

## **DRUGS: ABSOLUTISM, RELATIVISM AND REALISM**

### **Deviance**

Behaviour in human societies is governed by rules or norms. There are appropriate and inappropriate ways of acting whether one is talking about a classroom during a lesson, running in a marathon or dancing at a disco. The sociology of deviance focuses upon rule-breaking: it looks at who breaks rules, why they do and what happens to them. Much of sociology, of course, is concerned with how social order occurs, the way in which society manages to hang together. The study of deviance looks at the other side of the coin.

Ironically, to study deviance is often a short cut to understanding why people conform. And, of course, the sociology of deviance involves precisely the same theories as those occurring in the rest of sociology, merely approaching the same problems from the reverse direction.

Deviance and crime (that is deviant behaviour which involves law-breaking) are the staple fare of much of our mass media. For example, every evening on British television there is on average five hours of police drama programmes on four channels. Even the Western, of course, is a very stylized study in rule-breaking: of crime, robbery and deceit in a mythical frontier America. The news, too, is full of stories of crime, terrorism and disaster, and tends to highlight *bad* news, the deviant side of events and happenings. The way in which deviance and deviants are presented, however, are often grossly stereotypical. Part of this is because the media are part of the entertainment business: newspapers have to sell and television channels have to compete. Journalists the world over have discovered that audiences avidly consume news which titillates their sensibilities and confirms their prejudices. It is not difficult for the more discriminating television viewer to realize that the Western he is watching is a moral tale and not a depiction of reality. It is considerably more difficult for

someone watching a popular television police drama to realize that the story unfolded is in ninety-nine times out of a hundred completely inaccurate in its depiction of crime, of how the police attempt to control crime, and of their likely chances of success. None of this would have much significance if we had direct knowledge of these events. But in the highly complex, socially segregated world we now live in, we have often very little real knowledge of alternative versions to run against mass media stereotypes. Thus far more people have read articles in the newspapers or watched television programmes about heroin addiction than have ever met a heroin addict, and they have no reason to disbelieve the images presented to them. Yet among experts on drugs, there is a great controversy as to why people use heroin, and even about how many heroin addicts there are and what addiction means.

The study of crime and deviance, then, is crucial, firstly, because the study of deviance helps us to understand how society works and gives us insights into the policies which might help solve major social problems. Burglary, drug abuse, prostitution, child abuse, wife battering, racist attacks, muggings . . . the list of serious problems in our society is endless. Many seem almost intractable, and the need for rational, well-thought out policies is paramount. Yet, secondly, despite this, there is no area which attracts more irrationality than public pronouncements on deviance. This is not new: witches, the archetypal deviants of the Middle Ages, were a prime repository of people's fears, concealed desires and worried projections. Today, the mass media provide us with a daily stream of images, often equally fantastic, with regard to modern deviants. Thus we have a contradiction: the area of human life where rational action is most necessary is also the greatest focus of irrationality.

This is the reason why it is important to be objective and systematic about our study of deviance. In approaching the sociology of deviance, we will take two major perspectives and

contrast them with their conceptions of the problem point by point. We have chosen drug use as the deviant activity to illustrate the argument, both because it is a typical issue and because there are well-developed views in this area. But you should hold in mind throughout that these positions are typical of any area of deviant behaviour. So it would be useful, if, when you have completed reading this chapter, you thought how the two perspectives would apply, say, to mugging or rape or child abuse.

Drug use to change one's mental state, referred to as psychoactive drug use, is present in nearly all known human societies and groups. The few social groups who have not used drugs at all, for instance puritanical religious societies such as the Mormons, are historically exceptional. Most societies use drugs, though the drugs they use vary immensely: alcohol and tobacco in advanced industrial countries, marijuana in India and North Africa, opium in the Far East, peyote among some American Indian people, amanita mushrooms among Norse warriors, kava in Polynesia, the henbane and thornapple used by medieval European witches. To this host of naturally occurring psychoactive substances we have now added a series of synthetic compounds, for example: heroin, the amphetamines, the barbiturates and LSD.

In contemporary Britain, a wide variety of drugs is used. For every £1 spent on food, 64p is spent on alcohol and tobacco: indeed there are drug supply shops - pubs and tobacconists - on many a street corner. Caffeine in the form of tea is consumed at the rate of four cups per day for every man, woman and child in the country, and this is supplemented by vast quantities of coffee. The National Health Service spends £60 million a year on tranquillizers, stimulants and anti-depressants. No one knows how many people have smoked marijuana, but a reasonable estimate would be in the region of 10 million, and within certain groups, such as Afro-Caribbeans, smoking is a cultural norm. Add to this the increasingly fashionable habit

of snorting cocaine, the widespread, more down-market, use of illicit amphetamines, and the spread of heroin abuse in the inner cities, and one can truly talk of a society in which drug use is wide-spread, various and commonplace. A whole series of questions then arise: why do certain people take particular kinds of drugs? What is the basis of social reactions against drug use? What policy conclusions can we come to as a rational basis of drug control? We will attempt to answer these questions from two different theoretical perspectives.

The positivism which emerged in the nineteenth century, attempted, under the influence of Darwinism, to carry through a radical change in the dominant conception of the place of humankind in nature. Just as Darwin's theories served to replace the conception of the human species as a unique category of divine creation into one which saw *homo sapiens* as only one species within the wider evolutionary context of life on this planet, positivism's tried to show that human *behaviour*, too, was understandable because the same scientific laws governed all living activity. Human behaviour, however, could be guided by rationality, equality and free-will.

Positivism's major postulate, from which all of its major characteristics derive, is its insistence on the unity of the scientific method: that the premises and instruments which had proved so successful in the study of the physical world and of animal biology are of equal validity and promise in the study of society and humans. From this premise, positivists proceeded to propound methods for the quantification of behaviour, so as to claim the objectivity of the scientific expert and to assert the determined, law-governed nature of human action.

There have been many varieties of positivism both in criminology and in the social sciences in general. The particular version we will focus on here is by far the most widespread variant, both as a theory and as used in public practice. The theory admits that biological, physiological, psychological and social influences all contribute to the creation of the criminal, but sees the fundamental predisposition to crime or deviancy as situated in the individual. Furthermore, the social order is seen as consensual; crime is therefore the result of the under-socialization of the individual into this consensus. This type of positivism – what might be termed individual positivism – is the focus of our present analysis.

There was little sustained and concerted effort to dislodge positivism until the 1980s, when the ‘New Deviancy’ or ‘labelling’ theorist criticized the accepted paradigm: the way in which crime and social intransigence had been viewed for a century. They drew, however, upon a very substantial body of theory and research that had been developed over decades by the Chicago School of Sociology, especially the symbolic interactionists (see above, pp. 17-25). The key works were Howard Becker’s *Outsiders* (1963) and David Matza’s *Becoming Deviant* (1969). Their critique focused directly on the main tenet of positivist criminology: that the criminal or deviant was suffering from a lack of socialization, arising out of either a genetic inability to become fully human or from environmental influences which had impaired his or her social development. The social world was envisaged as a taken-for-granted consensus, where all ‘adequate’ men and women agreed about the essential fairness and rationality of their society. To steal, to be gay, to smoke marijuana, to engage in acts of violence – all these activities were viewed as indicative of a fundamental malaise on the part of the individual involved. The task of the positivist was then presented as ‘progressive’, for whereas conservative law and order campaigns called for severer punishment of the offender, the ‘scientific’ expert advised appropriate diagnosis and treatment in order to deal with the

irrational compulsions which had propelled criminals or deviants into their anti-social actions. The view of schizophrenia as the consequence of biochemical disorder; drug treatment programmes inflicted on Californian criminals; the labelling of Soviet dissidents as mentally ill, were all instances of correctional or positivist conceptions of deviance which went largely unchallenged until the 1960s.

The 'new wave' of deviancy theorists trenchantly dismissed such notions. A satisfactory explanation of criminal action, they argued, needed to answer two questions: why did the individual *wish* to commit the crime; and why was the action considered criminal or deviant in the first place? Positivism had mystified both answers: the first by taking from the criminal any sense of human purpose, the second by totally ignoring the problem of social reaction. The reasons for criminality were reduced to non-human, material factors either of the individual's inner physiology or of his or her social environment, which impelled them into crime. On the first point, the new deviancy theorists insisted on using a model of a fully human actor: a person whose choice, whose deviancy was understandable and comprehensible as part of an overall career in the world of society. On the second issue they accused positivism of having managed to discuss crime for nearly a century without recourse to a theory of the State. That it was the State which punished the criminal or deviant was taken for granted, because all decent-minded men were in agreement as to what constituted social behaviour, and the State simply acted on the basis of that consensus.

At this juncture, the new deviance theorists introduced their most characteristic concept: labelling. Society, they argued, did *not* consist of a monolithic consensus, but rather of a pluralistic array of values. For an action to be termed criminal or deviant demanded two kinds of social activity: one, a group or individual acting in a particular fashion; the other,

another group or individual, with different values, labelling the first kind of activity as 'deviant'.

