The Discovery of Marijuana Use by a Parent of an Early Adolescent*

CASE

Philip, a 14-year-old male, is brought to your office by his anxious parents who recently discovered that he was using marijuana. Over the past 2 months, he has appeared moody, irritable, and has been losing interest in his school work. His parents had attributed these behavior changes to “teenage years” until his mother discovered a marijuana cigarette in his room. His father responded with anger directed at the youth. Philip had a happy and productive childhood before this event. He was a solid “B” student with several friends and a modest interest in participatory sports. He has two older siblings in college. The family was close and previously had enjoyed time together. Philip’s father stated that the use of drugs was absolutely forbidden in his family, and he felt that Philip had “let ‘him’ down.”

Index Terms: early adolescence, marijuana use.

Dr. Martin T. Stein

The journey through adolescence is an eventful time for clinicians, parents, and youth. The youngster has a multitude of developmental experiences in her/his educational, social, sexual, and psychological life for the first time. The discovery of drug use by a concerned parent in this case illustrates one of those new events.

Both Drs. Schonberg and Heyneman approach this case from a contextual and developmental perspective. Dr. Heyneman cautiously differentiates “drug use” from a “primary drug problem.” Dr. Schonberg emphasizes the importance of knowledge about the epidemiology of drug use, i.e., experimentation in early adolescence must be seen as a problem worthy of careful clinical evaluation. For each clinician, the evaluation is guided by a need to understand the marijuana use in the context of the youngster’s previous medical and psychological history, his educational performance, social skills, and family patterns. Both commentators agree that, without more information, it would be premature to conclude that Philip’s case is consistent with a developmental phase with drug experimentation. Dr. Heyneman’s review of specific criteria that may differentiate a minor drug problem from a major one is especially helpful for the primary care clinician.

The decision to refer for further evaluation and counseling is difficult. Availability of services (financial and geographic factors) and willingness of the patient and family to follow through on a referral are critical issues. Some pediatricians with special interest and training in adolescent developmental problems may be qualified to manage a patient like Philip when the initial evaluation suggests that the problem is limited to drug experimentation in a youth who is functioning well in other spheres.

Martin T. Stein, MD
Department of Pediatrics
University of California, San Diego
La Jolla, California

Dr. S. Kenneth Schonberg

The discovery of marijuana use by a 14-year-old boy should be a cause for concern. Although nearly half of all adolescents will try marijuana at least once before graduating from high school, use during early adolescence remains relatively uncommon, with less than 15% of teens reporting such use before entering high school.1 Most adolescents who use marijuana will suffer neither acute nor long term consequences, and, in the older adolescent, such use is normative and not necessarily an indication of any underlying pathology. In contrast, although use by younger teens would appear to be increasing, this behavior is often a marker of both underlying difficulties and the risk of more significant substance abuse in subsequent years.2 Hence, this presentation should be taken seriously and should not be assumed to be normative for a 14 year old.

Areas of exploration with the boy and the family should include not only his drug use pattern but also, and of greater importance, a broad assessment of his mood, academic performance, and social circumstances. It would be extremely rare for an adolescent of any age, and certainly a young adolescent,
to present with a pure drug problem, i.e., if the marijuana use were to cease, we would find ourselves with a rather healthy, well adjusted young man. A far more likely scenario is that the drug use is secondary to some other as-yet-to-be-determined difficulties. Some indications of these difficulties are noted in the case vignette. His moodiness, irritability, and loss of interest in school work are difficult to attribute to the pharmacological effects of marijuana and are most certainly indications of other difficulties.

Do those difficulties relate to problems with academics, loneliness secondary to siblings leaving for college, an underlying depressive disorder now emerging in a young teen, conflict within the family, or a combination of these issues? Evidence that would support any of these conclusions should be sought by questions directed to the family and to the patient.

The interview of the youth should focus on academic achievements and goals, including an assessment of his current performance and his perspective on the reports of loss of interest in school work. What are his activities other than schooling? What does he do for fun? What are social activities for him and his peers? Is drug use a part of the social scene, and what are his personal attitudes and behaviors relative to marijuana, alcohol, and other drugs? Is he frequently sad? Does he ever think of hurting himself? Besides the recent tension surrounding the discovery of the marijuana, is his relationship with his parents pleasant or abrasive? What is his appraisal of the issues that precipitated this visit to the doctor?

A separate conversation with the parents should be used to ascertain their perspective on their son’s difficulties and their relationship with him. The areas of exploration would parallel the questioning of the boy. Two other issues would also require clarification. Is their anxiety limited to the discovery of marijuana and uncertainties about the consequences of drug use, or do the parents have more general concerns about his behavior or performance? Does the father’s disappointment at being “let down” regarding an “absolutely forbidden” behavior manifest as anger or concern?

