Eleventh Edition

Drugs in American Society

Erich Goode
Stony Brook University

Mc Graw Hill

DRUGS IN AMERICAN SOCIETY, ELEVENTH EDITION

This book is printed on acid-free paper.

1 2 3 4 5 6 7 8 9 LCR 27 26 25 24 23 22

ISBN 978-1-264-29978-2 (bound edition)
MHID 1-264-29978-8 (bound edition)
ISBN 978-1-265-67139-6 (loose-leaf edition)
MHID 1-265-67139-7 (loose-leaf edition)

Portfolio Manager: *Katie Stevens*
Product Developer: *Francesca King*
Marketing Manager: *Nancy Baudean*
Content Project Manager: *Rick Hecker*
Buyer: *Laura Fuller*
Designer: *Beth Blech*
Content Licensing Specialist: *Brianna Kirschbaum*
Cover Image: *(Human Mind series): agsandrew/Shutterstock.*
Compositor: *MPS Limited*

Library of Congress Cataloging-in-Publication Data

Name: Goode, Erich, author.
Title: Drugs in American society / Erich Goode, Stony Brook University.
Description: Eleventh edition. | New York, NY : McGraw Hill LLC, [2023] |
Includes bibliographical references and index.
Identifiers: LCCN 2021042699 (print) | LCCN 2021042700 (ebook) |
ISBN 9781264299782 (hardcover; alk. paper) | ISBN 9781265671396 (spiral bound; alk. paper) |
ISBN 9781265684075 (ebook)
Subjects: LCSH: Drug abuse—United States. | Drugs—United States. |
Drug utilization—United States. | Drug abuse and crime—United States.
Classification: LCC HV5825 .G63 2022 (print) | LCC HV5825 (ebook) |
DDC 362.290973—dc23
LC record available at https://lccn.loc.gov/2021042699
LC ebook record available at https://lccn.loc.gov/2021042700

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About the Author

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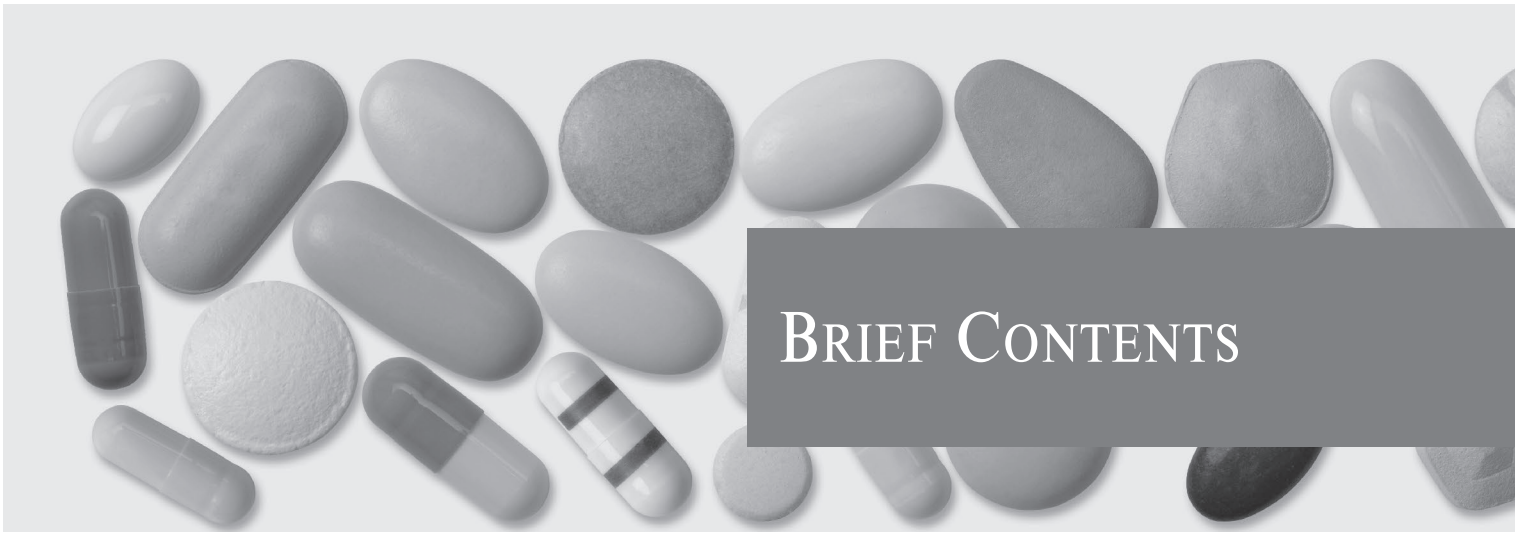
Erich Goode is Sociology Professor Emeritus at Stony Brook University. He received his Ph.D. in sociology from Columbia and a master's in nonfiction writing at Johns Hopkins. Goode has taught at Stony Brook University, New York University, the University of North Carolina at Chapel Hill, and the University of Maryland at College Park. He's the author of a dozen books, mainly on drug use and deviant behavior, including *The Marijuana Smokers* (Basic Books, 1970), *Between Politics and Reason: The Drug Legalization Debate* (St. Martin's Press, 1997), *Justifiable Conduct: Self-Vindication in Memoir* (Temple University Press, 2013), *Deviant Behavior* (Routledge, 13th edition, 2022), and *The Taming of New York's Washington Square Park: A Wild Civility* (NYU Press, 2018). He lives in New York City with his wife, Barbara Weinstein, a historian who teaches at New York University.



