CHAPTER 1

Drug Controversies and Demonization

“D”rugs appeal to us because they deliver a variety of moods and states not immediately available from our surrounding realities. These may take in complete relaxation, ecstatic happiness, the negation of suffering, radically transformed perceptions, or just a sense of being alert and full of potential energy” (Walton, 2002).

Drug use is ubiquitous in American society and throughout the world. The U.S. Substance Abuse and Mental Health Services Administration’s National Survey on Drug Use and Health estimated that in 2010, 22.6 million Americans aged 12 or older, or 8.9% of the population in that age group, used an illegal drug during the month prior to the survey (Substance Abuse and Mental Health Services Administration [SAMHSA], 2011). The same survey indicated that 131.3 million people (51.8% of the population aged 12 or older) were current (past month) users of alcohol, while 69.6 million reported current use of a tobacco product in 2010. The use of prescription drugs is also widespread—almost half (47.9%) of the population takes at least one prescription medicine, and one in five (21.4%) used at least three in 2010 (SAMHSA, 2011). In 2010, more than 3.7 billion prescriptions were filled at retail pharmacies in the United States (this figure does not include mail, Internet, and other types of prescription purchases; Kaiser Family Foundation, 2011), and the $234.1 billion spent on prescriptions in 2008 was nearly six times higher than the amount spent in 1990. And in 2010, an estimated seven million Americans (2.7% of the population) reported use of prescription drugs for non-medical purposes (SAMHSA, 2011).

The widespread use of drugs, both legal and illegal, is by no means restricted to the United States. The United Nations Office on Drugs and Crime (UNODC) estimates that approximately 210 million people (roughly 5% of the world’s population aged 15 to 64) used illegal drugs at least once in the past month (2011), and the retail value of the world trade in illicit drugs is at least $322 billion (United Nations World Drug Report, 2007). Although the estimates vary widely, globally,
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between 125 and 203 million people use marijuana, 14 to 56 million use amphetamines, 12 to 21 million use opioids, 14 to 21 million use cocaine, and 11 to 21 million inject drugs (UNODC, 2011). Data such as these have led some commentators on drug use to assert that intoxication is not unnatural or deviant; instead, absolute sobriety is not a natural or primary human state. As Andrew Weil (1986) suggests, “the ubiquity of drug use is so striking that it must represent a basic human appetite” (p. 17).

While drugs—both those that are currently illegal in the United States and those that are legal—provide a number of benefits to those who use them, all drugs are also associated with certain harms. For example, it is estimated that more than 440,000 deaths in the United States in the year 2010 were related to tobacco (Centers for Disease Control, 2011), more than 24,000 to alcohol (excluding accidents and homicides), and more than 27,000 to prescription drug overdoses. It is important to note that all of these drugs are currently legal in the United States. In contrast, there were fewer than 20,000 deaths related to all illicit drugs combined in 2010, and there were no deaths related to the use of marijuana; in fact, marijuana alone has never been shown to cause an overdose death. If we consider deaths associated with the use of particular substances to be at least one acceptable measure of their harmfulness, we may question why alcohol and tobacco are legal substances, while marijuana and drugs such as cocaine, ecstasy, heroin, and methamphetamine are currently illegal.

We may also question why the most noteworthy response to the alleged illegal drug problem in the United States has been the incarceration of massive numbers of people. In fact, there are more people imprisoned for the commission of drug offenses in the United States—close to 500,000—than are incarcerated in England, France, Germany, and Japan, for all crimes combined. Examined in another way, the United States has 100,000 more people incarcerated for nonviolent drug offenses than all the countries of the European Union have for all crimes combined, despite the fact that the European Union has 100 million more citizens (Wood et al., 2003).

These paradoxes require us to consider the distinction between legal and illegal drugs, and, more directly, to examine how certain drugs have been demonized in order to justify their illegal status.
DEMONIZING (ILLEGAL) DRUGS:
THE SOCIAL CONSTRUCTION OF DRUG “EPIDEMSICS”

The data presented above indicate that the use of psychoactive substances—both legal and illegal—is widespread throughout the United States and the rest of the world. It appears that people need to ingest an increasingly diverse array of substances in order to alter their consciousness. But this need for psychoactive substances extends to other constituencies, including government and criminal justice system officials and the popular media. As O’Grady (2010) notes, “the drug warrior industry, which includes both the private sector and a massive government bureaucracy devoted to ‘enforcement’ has an enormous economic incentive to keep the war raging.” Government officials need drugs in order to create heroes and villains and, in many cases, to divert attention from policies that have led to drug use in the first place. Criminal justice system officials need psychoactive substances in order to justify increases in financial and other resources devoted to their organizations, and the popular media need drugs in order to create moral panics and sell newspapers and advertising time.

As a result of these needs, throughout the 20th century and into the 21st century, government and criminal justice system officials in the United States, frequently assisted by the popular media, have engaged in a concerted campaign to demonize certain drugs in order to justify their prohibition. A number of tactics have been used in this endeavor. One strategy used in emphasizing the dangers of (illegal) drugs is to claim, often without any sound empirical data, that the use of these substances is responsible for a significant proportion of the crime that occurs in society. For example, when President Nixon was attempting to justify his administration’s war on drugs in the early 1970s, which he referred to as the United States’ “second civil war,” he claimed that heroin users were responsible for $2 billion in property crime annually. This was a rather strange calculation, given that the total amount of property crime in 1971 amounted to only $1.3 billion (Davenport-Hines, 2001).

A second frequently used strategy is to attribute unique powers to (illegal) drugs that allegedly induce users to commit bizarre acts (including sexually deviant acts) while under their influence. Sullum (2003a) refers to this tendency as “voodoo pharmacology”—the idea that (illegal) drugs are incredibly powerful substances that can take control of people’s behavior, turning them into “chemical zombies.” Zimring
and Hawkins (1992) emphasize a similar theme in their discussion of the metaphorical notion of the unique psychoactive drug that leads to a situation whereby each new substance identified as being problematic is viewed as chemically, physiologically, and psychologically both novel and unique.

Illegal drugs have also been demonized over the past 100 years by claims that they are consumed primarily by members of minority groups and that the substances are distributed primarily by evil foreign traffickers. As Musto (1999) suggests, “the projection of blame on foreign nations for domestic evils harmonized with the ascription of drug use to ethnic minorities. Both the external cause and the internal locus could be dismissed as un-American” (p. 298). A definitive example of the attribution of drug problems to members of minority groups and foreigners appeared in a 2003 U.S. Drug Enforcement Administration (DEA) publication, titled *Drug Trafficking in the United States*:

Cocaine and heroin come through Mexico. Ecstasy has increased at an alarming rate; Israeli and Russian drug trafficking syndicates are the principal traffickers of MDMA worldwide. Finally, groups based in southeast and southwest Asia smuggle heroin into the United States. Street gangs such as Crips and Bloods, and groups of Dominicans, Puerto Ricans, and Jamaicans dominate the retail market for crack cocaine. (p. 3)

More recently, and consistent with this theme, Arizona governor Jan Brewer commented, “I believe today, under the circumstances we’re facing, that the majority of the illegal trespassers that are coming into the state of Arizona are under the direction and control of organized drug cartels and they are bringing drugs in” (as quoted in Davenport, 2010).

