CHAPTER

6 THEORIES OF DRUG USE

Here, we'll look at explanations for the causes of drug use. To understand the cause of a phenomenon such as drug use, we need a theory. A **theory** is simply an explanation for a general category of phenomena—any set of events or conditions. The word *general* is important, because scientists don't usually apply the term *theory* to a unique event or condition. Astrophysicists have theories or explanations about the birth, movement,

and death of stars; biologists have theories about genetic changes in organisms over time; sociologists and political scientists have theories about voting behavior.

One major type of theory of drug use would be the attempt to explain why people use drugs. There are two absolutely necessary preconditions for use: the **predisposition**, or motive or susceptibility, to do so, and the **availability** of one or more psychoactive substances. Each of these two preconditions is *necessary but not sufficient* to explain drug use. If a drug is not available in a particular locale, drug use is not possible—whether or not a predisposition to use is present. Likewise, without the predisposition to use, use cannot take place; *by itself*, availability does not explain use. Each is an essential—or necessary—condition for use; neither is sufficient for it to take place. In this chapter, we focus mainly on the predisposition or motive, on the factors that make drug use seem desirable and enticing—an activity in which someone wants to engage.

For millennia, humans have asked, "Why do they do it?" about a variety of anomalous, unconventional, or deviant behaviors. The ancient Greek philosophers began thinking about the forces and factors that lead some of us to go astray. But, for the most part, until just a few hundred years ago, the dominant theory for wrongdoing was **demonology**, meaning the devil (or evil spirits) made them do it. Demonology has not completely disappeared in the popular or public mind, however. Toward the end of a course on criminology taught at a small Bible Belt college, Frank Schmalleger asked his students to speculate on which theory of crime they thought made the most sense: biological, psychological, or sociological. The overwhelming majority of the class chose none of these three, instead asserting that "the devil made them do it" explanation was the most valid (1996, p. 88).

In contrast, nearly all intellectuals, experts on, and researchers of human behavior favor a *materialistic* or *naturalistic* explanation, one rooted in the social, psychological, or biological worlds. Social scientists look to such forces as childhood socialization, urban decay, poverty, and bonds to conventional society to account for why people do the things they do. However, once we agree that it is forces in the material world, rather than demons and evil spirits, that best explain drug use and abuse, we are still left with an almost bewildering array of theories.

In the world of the natural and social sciences, as we just saw, a theory is an explanation for a general class of phenomena. Dozens of explanations have been proposed for drug use and abuse. And therefore, presumably, a theory of drug use would be an explanation of why people use and abuse drugs. But not all the theories that have been proposed address this specific issue. Most theories do not explain the entire spectrum of use; some are more narrowly focused. Most concentrate on illicit use or drug "abuse," or on alcoholism. Some focus entirely on addiction, usually to the narcotics. Some focus on the individual, others on society, and still others on the individual's relationship to society. While a number of theories deal with initiation into drug use, several focus on continued or habitual use. Nearly all these theories are *partial* in scope: They select one or a limited number of factors that are believed to cause drug use or abuse. Most theorists admit that the factor they focus on, *in combination with others*, influences drug taking. Hardly any researcher in the field believes that one factor, and one alone, explains the phenomenon under investigation. Moreover, a factor is not a theory; most theories put together several factors to form a coherent explanation, an argument with several different pieces that articulate with one another. This means that most theories of drug use are not contradictory or in competition with one another; most cover aspects of the same phenomenon yet may be regarded as complementary rather than contradictory.

As is true of theories of crime, theorists and researchers have proposed three broad *types* of explanations for drug use: (1) *biological* theories (Clayton and Akins, 2007, pp. 38–41; Goldberg, 2009, p. 60; Mooney, Knox, and Schacht, 2009, p. 88), (2) *psychological* theories (Leonard and Blane, 1987; Jung, 2001; Abadinsky, 2008, pp. 204–221), and (3) *sociological* theories (Shaw, 2002; Levinthal, 2010, p. 19; Abadinsky, 2008, pp. 184–203). Each focuses on a different range of factors as crucial in determining why people use and abuse psychoactive substances. Even within each broad type, there is a range of specific theories. All biological theories, and nearly all psychological theories, are individualistic in that they focus on differences between and among people. They can be referred to as "kinds of people" theories: Person X is different in some way from person Y (or has had different kinds of experiences from person Y), and therefore, person X is more likely to use drugs than person Y. In contrast, most sociological theories tend to focus not on individual differences but on *group* or *category* differences (persons in group X differ from those in group Y) or *structural* differences (the structures within which persons are *located* differ, such as cities, neighborhoods, time periods, social conditions, or countries). At the same time, some sociologists do promulgate more individualistic explanations; in this chapter, we'll encounter a few. Since most of these theories explain only a piece of the puzzle, most of them are complementary rather than contradictory. Still, some explanations do contradict others: If one is true, one or more others cannot be true. It's important to understand the implications of each one so that we have a clear idea of what manner of evidence confirms or falsifies it.

BIOLOGICAL THEORIES

Biological theories are those "kinds of people" explanations that postulate specific physical mechanisms in individuals that impel or influence them either to experiment with drugs or to abuse them once they are exposed to them. Some are constitutional, that is, are based on mechanisms that are present at birth and vary from one person to another. Others are partly environmental; that is, inborn factors *in conjunction with* environmental factors generate drug-using behavior. Two of these explanations are genetic theories and the theory of metabolic imbalance.

Genetic Factors

According to one line of thinking—**genetic theories**—the genetic makeup of individuals predisposes them toward drug abuse and alcoholism. A gene or combination of genes influences the specific biological mechanisms relevant to substance abuse—such as being able to achieve a certain level of intoxication when using drugs, becoming ill at low doses as opposed to much higher doses, lowering or not lowering anxiety levels when under the influence, or having the capacity to metabolize chemical substances in the body. Any and all these factors could vary from one individual to another or from one racial or national group to another, and could influence continued use. This "genetic loading," in combination with environmental and personality factors, could make for a significantly higher level of drug abuse or alcoholism in certain individuals or groups in the population (Schuckit, 1980). Indeed, the tendency to prefer alcohol to other beverages can be bred in animals, suggesting the relevance and strength of the genetic factor in drug use and abuse.

Most of the research attempting to demonstrate a genetic factor in drug abuse has focused on alcoholism. Studies have shown that adopted children have rates of alcoholism closer to those of their natural parents than to those of their adoptive parents (Schuckit, 1984, p. 62). One study found that 30–40 percent of natural children of alcoholics become alcoholics themselves, as opposed to 10 percent for the general population (Kolata, 1987). Some experts conclude that the rate of heritability of alcoholism—the chance of inheriting the disorder—is "similar to that expected for diabetes or peptic ulcer disease" (Schuckit, 1984, p. 62). Now that the entire human DNA sequence has been "decoded," it is possible that in the coming decades scientists will discover a genetic link with alcoholism.

No researcher exploring the inherited link with alcoholism asserts that genetic factors compose the only or even the principal factor in compulsive drinking. Rather, they posit a genetic *predisposition* toward alcoholism. Inheritance is one factor out of several. Alone, it does not "make" someone a compulsive, destructive drinker. In combination with other variables, genetic factors may facilitate or make the process more likely, however.

What are some precise mechanisms that may push someone in the direction of alcoholism? What's the lynchpin between biology and abusive drinking? One study found that the sons and daughters of alcoholics tend to be less affected by alcohol than are the sons and daughters of nonalcoholics: Their coordination is less debilitated, their bodies produce a lower hormonal response, and they feel less drunk when they imbibe a given quantity of alcohol. According to researchers Marc Schuckit, Jack Mendelson, and Barbara Lex, 40 percent of the children of alcoholics exhibit a significantly lower sensitivity to alcohol in these three respects, while this was true of only 10 percent of members of control groups (Kolata, 1987). In addition, researcher Henry Begleiter found that boys who do not drink but whose fathers are alcoholics have brain waves significantly different from boys who are sons of alcoholics (Kolata, 1987). Many researchers point out that inherited mechanisms, in combination with other factors, could lead to an increased likelihood of chronic, compulsive, destructive drinking.

Metabolic Imbalance

A second biological theory postulates **metabolic imbalance** as a possible causal factor in at least one type of drug abuse—narcotic addiction. Developed by Vincent Dole and Marie Nyswander (1965, 1980; Dole, 1980), this theory argues that heroin addicts suffer from a metabolic disease or disorder, much as diabetics do: Once certain individuals begin taking narcotics, a biochemical process "kicks in," and physiologically, they begin to crave opiate drugs in much the same way that the bodies of diabetics crave insulin. Repeated doses of a narcotic complete their metabolic cycle; narcotics act as a stabilizer, normalizing an existing deficiency. The narcotic abuser can never be withdrawn from narcotics because his or her body will continue to crave them, just as diabetics cannot be withdrawn from insulin; in both cases, the substance provides what the body lacks and cannot provide.

No precise biological mechanism corresponding to metabolic imbalance has ever been located. The best that can be said about this theory is that the treatment program based on it, methadone maintenance, has helped a certain proportion of addicts—a far

lower proportion than its proponents claim, and a higher proportion than its critics claim. We'll explore the various available drug treatment modalities in more detail in Chapter 15. Here, it is enough to know that hormonal imbalance has been proposed as a factor influencing drug abuse in certain individuals, even though its existence has never been established empirically. The only evidence supporting it is that some addicts behave *as if* they suffer from a metabolic imbalance. Comparing their early with their later writings on the subject, it is clear that the proponents of the metabolic imbalance theory have retreated somewhat from their original insistence on the importance of this factor (Dole and Nyswander, 1980). It is possible that the theory is relevant only on the clinical, and not the theoretical, etiological, or causal, level. Indeed, it may remain as a relevant theory only in order to justify the maintenance of addicts on methadone for life.

PSYCHOLOGICAL THEORIES

Theories relying on psychological factors fall into two basic varieties: those emphasizing the mechanism of reinforcement, and those stressing that the personalities of the drug user, abuser, and especially the addict are different from those of the abstainer and are causally related to use and abuse. The mechanism of **reinforcement** is fairly straightforward: People tend to maximize reward and minimize punishment; they continue to do certain things because they have a past history of being rewarded for doing them. Drug users are individuals who have been rewarded for use, and hence they continue to use. Whereas **reinforcement theories** underplay personality factors, personality theories, as we might expect from their name, emphasize their important role in causing drug use and abuse. The precise personality configuration that its supporters argue determines drug use and abuse varies with the theorist; theorists invoke one or more personality factors over others. The key factor that binds these **psychodynamic theories** together, however, is that they postulate that certain individuals have a type of personality that impels them into the arms of drug use and abuse.