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Preface and Acknowledgments

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A student in one of my drug courses asked me where I obtained the drug-related stories, accounts, and anecdotes that I narrate in my lectures. I told him that I seek out and talk to a lot of drug users and ask them if they'd allow me to interview them about their experiences with psychoactive drugs—or if they'd be willing to write a personal, first-hand account of their experiences. He asked me if I fabricated anything—if any of the accounts were fictional or "made up." I probably looked at him in horror, but managed to tell him that, as a sociologist, making anything up—inventing it, fabricating it—is an absolute taboo; for us, it's the equivalent of stealing. As with all other social scientists, indeed, all academics, I'm bound to a pact to tell the truth about my research. Then he asked if I thought any of the people I interviewed "made stuff up" about their drug experiences. I thought about the question for a couple of seconds and said that I couldn't know that for sure, but after talking to a lot of people for a long time about their drug use, I've developed a sense for what kinds of statements make sense and what ones don't, but I could be wrong. The specific details, the particulars, well, who knows? They could be mistaken about whether their accounts happened in this way or that. But I do have faith in the veracity of the broad outlines of these accounts. I agreed that it comes down to the fact that drug researchers are forced to rely on their informants to tell the truth. I continue to keep my eyes and ears open for fresh, recent accounts to enliven the principles and generalizations that provide the foundation of this volume—but, I added, I'm only interested in factually *true* accounts.

The first edition of this *Drugs in American Society* was published a half-century ago, when systematic, reliable, nationally-representative data on drug use were not available; the information that social scientists used back then to draw conclusions about the consumption of mood-altering drugs was patchy, incomplete, and in all likelihood, skewed. Today, if anything, there is virtually a churning sea of informative data about the subject of this book, and the task is sifting through it all. (In fact, fairly frequently, different sources promulgate slightly different statistics, a glitch no acute observer of the drug scene should be distressed by.) Much of this information is produced by ongoing data-gathering enterprises, mainly government sponsored, that conduct surveys, often regularly, so that it is possible for the interested student, scholar, researcher, and nonprofessional to produce an up-to-date picture of the drug situation in the United States. It seems almost redundant to mention this and, when relevant, I shall make the point more forcefully: The COVID-19 pandemic has impacted on virtually all aspects of our lives, beginning, in the United States, early in 2020. Here's a good example: Since most Americans ventured from their homes significantly less during 2020, they took to the nation's roadways less often, in fact, about 15 percent less. That means that not only did we drive fewer miles, but also had fewer roadway accidents—and

specifically, fewer alcohol-related highway accidents. This had nothing to do with driving more safely, it had to do with driving less. It is also possible that staying at home tamped the crime rate down a bit, but it's possible that crimes such as domestic assault rose as well. Hence, when perusing the relevant trend statistics that include 2020, we should keep this qualification in mind.

I've followed several widely-used conventions that the reader ought by now to have become aware of. As of early 2020, a substantial number of newspapers, such as *The New York Times*, and magazines (*The New Yorker*) began capitalizing the first letter of the word "Black" as it refers to a racial category of humanity; I follow that convention. *The Washington Post* stands virtually alone in also capitalizing the word "White" as it refers to the racial category. I don't follow this convention of capitalizing the "W" in "white," again, as it pertains to race, because the constituent ethnicities among whites—Irish American, Italian American, Jewish, and so on—are already capitalized. (The word "Indigenous" should also be capitalized, as well as the term, "Native American.") In contrast, "Black" is considered a racial/ethnic category unto itself, as are "Hispanic" and "Latino." These conventions will eventually attain universal usage. It's also important to note that numerous Black folks living in the United States do not have an American heritage, that is, they or their ancestors came to the U.S. directly from Africa and so they have no history of enslavement, and thus, they do not identify as Americans as such; consequently, the term, "African American," is inappropriate for them, and "Black" seems to fit better. In addition, Black Caribbeans or Blacks emigrating from Brazil, who live in the U.S. are not likely to identify as "African Americans"; they too prefer to the term, "Black."