Government and criminal justice system officials and media sources have also demonized drugs through assertions that their use results in death and references to the threat they supposedly pose to children. Finally, government, criminal justice system officials, and media sources have demonized drugs through the misrepresentation, distortion, or, in some cases, suppression of scientific studies on the effects of these drugs.

In order to preface our discussion in later chapters on the effects of and policies to deal with both legal and illegal drugs, this chapter addresses the demonization of drugs and the social construction of drug epidemics in the United States over the last 100 years. It is important to state at the outset that in critically examining these issues, we are not suggesting that drug “epidemics” are constructed without any foundation.
whatever; obviously, at least some use of the substance in question has to occur in order for a particular drug to be a candidate for “epidemic” status. But in this context, it is important to consider the meaning of the term *epidemic*. In the 1300s, the bubonic plague claimed the lives of 25 million people, one-third of the world’s population (“Past Pandemics,” 2005); the Irish famine of 1846 to 1850 resulted in the death of as many as one million people out of a population of eight million (Bloy, n.d.); tens of millions of people around the world had died of HIV/AIDS–related causes by 2010 (including 1.8 million in 2010 alone), and at least 34 million people are currently HIV positive (United Nations, 2011). Most of us could agree that these are examples of epidemics. However, to use the term *epidemic* in the context of statistics that 1.4% of Americans report ever using heroin in their lifetime, 2.8% report ever using crack cocaine, 3.6% report ever using ecstasy, and 4.3% report ever using methamphetamine is alarmist and misleading (SAMHSA, 2001). This is not simply a matter of semantics, but rather it points to the misapplication of scientific terminology, which, in the context of drug use and with respect to its implications for policies, is inappropriate.

In addressing the demonization of drugs and the social construction of drug epidemics in this chapter, we are also not suggesting that the substances in question are harmless—as will be discussed in Chapters 3 and 4, no drugs are. However, as will be seen, government and media accounts have created myths about certain substances through the exaggeration of harms associated with them; it is necessary to deconstruct these myths.

We will provide several examples of the social construction of drug epidemics, focusing on different substances over different historical periods, including crack cocaine in the 1980s, heroin in the 1990s to 2000s, ecstasy in the 1990s to 2000s, methamphetamine in the 1990s to 2000s, as well as “spice/K2” and “bath salts” in the 2000s to 2010s. We devote considerably more attention to marijuana, given that this substance continues to dominate the United States’ drug war in terms of number of arrests and larger criminal justice system activity. In order to set the stage for the discussion of constructed drug epidemics, we begin with a discussion of the “glue-sniffing epidemic” that emerged in the United States in the late 1950s and early 1960s. The principles outlined by Brecher (1972) in his discussion of this particular epidemic are strikingly similar to those that have been applied in constructing drug epidemics in both earlier and later time periods and also for other substances.

### GLUE-SNIFFING

Glue sniffing, while likely engaged in (perhaps inadvertently) by a significant proportion of young people, was virtually unheard of in the United States before 1959. The media first mentioned this issue in that year after children were arrested in Tucson, Arizona, and Pueblo, Colorado, for glue-sniffing (Brecher, 1972). The phenomenon then apparently surfaced in Denver, where a juvenile court judge said he viewed glue sniffing as “the number one problem in the metropolitan area” (p. 324). At least partially as a result of considerable media attention to the practice, 130 youth were arrested for glue sniffing in Denver over a 2-year period, and in October
1961, the *New York Times* published an article describing a similar problem with glue-sniffing in New York City. Within 5 months, police in New York had arrested 778 individuals for glue sniffing.

Similar to the pattern we will see for other substances addressed in this chapter, media sources began to recount bizarre acts and behaviors that were allegedly caused by glue inhalation. In a 1962 *Newsweek* article, for example, it was noted that “a 12-year-old boy, discovered sniffing airplane glue by his father, snatched up a knife and threatened to kill him.” The same article quoted a Miami police officer who asserted, “It’s common for boys who sniff glue to become belligerent. They are willing to take on policemen twice their size” (as cited in Brecher, 1972, p. 329). Federal government officials also began to weigh in on the problem, emphasizing another consistent theme used to demonize drugs: the idea that glue sniffing led to involvement in sexual (and homosexual) activities (see box).

An FBI Bulletin (1965) on the topic of glue-sniffing noted, “Glue-sniffers have described how a number of children, boys and girls, meet in unoccupied houses where they will sniff glue together and later have sexual relations, both homosexual and heterosexual. . . . Recently, while conversing with deputy probation officers, I have been informed that several episodes of homosexual relations have occurred between adults and children under the influence of glue. Some of these sexual perverts are encouraging the children to sniff glue with the intentions of having homosexual relations with them. (cited in Brecher, 1972, p. 330)

Brecher (1972) further notes that an additional strategy in constructing the glue-sniffing epidemic was to report on deaths allegedly caused by the activity; a number of popular magazines and newspapers contained reports that nine deaths had been caused by glue sniffing. However, when these deaths were subject to further investigation, it turned out that at least six (and possibly seven) of them were the result of asphyxiation caused by the glue-sniffer’s head being covered by an airtight plastic bag. Another of the deaths attributed to glue sniffing involved a young person who was suffering from other ailments and had sniffed gasoline fumes, but not glue. Attributing the ninth death to glue sniffing was also problematic because the individual in question had not even been sniffing glue before his death.

Brecher (1972) concludes that this glue-sniffing “epidemic” was constructed by the media and government, and that the distortions with respect to the dangers associated with glue sniffing may have inadvertently contributed to an increase in drug use among youth.

It seems highly likely, in retrospect, that the exaggerated warnings against glue sniffing were among the factors desensitizing some young people to drug warnings in general. Most teenagers knew of others in their own neighborhoods who had sniffed glue repeatedly, and who did not drop dead or go to the hospital with brain damage, kidney damage, or liver damage. (p. 332)
A related “epidemic” associated with the use of solvents emerged in 2001. Referring to alleged increases in the use of solvents by young people, Dr. Jo Ellen Dyer of the California Poison Control System commented, “I would say we’re at epidemic proportions. This is the new major drug of abuse out there” (as quoted in Pena, 2001). Evidence for this particular epidemic was that there were six deaths nationwide associated with solvent use over a one-and-a-half-year period.

**MARIJUANA**

As discussed above, one of the prominent strategies used to justify prohibition of a particular substance is to emphasize a wide range of negative effects associated with its use. Although most would agree that marijuana is the most benign of currently illegal drugs, an examination of the history of its portrayal by government officials and in media sources reveals a number of recurrent themes that served to demonize the substance and rationalize its prohibition. At various points in history, marijuana has been portrayed as a substance that is primarily used by members of minority groups, as a substance that causes violence and “aberrant” sexual behaviors, as a substance that causes amotivational syndrome, and as a substance that is a “gateway” to the use of harder drugs.

