The public controls and supports social institutions and thus creates the social setting in which the illegal user operates. This setting is the predominant influence on drug use, and in order to understand its impact We must understand the public that shapes it.

Here we discuss the common attitudes toward illegal drug use, showing how they are based to a large extent on inadequate information, poor arguments, and extraordinary examples—the chronic heroin user with his destroyed veins, the suicidal barbiturate addict with gangrened limbs. We go on to explain the social and psychological functions of these attitudes and show that they maintain themselves in the face of a mass of contradictory evidence.

The public response to nonmedical drug use is overwhelmingly one of moral disgust, condemnation, and fear at the threat of social and personal chaos that drug use seems to portend. During the years 1965-69 we questioned 430 people about this subject, and their answers confirmed the findings of the national polls. In Time magazine's poll, conducted by Lou Harris in 1969, over 90 percent of those questioned associated drug use with moral corruption and decay. Forty-two percent of the parents questioned were willing to turn their own children over to the police if they used drugs; and 73 percent of parents said they would report a son to the police if they knew that he was selling marijuana to his friends for a profit. In a Massachusetts poll conducted by the Boston Globe in 1969, 83 percent regarded nonmedical drug use as their greatest concern for the future of the country in general and for youth in particular. Even among the young (18 to 25), 63 percent expressed deep concern about "drug use as a very serious problem." "It's a problem that hits the very young and shatters their minds. The government should crack down," was the feeling of typical interviewees. In our interviews there was almost unanimous agreement among nonusers on this point, despite the interviewees' varying class, educational, and professional background.

Public attitudes both reflect and inspire the treatment of drug use by the mass media. Newspapers are full of stories about drugs. On August 14, 1970, a day chosen at random, when there was no sensational item of drug news, the Boston Globe devoted 11 columns, the Washington Post 16, and The New York Times 19 to it, and discussed the problem in terms more suitable to a major cholera epidemic than to a practice that in fact does serious harm to a very small number of people. As often happens in an emotionally charged atmosphere, the opinion-forming groups in society—the politicians, journalists, teachers, doctors-use the increasing number of newspaper reports of young people damaged or killed by drug use as irrefutable evidence of a drug epidemic. In fact, the drug problem is exaggerated by the newspapers and we suggest that it is worsened by this overreaction.
Nevertheless, the shock and fear are very understandable. Not only has the whole issue changed in a remarkably short time, but the drug users themselves are deliberately provocative.

The underground press, an acknowledged spokesman for the drug scene, makes extravagant claims for drugs and strikes at the very foundation of the average man's view of Western society:

*How can they [the square world] believe they have the truth about life? Those bastards building their atomic bombs, computers, foul motor cars and dehuman space ships have a monopoly on nothing. They have produced a culture with an unbalanced rational consciousness which has given rise to the precarious state of modern civilization. Anything that differs is immediately denounced as a crime against nature.*

*This artificial society manifests hysteria when [phantastica] drugs [hallucinogens, psychedelics including marijuana, THC and lots more] are suggested for purposes of self exploration and the enhancement of sensory experience. The psychotropic drugs which are socially acceptable, including alcohol, barbiturates and tranquilizers, are far more likely than phantastica to rob man of his initiative and individuality. The phantastica allow man greater freedom of choice to act for himself free of blind conditioning and cultural imperatives—they have more to offer than abstract ideologies. If nothing else they may free man from the crap that normal consciousness is a unitary state of man and not a value judgment. Phantastica drugs will deepen man's understanding of nature, leisure, comfort, and his goals in life. They enhance and diversify experience. It is impossible to predict what the future will bring, but it can be said with absolute confidence that alternative consciousness, once the prejudice and cowardice about them are overcome, will help man to evolve so that he can change his own structure as well as his environment. We hope to God his life will never be the same again.*

The paper contends that marijuana use (with a touch of the psychedelic ideology) enables us to alter our perceptions of reality. It also condemns the Western scientific technological view that reality is measurable and objectively verifiable as a constricting repressive force. Some well-publicized psychiatrists, R. D. Laing, for example, support the idea that society's view of objective reality is simply a method of imposing conformity on its members.

This call to perceive new realities can provoke envy if the fresh vision is presented as poetic, idyllic, or sensual. But it can also frighten those who find one reality more than enough to cope with, especially if they are challenged to face this unfamiliar world when they are well past the
age when it might have been an adventure. For ordinary members of the general public, Laing, Leary, and the newspaper IT stir up primitive fears of social chaos. They are terrified by the prospect of a society where anyone can drop out: our present interdependent society could not continue to function; our social institutions would break down; traditions and values would no longer be upheld or even, perhaps, tolerated.

By reacting in this way, most members of the public reveal that they have accepted the drug users' wildest imaginings and see illegal drugs as fantastically powerful. This is hardly surprising when we reflect that the general public already believes in the power of medically prescribed drugs. Our rapidly increasing dependence on medically prescribed drugs for survival, freedom from pain, and longevity was given shocking but short-lived publicity at the Kefauver hearings in 1951, at the time of the thalidomide scandal in 1965, and again at the 1966 American Medical Association convention.*

Expenditure on drugs is rising faster than either general consumer spending or population growth. Measured in doctor visits and hospital days, adverse drug reaction has become one of our largest disease entities.

We believe this increasing devotion to medical drugs bears witness to a deep-seated fantasy, shared by both doctors and the public, of the possibility that drugs can enable us to lead lives unmarred by physical or mental distress. Although the overall efficacy of many of the drugs (e.g., the tranquilizers and energizers) is still unproved, doctors argue that they must prescribe them because their patients demand and need them. Or they will contend with some validity that an inexpensive course of tranquilizers can sometimes help a patient as much as extended and costly psychiatric treatment and, more important, can do so very much more quickly.

