Adolescence and drug abuse

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"DOCTOR, I think that my child is taking drugs." In this frequently met problem, it is often difficult for the physician to determine what course of action he should initiate. Should he pass such occurrences off as normal behaviour for the youth of today? Should he summon the aid of the law? Should he brand the patient as a drug addict? Is there anything that the family physician can do? Certainly, this is a common problem in adolescent practice. A study early in 1969 by the Alcoholism and Drug Addiction Research Foundation of the Province of Ontario indicated that at least one quarter of the 13 to 20 year olds in school in London, Ontario had had some experience with illicit drugs; this figure is now likely to be much higher.

Adolescent drug consumption falls roughly into four categories. First, there is the normal adventuresome adolescent who samples drugs in his desire to experience new thrills; this individual is generally no problem to the family physician, because he either terminates his drug activity after a few experiences, or continues to use drugs on a moderate basis, similar to the way in which his elders take a social drink. Secondly, there is the adolescent who is drawn into drug use because this is the socially acceptable practice among his friends; often, his succumbing to peer-group pressure is indicative of his low self-esteem, and his use of drugs is merely symptomatic of his difficulty in socializing. Thirdly, there is the adolescent in an identity crisis, who uses drugs in an attempt to unravel his difficulties in coping with life. Lastly, there is the heavy drug user—the addict, if you wish—who uses drugs as a passive escape from the world in which he finds it impossible to live; this individual has a serious problem, and his drug abuse is indicative of his underlying emotional conflict.

To begin, let us talk of the normal adolescent drug experience. With drugs so readily available, all adolescents have the decision to make whether or not to experiment. This dabbling in drugs probably has the same significance as the underage alcohol experimentation that is seen in many youths. When his studies do not suffer, and the individual is able to carry on his daily activities without difficulty, this experimentation is probably of little significance, and hence requires little therapeutic endeavour.

It is often difficult to separate the normal adolescent from the next category—the youth who consumes drugs, not entirely from his own curiosity, but also to become an accepted member of his peer group. Adolescents, especially the younger ones, have a great need to be accepted by their peers, and with a significant number of their friends experimenting with drugs, many are drawn unwillingly into drugs to remain a member in good standing in the group. This peer group pressure constitutes a great problem for the youth on the emotional borderline, the poor socializer who has to do as the group does at all times; because of his inadequate feelings, he is in the greatest danger of falling prey to the disintegrating influence of drugs. This individual requires more attention by the family physician. It is often difficult to determine who is a carefree experimenter, and who is living out a life that is in opposition to his beliefs and wishes, but who feels compelled to be accepted. The latter individual requires counselling.

Thirdly, some adolescents, finding growing up painful, seek refuge in drugs to ease their frustrations and to help them find answers to their endless questions. Adolescence is a period of many changes—physical, emotional, intellectual and social—and it is a

difficult time of life for children from the happiest environment. The younger teenager has a great need to feel accepted; the later teenager, in his painful metamorphosis from child to adult, gains an adult's intellect before the adult's emotional make-up. Drugs are a great threat to the late adolescent in his identity crisis, a normal period through which most adolescents pass. During this, the existentialist period, the youth is obsessed with the problems of the world, and with weighty thoughts as to what his purpose on earth may be, and what he will do with his life. This period of questioning and frustrated bewilderment is a normal phenomenon, and sets the stage for the merging of the adult intellect and emotions into a functional unit. This time of life is difficult to cope with at all times; coupled with drug abuse, this period can be devastating to a developing personality.

Lastly, about five per cent of the 13 to 20 year olds have a serious drug problem; or, more properly stated, they have a serious problem which they attempt to resolve through drugs. The drugs are not the problem in themselves (as evidenced by the much greater number of young people who experiment with them, but do not become addicted); the drug abuse syndromes are merely symptomatic of an underlying emotional disorder that cries for attention. What differentiates the youth who dabbles in drugs in his quest to experience all, and the youth who uses drugs as a passive escape from a world in which he finds it impossible to cope? Statistics indicate that the average curious youth will sample drugs; however, he does not get into trouble unless he has some emotional or adaptive problem for which the drugs offer a passive escape. The prototype of the heavy drug user is the picture of emotional and cultural deprivation; these individuals come, not only from families of low socio-economic states, but also from families where the income and education of the parents may be adequate, but the necessary warmth and family unity are deficient. Deprived at home of the emotional warmth needed to nurture a developing person, these children do not adapt well to school and social life. Because they are so poorly integrated into the traditional life of school and home, and because of an innate desire for acceptance, they quite naturally migrate to the drug subculture of the street, where they simultaneously gain acceptance by other youths such as themselves and chemical escape from the torments of the world in which they do not fit, and in which they are miserable.