*The Portrayal of Marijuana: 1800s to 1960*

Marijuana has a long, rich, and fascinating history, both in the United States and globally. Hemp was used for shipbuilding around 470 B.C., and the cannabis plant was cultivated for its psychoactive properties throughout Asia and the Far East as early as the first century B.C. (Davenport-Hines, 2001). Although the exact date when the substance was introduced to Western Europe is not known, an archeological investigation at two Bronze Age (roughly 6,000 B.C. to 2,500 B.C.) sites uncovered the remains of marijuana seeds and pipes that were apparently made specifically for smoking the substance (Walton, 2002). In Britain, a law passed in the 1500s required that farmers set aside part of their land for the cultivation of hemp (Walton, 2002), and similar laws were passed in the United States, where hemp was also used as money from 1631 until the early 1800s (J. Gray, 2001). Medicinal use of marijuana was also fairly common in earlier eras: George Washington grew the substance for this purpose, and Queen Victoria used it for relief from menstrual cramps.

Early reports on the effects of marijuana indicated that it was a relatively benign substance, especially when compared with alcohol. For example, the 1893 Indian Hemp Drugs Commission, which had been appointed by the British government to examine cannabis use in India, concluded, “On the whole, the weight of the evidence is to the effect that the moderate use of hemp drugs produces no injurious effects on the mind. . . . The temptation to excess is not as great as with alcohol” (Indian Hemp Drugs Commission, 1893, pp. 264, 286).

Similarly, in an article published in the *Journal of Mental Science*, Walsh (1894) wrote,
It would seem that the moderate use of hemp drugs may be beneficial under certain conditions; at any rate such moderate use cannot be harmful. . . . [T]here is not, in my opinion, any specific property in hemp drugs which incites to violence or crime. (p. 27)

An editorial in the same journal noted, “apparently it is much less liable than alcohol to induce men to commit violent actions” (“Editorial,” 1894, p. 107).

Despite a lack of scientific evidence identifying any significant deleterious effects of marijuana, when the U.S. federal government decided to create marijuana legislation in the 1930s, the Federal Bureau of Narcotics (FBN) initiated a vigorous antimarijuana propaganda campaign. The Bureau and its director, Harry Anslinger, provided media sources with “information” on the effects of marijuana that was widely reported and served to demonize the substance. Mosher’s (1985) content analysis of articles addressing the topic of marijuana published in popular magazines and newspapers identified a number of themes that were emphasized in order to justify legislation banning marijuana. From 1900 to 1934 (just prior to the passage of the Marijuana Tax Act in 1937), most articles on the topic asserted that the primary users of marijuana were members of minority groups—in particular, Mexicans. For example, one commentator from Sacramento, California, noted, “marijuana, perhaps now the most insidious of narcotics, is a direct by-product of Mexican immigration. . . . Mexican peddlers have been caught distributing sample marijuana cigarettes to schoolchildren” (cited in Musto, 1999, p. 220). The purported effects of the drug ranged from “temporary elation” (“Facts and Fancies,” 1936, p. 7) to “the most violent of all sexual stimulants . . . reason dethroning and causing its users to enter into criminal life” (Simon, 1921, p. 14).

An article published in the *St. Louis Dispatch* in 1934, titled “Drug Menace at the University of Kansas—How a Number of Students Became Addicts of the Strangely Intoxicating Weed,” noted,

The physical attack upon the body is rapid and devastating. In the initial stages the skin turns a peculiar yellow color, the lips become discolored, dried, and cracked. Soon the mouth is affected, the gums are inflamed and softened. Then the teeth are loosened and eventually, if the habit is persisted in, they fall out. Like all other drugs, marijuana also has a serious effect on the moral character of the individual, destroying his will power and reducing his stamina. (cited in J. Gray, 2001 p. 24)

Between 1935 and 1939, a number of articles suggested that cannabis posed a specific threat to young people; for example, a *Scientific American* article referred to the substance as the “assassin of youth” (“Marijuana Menaces,” 1936, p. 150). Other articles emphasized that the use of marijuana led to violent crime, sexual immorality, and a variety of adverse psychological effects. For example, an article appearing in the popular magazine *Survey Graphic* reported “Victor Lacata, while under the influence of marijuana, murdered his mother, father, sister, and two
brothers with an axe.” The same article recounted the case of “Lewis Harris, 26, arrested for the rape of a nine-year-old girl while under the influence of marijuana” (“Danger,” 1938, p. 221). At a meeting of the American Psychiatric Association in 1934, Dr. Walter Bromberg similarly emphasized marijuana’s effect on involvement
in sexual activity, albeit with a different focus: Marijuana “releases inhibitions and restraints imposed by society and allows individuals to act out their drives openly [and] acts as a sexual stimulant [particularly to] overt homosexuals” (as quoted in Musto, 1999, p. 220). With respect to the adverse psychological effects allegedly associated with marijuana, an article in *Scientific American* listed, among others, “the weakening of power to direct thoughts, emotional disturbances” and “irresistible impulses which may result in suicide” (“Marijuana More Dangerous,” 1938, p. 293).

In addition to antimarijuana propaganda appearing in popular magazines and newspapers, there were a number of movies produced in the 1930s and 1940s that further served to demonize the substance.

*Reefer Madness* (1935), produced largely in collaboration with the Federal Bureau of Narcotics, was the best known of these movies. The film depicted marijuana as a “demon weed” that was capable of altering the personalities of young people who, after smoking the drug, went insane, immersed themselves in “evil” jazz music, and committed suicide or went on murder sprees (Talvi, 2003b). Perhaps less well-known are other antimarijuana films produced in this era, including *Weed With Roots in Hell* (1936), *The Devil’s Harvest* (1942), and *She Shoulda Said No (Wild Weed)* (1948) (Schlosser, 2003).

In the 1940s, research conducted under the auspices of New York Mayor LaGuardia’s Commission refuted some of the earlier reports of marijuana’s allegedly negative effects. Allentuck and Bowman (1942) studied 77 marijuana users and concluded, “while exerting no permanent deleterious effects, marijuana gives rise to pleasurable sensations, calmness, and relaxation and increases the appetite” (p. 249). These authors also suggested that the substance had valuable therapeutic applications.

In response to this and another 1942 publication on the topic of marijuana that had stated “unqualifiedly that the use of marijuana does not lead to physical, mental, or moral degeneration and that no permanent deleterious effects from its continuous use were observed” (as cited in Davenport-Hines, 2001, p. 278), the head of the FBN, Harry Anslinger (1943), wrote an editorial in the *Journal of the American Medical Association* stating that “unsavory persons” who were engaged in the marijuana trade would “make use of the statement in pushing their dangerous traffic” (p. 212). The editorial also stated that a boy had read an account of the LaGuardia Commission report and that this had led him to initiate the use of marijuana.