England and the United States share a remarkably similar set of emotional attitudes on drug use, especially the fear of an epidemic and the value of police action in averting one. When the number of known heroin addicts in the United Kingdom grew from 172 in 1962 to 2,340 in 1968, discussion emphasized the percentage of increase, not the extremely small numbers involved. This disproportionate emphasis was clear in our interviews with British police. In an interview in April, 1968, Inspector S. pointed out that the number of addicts in Britain had doubled in a five-year period, and estimated that if the present rate of increase continued, by 1980 the figure would quadruple. He agreed that there were only about 2,500 addicts in the entire United Kingdom (2,340 of whom were heroin addicts), but still stressed the percentage of increase. He also agreed that the enormous publicity surrounding drug use might have stimulated many restless and disturbed young people to try drugs, but disputed the truth of the interviewer's observation that given the extent of the publicity and the large number of susceptible
youngsters, 2,500 was a remarkably low total. Inspector S., like most of the public in both the United States and Great Britain, believed that the vigilance of the police and the formation of drug squads by many small police forces were important factors in keeping down the number of users.

During the same period, however, the campaign against marijuana use was as strong as that against heroin, and a study of Student apprentices (a low-risk group) showed an increase from 12 percent users in 1967 to 35 percent in 1969. These figures must cast some doubt on the efficacy of police action. As for fears of an epidemic, it is now thought that the increase in heroin use in 1968 that gave substance to these fears took place only on paper; in that year England shifted from doctors prescribing to the drug-control clinic program, where for the first time addicts had to register if they were to get their drugs. In 1969 the number of heroin users decreased, and this is seen by some investigators as an indication that despite poor facilities, inadequate staffing, and few efforts at rehabilitation, the clinics are succeeding in controlling heroin use. Thus the evidence of a heroin epidemic is, to say the least, conflicting, and the "drug epidemic"—and by this is meant especially the heroin epidemic—was and still is the battle cry of antidrug propaganda in both England and the United States. It was plainly one of the fears invariably voiced by the 430 people we questioned on their attitudes toward drug use.

We would like to describe a typical example of this group. We shall call him "Mr. Fry." He is not a closed-minded bigot, a depressed, gray-flannel conformist caught in a middle-aged sense of futility, nor does he feel threatened by the changing concepts of welfare. But Mr. Fry would have responded along with the majority to the Boston Globe and Time magazine polls.

A 43-year-old white, nominally Protestant college graduate, Mr. Fry has been comfortably married for 17 years, and has three children; his job is demanding, but he and his wife enjoy their leisure activities and drink and smoke moderately. He describes himself as a political liberal, and he keeps himself well informed, but he is not politically active. His national voting record is 1948—Truman; 1952—Stevenson; 1956—Eisenhower; 1960—Kennedy; 1964—Johnson; 1968—Humphrey. He thinks we should not have gotten into the war in Vietnam, but is unsure about how to get out; he is against unilateral withdrawal. He is in favor of civil rights and the "Negro cause," despite his friends' fear of riots and unrest. The death of Martin Luther King, whom he greatly admired, distressed him even more than the assassination of the Kennedys. He is worried about law and order, while disliking the phrase, and would like "younger people" (his age) in government. Mr. Fry is unsympathetic to college student unrest; he does not see their grievances as valid (apart from Vietnam), unlike those of the Negroes. The invasion of Czechoslovakia rearoused some fear of Russia, but he still regards the Cold War as exaggerated, and is convinced that but for Vietnam, we would be on better terms with Russia. China is seen as a more serious threat. He strongly supports the United Nations: "It should have more teeth."
He and his wife had sexual relations for a year before they married. He believes this strengthened the ties between them, and he approves of greater sexual freedom among the young. Since marriage he has had two "flings," but does not think such a thing will happen again, and is critical of associates who make a practice of adultery. He dislikes organized religion.

Mr. Fry describes himself as "damned worried." Not given to apocalyptic visions, he nevertheless dreads and conceives possible the breakdown of his own world. He perceives the irony of his increased personal security—good job, wife, home, friends—and decreased sense of relationship to the social context in which his children are growing up. He fears for the family as an institution in the twenty-first century.

The flurry of conflicting reports on drug use confuse him, and he is in some doubt as to what attitudes he should adopt to help maintain the social institutions he values—the law, schools, the police, the medical profession. He is also guiltily aware of a parallel between smoking and marijuana use; however, he pushes back incipient doubts and accepts the position: drugs are a threat, and nonmedical users are bad; they must be controlled and shown the error of their ways, for his sake and theirs.

During his interview, he constantly made such remarks as: "They have no sense of responsibility or they wouldn't even think of dropping out. They would want to work and contribute to society." "They will scramble their brains with that stuff so that they won't ever get anything done." He sees these not as the value statements they are, but rather as truths about what is right and good. "If so much as one sick kid is pushed out of this society by a drug," he goes on to say, "it is too much." He can justify his paternalistic position because he wants to help, though he would think it ridiculous to ban sugar, which is harmful to an impulsive diabetic. However, the diabetic doesn't offend, disturb, or frighten him.

Mr. Fry has almost ceased to question his attitudes toward drug use. He accepts that it is bad; most of the time it seems a simple, unarguable fact, though some doubts still linger in the back of his mind and he eagerly questions any "expert" he meets.

We also interviewed city employees, steelworkers, secretaries, housewives, carpenters, machinists, insurance salesmen, clerks, and police officers, and found not just unanimity of
opinion that nonmedical drug use was wrong, but also a hyperemotional conviction that somehow someone should do something about it, i.e., stamp it out. Each fresh exposé in the mass media was seized on as an illustration of the extent of the evil, and served to still any remaining doubts. These interviewees saw the nonmedical drug user as one important representative of the uncontrolled social forces that were destroying all that they had worked toward.

And they saw drug users as arising on either side of them in the social framework. One group of drug users emerged from dispossessed ethnic minorities, whose demands for a just share of the economic pie many of our interviewees saw as inordinate, hasty, and threatening. The other group arose from that section of the middle class they aspired to. The breakdown in order and legitimacy in that very group who enjoyed the fruits of this society left our hardworking, less affluent interviewees feeling squeezed, and as though they had no place to go. These interviewees smoked and used alcohol and were less guiltily aware of the similarities between these practices and marijuana use than Mr. Fry's group. They resented the student drug-users' assault on the use of alcohol as a hedonistic exercise similar to arcane rituals with a joint or a sugar cube.

