SOC 3290 Deviance
Lecture 26: Drug Use 2

In the last class we considered some of the myths about drug use, analyzed the effects of various illegal drugs, and examined the connection between these, AIDS and crime. We also looked at the extent of illegal drug use. Today we will continue by looking at the characteristics of drug users, the process of becoming a drug user, theories of drug use, and various policy responses to the problem of illegal drugs.

A Social Profile of Drug Users:

The poor, particularly poor minorities, are considerably more likely than the non-poor, the middle class, or the affluent to use illegal drugs. But the poor are not more likely to use all kinds of drugs. Research has shown that socioeconomic groups often differ from each other in the type of drugs they are likely to use. Moreover, within each group, not all members use drugs. Which, then, are more likely than others to use drugs? Research has uncovered certain social and social-psychological characteristics that distinguish users from others.

The first of these relates to the connection between socioeconomic status and drug types. Generally, those with higher status (on education, occupation and income) tend to use certain drugs, whereas people of lower status use different ones.

There is, for example, a strong connection between higher status and marijauna: the higher the status, the more likely is pot use. It is particularly popular among college students, for example.

On the other hand, heroin is the most popular drug among lower status people, particularly those who live in poor, inner city neighborhoods (e.g. Vancouver's downtown East side). The affluent and their kids typically stay away from heroin, and this has long been the case - even in the 1960's. But since the mid-1990's more affluent whites have turned on to heroin - mainly because the drug is frequently becoming pure enough to snort or smoke with no risk of AIDS.

Cocaine has long been associated with the affluent because of its high cost, but cost has gone down, and there are now new forms, such as crack, that have increased its use among the poor. In fact, crack is now often called "the poor person's drug."

As for the newly popular drugs, such as speed and the date rape drug, the former seems to have a special allure among the working class to achieve euphoria, lose weight, enhance self-confidence and increase energy. The latter appears popular with young drinkers for its parallel - but more potent effect.

It must be noted, however, that regardless of the drug in question, the use of a particular

drug doesn't necessarily mean that the user uses or will continue to use only that drug. Moreover, under peer influence, they may graduate from using relatively soft drugs to harder ones. All the same, most users tend to favor a certain drug over others.

As for the social and social-psychological characteristics, these also help distinguish drug users from non-users. First, males are more likely than females to use drugs, reflecting a greater tendency among males to engage in deviant activities. Indeed, the more deviant the drug use, the greater the gender difference becomes (they are only slightly more likely to use drugs at all, but much more likely to use them regularly, and extremely more likely to use them so heavily that they become addicts). Secondly, young people are more likely to use drugs, older teenagers have the highest use, followed by young adults. This can be attributed to freedom from parental supervision and, more importantly, freedom from inhibiting adult responsibilities such as employment, marriage and raising kids. Research has long shown, for example, that the unemployed, unmarried and childless are more likely than those with jobs, spouses and children to use drugs.

Next, drug use is related to parental and peer influences. Users are likely to have parents who use legal drugs such as tobacco, alcohol, and prescription drugs for relieving tension and combating insomnia. Users this first learn from parents to use legal drugs before turning to illegal ones. Users are also more likely than non-users to have poor relationships with their fathers. When used for the fist time, the drugs are usually given by friends, and users generally have at least a few friends who use the same drugs. Continued use also depends significantly on their friends' drug use.

Third, among high school students, drug users more often cut classes or skip whole days of school, are more likely to drop out, have weaker commitment to religion, and go out evenings for fun and recreation more often. They are thus less strongly tied to the school, church and home.

Finally, among college students, drug users are more likely to have majored in the social sciences, fine arts and humanities than in the natural sciences. They are also more likely to favor liberal politics, to be estranged from religion, and to have a generally permissive and anticonventional outlook. In short, they are more likely to be non-conformists than conservatives. Not surprisingly, then, many young people who smoke pot today, for example, are children of the baby boomers who took to pot as their "drug of defiance" against conventional society.

