DRUGS in American Society

Third Edition

ERICH GOODE

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THIRD EDITION

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DRUGS IN AMERICAN SOCIETY

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PREFACE

The changes that have taken place in the world of drug use since the publication of the previous edition of this book (1984) have been massive, perhaps even more so than for the period between the first (1972) and the second editions. Consequently, I found that a thorough revision and updating of *Drugs in American Society* was necessary. As with the second edition, more of this edition's pages are completely new than were carried over from the previous edition, even in rewritten form. The drug world has changed, public attitudes toward drug use have changed, I have changed, and far more information now exists concerning drug use.

A number of subjects that were barely in evidence in the early 1980s (when the previous revision was undertaken) or did not seem crucial enough to merit a discussion, now seem to me to be so important that they cannot be ignored. They include: the connection between intravenous drug use and acquired immunity deficiency syndrome (AIDS); the use of "crack"; mandatory drug testing; the failure of the British system of maintaining addicts on narcotics; the decline in new recruits to narcotic use and addiction in the United States; the growing internationalization of drug smuggling into the United States; the appearance of and growth in the use of "designer" drugs, including "ecstasy" (MDMA) and fentanyl, a narcotic; the divergence of lower- and middle-class patterns of drug use; the irrelevance of the distinction between physical addiction and psychological and behavioral dependence; the massive rise in cocaine abuse and dependence; the growing awareness in the study of drug use of controlled narcotics use; and the growing "hard line" toward illegal drug use ("zero tolerance"). In short, the world of drug use has changed drastically in the past half-dozen or so years.

Perhaps the most momentous of these changes has been the emergence of a "moral panic" in the United States about illicit drugs: the dramatic rise of public concern about the danger of drug use and what to do about it. The number of articles published in newspapers and popular magazines more than tripled between the middle and the late 1980s. Television news stories about drug arrests, seizures, and drug-related homicides have multiplied many times over. TV and newspaper propaganda advising the public not to take drugs appear with daily regularity. Organizations designed to combat drug abuse—usually with mere words—have cropped up like mushrooms after a spring rain. The position of drug abuse on the American public's list of "most serious" social problems has marched steadily upward during the

past half-dozen years. In 1988, a New York Times/CBS poll reported that 16 percent of the respondents questioned said that drugs was the most important issue facing the nation today—and no other concern was ranked as highly. The subject of drug abuse and what to do about it has assumed major importance in the speeches of politicians and other notables. In 1988, President Ronald Reagan stated at the graduating ceremony of the Coast Guard Academy that drugs are "the foremost concern in our country." In a recent poll, the American public was asked whether the "most important international problem" was stopping drugs or stopping communism. More than six respondents in ten (63 percent) said stopping drugs, while only one-fifth (21 percent) said stopping communism. According to Senator Christopher Dodd (D-Conn.), in the late 1980s, politicians engaged in a "feeding frenzy" to assure their constituents that they are concerned with the drug issue. "Things are getting a little crazy out there," added Dodd. In short, from the point of view of public concern, drug use has become a social problem of the highest magnitude—indeed, perhaps *the* social problem of central importance for the 1980s and the 1990s as well. That all of this has taken place in a period during which the actual use of drugs has declined is remarkable.

It is a central thesis of this book that conventional anti-drug thinking cannot hope to understand the reality of the drug world. Once you build an argument on the simple "drugs are bad, don't use drugs" message, you are forced to bend and twist evidence to fit that simplistic point of view. Moralistic thinking assumes that there is something that is unique and completely different about illegal drug use that is not shared by phenomena in the conventional world. Illegal drugs possess no magical intrinsic quality that is not also shared by legal drugs—indeed, by many ordinary, everyday entities, phenomena, substances, and activities as well. "Drugs can kill" says the anti-drug propagandist—a true but obvious statement. And so can alcohol, a drug, and tobacco, which contains at least one major drug. So can cars, boats, motorcycles, boxing, sky-diving, scuba diving, and shoveling the snow from one's driveway in the wintertime. They all kill—some people, some of the time, under certain conditions. Like a number of other activities, taking illicit drugs to get high entails a certain risk.

