# The ABC's of Parenting Teens: A Quick Reference Guide

**By Raymond Coleman, M.D.**

Why another parenting "How to…" manual? As a dad and a pediatrician, I have become increasingly aware that parents are often confused about how much to parent! Yet moms and dads still need concise and conveniently presented information on the everyday issues they face with their adolescents. This notebook is presented in that spirit.

Adolescence as a developmental process hasn't changed: "Kids! What's the matter with kids today?," the refrain from the **1960's** musical Bye-Bye Birdie is "time honored." Teens still struggle to separate from parents as they try to establish their own social, moral, and sexual identity. Along the way to becoming independent and competent young adults, they often test parent's rules to the "max": they try on different personalities and life styles for size; they act as if they are indestructible and take risks; they generally challenge the status quo and legitimacy of the preceding generation. For most kids this period of rapid bodily and emotional growth is an ultimately successful, but at times turbulent, venture.

What has changed is the perception that the older child needs less parenting: in reality they may need more! Children hop from the innocence of the elementary school years to the challenge of middle school where the pace of life has sped up. Kids are **first** faced with decisions about drugs, alcohol, tobacco, and even sexuality in middle school, not high school. There is little or no "sanctuary" of middle childhood, and kids need a new competency to be able to handle this unfamiliar and risky environment. (There is also a certain level of parental "cluelessness" as to what their children face at this age).

Suburban teens seem to have ready access to money, automobiles, and too much free time. The high gloss, multi-media environment that parents and children live in seductively lures them all by encouraging alcohol consumption, glamorizing the drug culture, and preaching sex appeal over responsibility: for every one public service announcement touting moderation or underage abstinence, the alcohol beverage industry "counters" with 25-50 commercials promoting their products, and when the old cigarette commercial suggested that young women had "come a long way, baby," it was a correct statement---but in the wrong direction!

Meanwhile, many parents find that they have become participants in a world that is no longer children centered or child friendly. Many Mom(s) and Dad(s) both have to work, and they have to find ways---between the tension of profession/office responsibilities and home---to spend the time (both quantity and quality) with their teens to give them the supervision and input they developmentally require (from their own parents).

It is possible (and appropriate) for parents to define their value systems and consistently communicate with their adolescents, while maintaining the responsibility of knowing where their kids are, who they are with, and what they are doing.

This "dictionary" is not intended to offer a comprehensive discussion of every facet of teen life, nor to duplicate the extensive literature on adolescent growth and development, and behavior. It should provide parents with some timely information and an opportunity to think ahead a little about each topic. Since a lot of the tension between parent and teen is over issues of "territory" and "whose life is it anyway?" this text can serve as a framework for discussions about appropriate expectations and boundaries. It is also predicated on the belief that parents continue to be important role models and still have a significant influence on the behavior of their children: they are capable of helping their teens by being available to talk to them and being around when they are needed. Parents should be empowered to parent. That's what they're supposed to do!

**Revised March, 2012**

## Accidents

Given the feelings of invincibility, the need to take risks, and at times "live on the edge," accidents of all kinds are a significant cause of adolescent injury and death. Poor impulse control and an inability to assess potential consequences are contributing factors. In a review of annual statistics for 2009, researchers from the Centers for Disease Control (CDC) using the Youth Risk Behavior Survey (YRBS) found that for 10 to 24 year olds nearly ¾ of all deaths were caused by four "activities": motor vehicle accidents 30%; other unintentional injuries 15%; homicide 15%; and suicide 12%. Nationwide, 9.7% of students had rarely or not used seat belts; 28.3% had driven with someone who had been drinking; 9.7% had driven in a car one or more times when they had been drinking; 17.5% had carried a weapon; 31.5% had been in a physical fight in the past 12 months. In an ideal world, all teens would wear seat belts, as well as wear protective helmets for motorcycling (31.9% rarely or never), rollerblading, bicycling (84.7% rarely or never), skiing, etc. (Scooter riders need helmets, and snowboarders should don helmets and wrist guards---compared to skiers, they sustain more upper body injuries). Home trampolines require "one on one" supervision, even with safety netting and other precautions.

Adults can teach kids preventative measures about weather conditions, driving, and avoiding hazardous situations---mainly by thinking ahead, concentrating on the task at hand, and having the proper equipment, training, and clothing. Kids need to know that there are times when they are more vulnerable (during illness, when they're tired, in a hurry, or under the influence of medication or drugs).

## Alcohol

Alcohol is the most commonly used and abused drug by adolescents and young adults. According to a 1992 report from the Surgeon General of the United States, underage drinking "is a reflection of social tolerance for illegal consumption, peer pressure, poor enforcement of underage drinking laws, at times parental complacency, a culture that encourages consumption…"

Data on consumption has shown a steady decline since a "peak" in the mid-1990's, which has continued, achieving historically low levels of use and binge drinking. According to the Youth Risk Behavior Survey (2001) 29.1% of those interviewed had their first drink before age 13. 2012 data: each day 4,500 kids under age 16 have their first drink, and each year there are 5,000 underage deaths associated with excessive alcohol intake! (*Washington Post*). In 2011, according to the Monitoring the Future Study[1], 26.9% of 8th graders, 49.8% of 10th graders, and 63.5% of 12th graders had used alcoholic beverages in the previous year, and 10.5% of 8th graders, 28.8% of 10th graders, and 42.2% of 12th graders had been drunk in that same time frame. Binge drinking (5 or more drinks at one time for males, 4 for females) is a phenomenon that has become increasingly common in high school and college. 2011 data---asking about behavior in the two weeks prior to the survey---documented a drop from 1991 to 2011 of 10.9% to 6.4% amongst 8th graders, 21.0% to 14.7% amongst 10th graders, and 29.8% to 21.6% amongst 12th graders. A 1999 survey[2] of 119 colleges nationwide found that 2 out of 5 students surveyed were binge drinkers; rates of abstaining--19%--and frequent binge drinking (defined as 3 or more times in the past two weeks or once a week on average)--23%--were significantly increased over previous surveys. Data from the University of Maryland at College Park[3] suggest an alarming rate of alcohol associated morbidity: in the year of the study 47% of students incurred "1 to 4" adverse experiences from alcohol use (missed classes, trouble with school authorities or the law, property damage, hangover, memory loss, unwanted sexual encounter, etc.)

Alcohol is a potent central nervous system depressant. It blurs judgment and impairs reflexes and motor skills. It is capable of causing coma and death by acute intoxication (there have been several well publicized deaths on college campuses secondary to drinking binges). It places its user in personal jeopardy, while potentially causing injury to others, if that person becomes belligerent or chooses to drink and drive.

---

[1] Monitoring the Future Study, Centers for Disease Control & the University of Michigan: annual statistical review of drug, alcohol, tobacco use

[2] Wechsler et al, Harvard School of Public Health

[3] Center for Substance Abuse Research at the University of Maryland, College Park

- From a legal standpoint, it is against the law for anyone under age 21 to purchase or possess alcoholic beverages.
- It is illegal for anyone under age 21 to drive with a blood alcohol level of .02% or more.
- It is illegal to use a falsified identification card to purchase alcoholic beverages.
- A minor not in possession of alcohol, but in the presence of other minors with alcohol on their person can be charged under the principle of "constructive possession."
- Adults found guilty of obtaining liquor for anyone under age 21 are subject to fines, as well as jail time if convicted of contributing to the delinquency of a minor.

A common scenario: a "chaperoned" party where the parents are "upstairs" and behavior gets out of hand, with uninvited guests and the appearance and consumption of alcohol: neighbors call the police to report the rowdiness and/or kids leaving the party are pulled over for driving under the influence, and the property owners of the party site are charged for contributing to the delinquency of minors (they are responsible for the behavior in their household). Two commonly heard parental refrains about alcohol use are the following:

"I'd rather have my son or daughter drink at home; they're going to do it anyway; this way I know they are safe."

"If I don't allow my son or daughter to go to un-chaperoned parties, they will be socially isolated and miss out on a lot; they have good values, and I trust them to do the right thing."

Parents shouldn't enable teen alcohol use! They should be good role models in demonstrating responsible alcohol consumption. They should be aware of family history (there is a strong genetic and familial tendency for alcoholism). They should be realistic about the availability of alcoholic beverages in their household. They should be absolute about the rule of "no drinking and driving," which should also include not transporting any rowdy or intoxicated passengers---young and inexperienced drivers need to keep their eyes on the road, not on the back seat; other arrangements for transportation can always be made.

The challenge comes in dealing with the concept of "zero tolerance." How do parents help young adults develop good judgment about alcohol use when underage drinking is illegal? Just saying "no" to underage drinking is something we can all sign on to, but it defies reality. Parents have to teach responsible alcohol consumption, which means finding ways of gaining experience with alcohol intake in controlled settings. Parents need to keep the lines of communication about alcohol use open! Denial, or minimizing a problem, is a convenient, but not terribly effective, strategy.

But beware! Several years ago a local newspaper printed a prom season editorial discouraging parents from renting hotel rooms for their kids: the parental intent was to decrease the likelihood of drinking and driving and its sequelae; the "trade off," however, was the potential for high risk sexual activity, violence, and property damage on site in the hotel room!