Becoming a Drug User:

Chein et. al. (1964), in a classic study of heroin use, identified four stages in the process of becoming involved with the drug: (1) *experimentation*; (2) *occasional use* (once a week or less); (3) *regular use* (once a day or more); and (4) *futile efforts to break the habit*. It was noted that a user may go through all these stages or may stop at any stage. A person may experiment but not repeat. Another may use heroin occasionally, but never regularly. A third may become a

regular user but manage to break the habit. And a fourth may go through all the stages, become hooked, and be unable to break free. Among the users of various drugs, heroin users seem most likely to escalate to this last stage of addiction, with users of other illicit drugs more likely to remain in the earlier stages.

Heroin is most addictive not only because of its chemical properties but, more importantly, because most users are relatively poor and use the drug to cope with the stresses of their life problems like low pay, unemployment and racism. Since the relief from the drug is fleeting and the stresses always recur, extended use of heroin is likely to occur; and since the drug is highly addictive, its users have the greatest chance of getting hooked. Conversely, users of pot, cocaine and other drugs may be less likely to get addicted because - as surveys show - they are mostly young people who use drugs as part of their recreational activities and social lives - not to get away from problems. Thus, without the compulsion to use drugs to deal with difficult, intractable problems, they are more likely to remain occasional users.

Whatever stage drug users may end up in, how is it that they get involved with drugs in the first place? They usually have been offered the drug by their friends in a simple, casual way (e.g. at a party). Contrary to the stereotype, it isn't the stranger who acts as a "pusher" to urge drugs on the innocent young: it is their friends.

Once having tried the drug, would-be users go through a learning process - with explicit or implicit instruction from their drug-introducing friends. Becker (1963) for example, has identified 3 steps in the process of learning to become a marijuana user: (1) *learning the technique* to get high (e.g. don't smoke a joint like a regular cigarette, watching your friends or being told to inhale deeply and hold it); (2) learning to *recognize* the drug's effects (e.g. rubbery legs, the "munchies," and unawareness of the passage of time); (3) learning to *enjoy* the drug effects (e.g. dizziness, thirst, misjudging time and distance, or sensing things in strange ways may be initially seen as unpleasant by novices, who have to learn to redefine these sensations as pleasurable through friends' encouragement).

With the use of cocaine, heroin, or other illegal drugs, the beginner may also have to learn the first step (techniques), but the second and third steps may not be *as* necessary because the effects are usually more clear-cut and predictable than the effects of marijuana. In virtually all cases of initial cocaine use, for example, the user feels its effect as extremely pleasurable - hence no need for users to learn to recognize and enjoy the drug effects.

What Causes Illegal Drug Use?

Theories designed to explain why some individuals are more likely than others to use or abuse drugs may be divided into three major types: biological, psychological, and sociological. Biological theories see the causes of drug addiction in factors like an inborn high tolerance for drugs or a metabolic disorder that creates a craving for an illicit drug. Psychological theories see the causes of drug use in specific personality traits such as low self-esteem or unconventionality.

Sociological theories see drug use as stemming from social forces, such as the drug subculture or peer influence.

The biological theories are the least credible, as they have failed to be supported by scientific research. Moreover, the so-called biological causes could well be the effects of drug abuse - not the cause. However, there are ample data to support the other two types of theory, and we will discuss three specific examples.

First, economic deprivation theory, rooted in the work of Elliott Currie (1993), notes that 40 years of accumulated research points to the fact that drug use and abuse is intimately related to conditions of mass social deprivation, economic marginality, and cultural and community breakdown. He further explains why poor people turn to drugs in response to poverty-related social conditions. First, drugs can fulfill the need for status: denied status in conventional society, being in the drug culture is like being a movie star in the local area - so many people depend on you. Second, drugs help the user cope with the harsh, oppressive realities of poverty. Third, drugs provide a sense of structure or purpose to shattered lives, riddled with monotony, unemployment and an unstable family life. Fourth, poor communities are relatively saturated with easily available illicit drugs, so it is easy to drift into use without considering the consequences. In sum, grinding poverty can push people to use drugs as a way of meeting normal human needs that have been systematically thwarted by society. Such a theory may be useful in explaining drug use among the poor, but useless for explaining it among the affluent.