The 1980s will be remembered for some of the silliest utterances ever made on the subject of drug use. A number of them originated with the First Lady, Nancy Reagan. In 1986, Mrs. Reagan was quoted as saying: "Drug use is a repudiation of everything America is." Within months of this statement, the American Tobacco Institute issued a lavish, expensively produced pamphlet on tobacco, a substance which, the title of the pamphlet declared, is "deeply rooted in America's heritage." And, as we see in this volume, alcohol has a distinguished history in America: The Indians made alcoholic beverages before Columbus arrived on these shores, and the Puritans brought more beer to this continent than drinking water. Even if we pretend that alcohol and tobacco are not drugs, it is clear that the American government has supported regimes abroad that have been involved, directly or

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indirectly, in the drug trade. The major source of income of the Afghan rebels has been the cultivation and sale of opium, and the U.S.-supported "contra" rebels have been involved in the sale of marijuana and cocaine for several years. Nearly 20 million Americans use marijuana regularly; cocaine attracts nearly six million users. To paraphrase a saying, "psychoactive drug use is as American as apple pie." It is not going to disappear from the landscape by issuing silly, misinformed statements.

In 1988, Nancy Reagan asserted that the casual drug user is an "accomplice to murder," presumably a reference to the fact that all drug users, casual and more intensely committed, support an industry which sells a product that kills some users. The fact that cigarettes kill far more users than illegal drugs do seems to have escaped Mrs. Reagan; are cigarette manufacturers and executives "accomplices to murder"? (The same year that Mrs. Reagan issued this absurd statement, author Larry White published a book on the cigarette industry with the title *Merchants of Death.*) While no one seriously doubts the dangers of illicit drug use, it is crucial to understand the place of drugs in the context of the many other problems that American society faces.

Most people who take illegal mood-altering drugs are not harmed by that use. A minority (perhaps on the order of one in ten) of the users of a number of illicit drugs end up taking their drug of choice so frequently and in such a quantity that they threaten or destroy what they previously valued—school, an education, a job, a career, relations with loved ones, monetary savings, property, a house, a car, their self-respect, their health. What is becoming clear is that the causal mechanism here lies less in the substance in question—the particular drug they use—and more in the characteristics of the user. Many individuals, in all likelihood a majority, can use illegal drugs, possibly any and all illegal drugs currently in use, regularly, in a controlled fashion, without becoming dependent on them. A minority cannot, and ruin their lives and the lives of others in the process. To claim that most or all recreational drug users live a life of horror and misery is dishonest or self-deceptive. Such a statement calls for a close look at the evidence—which I've attempted to do in this book.

In the past few years, the call for some form of legalization of currently illegal drugs has become bolder, more assertive. In 1988, Kurt Schmoke, Mayor of Baltimore, shocked the United States Conference of Mayors by calling for the decriminalization of narcotics. Such a move would, he said, "take the profit" out of drug sales. In my view, this position is not only naive; such a move would be catastrophic. Level of profit in the drug trade is only partly dependent on the legal status of drugs. The fact is, a number of drugs are *highly* pleasurable or reinforcing; the current criminal sanctions against the possession and sale of these drugs deter the curious, the timid, the conventional. If decriminalized or legalized, the drugs that are now illegal would be used by *many* more times the number of individuals currently using them. Alcohol Prohibition (1919–1933) is often cited as an example of the failure of applying criminal sanctions to the possession, use, or sale

of a drug, but this turns out to be not only a cliché but a poor example as well: In fact, alcohol consumption did decline significantly during Prohibition, as we'll see in this book.

The fact is, the criminalization of certain drugs has a range of effects, some good, some bad. It fails to deter all use, it does deter some use, and it has some consequences that all would agree are bad. Criminalization increases the price of drugs, makes money-making criminal activity among drug users much more likely, strengthens the criminal underworld and the drug-using subculture as well, and makes illicit drug use and sale a more dangerous activity in a number of ways than would otherwise be the case. On the other hand, criminalization does keep drugs out of the hands of a certain proportion of the public. Cocaine, for instance, is a *far* more pleasurable drug than alcohol, and yet, there are sixty million regular alcohol users and only six million regular users of cocaine. Is it not reasonable to assume that if legal sanctions were removed from cocaine possession and use, the number of users of that highly reinforcing drug would increase—possibly to the level of alcohol use? The either–or thinking that most observers of the drug scene bring to the problem makes the assumption that one solution will have mostly positives while another, mostly negatives. In fact, any solution will be a mixture of positive and negative; it is our job to pick out the one that will be least disastrous.