**Of all the drugs available to teens, alcohol is the one most likely to wreak havoc: the drug most likely associated with an automobile accident, a date rape, an unwanted pregnancy, or the acquiring of a sexually transmitted infection!**

## College---Career

For many adolescents preparation for college is a natural and expected transition from high school, and it begins several years before applying with the taking of the PSAT and SAT exams, much less the importance placed on honors courses, AP classes, and grades. In addition, the rules at home often change during the senior year in anticipation of the freedom of campus life.

Parents can help guide this process by encouraging the importance of becoming a life time learner with enthusiasm for knowledge rather than a grade or an SAT score as an end point. The high stakes game of college acceptance probably needs to be played out as the rules dictate, but it's almost certainly true that an excellent education can be attained at an in-state school at reasonable expense compared to a high priced, prestigious out-of-town institution. (The pressure cooker atmosphere at many schools that **over-emphasizes** the competition to be No. 1 in the classroom, on the athletic field, or on the stage, etc. seems to **de-emphasize** the importance of the more useful life long goals of

personal integrity, commitment to accruing knowledge and wisdom for its own sake, its application to responsible citizenry and community, etc.)

Parents also must be certain that their children have the information they need to be able to function successfully away from home.

From a physician's perspective I would like to have one last opportunity to go over "everything" with the high school graduate, just so I know they understand what they need to know about drugs, alcohol, sex, money, time management, etc. before they march off (regardless of what they should have heard from parents, teachers, clergy, physicians, etc.) More often than not, I'm surprised at what our intelligent offspring don't know!

Some kids may not be ready or interested in a post high school education. Assuming that they are capable, graduation, though, means they should be able to "pay their way" via a full time job with appropriate benefits or job training (or a VISTA or AmeriCorps type program). There may be no other substitute for the experience of working a 40+ hour week to stimulate thinking about future employment goals or desired standard of living needs.

## Communication

For many parents and their off spring the act of conversation seems a lost art! Surveys suggest that parents are not talking to their kids about drugs and sex, etc. to the extent that they should be. When kids run up to their room, slam the door, and turn on their music, parents feel shut out. Parents need to respect their children's space, but they also need to stay engaged, and use the time they have to show interest in their children's activities, to share with them what happened during their day, etc. It's still important for families to sit down and have meals together and to have other "designated" family time(s).

When teens do face parents over an issue, a request, adults often find themselves reacting without thinking: a snap decision is made before they truly appreciate what all the variables are! Therefore, first of all, listen carefully, and then talk. Don't raise your voice; don't get into an act-react mode, don't tease. Try to understand their frame of reference. Mete out your advice and feelings calmly, and, if at all possible, be certain both parents are in agreement—even if this means not giving an immediate answer before checking with a spouse.

A problem that cropped up in our house was the following scenario: my son would at times be confronted with the dilemma of sharing information with my wife and I, and then be faced with various punishments for his actions: "How can I tell you guys things, if I'm going to get nailed?" If parents create a situation where their kids are afraid to talk to them for fear of consequences, they may win a variety of small "battles" where the risks are relatively low, but lose the "war" over major issues. My answer to my son was that my wife and I would always be his best advocates, and would always act in his best interests; this may mean that he still has to face appropriate consequences, but honesty has a way of being rewarded. We hope there will never be a time or situation that he is afraid to come and talk with us.

Writing a letter is also a great way to get your thoughts out in an uninterrupted fashion, and to have a "hard copy" of your feelings and advice:

Dear _____

Because I sometimes have difficulty finding the right words, or time, or place to talk to you……or because both of us may feel awkward about dealing openly with certain subjects, I am writing this letter. There are some things I want to tell you.

Even though times have changed, I have been where you are now. I understand you may very well make decisions with which I disagree, try on a personality or a behavior of which I disapprove, and generally test the borders of my rules to the limits. Wanting to make your own decisions, wanting to be independent and in control of your own person are all normal "rites of passage" to adulthood.

However, my job as a parent is to parent: to set reasonable guidelines and expectations, and to give you all of the information you need to be knowledgeable and responsible, including an understanding and acceptance of the consequences of your actions. I can help by telling you all about tobacco, alcohol, and drugs, and about being sexually active. I would hope this information helps you

make decisions that only you can make about yourself and the things you do, and do not want to do. I will not be there to tell you when to "run with the crowd" and when not to.

I also hope that you would strongly consider abstinence from "all of the above". (It is the safest and only fool-proof policy). I just ask you to be certain that your behavior is worth the potential consequences. The endpoint shouldn't have to be an automobile accident, the acquiring of a sexually transmitted infection, a date rape, an unwanted pregnancy, or a drug overdose. Understand that mixing alcohol or other drugs on top of a situation of which you are uncertain or uncomfortable only increases the chances of making the wrong choice, of being out of control.

There are lots of things I can protect you from, but some consequences are irreversible (personal injury, arrest for illegal activity).

Therefore, I will not put myself in the position of condoning behavior of which I disapprove. I will not allow parties in our home where alcohol or drugs or tobacco are available to you and your friends. Nor will I go along with renting a hotel room after a homecoming dance or a prom. Nor will I accept that going to unsupervised parties or totally un-chaperoned trips to the beach are appropriate at your age.

You and I will have to negotiate the rules we will both follow. You will gain my trust by acting responsibly, and, in return, you will receive the increasing privilege and control you want. Believe me, I really do not want to micro-manage your life! Although I am always around for you, many of these decisions are truly your own.

I am happy to talk with you about anything, anytime, but if you feel you cannot share certain things with me, I want you to know how you can get help, if the need should arise, from a responsible adult in whom you can trust and confide.

I love you very much,

## Concerts

Attending music concerts has become an integral part of the teenage experience. The "givens," however, often involve the presence of illegal drugs on site, and the necessity of high speed, late night driving to and from the usual venues. At what age does a parent feel comfortable letting a teen and his or her friends "take the challenge?"

When my then fourteen year old daughter wanted to hear the Rolling Stones, she was allowed to go with several friends and a parent (lucky father!). She was as impressed with the antics in the audience as much as she was with the music on stage: several kids behind her were passing a joint, and the sparks and ashes were falling in her hair! The presence of adults and police did little to suppress the desire to "light up".

Parents shouldn't put kids in situations that they are not capable of handling. It may be that "tagging along" or driving isn't such a bad idea if it controls some of the problems and provides a filter to prevent other unacceptable activities. The kids certainly won't like the suggestion, but it offers another opportunity to have a discussion about risky behaviors, trust, etc.

## Contracts

There is (at times) an inherent hypocrisy in signing a contract or pledge (they're often made to be broken), but the issues at least are laid out on the table for both parents and teens to see and deal with. Although there may be a desire to have an entirely comprehensive document, it seems more reasonable to have a list of 3-4 items which are most important in terms of health and safety. Expectations about drugs and alcohol and tobacco, car safety, home/school responsibilities, car behavior are areas to be highlighted.

Family Rules

1. Our family is bound by the three C's: Communication, Cooperation, & Courtesy
2. This family adheres to the Honor Code:
   - No lying
   - No cheating

No stealing
No swearing or making obscene gestures
No bodily injury to others
No breaking of Family Rules--even if parents are not present.

3. List of household responsibilities….
4. Allowance/Money: related to #3…
5. Parties: children will only be allowed to attend parties they are invited to, and if chaperoned by a responsible adult.
6. Alcohol, tobacco, and substance use…
7. Automobile privileges…
8. Friends…

Rules can change in the context of a discussion by the family. We love you very much.

## Curfews

Adolescents can get into trouble at any time of the day or night! Setting a time to be home at night has more to do with a parent's need not to have to wait up worrying to all hours of the morning than it has to do with the teen's activities.

However, most states have laws that mandate that provisional drivers have to be off the road by 12 midnight. There also tend to be more drunk drivers on the roads and more hazardous driving conditions in the early morning hours. Therefore, curfews are reasonable, in combination with the obligatory phone call if plans change, or if there is a legitimate reason the curfew may not be met. Talking with other parents in the community may be a good way of deciding on the particular time home limit. Many kids find having a curfew a good way to end the evening, when they are uncomfortable in a particular situation: in that case "it's my parents fault," not theirs!

A technique that many parents use is to ask "yes" or "no" questions or to use a "password" when their child checks in; if there is a problem, arrangements can be made judiciously, without engaging in a potentially embarrassing conversation.

## Dating

Most teens become interested in individual (non-group) dating around age 14-17. Going to movies, the mall, neighborhood parties, maybe school sponsored events as a last resort are the favored activities. Parents can encourage group dating, help chaperone parties, and secure some community standard about supervision at parties. Parents can help sponsor the neighborhood "hang outs" in cooperation with local businesses so teens can have a place to call their own.

Parents need to talk about privacy, intimacy, and sex. Both genders need to be certain that they understand the need to respect each other; and they need to be certain they are in control: mixing drugs and alcohol on top of a social situation only increases the chances of making a bad decision, of being out of control! (2009 YRBS data: 9.8% of adolescents report experiencing a violent act in a dating situation; 7.4% were forced to have sexual intercourse----in the 12 months preceding the survey).

Multi-media set the stage by portraying adolescents in seductive dress and suggestive roles. Dr. Mary Pipher's bestseller, Reviving Ophelia, casts today's environment as an increasingly hostile one for young women.