Secondly, cognitive association theory attempts to explain drug addiction. Lindesmith (1968) argues that addiction only occurs when there are effects that follow the removal of a drug, the user recognizes that these are withdrawal effects, and the drug is subsequently used to alleviate these. Lindesmith has collected convincing data to support the theory. He found that among patients who had been given morphine to kill their post-surgery pain, some later became addicted while others did not. The difference had to do with whether the patients knew that their nausea and other symptoms were caused by their suddenly discontinuing the use of morphine. Those who did cognitively associated these unpleasant feelings with their prior use of morphine, and ended up addicted because they demanded more. In contrast, the other patients who had the same symptoms without knowing the cause of it did not become addicted - they had been assured by the doctor that such discomfort was normal for a patient recovering from surgery and that it would eventually stop by itself. Hence, these patients “toughed it out” rather than demanding more morphine.

Thus, according to this theory, the cause of addiction is the user’s cognitive association between withdrawal distress and prior drug use. To further back this up, Lindesmith notes that the mentally ill, the mentally challenged, young children and animals usually are immune to addiction because they cannot understand the meaning of withdrawal symptoms, even if it is explained to them. The theory can also explain why people with average intelligence can easily get hooked on drugs once they experience withdrawal distress. However, a deeper reason may also be that, in a modern, hedonistic society, we want to eliminate distress instantly rather than

stoically endure it until it passes.

The third theoretical approach we will consider is social-psychological theory. This provides essentially a variety of social and psychological factors that lead people into drug use. Among the sociological factors, some come from the wider society, others from the individuals most closely associated with potential users. A prime example of societal factors is the legal drug culture in our society. Alcohol, tobacco, and prescription drugs are pushed on the general public either directly or indirectly. The alcohol and tobacco industries spend large sums each year on advertizing, and the pharmaceutical industry sends sales representatives into doctor's offices with lots of free samples to push on patients - and now they're advertizing directly to consumers as well. Moreover, the general public demands these drugs to help ease their aches and pains, psychological stresses, a sense of social incompetence and awkwardness, or merely existential emptiness or boredom. Given this drug culture, many people become accustomed to using legal drugs - which make it easier to try illegal ones. This is why many people use illegal drugs only after they have drunk or smoked, and see peers and role models like parents doing the same - "My parents drink, why can't I toke?"

Other social factors that more immediately sway individuals towards drug use can be drawn from various deviance theories. These factors include: (1) lack of attachment to conventional persons or institutions; (2) having friends who use drugs; being a member of a drug-using subculture; and (4) easy access to drugs.

As for the psychological reasons behind drug use, research has found the following factors important: poor self-concept, low self-esteem, or self-rejection; feelings of distress, powerlessness, or hopelessness; being unconventional or rebellious; receptivity to uncertainty, risk-taking, or new experience; and expecting drugs to enhance status or mitigate life's problems. Clinical evidence adds that people with people with a certain type of personal problem tend to prefer one drug after experimentation with various substances, and to use it regularly because it helps relieve their specific problem (e.g. heroin is used by the restless, aggressive or angry to mellow themselves out; cocaine by the depressed, shy, or bored to give themselves energy, self-assurance and sociability).

The "War on Drugs":

As I noted last class, historically the "war on drugs" has turned out to be a war on powerless group, particularly minorities.

The earliest attempts to battle drug use appeared in the form of city ordinances against opium dens in San Francisco, soon followed by other U.S. cities. In both Canada and the U.S., the custom of opium smoking had been introduced by Chinese coolies, unskilled laborers who were imported to work on the railroads. At first, these opium dens were tolerated. But soon the Chinese labor pool was seen to present a threat to the white labor market because they were hired to work long hours for low wages. White laborers started a campaign against the Chinese and their opium dens - which "enticed little white boys and girls into becoming opium fiends." In

Canada, federal drug laws against opium were similarly instituted after a 1907 Vancouver labor riot against the Chinese, in which the opium dens made a convenient political scapegoat. In either case, these anti-opium laws were, in practice, anti-Chinese laws. In the U.S., Congress passed a law in 1909 prohibiting the importation of opium for smoking, followed by the Harrison Narcotic Act in 1914 - which prohibited the sale or possession of opium and its derivatives. By this time, a socially undesirable class, including prostitutes, thieves and hoodlums had been known to use the forbidden drugs and therefore became known as “dope fiends.” In contrast, opiate users of higher social status were largely unaffected by the law since they were able to legally obtain the drugs from their physicians for “legitimate medical purposes.”