Human being, acting creatively in the world, constantly generated different systems of values. But only certain groups variously and vaguely termed 'the powerful', 'the bureaucracy', 'the moral entrepreneurs' – have more power than others and enforce their values upon the less powerful, labelling those who infringed their rules with stereotypical tags. Groups and individuals that develop value-systems and modes of behaviour that conflict with the dominant codes, conversely, are labelled, by the authorities, as 'homosexuals', 'thieves', or 'psychopaths'. Moreover, this very act of labelling, by limiting the future choices of the actor, and by being presented to the actor as the truth about his nature, with all the force of authority, had a self-fulfilling effect. The old adages 'once a thief always a thief', 'once a junkie always a junkie', *became* true, not because, as earlier criminologists had maintained, this was the 'essence' of the people involved, but because the power of labelling transformed and cajoled them into acting and believing as if they possessed no freedom in the world.

These two contrasting ways of approaching the explanation of drugtaking, and these two different world-views, are found throughout the study of deviant behaviour as a whole, not only in the works of sociologists and psychiatrists, but in the commentaries of politicians, journalists, priests, or anyone, in fact, who tries to understand or interpret the social world around him.

Positivists view society as an organic entity, comparable to the human body: each part has its place in an organized division of labour. Over and above individual ends stands the notion of

the general social good. New deviancy theorists, on the other hand, contest this, seeing society as a multitude of groups, each with their own ends and interests, who agree and cooperate over certain issues but who conflict, sometimes drastically, over others.

From these initial stances a number of fundamental points of contrast between the two schools can be made, concerning both their explanations of drug-taking, and their advice as to what ought to be done in order to ameliorate the problem, though the absolutist approach has almost totally dominated the study of drug-taking. We will take these point by point, illustrating them by quotation.

We start with the two most significant questions we can ask of any interpretation of social behaviour. First of all, what is its conception of social order? How do the writers conceive of the way in which society maintains itself? Secondly, what is their conception of human nature? How do they understand the processes which motivate and determine the behaviour of human beings? For all statements about human activities, whether they are stories about the wayward in the *News of the World* or theoretically sophisticated analyses of human behaviour in psychology or sociology textbooks, must of necessity contain – however implicitly – conceptions of social order and human nature. So the prime questions one must ask, before looking at any detail whatsoever, are the ‘global’ questions: how does the author see society hanging together, and what, in his or her view, makes human beings tick?

### **The Basis of Social Order**

Society, according to the positivist, is held together by a consensus of values. Coercion is only necessary in a limited number of cases where recalcitrant ‘undersocialized’ individuals refuse to recognize their problems and are unwilling to be integrated into society. The

positivist sees the vast majority of people agreeing as to what is correct behaviour and what is reprehensible; moreover, that there is a large degree of agreement over the ends that people should pursue and little conflict between the interests of different groups. Behaviour, according to this consensus, is seen to be functional to the organic system they envisage society to be, and behaviour which violates this consensus is dysfunctional to society. Legal drug-taking – alcohol, caffeine, amphetamines and barbiturates on prescription – is seen as behaviour in tune with the values of society and as activities which help to keep the system functioning. Illegal drug-taking, on the other hand, is contrary to these values and deleterious to the body politic.

The basic image that ‘new deviancy’ theorists have of social order is that of a pluralism of values. Individuals live in an overlapping world of normative ghettos. In contrast to absolutism, the notion of a consensus in society is challenged and replaced by the concept of a diversity of values. Consensus is seen as a mystification, an illusion foisted on the public by the powerful. More precisely, it is an attempt by the powerful to foist their own particular value system on the diversity of groups within society. This is achieved, on the one hand, by their control over the major ideological apparatuses within society (e.g. the mass media, the educational system) and on the other, by their control and use of the repressive apparatus (e.g. the police, the courts). Consensus is thus a human construct, a system of values created by a specific group of people, but it is presented as if it were something outside and above human creation.

New deviancy theorists deny the possibility of speaking *ex cathedra* on behalf of society in general. Different groups, they argue, have different norms as to appropriate drug use. What is deviant or normal, then, cannot be judged in an absolute fashion: one cannot say that to act

in a certain way is absolutely deviant or normal; one can only judge the normality or deviancy of a particular item of behaviour relatively, against the standards of the particular group you choose as your moral yardstick. To act in a certain way, then, can be simultaneously deviant *and* normal, depending on whose standards you are applying. In this perspective, the smoking of marijuana may be normal behaviour amongst young people in Notting Hill and deviant to, say, the community of army officers who live in and around Camberley. Similarly, to drink to the point of collapse may be valued behaviour amongst merchant seamen but would be anathema to members of the Temperance League.

New deviancy theorists do not deny that there *can* be consensus: that a majority opinion can exist concerning a particular type of behaviour – for example, the use of heroin – but this is not sufficient to justify embracing an organic image of society. There is a vast difference of opinion in Britain, for example, as to the proper use of alcohol and cigarettes, and there are sizeable populations which take barbiturates, marijuana or amphetamines. Moreover, the relativists would suggest that a consensus, where it exists, is often created by the persuasive manipulation of public opinion through means such as the mass media, by groups possessing sufficient power to propagate their own particular values and notions of appropriate and reprehensible behaviour. In the field of drug use they would point to the activities of the Temperance Movement in the States before Prohibition.

Drug-taking, then, is not necessarily deviant nor necessarily a social problem; it is deviant to groups who condemn it and a problem to those who wish to eliminate it. To talk of a personified ‘Society’ which must be protected is to camouflage a simple conflict between two groups: those who wish to pursue a particular activity unmolested and those who feel that this activity threatens their interests or conceptions of proper behaviour.

## **The Conception of Human Nature**

Positivist and new deviancy theorists have basically different perspectives on human nature. To the absolutist, a person's psychic make-up is like a blank sheet of metal on to which are stamped the homogeneous values of society. Human beings are programmed, so to speak, to react in the right way at the right time: to emit appropriate responses to prearranged cues. Here and there, however, the machinery goes wrong: child-rearing is inadequate, social control of adults is weak, or the norms inculcated are unclear, and then imperfections are built into the printed circuits of normality. Individuals, through no fault of their own, are unable to fulfil the 'normal' roles expected of them. Human deviancy is seen as not morally reprehensible, because it is a product of forces which is beyond the control of the individual.

In contrast, the new deviancy theorists' conception of human nature is one which emphasizes free-will and creativity. People create meaning in the world and, in striving towards their various cultural goals, impose a multitude of interpretations on the social and physical world around them. Hence human behaviour has to be understood in the light of the meanings imparted to it by the people involved. Reality is not 'given' or predetermined: it is socially constructed. Human rationality is therefore not universally the same: it varies according to the logic and norms of a particular culture; it is relative rather than absolute. Human nature is then open and in principle boundless. But though human beings are born free, they lose their freedom because of the structures through which society controls their behaviour.

For the new deviancy theorists, human beings are seen as independent of the values and ideas they receive from their surroundings; accepting or rejecting them as they see fit and, more

importantly, creating new values in accordance with their interests and values. In this view, culture is seen as a collection of approved solutions to problems occurring amongst members of society. But people experience problems for which there are no suitable available solutions in their culture. Therefore, in certain situations they create new cultural responses and forms in face of the inadequacy of the established social order. The widespread use of drugs in our society suggests that they provide significant solutions to certain widespread problems. The difference between legal and illegal drug-taking, however, is that, by and large, the taking of illegal drugs involves developing hitherto forbidden solutions to individual or collective problems, while legitimate drugs – alcohol, caffeine, and nicotine – are acceptable.

New deviancy theorists, then, see people as morally responsible for their choices to the extent that fate is not determined, but partly in their own hands. If people have a degree of free choice, then, it is a mystification to regard people who deviate from your own standards as ‘ill’; it is better to say candidly that one disapproves of a particular form of behaviour (for example, the use of amphetamines) for moral reasons and will do all in one’s power to eradicate such practices, than to hide behind a mask of therapy and a vocabulary of healing. At the same time, the relativist will freely admit that a certain proportion of drug-takers do willingly act as if they were determined creatures, but would argue that such fatalistic lifestyles are initially chosen and internalized; they are not proof that man is intrinsically devoid of free-will.

### **Why do People Take Drugs? (The Absolutist Case)**

The positivists’ view of society is that of a vast area of agreement, on the edge of which lie a tiny minority of deviants. These are the diseased cells in the body of society – a pathology

not only at the social but at the individual level as well: that is, the individuals who make up the social pathology are personally inadequate. A person is seen as being unable to act 'normally' because, for various reasons, he or she has not inculcated the norms of society. Two major reasons are given for this: either he is undersocialized or he is 'sick'.

The undersocialized drug-taker is seen, to use Freudian terms, as having a weak superego, an inadequate ego and – if a man – lacking in proper masculine identification. He is, in short, psychopathic. Because of his lack of norms he has a personality which is immature and infantile.

Most individuals addicted to drugs are considered self-centred and narcissistic and are interested only in satisfaction of their own primitive needs. This is a very infantile form of behaviour; it is acceptable in infancy but not in adults. These individuals have not matured in a healthy way and so do not accept mature roles. They make poor husbands and wives, fathers and mothers; they are poor sexual partners because their social development has been retarded. They experiment with many types of sexuality but usually they cannot accept a mature heterosexual role. They are not interested in giving to anyone; they are interested only in receiving (Rasor, 1968, p. 18).

