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Problematic technology use during adolescence: Why don't teenagers seek treatment?

In recent issues of *Education and Health*, I have briefly reviewed the empirical evidence relating to problematic use of technology by adolescents including online video gaming (Griffiths, 2014), social networking (Griffiths, 2013a; Kuss & Griffiths, 2011), and mobile phone use (Griffiths, 2013b). Most of the research studies that have examined 'technological addictions' during adolescence have indicated that a small but significant minority experience severe problems resulting in detriments to education, physical fitness, psychological wellbeing, and family and personal relationships (Griffiths, 2010; Kuss, Griffiths, Karila & Billieux, 2014). Given these findings, why is it that so few teenagers seek treatment? This article briefly outlines a number of reasons why this might be the case by examining other literature on adolescent drug use and adolescent gambling (e.g., Chevalier & Griffiths, 2005; 2005; Griffiths, 2001). Three different types of explanation are discussed: (i) treatment-specific explanations, (ii) research-related explanations, and (iii) developmental and peer group explanations.

Treatment-specific explanations

This first set of explanations directly concern aspects of treatment-seeking behaviour that may impact on whether adolescents would seek treatment for problematic technology use.

Adolescents do not seek treatment in general: Griffiths and Chevalier (2005) noted that teenage males rarely contemplate seeking treatment for anything (apart from life-threatening traumas and extremely severe acne). Female adolescents are a little more likely than young males to consult health professionals (especially for gynaecological reasons). The reasons why adolescents in general do not

consult health professionals are their perceived invincibility, invulnerability, and immortality. In addition, adolescents are constantly learning and appear to want to resolve their own problems rather than seek help from a third party. Who better than themselves knows what to do with their lives and whatever problem they are facing? They might experience more denial than adults, but come to the conclusion that others (usually adults) do not understand them. Ultimately, if adolescents rarely present themselves for any kind of treatment, it would be surprising to see them turn up for very specific treatments related to problematic technology use.

Adolescents may acknowledge they have a problem concerning their use of technology but do not want to seek treatment: Again, this explanation is plausible, but there is little empirical evidence to support the claim. However, it has been noted that families of adolescent problem gamblers are often protective – if not overprotective – and try to keep the problem within the family (Griffiths, 2002). Therefore, it may be speculated that seeking formal help for problems with technology use may be a last resort option for most adolescents and their families.

There are few or no treatment programmes available for adolescents: It is true that specialized treatment programmes for problematic technology use are almost non-existent in the UK. Although there are a few private addiction clinics that treat gaming addicts, services specifically for adolescents with problematic technology use appear to be few and far between. It could be argued that this is a 'Catch 22' situation. If only a few adolescents turn up for treatment, treatment

programmes will not be able to provide specialized services, and adolescents with problematic technology use do not turn up for treatment if it does not exist.

Available treatment programmes are not appropriate and/or suitable for adolescents: To some extent, this explanation is interlinked with the previous reason, but is different. The explanation here is that there may be treatment programmes available, but that most are adult-oriented (e.g., group therapy in private and/or residential addiction treatment clinics). Adolescents may not want to be integrated into what they perceive to be an adult environment.

Attending treatment programmes may be stigmatising for adolescents: Adolescents might not seek treatment for problematic technology use because of the stigma attached to such a course of action. Seeking treatment may signify that they can no longer participate in the activities by which they and their group define themselves. Furthermore, it may draw attention to what they perceive as a 'failure' in their lives.

Adolescents may seek other forms of treatment, but problematic technology use are less likely to be seen as requiring intervention: Adolescent problematic technology use is associated with other comorbid behaviours such as substance abuse (van Rooij, Kuss, Griffiths, Shorter, Schoenmakers & van de Mheen, 2014) and problem gambling (Wood, Gupta, Derevensky & Griffiths, 2004). Adolescents may engage in all of these behaviours for the same reasons (to feel part of their peer group, to modify their mood state, to escape other problems in their lives, etc.). Therefore, the few adolescents who do seek treatment may do so for a comorbid behaviour rather than for problematic technology use itself. In most Western societies, problematic technology use is not perceived as a real problem, especially when compared with problems related to alcohol or substance abuse.

Treating other underlying problems may help adolescent problematic technology use: Problematic technology use could be (and quite often is) symptomatic of an underlying problem such as depression, dysfunctional family life, physical disability, lack of direction or purpose of life (Király, Nagygyörgy, Griffiths & Demetrovics, 2014; Kuss et al., 2014). Therefore,

if these other problems are treated, the symptomatic behaviour (i.e., problematic technology use) should disappear, negating the need for specific problematic technology use-specific treatment.

Research-related explanations

Another set of explanations may relate to the fact that the empirical research that has been carried out into problematic technology use is over-inflating the prevalence rates because of many different factors. The implication here is that adolescents are not turning up for treatment because there is no real problem in the first place.

Adolescents with problematic technology use may lie or distort the truth when they fill out research surveys: This is a reasonable enough assumption to make and can be made against anyone who participates in self-report research – not just adolescents. All researchers who utilize self-report methods put as much faith as they can into their data but are only too aware that other factors may come into play (e.g., social desirability, motivational distortion, etc.) that can either underscore or overplay the situation. In these particular circumstances, it may be that adolescents are more likely to lie than adults. However, it seems unlikely that any differences would be due to this factor alone.