In addition to attempting to discredit the findings of scientific studies indicating that marijuana was not as dangerous a substance as had previously been reported, the FBN and the popular media began to emphasize new themes in order to justify prohibition of the substance. The most prominent and enduring of these themes was the notion that marijuana was a stepping-stone or gateway drug. This theme was illustrated in an article in the *New Yorker*, which noted, “most drug addicts begin on marijuana, which though rarely habit-forming, is very apt to lure users of it on to the deadlier drugs” (“Saw-toothed,” 1951, p. 18). Similarly, an article in *Newsweek* asserted, “marijuana may not be more habit-forming than alcohol, but it makes the switch to heroin easy” (“Reefers,” 1954, p. 17).
Interestingly, despite FBN Commissioner Anslinger’s efforts to demonize marijuana and to have legislation passed prohibiting use of the substance, he initially rejected the idea that marijuana was a gateway drug. In the course of legislative hearings on the substance in the 1930s, Anslinger was asked whether “the marijuana addict graduates into a heroin, an opium, or cocaine user.” Anslinger responded, “No sir, I have not heard of a case of that kind. The marijuana addict does not go in that direction” (as quoted in Brecher, 1972, p. 416). Later, Anslinger would change his views on this issue, asserting, without providing any scientific evidence to support it, that “over 50% of heroin users started on marijuana smoking . . . and they graduated to heroin; they took to the needle when the thrill of marijuana was gone” (as quoted in Davenport-Hines, 2001, p. 285). Such assertions were, of course, useful in justifying federal legislation banning marijuana.

Popular conceptions of the dangers of marijuana use and the legitimacy of employing criminal sanctions against the substance did not really come into question again until the 1960s. In what Himmelstein (1983) refers to as the “embourgeoisement” of marijuana, the consensus over the dangers of the drug that had been established in the 1930s and largely survived into the 1950s began to disintegrate when use became associated with middle-class youth in the 1960s (p. 98). But it is also important to note that the identification of marijuana use with middle-class youth provides only a partial explanation of changes in portrayals of the substance and the relaxation of criminal penalties associated with it in the 1970s (see Chapter 11). Marijuana itself, regardless of propaganda to the contrary, is simply not an extremely dangerous substance. If marijuana was actually a significant contributor to violent crime, as several commentators have alleged, it is probable that there would have been calls for more severe penalties for users and traffickers in the drug rather than the reverse. In addition, a considerable number of scientific experts, primarily from the medical profession, were willing to argue that marijuana was a relatively safe substance.

**The Portrayal of Marijuana: 1960s to 1980s**

“If an enemy nation were to plan to undermine America’s fortune, they could not think of a more effective strategy of poisoning our youth. Marijuana is such a poison” (“Putting a Match,” 1980, p. 12).

This statement by Robert L. Dupont, the former director of the National Institute on Drug Abuse, is reflective of the fact that marijuana had still not received full social acceptability in the United States as of 1980. It is also reflective of the confusion and controversy surrounding the regulation of the substance. Only 4 years earlier, Dupont had recommended decriminalization of marijuana (“Marijuana: A Conversation,” 1976).

As mentioned above, several portrayals of marijuana in popular magazines prior to the 1960s emphasized that it caused violence and crime; however, in the
debate over the drug that occurred in the 1960s through the 1980s, these themes were largely ignored or denied. This is not to suggest, however, that popular literature and government sources universally portrayed the substance as benign. One of the most blatant examples of distortion and misinformation regarding the effects of marijuana was published in the prestigious *Journal of the American Medical Association* in 1971. Psychiatrists Kolansky and Moore studied 38 individuals, most of whom smoked marijuana once or more per week, and reported that “these patients consistently showed very poor social judgment, poor attention span, poor concentration, confusion, anxiety, depression, apathy, indifference, and often slow and slurred speech.” A 20-year-old male subject “developed delusions of grandeur six months after starting to smoke marijuana—[he] believed he was in charge of the Mafia.” An 18-year-old boy who smoked marijuana and hashish for a 3-year period “became a vegetarian and practiced yoga. He had the delusion that he was a guru and eventually believed that he was the son of God who was placed on the earth to save all people from violence and destruction.” A 19-year-old boy who smoked marijuana for 4 months “[believed] he had superhuman powers; he felt he was able to communicate with and control the minds and actions of animals, especially dogs and cats” (Kolansky & Moore, 1971, p. 489).

But perhaps most bizarre in the Kolansky and Moore (1971) article was their assertion that the use of marijuana led to involvement in aberrant sexual behaviors. They noted, for example, that 13 females aged 13 to 22 exhibited

an unusual degree of sexual promiscuity, which ranged from sexual relations with individuals of the opposite sex to relations with individuals of both sexes, and sometimes, individuals of both sexes on the same evening. In the histories of these individuals, we were struck by the loss of sexual inhibitions after short periods of marijuana smoking. (pp. 490–491)

Further,

A 17-year-old boy was seduced homosexually after an older man gradually introduced him to marijuana smoking over a period of one year. . . . He continued to smoke marijuana and gradually withdrew from reality, developing an interest in occult matters which culminated in the delusion that he was to be the messiah returned to earth. (p. 488)

Finally,

Shortly after a 14-year-old boy began to smoke marijuana, he began to demonstrate indolence, apathy, and depression. Over a period of eight months, his condition worsened until he began to develop paranoid ideas. Simultaneously, he became actively homosexual. (p. 488)
While one hopes it is obvious that many of Kolansky and Moore’s assertions regarding the effects of marijuana are inaccurate, it is also important to address some of the methodological problems with this study. It is notable that Kolansky and Moore only studied subjects who volunteered for the study, which may indicate that these individuals had prior psychological problems not directly attributable to their use of marijuana; unfortunately, the authors provided very little background information on their research subjects. Furthermore, Kolansky and Moore made no effort to explain the specific mechanisms through which marijuana supposedly caused the effects they identified. Their definition of sexual promiscuity is also questionable because they did not delineate how many times a particular individual would need to engage in sexual relations to be labeled sexually promiscuous. One would expect single males and females of the age of the subjects in this study to be sexually active, so the attribution of this activity to marijuana use seems highly questionable.

Despite these methodological problems and the rather outlandish claims regarding the effects of marijuana, it is notable that Kolansky and Moore’s findings were widely cited in popular magazines in the early 1970s (Mosher, 1985). Carlton Turner, who served as drug czar under President Ronald Reagan, linked the smoking of marijuana to anti-authority behavior, and, echoing Kolansky and Moore, argued that use of the drug could turn young men into homosexuals (Busse, 2003). And as late as 1999, the head of the United States Public Health Service suggested that marijuana should not be prescribed as medicine for AIDS patients because such individuals would become “crazed” by the high and would be more likely to practice unsafe sex as a result (Manderson, 1999).