## Depression

There should be little surprise that the prevalence of depression increases during the adolescent years. Data from the 2009 YRBS: in the 12 months prior to the survey 33.9% of female and 19.1% of male students felt sad or hopeless for two or more weeks in a row, to the extent that they stopped their normal activities. 13.1% of students had seriously considered attempting suicide. Nationwide, 6.3% of students had attempted suicide one or more times. However, the signs of depression, such as significant moodiness, irritability, changing sleeping and eating patterns, and lack of energy may all be part of the "norm" at this age! Parents should be aware of family history. A clustering of symptoms that seem to be affecting what a teen should be doing functionally is cause for evaluation. If anything,

teen depression is under diagnosed, and the erratic behavior that marks bi-polar disorder may be poorly understood and not linked to an underlying mood disturbance that can be successfully treated with medication. Many physicians use an in office questionnaire as a screen (see the appendix and refer to your physician for interpretation). In addition, individuals with depression, bipolar disorder, attention deficit disorder, etc. may be particularly vulnerable to the effects of street drugs.

Parents need a better handle on the various stressors (triggers) that affect their children, and they need to find ways to be on top of changing behaviors.

## Discipline

Parents need to be able to keep their perspective about meting out consequences (you don't gain respect by being all powerful, inconsistent, or excessive): a missed curfew means and earlier time in the following weekend; a lack of performing responsibilities means the suspension of allowance, or decrease in other privileges. The punishment should be specifically directed and self-limited: grounding a child "until the year 201_" doesn't exert much weight. On the other hand repetitive behavior that is unacceptable is met by a suspension of particular privileges "until such time as the teen has changed his or her attitude or behavior." This open-ended approach gives parents more flexibility and doesn't lock them into an arbitrary time frame.

One parent, when faced with a pattern of continual reprimanding and grounding, finally decided to "ground" her daughter to weekends with the family: the idea was initially met with total disdain, but over time, the daughter planned the activities, became less oppositional, and the goals of positive, supervised time, and a return to a semblance of family life normalcy were achieved.

Accept that punishing the teen may at times limit the parent's activities, as well.

Most kids are willing to accept limits and consequences that are reasonable and consistent.

## Dress

Although appearance and clothing may not strictly be parent's territory, there is still some room for guidance. Kids are often dressed like adults from an early age--check out department store fashion guides! Advertising is routinely based on the seductive, or even the "drugee", look with products like "Passion," "Opium," "Obsession," etc. Teens learn to copy what they see around them, and these days TV, movies, music videos, etc. present an enticing array of wardrobe possibilities. Ironically, for all of their need to rebel, teens are great conformists, once they pick a particular "style".

Limit setting on attire, however, seems to be more of a school jurisdictional issue than a family issue: many school districts are considering dress codes. School is a serious place; although there is room for individual expression in apparel, there are certain subjective limits to how outrageous or seductive appearance can be. Parents should draw fairly broad guidelines, with some attention to hair, make-up, body piercing (33-50% of 12-18 year olds have one or more), tattoos (10-16% of 12-18 year olds have permanent markings), as well as recommendations for reasonable school attire; however, this topic may be a "minimal" issue to joust over, except in the extreme.

## Driving[4]

The acquiring of a driver's license is a significant milestone for adolescents. However, traffic accidents are the leading cause of death for teens and young adults: more than 5,000 young people die every year in car crashes and thousands more are injured. Drivers who are 16 years old are more than 20 times as likely to have a crash as are other drivers, with lack of driving experience, tendency not to wear seat belts, speeding, and night driving being significant risk factors.

There are lots of ways to help kids become safe and responsible drivers[5]: adults can be certain teens have enough driving experience by designing driver's education classes with maximum "behind

[4] Adapted from "The Teenage Driver" pamphlet, the American Academy of Pediatrics

the wheel" training; legislators can pass minimum drinking age and zero tolerance laws to decrease alcohol related accidents; parents can insist on the use of seat belts, support curfew laws, and participate in "safe ride" programs that get them involved in offering transportation for parties and proms.

Most importantly, parents can be safe and courteous drivers themselves (there is no room for "road rage"), and they can discuss "house rules" about driving long before their son or daughter acquires a license: they can require good grades (after all, many insurance companies offer discounts for "B" students); they can remind their kids to stay focused and not be distracted by loud music or talking on a cellular phone' they can curtail driving privileges if the rules are broken, even if inconvenient for the parent: car pools or public transportation can be reasonable alternatives; and they can adopt their own "graduated" licensing system:

**STAGE 1**

Teen must have a valid learner's permit.
Teen must drive with a licensed adult driver at all times, preferably a parent.
Teen will not drive after sunset.
Teen and all passengers will wear seat belts.
No use of tobacco, alcohol, or other drugs in the vehicle.
Teen must remain free of tickets and automobile accidents for 3-6 months before moving on to the next stage.

**STAGE 2**

Teen must have a valid driver's license.
Teen must drive with a licensed adult driver during the nighttime hours, preferably the parent.
Teen is allowed to drive unsupervised during daytime hours.
No use of tobacco, alcohol, or drugs in the vehicle.
Teen and all passengers must wear seat belts.
Teen must remain free of tickets and automobile accidents for 3-6 months before moving on to the next stage.

**STAGE 3**

No restrictions on driving as long as the teen remains free of tickets and automobile accidents.
No use of tobacco, alcohol, and drugs in the vehicle.
All passengers must wear seat belts.

**The flurry of recent accidents in the county involving adolescents have occurred in the early a.m. hours, with multiple automobile occupants.**

Parents control the car keys, and they have the responsibility to ensure that their children are safe and competent drivers. In most states parents have the right to have their child's provisional license revoked and parents can request a copy of their child's driving record, as well.

Teens can also contribute to the cost of gasoline and insurance, within reason.

## Drugs

Drugs have become a pervasive part of the adolescent landscape: they're readily available, and illicit drug use by teens ---which had almost doubled between 1992[6] and 2002, had shown a steady decline: for use of any illicit drug in "the past 12 months" for 8th graders a drop from 24% in 1996 to 13% in 2007; for 10th graders, from 39% to 28%; and for 12th graders from 42% to 36%, driven primarily by decreasing rates of marijuana use and concomitant increase in disapproval rates for drug use. However, over the past

[5] Maryland state law requires a period of 4 months before a provisional license can become a permanent license, as well as 30 hours of classroom time and a minimum of 60 hours of supervised driving (must be documented by a parent).

[6] Monitoring the Future study, The University of Michigan

four years use of any illicit drug has begun to rise, primarily driven by increased use of marijuana. In 2011, 50% of high school seniors reported trying an illicit drug at some time, and 25% had used in the previous 30 days. The data for 10th graders, respectively: 38% & 19%; and 8th graders: 20% & 8.5%. Ecstasy is also making a "comeback."

There also continue to be high rates of non-medical use of prescription drugs, particularly opioid pain killers (Vicodin, Oxycontin), as well as sedatives and barbiturates, and stimulants. (Someone in this country dies every 19 minutes from a prescription drug overdose/misuse (Dr. Drew, CNN).

Nevertheless, adolescents continue to be inundated with media imagery that seems to glamorize drug use: our new cultural icons are sports and entertainment "personalities" who often achieve greater notoriety and fame as many go down in flames from their drug abuse (Janis Joplin, Jimi Hendrix, Jerry Garcia, Curt Cobain, John Belushi, River Phoenix, Brittany Murphy, Heath Ledger…….)

Just as chilling is the acquiescence that exists in addressing this problem: didn't many parents experiment with drugs as adolescents? Isn't this just a "rite of passage?" (Although parents may want to share their personal experience with drug use with their children, there is fairly good data to suggest that this kind of "honesty" empowers teen drug experimentation and use. In the end what parents did or didn't do has little to do with today's teens deciding what they will or won't do. Kids need to take responsibility for themselves).

If it is difficult convincing adults about the dangers of drugs, it is even more of a challenge to be absolute about these chemicals with adolescents, who may see many of their peers using, getting "high," and then marching back to school or home with few if any observable consequences.

Are there really problems with occasional (social) use of street drugs like marijuana?

The "bottom line" is that drug use of any kind changes how people experience life around them. Drugs that affect the central nervous system alter the way the user perceives reality, to the extent that what is in fact a distortion becomes accepted as "actual." Relying and acting on this "new" world view commonly puts the user in compromising situations where impaired judgment is a recipe for disaster. The concept of "casual" or social drug use is a semantic construction, just as is the distinction between "hard" and "soft" drugs. What matters most is the effect the drug(s) is having on a given individual's ability to function.

Ironically, of all the interventions adults can make, the following "structural" changes probably could have the most impact on preventing or minimizing high risk behavior: a computerized school attendance system that lets adults know "where the kids are," a closed lunch policy so students aren't allowed to go "off campus" for lunch; and a late bell schedule so that students have a minimum of free time between school release and parents being around for them.

## Marijuana[7]

**Prevalence**: According to the Monitoring the Future Study (national data from the Centers for Disease Control), in 2011 12.8% of 8th graders, 28.8% of 10th graders, and 36.4% of 12th graders had used marijuana in the past year; 7.2% of 8th graders, 17.6% of 10th graders, and 22.6% of 12th graders had used in the "past month;" and 1.3% of 8th graders, 3.6% of 10th graders, and 6.6% of 12th graders had used daily. (YRBS data: 10.2% of those surveyed had tried marijuana by age 13).