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Prologue

Landing on a hidden airstrip in two helicopters and a light plane, forty police officers assaulted and took the jungle compound in a hail of gunfire. Dubbed Tranquilandia, the "land of tranquillity," the complex was devoted entirely to the production of cocaine. Set deep in the Colombian Amazon basin, far from a town of any size, it included a dormitory large enough to sleep eighty; a Betamax video recorder; a dining area equipped with a refrigerator, microwave oven, and dishwasher; and bathrooms furnished with showers and flush toilets made of Italian ceramic. Fresh supplies of pigs and chickens were flown in daily. Some 1,000 employees—including cooks, waiters, and plumbers—were on the settlement's payroll. Just outside the compound, there were nineteen separate laboratories for processing and refining cocaine.

Before the raid, Colombia's total annual cocaine production was officially estimated at 50 tons per year. Tranquilandia alone was capable of producing 300 tons a year. In the raid, the police arrested 40 workers and seized 14 tons of the drug. They poured the confiscated cocaine, valued at $1.2 billion, into the nearby Yari River, which ran white with the powder (Iyer et al., 1986).

James, 62, is surrounded by his daughter and several friends. His is wearing a bathrobe and isn't feeling well. He says his problem is medical; everyone else knows better. He has recently lost his architectural firm; his telephone has been disconnected for nonpayment of bills; a woman who loves him has decided to marry another man; a chess partner says James has begun cheating; a former business partner says his once-brilliant mind has become "addled into dull predictability." His daughter, holding her 9-month-old baby, speaks up: "Daddy, we are here because we love you." James says he understands her concern; he says he has the flu and has been getting daily shots from his doctor. His daughter replies that she checked with his doctor, and he hasn't seen him for two years. Finally she tells him, "We think your problem is alcoholism." James protests, "That's preposterous! My problems have nothing to do with alcohol. Look, can't you understand? I'm sick, yes; depressed, yes; getting old, yes. But that's all."

After fourteen hours along these lines, James, exasperated, admits, "Geez, if I couldn't go down to the pub for a few, I think I'd go nuts!" His daughter places her baby on his knee. "Look at your granddaughter," she says. "This is your immortality, Daddy, and she needs you. Please don't die. Please choose life, for us." James puts his head in his hands. No one speaks.

Looking up, his face the color of gravel, he agrees to go to a local hospital. The tests reveal extensive liver damage, an almost certain sign of alcoholism. Still, James protests. "It could be my lousy diet," he says. Finally, after more arguments, he decides to check into a treatment center. Halfway through the program, James begrudgingly concedes that the treatment saved his life. "A person I haven't known for years is taking the place of alcohol. I like and respect him, and I never want to lose him, or my family, again" (Franks, 1985).

After hearing an antidrug lecture by a deputy sheriff at her church, Deanna Young, 13, decided to act. She went home and filled a plastic garbage bag with pills, cocaine, and marijuana and took it to her local police precinct. She explained that her parents, Bobby Dale Young, 49, a bartender, and Judith Ann Young, 37, a court clerk, were drug users. The Youngs were arrested, then released on their own recognizance; Deanna was taken to a county shelter for abused and abandoned children. She turned her parents in, she explained, to protect them, to get them off drugs—because they couldn't stop on their own. It was, she said, "for their own good." A few months later, a social service petition charging that Bobby and Judith Ann are unfit parents was dismissed by a local judge (Johnson, 1986). Deanna is now living with her parents again. Said Judith Ann, "We're just very happy to be all back together and have this all behind us" (*The New York Times,* September 10, 1986, p. A18).

Lorraine Mitchell has been a cigarette smoker for twenty-two years. In August 1984, Suffolk County, where she lives and works, passed a law requiring companies with more than fifty employees to ban smoking in rest rooms, conference rooms, hallways, and elevators. In November, the firm for which Lorraine works, going considerably beyond the county law, banned smoking in all of its work areas. To smoke during work hours, Lorraine, who smokes a pack and a half per day, must leave her desk and step outside. "I understand why they're doing it," she commented. "But it's a pain in the neck in the winter." Seven of the firm's employees smoke, and during the day they can be seen in the parking lot, filling the "butt bucket" that stands by the president's parking space. In the winter, Lorraine joins another employee for a smoke in her car during breaks and lunch hours. Members of the firm were given the option of staying with the firm or leaving because of the new rule. Said a vice-president, "Nobody left." Commenting on the law, the county Commissioner of Health Services said, "The air has never been cleaner in Suffolk County. . . . Common sense has won out" (Ketcham, 1986).