A more common theme regarding the effects of marijuana that emerged in the 1960s and that continues to be emphasized in the current period is the notion that its use leads to indolence, or what is sometimes referred to as “amotivational syndrome.” Thus, an article in Life magazine suggested, “potheads tend to be irresponsible and uninterested in things like keeping a job or supporting a family” (“Marijuana: Millions,” 1967, p. 18). Similarly, quoting the director of the Bureau of Narcotics and Dangerous Drugs, an article in Time magazine noted, “pot can be psychologically habituating, often resulting in amotivational syndrome in which the user is more likely to contemplate a flower pot than try to solve his problem” (“New Views,” 1971, p. 65). However, as Weil and Rosen (1998) suggest, the assertion that marijuana causes amotivational syndrome is also of questionable scientific validity. While it is true that some people who lack motivation tend to engage in marijuana use, it cannot be concluded that marijuana is the cause of this behavior.

The contention of a relationship between marijuana use and homosexuality was echoed at a political convention in Vancouver, British Columbia, in 1979. Delegates to this convention were informed that cannabis contained female estrogen that was affecting male users of the substance. “The growing gay population is largely due to cannabis. . . . Unless the data we have is soon transmitted to the public, we will probably witness the decline of Western civilization as we have known it.” (“Socreds Told,” 1979, p. 3)
smoking, it is unlikely that marijuana consumption is the cause of their lack of motivation. “Heavy pot smoking is more likely to be a symptom of amotivation than a cause of it, and those same young people would probably be wasting their time in other ways if pot were not available” (p. 119).

Considered in its totality, however, the portrayal of marijuana in popular media sources from 1960 to 1980 stressed that the earlier information on the substance had overemphasized its dangers (Mosher, 1985). As will be discussed in further detail in Chapter 11, this led to a general relaxation of penalties for marijuana possession in a number of states and decriminalization of marijuana in 11 states. However, between 1980 and 2010, several million people were arrested for marijuana offenses in the United States, the overwhelming majority for simple possession of the substance. For example, in 2009, of 858,408 arrests for marijuana in the United States, 88.4% were for simple possession (FBI, 2011). And given that, in the same year, marijuana arrests accounted for 51.6% of the 1,663,482 drug arrests in the United States, statistically speaking, the war on drugs is, in essence, a war on marijuana use and possession. As such, it is important to examine the official rationalizations for this continued war on marijuana in the context of scientific evidence on the effects of the drug.

The Portrayal of Marijuana: 1980 and Beyond

It is ironic that Drug Czar John Walters cites the movie Reefer Madness in his opinion/editorial “The Myth of Harmless Marijuana.” Indeed, many of Mr. Walters’ more egregious claims about cannabis appear to have been lifted straight from the 1936 propaganda film. (Stroup & Armentano, 2002, p. 223)

The Office of National Drug Control Policy (ONDCP) and President George W. Bush’s drug czar, John Walters, justified the continuing war on marijuana and the arrest of hundreds of thousands of people for possession of the substance by invoking a number of old, and some new, themes regarding the dangers associated with the substance. These themes have been emphasized in both official ONDCP reports and in an opinion-editorial article written by Walters and published in the Washington Post titled “The Myth of Harmless Marijuana” (Walters, 2002).

The first of these themes is one we discussed earlier—the notion that marijuana leads to violence. A 2002 ONDCP report suggested “the truth is that marijuana and violence are linked” (ONDCP, 2002a). Similar allegations have been made by local law enforcement officials in some jurisdictions. For instance, the commander of the Bronx, New York Narcotics Division claimed,

Some people may think the drug [marijuana] is benign, but the distribution network certainly is not. For some of our policy makers... sometimes their only connection to marijuana was watching the Grateful Dead at the Fillmore
East. Times have changed. None of the dealers in the Bronx are smoking joints and discussing Nietzsche. (Flynn, 2001)

But as is typically the case, despite claims that police in New York were witnessing increasing violence among those involved in marijuana distribution, “it is unclear how much the number of violent incidents has grown . . . [because] New York City does not keep statistics on marijuana-related violence” (Flynn, 2001).

It is worth considering the alleged connection between marijuana and violence in the context of reports from non–U.S. government agencies and scholarly research on the issue. The Canadian Senate's 2002 report on cannabis noted, “cannabis does not induce users to commit other forms of crime. Cannabis use does not increase aggressiveness or anti-social behavior” (Government of Canada, 2002, p. 4). Similarly, the British Advisory Council on the Misuse of Drugs concluded in its 2002 report,

Cannabis differs from alcohol . . . in one major respect. It does not seem to increase risk-taking behavior. . . . This means that cannabis rarely contributes to violence either to others or to oneself, whereas alcohol is a major factor, in deliberate self-harm, domestic accidents, and violence. (Advisory Council on the Misuse of Drugs, 2002)

The key difference between the claims in the ONDCP report and those of other sources appears to be related to the former’s apparent confusion over the effects of marijuana versus the effects of marijuana’s status as an illegal drug. While there is virtually no scientific evidence indicating that marijuana induces psychopharmacological changes causing an individual to be violent (Weil & Rosen, 1998), because the substance is distributed in illegal markets where individuals and organizations may compete for domination, violence may ensue. If marijuana were a legal substance that could be purchased in legal contexts, such potentially violent turf battles would not occur.

The 2002 ONDCP report also claimed that “60 percent of teenagers in [drug] treatment have a primary marijuana diagnosis. That means that addiction to marijuana by our youth exceeds their addiction rates for alcohol, cocaine, heroin, methamphetamine, ecstasy and all other drugs combined” (ONDCP, 2002a). Leaving aside the fact that marijuana is not a physically addicting substance (see Chapter 4), it is important to note that the increase in marijuana treatment admissions is almost exclusively the result of an increase in teenagers referred to drug treatment by the criminal and juvenile justice systems. This, in turn, is at least partially the result of the tremendous increase in marijuana arrests of juveniles over the last decade or so. According to the federal Drug and Alcohol Services Information System, 54% of all adolescent admissions for marijuana treatment are through the criminal justice system (cited in National Organization for the Reform of Marijuana Laws [NORML], 2002).

In further emphasizing the alleged dangers of marijuana, the 2002 ONDCP report, referring to Drug Abuse Warning Network (DAWN) data, claimed that “as a factor in emergency room admissions, marijuana has risen 176% since 1994, and
now surpasses heroin” (ONDCP, 2002a). This statement is also misleading, in that it implies that marijuana use is a causal factor in emergency room admissions. As will be discussed further in Chapter 5, for every emergency room visit related to drug use, hospital staff can list up to five drugs the individual reports having used recently, regardless of whether the particular drug was the cause of the visit. Because a far greater proportion of the population uses marijuana than uses other illegal drugs, it is far more likely to be reported by patients. Marijuana is infrequently mentioned independently of other drugs in these DAWN data; in fact, mentions of marijuana alone accounted for less than 4% of all drug-related emergency room visits (NORML, 2002).