**Mode of use**: Marijuana---the active ingredient is delta-9-tetrahydrocannabinol---is a green to grey mixture of dried leaves or flowers from the plant Cannabis sativa. It is usually smoked as a cigarette or a "blunt"---a cigar that has been hollowed out and filled with marijuana instead of tobacco---or in a bong or pipe. There is no certainty of a user knowing the strength or purity of a particular batch (5-15% of marijuana bought on the street may be adulterated with other drugs) ---even if "home grown." Cutting marihuana with PCP or formaldehyde has some popularity, and the response to these combinations can be unpredictable and extremely toxic!

**Pharmacology**: Once a joint is inhaled, cannabinoids are rapidly absorbed, with onset of intoxication or a subjective "high" within minutes. This state may include euphoria, tranquility, time distortion, intensification of ordinary sensory experiences, difficulty in thinking, and relaxation. These effects are

[7] National Institute on Drug Abuse, Infofax: Marijuana
National Institute on Drug Abuse: National Conference on Marijuana use Conference Highlights, 1995

produced by the binding of THC to specific receptor sites throughout the brain, particularly in the cortex (responsible for complex higher cognitive reasoning and function; the hippocampus (important in memory formation, interaction with the neuroendocrine system, and processing of information from the cortex, along with the basal ganglia), and the cerebellum (the processor of cortical information relating to motor function). The lipid soluble cannabinoids bind to the cell membrane and alter cell function in ways that change the regulation and release of neurotransmitters. The development of tolerance may be dependent on an increase of cannabinoid receptors with chronic use. If the definition of an addictive substance is one that produces tolerance, causes compulsive craving and drug seeking and use, as well as a physical dependence and withdrawal symptoms when the drug is not being used, marijuana meets these criteria!

**Adverse Effects**: Continued use may be associated with deterioration in function manifested by an "amotivational" syndrome, impairment of short term memory and recall, paranoia, sleep disturbance, decreased energy, and effects on the secretion of hormones, which may be related to changes in reproductivity, male breast enlargement, and the individual's ability to react to stress. Compared to non-users, young people who smoke marijuana are more likely to have lower achievement scores, higher rates of delinquency and aggressive behavior, greater rebelliousness, and more problems with parents.

Although well defined studies on long term use are hard to come by, anecdotally, it is not uncommon to see a chronic user who is emotionally stunted by his or her drug use; for instance, an 18 year old with a 4 year history of regular use may be the developmental equivalent of a 14 year old.

Studies on women who smoke daily during pregnancy demonstrate sustained effects on the developing central nervous system in their children, who may have deficits in "executive" function, related to pre-frontal lobe activity, an area dense in cannabinoid receptor sites.

A single marijuana joint is equivalent to approximately 4 tobacco cigarettes, and carries even more irritants and carcinogens to the lungs, causing cough, increased mucus production, frequent colds, chronic bronchitis; however, recent studies have not documented any decrease in lung function with moderate use. These effects are mediated in part by the effect of the drug on the immune system: changes in macrophage (scavenger cell), T-lymphocytes and B-lymphocytes modify the ability of these cells to perform their designated protective functions.

**Screening**: Marijuana can be screened for in the urine; it can be detected 4-30 days after last use depending on the pattern of use. (There are a variety of ways to test for drugs, including some "home kits" using hair, urine, or residue---available at drug stores and/or the Internet). Urine testing is the most common and is reflective of recent drug use. The specimen is usually collected under direct observation to ensure the reliability of the sample. Users believe they can affect the sensitivity of the test by diluting their urine by drinking large volumes of fluid---tea, and other high caffeine soft drinks are favorites---or by using herbs like golden seal---available at markets, health food stores, etc. A "negative" test does not guarantee a "drug free" state. It is also important to know the sensitivity of the lab test being run: marijuana can routinely be screened for by kits detecting at the "20-100 nanogram" range. If you are suspicious, opt for the more sensitive test. In the end, a child's behavior is the best indicator of continued drug use.

(The controversy over the de-criminalization or legalization of marijuana and/or its medical usefulness for conditions such as chemotherapy induced nausea and vomiting, HIV wasting, glaucoma, etc. tend to confuse the argument about drug safety for both teens and adults: marijuana, like any other drug, has significant side effects along with potential advantages. The medical benefits are probably exaggerated[8], but not necessarily insignificant, relative to alternatives---more effective pharmaceutical agents---but the "down" side has to be factored into the equation!)

## Inhalants[9]

Inhalants are chemicals that can be inhaled to produce a variety of central nervous system effects. Since they have properties similar to anesthetic agents, they tend to slow down body function.

**Prevalence**: In 2011, according to the Monitoring the Future Study, 7.0% of 8th graders, 54.5% of 10th graders, and 3.2% of 12th graders had used these chemicals in the previous year. The increased use

[8] Marijuana can decrease the abnormal eye pressure of glaucoma, but a patient would need to smoke a joint every 2 hours around the clock to get adequate drug effect; the mentation and mood changes that accompany drug use also limit its application in many patients.

[9] National Institute on Drug Abuse, Infofax: Inhalants

amongst younger teens attests to the fact that these substances are inexpensive and readily available as components of common household items, such as solvents, glues, gasoline, cleaning fluids, aerosols (nitrous oxide as the propellant), paint thinners, correction fluids, etc.

**Adverse Effects**: Inhalants cause intoxication rapidly after use; there is a narrow margin between desired drug effect and toxicity (hearing loss, limb spasms, bone marrow suppression, liver and kidney damage, blood oxygen depletion, and central nervous system damage). Death from inhalants is caused by a high concentration of fumes. The use of plastic or paper bags to inspire inhalants increases the risk of suffocation. Breath odor may provide a clue to use.

**Screening**: There is no practical way of testing for exposure to inhaled drugs; look for redness and irritation around the mouth from "huffing."

## Cocaine[10]

Cocaine, whether as a powder, free base, or "crack", is a potent, addictive central nervous system stimulant that is commonly sniffed, snorted, or smoked.

**Prevalence**: In 2011, according to the Monitoring the Future Study, 1.4% of 8th graders, 1.9% of 10th graders, and 2.9% of 12th graders had used the drug in the previous year.

**Pharmacology**: Cocaine interferes with chemical transmitters in the brain that are associated with pleasure (dopamine). Physical effects caused by the drug: dilated pupils, increased temperature, heart rate and blood pressure, and weight loss. The faster the rate of absorption, the more intense is the immediate euphoria caused by the drug, but the shorter the duration of action.

**Adverse Effects**: Because tolerance develops rapidly to the cocaine "high," users seek, but often fail to achieve, the pleasure they crave, causing continued use even in the face of devastating physical and social consequences. Users can experience paranoia, aggressive behavior, and severe depression when drug use is interrupted. Prolonged snorting can cause ulceration of the nasal lining; cocaine related deaths are often the result of cardiac arrhythmia and arrest or seizures.

## LSD[11]

LSD (lysergic acid diethylamide) is a hallucinogen. It is commonly sold in tablet or capsule form, or as a liquid impregnated on absorbent paper. It is colorless, with a slightly bitter taste. It is usually taken by mouth.

**Prevalence:** Data from the 2011 Monitoring the Future Study reported that 1.1% of 8th graders, 1.8% of 10th graders, and 2.7% of 12th graders had used LSD, or "acid" in the previous year, a light upward trend.

**Pharmacology:** The drug has onset of action within 30-90 minutes after ingestion. The physical effects include dilated pupils, increased body temperature, pulse, blood pressure, and sweating, sleeplessness, dry mouth, and tremors.

**Adverse Effects:** The user may experience rapid emotional mood swings, and delusions and visual hallucinations which can cause panic, as well as terrifying thoughts, fear of death, and despair---a bad "trip." Users lose a sense of time and "self." These effects may begin to clear within 12 hours. "Flashbacks"---often rapid onset recurrences of part of a previous drug experience---occur without re-exposure to the drug and can be disorienting and frightening.

LSD is not considered addictive, but it does produce tolerance. Fatal accidents have occurred during states of intoxication.

**Screening:** Urine testing for LSD is possible, but technically difficult.

## Methamphetamine[12]

Methamphetamine is a potent stimulant that has greater effect on the central nervous system than amphetamine. It is highly addictive. It is referred to as "speed", "meth", or "ice" or "crystal" in its crystalline form.

---

[10] National Institute on Drug Abuse, Infofax: Cocaine

[11] National Institute on Drug Abuse, Infofax: LSD

[12] National Institute on Drug Abuse, Infofax: Methamphetamine

**Prevalence:** In 2011, according to the Monitoring the Future Study, 0.8% of 8th graders, 1.4% of 10th graders, and 1.4% of 12th graders had used crystal methamphetamine in the past year.
**Pharmacology/Adverse Effects:** Methamphetamine releases high levels of brain neurotransmitters that enhance mood. The drug is usually taken by snorting or ingestion, or by smoking, allowing the user to experience an intense "rush"---a short lasting, but highly pleasurable sensation. Wakefulness, increased activity, decreased appetite, and euphoria are common drug manifestations. The drug can also cause irritability, confusion, seizures, anxiety, and paranoia. Methamphetamine can cause direct damage to brain cells, and can produce a Parkinson's Disease-like state. The increased blood pressure and heart rate caused by the drug are also associated with stroke, as well as cardiovascular collapse and death.
**Screening:** Amphetamines can be detected in the urine within 48 hours +/- of use.