On the whole, the various socioeconomic groups agree on the evils of drug use, seeing in it the seeds of destruction for society and of the breakdown of normal standards of decency and self-control. We will examine the three principal attitudes that support this view.

First, and perhaps most basic, is the attitude that there is little need to differentiate among different sorts of nonmedical drugs. All drugs are equally bad and equally dangerous. Marijuana and heroin are admittedly different from each other, but, the argument goes, the first will lead to the second in an almost inevitable progression.

The second attitude is based on the belief that drugs are extremely powerful; they cause dependency which is physically destructive and turns people into criminals or indolents and generally enslaves them in a remarkably short time.

The third is that drug use is a symptom of intrinsic weakness expressed as emotional disturbance, and that the strong probability is that all drug users become mentally sick. (This argument sometimes swallows its own tail by stating further that one would have to be sick in order to use a drug.)
These three attitudes are different ways of saying that nonmedical drug use is wrong; they do not flow from informed and thoughtful opinions on the rights and wrongs of drug-taking (although they are based on strongly held values). In our experience, most people are not open to argument or even able to assimilate fresh facts on the subject of drug use. Normal standards of rational discussion are abandoned: there is no attempt to define terms, and the argument often shifts ground, or returns in circular fashion to points already shown to be false. We hope to expose the quality of public debate on the subject: in our opinion it is based on a desire to convince or control, not on a desire to find out what is true.

1. Drugs are all alike and all equally dangerous.

In our survey of the Boston Globe, the Washington Post and The New York Times on August 14, 1970, of 16 headlines about drugs, only one specified which drug was involved; 10 used the word "drugs" and 5 "narcotics." Ten of the stories never specified which drug was involved, and 3 did not specify until the last paragraph. The arrests of the Kennedy and Shriver children received the same rather cavalier treatment: UPI put out a report listing 22 other children of famous parents who had been arrested and detailing the circumstances. They had searched as far back as 1963 to garner their information, and called 9 of the items simply "drug" or "narcotic" arrests, without specifying further. Neither Time magazine nor the Globe found it necessary to differentiate among the various drugs in their polls. "Drug use" was a general concept acceptable to both the pollster and his subjects. It meant the whole range of drugs, from marijuana, the psychedelic group, the barbiturates, and amphetamines to the opiates.

Our own interviews confirmed the existence of this confusion. Some of our interviewees were able to differentiate among the drugs, particularly as to whether they were "hard" or "soft," but during the questioning and discussion they made little or no distinction.

Most U.S. federal and state laws classify all drugs under one heading. "Hard" and "soft," marijuana, cocaine, heroin—all drugs are legally branded as equally responsible for moral corruption. Chief Justice G. Joseph Tauro, of the Superior Court of Massachusetts, has by his own account devoted several months to the study of the marijuana issue. Yet in his discussion of the relationship of marijuana to crime he says: 7

On the national level, Director John E. Ingersoll of the Bureau of Narcotics and Dangerous
Drugs has reported a 774 percent increase in drug abuse arrests for the past eight years.

He clearly implies that the 1969 statistic is relevant only to marijuana, and goes on to link marijuana to violent crime in the following case, where the defendants claimed to be acting under the influence of a nonhabit-forming drug:

For example, two young men were recently brought before me in the First Criminal Session accused of armed robbery and attempted murder. They had approached an automobile containing a young man and his fiancee and announced their intention to rob him. At the repeated urging of his companion to kill him, the armed defendant fired at the man from point-blank range. There was no provocation and no scuffle—just a senseless attempt to kill! Only the instinctive reflex of drawing his left arm across his chest saved the victim. The bullet smashed his elbow rather than his heart.

Of course, in some important ways nonmedical drugs are alike: they are all mind-altering; they are all capable of producing dependency of one sort or another; they all induce states of intoxication; they are all potentially dangerous to the health of the user and to the safety of the community; and they are all illegal. But the differences are far greater than the superficial similarities.

These drugs vary in a number of ways, each crucial to an accurate understanding of how drugs work. Heroin and barbiturates produce tolerance and withdrawal symptoms; LSD and marijuana do not produce withdrawal but LSD produces tolerance. Some are taken orally, some smoked, others sniffed or injected. Heroin can be detected in the body a day after use; LSD metabolizes quickly. Psychic effects vary widely: some can be used without disrupting daily life; others, at least in the present setting, cannot. Finally, the effects of any single drug are not certain and definite, but depend on many psychological and physical factors.

And yet these differences among drugs have been widely aired in public. The New York Times published a series of five long articles each by a different staff member—an unusual procedure for that paper—on a number of aspects of the drug issue including a detailed differentiation among drugs. In 1969 Time magazine devoted a large part of a special issue to discussing drugs; Newsweek, "Look," and "Life" did the same in 1969 and 1970. All these were serious and factual reports giving ample and correct information. Local newspapers, too, such as the Boston Globe, have provided serious reportage on the subject. Herbert Black, chief medical reporter for the Boston Globe, estimates that his paper has published educational information about
drugs on as many as fifty occasions. Admittedly, these educational efforts are meager in comparison with the heavy output of sensational stories and articles that do not bother to differentiate. But Mr. Fry, and in fact most of our subjects, had been exposed to accurate information again and again. The fact that on the whole they noticed or remembered only what was sensational and inaccurate indicates a powerful inhibition of knowledge on this subject. The public unconsciously censors the available information and registers only what fits in with preconceived attitudes. It is an unusually comprehensive example of selective perception.