The ONDCP has also justified the continued prohibition of marijuana on the grounds that the THC (the main psychoactive ingredient) content of marijuana in circulation in the current period is much higher than in the past, allegedly making it a more dangerous substance. In the 2002 ONDCP report, it was noted that the average THC levels of marijuana in samples seized by the Drug Enforcement Administration had increased from less than 1% in the late 1970s to more than 7% in 2001. It was also asserted that the potency of more powerful sinsemilla strains of the substance had increased from 6% to 13%, and reached as high as 33%. Based on these data, drug czar John Walters was widely quoted in the media claiming that the potency of marijuana had increased as much as 30 times its previous potency, and commented, “It’s not your father’s marijuana” (as quoted in Forbes, 2002). As Forbes (2002) revealed, however, Walters’s claims were tremendously misleading. First, the figures provided for “today’s sinsemilla” were, in fact, based on data from 1999. Walters conveniently ignored data from 2000 and 2001, probably because the potency of sinsemilla strains of marijuana peaked at 13.38% THC content in 1999. In addition, high-grade marijuana such as sinsemilla tends to be prohibitively expensive for most users and constitutes only a small percentage of the overall marijuana market. It is thus highly unlikely that a majority or even a significant minority of users were consuming this high-THC-content marijuana.

Walters’s distortions with respect to the THC content of marijuana samples went even further. According to a study published in the Journal of Forensic Sciences (and based on data from the federal government’s own marijuana potency monitoring project housed at the University of Mississippi), the THC content of marijuana samples increased threefold over the 1980–1997 period, from approximately 1.5% in 1980 to 4.5% in 1997 (ElSohly et al., 2000). We therefore must question where Walters obtained the previously mentioned figure of 7%. As Zimmer and Morgan (1997) further point out, a small number of low-THC-content (approximately 1% THC) samples seized by the Drug Enforcement Administration in the 1970s are typically used to calculate the dramatic increases in the potency of the drug (p. 137). However, these samples were not representative of the marijuana that was available to most users, and very few people smoke marijuana with such low THC content (Forbes, 2002).

The discussion above emphasizes how the ONDCP and drug czar Walters presented misleading information with respect to increases in the THC content of marijuana; however, we do not deny that marijuana at the high end of the THC continuum is probably more widely available than in previous years. It does not necessarily follow, however, that marijuana is now more dangerous to users.
Research suggests that consumers of hard liquor typically consume fewer drinks than those who drink beer and wine, which have a lower alcohol content, in order to experience the psychoactive effects of alcohol (Weil & Rosen, 1998). Similarly, consumers of high-potency marijuana will generally smoke less of the substance; studies have shown that most users smoke until they experience a high (Wanjek, 2002). This is further confirmed from data derived from Monitoring the Future surveys on drug use, which indicate that the average size of marijuana cigarettes that users consume has declined over time (Forbes, 2002; Wanjek, 2002). This would imply that marijuana smokers are aware of the fact that they are consuming a higher-potency substance and are regulating their intake accordingly. In addition, marijuana poses no risk of fatal overdose, regardless of THC content; as noted earlier, there has never been a documented death from marijuana consumption (Zimmer & Morgan, 1997). In fact, one estimate suggests that a person would have to consume approximately 100 pounds of marijuana a minute for 15 minutes in order to induce a lethal response (Schlosser, 2003). Furthermore, since the substance’s most serious potential hazard is related to consumers’ intake of potentially carcinogenic smoke, it could be argued that higher-potency marijuana is actually less harmful because it permits users to achieve the desired psychoactive effects while inhaling less burning material (NORML, 2002; Sullum, 2003a).

Perhaps the most prominent argument used by the ONDCP to justify the continued prohibition of marijuana is one that, as noted above, first appeared in the 1950s: the notion that marijuana is a gateway drug.

The truth is that marijuana is a gateway drug. . . . People who use marijuana are eight times more likely to have used cocaine, fifteen times more likely to have used heroin, and five times more likely to develop a need for treatment of abuse or dependence of any drug. (ONDCP, 2002a)

Before examining the empirical support (or lack thereof) for the gateway drug hypothesis, it is important to examine its theoretical logic.

As Kandel (2003) explains, the gateway drug hypothesis is based on three interrelated propositions. First, the notion of “sequencing” implies that there is a fixed relationship between two drugs, such that the use of one substance is regularly initiated before the other. Second, “association” implies that the initiation of one drug increases the probability that use of the second drug will be initiated. Finally, the notion of “causation” suggests that the use of one substance actually causes use of the second substance. These facts are generally marshaled in support of the gateway effect: (1) Marijuana users are more likely than nonusers to progress to the use of harder drugs such as cocaine and heroin; (2) more individuals who have used hard drugs tried marijuana first; and (3) the greater the frequency of marijuana use, the greater the likelihood of hard drug use.

A 1994 report by the Center on Addiction and Substance Abuse was one of the first to present statistical evidence in support of the gateway drug hypothesis (cited in Zimmer & Morgan, 1997). This report claimed that marijuana users were 85 times more likely than non-marijuana users to have used cocaine; this figure was derived from respondents’
reports of lifetime use of marijuana and cocaine in the 1991 National Household Survey on Drug Abuse. However, in an interesting twist on mathematical logic, in order to obtain this factor of 85, the report divided the proportion of marijuana users who admitted they had ever tried cocaine (17%) by the percentage of cocaine users who had never tried marijuana (.02%). In other words, the risk factor is large not because a substantial proportion of marijuana users try cocaine, but because very few people try cocaine without trying marijuana first. As Zimmer and Morgan (1997) point out, a similar relationship exists between other kinds of common and uncommon activities that tend to be related to one another. For example, most people who ride motorcycles, which is a relatively rare activity, have also ridden a bicycle, which is a fairly common activity. It is also likely that the prevalence of motorcycle riding among individuals who have never ridden a bicycle is quite low. Sullum (2003a) offers a similar analogy, noting that people who engage in bungee jumping are probably more likely to try parachuting than people who don’t engage in bungee jumping. It would stretch logic, however, to claim that bicycle riding causes motorcycle riding or that bungee jumping causes skydiving. Similarly, it is misleading to suggest that marijuana use causes cocaine use.

Having said that it is necessary to question the logic of the gateway drug hypothesis, it is also important to review recent research on this issue. A longitudinal study based on a sample of 311 monozygotic (identical) twins in Australia found that individuals who had used marijuana by the age of 18 had odds of other illegal drug use and/or clinical diagnoses of alcohol dependence and drug abuse that were 2.1 to 5.2 times higher than their twin who did not use marijuana before the age of 18 (Lynskey et al., 2003). While this study would appear to provide evidence in support of the gateway drug hypothesis, the authors did not claim that they had presented incontrovertible proof. They noted that if the association between early use of cannabis and the use of other illegal drugs is causal, the particular mechanisms through which this association operates are not completely clear. Lynskey and colleagues outline three possible mechanisms that might explain the association: (1) Early experiences with marijuana, which often produce pleasurable psychoactive effects, may encourage the continued use of marijuana and experimentation with other drugs; (2) experiences with marijuana that do not result in short-term harm to the user may serve to reduce the perceived risks associated with the use of harder drugs; and/or (3) experience with and access to marijuana may provide users with access to other illegal drugs via contact with individuals who deal in such substances (pp. 430–431).