Reinforcement

A major psychological theory underplays the idea of personality differences between users and nonusers, and emphasizes the role of reinforcement. Even animals use certain drugs compulsively under the right experimental conditions, casting doubt on the need to invoke psychodynamic variables in the development of addiction (Wikler, 1980, p. 174; McAuliffe and Gordon, 1980, p. 139). In addition, experiments have shown that, independent of personality factors, human subjects who are administered opiates without knowing what they have taken wish to repeat taking the drug; their desire grows with continued administration (McAuliffe, 1975). For some aspects of the drug-taking process, a consideration of personality variables is not necessary. (At the same time, there is individual variation in reactions to and experiences of drug effects.) However, it is an axiom in science that *you can't explain a variable with a constant*. If two people are taking the same highly reinforcing drug (a constant) and one becomes addicted to it and the other does not (a variable), it is insufficient to argue that reinforcement explains continued use because it does not account for the difference in behavior. Consequently, we need to bring into the picture variables or factors in addition to simple reinforcement.

There are two distinctly different types of reinforcement—positive and negative—and consequently two different theories that cite reinforcement as a mechanism in continued drug use. (Actually, some approaches make use of both these mechanisms—different types of reinforcement for different types of drugs or drug abusers.) **Positive reinforcement** occurs when the individual receives a pleasurable sensation and, because of this, is motivated to repeat what caused it. In brief, "The pleasure mechanism may . . . give rise to a strong fixation on repetitive behavior" (Bejerot, 1980, p. 253). With respect to drug use, this means that getting high is pleasurable, and what is pleasurable tends to be repeated.

According to this view, the continued use of all drugs that stimulate euphoria is caused by their "extremely potent reinforcing effects" (McAuliffe and Gordon, 1980, p. 137). Inferring from the way that users behave, it is difficult to draw a sharp distinction between a strong psychological and a physical dependency. Indeed, physical dependence is not even a necessary mechanism for the proponents of the theory of positive reinforcement. What is referred to as "addiction" is simply an end point along a continuum indicating that "a sufficient history of reinforcement has probably been acquired to impel a high rate of use" in the user (McAuliffe and Gordon, 1980, p. 138). This also means that ongoing, even compulsive, use and abuse do not require the mechanism of a literal physical addiction to continue taking place. Many users are reinforced—they experience euphoria—from their very first drug experience onward, and the more they use, the more intense the sensation and the greater the motivation to continue use.

Negative reinforcement occurs when an individual does something to seek relief or to avoid pain, thereby being rewarded—and hence motivated—to do whatever it was that achieved the relief or alleviated the pain. In the world of drug use and addiction, when someone who is physically dependent on a particular drug undergoes painful withdrawal symptoms upon discontinuing the use of that drug and takes a dose to alleviate withdrawal distress, he or she will experience relief with the termination of the pain. Such an experience will motivate the addict to do what has to be done to obliterate the painful sensations associated with withdrawal.

While positive reinforcement can occur with *any* euphoric drug—indeed, with any pleasurable sensation (Bejerot, 1972, 1980)—the theory emphasizing the mechanism of negative reinforcement as a major factor in drug abuse is largely confined to drugs that produce a physical dependence, especially the opiates. Relatively little attempt has been made to apply this theory to explain either the continued use of nonaddicting drugs or the use of opiates that does not involve a literal physical dependence. (However, some nonaddicting drugs, such as cocaine and marijuana, may provide relief from depression; some researchers also mention this factor as a reason for continued use.)

The argument invoking negative reinforcement goes as follows: Initially, pleasure dominates as a motivating force in use. Hence, the first few weeks of narcotic drug use have been called the "honeymoon" phase of drug addiction. However, the user gradually becomes physically dependent without realizing it. Because of the body's growing tolerance to the narcotic, the user, in order to continue receiving pleasure, is forced to increase the doses of the drug—eventually to a point at which addiction takes place. If use is discontinued, whether because of arrest, disruption of supply, or lack of money to purchase the drug, painful withdrawal symptoms wrack the addict's body. Because the user

recognizes that doses of a narcotic can alleviate these symptoms, an intense craving is generated for the drug over time.

According to Alfred Lindesmith (1947, 1968), a proponent of this theory:

> The critical experience in the fixation process is not the positive euphoria produced by the drug but rather the relief of the pain that invariably appears when a physically dependent person stops using the drug. This experience becomes critical, however, only when an additional indispensable element in the situation is taken into account, namely a cognitive one. The individual not only must experience withdrawal distress but must understand or conceptualize this experience in a particular way. He [or she] must realize that his [or her] distress is produced by the interruption of prior regular use of the drug. (1968, p. 8)

The "perception of withdrawal symptoms as being due to the absence of opiates will generate a *burning* desire for the drug" (Sutter, 1966, p. 195). According to this theory, addicts continue taking their drug of choice *just to feel normal.*

As originally stated, the theory does not account for most narcotic use among addicts. The majority of addicts and other compulsive drug abusers *do* experience euphoria, and this is a major factor in their continued drug use. In one study of addicts, all of whom used heroin at least once a day, 98 percent of the sample (63 out of the 64 interviewed) said that they got high or experienced euphoria at least once a month, and 42 percent got high *every day* (McAuliffe and Gordon, 1974, p. 804). In this sample, euphoria was consciously desired and sought: 93 percent said that they wanted to be high at least once a day, and 60 percent wanted to be high all the time (McAuliffe and Gordon, 1974, p. 807). Heavy, compulsive heroin users continue to seek and achieve euphoria, and its attainment is a major motivating force behind their continued use.

Researchers have offered a resolution to the apparent conflict between the positive and the negative reinforcement models of drug addiction. (While the negative reinforcement school argues that only the avoidance of pain and the desire to feel normal motivate the addict, the positive reinforcement advocates argue that both factors, as well as others, may be operative.) It is likely that there are actually two types of narcotic addicts: the *maintainers* and the *euphoria seekers*. The maintainer takes just enough narcotics to avert withdrawal distress. Some addicts lack the financial resources and are unwilling to engage in a life centered on the commission of crime to obtain enough heroin to attain euphoria. They are simply staving off the agony of withdrawal, "nursing" their habit along (McAuliffe and Gordon, 1974, p. 826). To achieve the high they really want would require taking such substantial quantities of the drug that their lives would be transformed utterly and completely. They would have to work very hard and run a substantial risk of harm and arrest. Not all users want to commit crimes to get high; not all think the chance of arrest is worth threatening such valued aspects of their lives as their jobs, families, and the freedom to come and go where and when they want. They prefer to maintain a habit rather than risk what they have in order to achieve euphoria. They have retained most of their ties with conventional society and "let loose only periodically" (McAuliffe and Gordon, 1974, p. 822).

In contrast, the pleasure-seeking addict takes narcotics in sufficient quantities and at sufficiently frequent intervals to achieve euphoria. This habit is extremely expensive and hence typically requires illegal activity to support it. In addition, the lifestyle of the euphoria-seeking addict is sufficiently disruptive that a legal job is not usually feasible;

he or she must resort to criminal activity instead. It is also difficult for the nonaddict to fit in with and be capable of tolerating the addict's lifestyle, so marriage and family are a chancy proposition unless the addict's spouse is also addicted. And because heavy opiate use depresses the sexual urge, erotic relationships are problematic. The euphoria-seeking addict has sacrificed conventional activities and commitments for the pursuit of pleasure, and to engage in this pursuit, a commitment to a deviant and criminal lifestyle is also necessary. Such sacrifices would make no sense "if they were directed solely toward reducing withdrawal symptoms, which could be accomplished with much less effort, as every addict knows" (McAuliffe and Gordon, 1974, p. 828).

Inadequate Personality

Some researchers suggest that psychological pathologies, defects, or inadequacies explain drug abuse. There is something wrong in the emotional or psychic life of certain individuals, they say, that makes drugs attractive to them. Abusers take drugs as an escape from reality, as a means of avoiding life's problems and retreating into euphoric bliss and drugged-out indifference. Euphoria, says one inadequate-personality theorist, is adaptive for the immature individual who lacks a sense of responsibility and independence, and the ability to deter hedonistic gratification for the sake of achieving long-range goals (Ausubel, 1980, pp. 4–5). Although drug use is adaptive for the defective personality in that it masks some of life's problems, it is adaptive only in an exclusively negative way: The problems never get solved, only covered up, and meanwhile, the drug use itself generates a host of other, more serious problems. Normal people, who do not share this inadequacy, do not find drugs appealing and are not led to use them. Not all drug users share personality inadequacies and defects to the same degree; some will be impelled to experiment or use simply because of social pressure or availability. However, the more inadequate the personality, the greater the likelihood of becoming highly involved with drug use, and the more that use becomes abuse and eventually addiction. For the weak, drug abuse is a kind of crutch; for the strong, experimentation leads to abstention, not abuse. For the inadequate-personality theorist, drug abuse is an adaptation or a *defense* mechanism, a means of obliterating feelings of inferiority (Wurmser, 1980, pp. 71–72).

One major variety of the inadequate-personality approach is the self-esteem or **self-derogation perspective**. This theory holds that drug use and abuse, like deviant and criminal behavior generally (Kaplan, 1975, 1980), are responses to low self-esteem and self-rejecting attitudes. (But it does not apply in societies in which the particular type of drug use being explained is practically universal and normatively accepted by the majority.) Low self-esteem could come about as a result of "peer rejection, parental neglect, high expectations for achievement, school failure, physical stigmata, social stigmata (e.g., disvalued group memberships), impaired sex-role identity, ego deficiencies, low coping abilities, and (generally) coping mechanisms that are socially disvalued and/or are otherwise self-defeating" (Kaplan, 1975, p. 129). For some individuals, normatively approved activities and group memberships are sources of painful experiences; deviant or disapproved activities and memberships, however, are effective sources of self-enhancement. Drug use provides exactly such a deviant activity and group membership, and one that permits a deadening of the painful feelings stirred up by self-rejection. It is difficult to reconcile such self-derogation theories, which explain drug use as in part a consequence of social

rejection, with the fact that illicit drug users tend to have more, not fewer, intimate friends than nonusers (Kandel and Davies, 1991), as the theory would predict. In addition, in recent years, the entire edifice of self-esteem theory—that low self-esteem "is to blame for a host of social ills, from poor academic performance and marital discord to violent crime and drug abuse" (Goode, 2002, p. D1)—has come crashing to the ground. Most researchers no longer believe that a poor sense of self accounts for any of the behaviors that were once attributed to it, and that includes drug abuse.

Problem-Behavior Proneness

In a third type of psychological theory of drug use, researchers see the phenomenon as a form of deviant or problem behavior. In sociology and in social psychology, the branch of psychology most influenced by sociology, the term *deviant* has no negative, pejorative, or pathological connotations. Instead, it refers to behavior that is not in accord with the norms of, and so tends to be condemned by, the majority. Likewise, "problem" behavior is not necessarily bad or pathological; the term simply denotes behavior that has a certain likelihood of getting the individual who enacts it in trouble. Social psychologists have found that drug users typically have attitudes, values, and personalities that depart significantly from those of the nonuser majority. And these, in turn, make it likely that users will engage in behavior that, likewise, departs from the conventional path. These are statistical, not absolute, differences; many users and nonusers may be similar to one another in a number of ways but differ substantially from one another in other important respects. Still, the statistical differences are there, and they are often quite striking. What are they?

Before we examine the literature on the subject, it must be stressed that **problem-behavior proneness** is a dimension, the key elements of which are unconventionality and the willingness to take risks. Not all problem-behavior-prone individuals are at the extreme end of the spectrum—that is, are so unconventional and so willing to take risks that they are unlikely to survive in polite society. In fact, *moderately* unconventional and *moderately* risk-taking individuals are often among society's most creative, innovative, and successful individuals: artists, inventors, writers, scientists, even academics. Without unconventionality, risk taking, and a certain tolerance for both, society is likely to be repressive, and social change is likely to be sluggish or nonexistent. Many problem-behavior-prone youngsters are bright, do well in school, and are headed for successful careers. The concept has no meaning outside a specific social and cultural context, and a society that provides a place for eccentrics may also profit from their often considerable contributions—just as it often also punishes their unconventional behavior. But other things being equal, the problem-behavior-prone youngster is more likely to use a wide range of drugs than is the one who follows the rules, plays it safe, and takes few risks.

With respect to users' personalities and attitudes, a great deal of research (for instance, Jessor and Jessor, 1977, 1980; Robins, 1980) has demonstrated that users, in comparison with nonusers, tend to be more rebellious, independent, open to new experience, willing to take a wide range of risks, tolerant of differences, accepting of deviant behavior and transgressions of moral and cultural norms, receptive to uncertainty, pleasure seeking, hedonistic, peer-oriented, nonconformist, and unconventional. (Once again, some of these qualities are also related to imagination, creativity, and certain kinds of

talent, ability, and accomplishment.) In addition, users tend to be less religious, less attached to parents and family, less achievement oriented, and less cautious. This personality manifests itself in a wide range of behavior, much of it not only unconventional but problematic for the individual and for mainstream society: earlier sexual behavior, and with a wider range of partners; underachievement in school and on the job; and at least mildly delinquent behavior.

Researchers who emphasize the unconventional personality as a key factor in drug use can demonstrate the validity of their approach with longitudinal studies. They can predict *in advance*, before youngsters have used drugs, with a high degree of accuracy, which ones will experiment with and use psychoactive substances and which ones will not. With respect to personality, the adolescent *less* likely to experiment with and use drugs "is one who values and expects to attain academic achievement, who is not much concerned with independence, who treats society as unproblematic rather than as an object for criticism, who maintains religious involvement and a more uncompromising attitude toward normative transgression, and who sees little attraction in problem behavior relative to its negative consequences." The adolescent *more* likely to experiment with and use drugs "shows an opposite pattern: a concern with personal autonomy, a lack of interest in the goals of conventional institutions, like church and school, a jaundiced view of the larger society, and a more tolerant view of transgression" (Jessor and Jessor, 1980, p. 109). A "single summarizing dimension underlying the differences between users and nonusers might be termed conventionality-unconventionality" (Jessor and Jessor, 1980, p. 109).

Like most theories, the view that drug users are more unconventional and risk taking than nonusers sees the relationship as a matter of degree. The more unconventional the youth, the greater the likelihood that he or she will use drugs. In addition, the more unconventional the youth, the more serious the drug involvement. *Mildly* unconventional youngsters are likely to drink and experiment with marijuana but do little else. *Moderately* unconventional youngsters will drink alcohol more heavily, use marijuana regularly, and experiment with other drugs. *Highly* unconventional youngsters have a much greater chance of becoming seriously involved not only with alcohol and marijuana but with more dangerous drugs as well. It is possible that this explanation accounts for the typical or modal drug user—mainly, the "recreational" drug user. However, an account of why some recreational users become compulsive, abusive, and addicted consumers of psychoactive substances requires a separate theory or the introduction of additional factors. What causes someone to *use* drugs may be different from what causes someone to *abuse* them.

SOCIOLOGICAL THEORIES

In contrast to biological and psychological theories, which emphasize the individual (the "kinds of people" explanations), sociologists tend to make broader, structural factors the focus of their theories. For most sociologists, the crucial factor is not the characteristics of the individual, but the situations, social relations, or social structures in which the individual is, or has been, located. More specifically, it is the individual *located within* specific structures. (See Table 6-1.)

TABLE 6-1 Sociological Theories of Drug Use

Theory	Explanatory Factor	Proponents
Anomie/strain	Disjunction between means and ends	Robert Merton; Richard Cloward and Lloyd Ohlin
Social control theory	Absence of bonds to conventional society	Travis Hirschi; others
Self-control theory	Inadequate parenting, leading to lack of self-control	Michael Gottfredson and Travis Hirschi
Social learning and subcultural theory	Deviant socialization	Edwin Sutherland; Ronald Akers; Howard Becker
Selective interaction/ socialization	Attraction to unconventionality, and influence by peer groups	Bruce Johnson; Denise Kandel
Social disorganization	Community or neighborhood disorganization	Many
Conflict theory	Differences in power, resources, and opportunities	Elliott Currie; Harry Levine; many others

Sociology proposes seven partially overlapping **sociological theories** to help explain drug use: (1) anomie, (2) social control, (3) self-control, (4) social learning and subculture, (5) selective interaction/socialization, (6) social disorganization, and (7) conflict theory. (I'll mention an eighth theory, routine activities theory, only in passing.) The overlap among these theories is sufficiently great that some of the theorists who endorse one of them also support one or all of the others.

Anomie Theory

In the 1930s, sociologist Robert K. Merton generated what came to be referred to as the **anomie theory** of deviant behavior. In his view, deviant behavior—illicit drug use included—takes place when avenues to material success are blocked off. Anomie theory, as Merton developed it (1938, 1957, pp. 131–160; 1968, pp. 185–248), argues that in a competitive, materialistic, achievement-oriented society, success is encouraged as attainable for all members but actually is attainable for only a small proportion of society. Individuals who do not succeed must devise "deviant" or disapproved adaptations to deal with their failure. Those who have given up on achieving society's materialistic goals, whether by approved or disapproved means, become **retreatists**. "In this category fall some of the adaptive activities of psychotics, autists, pariahs, outcasts, vagrants, vagabonds, tramps, chronic drunkards, and drug addicts" (Merton, 1957, p. 153). An extension of this theory holds that the person who is most likely to become a drug addict is someone who has attempted to use both legal (or legitimate) and illegal (or illegitimate) means to achieve success, but has failed at both. The addict is a "double failure" and has "retreated" into the undemanding world of addiction.

Other researchers have refined anomie theory but, some believe, not entirely successfully. In response, critics have launched devastating attacks on anomie theory and its application to drug use and abuse. The anomie perspective experienced an eclipse in the late 1960s and remained at a low ebb throughout the 1970s and early-to-mid-1980s. At that time, many researchers believed that it had been discredited and "disconfirmed"

(Kornhauser, 1978, p. 180), that it was irrelevant to an understanding of the etiology, or causality, of drug use. Some argued that it had become something of an embarrassment to the field, and, as it applied to drug use and addiction, it was regarded by many researchers as fanciful, generated in the almost total absence of knowledge of the world of drug use (Lindesmith and Gagnon, 1964; Preble and Casey, 1969).

The image of the model addict that predominates in anomie theory is that of the Chinese opium addict, puffing on his pipe in a dreamy, somnolent state. In fact, the world of the addict is anything but undemanding. It is a brutal, abrasive world requiring substantial skill and effort even to survive (Preble and Casey, 1969). And it is not the poorest members of poor communities—the most clear-cut "failures"—who turn to heroin, but those who are a rung above them financially and occupationally.

Many drug researchers felt that these and other critiques fatally weakened anomie theory. However, beginning in the late 1980s, anomie theory underwent a renaissance; sociologists began to look at the perspective in a new way, revised some concepts and assumptions, and pursued fresh lines of research (Messner and Rosenfeld, 1997). Is the anomie approach relevant to drug abuse after all?

It is possible that the earlier judgment about the theory was premature and overly harsh with regard to at least one sphere of behavior—that of drug selling. Since legitimate achievement is blocked off for a significant proportion of society, one avenue of illegitimate achievement is rendered more attractive as a consequence. And what is drug dealing but an *innovative* attempt to maintain the goal of achieving material success by engaging in an illegitimate, illegal, and deviant activity? Drug dealing is an innovative adaptation to blocked or frustrated material success for many members of society who have learned to expect that success but who live in a setting in which high levels of achievement are all but impossible. Hence, anomie theory has a great deal to say about one major aspect of the drug scene (dealing), but not drug use, abuse, or addiction.

Social Control and Self-Control Theories

Two major theories that attempt to explain deviant and criminal behavior—and, by extension, drug use and abuse as well—are social control or bonding theory and self-control theory, or the "general theory of crime." Both are individualistic theories and not group or structural theories, the approach adopted by most sociologists. These two theories make extensive use of the concept of control and focus on why some people *conform* to society's norms and laws. Both assume that deviance and, by extension, drug use do not need to be explained. If left to our own devices, *all* of us would deviate, break the law, use drugs, and get high; we would simply be doing what comes naturally. What really needs to be explained is why some people do *not* deviate from the norms, violate the law, use drugs, or get high. These two theories differ considerably in the emphasis they place on the dynamics of deviance, crime, and drug use, and the relevant explanatory time frame.

According to **social control theory**, what causes drug use, like most or all deviant behavior, is the absence of the social controls encouraging conformity. Most of us do not engage in deviant or criminal acts because of strong bonds with or ties to conventional, mainstream persons, beliefs, activities, and social institutions. If such bonds are weak or broken, we will be released from society's rules and free to deviate—and this

includes drug use. It is not that drug users' ties to an unconventional subculture attract them to drugs; it is their *lack* of ties to the conforming, mainstream sectors of society that frees them from the bonds keeping them from using drugs. It is the *absence* of these bonds that explains illicit, recreational drug use.

Delinquency, deviance, and criminal behavior—including recreational, nonmedical drug use—are matters of degree. Just as most of us engage in at least one technically illegal act in our lives, a very high proportion of the American population eventually uses at least one drug outside a medical context. Social control theory does not assert that persons with strong ties to conventional society will *never* engage in any deviant action, regardless of how mild, including using a drug recreationally. It does, however, assert that both deviance and control are matters of degree: the more attached we are to conventional society, the lower the likelihood of our engaging in behavior that violates its values and norms. A strong attachment does not absolutely insulate us from mildly deviant behavior, but it does make it less likely.

Social control theory emphasizes the actor's stake in conformity. The more we have "invested"—with respect to time, emotion, energy, money, and so on—in conventional activities and involvements, the more conventional our behavior is likely to be. A "stake" could be anything we value, such as a loving relationship, good relations with our parents, a family, children, an education, work, a satisfying job, and/or a career. Someone who has "invested" in these positively valued, reward-laden enterprises is less likely to engage in behavior that may undermine them than is someone who has no such investments. One or more stakes in conformity tend to act to keep us in line and away from the clutches of drug abuse.

The more *attached* we are to conventional others—parents, teachers, clergy, employers, and so on—the less likely we are to break society's rules and use drugs. The more *committed* we are to conventional institutions—family, school, religion, work, and so on—the less likely we are to break society's rules and use drugs. The more *involved* we are in conventional activities—familial, educational, religious, occupational, and so on—the less likely we are to break society's rules and use drugs. And the more deeply we *believe* in the norms of conventional institutions—again, family, school, religion, work, and so on—the less likely we are to break society's rules and use drugs. Drug use is "contained" by bonds with or adherence to conventional people, institutions, activities, and beliefs. If these bonds are strong, recreational drug use is unlikely. Control theory has a kind of commonsensical flavor to it, and it also has a loyal following in the fields of the sociology of deviance, criminology, and the sociology of drug use (Hirschi, 1969).

Self-control theory represents another explanation of drug use and other unconventional, deviant, and/or criminal behavior. Self-control theory sounds a great deal like the "social" control theory we just looked at; however, the two are really quite different. Many of the assumptions made by the latter are rejected by the former. Travis Hirschi, a sociologist, has been a major proponent of social control theory. Starting in the late 1980s, in collaboration with Michael Gottfredson, he developed an altogether different and to some degree contradictory perspective; in 1990, they presented self-control theory in book form, titled *A General Theory of Crime*.

Self-control theory does share with social control theory the assumption that drug use and crime involve "doing what comes naturally"—in the absence of controls, most people would engage in them. What is necessary to explain, then, is *how* controls come to be absent.

It is here that the two theories diverge. The proponents of self-control theory conceive of crime as including not only the criminal act itself but also a variety of other illegal, illegitimate, deviant, and self-interested actions. The authors define crime as "force or fraud in pursuit of self interest." This encompasses an extremely diverse kettle of fish, but the authors explicitly state that drug use and abuse qualify (Gottfredson and Hirschi, 1990).

Drug use and crime are similar activities, they argue, because "both provide immediate, easy, and certain short-term pleasure" (p. 41). Crime and drug use are basically *the same sort of behavior*. They involve grabbing what someone wants without regard for the social or legal consequences. Getting high is fun—why not do it? Stealing gets you what you want—go ahead and do it! Both behaviors manifest low levels of self-control (pp. 233–234). Compared with law-abiding citizens and nonusers, criminals and drug users (whose personnel heavily overlap) are hedonistic, short-sighted, nonverbal, inconsiderate, and intolerant of frustration. In a nutshell, the "general theory" of crime's explanation of drug use is that some people find drugs attractive because they lack self-control. They take the easy, self-indulgent route; they are pleasure oriented. They do not think about the consequences—the possible harm to themselves or others in using drugs or doing anything else. They take shortcuts; they do whatever yields immediate gratification. They are grabbers, exploiters, liars, thieves, and cheaters; they are reckless, careless, violent, impulsive, insensitive, and self-centered. They have no concern for the long-range consequences of their actions. Drug use is simply a manifestation of their general orientation to life: Do whatever gets them what they want, whatever feels good, regardless of whether their actions harm others or even, in the long run, themselves. The usual controls that keep the rest of us in check do not operate in their lives.

What causes low self-control? Here again, social control and self-control theories diverge. According to self-control theory, a lack of self-control is caused by inadequate parental socialization. Parental socialization is a factor that operated in the past but that exerts a lifetime influence, whereas social control is a factor that operates only in the present. Parents who are lacking in strong affection for their children, who are unable or unwilling to monitor their children's behavior, and who fail to recognize that their children are engaging in wrongdoing are more likely to raise offspring who both engage in criminal behavior and indulge in drugs. Hence, as we have seen, self-control is related to factors that take place very *early* in one's life, whereas social control operates more or less *throughout* one's lifetime.

The most important reason self-control theory and social control theory are incompatible or contradictory is that, in order for the forces of *social* control to operate, it is necessary for someone to have attained a certain level of achievement to begin with—and that requires *self*-control. If individuals lack self-control, they cannot get to the point where social control is relevant. Social control theory says that persons with a stake or investment in conformity—in the form of, say, a house, a marriage, children, or a college education—are more likely to conform to society's norms. How can persons who lack self-control achieve such a stake? They can't; their lack of self-control makes it difficult for them to purchase a house, hold down a job, sustain a meaningful marriage, have a rewarding relationship with their children, or do well enough in school to attend college and graduate. According to this theory, self-control is prior to and more pervasive than social control. Hence, in the book that articulates self-control theory, *A General Theory of Crime*, coauthor Travis Hirschi barely acknowledges the existence of a theory he once embraced.

Once again, as with all other factors or variables, self-control is a continuum, a matter of degree. The theory would predict that self-control and drug use are inversely or negatively correlate with each other: the lower the level of self-control, the greater the likelihood of drug abuse; the higher the self-control, the lower that likelihood is. It does not argue that all persons who lack self-control abuse drugs, only that they are *more likely* to do so than are those governed by strong self-control. Further, it would predict that the self-control and drug use are related to each other in a linear fashion: The experimenter is more likely to possess self-control than is the occasional user, and the occasional user is more likely to do so than is the regular user; the weekend marijuana smoker is more likely to possess self-control than is the crack or heroin addict; and so on. As with all sociological theories or explanations, self-control theory makes comparative or relative rather than absolute statements: the greater the self-control, the lower the likelihood of drug abuse.

Gottfredson and Hirschi argue that their theory demolishes all other explanations of drug use, including anomie and social learning theories, with the exception of two: social disorganization and routine activities theories. Self-control theory is **social disorganization theory** writ small. The key to drug use, as with crime and deviance in general, according to social disorganization theory, is that members of the neighborhood or community are unwilling or unable to monitor or control wrongdoing, and so it flourishes. The same applies to inadequate parenting. To the extent that parents are unable or unwilling to monitor or control their child's behavior, that child will manifest low self-control and hence will get high, steal, and engage in violent behavior. Neighborhood social disorganization and low self-control are structural versus individual levels of basically the same factor.

Routine activities theory argues that deviance and crime will take place to the extent that three factors are present: (1) a **motivated offender**, (2) something worth offending against (a **suitable target**, such as a quantity of cash), and (3) someone who can defend or protect that which is offended against (a **capable guardian**, such as a police officer). But routine activities theory ignores the motivated offender. To that extent, it is very different from self-control theory, which focuses *entirely* on the offender and simply assumes that low self-control leads to drug use, delinquency, deviance, and criminal behavior. However, self-control theory is (at least partly) consistent with routine activities theory in that, for both, opportunity is a major piece of the puzzle. Routine activities theory argues that persons offend to the extent that a suitable target is available and a capable guardian is absent—in a word, when the opportunity to offend exists. People will use drugs to the extent that they are available and agents of social control are not in the picture. Again, the theory does not raise the question of which people will follow up on the available opportunity, only that there are enough motivated offenders in the population to keep the enterprise of offending healthy and strong. In any case, routine activities theory has not been used much by researchers in the area of drug use; it applies most strongly to money-making crimes.

Social Learning and Subcultural Theories

The theory that criminal or deviant behavior is a product of learning was first elaborated by sociologist Edwin Sutherland in the third edition of his textbook *Principles of Criminology* (1939). He called this formulation the theory of **differential association** because the key mechanism in becoming criminal or deviant is the fact that one associates

differentially with social circles whose members define crime and deviance in favorable terms. The central tenets of this theory are that crime and deviance are learned in intimate, face-to-face interactions with significant others, or people to whom one is close. A person engages in deviant and criminal behavior to the extent that the definitions to which he or she is exposed are favorable to violations of the law—because of an excess of definitions favorable to legal and normative violations compared with definitions unfavorable to such violations. The key to this process, according to Sutherland, is the *ratio* between definitions favorable and unfavorable to legal and normative violations. When favorable definitions exceed unfavorable ones, the individual will turn to deviance and crime.

The social learning approach has been extended by sociologists who have blended Sutherland's theory of differential association with the principles of behaviorism in psychology. **Social learning theory** holds that behavior is molded by rewards and punishment, or reinforcement. Past and present rewards and punishments for certain actions determine the actions that we continue to pursue. Reward and punishment structures are built into specific groups. By interacting with members of certain groups or social circles, people learn definitions of behaviors as good or bad. It is in the group setting, differentially for different groups, that reward and punishment take place, and where individuals are exposed to behavioral models and normative definitions of certain behavior as good or bad.

Social learning theory has a clear-cut application in explaining drug use: It proposes that the use and abuse of psychoactive substances can be explained by differential exposure to groups in which use is rewarded. "These groups provide the social environments in which exposure to definitions, imitations of models, and social reinforcements for use of or abstinence from any particular substance take place. The definitions are learned through imitation and social reinforcement of them by members of the group with whom one is associated" (Akers et al., 1979, p. 638). Drug abuse is determined "by the extent to which a given pattern [of behavior] is sustained by the combination of the reinforcing effects of the substance with social reinforcement, exposure to models, definitions through association with using peers, and by the degree to which it is not deterred through bad effects of the substance and/or the negative sanctions from peers, parents, and the law" (Akers et al., 1979, p. 638). Social learning theory, then, proposes that the extent to which substances will be used or avoided depends on the "extent to which the behavior has been differentially reinforced over alternative behavior and is defined as more desirable" (Radosevich et al., 1980, p. 160). We tend to repeat what we receive rewards for doing. The theory does not, however, explain how a given individual falls into a social circle that defines an activity (such as drug use) in positive terms.

Subcultural theory and the theory of differential association are related but distinctly different. The central thesis of the subcultural theory is that involvement in a particular social group whose members have attitudes favorable to drug use is the key factor in fostering one's own drug use and that involvement in a group whose members have negative attitudes toward drug use tends to discourage such use. Drug use is expected and encouraged in certain social circles and actively discouraged, even punished, in others. Although subcultural theory has certain parallels with the theory of differential association, there are crucial differences as well. For one thing, Sutherland's theory of differential association and the social learning theory that grew out of it do *not*

require that the process of socialization take place within stable, identifiable social groupings. Indeed, Sutherland postulated that, in principle, deviant or criminal socialization could be effected through association with a single individual, such as a friend, or a small group of individuals, such as a delinquent gang. In contrast, subcultural theory identifies the socialization process as taking place through the assimilation of individuals into specific groups or social circles, with a resultant transformation in identity, values, norms, and behavior.

The first systematic application of subcultural theory to drug use was made by Howard S. Becker (1953, 1955, 1963), who focused on the process of becoming a marijuana user. Becker, like the other interactionists, was not concerned with the question of etiology or cause-and-effect explanations; the traditional question of why someone uses marijuana and someone else does not did not capture Becker's attention. His focus was not so much on the characteristics that distinguish the user from the nonuser (the characteristics that cause the user to use and the nonuser to abstain) but rather the question of how someone comes to use and experience marijuana in such a way that it will continue to be used to achieve pleasure. For this to take place, three things must happen, according to Becker's model.

First, one must learn how to use marijuana so that the drug is capable of yielding pleasure; one must learn the proper technique for smoking marijuana. Second, since the effects of the drug are subtle and ambiguous, one must learn to perceive them: One must learn that something is happening to one's body and mind and that it is the marijuana that is causing this effect. And third, one must learn to enjoy the effects. By themselves, the sensations that the drug generates are not inherently pleasurable. Without knowing what is happening to one's body, the feelings attendant upon ingesting marijuana may be experienced as unpleasant, unsettling, disorienting, uncomfortable, confusing, and even frightening. The drug's effects must be conceptualized, defined, and interpreted as pleasurable. How do these three processes come about? They depend, Becker said, "on the individual's participation with other users. Where this participation is intensive, the individual is quickly talked out of his feeling against marijuana use" (1963, p. 56).

Learning to enjoy marijuana "is a necessary but not a sufficient condition for a person to develop a stable pattern of drug use" (Becker, 1963, p. 59). Marijuana use is, after all, a deviant and criminal activity (and it was even more so in the 1950s and early 1960s, when Becker wrote about the subject). The individual must also learn how to deal with a society that punishes users in its attempt to eliminate use. Deviant behavior can flourish when "people are emancipated from the controls of society and become responsive to those of a smaller group" (p. 60)—in Becker's words, a "subcultural group." To continue smoking marijuana, users must have a reliable supply of the drug, keep their use from relevant disapproving others, and nullify the moral objections raised by mainstream society. These three processes, again, require normative and logistic support from the marijuana-using subculture.

An interesting feature of Becker's model is that it turns the traditional view of drug use on its head. Far from motives causing use, Becker proposed the opposite—that *use causes motives*. One does not learn that drug use is acceptable and then use drugs as a result; rather, one first uses drugs and, during the course of drug use, learns the necessary justifications and explanations that provide the motivation for further use. In a group

setting, one is furnished with "reasons that appear sound for continuing the line of activity" he or she has begun (1963, p. 39). As Becker summarized the matter:

> To put a complex argument in a few words, instead of deviant motives leading to the deviant behavior, it is the other way around; the deviant behavior in time produces the deviant motivation. Vague impulses and desires . . . are transformed into definite patterns of actions through the social interpretation of a physical experience which is in itself ambiguous. Marihuana use is a function of the individual's conception of marihuana and of the uses to which it can be put, and this conception develops as the individual's experience with the drug increases. (1963, p. 42)

The individual's involvement with the marijuana-using subculture is the key factor in use. People do not begin using the drug on their own; individualistic theories cannot account for use. The characteristics of individuals count for nothing in the absence of social circles whose members explain use to the novice, supply the drug, and provide role models. It is only through contact with other users, Becker reminds us, that use, especially regular use, can take place.

Becker's model does not include any discussion of specific individual or group characteristics that cause someone to use. His theory is very close to a "pure" subcultural model, discussing the mechanisms of the socialization of the novice without mentioning the fact that only certain types of individuals and members of only certain types of groups are likely to be attracted to marijuana use. Becker seems uninterested in the fact that people who have certain attitudes, beliefs, and personality characteristics, or who engage in certain forms of behavior, are a great deal more likely to be attracted to social circles or subcultural groups whose members use drugs. Becker's model seems to presuppose an almost random recruitment into drug subcultures—although, once an individual is recruited, selective interaction and socialization are the major mechanisms at work.

For Becker, the *content* of the user subculture—apart from its use of the drug and its definition of the drug and its use—is secondary. Becker did not touch on any potentiating factors in use at all. He does not explain which individuals are more likely to be attracted to the use of the drug or which individuals are likely to be attracted to other individuals or groups who are users. He does not deal with the issue of the compatibility between a given individual and the content of a specific subculture—what it is that draws a novice to a circle of individuals who use marijuana. Following the interactionist approach, Becker underplayed the question of cause or etiology. Why someone finds him- or herself in the company of others who smoke marijuana and actually ends up using the drug—rather than turning down the chance—is something of an unexplained or "black box" factor in Becker's analysis. He assumed that the user's subculture is favorable toward use and defines it as such. But he made no assumption about any other values or behaviors that might or might not be consistent or compatible with use itself.

Selective Interaction/Socialization Theory

The term *selective interaction* refers to the fact that potential drug users do not randomly "fall into" social circles of users; they are attracted to certain individuals and circles—subcultural groups—because their own values and activities are compatible with those of current users. There is a dynamic element in place: Even before someone uses a drug for the first time, he or she is "prepared for" or "initiated into" its use—or, in a sense,

socialized in advance—because his or her values are already somewhat consistent with those of the drug subculture. As a result, one chooses friends who share these values and who are also likely to be attracted to use and to current users. I call this process "selective recruitment." In addition, once someone makes friends who use drugs, he or she becomes socialized by a using subcultural group into those values compatible and consistent with use. This is why I call this the **selective interaction/socialization model.** Johnson (1980) calls it the subcultural model, and Kandel (1980a, pp. 256–257) calls it the socialization model. It is both a subcultural and a socialization perspective, but it does not follow the lines of Becker's classic argument, and it is a somewhat different process of socialization from the traditional model.

Studying drug use in a college setting, Johnson (1973) made use of both the subcultural and the socialization models. He demonstrated that drug use occurs because adolescents are socialized into progressively more unconventional groups (p. 5). Briefly stated, Johnson's argument holds that the more adolescents are isolated and alienated from the parental subculture, and the more involved they are with the teenage peer subculture, the greater the likelihood that they will experiment with and use a variety of drugs. The peer subculture provides a transition between the parental and the drug subcultures. For the most part, the parental generation is conventional and antidrug, and also opposes a number of other unconventional and deviant activities. Adolescents who are strongly attached to, influenced by, and committed to the parental subculture tend to adhere more closely to its values and follow its norms of conduct. As a consequence, they are more likely to abstain from drugs than is the teenager who is isolated from his or her parents and involved with peers, who favor more unconventional norms, and therefore is more likely to accept certain forms of recreational drug use, especially marijuana smoking.

Not only does the peer subculture exist somewhat independently of and in opposition to the conventional parental generation, it also emphasizes activities in contexts in which parental control is relatively absent. There is something of a competition for prestige and status within peer groups. Higher status is granted in part as a consequence of engaging in activities and holding values that depart significantly from parental demands and expectations. These include alcohol consumption, marijuana use, the use of certain hard drugs, some delinquent activity (including what Johnson calls automobile deviance—speeding, driving without a license, and so on), shoplifting, hanging out, hooking up, and cruising.

Johnson's study found that if one has marijuana-using friends, one tends to use marijuana; if one does not have marijuana-using friends, one tends not to use marijuana. The more marijuana-using friends one has, the greater the likelihood of using marijuana regularly, buying and selling marijuana, and subsequently using hard drugs. In addition, having marijuana-using friends and using the drug regularly tend to be strongly related to sexual permissiveness (having sex early and with a number of partners, and approving of sex in a wide range of circumstances), political leftism, plans to drop out of college, and engagement in delinquent acts (Johnson, 1973, p. 195). Note that marijuana use is instrumentally involved in this process; using marijuana vastly increases the chance of engaging in numerous other drug-related activities. But Johnson's study suggests that it is not the physiological action of the drug itself that does this, but the subcultural involvement that marijuana use entails. Marijuana use is an index or measure of subcultural

involvement, and the more involved one is with the drug subculture, the more socialized by it, influenced by its values, and engaged in its activities one is.

The selective interaction/socialization model of drug use has been explored most systematically and in the greatest empirical detail by sociologist Denise Kandel. Kandel can be said to be the principal proponent of the perspective. Kandel's approach is eclectic and makes use of concepts taken from social learning theory, the social control model, and the subcultural approach. She places less emphasis on "selective recruitment"—the fact that young people who eventually use drugs are different from those who never use, even before use takes place—and relatively more on the processes of selective interaction and socialization.

Adolescents vary with respect to a range of individual and social background characteristics. Likewise, adolescent social gatherings or groups have different and varying characteristics. Some are more compatible with a given adolescent's own traits; some are less so. As a general rule, people of all ages, adolescents included, tend to gravitate to groups whose characteristics are compatible with or similar to their own and to avoid those that are incompatible or dissimilar. However, in early adolescence, young people tend to be "drifters"—their early drug use, mainly of beer and wine, or nonuse is dependent mainly on accidental, situational factors. If they are in a circle of adolescents who drink, their chances of drinking are greater than if they are in a circle of nondrinkers. Early on, general peer climate powerfully influences patterns of substance use, and young adolescents are not strongly motivated to select a peer group that reflects their own interests and inclinations.

Adolescents are socialized by several different "agents." Socialization theorists locate four main agents of socialization: parents, peers, school, and media. Two are tightly related to drug use—parents and peers. Adolescents tend to internalize definitions and values and to engage in behavior enacted and approved by significant others. The impact of the various agents of socialization depends on the values and behaviors in question. For broader, long-term values and behaviors, such as religion, politics, and lifetime goals, parents tend to be most influential; for more immediate lifestyle behaviors and values, peers are most influential (Kandel, 1980a, p. 257).

The parental influence on the drug use of teenagers is small but significant: Parents who use legal drugs (alcohol, tobacco, and prescription drugs) are more likely to raise children who both drink hard liquor and use illegal drugs than are parents who abstain from drugs completely. In the earliest stages, parental example will influence substance use in the form of beer and wine and, a bit later on, hard liquor. However, peer influence on drug use is even more formidable. Teenagers, especially older ones, tend to associate with one another partly on the basis of similarities in lifestyle, values, and behavior—and drug use or nonuse is one of those similarities. Friends typically share drug using patterns: Users tend to be friends with users, and nonusers tend to be friends with nonusers. Of all characteristics that friends have in common—aside from the obvious social and demographic ones, like age, gender, race, and social class—their drug use or nonuse is the one they are most likely to share (Kandel, 1973, 1974).

Selective peer group interaction and socialization represent probably the single most powerful factor related to drug use among adolescents. Imitation and social influence play a significant role in initiating and maintaining drug use among teenagers. Over time, participation in specific groups or social circles reinforces certain values and patterns of

activity. Association with friends whose company one enjoys reinforces the values shared and behaviors engaged in with those friends. And the closer one's bond, the greater the likelihood of maintaining the values and behaviors that are shared. Note, however, that adolescents do not choose friends at random: They are, in a sense, socialized "in advance" for participation in certain groups. They choose and are chosen by certain groups because of that socialization process, and likewise, participation in those groups socializes them toward or away from the use of illicit drugs. We have a reciprocal or dialectical relationship here.

Kandel's model of adolescent drug use is dynamic in that she does not end her analysis with substance use per se—at the point when someone has experimented with a psychoactive substance or with continued use over time. Kandel is interested in drug use *sequences*. For her, to focus on a single drug would be fallacious; adolescents use several drugs, and they use them in specific patterns and in specific "culturally determined" and "well-defined" developmental stages. The "use of a drug lower in a sequence is a necessary but not a sufficient condition for progression to a higher stage indicating involvement with more serious drugs" (Kandel, 1980b, pp. 120, 121). These stages can be reduced to four: (1) beer and/or wine, (2) cigarettes and/or hard liquor, (3) marijuana, and (4) other illegal drugs (1980b, p. 121). Adolescents rarely skip stages; drinking alcohol is *necessary* to smoking marijuana, just as marijuana use is necessary to moving on to more dangerous drugs such as cocaine and heroin.

Kandel supports the idea that unconventionality is related to drug use generally. However, she argued that the relevance and importance of specific variables are dependent on the young person's stage in life and the relevant drug used; there is a *time-ordering* of specific factors. In the early stages of substance use, early in adolescence, as noted above, the most important drugs used are beer and wine, and the most crucial causal factor is general peer climate. The less serious the drug use (beer and wine versus heroin and cocaine), and the more widespread it is, the more important the role played by accidental situational features and by broad peer-subcultural attitudes and drug-related behavior. Here, most adolescents are "drifters" with regard to drug use; users' attitudes toward and beliefs about drugs are not significantly different from nonusers'. At this point, most adolescents are "seducible" with respect to psychoactive substances, particularly beer and wine.

At later stages, different factors come into play. For marijuana, in middle adolescence, attitudes toward the drug are very important, peer influence remains strong, and parental influence is fairly weak. In later adolescence, three factors that were less crucial earlier loom especially large. First are psychological pressures: More troubled adolescents will tend to progress from marijuana to "harder" drugs; less troubled ones will be less likely to do so. Second is the relationship with parents: The more alienated an adolescent is from his or her parents, the greater the likelihood that he or she will progress from marijuana to more dangerous drugs. Intimate relations with parents tend to "shield" the adolescent from the more serious forms of drug use. And third, while peer climate in general declines in importance over time, having at least one specific friend who uses one or another dangerous drug assumes central importance. Here, the adolescent breaks away from peer circles who do not favor the use of more dangerous drugs and gravitates to specific individuals who use them. "The individual who progresses to the use of other illicit drugs may, as a result of his drug-related behavior, factors of availability, or

family difficulties, move away from long-term friendships and seek less intimate relationships with those who share his attitudes, behaviors, and problems" (Kandel, Kessler, and Margulies, 1978, p. 36). This adolescent is no longer a "drifter" but a "seeker."

A Conflict Theory of Drug Abuse

More than three decades ago, the National Institute on Drug Abuse (NIDA) issued a volume titled *Theories on Drug Abuse* (Lettieri, Sayers, and Pearson, 1980). Conspicuously absent from this compendium was one of the more currently influential theories of drug abuse, **conflict theory**. This perspective is distinctly "macro" in its approach: It examines the big picture, the larger, structural factors—forces that influence not merely individuals but members of entire societies, cities, neighborhoods, and communities. Conflict theorists have focused their perspective more or less exclusively on the heavy, chronic, compulsive abuse of heroin and crack, and only marginally on the use of alcohol, tobacco, and marijuana. Hence, conflict theory explains only a portion of the drug abuse picture; it is not a complete explanation of drug abuse—no explanation can be that—but one that addresses the issues that much of the public finds most troubling.

Proponents of conflict theory hold that the heavy, chronic abuse of crack and addiction to heroin are strongly related to social class, income, power, and locale. A significantly higher proportion of lower- and working-class inner-city residents abuse hard drugs than is true of more affluent members of the society. More important, this is the case because of the impact of a number of key structural conditions, conditions that have their origin in *economics* and *politics*. More specifically, several key economic and political developments have taken place in the past three decades or so that bear directly on differentials in drug abuse.

Sociologist Elliott Currie spells out this perspective in *Reckoning: Drugs, the Cities, and the American Future* (1993), as does Harry Gene Levine in his paper "Just Say Poverty: What Causes Crack and Heroin Abuse" (1991). In my view, it is one of the more adequate and comprehensive explanations for a number of recent developments in the world of drug abuse. Connections that have always existed between income and neighborhood residence, on the one hand, and drug abuse and addiction, on the other, have become exacerbated by these recent developments. What are these crucial recent developments?

First, since the early 1970s, economic opportunities for the relatively unskilled and uneducated sectors of society have been shrinking. In 1970, it was still possible for many heads of households with considerably lower-than-average training, skills, and education to support a family by working at a job that paid them enough to raise their income above the poverty level; this was especially the case if more than one member of the household was employed. Today, this is much less likely to be true. Far fewer family breadwinners who lack training, skills, and education can earn enough to support a family and avoid slipping into poverty. Decent-paying manual-level jobs are disappearing. Increasingly, the jobs that are available to the unskilled and semiskilled, the uneducated and semieducated, tend to be dead-end, minimum-wage, poverty-level jobs. The bottom third or so of the population is becoming increasingly impoverished, and one consequence of this development is the growing attractiveness of drug selling.

As a result—and this is the second of our recent developments—the poor are getting poorer; ironically, at the same time, the rich are getting richer. That this seems always the case is part of our collective wisdom, but it hasn't always been so. Between 1945 and 1973, the incomes of the highest- and lowest-income strata grew at roughly the same annual rate. However, since 1973, the income of the top fifth of the economic ladder has grown at a yearly rate of 1.3 percent, while that of the lowest stratum has decreased at a rate of 0.78 percent a year (Cassidy, 1995). Additional factors such as taxes and entitlements (including welfare payments) do not alter this picture much. We are living in a society that is becoming increasingly polarized with respect to income. A few relevant facts should put these developments into perspective. (All figures are adjusted for inflation, of course.)

- Over the past 30 years, the share of the richest 1 percent of the population in the nation's total income has doubled. Meanwhile, the income of the bottom fifth of families "actually fell slightly" (Krugman, 2002, p. 67).
- Today, the nation's top 1 percent of the population earn as much as the poorest 40 percent combined. And the nation's 13,000 richest families earn nearly as much as the country's 20 million poorest households put together.
- In 1992, the richest 400 families in the United States earned 0.5 percent of the total of all incomes earned. In 2000, they earned more than double that share—1.1 percent. During this period, their incomes increased at 15 times the rate of the bottom 90 percent of the population (Johnston, 2003).
- Thirty years ago, the richest 0.01 percent of taxpayers earned 70 times the average family income; today, they earn 300 times that (Krugman, 2002).
- Over the past 30 years, the average salary of the top 100 chief executive officers has zoomed from $1.3 million (39 times the pay of the median worker) to $37.5 million (more than a *thousand* times the average worker's pay).
- During the past 30 years, among the nation's top 10 percent of income earners, *most* of the gains went to the richest 1 percent of all families; and in that 1 percent, 60 percent of the gains went to the top 0.01 percent of families (Krugman, 2002).

This development is not primarily a racial phenomenon. The income gap between African American and white households hasn't changed much since the end of World War II, but what has changed is that, among *both* blacks and whites, the poor are getting poorer and the rich are getting richer. Among married couples, both of whom have jobs and work year-round, the black-white income gap has practically disappeared. But among African Americans, there is a growing underclass whose members are sinking deeper and deeper into poverty. Ironically, at the same time that the black middle class is growing, the size of the poverty-stricken inner-city underclass is also growing. Again, one consequence of the polarization of the class structure is the increased attractiveness and viability of selling drugs as a means of earning a living. Not only are the poor becoming poorer, but the visibility of the display of affluence among the rich acts as a stimulus for some segments of the poor to attempt to acquire that level of affluence through illicit or illegitimate means—again, a factor that increases the likelihood that some members of the poor will see drug dealing as a viable livelihood.

A third development is especially relevant to the issue of the distribution of illegal drugs: community disorganization and political decline. As a consequence of the economic

decline of the working class and the polarization of the economy, as well as the "flight" of more affluent members of the community, the neighborhoods in which poor, especially minority, residents live are becoming increasingly disorganized and politically impotent (Wilson, 1987, 1997). Thus, they are less capable of mounting an effective assault against crime and drug dealing. The ties between such neighborhoods and the municipal power structure have become weaker, more tenuous, even conflictual. The leaders of such communities increasingly have learned that they cannot expect the resources once extended to them. All these factors make drug dealing in such communities more viable.

In such neighborhoods, criminals and drug dealers make incursions in ways that would not be possible in more affluent, more organized communities, which have stronger ties to the loci of power. In cohesive, unified, prosperous neighborhoods, buildings are not abandoned to become the sites of "shooting galleries"; street corners do not become virtual open-air markets for drug dealing; the police do not as routinely ignore citizens' complaints about drug dealing, accept bribes from dealers to look the other way, steal or sell drugs, or abuse citizens without fear of reprisal; and innocent bystanders do not become victims of drive-by gangland turf wars. In communities where organized crime becomes entrenched, it does so either because residents approve of or protect the criminals or because residents are too demoralized, fearful, or impotent to do anything about it. Where residents can and do mobilize the relevant political forces to act against criminal activities, open, organized, and widespread drug dealing is unlikely. In contrast, where communities have become demoralized, disorganized, and politically impotent, drug dealing is far more likely to thrive. And many poor, inner-city minority communities have suffered a serious decline in economic fortune and political influence over the past generation or so. The result: Drug dealers have been able to take root and flourish (Hamid, 1990).

These three developments—the decay of much of the economic structure on which the lower sector of the working class rested, the growing economic polarization of the American class structure, and the physical and political decay of poorer, especially minority, inner-city communities—have contributed to a fourth development: a feeling of hopelessness, alienation, depression, and anomie among many inner-city residents. These conditions have made drug abuse especially attractive and appealing. For some, getting high—and doing so frequently—has become an oasis of excitement, pleasure, and fantasy in otherwise dreary lives. Let us be clear about this: *Most* of the people living in deteriorated communities *resist* such an appeal; most do *not* abuse drugs. Our structural or macro-oriented conflict theories do not explain why some members of a blighted community turn to drugs while others—*most* residents—do not. But *enough* succumb to drug abuse to make the lives of the majority unpredictable, insecure, and dangerous. A violent subculture of drug abuse flourishes in response to what some have come to see as the hopelessness and despair of the reality of everyday life for the underclass.

Conflict theory argues that there are two overlapping but conceptually distinct forms or types of drug use. The first, which encompasses the vast majority of illegal users, is "casual" or "recreational" drug use. It is engaged in by a broad spectrum of the class structure, but it is most characteristic of the middle class. This is "controlled" drug use, drug use for pleasure, drug use that takes place experimentally, or once or twice weekly,

once or twice a month; it is drug use in the service of other pleasurable activities. This type of drug use is caused by a variety of factors: unconventionality, a desire for adventure, curiosity, hedonism, willingness to take risks, sociability, and, as we saw, involvement with a subcultural group. Relatively few of these drug users become an objective or concrete problem for society, except for the fact that they are often targeted or singled out *as* a problem.

The second type of drug use is **abuse**—compulsive, chronic, heavy drug use that often reaches the point of dependency and addiction; it is usually accompanied by social and personal harm. A small percentage of recreational drug *users* progress to becoming drug *abusers*. For all illegal drugs, there is a pyramid-shaped distribution of users: many experimenters at the bottom, fewer occasional users in the middle, and a small number of heavy, chronic abusers at the pinnacle. This second type of drug use is motivated, as we've seen, by despair, hopelessness, alienation, poverty, and community disorganization and disintegration. By abusing drugs, users are harming themselves and others, including the community as a whole. Use results in medical complications, drug overdoses, crime, violence, imprisonment, and even a trip to the morgue. Experts argue that moving from the first type of drug use (recreational) to the second (abuse) is far more likely to take place among the impoverished than among the affluent, by residents of disorganized rather than intact communities (Currie, 1993; Johnson, Elmoghazy, and Dunlap, 1990; Levine, 1991). And, while drug abuse is facilitated by the political developments discussed previously, when abuse becomes widespread in a community, it contributes to *even greater* community disorganization. Inner-city residents become trapped in a feedback loop: Powerlessness and community disorganization contribute to drug abuse and drug dealing in a community, which, in turn, entrench these communities in even greater powerlessness and disorganization.

Drug abuse is far from unknown among members of the middle class and residents of politically well-connected communities. Significant proportions of *all* categories of the population fall victim to drug abuse, and both "micro" and "macro" forces operate. Micro or personal forces may be sufficient to impel some members of affluent communities into drug abuse. And most members of communities subject to the macro forces addressed by conflict theory resist the blandishment of drug abuse. While *some* members of *all* economic classes abuse cocaine and heroin, those members of the lowest economic strata are *more likely* to do so. To deny this would be to deny that living at the bottom of the economic hierarchy in this society creates problems for those who do. But even if there were no class differences in drug abuse, *drug abuse has especially harmful consequences in poor, minority communities*. Drug abuse more seriously disrupts the lives of persons who lack the resources and wherewithal to fight back effectively than is true of those who possess these resources. Poor neighborhoods are especially vulnerable to intrusions by drug dealers and increases in drug abuse.

Poor and minority people and neighborhoods are already struggling with a multitude of problems; drug abuse is another major exacerbating difficulty. Members of more affluent neighborhoods are more likely to have connections, ties with city hall and the state house, "clout" or political influence, money to tide them over, bank accounts, mobility, autonomy, and so on—a variety of both personal and institutional resources to deal with the problems they face. Hence, the drug abuse of some of their community's members is not as devastating as it is among the poor and the powerless. And

the neighborhoods in which they live, likewise, get favored treatment from the powers that be; they are less likely to fall victim to the many marauders and exploiters who prey on the powerless and the vulnerable.

In contrast, poor, minority communities are shortchanged by local, state, and federal governments, and bypassed by developers and entrepreneurs. Banks are reluctant to lend money to open businesses in such communities; stores that do open tend to be undercapitalized and frequently fail; landlords abandon buildings that become shooting galleries. It is the vulnerability and powerlessness of such neighborhoods that make them a target for both petty and organized criminals, for drug dealers small and large, and for corrupt officials and police officers. And vulnerability and powerlessness enable drug abuse to flourish in such communities and wreak havoc with their residents' lives. When we ask, "Why drug abuse?" our answer must be tied up in issues of economics and politics.

SUMMARY

A number of factors are at work in encouraging drug use; no single factor or variable can completely answer the question of why some people use drugs and others do not. The main theories of drug use and abuse can be boiled down to three: biological, psychological, and sociological explanations.

Biological theories are based on constitutional or inborn differences between persons who become drug users and those who do not. One such theory is genetic. Some progress has been made in locating a genetic predisposition to alcoholism, but it is only one factor among many. Another theory locates the cause of one type of drug abuse, narcotic addiction, in metabolic imbalance. Methadone maintenance providers argue that once persons with a metabolic imbalance begin using heroin, a physiological process "kicks in" to make their bodies "crave" narcotics and render them prone to becoming heroin addicts. No concrete evidence supports this theory, but methadone maintenance seems to be one therapeutic program, evidence suggests, that lowers narcotic addiction and criminal behavior.

Psychological theories focus on one of three factors—positive and/or negative reinforcement, inadequate personality, and problem behavior proneness. Do drug users and abusers have "inadequate personalities"? Users' personalities are no doubt different from those of nonusers. However, this would have to be established *before* use takes place, since socialization by user groups is likely to transform the individual's personality, or at least his or her values. One value common in deviant or unconventional groups, these theorists argue, is self-deprecation—in a phrase, low self-esteem. In contrast, other theorists argue that users who continue to take narcotics, once addicted, do so to avoid the painful withdrawal symptoms of discontinuing the administration of the drug. Still others claim that continued use results from the jolt of pleasure, or the "rush"—in a phrase, *positive reinforcement*—that users get from administering a gratifying drug. All or nearly all persons who administer one or more reinforcing drugs receive that jolt of pleasure, but not all continue using these drugs. Other factors are at work.

The "problem-behavior-proneness" perspective offers a somewhat different take on drug use. Individuals with certain kinds of personalities and values are more likely to get

into trouble than are those with more mainstream or conventional personalities and values. This can be predicted in advance by the degree of the individual's unconventionality: Someone who strays from society's mainstream values and behavior in one dimension, as well as in general, is likely to stray in other dimensions as well. Users are more rebellious, critical of and alienated from conventionality, independent, open to new experiences, pleasure seeking, peer oriented, and risk taking, and less mindful of real-life consequences than are nonusers. The evidence linking unconventionality, the rejection of mainstream institutions, and the recreational use of psychoactive drugs is incontrovertible. But are these personality characteristics, or are they subcultural in nature? Sociologists would tend to see them as originating in the subcultural group, as values that characterize certain social circles; psychologists would emphasize their individualistic psychodynamic origin. This dispute is unlikely to be resolved overnight. Still, the differences between users and nonusers are significant, powerful, and almost certainly causally connected to use, and they increase in relevance with higher levels of involvement. Hence, such differences cannot be ignored.

All the sociological perspectives shed light on the phenomenon of substance use and abuse—anomie theory, the social control and self-control theories, subcultural and social learning theories, the selective interaction/socialization theory, and conflict theory.

Anomie theory argues that drug use can be explained in terms of individuals being socialized to want, need, and expect material success, but failing to attain that success. As a result, they "retreat" into a state of drugged-out bliss and oblivion. One adaptation to success or failure in the legal or legitimate realm is attempting to attain success in illegal or illicit enterprises—drug dealing, for instance.

Social control theorists argue that deviant, delinquent, and criminal activities can be explained in terms of weak or absent bonds to conventionality or a "stake" in conformity. Self-control theorists argue that drug use, nothing more or less than a manifestation of a selfish quest for short-run, hedonistic self-indulgence, is a by-product of poor or inadequate parenting, which causes or leads to low self-control.

Drug use is learned and reinforced within a group setting. Future drug users interact with current users and learn appropriate definitions of the drug experience, which has a strong impact on their future experiences and behavior. Individuals learn how to smoke, snort, and inject; how to recognize and enjoy drug effects; how to ensure a drug supply; and how to keep their use secret from conventional, disapproving society. All of this is part of the "lore" of the user subculture.