With respect to commercially manufactured and distributed drugs, I use the lower-case for the first letter of a generic drug name and capitalize the specific or brand name. Thus, the generic narcotic "oxycodone" begins with a lower-case "o," while its brand name, "OxyContin," is capitalized. The same practice applies to fentanyl/Duragesic, hydromorphone/Dilaudid, diazepam/Valium, methadone/Dolophine, secobarbital/Seconal, dextroamphetamine/Dexedrine, and so on. It's also important to note that a single chemical or generic drug may be the basic ingredient in multiple specific or brand-name drugs. Moreover, these different brands may be sold in different forms, each of which requires a different method of administration—in the form of a pill, nasal spray, dermal patch, in injectable liquid form, and so on. In addition, some brand names may contain a combination of substances in addition to the main ingredient. And some of the brand name drugs are mixed with other substances, while others contain only the generic.

Here's another convention we all have to contend with in in our increasingly electronic age and which the reader should aware of: With each succeeding edition, I rely increasingly on Internet materials rather than paper documents. One result of this tendency is that, given that many electronic publications lack pagination, I do not refer to the pages on which a given quote appears. Related to that point is the fact that some sources capitalize the first letter of the word, "Internet," while others don't; I do. At this point, it's optional.

As I said in the previous edition, the two most impactful recent changes that have taken place in the world of drug use are virtually exact opposites: the mainstreaming or *de*-deviantization, or growing respectability of marijuana use and the growing nasty, gloomy side of opiate and opioid abuse. Marijuana will never become fully respectable everywhere, but, as a *New York Times* reporter said less than a half-dozen years ago, we are living in an era in which cannabis is "quietly condoned," even "tacitly approved" (Hoffman, 2017). Moreover, the once-respectable, fashionable, chic, and supposedly sublime world of cigarette smoking (Klein, 1994) is, year-by-year, falling further out of favor, especially among the well-educated—a quality shared by all of the readers of this book. Consider this startling statistic: In 2019, more than *four times* as many high school seniors smoked marijuana during the 30 days prior to the survey than smoked one or more tobacco cigarettes. Taking the name of the study that produced this statistic—Monitoring the

Future—this obviously spells eventual doom for the cigarette industry, since, the reasoning goes, today's students are tomorrow's adults, and they will carry many of their practices into the future. But anyone with a modicum of prescience knew this back in the sixties, when the Surgeon General's report, *Smoking and Health*, was published, indicating that smoking takes a catastrophic toll on the smoker's health, and shortens life by as much as a decade. The health of everyone in the smoker's ambit, smoker and non-smoker alike, likewise suffers.

I owe a debt of gratitude to everyone who has assisted me in putting this book together. In the previous edition, I thanked dozens of editors, friends, students, scholars, experts, researchers, informants, respondents, and interviewees who were instrumental by providing me with needed information, advice, and narratives; I do so here again. My wife, Barbara Weinstein, helped me in multiple ways to stay emotionally afloat to complete the revision of this volume. All the others are too numerous to mention; as I said, I thanked them in this book's previous edition. They include the editorial staff at McGraw Hill, with whom I have enjoyed a productive and amicable relationship for decades, casting changes not with standing.

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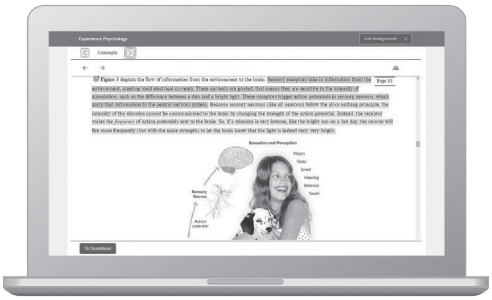

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CHAPTER

1

An Introduction to Drug Use

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What do you think humanity's two dozen or so most transformative achievements are—those that have made every-day life for many of us substantially different from the way it was earlier, without it? Most of us, I'd guess, would immediately recite the most obvious and oft-cited roster of inventions and innovations: fire, agriculture, language, the wheel, the domestication of animals, the printing press, sanitation, medication, anesthesia, central heating, electric lighting, the car, the airplane, the computer. And, chances are, we'd also come up with humankind's most outstanding artistic, intellectual, scientific, and social-organizational

innovations as well: music, literature, the representational arts, mathematics, cities, laws, human rights, a reasonably democratic political system, a more or less accountable and fair criminal just system, currency monetization, empirical science, a universal and compulsory formal education, and a merciful and empathetic, justice-oriented religion. All good, all positive, all righteous and beneficial.