David is 35; both of his parents are lawyers. He has a bachelor's degree from an Ivy League university and several years of graduate education; he works as an advertising executive. He is successful and extremely well paid, but he lives modestly because he supports three ex-wives, each with two children.

David is charming, articulate, and clearly intelligent. He smokes marijuana every day, usually at night, after work; he indulges only occasionally during the day. He has taken LSD more than a dozen times, but only in a protective environment, with close friends nearby and no obligations facing him. He also uses opium when he can obtain it, the usual array of uppers and downers, usually for instrumental purposes—such as being alert in order to work harder, or getting to sleep at night—and a fair quantity of cocaine. As I interview him, he is smoking a marijuana joint.

"I use marijuana to relax," David explains, "to contemplate, and to enjoy myself." He draws deeply on his joint, exhales languidly, and speaks slowly, deliberately, from the back of his throat. "It makes me feel good, and I get a lot of insight from it. My dimensions of thinking shift, especially with other people. . . . I'm more able to get away from my own private perceptions and observations, and more able to perceive who the other person is, and suspend all of life's petty 'games.' " David takes another deep drag on his joint and stares into space for a minute or two. "Anyway, I feel good when I'm stoned. That's why I do it. That's why I do it *regularly.* I mean, in the last year, I've smoked pot on 365 days. It's fun. Food tastes better, sex is more expressive and enjoyable—yes, pot is an aphrodisiac, at least it is for me—I enjoy music more, I use my imagination more listening to music." He pauses, then adds, "When someone asks me, why do I smoke dope, I answer, why not? There are no negatives, only positives. Really. Why not?"

Ginny is 29. She's a college graduate and works as a dress designer in New York City. She is divorced, and she has one child. Until three or four months ago, she smoked marijuana once or twice a week; when she met her current boyfriend, she began smoking every day. Her use of the drug is totally dependent on her social environment, usually the man she is dating at the time. She doesn't buy marijuana but uses it only if it is offered to her; she never smokes it alone. She has experimented with other drugs—she took opium once, LSD three times, and amyl nitrite several times—but cannot imagine using any of them regularly. She used to be a fairly heavy drinker, but has given up alcohol entirely.

"When I smoke grass," she explains, "I'm much more relaxed. I'm *very* relaxed. It slows my movements down. It makes me tired. Heavy. Motions are more effort. It's harder to do things; you forget what you're doing. I couldn't cut or sew a dress high. Like, with reading or writing, you have to concentrate more—you can't keep your mind on what you're doing." Ginny pauses and looks out the window. "For me, marijuana isn't a serious drug; it is always a happy drug. If I'm depressed to the point that I want to cry, I feel better if I'm high, as if I don't have to cry. I become funnier—people laugh at what I say." She pulls a tobacco cigarette out of a pack, lights up, and puffs contemplatively. "My senses are more receptive. With sex, my sensitivity level is higher. Through grass, I learned to control my orgasms. Sex is better—it's different. But I have a lot of interest in sex anyway, so my interest in sex doesn't increase. It makes me calmer, though. More relaxed.

Those lousy late-night movies you could never watch straight, you can watch when you're high. You can enjoy something unrelated to the structure or the plot of the movie. And you don't evaluate or judge so much. You just get into things more—some things anyway." Ginny is staring out of the window again. I ask her why she smokes marijuana—an almost redundant question at this point. She doesn't seem surprised by the question. "Why do I smoke grass? I enjoy it. It's part of my life. It's part of the lives of the people around me, it's part of what I do. It makes my life more fun. It's good, it's mellow, it's, uh. . . . Well, it's *me,* you know? *Why the hell not?*"

In Afghanistan, the fields burst with red, purple, and white poppies. When the petals fall from the plants, farmers take a knife and slit open the golf-ball–size green pods, out of which a thick, blackish gum—opium—oozes. Reapers walk through the fields of the 3-to-4-foot plants, scraping the gum from the pods with small serrated blades and placing them in tin cans tied around their necks. Although Islam forbids smoking opium, it says nothing about growing it. "How else can we get money?" said Mohammed, a teacher, whose brother Nazim is a powerful rebel commander. "We must grow and sell opium to fight our holy war against the Russian nonbelievers."