Around 1900 in the U.S., many state laws and municipal ordinances were also enacted against cocaine. These were, in reality, antiblack laws. In those days, cocaine was widely used by blacks, but whites feared, among other things, that it could “spur blacks to violence against them, stimulate sexual assaults on white women, improve marksmanship, make them invulnerable to bullets, give them superhuman strength, and make them more cunning and efficient.” The anti-cocaine laws, then, were meant to control blacks and “keep them in their place.”

Then, in 1937, Congress passed the Marijuana Tax Act (in Canada, pot was added to the earlier list of prohibited drugs in the 1920's without debate, following agitation by Emily Murphy in her serialized book “The Black Candle”). This anti-marijuana law was, in effect, an anti-hispanic law. Mexican migrant workers in the Southwest had been known to smoke pot, and Anglo-Americans had spread rumors that it led them to commit violent crimes.

In the 1950's, the social problem of heroin use was blamed on the communists, who were believed to push heroin as part of their conspiracy against the West, and the death penalty was imposed in 1956 in the U.S. for heroin peddling.

In the 1960's, horror stories about the effects of marijuana and other illicit drugs were widely publicized (e.g. being blinded by staring at the sun while on acid; shaving oneself bloody; the baby sitter baking the baby rather than the turkey, etc.). Drug laws and enforcement were intensified as a result, serving to punish youth who dared reject conventional values, scorn the establishment, or protest the Vietnam War. Interestingly, in Canada, despite the LeDain Commission’s (1970-71) report urging decriminalization of marijuana, the government refused to abandon their tough, criminal policy.

Since the late 1960's, however, large numbers of conventional, middle-class whites have used drugs, particularly marijuana. Many celebrities and successful, respectable people have turned cocaine into a status drug. Drug use has stopped being associated exclusively with powerless minorities, anti-establishment youth, and social undesirables. Hence, today affluent and respectable drug users are more likely to go free or receive light sentences, while minorities continue to suffer the brunt of anti-drug law enforcement efforts.

Punitive Strategy: Law Enforcement:

Compared to their affluent and white counterparts, the poor and minority drug users are more often arrested or imprisoned (e.g. in the U.S., African-Americans and Hispanics; in Canada, individuals of African, Aboriginal and Oriental backgrounds). Moreover, they tend to receive much loner sentences than well-off white offenders. All this suggests how today's law enforcement against drugs continues the historical pattern of drug laws against minorities. Law enforcement does more than discriminate, it worsens minority drug problems by siphoning off funds that could have been better used for drug education and treatment programs in the communities where the problems of drug addiction are most concentrated, and such programs are most needed.

Law enforcement is also aimed at poor countries that produce most of the illicit drugs consumed in the West. Persuasion, money, foreign aid, threats to oppose international loans, even soldiers have been employed against countries that fail to reduce drug production. In addition, the U.S. Customs Service and the Canada Customs and Revenue Agency, along with many others, have often made the news by intercepting large shipments or busting distribution networks.

All the same, illegal drugs are still easily available on the street, for the most part because as long as the demand for them is great, there are always some countries and many smugglers to supply them.