But very few of us are likely to come up with the central subject of this book: the discovery of the alteration of our consciousness by ingesting a psychoactive substance. Of course, most medicine is made up of substances we'd call "drugs," and drug as medication does constitute a major blessing to humanity. But that's the body, not the mind. *Getting high* shouldn't be part of the package, many of us feel; that's widely considered a drawback, even a curse—not an asset. In a TED talk delivered in 2014, Ethan Nadelman, an advocate for the legalization of marijuana, declared that humanity's desire for consciousness-alteration is as "fundamental" as the desire for food, sex, and human companionship. In contrast to the positive achievements enumerated above, most of us think of recreational drug use as a social problem in need of a remedy, with lots more negatives than positives. True, most adults drink alcohol, and typically consume it in fairly moderate quantities that only rarely, for most drinkers, if ever, bring us to a state of drunkenness. "I drink to relax," we'd say; "I never get drunk." Well, hardly ever. But isn't relaxation an altered state of consciousness? Most of us don't consider it so. In our minds, alcohol doesn't count as a consciousness-transforming substance. And it does have a lot of drawbacks in addition to its convivial side. But even more so than alcohol, admittedly with more plusses than minuses, a minority of the population takes one or more of the illicit drugs to achieve a decidedly altered state, and that's where the trouble comes in. Most of us feel that recreational drugs weigh in more heavily on the negative column. Still, most of these recreational users of illicit enjoy getting high, and for them, that's a plus.

Many people also think also that drug-taking is a distinctly recent phenomenon. This is far from true. Our paleolithic ancestors foraged for food. Nature is abundant in plants that harbor chemicals that, when ingested, have *effects*; more specifically to our interests here, one of the effects that a substantial number of these plants have is that they influence the way the brain works. When brain chemistry is altered, we think, feel, and do many things that are significantly and substantially different from our quotidian, every day, habitual thoughts, feelings, and behavior. At extremely high levels of ingestion, these effects can even be toxic—some of them sicken and even kill us—and, so, prehistoric humans learned to avoid such substances. A lot of substances put us in a psychic state we experience as pleasurable; they make us more voluptuous, sensuous, or contemplative, or capable of appreciating dimensions of reality that stretch beyond the ordinary ways of thinking and feeling. Many ancient peoples came to use such substances for spiritual purposes.

We've been ingesting drugs for millennia, so putting a precise date on the first human ingestion of psychoactive plants is sheer conjecture, because nearly all physical traces of this remarkable event has long ago vanished into the mists of primaeval obscurity. But paleontologists and archaeologists have discovered evidence of psychoactive drug use in materials that represent, at the very least, if not *the* most ancient drug-taking episodes, at least they stretch back thousands of years.

There are two over-riding themes of this book, two transitions that mark transformations that the chronicler must incorporate into the historical narrative. The first is, as

I indicated above, the introduction of drug use to humankind: At some point, in the very distant past, we discovered what they do *to* us, as well as what we can do *with* such substances. The theme of this transformation is the transition *from non-use to use*—a truly momentous event in human history. It constitutes the attainment of a distinctly different level of consciousness—a new way of thinking and feeling, with both benefits and risks.

The theme of the *second* transformation is *social* rather than perceptual and intellectual. Humanity's next step as regards some drugs was the *domestication* of the use of psychoactive substances. How is the transformation of the human mind that drugs induce *handled* in such a way that it becomes a civil, non-disruptive, non-toxic experience? Has this stage already been accomplished? If so, when did it take place? And with *which* drugs? I document this transformation for alcohol in Chapter 7. There is probably a level at which even cigarette smoking can be "tamed," that is, where no harm comes to the smoker's health as a result of use, although that's likely to be accomplished at extremely low levels—a couple of cigarettes a day, one cigar a week. But smoking's *social* taming is now accomplished by means of *banishing* the smoker from public places. The number of public locales in which smoking would be wild, untamed, violative, and disruptive—professional meetings, restaurants, libraries, most parties, movie theaters, and so on—are so great that, by its very nature, public smoking has become a furtive, sneaky affair. Each drug has its own history as regards domestication or taming, which I discuss, each in turn, in Chapters 7 through 10. Heroin can't be tamed or domesticated, nor can crack or methamphetamine; getting high on them discourages sociability, and can't be woven into every-day life. (To be more specific, sociability among heavy users is unrecognizable as sociability to the conventional person.) Most alcohol consumption is domesticated, but some of it, at the higher end of the use spectrum, among a minority (but substantial number) of imbibers, drinking is out-of-control, harmful, even catastrophic. Meanwhile, marijuana is in the process of becoming domesticated: legalized in some places, even sold in pot shops, cooked into food, used as medication—and hence, conventionalized, tamed, and brought under control. Common sense dictates that cocaine can't be tamed—it's a "wild" stimulant, like meth (Goldstein, 1994, Chapter 11)—but a criminologist and a drug researcher (Decorte, 2000; Decorte and Slock, 2005) have produced two fat volumes arguing that such a state of affairs has already been accomplished for coke.

Elisa Guerra-Doce (2015), a Spanish archaeologist, has conducted research on the use of psychoactive substances in prehistoric Eurasia; she has examined fossilized cactus and mescal beans, alcohol residue in shards of pottery, poppy seed capsules, fragments of coca (a leaf containing cocaine) in mummy hair and human dental remains, and nicotine, even opium, in pipes. Some of these remains date back 8,000 or more years, some only hundreds, but the most ancient of them tell the same story: Humans began *intentionally* self-inducing an intoxicated state longer ago than we first devised writing, as long ago as when we built our first settled communities. Most paleontologists date the dawn of alcohol consumption at the Paleolithic Era, roughly 12,000 years ago. Ernest Abel dates the first consumption of cannabis at 10,000 B.C.E. (1980). Iain Gately places the earliest human puff on a tobacco pipe at roughly 6,000 years ago (2001). Paintings on murals 10,000 years old suggest that ancient dwellers of the Sahara region used magic mushrooms, or psilocybin. Documents from 3400 B.C.E. indicate that the early Sumerians smoked opium (Knox, 2016). The message of the drug-related artifacts that homo sapiens

have left behind seems clear: There's *something* in the human central nervous system (CNS) that motivates humans to *seek* the altered states of consciousness.

Not all of us seek this altered state, but all of us have the neurological wiring to achieve it. Of course, we can attain transformations of our every-day consciousness in many different ways. Prayer and meditation introduce us to the spiritual dimension; fasting or abstaining from eating food causes light-headedness; spinning around induces dizziness. Sex, daydreaming, listening to music, sleep—multiple common experiences give rise to mental states that cause us to transcend our routine, run-of-the-mill mentality. Some experts have argued that seeking such states is hard-wired into us; it is a drive much like an instinct (Weil, 1973, 2004). Whether or not we agree with this claim, our DNA undeniably *enables* us to alter our sense of awareness, our perceptions, our very consciousness by means of drug-taking. That capacity is laid down in our genes, encoded in our neurological wiring, and, as a consequence, *some* members of *nearly all* societies seek one or another psychoactive state—that is, getting high. It is, to emphasize the point, very close to a cultural and societal universal. And taking drugs is a *dependable* method of attaining this out-of-the-ordinary psychoactive state. Moreover, drug-taking may also be among the most *transformative* of such methods, that is, among many ways of seeking such states, altering our consciences by taking a chemical substance reliably induces the most immediate, untutored, and dramatic changes in the way we think and feel in our ordinary, every-day lives.

But, to reiterate a point work repeating: This transformation is a mixed blessing, and the domestication of psychoactive substances is accomplished only after decades, even centuries, of stumbles and countless victims along the way. One need only gaze at William Hogarth's print, "Gin Lane" (1751), to comprehend the catastrophic impact of the wild or undomesticated use of distilled spirits. It depicts a baby, falling out of its drunken mother's arms, possibly to its death; a starving, skeletal man too stupefied with drink to feed himself; a street brawl; a woman in rags selling essential kitchen implements to a pawn broker, presumably to obtain enough money to purchase a bottle of gin; two men tossing a naked woman's body into a coffin; a man hanging himself; and a building collapsing due to poor construction. This urban scene is chaotic, lawless, unruly, and dangerous, and the cause is simple: uncontrolled drinking. We're all familiar to the assault on civility that heavy, untamed drinking inflicts. Still, today, *typically,* drinking is civil, polite, restrained; for the most part, tippling has become *domesticated*.

Given the effects that they cause, is domestication even possible with the currently illicit drugs?

Terry approaches the superintendent of his building, who, he knows, occasionally snorts heroin, hands him $20, and asks him to cop a bag from his dealer so that he could try this alluring but dangerous drug. "You want *heroin?*" the super asks him incredulously. "Are you *sure?*" Alone one afternoon, Terry sniffs up the contents of the tiny bag the super bought for him, feels woozy, and falls asleep until six in the morning. He didn't even get high from the experience he explains to me. "I wonder what was in that bag," he says. "Maybe my super ripped me off."

At a party, in spite of his warning, Sam's girlfriend, Susan, consumes a dozen strong mixed drinks, begins shouting, singing, and, while attempting a solo dance, stumbles and falls. "Time to go," Sam tells her, helping Susan to her feet. Leaving the party together, they only get as far as the bushes outside when she burbles, "I gotta, I gotta. . . ," drops

to her knees and vomits. A couple of years later, after they had broken up, a mutual friend tells Sam that Susan overdosed on a mixture of a quart of vodka and a handful of hydrocodone tablets. There is no funeral.

Jason's physician diagnoses him with liver cancer; he checks into a local hospital and undergoes an operation in which half his liver is removed. Lying in the recovery room, his oncologist administers a combination of morphine and fentanyl to diminish the post-operative pain. While under the influence of the drug cocktail, Jason begins having a series of frightening and bizarre hallucinations, so scary that, after the effects have worn off, he begs his doctor to take him off the narcotics and put him on aspirin and acetaminophen. "I can deal with the pain," he tells her. After his release, a biopsy reveals that Jason's liver is negative for cancer, and the operation was all for nothing.

Walking to a friend's apartment, Mark meets and picks up a young woman, Sally, who seems interested in taking some of the cocaine he says he had stashed with his friend, Mike. Later, she squats on the floor of Mike's apartment, pulls a syringe kit out of her jacket, takes out a tiny spoon, taps half the coke out of the envelope Mike gives her into the spoon, liquefies the coke, draws the liquid into a syringe, and injects it into her bare right arm. When she collapses onto the floor, Mike immediately calls EMS. "The girl spent a month in the hospital in a coma," he tells me.

Three lessons emerge from these anecdotes. The first is that drugs are *psychoactive*; taking them not only produces effects, it produces profound effects specifically on the human *mind* as well as the body. The second lesson is that, for the most part, humans *like* to take drugs; they take them *because* of the psychoactive effects that drugs have, because users enjoy these effects. And the third lesson that these true stories convey is that, in addition to their mind-altering effects, drugs also have *side effects,* some of which are unpleasant, potentially harmful—and even, in some cases, lethal. These three "lessons" constitute a great deal of the subject matter of this book. What causes unpleasant, potentially harmful and dreadful drug effects? After all, millions of people ingest these substances, risking arrest as well as medical harm; what's the point of taking something that can make you sick or even kill you? Sometimes the user takes too large a dose, or the dose is mixed with a harmful ingredient, or the user suffers an allergic reaction, or takes the substance in a setting, or while engaging in activities, in which consumption is inappropriate, or the user may be accompanied by people with whom he or she feels uncomfortable.

To emphasize the point, obvious as it might seem, users take drugs in order to get high, whereas most drinkers don't drink to get drunk. Puffing on a marijuana joint, snorting a line of cocaine intranasally, chewing a wad of peyote cactus, injecting a solution of heroin IV, all enable us to attain a psychic state that many of us experience as gratifying, enjoyable, exhilarating, intoxicating, mind-bending. But psychoactivity is a coat of many colors; the mind can be bent in different directions; some of them are pleasing to most of us, while many have psychic effects that some of us find unsettling, disturbing, even unpleasant—and all of this, taken together, is the story that drives this volume. While it is true that most drinkers don't necessarily imbibe to get drunk, they do drink to achieve a pleasant state of mind, whether we call it relaxation, peacefulness, tranquility, or being laid-back. And yes, achieving it is an alteration of the every-day, ordinary state of consciousness.

Drug taking is a cultural universal; it is an activity in which a *substantial* number of the members of *all* societies partake. It is extremely widespread, both in American society and globally. Getting high is as primordial and virtually as ubiquitous as humankind itself. The enticement of drug-taking includes the pleasurable experiences users anticipate and which most users feel most of the time when they engage in it, and it also includes the risk of the likelihood of disagreeable or harmful side-effects.

Knowing that ingesting psychoactive substances influences the workings of the human mind should clue us in to another important fact: When sociologists think about drug use, we also investigate how their ingestion influences human behavior. Users usually not only *like* the feelings that drugs induce, but they are also aware that they *do* some things that are different while they are under the influence from what they do normally. Illicit drugs are taken *recreationally*, not only for the high or "intoxication," but also for the activities the high accompanies; some drugs accentuate sociability, while others induce users to become more withdrawn. What do users *do* when they are high? For the most part, with marijuana, they engage in fun things: hanging out with friends, socializing, talking, partying, dancing, flirting, eating, watching movies, making love. Users consider smoking marijuana, like drinking alcohol, an *enhancer* of these activities; they are synergistic. Smoking and socializing are more enjoyable than either is, separately. In contrast, with some other drugs, the high *is* the drug experience; shooting heroin, experiencing a rush or flash of pleasure, then nodding out, is what heroin users, especially addicts, enjoy most. Often, there's no true socializing to be had with the high.

Drugs do not directly *cause* behavior; they do not have standard, uniform effects on everyone. In fact, in the quantities most people take, there's quite a great deal of variability in effects from one individual to another. Yes, in larger doses, some drugs do cause discoordination, and in still larger ones, they can even cause death. Still, most drugs, taken in low-to-moderate doses, will make certain types of behavior *more likely*—but not certain. For instance, certain levels of blood-alcohol concentration (BAC) diminish human coordination in the performance of mechanical activities, such as driving. It doesn't matter that Melissa's coordination is diminished less than Scott's at a certain dose—the fact is, for people in general, alcohol tends to diminish human coordination.

Every social scientist looks for generalizations; they are the coin of the realm in the systematic study of everything we would want to know about. Anecdotes such as the ones we encountered above capture our attention, draw us into the material, but the prize in every discipline is making valid and true statements that have a broad scope, universal applicability, that apply to most people in most places during major swathes of human history. But we also want, in these generalizations, to encounter the specifics as well—the human-interest stories, variability, the human panoply of diversity and individuality.

To us, as students, researchers, or instructors of drug use, what makes psychoactive drugs interesting and distinctive is their capacity to influence mood, emotion, and intellectual processes. This is the case because, as I said, it is specifically the psychoactivity of certain chemical substances that gives them their popular appeal, that impels substantial numbers of the members of societies everywhere to experiment with and use them. And it is precisely this appeal that initiates the chain of events that leads to their scrutiny by physicians, pharmacologists, neurologists, psychiatrists, psychologists, epidemiologists, and social scientists. But it is also their "side effects"—those toxic consequences of ingesting the wrong drug, by the wrong person, or too much of the drug, or under the wrong

circumstances—which bring medical and psychiatric specialists into the picture. Psychoactive drugs are interesting for a variety of reasons, including their potential impact on human behavior and society's attempt to control them. The psychoactive appeal of drugs leads to their potential for widespread use, which, in turn, leads to the possibility of widespread harm or problematic behavior, which further result in some form of social control, that is, legal restrictions on their distribution and use. Hence, societies raise the question, Is this drug harmful to users? When the answer seems to be in the affirmative, the next question becomes, "How can we limit and control the use of this drug?"

Drugs accrete a tradition, a *lore*: People take drugs and tell their friends about their experiences. Try it, you'll like it, it's fun. Or: Avoid it, it'll make you sick. People who take a drug *typically* experience positive psychic effects, enjoy the experience, and tell others about what they feel under the influence. But some drugs have more complicated effects; they are unsettling and disturbing. At substantial doses, certain substances will run you over like an onrushing truck. Drug-naïve individuals—persons who have never ingested a given psychoactive substance—hear descriptions of a drug's effects from friends and acquaintances who have used it. These descriptions are inspired by a drug's pharmacological action: how its chemical structure interacts with the CNS. It is the psychic effects that users enjoy that prompts their initial use. Drug *effects* are absolutely central to drug use. And these effects, whether observed or narrated, influence policy. The fact that marijuana possession and sale are being decriminalized and legalized suggests that the drug's effects may not be as harmful as the authorities once claimed.

Another reason why it's important to understand the psychopharmacology of drugs—the study of the impact of drugs on the mind—is that the action of some drugs conduces users to engage in certain actions. (*Conduce* means to "lead or contribute" to something.) For instance, to the sociologist and the criminologist, one extremely interesting (but disturbing) effect of certain drugs is that they make violent or criminal actions more likely. If taking a drug lowers our inhibitions, certain behaviors that would normally be unthinkable to users become acceptable under the influence. Alcohol, a drug that is strongly intertwined with violent and criminal behavior, plays precisely such a disinhibiting role. And if a drug is physically addicting or dependency-producing, *and it is illegal—and hence, relatively expensive*—it may not be possible to pay for a steady supply without resorting to a life of crime. To the sociologist, whether and to what extent drugs influence the enactment of unacceptable and/or criminal behavior is interesting and worth investigating.

By itself, the pharmacology of drugs does not *cause* the drug laws to materialize out of thin air. Nor is pharmacology the only factor in drug-related behavior. What people do under the influence, again, is partly a consequence of a society's cultural and legal structure—the social and legal norms spelling out and sanctioning appropriate and inappropriate behavior. Still, what a drug does to the neurochemistry of the human brain—and hence, the body—is relevant to the social scientist's interests. Thus, we need to begin by discussing drugs as psychopharmacological substances.

WHAT IS A DRUG?

Ask a dozen people for their definition of the word *drug*. I've done it and some of the answers I get are far too broad to be useful ("a chemical"), while others are too narrow—not to mention wrong ("an addicting substance"). In addition, some of these answers

dwell exclusively on the effects of substances ("drugs get you high"), while others focus on their social or legal status ("drugs are against the law"). The question, "What is a drug?" cannot be answered strictly objectively (from a substance's pharmacological properties alone) or strictly subjectively (the way a substance is seen, thought of, reacted to, and defined in societies around the world). Each of these types of properties is necessary to define "drugness"—that is, what a drug *is*.

Drugs is a concept that is defined both *materially*, with respect to drugs' essential or physically real properties, and *socially*, a construct that is both in our minds—in the way we picture or represent the world—and in institutions we have built to deal with certain substances. Drugs can be defined by what they *are* and what they *do*—in a real-world biochemical and pharmacological sense—as well as what they are *thought* to do, including how the law defines them and the way they are depicted in the media, how they are socially constructed and conceptualized. The first definition delineates the "objective," or *essentialist*, reality of drugs, while the second definition delineates the "subjective," or *constructionist* reality of drugs. Every phenomenon that has ever existed—including drugs—can be looked at through the lens of these two different definitions or perspectives.