Opium can be sold directly from the fields for $40 to $50 a pound. "That's 100 times more than I can get from another crop on the same land," said Ali, a young rebel commander whose family grows and harvests the poppy. "If one of our soldiers is sick or wounded, we must send money to his family. . . . We must also feed them and give them money for shoes and clothes. Where else can we get money?" Growing opium can make the difference between remaining on your land and living a precarious existence in a refugee camp, crowded into mud huts. Unlike nearly all other crops, opium has a ready market, poses no storage problems, is easy to transport, and commands a high price. Moreover, opium is harvested in the spring, which means that after harvesting it, farmers are free to grow other crops.

Kandahar, a provincial capital, has been largely destroyed in the fighting between Russian troops and Afghan rebels. On the outskirts of town, Mussa, a rebel commander, shows a visitor the ruins of his family's property. Drug cultivation, he explains, is above all a weapon for the rebels. "With the money they get from opium," he said, "Afghans can fight until all the Russians get out from our country" (Bonner, 1986).

Carl is 26, single, and a graduate student. He was born in South Africa. He was two when his father died; eighteen months later, his mother married a physician with two children. Carl's parents are moderate social drinkers who serve wine or beer at meals. At 12, he tried tobacco; at 19, he smoked a pack and a half a day, as he does today. At 16, he tried marijuana and settled into a pattern of smoking two to three times a week, but only in the late evening. Between the ages of 16 and 18, Carl used amphetamine sporadically on social occasions; now he uses it extremely rarely. When he was 17, he and a friend, whose father was also a physician, stole some morphine and sy-

ringes from the friend's father's office and injected one another with the drug. They both found the experience extremely pleasurable.

Carl moved to the United States at age 18 and entered college. He became friendly with a group who used psychedelics, and for the next year, he used these substances two or three times a month; today, he very rarely "trips." At 20, Carl's curiosity about heroin became piqued, he tracked down a source, and he began using the drug once a month. He has continued this practice, more or less, for the past six years. During a vacation to the wide-open city of Amsterdam, Carl used heroin almost every day, but he resumed his once-a-month pattern upon returning to the States. He always uses the drug in a group, almost always snorts or injects intramuscularly, and, if he injects, always sterilizes the needle. Carl purchases the drug from a close friend; if his friend left town, he admits, he wouldn't know where to obtain it.

Neither Carl's best friend nor his roommate knows about his use of heroin. "I don't want to be deceptive," he explains, "but some people have an exaggerated fear of heroin and make a big fuss about it. . . . It's nobody's business what I like, and I don't want to be judged for it." Carl controls the amount he takes. "The trick," he says, "is to get high with the least amount possible." If he takes too much, there are not only side effects but also the danger of escalating the quantity he uses—and, of course, the risk of physical dependence. If he takes too little, he doesn't get high. Carl hopes to be able to continue at his current level of use for the foreseeable future (Zinberg, 1984, pp. 1–3).

John grew up in a religious, middle-class family in Harlem; his father is a New York Police Department sergeant. "My father used to drive me around and point out junkies nodding out on the street. . . . I thought I could never become an addict." He experimented with marijuana, then cocaine, in the Catholic high school he attended. At Howard University, John's use of cocaine escalated to the point where he felt forced to invent lies to his parents to get more money to pay for his drug habit. Doing poorly academically, he dropped out of Howard after his sophomore year. At this point, he still regarded drug use as a peripheral part of his life.

In his early twenties, John decided to become a police officer. A month before taking his medical entrance exam, he abstained from cocaine and stayed drug-free for a year thereafter, through his stint in the police academy and during his first few months on the force. But the lure of cocaine became too great for him to resist. For nearly a year, his life revolved around freebasing, that is, smoking a potent crystalline form of cocaine. Toward the end of that year, he was spending nearly his entire paycheck on cocaine. After repeatedly showing up for work late and calling in sick a half-dozen times, he was ordered off active duty and asked to see a departmental psychologist. Fearful that he would be dismissed if he admitted his drug problem, he was evasive in his sessions with his counselor; moreover, he often missed appointments with him. After being out three more days of

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