The public's unwillingness or inability to distinguish among widely varying drugs is expressed very clearly in the progression theory: that the use of a mild drug leads inevitably to the use of a strong one, and then to increasingly large doses. Marijuana and heroin are widely believed to be linked in this way, and the major differences between the two drugs are thus evaded both in public attitudes and in the law. This belief influences in some way most discussions of marijuana. Even intelligent people who have grasped the distinctions between the two drugs are seemingly irresistibly drawn back into the progression theory. In a typical interview part of the dialogue was as follows:

"I'm in favor of increasing the penalties for the bastards who start those kids off." "Start them off?" "Right. I heard of an eighteen-year-old kid in Brooklyn who got started at a party on pot. He was a weak kid, and inside three months he was injecting heroin. He went just like that."

There is no evidence of a causal connection between the two drugs, and all attempts to establish the truth of the progression theory have failed. The theory was explicitly denied in the 1937 marijuana hearings, but drug progression again became a matter of public concern in the 1940s and 1950s when an alleged increase in heroin addiction was attributed to prior marijuana use. The main support for the theory comes from studies showing a history of marijuana use in addicts. As Pet and Ball14 show, 80.4 percent of addicts at the U.S. Public Health Service Hospital at Lexington, Kentucky, had smoked marijuana. But this post hoc reasoning does not stand up. By the time these people became heroin addicts they had tried everything, including liquor and milk. The real question is, what percentage of marijuana users become heroin addicts? The answer appears to be very few indeed. In his extensive study of student drug use in 1968, Blum15 found that only 7 percent of marijuana users had tried opiates; making adjustment for the subsequent upsurge in marijuana use, this figure would now be around 3 percent. Blum, examining the population of the Oakland ghetto, found that teen-age heroin and marijuana users belonged to completely different groups who held different values. Few of the "heads" turned to heroin. These reports were confirmed by the marijuana users we interviewed, very few of whom were willing to try heroin.
Another argument used to support the drug progression theory is that heroin and marijuana arrests have been increasing at parallel rates. Bloomquist in California and Paton in England believe that these increases suggest a causal relationship between the use of the two drugs. Kaplan, however, conclusively demonstrates the fallacy in this argument.

The tenacity of the progression argument is more remarkable because of the other factors that appear to explain heroin use. Blum found a higher correlation between use of heroin and substances like glue and gasoline than between heroin and marijuana, while tranquilizers, sedatives, and amphetamines correlated with heroin use about the same as marijuana. Many heroin users were formerly speed freaks who began to use the drug to "crash" smoothly. Indeed, it appears that the absence of marijuana, rather than the reverse, may be closely related to heroin use. When the supply of marijuana dried up after Operation Intercept (a massive search and seizure effort aimed at reducing the flow of marijuana into the United States), many young people tried heroin and other drugs that had not previously interested them. A basic pharmacological text, The Pharmacological Basis of Therapeutics, finds evidence for progression lacking. And finally, although some writers on the subject still have not accepted their findings, every commission investigating the issue (including the President's White House Conference on Narcotic and Drug Abuse, the President's Commission on Crime, the President's Commission on the Mental Health of Children, and the Wootton Committee) has, sometimes reluctantly, come to the conclusion that the theory of drug progression is unfounded.

Perhaps the attraction of the argument for progression lies in the mechanism said to draw the user from the milder drug to the stronger—namely, the user's insatiable appetite for pleasure and passivity. Having once tasted the forbidden pleasures of marijuana, it is thought, he will soon grow accustomed to them and seek stronger drugs, particularly heroin. However, it does not by any means follow that someone who enjoys marijuana, with its experience-enhancing effects, will also enjoy heroin, which has a euphoric but deadening effect. The theory may be seen as an example of the public's desire to hold a monolithic position on drugs in order to avoid dealing with the ambiguities of conflicting information.

2. Drugs are extremely powerful; they cause dependency which is physically destructive and leads to crime.

Drugs are believed to be so powerful that a few doses induce a dependency that damages drug users and, by giving rise to apathy, indolence, and criminal activity, also damages society.
Let us look at some commonly held beliefs on drug dependency. Four hundred teachers attending a statewide meeting on the potential of drug education were asked how many doses of a drug (the type unspecified) were necessary to produce dependency. Thirty-four thought that one dose could do it. Over 250 thought that four or five doses would be sufficient. Not one of these teachers asked the questioner to differentiate among the drugs.

When the question was rephrased and the drugs specified as marijuana, LSD, and heroin, 50 of the teachers thought that one dose of heroin could produce dependency, while only 25 thought that one dose of marijuana could. But roughly the same large majority believed that as few as four or five doses of either of those drugs could induce dependency. Our interviews tally with these results. The huge majority of our interviewees believed nonmedical drugs to be enormously powerful and capable of inducing physical dependency after only a few doses.

In fact, the ability of drugs to produce physical dependency varies widely. The opiates, barbiturates, and amphetamines induce tolerance, so that increasingly large doses are needed, and barbiturate users, especially, suffer severe withdrawal symptoms when the drug is stopped. But even with these drugs the personality of the user and the situation in which use occurs—set and setting—have to be taken into account. It is a myth that one shot of heroin makes an addict. Addiction occurs much later, often after a long period of "chipping" or a weekend habit. It has been demonstrated that a number of doctors who were taking as many as four shots of morphine a day were able to stop without discomfort when they were on vacation. It appears that even the problem of severe withdrawal symptoms has been exaggerated. Withdrawal symptoms have been regarded as an inevitable and usually extremely unpleasant consequence of dependency. Yet Daytop Village on Staten Island, one of the best-known residential treatment centers for hard-core addiction, reports that it has never seen a full-blown example.* This is not to deny that withdrawal symptoms occur; but it is clear that their severity depends to a large extent on set and setting.

No physical dependency has been demonstrated as resulting from marijuana use. However, it is said to produce psychological dependency, or habituation, and this state is thought to be equally bad. It is not always clear how the words "dependency" and "habituation" are being used. Hundreds of thousands of people use marijuana regularly—say, every weekend—but are not enslaved to the drug in the sense that they seek it at all costs. When they are unable to get a supply, they can stop smoking without great discomfort. In this sense marijuana is less enslaving than tobacco. However, there are also a number of chronic users of marijuana in the United States and Great Britain, though no careful study has been made of them. Our brief study of the hard-core members of the Fantasia and Paradisio clubs in Amsterdam showed that except for their overwhelming interest in music, many of them seemed exactly like the junkie stereotype. They began to smoke as soon as they woke up in the morning, and remained stoned until they went to bed. Disturbing though these cases are, we must always keep in mind
the three groups of drug users we outlined in Chapter 1. These chronic users are of the first, dependency-prone group, and must be distinguished from the second, drug-experimenting group, who form the overwhelming majority of marijuana users.

Why does dependency on drugs so frighten the general public that they inhibit knowledge about it and construct myths around it? It is believed that drugs are physically destructive and lead users into criminal activity, although evidence to the contrary has been widely published. Certainly the mass media, and even reports from professional bodies, must take part of the blame for the fear of dependency and of its results. A police journal has described the physical destruction wrought by addiction in these terms:23

To be a confirmed drug addict is to be one of the walking dead. . . . The teeth have rotted out; the appetite is lost and stomach and intestines don't function properly. The gall bladder becomes inflamed; eyes and skin turn a bilious yellow. In some cases the membranes of the nose turn a flaming red; the partition separating the nostrils is eaten away—breathing is difficult. Oxygen in the blood decreases; bronchitis and TB develop. Good traits of character disappear and bad ones emerge. Sex organs become affected. Veins collapse and livid purplish scars remain. Nerves snap; vicious twitching develops. Imaginary and fantastic fears blight the mind and sometimes complete insanity results. Oftentimes too death comes—much too early in life. . . . Such is the torment of being a drug addict; such is the plague of being one of the walking dead.

However, medical authorities now widely agree that even heroin and the opiates cause no physiological damage. An addict may suffer from chronic constipation and reduced sexual potency, but assured of a drug supply he will live to a ripe old age. It is true that addicts risk collapsed or abscessed veins, and even death, but these result from unregulated doses and unsterile equipment. The addict who is a "walking death" has been brought to that condition by the present state of the law.

Marijuana also is nontoxic, unlike alcohol, which has been shown to cause destruction of brain tissue. Acute marijuana intoxication may reduce the heartbeat and produce reddened conjunctivae, but that is all. The chronic marijuana users we saw at the Paradiso and Fantasia clubs obviously suffered from malnutrition and consequently from general debilitation, resembling in this respect some addict groups; however, they showed little hypoglycemia, hypothermia, or depression of respiration—all symptoms ascribed to marijuana use by a number of professional observers. In our experience, no physical damage can be shown to result from the use of the drug itself.
Prolonged use of such drugs as the amphetamines and barbiturates may indeed have damaging physical effects, even when they are medically prescribed. We take full account of these dangers, but emphasize that the central conclusion to be drawn from this brief comparison is that only particular drugs used in certain ways are harmful. The distinctions among drugs must be carefully observed, and the monolithic attitude promulgated by the mass media must be broken down.

As we have said, it is also widely believed that the drug user becomes morally enslaved and falls very easily into criminal activity. In this view, the drug turns its user into something akin to the ordinary criminal. Here again we will distinguish between the dependency-prone and the drug-experimenting groups.

Studies of the first group demonstrate that the hard-core user was criminal before he began to use drugs. There is a specific "junkie" social and psychological profile: cigarettes at the age of six or seven, liquor and sex by 13, marijuana soon after; in late adolescence, promiscuity and petty thievery merge almost automatically into prostitution and organized crime. Drug abusers of this type definitely show an ascending use of drugs, typically moving toward the one with the big kick, heroin. And, of course, it must be remembered that once they have begun to use drugs, in the United States at least, they are caught in the vicious circle in which criminal activity becomes essential to support the drug habit. The British system, whatever its demerits, prevents the development of this cycle.

The second group of drug users, the drug experimenters, overwhelmingly uses marijuana, though there is also some use of psychedelic drugs among them. There is no evidence that their use gives rise to criminal activity. In fact, a careful survey of the studies done linking marijuana to aggression or crime concludes that there is strong evidence against the link between marijuana and crime. The survey analyzes several famous cases, which have been repeatedly quoted to illustrate the criminogenic effect of the drug. Tenuousness of the evidence is revealed in each instance. Other large studies (Indian Hemp Commission,25 La Guardia Report," Blum,27 Blumer,28 police/arrest figures") consistently find that, if anything, marijuana inhibits such antisocial activity." The marijuana user is criminal only in that he uses an illegal drug. The modern marijuana user usually comes from a social class different from that of the heroin addict, and he uses the drug differently; it is as much part of his ordinary social life as a martini in the evening is for his father.

3. Drug users are mentally ill.
Chief Justice Tauron described marijuana users as "the disaffiliated, the neurotic and psychotic, the confused, the anxious, the alienated, the inadequate, the weak." Harris Isbell," writing for the U.S. Public Health Service in 1951, described the psychological state of the addict:

The cause of addiction is not drugs but human weakness. Addiction is usually a symptom of a personality maladjustment rather than a disease in its own right. The psychiatric conditions which underlie drug addiction are chiefly the neuroses and the character disorders. . . . They [neurotic patients] include nervous tense individuals with a great deal of anxiety and many somatic complaints; compulsive neurotics; persons with conversion hysteria—strange paralyses, anesthesias, etc. Individuals with character disorders were formerly termed psychopaths. Usually they are irresponsible, selfish, immature, thrill-seeking individuals who are constantly in trouble—the type of person who acts first and thinks afterwards. The majority of addicts do not fall clearly into the neurotic or character disorder groups but have characteristics of both classes.

Marijuana was originally prohibited because it was thought to lead to insanity; LSD is believed to lead to certain short-term and probable long-term psychosis; and the frenzied need of the heroin addict for his fix is thought to verge on the insane. Again and again in our interviews these ideas were echoed and supported by the claim that if users were not mentally ill to start with, drugs would soon make them so. The evidence is by no means so clear-cut.

We will distinguish the three groups—the dependency-prone, the drug experimenters, and the third group who could be forced by social pressure into either camp—and then discuss some beliefs about the more common drugs.

Even among the first group, including hard-core heroin users, chronic marijuana addicts, and other "junkie" types, there is almost no evidence of mental illness. And yet it is still current thought among many doctors, and among most of the public, that addiction is a functional equivalent for psychosis. We suggest that the reason for this is that the addict's obvious disdain for social conventions, his abuse of his body, and his underlying fury at any effort, however well intentioned, to help him offend the professional observer. The doctor sees the addict as bizarre, cut off from society by his own attitudes. His use of drugs becomes a crazy action.

The long-standing belief that hard-core users are psychotic was finally disproved by Vaillant.
He conducted a study of heroin users (who form the bulk of this group) and found only one in the New York State mental hospitals. His work constitutes a breakthrough because it is a longitudinal study following up addicts after twenty-five years. Most of the reports about addicts from so-called experts have been impressionistic, and consist largely of generalizations from hard cases. Support for Vaillant's findings has now begun to appear from other sources. Myerson and Mayerm interviewed two hundred addicts in order to develop diagnostic criteria, and found no schizophrenics. They found many instances of bizarre behavior, but whatever the reasons for this, the addicts were not literally schizophrenic. However, the belief lingers tenaciously among the medical profession and the informed public that drug use is a psychotic equivalent, and this is used as one more reason for condemning drug use.

The second, drug-experimenting group differs on almost every count from the first group, but the two are confused in the public mind. There is virtually no evidence of mental illness among them. A group of students who began to use marijuana after 1966 were shown to differ only in minute details of attitude and personality from their fellow students who did not use the drug. The students who used marijuana delighted in exploding officially promulgated myths about drug use; this crusading sense of "fighting for the truth" gave them a certain cohesion. They also tended to be slightly more radical than their "straight" colleagues. The more conformist students, who fully accept their country’s values and are more or less typical "clean-cut" American boys, find it much harder to try marijuana.

Among college and high school students, drugs, especially marijuana, are so much in the air that it is entirely natural that experimentation should take place. Even where psychedelics and amphetamines are included in the experiments, charges of mental illness have not been proved.

Then there is the third group consisting of seriously neurotic youngsters who find the nonconformist support they need in the second, drug-experimenting group. Because everyone in adolescence seems to be in a state of turmoil, they blend with their fellows; but after two or three years, when the others have gone ahead and made the necessary life-decisions, they are left behind. Naturally, they search for another group who will accept them, and this is very likely to be a heroin-taking group.

It is far from clear that drug use itself causes mental illness in any of these three groups. With marijuana, psychedelic drugs, amphetamines, and barbiturates it is undoubtedly true that certain combinations of user and setting will precipitate psychoses, aggravate underlying conflicts, damage vulnerable personalities, and create other psychological disturbances. But it is also true that these drugs are usually used safely. Some doctors suggest that marijuana may
even be used to prevent the development of psychic disturbances. David Smith describes the following case which suggests that some research might possibly be carried out on the therapeutic uses of marijuana.

A 15-year-old white male in a wealthy bay area suburb improved his performance in school after he started smoking marijuana. Prior to this time he suffered from free-floating adolescent anxiety about "who he was" and "where he was going." There was very little family communication, although his parents continually advised him about his future objectives. The boy stated that he was not needed economically or any other way in the family or the community. When he started smoking pot, however, he became a "head" and entered into the "head subculture" whereby he established a new identity for himself. Temporary resolution of this adolescent crisis resolved his anxiety and he was able to perform much better in school.

LSD has inspired a number of horror statistics, and it is certainly true that there is danger of long-term damage or difficult reentry into society for prepsychotics and teen-agers who use the drug casually and without proper supervision. But when it is used carefully, and its effects are understood, the experience is temporary and, for many mature users, worthwhile. Amphetamines and barbiturates also have two faces. They are a familiar item in the doctor's armamentarium and, as such, reassuring. And yet excessive "upping" or "downing" can cause severe psychic dislocation, certainly as damaging as any of the effects of LSD. Ironically, public attention is seldom called to these drugs, presumably because they are so frequently prescribed.

THE FUNCTION OF THE PUBLIC ATTITUDE

1. To maintain the status quo

For seventy years drug use has been seen as symbolizing the destruction of much that ordinary people hold dear and that makes their world stable. This view serves to buttress the status quo in a number of ways. We will examine three viewpoints, briefly distinguishing between their manifest and latent functions.

First, by being greatly concerned about the potential danger of drugs, Mr. Fry is protected personally against drug-taking, alerted to the use of drugs by those close to him, and
predisposed to support antidrug measures. These are the manifest functions of his concern. The latent functions are to reinforce his desire to resist the temptation to take drugs and to be a "good" person. But the depth of his desire to maintain the status quo reaches into unconscious levels, and has driven Mr. Fry, normally a reasonable man, into regarding the marijuana smoker whose only crime is his use of the drug as a dangerous criminal. By censoring material that conflicts with his views, Mr. Fry minimizes the internal conflict that would arise were he to take note of all the information available to him. We know enough about nonmedical drug use to make Mr. Fry and the others we interviewed uncomfortable if they were to acknowledge all the facts.

Second, our vision of ourselves as upright and capable of judging is reaffirmed vis-à-vis drug use, and this strengthens our resolve to maintain the status quo. Mr. Fry, for example, on the subject of drug use felt on firm ground in an insecure world. He was keenly aware that he had done little to make the world a better place for his children, and his guilt about this immobilized his wish to control the younger generation. However, when it came to drugs, he knew what was right. His desire to protect the kids from themselves made him certain of his position, exorcised his guilt, and permitted him to feel perfectly justified in his wish to control. These are manifest functions. Mr. Fry is unaware of the latent function, by which his very willingness and power to judge the drug user affirms the uprightness of him who judges. The myths about drug use that Mr. Fry clings to—such as that of an inevitable drug progression—permit him to retain his sense of righteousness.

We can show how this worked also with the policemen we interviewed in the United States and England. Out of thirty-seven, five questioned the effectiveness of present marijuana laws, but not one doubted the need for some such law, and all asserted the social importance of a job that implemented existing laws which "supported the structure of society." In order to feel useful and beneficent when they enforced the drug laws, they felt that drug use had to be seen as bad for society. To deal with drug use directly and unequivocally, while maintaining their own self-respect, the police had to eschew all doubts on this subject. They were not so rigid on other questions: all but two of our interviewees expressed doubts about the value of the laws concerning sexual deviancy and abortion, although most of them personally condemned both practices. One difference they all noted between the sexual deviant and the marijuana smoker was that the former was generally repentant, whereas the new breed of drug users, they pointed out almost in chorus, does not accept the legitimacy of the police. Thus when the power to police and judge is accepted, doubts, too, can be accepted. But when those rights-given by law and supported as a social ethic—are questioned at their very roots, they must be affirmed in action. A convincingly single-minded performance quiets nagging doubts and reasserts the uprightness and correctness of those required to impose the law.

Third, we must remember that the very idea of following unfamiliar thought patterns can be
threatening; by deterring most people from reexamining controversial and complex issues this, too, serves to maintain the status quo. A very striking example of this phenomenon occurred in the experience of a psychoanalyst of deserved international reputation, whose training should have qualified him to be especially tolerant of unfamiliarity. For several weeks a patient whom he knew well complained of vagueness, lassitude, and disorientation which caused her general difficulty in concentrating on her treatment. She had had a few puffs (literally) of hashish in Morocco two months earlier. The psychiatrist, whom we shall call Dr. Ames, told her that if she used marijuana or any other psychoaffective drugs again, he would have to cease the treatment.

A colleague whom he consulted told him that even if the patient had been psychotic (which she was not) it was unlikely that marijuana would have such prolonged aftereffects. Dr. Ames admitted that what he had told his patient had become his usual routine. He was convinced, he said, that these drugs could stimulate a profound psychic disturbance, and described a case in which a long-lasting psychosis resulted from a single dose of LSD. It was pointed out to him that he had jumped from one drug to another. Dr. Ames accepted this correction with a note of irritation, as if it were fussy of his colleague to insist on such small distinctions. Sufficient doubts had been raised, however, for him to suggest a thorough physical examination for his patient. This showed a chronic, low-grade liver infection, which fully explained the symptoms.

Dr. Ames acknowledged later that his behavior sprang from a fear that his usual methods of working were threatened by his patient's use of drugs during treatment; he felt less confident of his ability to work effectively, and the manifest function of his stern warning was to keep the treatment going successfully. He was right to stipulate certain conditions to help the psychotherapy, but he was unaware of the latent function of his attitude. The emphasis with which he forbade drug use was considerably stronger and went further than would have been the case with almost any other of his patients' activities. His acceptance of stereotyped attitudes without the sort of evidence he usually demanded meant that he had unwittingly become the purveyor of public myths whose very existence functioned to control or make scapegoats of others—the antithesis of good psychiatric treatment. He used these myths to maintain the treatment on a straightforward and familiar level, the status quo.

2. To define evil

Public attitudes toward drug use have a second function: that of defining evil. We need evil in order to define good, and we love evil with a truly ambivalent love.
Public Attitudes Toward Illegal Drug Use

Written by Norman Zinberg

Our interviews illustrated real and practical ways in which the drug users have served this semimystical need. Deviants have always been used to define the boundaries of the socially acceptable, and until recently few people, including users themselves, protested against drug users as the epitome of all that good people didn’t want to be.

The portrait of a drug user in the pages of the 1930s Hearst magazines was an emaciated man in his twenties, usually black and probably illegitimate. He came from a squalid home with an alcoholic or criminal father and a prostitute mother. His use of heroin was the culmination of a long history of heavy smoking, drinking, use of other drugs, thievery, and various criminal activities. He was untrustworthy, fluctuating between sudden violence and whining cowardice, particularly when threatened with drug withdrawal.

But in the past few years the situation has changed. Marijuana has become the most frequently used drug, and vast numbers of relatively ordinary middle-class youngsters use it. The stereotype that offered such a clear-cut division between good and bad cannot function as directly today, when the drug user is likely to be someone who is your cousin, nephew, or child.

In a curious way the new drug user elaborates a new definition of evil and in the process creates sympathy for the heroin addict. Edward Kass, Deputy Director of the Massachusetts Division of the Federal Bureau of Narcotics and Dangerous Drugs commented, "I always thought that he [the junkie] and I understood each other pretty well. We got on, but we both knew what side we were on. I used to think that it would be a good thing if I got him and put him away for a long time. But now I see these kids throwing away their lives—these kids who have everything—I think I understand the junkies differently. They're really sick. They really can't help themselves. But these kids are just willful." To Mr. Kass, the new breed of drug users make a conscious choice of immorality, and the fact that they have so chosen gives him the right to judge them.

A number of doctors were interviewed as one part of our research into drug use because theoretically they should know more about drugs than anyone. We wanted to understand how their professional knowledge affected their positions about drug use. They were unanimous in their condemnation of nonmedical drug use, although several of them seemed slightly embarrassed, one, for example, saying, "As a doctor I should be more liberal, but I really think they should all go to jail." In spite of their greater knowledge, they did not differentiate among the variety of drugs that were used nonmedically. On being asked if it was important to distinguish, one answered, "What's the difference if you do it with an axe or a hammer?" When
pressed he went on: "These things are dangerous. You can't turn weapons over to children. And that's what all this self-medication that "goes on amounts to. Those crazy kids only show people how necessary it is to draw the line about drugs, all drugs that aren't carefully prescribed. Maybe they are doing us a service."

The doctors see nonmedical drug use as a direct threat to their professional role, and therefore do not distinguish among drugs. This enables them to draw a line against people who use drugs other than under medical auspices, which then includes anyone who believes in self-medication. The drug user epitomizes the disregard of medical sanctity so thoroughly that he makes it easy to state the virtue of medical supervision.

3. To protect psychological defenses

Every child, to defend against early developmental conflicts when he is weaned, must give up the passive pleasure of suckling and, for the sake of his muscular and psychological development, move on to greater autonomy. At some point he not only will strongly reject the bottle but will feel revulsion at the sight of another child clutching that previously beloved object. His revulsion protects him from the pain of his longing.

This universal experience of childhood has some bearing on how the general public reacts to drug use. Drugs seem to hold out the promise of undreamed-of pleasures, and yet at the same time are considered wrong. Now especially, when drug use has increased so vastly and is constantly in the news, many people find it more than ever necessary to take a strong stand against users. Mr. Fry always disliked drug use, but until recently the users were strange and undesirable characters somewhere "out there": now they are constantly thrust under his nose, and he is forced to reaffirm his decision to forgo that sort of pleasure. To strengthen his rejection he must not only decide objectively that he prefers other forms of relaxation; he needs to feel disgust at drug-taking because he fears being overwhelmed by ancient passive longings never completely laid to rest. And, of course, being a rational man, he marshals whatever reasons he can to justify his distaste. In this crisis situation the psychic mechanisms which select what he perceives and inhibit conflicting material, striving to remove offending stimuli, automatically take over and interfere with reason and objectivity.

The violent reaction to the fear of passivity is not unfamiliar. For example, physicians have long known that patients recovering from heart attacks sometimes find bed rest threatening. Doctors have to help the patient preserve an active image of himself while following a strict medical
regimen which stirs up great fears of passivity; and, indeed, they have found that some patients, once frightened into immobility after a heart attack, are difficult to reactivate.

Does the latter example lend credence to the fear that giving in to the longed-for passive experience of drug-taking will lead to total incapacity? Not at all. Mr. Fry is not an idiot; his observations and even his irrational reactions are based on valid human experience. Some experiences, however, have gotten out of perspective. To puff a marijuana cigarette or take a shot of heroin does not in reality pose the same threat as a heart attack. We think that with drug use threats of a very different order have become confused in many minds.

However, to show that people fear early passive longings throughout life and require strong defenses against them does not sufficiently explain why psychoaffective drugs have become such a focus for public fear: alcohol, for instance, also offers passive dependency, as so many psychiatrists and social scientists have pointed out. We would suggest that the reputation of marijuana—and still more, LSD—for disorganizing the minds of those who use it, buttressed by the realization that this use is out of medical control and beyond the law, makes these drugs especially terrifying.

In addition to fears of passivity and mental disorganization, another element contributes to making drug use disturbing and distasteful. The marijuana high is essentially a solitary activity. Again, in this respect it differs from alcohol; the typical alcohol user, whether suave at a cocktail party or maudlin in a cheap bar, is gregarious and loquacious. Drugs provide an intensely personal and private experience, and though marijuana users do gather and giggle a bit at each other, the amusement is more bemusement and represents little sharing of the inner experience. In this aspect, drug use resembles masturbation, the "solitary sin." A psychological interpretation of the very "private" drug experience will indicate why the moralistic society that still often thinks of masturbation as self-abuse, and as not only harmful but dirty, should also wish to suppress the drug user.

The new drug users are not divided socially from the public that abhors them. The public, therefore, must maintain a wide psychological distance, and how better than by disgust, self-righteousness and moral revulsion?

We have been comparing drugs with alcohol, and in this context one of the most telling contrasts between them is that alcohol is familiar. Its threat, as well as its capacity to stir up unconscious conflict, is dulled because we have so often watched other people take the trip and
emerge unscathed. We do not have the same comforting familiarity with drugs. Howard Becker suggests that when responses to marijuana and LSD are more thoroughly known, the secondary anxiety associated with them will vanish. There is evidence to bear him out: in the last six months of 1967 admission to the Massachusetts Mental Health Center or Bellevue for bad psychedelic trips ran approximately 10 percent a month; in the last six months of 1969, there were only three such admissions. There were probably many more bad trips during that period, but the sufferers knew what was happening and could wait it out. Familiarity can help one to deal with the common human fear of being overwhelmed by one's passive desires. But it will take some time for this familiarity to develop, and (if this psychoanalytic explanation holds) until the defensiveness relaxes, we can expect all the mechanisms just described to continue: the fear of passivity, of mental disorganization, and of solitary and unfamiliar activities.

In this chapter we have discussed some characteristic attitudes held by members of the public, and some of the arguments they offer in support of their attitudes. And we have indicated the underlying concerns that make it important for the public to maintain these attitudes even after they have been shown to be irrational. It has been our intention to show that this repetitious and shifting dialogue has itself become central to the drug "problem" in this country, rather than to refute the arguments point by point. Drug use lends itself to confusion because drug response is so susceptible to personality and atmosphere. Hence, a process by which many people invest emotion into attitudes and discussion, and are not open to changes in opinion, must be faced as an integral part of the issue. When members of the public ask, as they do so often, "What can we do about the drug problem?" we would ask in reply, "Who is the drug problem?" Mr. Fry would be very surprised and, unfortunately, feel very hurt to be told that he was as much a part of the problem as was any youthful drug user.

* In 1963, American consumers spent $2.3 billion on drugs, and $8.1 billion in 1969. This figure does not include the drugs charged to hospital or clinic bills, or money spent on drugs by public or private agencies.

* In order to educate the public, the inhabitants of Daytop produced and acted in a play, The Concept, which has been widely reviewed and discussed in many feature articles. This remarkable play is in part improvised, and after the performance the actors meet the audience, discuss drugs and answer questions. Early in the play an addict has a screaming, writhing withdrawal syndrome in jail. Later, after admission to Daytop, he starts the same process. The others in his group tell him to come off it, hand him a broom, and indicate that he works or leaves. Clearly, he is still uncomfortable; but the contrast between what he experiences at Daytop and what he experienced in jail is a key point in the play. Five of our interviews had seen the play and had retained an image of the horror of withdrawal but had forgotten its minimization under different social conditions. They clung to their belief about dependency despite the vivid presentation on stage and the discussion afterward.