Research conducted by Morral, McCaffrey, and Paddock (2002) based on analyses of data from the U.S. National Household Surveys on Drug Abuse found that associations between marijuana and hard drug use would be uncovered even if marijuana has no gateway effect. Instead, the well-documented associations between marijuana and hard drug use likely result from differences in the age at which young people have opportunities to use marijuana and hard drugs and differences in individuals’ willingness to try any type of drugs. In simple terms, marijuana is typically the first illegal drug used by young people because it is more widely available than other illicit substances. It is important to note that the Morral and colleagues study did not disprove the gateway theory; instead, it shows that an alternative explanation for the association between marijuana and hard drug use is possible.
Drugs and Drugs Policy

### Table 1.1
Percentage of Illegal Drug Use in the United States and the Netherlands: Lifetime Use Among People Aged 12 and Older in 2001

<table>
<thead>
<tr>
<th></th>
<th>United States&lt;sup&gt;a&lt;/sup&gt;</th>
<th>The Netherlands&lt;sup&gt;b&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana</td>
<td>36.9</td>
<td>17.0</td>
</tr>
<tr>
<td>Cocaine</td>
<td>12.3</td>
<td>2.9</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>3.6</td>
<td>2.9</td>
</tr>
<tr>
<td>LSD</td>
<td>9.0</td>
<td>1.0</td>
</tr>
<tr>
<td>Heroin</td>
<td>1.4</td>
<td>0.4</td>
</tr>
</tbody>
</table>

**SOURCE:** European Monitoring Centre for Drugs and Drug Addiction (EMCDDA, 2002b).

<sup>a</sup> Data obtained from the 2001 National Household Survey on Drug Abuse.

<sup>b</sup> Data obtained from EMCDDA (2002a).

Considering the scientific research assessing the gateway drug hypothesis as a whole, it is safe to say that there is no pharmacological basis for this theory. However, as noted above, there may be a relationship between marijuana use and the use of other drugs that is due to the fact that marijuana must be purchased in illicit markets. Here, it is worth considering the situation in the Netherlands. As will be discussed in more detail in Chapter 12, the Dutch decriminalized cannabis possession and retail sale of the drug in 1976, which, among other things, allowed for sale and use of marijuana in coffee shops. In the United States, 36.9% of respondents in the 2001 U.S. National Household Survey on Drug Abuse reported using cannabis at least once in their lifetime; in the Netherlands, the comparable figure was 17.0%. With respect to use of marijuana in the previous year, approximately 3% of people in the Netherlands, compared to 8.6% in the United States, reported such use (Dilanian, 2006). In addition, an earlier survey conducted in the city of Amsterdam found that the average age at which young people began use of cannabis was 20, compared to an average age of initiation of approximately 16 in the United States (Zimmer & Morgan, 1997, p. 52). But more relevant to the gateway drug hypothesis are data on the use of other drugs by people in the Netherlands compared to the United States. As Table 1.1 reveals (the data are the most recent comparable data available), only 2.9% of people in the Netherlands reported ever using cocaine, compared to 12.3% in the United States. Similarly, while 1.4% of respondents in the 2001 U.S. National Household Survey on Drug Abuse reported lifetime use of heroin, only 0.4% of respondents in a similar survey in the Netherlands reported such use. The fact that the Netherlands is a small, relatively homogeneous country with comparatively low rates of poverty and homelessness and with a superior health care system may contribute to lower rates of hard drug use in that country. However, these data raise the possibility that the lower rate of drug use in the Netherlands may be partially attributable to the success of the Dutch in separating the cannabis and hard drug markets (see box).
Chapter 1  Drug Controversies and Demonization

A government report from the Netherlands noted, “If young adults wish to use soft drugs—and evidence has shown that they do—they should...not be exposed to the criminal subculture surrounding hard drugs. Tolerating relatively easy access to quantities of soft drugs for personal use is intended to keep the consumer markets for soft and hard drugs separate, thus creating a social barrier to the transition from soft to hard drugs.” (as quoted in Zimmer & Morgan, 1997, p. 53)

Perhaps the most convincing evidence refuting the gateway drug hypothesis is that by the early 2000s, approximately 83 million people in the United States had tried marijuana at some point in their lives but had never used heroin. Data from the U.S. National Household Survey on Drug Abuse reveal that if individuals had ever tried marijuana in their lifetime, their chance of using other illegal drugs in the previous month was 1 in 7 for marijuana, 1 in 12 for any other illegal drug, 1 in 50 for cocaine, and 1 in 677 for heroin (Earleywine, 2003). As NORML (2002) noted, given such statistics on the prevalence of marijuana use and the use of other illegal drugs, for the majority of marijuana users, the substance is a “terminus” rather than a gateway. A National Academy of Sciences report (1999) observed, “there is no evidence that marijuana serves as a stepping stone on the basis of its particular drug effect.” A Canadian Senate Committee report similarly concluded, “cannabis itself is not a cause of other drug use; in this sense, we reject the gateway theory” (Government of Canada, 2002). In short, the claims of the ONDCP, drug czar John Walters, and others that marijuana is a gateway drug and therefore should retain its status as a Schedule I drug in the United States are not based on sound scientific evidence.

In his editorial in the Washington Post, John Walters also claimed, without providing any source, that “each year, marijuana is linked to tens of thousands of serious traffic accidents” (Walters, 2002). He also linked marijuana to brain damage in asserting, “the THC in marijuana attaches itself to receptors in the hippocampal region of the brain, weakening short-term memory and interfering with the mechanisms of long-term memory. Do our struggling schools really need another obstacle to student achievement?”

In this statement, Walters may have been referring to a study conducted by Solowij and colleagues (2002). This study compared 33 nonusers with 102 cannabis users who had smoked an average of two marijuana cigarettes a day for an average of 24 years and found that the latter experienced more problems related to impaired learning and retention and retrieval of information. The authors concluded, “These results confirm that long-term heavy cannabis users show impairments in memory and attention that endure beyond the period of intoxication and worsen with increasing years of regular cannabis use” (p. 1132). However, the authors of this study were careful to note that their research did not indicate that marijuana causes brain damage, and also that they had not been able to take into account a number of additional factors that may have affected the marijuana users’ memory impairment. In fact, a meta-analysis of 15 previously published studies examining the impact of long-term marijuana consumption on the cognitive functioning of adults
found that recreational marijuana use had only minor negative effects on learning and memory. There were no effects of marijuana on other cognitive functions, such as reaction time, attention, language, reasoning ability, and perceptual motor skills. This study suggested that the problems with respect to memory and learning indicate that long-term marijuana use may result in selective memory problems, but that the impact is relatively small (Drug Policy Alliance, 2003).

Related to the allegations that marijuana affects cognitive functioning are assertions that it can be a causal factor in users developing psychiatric illnesses. Thus, a 2003 ONDCP report claimed that marijuana use was linked to mental illnesses such as schizophrenia and depression (ONDCP, 2003b). This particular conclusion may have been based on two studies published in the *British Medical Journal* in 2002. In the first of these studies, Rey (2002) asserted that frequent cannabis use could increase the risk of suffering from depression or schizophrenia later in life. However, in a critique of this study, Iversen (2003) suggested that the existence of a causal relationship between cannabis use and psychiatric illness has not been proven. Referring to aggregate-level data, Iversen notes that if cannabis use causes schizophrenia, there would have been a substantial increase in the number of people diagnosed with schizophrenia when cannabis use increased substantially over the 1960 to 1990 period. However, the number of individuals diagnosed with schizophrenia did not increase over this period.