Thus sexual inadequacy is often seen as a lack of correct masculine identification, an attitude which leading heroin experts Chein *et al.* express in a revealing passage:

An extraordinarily high proportion of adolescent addicts can be seen as 'pretty boys'. They would not appear out of place in a musical comedy chorus. They are vain in their appearance. They spend much time preening. They are preoccupied with clothes, which they

wish to be of the finest materials and the latest styles. They spend much time before their mirrors experimenting with their hair, moustaches, and goatees . . . Adolescent addicts do not look, behave, or deport themselves as adolescent boys usually do; they do not try to appear manly, rugged, vigorous, energetic, rough-and-ready. These deviations suggest that they have strong feminine identification . . . They try to impress the observer with their independence and bravery, with their ability to function well in the most difficult circumstances. They know better than any middle-class professional person what life 'really is'. They boast of their exploits with women, crime, and narcotics, to prove what strong men they are. In one of Shakespeare's telling observations, 'they do protest too much'; the psychologically trained observer cannot help but see through to the problems of masculine identification beneath the veneer of masculinity (Chein *et al.*, 1964, pp. 224-5).

New deviancy theorists, on the other hand, reject the notion of drug use as a pathology; it is simply not possible to regard all the various activities popularly considered as deviant (for example, homosexuality, communism, heavy drinking, marijuana smoking, sexual promiscuity, abortion, prostitution and petty theft) as diseases in the body of society, for if we were to extract all these deviants there would be precious little left of the organism which the absolutists postulate! Rather, they suggest, what is a deviant form of behaviour is a matter of opinion, and opinions vary. The use of the word 'pathology' and organic metaphors are subtle means by which one group (who consider themselves normal) combat the values of those they consider different from themselves.

Further, there is a tendency for the middle-class observer to view social organization aimed at goals which he or she disapproves of, as *disorganized*, normless behaviour. Instead, many drug groups, the relativist would argue, are sub-cultures with finely-spun norms, dictating

what is appropriate and inappropriate behaviour for the drug-user. The tendency to view alternative values as an *absence* of values is a convenient method of ignoring groups whose existence questions the basis of one's own social world. Nowhere is this practice more prevalent than in descriptions of those drug sub-cultures which espouse values concerned with hedonism and excitement as major goals of life.

Thus D.P. Ausubel writes of the heroin addicts:

He fails to conceive of himself as an independent adult and fails to identify with such normal adult goals as financial independence, stable employment, and the establishment of his own home and family. He is passive, dependent, unreliable and unwilling to postpone immediate gratification of pleasurable impulses. He demonstrates no desire to persevere in the face of environmental difficulties or to accept responsibilities which he finds distasteful. His preoccupation with a search for effortless pleasure represents both an inappropriate persistence of childhood motivations which he has not yet outgrown and a regressive form of compensation for his inability to obtain satisfaction from adult goals (Ausubel, 1958, p. 42).

Thus, 55 per cent of addicts at the US Public Health Service Hospital were classified as having 'psychopathic diathesis', which is characterized by nomadism, irregular employment, unstable marital history, and tolerance to all forms of thrill-seeking vice. What is forgotten in these reports is that hedonism, thrill-seeking, lack of employment, unstable formal marriages, are often the 'norms' of the groups from which drug-users emanate. The middle-class social scientist, with his nuclear family, planned life and careful leisure, takes his or her pattern of life as the only possible form of civilized existence, any deviation from this being regarded as profoundly asocial.

Drug use is thus associated, in the minds of such scientists, with both social and personality disorganization. Moreover, the two are easily linked, since it is further argued that the 'weak' family structure associated with socially disorganized areas gives rise to personality inadequacies. Positivists substantiate their thesis by pointing to the groups where the incidence of drug-taking is high, namely the lower working class and Blacks, both groups which, they would argue, have poor child-rearing techniques and are therefore populated by inadequate personalities. Additionally, the high prevalence of adolescent drug-users is attributed to their as yet immature personalities, aggravated by living in areas where social control is weak (e.g., the ghetto or the large university campus).

A few positivist theorists, however, accept that a proportion of drug use occurs in individuals with essentially normal personalities, but see these personalities as having been 'infected' by contact with the 'virus' of addiction. The spread of addiction is thus often seen – especially by medical epidemiologists – as similar to an epidemic, and the victim is regarded as being 'sick'.

New deviancy theorists do not denigrate the notion of under-socialization. But they insist that it is used over-often, and used without reference to the particular group of which the person referred to is a member. If there are many different 'correct' ways of behaving in a society, then there are as many ways of being 'normal'. To suggest that a person with different norms from oneself is psychologically inadequate is merely a way of negating any argument as to the validity of one's own way of life. To new deviancy theorists, however, drug-taking groups are seen as having their own particular norms, against which the non-drug-taker would seem personally inadequate and undersocialized. The teetotaler in an Irish drinking group would soon find that the – in his eyes – 'asocial' gathering had a finely

developed set of values and required behaviour, which he would have a hard job living up to. Moreover, if he were to find himself involved in such a group for any length of time, he might himself begin to interpret any lack of social ease on his part as a sign of personal inadequacies. Richard Blum found that regular LSD users have a conception of the 'straight' world as consisting of people who are 'uptight' or – to use the vocabulary of psychoanalysis – of obsessive neurotics pursuing material and social status in an unbalanced manner! (Blum, 1965).

There is, however, a proportion of drug-takers to whom the models of the absolutist theorists *are* appropriate, for some individuals accept the idea that other people have of them of being people with a weak superego, inadequate ego and a lack of masculine identification. This ready-made sick role of the drug-determined individual, unable to make adult choices in terms of sex and occupation, is easily accepted by certain individuals. So a proportion of drug-takers do accept that they have an inadequate personality – an idea they readily pick up in clinics and hospitals manned by doctors who invariably have a positivist perspective on drug dependency. These clinics, then, are institutions where drug-takers are socialized into fitting in with positivist theory.

Now deviancy theorists deny any one-to-one simple connection between social disorganization and personality disorganization, for the apparent social disorganization of slum areas is often really organization which centres around different ends to those of respectable society, and what is perceived as faulty child-rearing practices on the part of individual families is more easily understood as different kinds of socialization practised in different kinds of groups, utilizing different techniques. To grow up as a mature adult in

Harlem or Brixton demands the inculcation of different norms, by different means, than that needed to produce a conforming citizen of White, middle-class Manhattan or Hampstead.

The inadequacy of the positivist' stress upon personal inadequacy becomes apparent when one considers that gigantic sections of the entire population, for example, Blacks and the working class, are presumed to be socially inferior. For instance, Hans Eysenck writes that:

There is no reason to assume any differences between social classes with respect to conditionability (i.e. genetic difference), but there are very good reasons for assuming considerable differences between them with respect to the degree of socialization to which they are subject (i.e. childrearing differences). Particular attention has been drawn, for instance, by Kinsey in the United States to the different value laid on the repression of overt sexual urges by middle-class and working-class groups. He has shown that where, for middle-class groups, parents put very strict obstacles in the way of overt sexual satisfaction of their growing children, and inculcate a very high degree of 'socialization' in them, working-class parents, on the whole, are much more lax and unconcerned. In working-class groups, for instance, he found pre-marital intercourse viewed as not only inevitable, but as quite acceptable to the group.

Similarly, with respect to aggression, there is a considerable amount of evidence too from a variety of sociological studies, carried out both in the United States and in Great Britain, to show a tendency for middle-class groups to impose a stricter standard upon their children than the working-class groups. The open expression of aggressiveness which is frowned upon in the middle-class family is often not only accepted but even praised in the working-class group (Eysenck, 1958, p.294).

That pre-marital sexual intercourse and overt aggression should be considered as essentially asocial is a gross middle-class ethnocentrism which demands that sexuality should be expressed in marriage and that aggression should only be channelled in ways approved by King and Country, if they are to be allowed the designation of truly 'social'. Considering the prejudices which the word 'drug' arouses, it is not surprising that the insinuation of personality defects is automatically affixed to all and sundry who stray beyond the narrow limits of the middle-class behavioural scientist's style of life; including the kinds of psychoactive drugs permissible in that sub-culture.

### **The Problems of Large-Scale Deviancy:**

#### **The Role of the Corruptor**

Positivist theory then, is especially vulnerable when we are considering deviancy on a large scale for, if deviant drug use is a product of sick individuals, would not large-scale use of, say, heroin, be a product of a sick society? One way of explaining this is the model of the epidemic: that it is a sickness that spreads like an epidemic through the population. Thus the cover of *Newsweek* in July 1971 is emblazoned with THE HEROIN PLAGUE; Melanie Philips, in the *Guardian*, 25 June 1984, talks of 'The White Plague'. Here, there is a transition from seeing heroin addicts as coming from a 'deviant' group to seeing them as coming from 'normal' groups. Thus in the American heroin panic of the early 1970s *Newsweek* wrote:

Ten years ago, heroin was a loser's drug [that] made helpless addicts of thousands of ghetto Negroes, a few jazz musicians and a handful of showbusiness types . . . an aberration

afflicting the black and the longhair minorities. Now all that has changed. New heroin users are turning up in . . . the glossiest suburban highschoools, on factory assembly lines . . . [Thus] the UCCLA psychiatrist Dr J. Thomas Ungerlindier says that since the heroin plague began, 'Nice Jewish boys are coming out of the woodwork – as well as Mormon kids, Japanese-Americans and all the other exemplars of healthy, hardworking, middle-class ideals' (5 July 1971, p.29).

Similarly, in Britain, an article in the *Sunday Times* by Dr Martin Plant, having noted the widespread use of heroin amongst the young, goes on to discuss the qualitative nature of the problem: 'Heroin is no longer for people with personality problems. The new users are often normal, young working-class and particularly unemployed' (8 April 1984, p.17).