Definitions may be more—or less—useful according to a specific setting or context. For drugs, three relevant drug contexts come to mind: medical utility, illegality, and, as we saw, psychoactivity. The "medical utility" definition regards a drug any substance used by physicians to treat the body or mind; the "illegality" definition regards as a drug any substance whose possession and sale are against the law; and the "psychoactivity" definition regards a drug any substance that influences the workings of the brain or mind, that has an impact on cognitive and emotional processes. If we use one definition, certain implications unfold that may—or may not—be fruitful in a different setting. But if we use another definition, different implications appear that could be useful or counterproductive, again, depending on what we wish to achieve. Even though both are tools, we don't use a hammer to saw wood or a saw to hammer a nail. Definitions, like tools, are useful only according to their context—what we want to use them for.

Medical Utility

One definition of what a drug is, is that it is *a substance that is used to treat or heal the body or mind*. According to this definition, physicians administer drugs to persons who are sick, disordered, or abnormal to return them to a state of normalcy or "ordinariness," to *remove* that which is pathological, abnormal, unnatural—the disease or medical condition—or "out of the ordinary." Can we define a drug by the criterion of medical utility? For instance, given that heroin is not approved for medical use in the United States, does our medical definition exclude heroin? Does it mean that heroin is *not* a drug? Well, if we were to follow that definition alone, yes, it does dictate that, in the United States, we may not regard heroin as a drug. And is penicillin a drug? Yes, if we were to adopt a strictly medical criterion as defining what a drug is, *of course* penicillin is a drug; it is used to treat bacterial infection. But is penicillin used illegally on the street? No, because it does not produce a "high" or intoxication. In the context of illicit use, penicillin is *not* a drug.

The medical definition contains both an objective (or essentialist) and a subjective (or constructionist) element. For a drug to be used medically, we assume that it *does*

something to the body—it acts as a healing agent. This is its objective reality. But in addition, a drug has to be *recognized* as therapeutically useful by physicians, and physicians in a given society may not adopt it as medicine even if it works as a therapeutic agent. Controversy may exist with respect to whether some drugs are medically useful. For instance, as of this writing, marijuana is recognized and legitimated as medicine in 33 states, plus the District of Columbia, but not in the other 17 states, and it is not so recognized by the federal government. Heroin maintenance programs are legal in much of Western Europe—Switzerland, the Netherlands, Denmark, and Germany—but not in the United States. Same substance, objective speaking; different legal and social construction. This is the subjective reality—the "socially constructed" side of the medical definition, or how drugs are defined, how the medical profession regards or *defines* substances.

This means that the same substance can be defined *as* a drug and *not* as a drug—depending on the context or the setting. Within the context of medical therapy, the definition of a drug as medicine is useful. *Outside* that context, it is less useful. However, it's also true, as we'll see, that a medical definition may *determine* a substance's legal status; if it is *not* recognized as medicine by the government, this often induces members of a society to criminalize its possession and sale. Since most of the drug use we'll be looking at in this book is recreational—users engage in it for the purpose of getting high, for the effects themselves—the medical definition of drugs is not as useful to us in our quest to understand the causes, consequences, and implications of drug use. It's also interesting that Keith Stroup, who founded NORML, an organization that lobbies for the legalization of cannabis, found that when marijuana began to be legalized *as medicine*, state by state, his efforts to legalize and decriminalize the drug were facilitated because that gave it a more harmless and benign public image. (See Keith's Q & A at the end of Chapter 13.)

Illegality

How a drug is defined is also determined by a substance's *legal* status—whether the possession and sale of a given substance are legal or illegal. According to this definition, the law and law enforcement define what a drug is. If the possession and sale of a substance are against the law and likely to generate criminal punishment, then that substance, according to the dimension of illegality, is a drug. The legal status of drugs is a *socially constructed* definition: When a drug law is enacted, a category of illegal substances is created. Societies vary with respect to their drug laws. The same substance may be legal in one jurisdiction and illegal in another. Same substance, different status with respect to "drug-ness." In addition, drug laws change over time; substances move from being legal to illegal, and vice versa. Presumably, the possession and sale of certain drugs result from their physical or material properties: They are *considered* harmful and thus, are prohibited by law. Though the legal definition of what drugs are is a social construct, it is hypothetically based on their physical (or essentialist) properties.

But here, as in the medical world, controversy is the rule. For instance, some marijuana users proclaim, "Marijuana's not a drug—it's a gentle, natural herb! How can you outlaw nature?" But, as we have discussed, the possession of marijuana (or cannabis) is *legal* in some states, decriminalized for small-quantity possession in others, legal only *as medicine* in still others, *both* decriminalized *and* approved as medicine in other states,