## Ecstasy[13]

MDMA (methylenedioxymethamphetamine) is a mind-altering drug with hallucinogenic and amphetamine-like properties.
**Prevalence:** In 2011, according to the Monitoring the Future Study, 1.7% of 8th graders, 4.5% of 10th graders, and 5.3% of 12th graders had used the drug in the past year, a slight and continuing upward trend since the previous surveys.
**Adverse Effects:** Problems associated with drug use include confusion, depression, sleep disturbance, anxiety, paranoia, nausea, blurred vision, faintness, chills, sweating, as well as increased heart rate and blood pressure. Like methamphetamine it can cause direct damage to the nerve cells which are responsible for regulating aggression, mood, sexual activity, sleep, and sensitivity to pain. The drug is commonly used at raves and rock concerts. Because the drug causes teeth clenching and grinding users commonly employ baby pacifiers to prevent dental injury; Prozac is also used to modify the drug's effect.

## PCP[14]

PCP (phencyclidine) is a powerful and addictive hallucinogen commonly available as a bitter tasting tablet, capsule, or powder. It is normally smoked, snorted, or eaten. When "cut" with marijuana, it is referred to as "boat."
**Prevalence:** Monitoring the Future Study data from 2011 report 1.3% of 12th graders had used PCP in the previous year.
**Adverse Effects:** The drug can have highly unpredictable effects, and has the reputation as a drug that may not be worth the risk. However, users may experience a sense of increased strength, power, and invulnerability. Increased heart rate and blood pressure are pronounced; numbness and motor incoordination may occur. Users can become exceedingly violent or suicidal. High doses of PCP can cause seizures or coma. Death most often results from accidental injury or suicide during intoxicated states.
**Screening:** The drug can be detected in the urine.

## Heroin[15]

Heroin is a highly addictive substance processed from morphine, a naturally occurring component of poppy plant seed pods. Street names include "smack," "skag," "H," and "junk."
**Prevalence:** According to the 2011 Monitoring the Future Study, 0.7% of 8th, 0.8% of 10th, and 0.8% of 12th graders had used the drug in the previous year. However, the trend is changing: in 1988 the mean age of use was 27; by 1995 the age of self-reported users had dropped to 19! The drugs on the street are also purer and cheaper, with intravenous use and "skin popping" being replaced by snorting.
**Adverse Effects:** After a "hit" the user feels a surge (rush) accompanied by a warm flushing of the skin, dry mouth, and a feeling of heaviness of the extremities. The user will often "nod" off, with alternating periods of wakefulness and drowsiness. Mental functioning becomes clouded due to the central nervous

[13] National Institute on Drug Abuse, Infofax: Ecstasy
[14] National Institute on Drug Abuse, Infofax: PCP
[15] National Institute on Drug Abuse, Infofax: Heroin

system depression. Tolerance is common, with increasing dosage required to achieve a particular "high." Withdrawal can lead to severe craving, restlessness, muscle and bone pain, sleeplessness, and cold flashes with goose bumps (going "cold turkey"). Major withdrawal symptoms peak within 48-72 hours. Heroin is the second leading cause of death from drug overdose. It is also associated with spontaneous abortion, collapsed veins, hepatitis C, etc.
**Screening:** Heroin may show up in the urine within 48 hours of use.

## Ketamine[16]

Ketamine hydrochloride (Special K, new Ecstasy, Ketalar), widely used as an animal tranquilizer, is a powerful hallucinogen. It is usually snorted or smoked. According to data from the 2011 Monitoring the Future study, 0.8% of 8th graders, 1.2% of 10th graders, and 1.7% of 12th graders had used the drug in the previous year.
**Adverse Effects:** The drug effect can include profound hallucinations, such as visual distortions, and lost sense of time, sense, and identity. Duration of effect: 30 minutes to two hours. It is commonly used in the "rave" scene, along with other drugs like Ecstasy and cocaine.

## Rohypnol & GHB[17]

Rohypnol (flunitrazepam) is a sedative related to, but much stronger than, Valium. It is not legally available in the United States and is known on the streets as "roofies", R2, and the "forget pill." Data from the 2011 Monitoring the Future study: 0.8 % of 8th graders, 0.6% of 10th graders, and 1.3% of 12th graders acknowledge experience with Rohypnol in the previous year; and 0.6% of 8th graders, 0.5% of 10th graders, and 1.4% of 12th graders with GHB.
**Adverse Effects:** It causes a sleepy, relaxed, and drunk feeling that lasts 2-8 hours. Because it is a tasteless and odorless chemical that can be slipped into an alcoholic beverage, rohypnol has developed a reputation as the "date rape" drug: within ten minutes of ingestion, the victim may feel dizzy, disoriented, have difficulty speaking and moving, and then pass out. They will have no memory of what happened while under the drug's influence.

Because of its use in combination with other drugs, it can be a dangerous depressant.

GHB (gamma hydroxybutyric acid), a drug occasionally used to increase muscle mass, is available in liquid and powder from. It is also tasteless and has reportedly been used in cases of date rape. The FDA has reported an increasing number of GHB related illnesses (nausea, vomiting, respiratory problem, seizures, and coma).

## Steroids, Androstenedione, Creatine[18]

According to the 2011 Monitoring the Future Study, 0.7% of 8th graders, 0.9% of 10th graders, and 1.2% of 12th graders had used anabolic steroids in the previous year. This represents a slow decrease that counters an earlier upward trend in use, spurred by the popularity and promotion of a variety of muscle building supplements, and in keeping with the just published Mitchell report on steroid use in major league baseball players.

Anabolic steroids are chemicals related to testosterone, the male sex hormone produced by the testes and adrenal glands. They increase muscle mass and allow the user to attain a competitive advantage, but at a cost of interference with normal growth and the potential for the development of mood disturbances, acne, and tumors of the liver. They are banned from all organized sports.

Androstenedrione (andro) is a precursor hormone in the production of testosterone. Proponents of andro claim that the body converts the supplement into testosterone, thereby allowing athletes to train

[16] Partnership For a Drug Free America: Drug Resource Net: Ketamine
[17] Partnership For a Drug Free America: Drug Resource Net: Rohypnol, GHB
[18] Mayo Clinic: On Line Health Oasis" Muscle Building

harder and recover more quickly. However, there are no scientific studies documenting a mechanism of action. Androstenedione can be found in meat and some plant products. The concentrated form available in pills may have a variety of unwanted side effects. Many team physicians and other representatives from sports teams have recommended it be banned from all competitive sports.

Creatine is a chemical that can increase short term bursts of muscle power. It is also felt to be able to increase lean muscle mass. It works by making more fuel available to muscles for activities of short duration like weightlifting and sprinting, and by reducing waste products. It is thought to be able to enhance performance and decrease fatigue. Creatine is regularly produced by the liver and is available in meat products. It is stored in muscles and excreted by the kidneys. Concerns about creatine relate to the lack of knowledge about long term use: can the kidneys handle increased loads over time? What are the effects on adolescents who assume that if one tablespoon a day of supplement is good, three tablespoons may be better?

Creatine and andro, as well as "newer" steroid precursors, are not regulated like other drugs, and there are no assurances about the purity of products purchased. In the end, there are no easy alternatives to dedicated fitness training. Supplements are needlessly expensive and potentially dangerous chemicals; that's the bottom line!

## Other Drugs

Common "over the counter: medications, as well as prescription drugs can also be abused:

In Montgomery County, Benedryl (diphenhydramine) is increasingly associated with automobile accidents; 25 mg is equivalent in sedative effect to one beer, and it is often used in combination with alcohol.

Dextromethorphan can be concentrated into a dry powder and snorted, and as such, has hallucinatory properties.

Pain killing narcotics like Vicodin (hydrocodone) and Oxycontin (oxycodone) in 2011 had been used in the past year by 2.1% of $8^{th}$ graders, 5.9% of $10^{th}$ graders, 8.1% of $12^{th}$ graders, and 1.8% of $8^{th}$ graders, 3.9% of $10^{th}$ graders, and 4.9% of $12^{th}$ graders respectively (Monitoring the Future data). These drugs can cause constipation, nausea, sedation, dizziness, headache, sedation, and severe respiratory depression leading to death; they are also highly addictive.

Dexedrine and Ritalin. Although not often abused by the individual to whom the medication has been prescribed, if snorted can have powerful amphetamine effects: Ritalin, like cocaine, is exceedingly irritating to the nasal lining. (There are no specific rules in either public or private schools that mandate supervision of afternoon doses of stimulants: students, with parental permission, can medicate themselves. Physicians should be more insistent that designated health care personnel take responsibility for meting out "in school" medication.)

*Salvia*, a plant related to garden annuals, contains naturally psychoactive chemicals that are hallucinatory; has become increasingly popular (1.6% of $8^{th}$ graders, 3.9% of $10^{th}$ graders, and 5.9% of $12^{th}$ graders report use in the "past year." In the 2011 survey)

Chemicals marketed as "bath salts"---not sold for human consumption---with names like Ivory Wave, Bliss, White Lightning, etc. when snorted (the common mode of use) can cause PCP-like hallucinogenic effects. The active ingredients are methedrone and MDPV, and have been responsible for an increasing number of ER visits secondary to adverse reactions.

"Legal" smokable herbal blends that mimic the effects of marihuana are increasingly popular (and responsible for adverse reactions requiring ER visits). A brand name product, K2, or "spice," contains synthetic chemicals designed to act on cannabinoid receptors in the brain. It is undetectable on drug screening and more potent than natural "weed." 11.4% of $12^{th}$ graders use in the 2011 survey.

One tool to assess the likelihood of problems with drugs is to use the **CRAFFT** questionnaire: "Have you ever ridden in a **C**ar driven by someone, including yourself, who was "high" or had been using alcohol or drugs? Do you use alcohol to **R**elax, feel better about yourself or fit in? Do you ever use alcohol or drugs while you are by yourself or **A**lone? Do you **F**orget things you did while using alcohol or drugs? Do your **F**amily or **F**riends ever tell you that you should cut down on your drinking or drug use?

Have you ever gotten into **T**rouble while you were using alcohol or drugs? (An answer of "yes" to two or more questions suggests the need for further assessment).

## Eighteen

For many adolescents 18 seems the "magic" number: they're no longer minors; they're legal. They can sign themselves in and out of school without parental consent. They feel empowered!

In reality, turning eighteen means more responsibility and more liability. They can be tried in adult court, not juvenile court. They have to act their age!

## Enabling

Parents are, at times, part of the cure as well as the problem: enabling refers to behavior that---on the surface---may seem appropriate or protective, but which is often destructive by shielding the adolescent/young adult from the natural and logical consequences of his/her behavior. Some of the actions parents may need to take are counter intuitive to their idea of what it means to be nurturing, but action or inaction that ultimately validates unacceptable behavior (denial, minimizing, etc.) doesn't lead to healthy resolution of the problem and may make things worse!

## Family Values

Although "family values" have recently taken on political or religious connotations, they are simply those ethical constructs that parents feel most strongly about. In an ideal world parents would sit down and define their values and make certain they are properly conveyed to their children, not as Puritanical overseers, but as the natural handing down of family traditions and core "rules of living" beliefs, such as honesty, fair play, being responsible for your place and space, healthy mind, healthy body, etc.

## Food

Adolescents need a healthy caloric intake to grow, with representation from the 4 major food groups: breads, grains cereals and pasta; fruits and vegetables; dairy products; proteins: meat, poultry, fish, eggs, nuts, beans. An erratic and unpredictable lifestyle, the rushing out the door in the morning without breakfast, the dependence on and convenience of "fast food" during the rest of the day, the emergence of the "couch potato" syndrome and overeating and obesity on one hand and dieting and eating disorders (anorexia nervosa and bulimia) on the other all take their toll on the young adult's body. Adolescents also tend to drink too much soda and juice and eat fewer portions of fresh fruits and vegetables than recommended.

As a general rule, the body has inherent hunger and thirst mechanisms that need to be fulfilled. An appropriate caloric intake is a necessity, whether it's a "high protein" regime favored by athletes, or a vegetarian menu. Young women need approximately 2000-2200 calories per day on average, while boys may require 2500-3000+ calories depending on activity and growth. These intakes may provide enough iron, calcium, protein, and fiber but a multi-vitamin, particularly for menstruating females, is recommended, with emphasis on increasing vitamin D (400-800IU/day) and calcium (1300mg/day); other special "nutritional" supplements don't hold any advantage to common sense intake of normal foods.

The recent phenomenon of increasing obesity in all segments of the population needs to be addressed by our adolescents: the consumption of soft drink and juices (as well as sports drinks) provide essentially wasted calories along with the "super size" credo of fast foods, compounded by a dramatic fall off in meaningful exercise. These trends put our kids at significant risk, with or without family history, of developing high blood pressure, diabetes, heart disease, etc.

Rapid alterations in body weight should be a warning sign under any condition and need to be dealt with by a physician.

## Limousines

Limos are a favored means of transportation for Homecoming and Prom celebrations. Most companies have strict policies about alcohol, drugs, and tobacco not being allowed in the vehicle. Drivers will often alert a responsible adult, if there is a problem. However, it may be wise to be certain about individual company policy when the contract is signed. In addition, a list of people to be transported and an itinerary of destination, as well as drop off and pick up points and times is advised.

## Medical Care

Although they are not financially responsible, teens can come to the physician's office by themselves and enter an examining room knowing that they will be treated and that confidentiality (within limits) will be observed. (Confidentiality is broached **only** if the physician thinks there is an imminent risk to the adolescent's health).

Parents are usually requested to leave the examining room when the child is age 11-12. The pre-teen then begins to take on greater responsibility for his, or her, own health care and in communicating with the health care provider. Most physicians use a combination of direct interviewing and written questionnaire to get the information they need about the adolescent. (The teen is reassured that these questions are asked of everyone; and that the doctor has not been "put up" to any specific item by a parent). Even if the adolescent decides not to answer the questions honestly, he or she knows that the issues are "okay" to discuss with the physician.

## Money

Adolescents do better if they either earn part of their allowance by performing reasonable chores around the house, or by holding down a job for extra cash. Although parents basically take care of all of their fundamental needs (food, clothing, and shelter), teens can apply their own funds towards the cost of additional clothing, gas, auto insurance, entertainment, etc. Giving kids carte blanche access to money for any request doesn't build responsibility and discipline, and sets them up for over spending when they head off to college, having never been given the opportunity to budget or use financial discretion.

## Music/Media

There will always be a difference of opinion about music appreciation between one generation and the next! Big band, swing, and jazz gave way to rock and roll, and heavy metal and gangsta rap become the rage of the MTV "X" and "Y" generations. Although there has always been some controversy about music lyrics, for the most part the problem with the recent trend in popular music---at least as demonstrated by hard rock---seems to be its association with violence, misogyny (hatred of women), and intolerance. Heavy metal and rap videos are far more likely to show even young children carrying a weapon, and there is little doubt that these images (as well as those on video "games") are particularly powerful in de-sensitizing children and teens to the realities of violent behavior, as well as helping to form attitudes about sex and drugs (other common themes).

Although parents don't have the stamina or time to screen everything that their kids listen to or see, they do need to understand the impact of various form of media on their children. The total amount of time kids spend in front of a television or a computer monitor is commonly in the 3-4+ hours per day range, not including use of cell phones to talk/text, access the internet, etc. There may be useful activities in progress, but there is mounting evidence that the sheer amount of time engaged in these behaviors can potentially blunt emotional development by decreasing the opportunity for other kinds of activities that are responsible for personal growth.

Additionally, the Internet opens up a world of incredible access to information, as well as inherent dangers: exposure to pornographic material, loss of confidentiality in "chat" rooms, "over exposure" on video programs such as YouTube and Facebook, etc. Adolescent's use of these new media tools needs to be monitored discreetly, as well as cell phone use and the phenomenon of "texting." The principal at a local high school---in response to a "sexting" scandal---suggests that parents (who pay for the cell phone service) should dramatically limit use, charge the phones in their room at night, and have the right (decided upon when the teen gets the cell phone) to review the call list: something worth discussing, as is the

balance between privacy and reasonable supervision. Talking about being a good "digital citizen" or a "digital code of ethics" has to start early. **The most important things happen "off-line!!"** See the index for some references that might be helpful.

## Negotiating

Rules will change as children grow; parents need to be able to make reasonable adaptations to "house rules" as the child shows the capacity to take on more responsibility. The question may be what is appropriate behavior for the 14-15 year old, much less the 2nd semester senior? Networking with other parents in the community may serve as a bench mark of establishing and evolving standard of privileges and expectations. But in the end, parents are supposed to parent, and most teens will continue to respect limits that are reasonable and consistent.

## Over-Parenting

For many parents it is natural to want to micro-manage every aspect of their children's lives. Although this may have been an appropriate strategy for the younger child, it becomes increasingly problematic in the middle school and high school years when the need to separate from parents is a developmental imperative for the teen. A well meaning, but constantly hovering, parent may inhibit the process of a child's climb toward accepting responsibility on one hand, and push a child to "over shoot" in the attempt to separate from parents on the other: if the parent doesn't understand or respect the adolescent's need for some "territorial imperative," some kids rebel to this infringement by moving away from the family (and its values) at break neck speed.

Teens need parents to be around more than ever, and supervision is still a necessary parental responsibility; but so is giving teens some space of their own: this balancing act may be the true test of effectively parenting the adolescent.

## Parties

In an ideal world all parties should be chaperoned and drug, alcohol, and tobacco free. In the real world there is an excellent chance that teens will frequent parties not supervised by responsible adults, much less that drugs and alcohol may be available even if there is a chaperone on site!

It may be easy to "lay down the law" that your child will only attend chaperoned get-togethers, and that parents will go to every effort to "check out" party locales; however, it may not be totally feasible to "bring this off" and there is something to be said about defining your expectations for your child, and accepting a certain amount of "trust."

It is important for parents to talk with other parents about what is an acceptable standard of behavior for parties; keeping eyes open and listening to the last minute rumors that spread around school as the weekend approaches may also be good barometers as to what to expect on a Friday or Saturday night. Many communities also have confidential police "hotlines" to call in to report a rowdy party in the neighborhood.

In another "real life" scenario, a planned co-ed sleep over after a homecoming dance changed course when kids brought in drugs and alcohol after the chaperoning parents went off to bed: these parents had given their guarantee to the other parents that the kids would be safe and everything would be above board---in their house; one of the kids who didn't like the situation left and informed his parents, who were then left with the dilemma of remaining "mum" or confronting the other parents, and holding up their son to the wrath of his peers. It should come as no surprise that many parents would choose not to "rock the boat" in this instance. However, if adults do what they are supposed to do, it's always easier for the kids to get the right message, to hold up their end of the bargain!

## Peers

Parents can't always pick their children's friends, but they can get a sense of which crowds they approve of---realizing that even the most clean-cut, up front appearing kids can be "bad news"---and try to steer their children in a healthy direction. In other words, "peer pressure" can be positive or negative.

In high school peer groups are often centered around particular activities, such as sports teams, music and drama groups, etc. Kids who are busy and goal directed often are less likely to get into trouble.

A good way of approaching a lot of these issues is to get together with the parent(s) of your child's friends and discuss expectations, "common ground," values so there can be some consistency in approach from household to household.

## Respect

Respect is a two way street! Rebellion is a normal part of adolescent adjustment, but this does not mean that civility and understanding between parent and child aren't in order.

## Responsibility

Sometimes it's best to let kids weather the consequences of their behavior instead of parents trying to intervene to "lessen the blow." Growing up means learning to deal with the lessons of reality, and parents who always come to the rescue don't advance this needed life skill. Parents are always there in the background, and they're unlikely to let their kids get in too far over their heads. But at the high school level, teens should be able to get up in the morning, feed themselves, get to school on time, do their school work, do their laundry, keep their place and space reasonably tidy, and obey reasonable house, school, and community rules. They need to become good organizers of time; they need to be reliable, and honest. Failure to conform to expectations or standards should trigger a "logical" or "natural" response from a parent, school, etc.

As children demonstrate responsibility, parents grant increasing privilege and opportunity. Inherent in that responsibility, however, is the need to take ownership of one's behavior, without externalizing blame.

## School Work

Parents can put their children in a place where they have all of the resources to succeed academically, but parents can't do the work for their children. Students can be evaluated for learning disabilities; they can be tutored, taught good study skills, provided with reference materials, computers, extra time to complete assignments, tests, etc.

Parents "riding shotgun" at this age is---more often than not---a set up for confrontation: our kids need to take responsibility for their studies. If the worst that can happen is a poor grade or a failed course, it is better that it should occur at this level than later.

## Self-Discipline

Developing self-discipline may be the most essential of all protective "traits," the ability to delay immediate gratification, to let the other guy go first, to control one's temper, etc. In any real life situation, whether it's being in an agonizingly slow check-out line at the grocery store or at a party where lots of people are drinking, drugging, or smoking, the power to allow the body to relax, to fend off intimidation, to "hold the line" on the side of conscience versus temptation, is a basic self-survival skill.

In a world where children are confronted with the "image is everything" credo of mass marketing, where there seem to be few if any consequences to even flagrant misbehavior, where what was unacceptable a decade ago may now be calmly accepted as the "norm," teaching children self-discipline is far from an easy task. However, parents' teaching by example still goes a long way.

## Sex

Adolescents are sexually active. The most recent survey reported in the Centers for Disease Control's MMWR Surveillance Survey for 2007 indicate that 7.1% of students had sexual intercourse for the first time before age 13; 45.9% of female adolescents and 49.8% of male adolescents are sexually experienced and approximately one third had sexual intercourse in the three months prior to the survey.

Additional perspective from the Guttmacher Institute: By age 15, only 13% of never married teens have ever had sex, but by the time they reach 19 seven in ten have engaged in sexual intercourse. Most young people have sex for the first time by age 17, but they do not marry on average until their mid-twenties: this means that young adults are at risk of unwanted pregnancy and sexually transmitted infections for nearly a decade! Of those currently "active" 61.5% report either they or their partner had used a condom during last sexual intercourse, while 16% had used birth control pills; 14.9% of those surveyed had had intercourse with 4 or more partners during their life. An estimated 34% of girls in the U.S. will experience a pregnancy by age 20, and most of these pregnancies are unintended (twice the rates of Canada and Europe). (22.5% of those currently sexually active had drunk alcohol or used drugs prior to last sexual intercourse, and, again, 9.9% of students report some form of dating violence, and 7.8% had been physically forced to have sexual intercourse.)

Each day (data from the "Day in the Life of the American Child" from the Children's Defense Fund---2009) 1,210 babies are born to teen mothers. In 2006 (Guttmacher Institute data) there were 200,420 abortions among 15-19 year olds: 27% of pregnancies in this age group ended in an abortion..

It has been estimated that as many as 25% of adolescents develop a sexually transmitted infection prior to graduating from high school. Approximately one in four new HIV infections occur in young people between the ages of 13 and 21[19]. (Data from an inner city population in Baltimore, Maryland, documented 14-15 year olds as the most common age group to contract Chlamydia infection, a sexually transmitted disease).

Although most school systems have health curriculums in place, it is still a vital parental responsibility to talk about human sexuality. Other major sources of information about sex come from TV sitcoms, movies, and music videos where the message is often one of seduction, extra-marital sex, or irresponsible sex: adults having unprotected, casual, "spontaneous" sex. Sex as a normal and healthy part of a committed relationship, where both love and planning have a role, doesn't have the same audience appeal. For better or worse contraception never is dealt with.

Whether parents believe that abstinence is the safest and most fool proof, as well as the most moral standard, they still need to talk---in the same breath---about "safe(r)" sex. Teens need to know that latex condoms provide excellent, but not complete, barrier protection against most sexually acquired infections, particularly HIV, Syphilis, Herpes, Gonorrhea, and Chlamydia infections---but not human papilloma virus (the cause of venereal warts). Condoms when used by themselves, however, do not provide adequate protection against pregnancy: the woman should be on birth control pills or using other forms of female contraception, as well. If contraception techniques fail, teens need to know about the availability of "morning after" medication---essentially double dose high estrogen birth control pills. If there are new symptoms suggestive of an STI---sexually transmitted infection--- (although many significant infections can present without symptoms), they need to know how to get confidential treatment ASAP---adolescents can legally receive advice and treatment for these conditions without parental consent.) **THOSE ARE THE FACTS.**

(A vaccine that prevents human papilloma virus---HPV---is being recommended for females age 11-12+: the vaccine provides effective protection against the most common strains of the virus, with the main intent on being the prevention of cervical cancer later in life related to HPV infection acquired earlier in life. The vaccine also is effective in preventing genital warts, but does not preclude the need for routine PAP smears; males also should be vaccinated for protection against genital warts, as well as the longer term risk of developing HPV related cancers (prostate, penile, oral…) At present we are screening sexually active adolescents for HIV, syphilis (blood test) and Chlamydia and gonorrhea (urine test).

Researchers still fight the myth that talking about sex makes kids more promiscuous. There is also little data to suggest that education alone has much impact on reducing high risk sexual activity, but parents need to take more responsibility in dealing with adolescent sexuality from the standpoint of communication and explanation: they can't assume their kids have the information they need! Later initiation of sexual activity is positively correlated with religious beliefs, being a better student, and a healthy parent child relationship; overbearing and overly strict parenting is just as likely to have a negative effect on this behavior as is permissiveness. (In addition, parents need to be aware of the phenomenon of oral sex in middle school, as well as the practice of auto-erotic asphyxiation---occlusion of the windpipe to produce euphoria, which has been associated with several deaths in the metropolitan area over the last few years).

[19] From information provided by the American Academy of Pediatrics

## Supervision[20]

What is appropriate behavior for 14-18 year olds? Having an adult around is the "norm," while going to the beach, Cancun, or Florida totally un-chaperoned isn't! This is a hard topic to sell to both parents and teens, and, of course, the issue of "trust" gets thrown in to confuse the issue.

The October, 1997 *Washingtonian Magazine* published an "expose" on the experience of "beach week." Many parents view this excursion as a "rite of passage." They understand that their kids have worked hard to graduate and are now ready for the pay-off relaxation they have earned on the shore. But what is acceptable? Who will chaperone? Is it necessary?

Reasons for: they'll be off to college soon, without any curfews or supervision. Why not let them have a "fling?"

Reasons against: since the place the kids will stay in at the beach will either be a family owned condo or rental facility (which an adult usually has to sign for), parents carry a responsibility and a liability for what goes on at that premises, a situation quite different from the activities of their children on campus (where kids are totally responsible for their own behavior). Beach week is not a disaster waiting to happen, but high risk behavior is more the rule than the exception. Why enable behavior you find unacceptable?

Parents have to decide for themselves what they will and won't allow, based on their own experience with their children, the amount of liability they're willing to accept, and common sense! They should go in with their eyes open and meet the problem straight on with their kids: denial or minimizing doesn't go very far in problem solving high risk adolescent behavior, nor does the "we've all been there and done it" ethic: times have changed!

## Territory

Despite "some of the above," dress, appearance, state of room, and school work are not usually parent's territory. Parents can do everything they can to give their adolescents the resources they need to be healthy and to succeed, but the kids have to do the rest, including an acceptance of the consequences of their behavior as the trade off for the "room" they request.

## Time

Children have lots of free time; they go to school early, and many come home early to an empty house. Beware of the "B" word: **BOREDOM**. Parents have to find ways to supervise their children as best as they can.

## Tobacco[21]

Tobacco products kill more than 430-440,000 Americans a year---a rate of more than 1,200 people each day---more than all deaths from alcohol, heroin, crack, automobile and airplane accidents, murders, suicides, and HIV combined. Each day 3,800 children in the United States begin to use tobacco, and each premature tobacco related death is "replaced" by two new smokers under age 25.

According to former FDA Commissioner David Kessler, "…while the epidemic of disease and death from smoking is played out in adulthood, it begins in childhood… (A) person who hasn't started smoking by 19 is unlikely to ever become a smoker. Nicotine addiction begins when most tobacco users are teenagers, so let's call this what it is: a pediatric disease."

Tobacco products are often the first "drug" experimented with in adolescence. It is also true that teens who smoke are about 8 times as likely to use illicit drugs and 11 times as likely to drink heavily as non-smoking youth. Therefore, adolescents who smoke "mark" themselves as risk takers, and aside from the significant down sides of smoking, parents need to view this activity as one possibly connected to other high risk behaviors.

- The average teen smoker begins at age 13 and becomes a daily smoker by age 14.5. 9 in 10 current smokers started before age 18. According to the 2011 Monitoring the Future Study, 18.4% of 8th

[20] From information provided by the American Academy of Pediatrics
[21] Advocacy Institute: Supporting the FDA Fact Sheet, 1995 & Report of the Surgeon General, 2012

graders, 30.4 % of 10th graders, and 40.0% of 12th graders had "ever" smoked. 6.1% of 8th graders, 11.8% of 10th graders, and 18.7% of 12th graders had smoked in the month prior to the survey. 2.4% of 8th graders, 5.5% of 10th graders, and 10.3% of 12th graders smoked daily, a continuing decrease in use from 2000! (2009 YRBS data: in the 30 days preceding the study, 8.9% of teens used smokeless tobacco and 14% smoked a cigar—at least once in that time frame).

- More than 800,000 middle school students and 3 million high school students smoke; almost 80% of daily smokers in high school still smoke into adulthood.
- In 1992, approximately 2/3 of adolescent smokers reported that they wanted to quit smoking.
- Tobacco advertising makes a difference: the tobacco industry spends $27 million a day; messages appealing to young people---but not necessarily targeting them according to the companies---are prominently displayed in retail stores and online.

The average smoker spends about $900-$1200 per year, while incurring throat and lung irritation, chronic cough and increased mucus production, bad breath, and frequent colds and respiratory infections. The long term threat of throat and lung cancer is too distant to frighten the adolescent smoker: they know all about the "down" side of smoking; they're just not ready "now" to quit!

## "A Tale of Tobacco"

Both of my parents smoked into their 30's; they quit when confronted with information linking tobacco to cancer and emphysema. Like many curious teenagers, I tried smoking "on for size" in high school and college, but never smoked more than a pack in my whole life.

My children received the standard anti-tobacco lecture; we were an outdoors family and respected the environment and clean air; our children were brought into the world with healthy bodies, and they were expected to take good care of themselves. My son would even run up to teenagers he found smoking and scold them (he was 9!)

But he started smoking, probably around 14, anyway (despite intermittent asthma that would occasionally leave him breathless).

Smoking became more than a habit; he started having frequent coughs and colds, but nothing too severe. After all, lots of kids smoked; it was easy to bum cigarettes; he was part of a club. Heck, he even received literature in the mail from pro-smoking rights groups.

Things became somewhat more complicated this fall however. His cough was more frequent, and he started having chest pain. A trip to the local ER revealed pneumonia. He started taking antibiotics, and he tried to cut down on his smoking. After initially feeling a little better, the chest pain became incapacitating. A new X-ray demonstrated a buildup of fluid in his lungs: he had a complicated infection. After two needle aspirations of his chest cavity, a thoracic surgeon inserted an endoscope into the right side of his chest tube to break up the pockets of fluid and free the lining of his lung. My son was in the hospital with a chest tube and intravenous antibiotics for another 4 days. The general anesthesia, the constant pain, and the threat of more extensive surgery should the condition recur motivated him to start wearing a Nicoderm patch (to prevent nicotine craving): he had decided that maybe smoking wasn't such a good idea after all! His girlfriend also decided to give the patch a try.

After about a month of medications and not smoking, he is just beginning to feel better. He used the nicotine replacement patch for three weeks and is now "going it alone" despite occasional cravings. Somehow, even though lots of kids in his college dormitory smoke, he has no desire to begin again. Although the kind of infection he had can also occur in non-smokers, I don't think he has any hesitation understanding that in his case tobacco was the culprit! It's amazing that his friends who smoke aren't impressed with his illness enough to quit themselves. Apparently, everyone has to experience things for themselves!

Hopefully, my son was lucky. His lungs should be close to normal in another 3-5 years without more exposure to tobacco. His girlfriend feels better and smells better, too. I hope other friends don't have to learn the hard way.

It's important for teens to "kick the habit". Although it is possible to quit "cold turkey," the addictive properties of nicotine are far more likely to be overcome successfully utilizing a nicotine replacement medication (skin patch or chewing gum) combined with individual and group support and

counseling. Most programs run 6-8 weeks. They have been successfully set up on site in high schools (where the kids are) or offered through community based organizations like hospitals and lung associations. Relapse initially is not uncommon, but an increasing number of motivated kids are able to become tobacco free!

## Trust

Despite the need to be around for their teens, unless they plan on being 24 hour a day bodyguards, parents have to rely on "trust" to a greater or lesser extent.

According to Webster's Dictionary, trust is defined as "assured reliance...a confident dependence on the character, ability, strength, or truth of someone or something." Trust is earned when the ability to accept responsibility for individual actions is demonstrated, and when kids are dependable. Trust is like a bank account: if the teen has played by the rules and acted reliably, he or she can withdraw from his or her "trust" account when special situations arise, when an additional privilege is desired. However, if an agreement is broached or a promise broken or---worst of all---the teen lies, the account is "closed" and doesn't re-open until an entirely new track record has been established.

## Violence

The United States has as many firearms as households (200+ million), and, according to a 1996 study by the Centers for Disease Control, had the highest rate of childhood homicide, suicide, and gun-related deaths of any of the world's 26 richest countries[22]. Violence is not something that just happens in the inner city. Knives and firearms show up in suburban schools with increasing frequency, and fighting and taunting language are a common part of the high school landscape[23]. Movies and music videos---usually hard rock and heavy metal---help "set the stage" by portraying increasingly violent images often involving young children. Each new "sequel" ratchets up the mayhem to keep up with an audience steadily desensitized to the "usual" violence offered in earlier productions.

Schools now offer "conflict resolution" programming to deal with the phenomenon of anger control amongst students. The schools of the future will probably be equipped with metal detectors!

According to data from the Children's Defense Fund's 2011 Archives, each day in America:

5 children die from abuse or neglect; 2,058 are reported abused or neglected
5 children or teens commit suicide
8 children or teens are killed by firearms
32 children or teens die from accidents
186 children are arrested for violent crimes

**So what's the "punch line"?: parents need to be around for their adolescents. They can facilitate responsible and healthy growth by providing a nurturing and supportive environment, by allowing teens the opportunity to do what they are capable of doing for themselves, by not permitting them to be in situations they are not yet ready to cope with, by not confusing "trust" with age appropriate expectations and, most importantly, by letting them accept the consequences of their actions.**

**Even if you do "all of the above" there are no guarantees, but parents can be proactive in thinking ahead and continuing to guide the growing up process of their children in positive ways. It seems like the better approach in helping to build healthy, competent, and successful young adults.**

---

[22] From information provided by the American Academy of Pediatrics

[23] This section was written prior to the incident at Columbine High School outside of Denver, Colorado, the Virginia Tech incident……

**Patient Health Questionnaire (PHQ-9)**

**NAME _____ DATE _____**

Over the *last two weeks*, how often have you been bothered by any of the following problems?

| | | Not at All | Several Days | More than Half the Days | Nearly Every Day |
|---|---|---|---|---|---|
| 1 | Little interest in doing things | 0 | 1 | 2 | 3 |
| 2 | Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3 | Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4 | Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5 | Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6 | Feeling bad about yourself – or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7 | Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8 | Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9 | Thoughts that you would be better off dead, or of hurting yourself in some way | 0 | 1 | 2 | 3 |
| | Add columns: | | | | |
| | Total: | | | | |

| | | |
|---|---|---|
| 10 | If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? | Not difficult at all _____<br>Somewhat difficult _____<br>Very difficult _____<br>Extremely difficult _____ |

# Resources

| | |
|---|---|
| Mothers Against Drunk Driving (MADD): www.madd.org | 214-744-6233 |
| Tough Love and Tough Love Manual | 800-333-1069 |
| National Clearinghouse for Alcohol & Drug Information | 800-729-6686 |
| National Institute on Drug Abuse, Infofax | 888-644-6432 |
| Outward Bound | 800-243-8520 |
| National Outdoor Leadership School (NOLS) | 800-710-6617 |
| | |
| Alcohol Hotline | 800-252-6465 |
| Alanon Hotline | 800-366-2666 |
| Cocaine Hotline | 800-262-2463 |
| AIDS Hotline | 800-342-2437 |
| National Runaway Hotline | 800-231-6946 |
| | |
| "You Can Quit Smoking" Brochure" | 800-358-9295 |

*Parent to Parent: Raising Kids in Washington,* Parents Council of Washington

*Reviving Ophelia* by Dr. Mary Pipher

*All Grown Up and No Place to Go* by Dr. David Elkind

WEBPAGES:

www.healthychildren.org

www.youngmenshealthsite.org

www.youngwomenshealthsite.org

www.chop.edu click "health information"

www.hazelden.com

www.drugfreeamerica.org

www.nida.nih.gov

www.mayohealth.org

www.readytoquit.com: to stop smoking

www.athinline.com bullying/texting info

www.urbandictionary.com texting lingo

www.netlingo.com "

www.askthe judge.com juvenile justice/rights

www.stopsportsinjuries.org