The image of the 'epidemic', however, is not adequate on its own to explain the spread of its use, for heroin use is not like smallpox, and one needs some linking concepts to explain how it is 'caught' on such a wide scale. The answer, in the present period, is that unemployment is driving young people into heroin abuse. Thus the analysis moves from the level of psychological to a sociological determinism: they are not abnormal people, but people placed in abnormal circumstances. To this another key has to be added - the notion of the 'pusher'. Drug-taking is seen as being facilitated by a small clique of unscrupulous, yet normal (i.e. economically motivated) individuals (the corruptors), manipulating or seducing a majority of innocent or immature bystanders (the corrupted). Thus every heroin smoker is induced to begin the habit because of the activities of a Machiavellian pusher. This is a sub-type of 'corruption theory' in general which sees, for instance, every strike as being engineered by a small group of Marxist agitators, or prostitutes becoming lured into the 'game' by pimps, or every delinquent as being led astray by other people's children. The corollary of this, as far

as the social control of drug-taking is concerned, is that the 'corrupted' must be viewed in a humanitarian light and treated leniently, while the 'corruptors' must be dealt with in a severe manner. They are the 'real' intransigent deviants. Thus, typically 'enlightened' opinion distinguishes between the penalties doled out for the possession and supply of drugs. We thus have an epidemic carried, so to speak, by random germs to youngsters who are socially weakened by unemployment. Because of the sickness notion, it is impossible to blame the addict but it is very easy to lay all the blame on the carriers. The theory of the corruptor presumes a body of innocents within society who are corrupted by normal people who are wicked and who seek to gain from their fellows' weakness. This is how the *Daily Mirror* sees the problem, for example:

#### **DRUGS: THE REAL CRIMINALS**

The drug pusher - the contemptible creature who  
Peddles poison for profit - deserves no mercy from  
the law. The criminal who sets out to hook young  
people on drugs deserves far more implacable  
retribution than the victim of the evil (*Daily Mirror*,  
12 March, 1970)

Deviance, in general then, does not ever occur out of volition. It is assumed to be essentially unpleasurable and can only occur either out of sickness or corruption. Given these assumptions, it is possible to discern the intervention of some corrupting agent in every situation of widespread deviance.

The *Daily Express* can thus discuss the wave of industrial disputes and student protest in the early 1970s in precisely these forms: 'The docks, the car industry, mines, major airports, electricity, the building trade, and the students have all been steadily infiltrated in one guise or another until the militants can disrupt the national life at will' (9 December, 1970).

In contrast, new deviancy theorists insist that deviance is a response to the social problems and predicaments with which people are confronted. It cannot be explained as the inevitable result of a 'sickness' - whether psychological or sociological - or the result of the Machiavellian wiles of outside agitators. They thus argue that illicit drug-taking is a response to problems faced by individuals, who are not corrupted, but who willingly embrace that kind of solution to their social difficulties. William Burroughs understood this well when he wrote:

If we wish to annihilate the junk pyramid, we must start with the bottom of the pyramid, 'the addict in the street', and stop tilting quixotically for the 'higher ups' so called, all of whom are immediately replaceable. The addict in the street, who must have junk to live, is the one irreplaceable factor in the junk equation. When there are no more addicts to buy junk there will be no junk traffic. As long as junk need exists, someone will service it (Burroughs, 1968, p. 10).

Very few studies of drug-taking have ever shown drug use to be initiated by pushers. In fact, most drugs are bought off low-level dealers who are themselves users. Certainly, the users pursue the dealers and *not* vice versa. The antagonism directed towards 'corruptors' is a mystification which, by scapegoating a few, manages to maintain the illusion that everything

would be all right in the social system if only we could eliminate the small minority of saboteurs intent on destroying its organic unity.

Furthermore, modern deviancy theorists are suspicious of the invocation of social determinants - such as unemployment - as inevitably leading to more widespread heroin use. First of all, they point out, the spread of heroin in the 1970s, particularly in the United States, was ascribed to *affluence*, not unemployment, as ten years later. Secondly, they are suspicious when they find that public concern with heroin only escalates when it is no longer confined to groups who are denigratingly seen as marginal ('Blacks and longhairs'). Thirdly, though there may be a relationship between unemployment and heroin, it is not a simple one-to-one relationship, because only a small minority of the unemployed take heroin. In fact, it involves *choice* and is only one of a number of possible choices. This is the vital missing factor in positivist analysis, for none of the positivist theorists seem to accept that people take drugs for pleasure, or if they do, they presume that it is only for a short while, until withdrawal symptoms set in, and that from then on they take drugs merely to gain relief from their 'sickness'. The modernists would say that this contradicts the evidence of drug-takers themselves, and takes no account of the context of continuous boredom that long-term unemployment entails. Here again, there is a parallel with discussions of deviancy in other areas. As we saw in the Introduction, the Chicago School in the 1930s broke new ground by stating the obvious: that delinquency could be enjoyable. As David Bordua mockingly remarked about positivist studies of gang delinquency:

I have purposely attempted to convey the distinctive flavour of essentially healthy boys satisfying universal needs in a weakly controlled and highly seductive environment. Compared to the deprived and driven boys of more recent formulations with their status

problems . . . or psychopathological ones . . . delinquency and crime were attractive: being a 'good boy' was dull. Fun, profit, glory and freedom is a combination hard to beat, particularly for the inadequate conventional institutions that form the competition (Bordua, 1962, p. 292).

### **Drugs and Moral Panic**

New deviancy theorists not only argue that the way in which drug use is conceived is wrong; they also deny the size of this problem. Images of drug use, they argue, are both qualitatively and quantitatively distorted, both by the mass media and in positivist discussions. This they term 'moral panic': periodic widespread public hysteria about particular social problems which not only blatantly exaggerates their extent and impact, but creates 'folk devils': distorted stereotypes of the how, why and whereabouts of the typical deviant. Examples of this are the 'Black mugger' panic of the early 1980s and the 'Mods and Rockers' panic of the 1960s (Cohen, S., 1972; Cohen and Young, 1981). But drugs are the source of moral panic *par excellence*.

Let us take, as an example, the heroin panic in Britain which started in 1984. If the more sensational reports are to be believed, we are only a short step from Sodom and Gomorrah. In May, the London Borough of Islington produced a well-thought out report on the problem of heroin use in their area. They hazarded an estimate that 15 per cent of young males were regular users. This was no doubt an overestimate. It was reported on the BBC news of that day, however, as 30 per cent. Thames Television reported it, in their headlines, as under 40 per cent. In the news story itself, it had escalated to 'nearly half of all young people in Islington'. Tony Moss writing in the *Sunday Times* had already written (8 April) that the majority - i.e. over 50 per cent - of kids in south-east London estates were experimenting with heroin. Dr Martin Plant, 'Scotland's foremost authority on drug addiction', had said that

'heroin is being handed out like Smarties'. The Angel area of Islington, it seemed, had a higher use of heroin than Harlem, and Clapham High Road more street-hustling than the Bronx.

Many kinds of people stand to gain by exaggerating the predicament. Very few, conversely, have reasons to be realistic about it. Journalists find drug scare stories remarkably good copy; social work agencies can lay claim to greater resources in the middle of a panic; the police can claim that special drug squads are necessary; and sociologists can apply for grants to study the phenomenon. Yet the one certainty, in the study of heroin use, is that, as with so many aspects of deviant behaviour, there are simply no hard facts. Thus thoroughgoing analysis of the American 'epidemic' of 1968-74 (a 'fact' which is usually regarded as incontestable) came to this conclusion:

One difficulty with the epidemic hypothesis is that almost all the indicators which have been used, by social scientists as well as the public, to document the 'epidemic' of heroin use are derivative. That is, they are not direct measures of the incidence or prevalence of drug use in the general population, but measures which infer such incidence or prevalence from various data gathered by law enforcement or medical agencies (Lidz and Walker, 1980, pp. 48-9).

They go on to point out that the figures based on the number of arrests rise and fall in proportion to the amount of money spent on policing drugs, as are the figures of the number of people treated in clinics. An important outcome is that moral panics produce what appears to be 'real' rises in all the relevant statistics.

The development of a moral panic typically goes through several stages:

1. Most deviancy, including heroin use, is unknown to official agencies - there is a large 'dark figure' of deviant behaviour.
2. The mass media, perhaps because of a particular individual scandal or a social survey, begin to focus on heroin as a problem.
3. The public and politicians become initially sensitized to heroin abuse.
4. Pressure is put on the police, on customs officers and on social services to tackle the problem.
5. They dig deeper into the dark figure, arresting more heroin users, catching more smugglers, and highlighting heroin abuse as a major issue in social work reports. So the figures rise.
6. The mass media respond to this use by putting more journalists into the field investigating heroin abuse.
7. More articles on heroin confirm to the public, the various agencies and - *very importantly* - to journalists themselves that there is a rapidly increasing problem.
8. More police, customs officers, social workers, politicians and journalists demand more funds for dealing with heroin abuse, which results in more agencies which pick up more heroin users.
9. More parents and social workers realize their kids and clients 'have a problem' and get them to register. More heroin users do likewise. The official figures increase even further.
10. To the mass media, this confirms their panic prognosis, so they pay even more attention to the problem. A vicious circle is set up with positive feedback to stage 2 of the process. A fantasy crime wave has now been created which need not *necessarily* involve any actual increase in users.

