem falters. The parent creates a competitive environment among siblings by frequently drawing comparisons between them. The child often is compared to the child who the parent himself or herself used to be. The overly demanding parent may be modeling an unattainably high level of success as a result of his or her own position in life. Conversely, an alternative is that the parent may be living vicariously through the child in expecting the child to compensate for areas in the parent's own life in which the parent wished he or she had succeeded.

4. "overly protective parent" script
   The overly protective parent conveys to the child his or her lack of faith in the child's ability to negotiate the world. The child fails to master his or her own environment. As a consequence, the child's restricted ability to self-actualize manifests in a compromised definition of self and future capacity. This can be an outgrowth of two dynamic styles that may not necessarily be mutually exclusive. In the first style, the parent can be viewed as narcissistically involved with the child in a way that uses the child to gratify the parent's own ego needs "to be needed." In this way, the parent attains and maintains his or her own measure of self-worth. In the second style, the parent can be defending against subconscious hostile and unwanted negative feelings toward the child and in turn compensating through the use of reaction formation.

In social construction therapy, the therapist assists families in recreating their respective stories through their families of origin " . . . (the origination of the development of the meaning system) and the story of their present family (the maintenance of the meaning system)" (Atwood & Zebertsky, 1993, p. 16). In enabling the teetotaler parent, the overly demanding parent, and the overly protective parent to accept their respective meaning systems as socially constructed, it then becomes possible to facilitate the deconstruction of these scripts to make room for the growth of their respective adolescents' self-esteem. This is accomplished through the expansion of the parents perspectives, descriptions, and explanations for social patterns that previously they have sought to exclude in order to preserve their original meaning system. For example, in working with the teetotaler parent, it becomes necessary for the therapist to challenge the black/white thinking of the parent in order to create space for the gray areas. The use of an artistic metaphor might signal the need for the family to allow the adolescent (and themselves) to add "color" to their life without having to resort to the use of chemicals. The family even can be invited to engage in a ritual that

concretizes the metaphor while signalling the expansion into a new level of awareness. As such, the family can be encouraged to participate creatively with each other in painting a new family pattern. The family can be freed up to experiment with the nuance of shade or design as it appears in art and ultimately is reflected in their changing social interactions.

The underlying theme for the adolescent that appears to place him or her at higher risk for substance abuse as he or she develops vis a vis the above-mentioned parental scripts is *the muted growth of his or her internal self-esteem*. It is as if the seeds get planted in a container that is too small. The parental scripts appear to be inhibiting growth. Archambault (1989) poignantly noted that in our society we often ask the wrong questions: What is so addicting and reinforcing about drug usage? Why do drugs make you feel good? Instead, Archambault believed we should be asking this question: Why is the rest of the adolescent's life so unreinforcing, so unpleasurable, that he or she is willing to sacrifice so much in order to use substances?

A basic assumption of social construction family therapy theorists such as Lax (Atwood & Zebertsky, 1993, p. 12) is that people cannot change under a negative connotation. Emphasis is therefore placed upon positive connotations. The approach utilizes the strengths of the family to facilitate change rather than remaining problem-centered. This is supported by basic learning theory that suggests that organisms are more responsive to positive reinforcement than to negative reinforcement. In a most relevant article, Coombs, Santana, and Fawzy (1984) asserted that drug use is a learned behavior that occurs within varied family contexts. They designed a parent training model that teaches parents in single/multiple family sessions to interact constructively with their children. Positive interactional patterns, including more praise, encouragement, and positive involvement were incorporated while parental criticism, complaining, and punishment were diminished. Their hypothesis was based on the reconstructive philosophy of the social learning model: Adolescent behavior is instigated and consequated within the family and the peer system. It is a derivative of social interaction. They asserted that by educating the parents to increase positive reinforcement rather than negative response to adolescent rebelliousness, the self-esteem of the adolescent could be enhanced within the family. In turn, this would make it unnecessary (or at least less likely) for the adolescent to seek approval from drug using peers.

Again, let us return to the image of the seeds in the small container. We help the seeds (the adolescent) become life affirming in seeking nurturance—to put down the destructive use of chemicals. In turn, we work with

the family (the container) to expand and to maximize the blossoming of the individual, i.e., the adolescent's self-esteem. In so doing, a significant step forward is taken to reduce the likelihood of the full-blown chemical dependent script taking root.

It can be difficult for a family to know whether or not their early adolescent has a substance abuse problem. In a society that legitimizes substance usage, compounded by parents who themselves were raised at a time when use of chemicals was often acceptable, the assessment becomes far too sophisticated. It is easier to "stick to the script"—deny—and hope that it will all blow over as the adolescent matures. As demonstrated in the case illustration of Peter, the family, in their inability to mobilize in a new direction, loses an opportunity to participate actively in engineering a new course. In so doing, the irony is that they increase the likelihood of following the chemical dependency script instead of the happily ever after script, which is their intention.

LATE ADOLESCENCE/EARLY ADULTHOOD SCRIPT: "THE HARDER WE RUN, THE LESS DISTANCE WE GO"

"Normal" Script

The socioculturally determined script for transition between late adolescence and early adulthood in Western society calls for a resolution of the major tasks of this developmental period, i.e., ***identity*** and ***separation***. The period between the ages of 18 and 21 is known to be a time of reduced restlessness and of increased integration of self. At this time, the adolescent is able to handle the tasks and responsibilities of adulthood. The adolescent has become a separate entity from the family and therefore does not need to engage in an oppositional stance in order to maintain self-definition. Adolescents no longer are as preoccupied with body image concerns. By ages 16 to 19, most adolescents have adjusted emotionally to their sexual capabilities. "They are comfortable with their bodies by now, even if not completely satisfied" (Bell, 1990, p. 63). The peer group values become less important as the late adolescent is better able to differentiate and maintain his or her own set of values.

With regard to identity development, Neinstein (1984) characterized four steps of ego development as follows: