

RECREATIONAL VERSUS MEDICINAL USE OF MARIJUANA

Even people who have no knowledge of the newest drug on the market for pain or disease likely grew up with knowledge about marijuana, just as they may have known about tobacco (*Nicotiana tabacum*) and the alcoholic beverages that are made from numerous plants. People who are using marijuana have a story to tell their nurse, pharmacist, or behavioral health practitioner. The first step in the care of the person using marijuana is to gather that story, which is the natural history of his or her use. Because marijuana has a large variety of applications, this section provides the first information a healthcare professional needs when caring for the user: knowledge about the plant and its traditional use.

Marijuana has four basic uses, as food, fiber, recreation, and medicine. It can also be used in excess, resulting in substance abuse. However, the boundaries between the various uses can be blurred. It is not always easy, for example, to distinguish recreational and medicinal use of whole marijuana leaf or seed. The difference may be determined best by the intention and practice of the user. Terence McKenna (1992, p. 163) suggested that the employment of the term “recreational” when applied to substance use “trivializes the cognitive impact of the substance used,” and that “low doses of most drugs that affect the central nervous system are felt by the organism as artificial stimulation or energy, which can be directed outward in the form of physical activity in order both to express the energy and to quench it.” However, “recreational use” is still a term used globally to describe the purpose of becoming intoxicated (using marijuana to “get high”) for personal amusement rather than for a health concern. People often choose to self-prescribe marijuana for recreational use. But people also consciously self-care or self-medicate with marijuana. There is an entire subculture today that promotes daily self-medication with marijuana (usually through smoking), just as there was a hashish-eating culture before the 19th century.

Some people perceive marijuana as a contributor to human society’s evolution to greater peace and tolerance. Two of the authors who have been recognized as providing some of the best insights into marijuana’s history of use are ethnobotanist Terence McKenna and author Martin Lee, 1994 winner of the Pope Foundation Award for Investigative Journalism. McKenna,

renowned for his work on plant hallucinogens, writes of marijuana in his book *Food of the Gods* (1992) that, although people tend to focus on episodes of intoxication when talking about plants/drugs like marijuana, individuals regularly use plants like marijuana – as well as other less intoxicating plants such as coffee (*Coffea arabica*) and tea (*Camellia sinensis*) that best ensure a response such as energy stimulation, relaxation, or mood elevation. When OHCPs ask about their self-medication patterns of use with tobacco, alcohol, and caffeine, people may reveal a regular history of use. McKenna writes that, “Plant use is an example of a complex language of chemical and social interactions. Yet most of us are unaware of the effects of plants on ourselves and our reality, partly because we have forgotten that plants have always mediated the human cultural relationship to the world at large” (McKenna, 1992). Marijuana use can thus be seen as yet another mediator of that relationship. Marijuana users have not forgotten the time-honored relationship with medicinal plants; they actively and consciously engage in it. Some even capitalize on it.

Healthcare professionals, who prescribe drugs or herbs in their practices, may advise and prescribe marijuana for medicinal purposes in states where it is legal to do so and warranted in care. Martin Lee, in his 2012 book *Smoke Signals*, writes that in the 19th century it was common physician practice to prescribe marijuana. The toxicology of a plant, as well as its history of safe use in a particular manner, is a consideration in risk-benefit shared decision making. Toxicology is determined not only by the constituents in a plant but also by the responses of the humans who use the plant. Healthcare professionals are challenged to understand the health behaviors of people engaged in plant use, especially when the healthcare professional has not experienced use of the plant. Because marijuana is currently an illegal substance under federal law, many healthcare professionals may not have firsthand experience with the effects of marijuana. Psychoactive plants such as marijuana, along with the user’s quest for an altered state of consciousness and possible involvement in a lifestyle that includes daily use, pose unique challenges to healthcare professionals.

Some marijuana users extend their partnership with marijuana well beyond nutritional, recreational, and medicinal use. Marijuana can be a substance of misuse, becoming habitual and detrimental to life, leaving the user unable to stop using even when it is identified as causing problems. Research suggests that between 9% and 30% of marijuana users may develop some degree of marijuana use disorder (NIDA, 2017c). People who begin using marijuana before the age of 18 are 4 to 7 times more likely than those who start using marijuana as adults to develop a

marijuana use disorder (NIDA, 2017c). There are no reports in the United States of anyone dying from marijuana use alone (NIDA, 2017c); however, people do report disturbing effects, such as anxiety and paranoia. There is an increase in the reports of such adverse effects to emergency departments, thought to be related to the rise in marijuana food manufacture and the cultivation of plants with higher THC levels (NIDA, 2017c).

According to the United Nations Office on Drugs and Crime (UNODC), as of 2015 there were some 183 million users of marijuana, roughly 3.8% of the global population, making marijuana the most widely used illicit drug in the world (UNODC, 2017a, 2017b). In the Western Hemisphere, marijuana use is on the rise. Estimates for the Americas show an increase from 37.6 million people (or 6.5% of the population aged 15 to 64 years) who used marijuana in 2005 to 49.2 million (or 7.5% of the population aged 15 to 64 years) in 2015 (UNODC, 2017a, 2017b).

Persons who stop using marijuana after a long period of use can have withdrawal symptoms like those of nicotine withdrawal: irritability, sleep problems, anxiety, decreased appetite, and craving – which can be the impetus for relapse. Withdrawal symptoms, however, are generally mild and peak a few days after use has stopped. They gradually disappear within about 2 weeks (NIDA, 2017c). Currently no medications have been approved by the FDA for treating marijuana use disorder or addiction, although promising research is under way to find medications to treat withdrawal symptoms such as sleep disturbances and to ease cravings and other effects of marijuana (NIDA, 2017a, 2017c).