## **The Effects of Drugs**

For positivists, the effects of drugs are a matter for scientific investigation. Their physical effects are charted in the laboratory and their social effects by surveys. The generalizations that emerge, moreover, are believed to have universal validity: such knowledge is also cumulative. So if you want to know the effects of marijuana or heroin use, you simply look them up in the pharmacopoeia.

A central part of positivist thinking is that human behaviour can be studied by the same methods that are used in the natural sciences. Thus in tackling questions like 'Does heroin lead to crime?' or the likelihood of escalation from marijuana and heroin, generalizations obtained from a certain number of cases are assumed – as in the physical sciences – to have a high degree of accuracy, expressed in terms of probabilities, whatever the situation in which the particular drug is used.

Thus Professor G. Joachimoglu, a distinguished member of the United Nations Drug Supervisory Body, writes:

In a paper presented to the International Congress of Criminology in Paris in 1950, Professor C. G. Gardicas mentioned a group of 117 individuals, by no means criminals initially, who became addicts and criminals after smoking hashish and were sentenced for threats, blackmail, murder, offences against property, and other offences. It is not necessary to go into further details. Hashish is a social evil and the International Conventions are of great importance for the protection of society (Joachimoglu, 1965, p.5).

Thus, because marijuana use correlated with crime in these 117 cases, this connection is assumed to have the same causal status as the observation that the ignition of hydrogen and oxygen together invariably yields water: to invoke universal laws, unrelated to either the desires of the individuals involved or the theoretical aspirations of the investigators. To take another example, newspaper reports about the Sharon Tate murders suggested that the film star and her friends were murdered by Charles Manson and his family 'because' the latter were high on speed. Likewise, the My Lai massacre in Vietnam was thought to have occurred 'because' American troops had been smoking marijuana. From these observations, marijuana and methedrine were linked irrevocably with murder. Strange and unpalatable acts were given instant explanations, while Manson and the G Is were excused responsibility for their behaviour. Less dramatically, invoking the use of drugs has become a routine basis for pleading 'mitigating circumstances' in court. Thus the heroin addict can plead that it was 'smack' that *forced* him to steal two lamb chops from the deep freeze in the local corner shop.

New deviancy theorists oppose such excuses. They argue that whereas it is undoubtedly true that drugs facilitate many forms of behaviour, it is to the strange cults of Hollywood that we must look for an explanation of the murder of popular film stars, and it is in the dehumanizing effect of wars that we will find the reasons for the murder of innocent Vietnamese peasants. Generalizations about drugs, that is, must always be grounded in specific cultures and particular social situations.

Theories evolved by social scientists, moreover, often have 'self-fulfilling' effects on the very drug-users whose behaviour the theories were erected to explain. They may either introject the interpretations others provide of their behaviour and act accordingly, or they may be

placed in situations where they have no option but to act in accordance with other people's definition of the situation and other people's ideas about their motivations and predictions as to how they will act.

People also learn the effects of drugs from other drug-users. Thus, H.S. Becker, in his classic article 'Becoming a Marijuana User' (1963), outlines the learning process involved in marijuana use. The novice – the naïve user – does not experience a 'high' at first; he may feel slightly strange, but that is all; and he is unable to interpret the meaning of the physiological sensations he is experiencing. Indeed, the novice may feel that nothing at all has happened to him – he may feel totally cheated by the drug – and it is not until a sophisticated user has indicated to him the likely effects that he realizes that he is in fact being affected by the drug. Moreover, it is not until the beginner learns firstly how to smoke marijuana and then – more importantly – how to interpret his feelings as pleasurable that he experiences a 'high'. Before this the effects of the drug are usually either ambiguous or physically unpleasant. A similar process is noticeable, in terms of more powerful drugs like heroin:

The learning process involved in the first trials of the drug is illustrated by incidents related to me by addicts. For example, a man who experimented with opiates in the presence of two addicts reported that he felt nothing except nausea, which occurred about half an hour after injection. It took a number of repetitions and some instruction from his more sophisticated associates before this person learned to notice the euphoric effects. In another instance an individual who claimed that she felt nothing from two closely spaced injections amused her addicted companions by rubbing her nose violently while she made her complaints. A

tingling or itching sensation in the nose or other parts of the body is the common effect of a large initial dose (Lindesmith, 1951, pp. 24-5).

Pharmacological generalizations about responses to drugs, moreover (in this case alcohol), are often applicable to particular cultures:

At this point it is necessary to interject a note of caution with reference to various physiological and psychological studies on the effect of alcohol consumption. We should not let ourselves forget that the subjects for these investigations have been drawn from our own culture and that there are very few cross-cultural studies of the physiology and the 'psychology' of alcohol ingestion. Such comparative studies as have been made raise more than fleeting doubts that what often passes for constant 'physiological effects' of alcohol in American research in reality may be manifestations of a variable cultural overlay. Thus, for example, in one study of the function of alcohol in a primitive Mexican culture located in the mountains of Chiapas, few of the more extreme types of behaviour which arise in connection with intoxication in our culture were found to occur. There, in the stage of feeling high, native men could play guitars, or handle a machete with perfect safety. In extreme intoxication there seemed to be less interference with speech than that observable in inebriation in our culture, and even in stuporous states that natives carried through with familiar routines and transacted complicated business of which later they had no memory. There seemed to be very little vomiting after over-indulgence, and there was little evidence of hangovers beyond mild tremors and shakiness. Little fighting arose in drinking parties, and there was no evidence of lowered inhibition in erotic behaviour. These people typically drank for the sense of warmth it induced and as a prelude to sleep (Lemert, 1951, p. 341).

Drug-induced behaviour thus involves an interaction between the physiological effects of the drug and the norms of the group of which the drug-taker is a member. These effects are socially induced and structured. In New York, for instance, the most common opiate addicts (addicted to opium, heroin and morphine) are lower class Black ‘junkies’ and physicians. One lives on the street, the other high in the wealthy apartment blocks of Manhattan. Although they take the same substances, their lives

<b>Morphine/Heroin users in New York City</b>	<b>Physician addict</b>	<b>Street Junkie</b>
Amount of drug used	Builds up to very large amounts over time	Small
Purity	Pure	Very dilute or unknown dilution level; heavily contaminated: talc, amphetamines, strychnine, etc
Mode of administration	Surgically sterile syringes	Makeshift, often dirty syringes
Motivation	To keep working despite painful illness, as part of a competitive culture	To gain a 'high', as part of a hedonistic culture
Effect	Loss of pain, calmness, ability to work	Immense pleasure
Length of use	Often many years	A few years
Prognosis	Low death-rate; cure in private clinic and return to practice	Early death from overdosing, infection or adulterants

**Figure 13**

and social status could scarcely be more different. Figure 13 illustrates these stark differences.

The effects of different social milieux are thus very marked. A New York street addict taking the daily injection that a physician takes would die of overdosing, and despite the total differences in lifestyle and prognosis, it is the physician who is usually very much more physically addicted.

## **Why People Take Drugs: The 'New Deviancy' Explanation**

Society consists of a large number of groups of people with their own norms and values. Each of these sub-cultures consists of solutions to problems experienced by people in their own part of the social structure; they have approved means of achieving desired ends. Old people, young people, working class, middle class, West Indian, Irish, criminals and doctors all face their own particular set of problems and all evolve cultural ways of solving them. Some of these problems can be solved by using consciousness-altering drugs. As explained earlier, the effects of drugs are also partially controlled by the culture itself. But only partially so; for certain drugs are more pharmacologically suited to aiding certain activities than others. Amphetamines, for instance, because they are stimulants, are a much more appropriate solution to the problem of a high work-load (for example, in the case of physician or student) than would be a depressant like alcohol. A specific drug is therefore adopted partly because of its availability, partly because of its pharmacological suitability. But its effects are then *restructured* and given meaning by the sub-culture concerned.

Alcohol, nicotine and caffeine are psychoactive drugs that are freely available in our society, together with – to a slightly lesser extent – prescribed barbiturates, amphetamines and tranquilizers. Their widespread use shows that they provide a common solution to the problems of a vast number of individuals. The extent and nature of their use is not, however, uniform but varies with the particular sub-culture involved. To take alcohol, for example, there are wide differences between the drinking habits and rituals of merchant seamen and businessmen, between Italians and Orthodox Jews. Each sub-group in society will have a conception of what is the appropriate situation for a drink; what the permissible and desirable

effects of alcohol are; how much it is necessary to drink to achieve this desired state; what meanings are associated with the drunken state (e.g. feelings of masculinity); what is normal and what is deviant drinking behaviour. They will have a definition of the social drinker and a notion, too, of the alcoholic. The phrase 'It's enough to turn a man to drink', for instance, indicates that there are definite theories as to the inception of alcoholism. And there are definite notions, too, of how an alcoholic acts. Thus the social drinker in our society is commonly seen as someone who 'holds his drink' and enjoys himself, while the alcoholic is seen as someone who is sick: he is determined and controlled by *the drug*, alcohol.

We argued above that the effects of drugs are related to the conceptions people have of them. Although alcohol is physiologically addictive; the ease with which one is able to cure oneself of this addiction; the speed at which one becomes addicted; and the type of behaviour displayed during addiction will be at least partly related to the social pressures and beliefs surrounding alcoholism. Both the roles 'social drinker' and 'alcoholic' are culturally defined solutions to particular problems. That is, the person who needs to relax and enjoy himself will find himself attracted to social drinking, while the individual who feels that it would be preferable to induce a state where he is 'out of control' (i.e. where he is determined) will be recruited readily to the role 'alcoholic'.

The definition of the alcoholic as the determined person thus attracts those who wish to opt out of particular social situations. They can then say 'It's not me who is doing this; it's the "booze"'. Similarly, the conceptions a sub-group holds of the typical marijuana smoker or heroin addict will attract certain individuals and repel others. The way we define the type of person who takes a certain drug, then, and its likely effects control to some extent the kinds of people who take specific types of drug. Society, that is, creates a series of psychoactive

'boxes' which certain kinds of people find congenial but others reject. The alcohol molecule itself does not contain a solution to a person's problems. Rather, the culture he belongs to defines the problem, states whether or not alcohol is relevant to its solution, and programmes and structures the administration of alcohol so as to provide an array of possible and permissible effects. In short, the psychoactive 'box' erected around alcohol in the particular sub-culture to which the individual belongs may or may not be capable of handling the problem which he faces.

The problems faced by an individual, of course, may not involve deviance at all. They may well be solved by the normal behaviour suggested by his culture. A man who feels it difficult to relax after work, for example, will find that there is a programmed psychoactive drug, alcohol, available, and that the role of 'social drinker' is a perfectly acceptable one which will solve his problem. But what of those for whom the culture provides no such 'normal' solution? The individual who faces a particular strain has two alternatives: to solve his problem in isolation, or to join with like-suffering others to create a collective solution. To take the individual solution first, a person facing severe strain, but unaware that there are others who feel likewise, will probably interpret his troubles in terms of self-blame and personal inadequacy rather than as a result of stresses commonplace in society. He will take recourse to the pervasive absolutist explanations of deviancy which are commonly held in our society. He will 'individualize' the problem and will fail to see himself - or be seen by others - as someone whose troubles are explicable in terms of the wider social context. The deviant's behaviour is then viewed as a matter of personal pathology, and labelled with a medical metaphor. Thus the isolated housewife using tranquillizers may think that both her dependency on drugs and the anxieties which generated it are her own fault, that she is the

only woman in the world who finds being confined to the house frustrates her personal development and sanity.

But isolated individuals may well find that there *are* roles associated with certain types of drug use and effects which are appropriate to them. The main such role, in any society, is that of the isolated alcoholic, but similar conceptions of heroin addicts exist in some deviant sub-cultures. Thus, for the adult middle-class Briton, the social drinker is the normal role. For his son, on the other hand, marijuana-smoking may be a normal psycho-active activity, with heroin use as a deviant one. That is, both 'straight' and 'hip' cultures have distinctive and different conceptions of what constitutes a 'sick' drug-user.

Not all isolated drug-takers view themselves as having pathological personalities. An alternative, and more insidious analysis, would be that although the person is 'normal', the drug to which he has been casually introduced - whether it be alcohol or heroin or tobacco - has such power to addict that it is impossible to resist its use.

Each way, individuals are seen to be sick: they either have a sick personality which has led them to addiction, or they have caught the 'sickness' of drug addiction. Such determined roles are peculiarly attractive to people who find themselves in impossible and irreconcilable situations. They enable them to continue a particular line of action, for example mainlining heroin, while at the same time both to condemn the practice in general, and at the same time to deny responsibility for the behaviour, in their own case, as a necessity.

Thus unemployed men excuse themselves for their inability to perform the 'normal' masculine role of worker, into which they have been socialized, because they have heroin

'sickness'. 'Physical' sickness caused by withdrawal from heroin will be interpreted as a confirmation that he suffers from a 'social' or 'psychological' sickness. His desire to avoid choice has become translated into a notion of himself as being unable to make a choice. Withdrawal symptoms are perceived as chronic and irresistible, so that one is 'forced' into using a greater dose. Physical dependency will then indeed become greater; withdrawal distress will increase; and so on. The addict has entered a spiral of involvement in the sick role.

### **Giving Deviants Meaning and Taking it Away**

Positivists argue that, as experts, they have a superior understanding of deviancy than the deviants themselves. Deviants, they say, because of their lack of cognitive ability and a tendency to conceal the real causes of their troubles, are the *last* people capable of understanding what is happening to them.

The study of social phenomena, positivists argue, should be value-free: social scientists should utilize objective concepts as in the natural sciences. Values merely decide which problems we are interested in; they must not be allowed to distort the evidence we examine.

Blackburn has criticized this position on the grounds that although this view assumes that 'once theories are thoroughly cleansed of all value judgements' 'they will be governed by the wholesome discipline of objective facts, the predictable consequences of this attempted purge of values is to orient theory and research towards certain crude over-abstracted value notions masquerading as scientific concepts' (Blackburn, 1969, p.205). This 'ideology of objectivity' which pretends to have evolved value-free concepts, in fact reflects middle-class values.

'Psychopathy', 'anomie', 'social disorganization', 'undersocialization', 'weak superego', lack of

masculine identification', 'retreatism': are all views of one group's behaviour as seen from the perspective of members of the liberal professions, part of the 'enlightened' middle classes. Because of their privileged social position, the views of those at the top are viewed as more 'realistic' than those of the lower echelons of society. As Becker has put it, there is a 'hierarchy of credibility'. The meaning that the individual drug-takers themselves ascribe to their activities is ignored.

Junkies, for instance, are said to be notorious liars. The 'real' causes of their action therefore, can only be discussed by experts who possess 'insight' into the problem. Occurrences in the drug-taker's past are then invoked as the 'real' explanations of present actions. Thus, for instance, a man is said to inject heroin into his veins because his father was a weak and ineffectual figure, or smokes marijuana because he was fixated at the oral stage of his development as a child. The taking of a drug is denuded of any meaning that individuals themselves attribute to it. Their ideas are merely rationalizations for the hidden forces which, unbeknownst to them, impel them to take drugs.

Drug dependency, like all deviant behaviour, tends thus to get explained by reference to events in the distant past which resulted in psychotic or asocial tendencies which became part of the deviant's psychic make-up. Both these approaches are 'essentialist', but in different ways: pharmacological analyses assume that a certain type of behaviour is automatically released in any individual under the influence of a specific drug; psychological explanations insist that the drug merely triggers off inherent repressed tendencies which are part of the essential nature of the individual in question. Both assign a minor role to social factors. These may cause peripheral variations in drug-induced behaviour but are never a major focus of analysis.

By contrast, not only are drug-taking groups regarded as asocial, but drugs themselves are seen to be 'desocializing': drug-induced behaviour is seen as bizarre, meaningless and uninhibited; it represents the release of primitive, instinctual passions. The drug-taker is seen to be temporarily transported 'beyond' the control of society. The study of drug-taking therefore concentrates on the pharmacological properties and effects of the drug in question or on the supposed formation of a personality predisposed to drug use in the early years of life, or acquired in the early stages of addiction.

Thus the addict is often characterized not only as having a weak ego, a defective superego and a lack of masculine identification, but also unrealistic aspirations and an 'irrational' distrust of major social institutions, all of which derive from the addict's family background. 'Realistic' behaviour is thus predicated upon the belief in the rationality of the major social institutions in the governmental agencies which protect our lives, property, and rights. Thus Chein *et al.* Note:

This does not prohibit us from regarding particular instances of such institutions with disapproval, anger or cynicism. But, despite such instances, we accept the institutions as a valid and potentially useful social arrangement. We generally trust persons who embody these institutions until they betray this trust; should they deceive us, we criticize them as individuals, though we maintain much of our regard for the institution *per se* (1964, p. 265).

Normality, then, involves a basic acceptance of society as it stands; distrust, even by the dispossessed or the underprivileged, is regarded as symptomatic of personal and family pathology.

Deviancy theorists acknowledge that events in the biography of the individual drug-taker, are, in general, likely to provide only very partial explanations of present drug use. Dependency, that is, is not caused by impersonal forces which impel the individual on to the road to addiction, but develops because the drug-taker responds to the forces which impinge upon him in ways that are socially available - and satisfying - to him. We therefore need to know his interpretation of the situation and his assessment of reality. To do so, we need to examine the values and the ideology of the drug-user. This is not to say the drug-taker's perception of the situation is necessarily an accurate one; simply that his or her evaluation of their own situation is a major component governing their behaviour.

Behaviour also has to be located within the context of the wider society. We do not adequately explain human action by assuming that it is the outcome of purely individual propensities (e.g. that a person is violent because he is a 'psychopath'; or that a woman has a large number of sexual partners because she is a 'nymphomaniac'). Rather, individuals can only be understood in terms of the sub-cultures of which they are a part.

As an instance let us look at the phenomenon of the relatively high level of drug addiction amongst physicians. Let us take the case of the doctor who is overworked and who has a painful gastro-intestinal disorder. As a member of the sub-culture of the profession of medicine, he has a considerable knowledge of drugs, in terms of their effects in various quantities, He also has access to them. Secretly, therefore, he prescribes himself daily shots of morphine. He does not think that he will become addicted; his expertise, he believes, will enable him to control its use. He also takes the opiate in order to pursue ends compatible with his profession (i.e. to continue working), rather than for pleasure, as with the lower-class

addict. If he does, eventually, become dependent on morphine, the addiction will be shaped, timed, administered and resolved in terms of the sub-culture of medicine to which he belongs.

Now, let us take a type of deviance that does not involve drugs: misbehaviour in the classroom. Positivists often assume that disruptive pupils are 'hyperactive'. They are suffering, that is, from an individual problem, of possibly metabolic origin, which *makes* them inattentive and rebellious in class. In contrast, the outstanding study of classroom misbehaviour dismisses all pathological interpretations, such as 'hyperactivity', and shows instead how the lower stream of the class realize that they are destined for low-skilled jobs where academic achievement is irrelevant. Their structural problem is that they are being asked to compete against middle-class standards for which their own background ill prepares them, in order to achieve academic qualifications irrelevant to their future jobs. They culturally 'solve' the problem by 'playing up' in the classroom, rejecting the teacher's discipline; and by despising 'swots' while at the same time evolving a sub-culture which gives high status to manliness and physical toughness. That is, they begin to evolve a culture which rejects standards which threaten their self-esteem and more relevantly fits their future work as labourers. They turn their misfortune into a virtue.

### **The Causes and Effects of Social Reaction Against the Drug-user**

From the positivist point of view, widespread deviancy is disruptive of social order. What is needed, then, obviously, is expert intervention. The task of the expert is thus not just that of explaining the deviant to the rest of society; he is also expected to reform and treat the rule-breaker. Certain personnel are therefore selected to mediate between society and the deviant. Chief among these - apart from the police and the clergy - are the social worker, the psychiatrist, the psychologist and the criminologist. They perceive themselves as having a

primarily therapeutic role: of assimilating the 'poor', the 'maladjusted', those with 'immature personalities', 'the under-socialized', 'the sick', 'the adolescent gone wrong' into the ranks of decent, well-integrated people like themselves. When some of their clients interpret these attempts at therapy as being punitive and coercive, they are said to be lacking in self-insight while the few who go further and accuse them of being professional ideologues with middle-class values are dismissed as unbalanced.

The expert, who is in a position of power *vis-à-vis* the deviant, will tend to maintain his position by eliciting from the deviant those responses which tend to verify his theories: a procedure which has been described as 'negotiating reality' (Scheff, 1968). If the deviant is cooperative and helpful, and shows insight into his or her problem, the expert will also be cooperative: he will provide material help or obtain an early release, will not give the 'client' shock therapy, but instead give warmth and sympathy and protection from the law. In short, successful therapy involves convincing deviants of the stupidity of their own ideas about their own behaviour and replacing those ideas by those of the therapist's, a process paradoxically called 'self-insight' (Berger and Luckmann, 1967).

But the expert not only has the power to 'negotiate' reality (to determine the sort of information which he is willing to see and hear); he also has the power to *change* reality. The stereotypes that experts hold about deviants therefore have very real consequences both for what happens to them and in terms of the way they perceive themselves. Thus individuals incarcerated in total institutions being to look, act, and feel like the anomic, under-socialized, psychotic, amoral individuals which the therapeutic personnel portray in their theories of deviancy.

Any protest by the deviants themselves against the treatment which they receive is seen as confirming the theory. Thus Chein *et al.* write of heroin users:

When the hospital staff attempts to impose controls which would be accepted, though not enjoyed, by most adolescents, adolescent addicts perceive this as a threat to their masculinity, so they are regularly involved in such problems as truancy, keeping late hours, refusing to get up in time for breakfast and refusing to turn the lights out at some curfew hour. They will let no one tell them how to conduct themselves, for to do so implies that they are not man enough to know themselves . . .(Chein *et al.*, 1964, p. 226).

The fragmentation of knowledge, the segregated middle-class existence of the expert, his or her power to negotiate reality and ignore protest, the seeming fulfilment of his hypotheses, all combine to ensconce him securely in a positivist position. These tendencies are particularly strong amongst experts on drug dependence, for drug use poses obvious medical and physiological problems, so that physicians and pharmacologists tend to specialize in this field. Their natural-science training makes it unlikely that they will be sensitized to the fundamental differences between physical and social phenomena, while their study of the human body encourages them to see society, too, as an organic system.

To the positivist social scientist, social reactions against certain kinds of deviant behaviour are simply natural. It is not questioned, for example, why society reacts against people who smoke marijuana but not against those who smoke tobacco. In contrast, deviancy theorists regard deviancy, not as a property inherent in certain kinds of activity, but as a label that is put upon some kinds of behaviour. From this point of view, studying what kinds of people condemn drug-taking is quite as important as studying those who take drugs. Hence, they

study the power structure of society: the ways in which certain groups are able to proscribe the behaviour of others, and legitimize only the kinds of behaviour they themselves engage in.

Social reaction to drug use, in fact, is often itself irrational. Thus moral panic and public concern about drugs is often out of all proportion to their real incidence and effects, for example in relation to actual mortality rates. Thus in the 1960s there was an enormous media coverage on the dangers of marijuana though there was no authenticated case of anyone ever dying of the drug. Yet around 200 people a day die of the effects of tobacco, and more people die of tobacco in one day than heroin in a year. Again, despite the considerable carnage resulting from adolescent motorbike crashes, newspaper headlines do not portray this as an 'epidemic' of deaths or call for sanctions against motorcycle manufacturers or describe retailers as 'pushers'!

Deviant activities, even though they may have no direct effect on those who merely observe them, are often condemned because they are seen as behaviour which, so to speak, 'dodges the rules'. People who live by codes of conduct which forbid certain pleasures, or demand the deferring of gratifications, react strongly against those they see as taking shortcuts. This is a partial explanation of the vigorous repression against what Edwin Schur (1973) calls 'crimes without victims': homosexuality, prostitution, abortion and drug-taking. And drug-taking is, of course, a target *par excellence* for moral indignation. A further common reaction to drug use is that of ambivalence, however, for the 'normal' person simultaneously covets and castigates the 'deviant' action. This, after all, *is* the basis of moral indignation, namely that the wicked are undeservedly realizing the covert desires of the virtuous. Richard Blum captured well this fascination - repulsion relationship to drug use when he wrote:

The amount of public interest in stories about druggies suggests attraction and repulsion in ordinary citizens. 'Fascination' is the better term, since it implies witchcraft and enchantment. People are fascinated by drugs - because they are attracted to the states and conditions drugs are said to produce. The other side to the fear of being disrupted . . . is the desire to release, for escape, the magic, and for ecstatic joys. Drugs represent keys to forbidden kingdoms inside ourselves (Blum, 1969, p. 335).

Moral indignation, then, is based on a conflict between values and desires: hence the remarkable interest in certain drug-using groups despite their minute size, and the denunciation, in the mass media, of the heroin addict (who presumably is 'enjoying himself') rather than the methylated spirits drinker (who presumably is too miserable to be attractive).

Social reactions against particular forms of drug-taking, in general, are proportional to the degree to which the group involved embraces values which are hedonistic and disdainful of work. Conversely, where drug-taking is linked to productivity, either because it aids work or facilitates relaxation before or after work, it is viewed with much greater favour, if not encouraged. Even the *same* drug, however, can be differentially evaluated according to the group which uses it and the ends which its use facilitates in the following ways:

### ***Amphetamines***

*Legal use.* Seventy-two million tablets were issued to British armed forces during the war to be used to combat exhaustion; astronauts carry stocks in case of emergency; civilians use them, on prescription, to slim and counteract depression.

*Tolerated use.* By teenagers to stay awake at all-night clubs and parties.

### ***Alcohol***

*Tolerated use.* 'Social' drinking at business functions or to relax after work at approved leisure times.

*Condemned use.* 'Problem' drinking, the clinical definition of which involves the disruption of work-habits and domestic duties.

### ***Opiate***

*Legal use.* Morphine to alleviate pain amongst the sick (the largest number of most heavily addicted people in Britain are the terminally ill).

*Condemnation, but little social reaction.* The use of morphine by physician addicts to enable them to continue working, addiction which is only discovered after admission into hospital for a 'cure'. The retrospective reaction of the doctor's community, however, is usually remarkably slight.

*Condemnation and harsh reaction.* Use of heroin by 'street addicts' for hedonistic reasons. In Britain, however, where addiction is perceived as an unpleasant sickness, the social reaction is less punitive than where the addict is seen as a criminal hedonist.

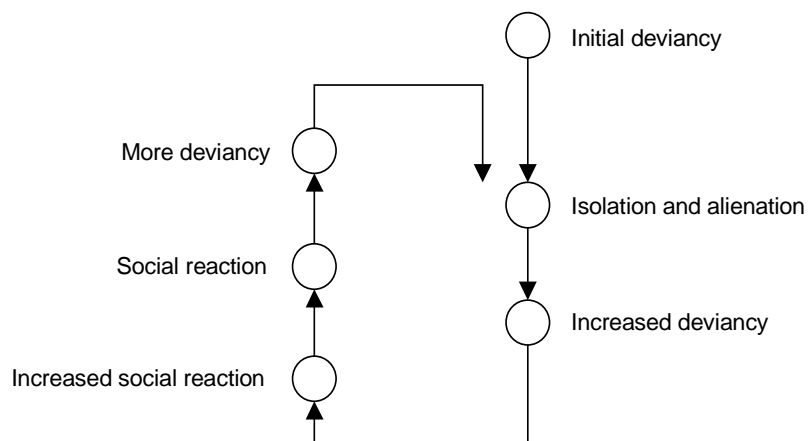
### ***Tobacco***

Probably one of the most universally acceptable drugs in the West, despite the immense health risk smoking involves. It is one of the few drugs which is tolerated during the performance of many occupational roles, since it does not interfere with efficiency and has a reputation for aiding concentration on the job at hand.