Screening instruments for assessing problematic gambling may not be valid for adolescents: Although there are many debates about the effectiveness of screening instruments for assessing problematic technology use (King, Haagsma, Delfabbro, Gradisar & Griffiths, 2013), it could be the case that many of these question-based screening instruments are not applicable, appropriate and/or valid for assessing adolescent technology use. For instance, King et al. (2013) reviewed 18 different instruments that assess problematic video gaming but only one had specifically been developed for adolescents.

Screening instruments for adolescent problematic technology use are being used incorrectly: With measures developed for adolescents, as with those for adults, there may be incorrect use of screening instruments. For instance, there may be a lack of consistency in methodology, definitions, measurement, cut

scores, and diagnostic criteria across studies, and particularly in the use of lenient diagnostic criteria for problematic technology use in youth in some studies (King et al., 2013).

Adolescents may not understand what they are asked in research surveys: Another reason that the prevalence rates of adolescent problematic technology use may be elevated is because of measurement error. If adult instruments are administered to youth (which some researchers including myself have done) adolescents may endorse items they should not, doing so because they do not fully understand the item. For instance, in research on adolescent problem gambling, Ladouceur, Bouchard, Rhéaume, et al. (2000) showed that many of the items on the adolescent version of the South Oaks Gambling Screen were misunderstood, with only 31% of youth understanding all of the items correctly.

Researchers consciously or unconsciously exaggerate the problem of adolescent technology use to serve their own careers: This explanation is somewhat controversial but cannot be ruled out without at least examining the possibility. If this explanation is examined on a logical and practical level, it can be argued that those of us who have careers in the field of problematic technology use (like myself) could potentially have a lot to lose if there were no problems. Therefore, it could be argued that it is in the researcher's interest for problems to be exaggerated. However, there is no empirical evidence that this is the case, and all researchers are aware that their findings will be rigorously scrutinized. In short, it is not in researchers' best long-term interest to make unsubstantiated claims.

Developmental and peer group explanations

Finally, there may be some explanations of why adolescents do not seek treatment for problematic technology use as being due to some aspects associated with adolescent development and peer group influence.

Adolescents with problematic technology use may undergo spontaneous remission and/or mature out of gambling problems, and therefore, may not seek treatment: There are many accounts in the literature of spontaneous

remission of problematic behaviour (e.g., alcohol abuse, heroin abuse, cigarette smoking, problem gambling), and problematic technology use is no exception. Because levels of problematic technology use appear to be much higher in adolescents than in adults (Kuss et al., 2014), and fewer adolescents receive treatment for their problematic technology use, it is reasonable to assume that spontaneous remission occurs in most adolescents at some point, or that there is some kind of "maturing out" process. There is a lot of case-study evidence highlighting the fact that spontaneous remission occurs in problem adolescent gamblers, and that gambling often ceases because of some kind of new major responsibility such as getting one's first job, getting married, or birth of a child (Griffiths, 2002).

Adolescent excesses may change too quickly to warrant treatment: Adolescence is sometimes about excess and many addictions peak in youth (Griffiths, 1996). It could be that transfer of excess is a simpler matter for adolescents. They might have an excess 'flavour of the month' syndrome, where one month it is binge alcohol drinking, one month it is joyriding, and one month it is video gaming. Adolescents may not seek treatment not because of spontaneous remission in the classical sense, but because of some sort of transfer of excess.

The negative consequences of adolescent problem gambling are not necessarily unique to problematic technology use and may be attributed either consciously or unconsciously to other behaviours: Some adolescents may attribute their undesirable behaviour or negative consequences to other potentially addictive behaviours that co-occur during adolescent development, such as alcohol abuse or using illicit drugs (Griffiths & Chevalier, 2005).

Adolescent problematic technology use may be socially constructed to be non-problematic: Problems, whether they are medical or otherwise, are socially constructed (Castellani, 2000). For example, denial may not be experienced because there is no perception of a problem. For instance, if the peer group, or school class of the adolescent is pro-technology use, actively engaged in technology use, and

shows signs of problems, it may appear to the adolescent that problems go with the territory. Playing the guitar is hard on the fingers, playing football is hard on the shins, and playing video games is hard on sleep, and schoolwork. Therefore, it may not be perceived as a medical, psychological, and/or personal problem, but merely a fact of adolescent life.

Conclusions

Although this list may not be exhaustive, it does give the main reasons why adolescents with problematic technology use may be under-reported in turning up for treatment. It is likely that no single reason provides more of an explanation than another. The reasons provided also raise many questions that require answers. Why do adolescents appear to be reluctant to seek help for problems related to technology use? What is the true prevalence of problematic technology use among youth? Are the available statistics on problematic technology use inflated by a lack of understanding of the survey questionnaire items? Where does problematic technology use fit among the many difficulties young people face during the developmental process? Are the heightened rates of problematic technology use among youth the result of having grown up during times of such extensive availability (i.e., a cohort effect) or are they merely a reflection of adolescent experimentation that they will grow out of (or a combination of the two)?

Research needs to address directions and magnitudes of causality among problematic technology use behaviours and other health and psychosocial problems. What is clear is that there is no single assertion made in this article provides a definitive answer to the treatment paradox in relation to adolescent problematic technology use. It is most likely the case that many of the plausible explanations interlink to produce the obvious disparities between

prevalence rates of adolescent problematic technology use and adolescents not enrolling in treatment programmes.

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