The drugs that can be obtained on the illicit market are myriad. Generally, the specific drug that the individual consumes is not particularly significant; although depressed people seem to migrate to the amphetamines, the passives to morphine derivatives and barbiturates, and the confused to marijuana and the hallucinogens, the drug consumption is usually of a mixed type. Whatever drug is most readily available on the street is the drug that is most commonly consumed at that time. The experimenters may try any of the drugs, but seem to settle for marijuana and LSD; however, more than the occasional person drifts into amphetamine abuse because of their mood-elevating effect, which relieves the boredom and frustrations of adolescence. The drugs are not often pure; the street product is commonly contaminated with belladonna derivatives, strychnine, and other dangerous contaminants. Also common are mixtures of chemicals of different types; for example, one may consume what he believes to be metamphetamine, only to find that he has taken an equal quantity of heroin with the amphetamine. Some of the more disturbed become so fixated upon the syringe as a pathway to bliss that they will inject virtually anything that is soluble into their veins to achieve the pleasure of the needle penetrating their skin. Others, recognizing that their drug abuse is really a drawn-out suicide, will try to hasten their death by injecting excessive quantities of the common drugs, or by injecting known poisons.

Let us now turn back to the original question. What can the family physician do? The literature is replete with descriptions of the various effects and syndromes related to the different chemicals; consequently, I shall not deal here with diagnosis of the various

syndromes. In the acute drug crisis—the bad trip—the doctor is usually of little help, except to furnish support to the patient in his disorientation, reaching out to him through the chemical haze to offer help. After the acute situation is over, the patient should be interviewed so that the physician can determine into which of the four mentioned categories the patient falls, and hence, what therapy is appropriate. The physician should neither be alarmed nor accepting; but rather, he should take advantage of his encounter with the patient to try to determine the nature of the underlying turmoil, if such is present. Adolescents usually find it difficult to communicate with adult figures concerning the difficulties which they all have, although they often would like to be able to accept adult counsel; the skilled family doctor can often bridge this communication gap through patience, compassion and warmth. The doctor who is able to reach the adolescent in difficulty is able to advise him in his confusion, and aid him through the metamorphosis from child to adult. Unfortunately, the most seriously disturbed are generally the least receptive to concerned attention; family physicians, working together with social agencies and paramedical personnel who are more closely in touch with young people, can often gain the patient's trust after the ground has been broken by individuals to whom the youth relates more readily. There are many people working with adolescents in trouble who themselves had a difficult time in their youth; accepting referral from such persons, and working with them, will aid the doctor in gaining the patient's acceptance of therapy. The youth who is heavily involved with drugs should have the gravity of his actions and the possible deleterious effects to his health impressed upon him. The counsellor should engage the youth in a close therapeutic relationship, wherein he attempts to turn the youth's attentions to the nature of his underlying problems; in this manner, the patient comes to recognize his problems and to gain insight into them as the first step in coping with them. Through continuing support and by urging insight and a realistic appraisal of the patient's turmoil, one hopes that the patient will become motivated to alter his life pattern of escape and use of artificial aids, and begin to cope with his difficulties in an adult fashion. This reality therapy, as I call it, where the patient comes to identify his problems and to deal with them, rather than to bury them, is very difficult to carry on, and is often quite unrewarding. Nevertheless, with a skilled, compassionate physician who neither censures nor accepts, many youths who might have been permanently lost can be helped to cope effectively with life, and to enjoy it. The family physician who is unwilling to take on this deeper form of psychotherapy by himself can still be of great help to the troubled youth by helping to clear up his misconceptions concerning health, both physical and emotional, and by guiding him to a qualified person for the in-depth counselling. Although adolescents often appear quite knowledgeable, they are often quite ignorant of the basic principles of health, and do not realize that there are trained persons to help them with their physical ailments and their psychological difficulties.

Adolescents are badly in need of family physicians who are sufficiently interested in them to take the time to talk with them. The family doctor can be a valuable person who can treat and counsel adolescents for their physical and emotional complaints, and at the same time can be an educator to the developing individual concerning health and mental hygiene.

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