The Debate Over Legalizing Drugs:

The apparent failure of the law-enforcement approach has led to calls for legalization of some - or all - drugs. Advocates of legalization argue that, like prohibition in the 1920's, current drug laws do more harm than good. They are said to generate many crimes, including homicide, since addicts are driven to associate with criminals to obtain the drugs, and to become criminals themselves to finance their habit. Drug laws are also said to encourage official corruption because huge profits from drug sales enable the criminals to bribe police to "look the other way." By legalizing drugs, it is argued that the government can take away obscene profits from drug traffickers, end police corruption, and reduce crime drastically. It is also argued that the large sums now spent on law enforcement can be better used for drug treatment and education, which will dramatically reduce drug use and addiction (and could be even further bolstered if the government enacted excise or "sin taxes" on drugs like they do alcohol and tobacco).

Yet most people oppose legalization, fearing that if drugs are legalized, drug use and addiction will skyrocket (like alcohol consumption did after prohibition was repealed). It is argued that this will hit the poor and minorities the hardest. Moreover, it can't solve the problem of widespread drug abuse, because its real root cause is poverty, racism or inequality - which need to be dealt with first.

In 1996 California and Arizona legalized pot smoking for seriously ill cancer and AIDS

patients, and similar moves have been made federally in Canada (by a procedure of applying for special "exemptions" to the law). Still, it is unlikely that illicit drugs will soon be legalized for use by the general population. It's not just that most people oppose this, but that policymakers recognize the one great success of the punitive strategy: making certain illicit substances harder to obtain than legal drugs.

The Supportive Strategy: Prevention and Treatment:

While the government largely stands behind the punitive strategy, the supportive strategy of preventing drug use through education and treatment for addicts nonetheless exists. To prevent drug use, school programs, TV commercials, and other educational efforts are focused on increasing public awareness of the harmfulness of drugs. Treatment involves hospitals, public health agencies, and drug treatment centers in programs for people with drug problems.

One example of a drug prevention program involves police officers teaching drug education classes at local schools. The idea is to prevent drug use by teaching kids about the perils of drug use, and helping them develop social skills to resist pressure to use drugs. Program administrators laud the success of such programs, but researchers have found otherwise (Elliott, 1995). Yet most parents support such programs - and point to their own kids as proof - even though it has been noted that they generally work for children who are unlikely to use drugs in the first place. Hence, such programs may simply reinforce pre-existing anti-drug attitudes among those who least need it, but do little for those most at risk (e.g. those with a family history of alcoholism, drug use, or criminality, poor child-rearing practices, early antisocial behavior in school, alienation, academic failure, and who socialize with drug-using friends). Thus, drug education alone can't work for such kids unless the family, the school, community and the larger society work together to deal with the impact of these problems on children.

The latter supportive strategy, drug treatment for addicts, comes in three types. *Chemical treatment* may include detoxification of the body from drugs (supposedly making the patient "more amenable to therapy") and maintenance therapy (giving the patient a similar drug, such as methadone for heroin addicts, that is able to safely prevent withdrawal distress without the high).

Psychological therapy, next, may include aversion therapy, personal therapy, and group therapy. The first involves making patients associate their drug of choice with some unpleasant experience (e.g. shocks). Personal therapy involves a psychotherapist helping patients discover and then seek to eliminate the psychological causes of their drug abuse (e.g. low self-esteem). Group therapy involves a group of addicts discussing and sharing their lives and personal experiences with drug abuse.

A third type of drug treatment is *therapeutic community*. This involves drug addicts living together like members of a family. Cut off from outside contacts, including family and friends, these addicts support each other, helping each other live a drug-free life (e.g. Synanon).

It is hard, if not impossible, to determine which of these treatments works better than others because patients in different programs vary significantly by age, ethnicity, employment status, length of drug use, and degree of addiction. Thus, a program successful with patients only mildly addicted may not be said to be more successful than a program that treats with little success patients who are heavily addicted. But many studies suggest that any treatment method can work better if the patients are employed and can earn a good income, receive adequate social support from others, or are free from a drug-abuse subculture (Abadinsky, 1993).

One final thing before we close this topic. Now that we have reviewed these matters, on Thursday I'm going to show you a recent film on one of Canada's most notoriously drug-plagued neighborhoods: the downtown east side of Vancouver. Remember, however, that this shows the worst of society's drug problems, and can't be taken as typical of all drug use.