The selective interaction/socialization and the subcultural perspectives do not address the question of why some people use drugs and others don't. Here, the selective interaction/socialization approach must be mobilized. Personality factors, especially problem behavior proneness, must be combined with group and subcultural factors. Social background, parental, personality, behavioral, and value characteristics predict which young people will gravitate toward one another—toward peer circles whose values and behavior are compatible with use. Once someone is selectively "recruited" into such a circle or group, his or her likelihood of use increases rapidly. Young people are socialized into values favorable to drug use by the social circles they interact in and are involved with. The more consistent these values, and the more concentrated and intense the interaction, the greater the likelihood of use. In addition, involvement in a using circle provides role models for use, so imitation comes into play here. Youngsters do not magically and

independently devise a solution to a psychological problem they may have and then rush out in search of a chemical substance to alleviate that problem, as the inadequate-personality theory seems to predict. Future users turn to drugs because they have friends who use and endorse use, and because they are relatively isolated from social circles whose members don't use and who actively discourage use.

However, as the theorists of this perspective emphasize, the relative importance of certain dimensions, factors, and variables shifts with the stages in a youngster's life, with his or her drug history, and with the drug in question. The dynamics or causal sequence of using (or not using) different drugs is somewhat different for each stage. In early adolescence, beer and wine are the drugs of choice, and here, peer factors—simply falling into or drifting toward a certain circle of users—play the most prominent role. Moreover, parents set a pattern for alcohol use: Parents who drink are more likely to raise children who also drink. Warnings not to drink have little impact in the face of parental examples. Once in a specific social group, the process of socialization takes over, and such socialization prepares the youngster for more serious drug use—initially, the use of cigarettes and hard liquor and, later on, marijuana. In middle adolescence, general beliefs and values, especially about drugs, play a more prominent role, as does peer influence. At this stage, strong differences in values and lifestyles predict marijuana use, and these differences increase with greater levels of use and involvement.

The conflict perspective shifts our attention squarely into the "macro" or big-picture level of causality; it is the larger or structural forces that influence or determine drug use, abuse, and dealing. Inequities in the control of economic and political resources help us understand why members of some communities and neighborhoods are more likely to use drugs and to become victims of abuse. Recent developments—especially the collapse of the lower rungs of the working class, the polarization of the economy, and an escalation of social, political, and economic disorganization in the poorest neighborhoods—have speeded up processes that have always existed. Over time, as the poor become poorer, the communities in which they live become increasingly politically impotent. Drug dealers are better able to gain a foothold in them, and their residents find drug dealing to be an attractive career option. Politicians learn that the demands of the leaders of such communities can be ignored without consequence. The physical decay of the community, the economic decline of its residents, and its shrinking political clout all contribute to the growing drug abuse of some of its residents and to the institutionalization of drug dealing on its streets. (Conflict theory is partially dependent on social disorganization theory.) Naturally, this approach does not explain why some residents of such neighborhoods turn to drug abuse and/or dealing while most do not. As with most other theories, conflict theory has to be supplemented with others.

In spite of what some theorists argue, the validity of one theoretical perspective does not imply the falsity of another. Each explanation addresses a portion of a large, sprawling, and complex phenomenon. No single theory of drug use or abuse could possibly explain everything that we might want to know about the drug scene. Macro processes may or may not be relevant to micro phenomena, and vice versa. Thus, explaining alcoholism says next to nothing about heroin addiction; accounting for drug experimentation says nothing about dependence; subcultural processes may operate alongside psychodynamics; and so on. In attempting to answer the question "Why drug use?" we need to be broad and eclectic in our approach rather than narrow, parochial, and dogmatic.

ACCOUNT: Multiple Drug Use

The subject of the following account, Sam, is a college student.

Most people think that hard-core drug users come from poor neighborhoods or broken homes, so I guess I'm not your typical drug user. I grew up in a small town in Ohio. The worst thing I ever saw was this long-haired kid smoking a cigarette on the steps of my school one day. I was confused because I thought cigarettes were only for adults. He looked like a loser, and from what I remember he was a troublemaker.

I didn't even know anything about drugs or alcohol until I moved to the suburbs of DC at the age of 13. At first I didn't have any friends. Kids made fun of me because I wore imitation Adidas shoes from K-Mart. This was considered taboo in my school, but in Ohio, K-Mart was a cool place to shop. One day at school, this guy Steve started talking to me. We became friends, and before I knew it, I was wearing Calvin Klein, and I was part of the "in crowd." I started hanging out at other kids' houses, and eventually, they hung out at mine. I told Steve that my parents were going out of town, and he said that I should have a party. I said okay, and then we started planning. We handed out directions and fliers for about a month prior to the party! (I can honestly tell you that I had no idea what I was doing, but I didn't want to let my cool friends down, and I didn't want to go back to being a loser in K-Mart tennis shoes.) We all took the bus to my house after school and set up for the party. We each grabbed a bottle of alcohol from my parents' bar and started drinking! I picked up a pretty green bottle with a yellow label, took a sip, and choked on it! I really didn't like the taste of the scotch, but I carried the bottle around all night, taking little sips of it! Before I knew it, a few hundred people were in my house, and everything was being destroyed. Eventually, the police arrived and kicked everyone out, but the damage was already done! My parent's house was trashed, and I had opened the door to an ugly world that I would have to live in for the next 15 years.

We continued to drink occasionally in junior high, and I tried a few cigarettes, but the real addiction started in high school. I had just started ninth grade at [a very affluent] high school. From time to time I would make eyes with this really pretty girl in the hallways. One day I saw her at a football game, and I told her she was cute. By the end of the game, we were kissing under the bleachers! Jody asked me if I wanted a cigarette, and I said sure! I remembered trying it, in junior high, and I figured if she was smoking it must be wonderful. As it turned out, she became my girlfriend, and I became a smoker. I feel that this evil habit was my biggest downfall. Nicotine took my normal mind and turned it into a nicotine-dependant, drug-craving machine. I loved smoking! I couldn't wait for class to end so that I could light up with my friends. What I didn't know was that I would spend the next 15 years trying to quit. For 15 years my lungs burned, I coughed all the time, and I couldn't exercise. But I loved my cigarettes! One day we skipped school and went down by the railroad tracks. I knew that Jody smoked pot, but I had never tried it. She pulled out a joint and started smoking it. I took a couple of hits, but I didn't feel much of anything. A few days later we smoked another joint in her apartment. This time I got high. I couldn't really tell what had happened to me, but I felt confused and overwhelmed. Over the next few months, we continued to smoke cigarettes and pot. Jody and I started skipping school to get high, and our grades started slipping. We didn't really care about school anymore.

My brother asked Jody and I if we wanted to go to the railroad tracks with him and his friends. We said sure. My brother's friend John offered us each a hit of acid. We were excited because we had talked about doing acid, but we could never find any. We each took a hit and waited for the fun to begin. Before I knew it I had lost my friends, and I was talking to a bear that had been painted on the wall. My

brother came up to me and told me to come with him because everyone was lying on the tracks waiting for the train to come, and he wanted me to try it. I lay down on the track and forgot about everything. Apparently the train was coming down my track, and I wasn't moving. My brother and his friend had to pull me off the track. I really don't remember this, but my brother tells me about it all the time.

My parents became so fed up with my behavior and performance in school that they sent me away to military school. While in military school, I was able to get my act together and finish out my freshman year. . . . Summer came around, and we were allowed to go home. I convinced my parents to take me to the beach because I felt that I deserved a break. While at the beach, I met some guys on the boardwalk. I told them my story, and they said that I could live with them for the rest of the summer. I begged my parents until they gave in. So my parents went home without me. I had no money, very few clothes, and no job. My new friends and I spent the summer going out and having parties at our house every other night. I was never quite sure as to who really lived in the house because so many people crashed there every night. We drank alcohol every night, smoked cigarettes all the time, and smoked weed whenever we could get our hands on it. I remember one time when one of the guys smoked some pot laced with PCP. He became really angry and kept punching the wall. Eventually, he had punched a hole big enough to walk from the kitchen into the bedroom without using the door. We thought it was really funny. Luckily, some of the guys worked at restaurants, so we could get free food sometimes. I also remember filling up cups with the free chili sauce from 7-Eleven, and sometimes that's all we had to eat. After a while the landlord kicked us out, and we all went back home. I was 14 and had decided that I didn't want to go back to military school, so I floated around from public school to public school, and then I quit going to school altogether. I started working as a part-time cashier at a gas station and moved into a group house with some strangers. I met this Nigerian guy at work, and he loved to smoke pot. He came over quite often, and we smoked pot on a regular basis. Our lease eventually ran out on our house, and I was forced to move back home with my parents.

My father decided that if I was going to graduate, he needed to get me into a school. He quit his job as a stockbroker and got a job teaching at a private school. . . . I was able to return to school. I studied hard, got straight A's my senior year, and was able to graduate. I was accepted by many schools, but my parents chose [a particular university] because it was affordable and close to home, and they had a great engineering program. I had no idea what I was getting into.

I moved into [a dorm] my freshman year. It was just one big party. Everyone was smoking pot, drinking alcohol, and no one really cared about school. I met this guy, Jan, who lived on my floor, and we became best friends. He was pledging a fraternity, and the following semester he convinced me to rush his fraternity. I was given a bid and decided to pledge. These guys seemed really different from me, but I trusted Jan and pledged the fraternity anyway. I was voted pledge class president, so I was responsible for all of my pledge brothers. I needed money to pay for the fraternity so I got a job bartending at [a local bar]. I would get drunk at work every night, come home at four in the morning, and have to be at the fraternity house at 7 A.M. to clean up after the parties. Pledging was really difficult. There was hazing, rampant drug use, alcohol and alcoholics everywhere. One time I was kidnapped by an older fraternity brother and taken to the [mountains]. We hiked for several miles and then set up our tents. Later, we built a fire, and he handed us each a bag of mushrooms. We made mushroom tea, and ate the rest of the mushrooms. I waited about a half an hour and then started hallucinating. I remember being really sad and then really happy and then really sad again. I would cry for a while, and then I would laugh uncontrollably. I remember seeing ballerinas in the trees, and the rocks were breathing. It was an exhausting trip, and I continued to hallucinate for a few days afterwards. I also remember one really bad experience when I was lined up with my pledge brothers and pissed on by one of the fraternity brothers. It was

degrading, but in the end, there was supposed to be some great reward. I never found it, even after living in the fraternity house for two semesters. To this day, I still wonder what purpose my fraternity served.

QUESTIONS

Which theory of drug use does this account illustrate? Would Sam have used drugs without social contact with friends who supplied them and endorsed their use? Does Sam's background strike you as one characterized by poor parenting? Is his life characterized by low self-control? How does anomie or "strain" fit into his pattern of drug use? What about his bonds to conventional others? His stake in conformity? Can theories explain individual cases—or are they generalizations that apply only to patterns?