The illuminating way of summarizing these reactions to deviancy, sees them as successive phases in a process that has been called *deviancy amplification* (Wilkins, 1965).

The argument starts from the proposition we discussed earlier: that under certain conditions society will define as deviant a group of people who depart from valued norms in particular ways. This negative societal reaction - by driving deviants into each other's company if they are to pursue those kinds of behaviour and by driving them out of 'respectable' society - increases the probability that deviants will act even more deviantly. Societal reaction will then increase at the same pace; more deviancy will be induced; in turn, the reaction escalates further. As a result, a 'deviancy amplification spiral' is entered into, where each increase in social control is matched by a corresponding increase in deviancy.

**Diagrammatically:**



**Figure 14**

It should not be thought that the deviant group is, so to speak, a pinball propelled in a deviant direction, or that the agencies of social control will inevitably react in an equally mechanical way to deviancy. The drug-taking group can create its own circumstances in various ways, and reactions on the part of society will also vary in accordance with the kinds of theories which both the society and the drug-using group evolve in order to explain each other and which they test out in the actual course of events - which range from arrest situations to casual encounters on the street, and from articles in the mass media to discussions among friends.

Overall, however, whatever these variations, it is the definitions imposed by the powerful on the situation that will be most decisive in shaping public policy and social attitudes.

### **Social Policy**

From the positivist position, the causes of drug-taking have to be ascertained by an expert; a diagnosis made; and intervention undertaken in order to treat the individuals involved. The parallel with medicine is explicit: an epidemic has occurred. Hence we must treat the individuals afflicted and control likely carriers. Deviant sub-cultures must therefore be eliminated.

All of this is anathema to the relativists. To them, the notion of an automatic transmission of drug use, whenever individuals contact drug sub-cultures, is a fallacy. Since people become socialized into drug cultures because they find them attractive in terms of solving problems which they face, to end drug abuse you must find alternative solutions to these problems

which do *not* involve the use of drugs. In the meantime, the cultures themselves contain and regulate drug use, so what must be attempted is to feed rational information into those cultures. This may seem to be only an interim palliative, but until we make determined efforts to tackle the root causes of drug-taking, it remains the most likely way of minimizing deleterious physical and psychological effects in the populations at risk.

The social reaction against drug use, despite the rhetoric and sometimes the reality of the humanitarianism it expresses, achieves precisely the opposite of its manifest aims. Instead of liberating the individual from addiction it confirms him as a deviant rather than obviating suffering; it ensures that the misery becomes inescapable. The myth that illicit drug use is intrinsically unpleasurable is thereby made to come true, and justified as 'treatment'.

Thus the nature of dependency and the life of the drug-taker cannot be understood merely in terms of the drug. Heroin addicts in Britain, the United States, Hong Kong and Japan all take the same drug but the pattern of addiction is remarkably different. Different social reaction against the drug-taker, in different cultures, and the various policies designed to control drug-taking, have remarkably different effects on the ways drug-takers behave. For example, in the United States, they are cast as criminals, legally harassed, and forced into crime (thus substantiating the stereotype) in order to find money for the high black market prices.

Organized crime grows up as an unintended consequence of narcotics legislation, an exploitative culture is set up which dominates the life of the addict. Since the strength of these adulterated drugs is low, death is not an inevitable consequence of a drug like heroin but a consequence of supply and cost on the market. On top of this, criminal exploitation, police harassment, therapeutic correction, and social stigmatization all give rise to a culture which defends itself against these very agencies.

If we wish to reduce the extent of drug-taking we therefore have to:

1. Eliminate the problems which are the underlying causes. This involves much wider areas of social life than the drug-taking sub-culture alone. Combating heroin use amongst youth, for instance, would involve fundamental alterations in the economy and in levels of unemployment. Above all, social problems must not be reduced to medical problems; they demand social solutions.
2. Look for viable alternatives to the use of drugs (some of which might also arouse social antagonism), including alternative drugs or safer methods of using existing ones.
3. Avoid, wherever possible, the onset of deviancy amplification. At the most immediate level, this involves changing the absolutist stereotypes held by many agencies of drug control (e.g., the police and the drug clinics). On a wider level, it involves a change in public attitudes, including those of parents and citizens.
4. At the level of the individual, the actor, too, has to realize that his or her problems are social, and that their solution can be achieved not by fatalistically accepting determined roles (such as the sick addict in the clinic) but involves action on their own part, and on the part of others) to change their social situation and thereby eradicate the root causes of their addiction.

We have used drugs as an example of deviant behaviour because it is a topical and controversial issue. But the same kind of analysis is valid in analysing other forms of deviance. Whereas the positivist will ascribe delinquency to poor family background or even inadequate physical type, and see its concentration among the lower orders as indicative of their poor social norms, childrearing practices or genetic stock, deviancy theorists observe that while all kids (and adults) commit delinquent acts, it is, however, only lower working-

class youngsters who get picked up by the police. The moral panic about youth crime, based on mass media stereotypes and inappropriate social reactions, is a process of deviancy amplification which eventually transforms the delinquent into the hardened criminal.

### **Absolutism, Relativism and Realism**

This chapter is obviously written with considerable sympathy for the 'new deviancy' approach. But there are problems with that approach, too.

It is as fallacious, for example, to depict human beings as being totally free as it is to see them as totally determined. People make real choices but they do so under circumstances which are not of their own choosing. Furthermore, they often make these choices on the basis of misconceptions and with inadequate knowledge, which limits the solutions they attempt and often makes things worse. New deviancy theory tends, then, to assume too much rationality in the drug-taker's behaviour. Resort to alcohol, for example, may make a person less competent and their confidence will then shrink even further.

In rejecting the positivist notion of people as being determined by their individual psychological and genetic past, and in studying the dynamics of the drug-taking community, deviancy theorists often neglect pressures which are built into society as a whole. The unemployed Black in the ghetto has very limited choices; the suburban housewife is stuck at home. Their freedom is limited. Further, by stressing the way in which administrative control of deviancy amplifies the problem, and by emphasizing the injustices of policing and the stereotypes of psychiatrists and social workers, attention is diverted from the injustices. Ghetto addicts are not driven to heroin use simply by false 'labelling', though this certainly

exacerbates their problems. They are driven into it because of the circumstances of the ghetto.

New deviancy theory rightly stresses that many of the dominant values of society are not directly in the interests of large numbers of its members and that there is a considerably greater diversity of interpretations of the world than is often recognized. This is not to say, however, that there is no sense at all in the notion of consensus, for it does, in fact, represent the interests and values of the majority. Condemnation of drugs may be based on particular conceptions of 'respectability' and on the desirability of hard work. Yet people *do* have to work, and families do have to bring up children, to keep up decent living standards and ensure that there is a compassionate relationship between people – all of which are threatened by the use of strong drugs. The Temperance Movement of the 1920s and 1930s may well have been based on a prudish and puritanical approach to alcohol, but it was also true that the culture of the drinking saloon and the bar threatened the impoverished family, brutalized many men and led to the domestic abuse of many women. The reaction of 'straight' society to drug use on the part of its more bohemian members often degenerates into mere stereotyping and fantasy – as many a jazz and rock musician has discovered, drug use both enhances and encumbers creativity. To argue against present systems of control is not the same as arguing against control, and however fallacious consensual stereotypes of drug use may be, there is a widescale consensus across all social groups that incoherence, impotence and early death are not social goods.

A realistic approach is to accept that there *is* a problem of drug use within society, but that the real problem is caricatured, exaggerated and converted into a moral panic by powerful

forces in our society. The mass media take real fears about drugs and inject hysteria into people's minds. But they would not be able to if there were no actual fears to play upon.

Drugs, then, really are a problem. The deleterious effects of many drugs have been grossly exaggerated, but this is not to say that they are innocuous. Heroin, for example, does not itself produce direct physical damage as tobacco and alcohol do, and most deaths are the result of using contaminated, dirty needles and overdosing because the strength of the dose is unknown. All of this, is, of course, largely the consequence of its illegality. But even if all heroin use were legal, it is an extremely strong drug. Even when used in pure form, with clean needles as in medical clinics, there is always a possibility of overdosing, and there is the tendency to go to the edge of one's tolerance- level. Physician addicts can often use large quantities of morphine or heroin over long periods of time without killing themselves, but it is a very different matter in hedonistic junkie sub-culture. It is precisely *because* drug use and effects vary by sub-culture that there are higher dangers in one culture than another.

Different groups use the same drugs with methods raging from extreme caution to abandon.

Similarly, while it is correct to say that tobacco and alcohol kill far more people than heroin or cocaine, it does not follow that other unpermitted drugs are innocuous. It would probably take 1 ½ lb of cannabis, for example, to kill you. But the inhalation of any substance into your lungs is not innocuous, and people who are already very unstable may become more unbalanced through constant smoking.

Conventional policies of drug control have lamentably failed. Why, then, many asks, should we continue with policies which manifestly only make things worse, and why should governments have the right to interfere in activities which harm no one but the deviants

themselves? Why should we interfere, in any case, with free individuals doing their own thing? The realistic answer is that individuals are not free. It is precisely the structural determinants which they choose to ignore which limit their freedom and the rationality of their choices. Nor is the exercise of power in itself an inherent evil, for power can be used to combat repressive institutions. And though widespread changes in society do undoubtedly evoke opposition from those with interests, material and ideological, in the status quo, radical reforms in minor areas of social life are possible without total transformation of the entire social order.