The synthesis of information gathered from the patient and the parents will lead toward an appropriate intervention. A spectrum of severity might include one extreme where the youth is emotionally secure and in need of brief office counseling within the capabilities of the general clinician. At the other extreme, there may be evidence of serious depression or other psychopathology requiring psychiatric intervention. It is most likely that the circumstances rest between the extremes and that the patient and his parents would profit from family counseling, which goes beyond the abilities and availabilities of most primary care practitioners.

S. KENNETH SCHONBERG, MD
Division of Adolescent Medicine
Department of Pediatrics
Montefiore Medical Center
Albert Einstein College of Medicine
Bronx, New York

REFERENCES

Dr. Ellen Heyneman
Adolescent drug use does not necessarily imply a primary “drug problem.” Experimentation with drugs is common during adolescence and often begins with “gateway” drugs, such as alcohol, nicotine, and marijuana. Drug use may be a symptom of other problems, such as a preexisting psychiatric disorder. Distinguishing experimentation from substance abuse or dependence may be difficult. Substance abuse suggests loss of control of drug use and adverse consequences, whereas substance dependence suggests a more complete loss of control, with monopolization of time, adverse consequences, and possible physiological changes.1

Obtaining an accurate history of adolescent substance use is essential to the appropriate management of the adolescent. A physician who appears judgmental or critical may be dismissed by the teenager as “out of touch” with the adolescent world and stands little chance of obtaining a truthful history. Adolescents are frequently angry at being brought to the doctor’s office involuntarily and may feel that they are no different than most of their friends. The adolescent, and often the family, may frequently wish to deny or minimize the extent of drug use. While maintaining an index of suspicion, the physician must obtain multiple histories from the adolescent and the family and yet convey a respect for the adolescent’s independence and privacy.

An appropriate assessment should include an evaluation of how the adolescent is functioning at school or work and with family and peers. The adolescent should then be questioned about specific drugs used, frequency, circumstances and mode of use, dosages, and drug effects and reactions, including the adolescent’s impression of both the positive and negative effects of each drug. A psychiatric history, including an assessment for a preexisting mood, conduct or anxiety disorder, attention-deficit hyperactivity disorder, psychosis, suicidality, or history of violence or sexual promiscuity should be obtained. Contributing factors, such as a history of physical or sexual abuse or other recent stressors, should be examined. A history from the family should be obtained, eliciting information about recent changes in the adolescent’s behavior, school performance and attendance, peer group and recent changes, legal problems, criminal behavior, running away, drunk driving, and episodes of intoxication. The level of family functioning, including the family history of substance abuse and parental psychiatric history, should be determined. The family’s level of
recognition and understanding of the adolescent's illness and their ability to provide needed limits and supports and to use community supports should be assessed. A thorough physical examination, including observations of general hygiene and nutrition, physical stigmata of drug use, cough, evidence of self-inflicted injuries or accidents, and signs of drug intoxication or withdrawal, should be performed. Lab studies, including a urine toxicology screen, may be indicated to help identify and monitor drug use. HIV testing should be performed when the adolescent is thought to be at risk.

Determining an appropriate treatment plan or referral for the adolescent requires knowledge of the available community resources, programs, and substance abuse professionals. Comprehensive programs designed specifically for adolescents appear to be the most effective means of providing care and preventive services. The range of services available include outpatient and day hospital programs, self-help groups, therapeutic communities, inpatient detoxification units, and inpatient or residential drug rehabilitation units.

Follow-up by the primary clinical provider is appropriate if: (1) the provider is knowledgeable in the area of substance abuse; (2) substance abuse is intermittent, experimental, and appropriate for age and sociocultural group; (3) no significant psychopathology is present; (4) function in educational, social, and vocational spheres is unimpaired; (5) reasonable progress is taking place in developmental tasks; and (6) no antisocial behavior is present. Adolescents with more severe impairment who do not meet the above criteria should be referred to a specialized practitioner or treatment program. Referral to an inpatient drug treatment program or specialized hospital should occur if: (1) compulsive or addictive drug use is present; (2) there is impaired function in educational, social, legal, or occupational spheres; (3) imminent danger is posed to physical or mental health of the patient; (4) persistent antisocial behavior is found; (5) there has been failure at previous outpatient treatment; (6) there is severe psychopathology; or (7) there is behavior presenting danger to self or others that requires containment or physical restraint.

Ellen Heyneman, MD
UCSD Medical Center and Children's Hospital
Children's Hospital and Health Center
San Diego, California

REFERENCES
The Discovery of Marijuana Use by a Parent of an Early Adolescent
Martin T. Stein, S. Kenneth Schonberg and Ellen Heyneman
Pediatrics 2001;107;971

The online version of this article, along with updated information and services, is located on the World Wide Web at:
/content/107/Supplement_1/971.citation