The second study published in the *British Medical Journal* followed a cohort of 1,947 14- and 15-year-old Australians for 7 years and found that daily consumption of cannabis resulted in more than a fivefold increase in anxiety or depression (Patton et al., 2002). The authors of this study did note, however, that “because the risks seem confined to daily users, the question about a direct pharmacological effect remains” (p. 1197). More generally, the question in this type of research, similar to what we discussed with respect to “amotivational syndrome,” is related to causal ordering. That is, does cannabis use lead to anxiety and/or depression, or do people suffering from these conditions self-medicate with cannabis?

Although not a point emphasized specifically by ONDCP in its discussion of marijuana, some commentators justify the continued prohibition of marijuana on the basis of its alleged carcinogenic effects. Leaving aside the fact that the substance causing by far the most cancer deaths (tobacco) remains legal in the United States, the scientific evidence does not indicate a strong relationship between marijuana consumption and cancer.

Researchers in Britain asserted that cannabis use was linked to cancer and claimed that there were as many as 30,000 deaths per year in that country caused by marijuana smoking (Henry, Oldfield, & Kon, 2003). Although these researchers did not have access to actual cannabis-related mortality data, they asserted that because the percentage of British citizens who smoked marijuana was approximately one-quarter of the percentage of British who smoked cigarettes, the number of deaths attributable to marijuana smoking would be about one-quarter the number attributed to cigarettes (p. 943). As Sidney (2003) pointed out, however, there are several differences between marijuana and tobacco smokers that have
implications for the estimates of Henry and colleagues. Compared to tobacco smokers, most individuals who use marijuana stop using the substance fairly early in their adult lives, and the typical marijuana smoker consumes about one marijuana cigarette per day, while tobacco users usually consume 20 or more cigarettes per day (p. 636). While it is true that marijuana smokers typically inhale more deeply and retain smoke in their lungs for a longer period of time each time they smoke (Zimmer & Morgan, 1997), the key issue with respect to the potential relationship to cancer is the total volume of toxic material accumulated over time, not the amount inhaled per individual cigarette. Sidney (2003) concluded, “Although the use of cannabis is not harmless, the current knowledge base does not support the assertion that it has any notable adverse public health impact in relation to mortality” (p. 636). The United States National Academy of Sciences Institute of Medicine affirmed this conclusion, noting, “there is no conclusive evidence that marijuana causes cancer in humans, including cancers usually related to tobacco use” (National Academy of Sciences, 1999).

Almost paradoxically, while claiming that marijuana is a dangerous substance, drug czar John Walters has also tried to silence critics of laws against marijuana through assertions that it is a myth that large numbers of Americans have been incarcerated for marijuana offenses. However, calculations based on Bureau of Justice Statistics revealed that 59,300 prisoners (3.3% of the total incarcerated population) in 1999 were convicted of violations of marijuana laws. In the same year, offenders charged with crimes related to marijuana comprised close to 12% of the total federal prison population and approximately 2.7% of the state prison population (C. Thomas, 1999). Schlosser (2003) further notes that the number of marijuana offenders sent to federal prisons in 1999 was greater than the number of offenders sent to such prisons for methamphetamine, crack, or cocaine powder, which are supposedly more dangerous drugs. Marijuana offenders were given life sentences under federal laws in 1992, 1993, and 1994, and over the 16-year period of 1984 to 1999, 16 people were sentenced to life in federal prison as a result of a conviction for a marijuana offense. Zimmer and Morgan (1997) note that 22% of those sentenced for the violation of marijuana statutes in Michigan in 1995 were sent to prison, as were 34% of those in Texas and New York. Similarly, under California’s “Three Strikes and You’re Out” law, more people had been sent to prison for marijuana than for all violent offenses combined. Schlosser (2003) also provides specific examples of the severe penalties imposed on individuals for marijuana offenses. In Oklahoma, a paraplegic who smoked marijuana to relieve muscle spasms was sentenced to life imprisonment plus 16 years for possession of marijuana with intent to distribute (two ounces) of marijuana, possession of drug paraphernalia, unlawful possession of a weapon, and maintaining a place resorted to by users of controlled substances. Another individual in the same state was found in possession of 0.16 of an ounce of marijuana and was sentenced to life imprisonment.

Finally, in one of the most egregious examples of government attempts to manipulate science to unveil the negative effects of marijuana, researchers at the National Institute on Drug Abuse, in an attempt to demonstrate that the substance was
physically addicting, conducted experiments in which they tried to induce monkeys to self-administer THC. As the Lindesmith Center (2001b) reported, when these attempts were not successful, the researchers taught the monkeys to self-administer cocaine, and “after strapping the monkeys into chairs and turning them into cocaine addicts, NIDA found that previously disinterested monkeys would willingly self-administer the THC when forced into cocaine withdrawal.”

To conclude this section, from the time marijuana was first prohibited at the federal level in the United States in 1937 to the present, the government, and at times certain media sources, have engaged in a concerted campaign to demonize it and thereby justify its continued prohibition. However, it is important to note that a number of government commissions, both in the United States and in other countries, have concluded that the possession and consumption of marijuana should not be subject to criminal penalties. The 1975 U.S. Shafer Commission report recommended that possession of cannabis should not be a criminal offense (Trebach, 1988). The 1973 Canadian LeDain Commission report concluded that the prohibition of cannabis was an excessive, ineffective, and costly tool for controlling marijuana use (Government of Canada, 1973). These conclusions were consistent with the Wooton report in Britain (1968); reports in the Netherlands (1971–1972); and the Baume Commission in Australia (1977) (cited in Fischer et al., 2003). And in 1995, the World Health Organization’s (WHO) Program on Substance Abuse, commenting on the effects of cannabis, noted, “on existing patterns of use, cannabis poses a much less serious public health problem than is currently posed by alcohol and tobacco in Western societies” (as cited in Jelsma, 2003, p. 190). However, in the final WHO report, the comparison to alcohol was deleted, likely in response to U.S. officials’ concerns. In Chapter 11, we address recent developments in marijuana policies in the United States.

CRACK COCAINE

The crack cocaine “epidemic” was constructed by media, government, and law enforcement officials in the mid- to late-1980s (Brownstein, 1996). Reinarman and Levine (1997) note that in July of 1986 alone, the three major television networks in the United States presented 74 evening news segments on drug-related topics, half of which focused on crack. Between October 1998 and October 1999, the Washington Post alone featured 1,563 stories about the drug crisis. Many of the stories on crack alleged that its use led to the commission of violent crime and that (smokable) crack cocaine was more addictive than cocaine administered nasally; this constituted one of the justifications for treating the former substance more severely than the latter in drug legislation passed in the 1980s (see Chapter 11). However, as Alexander (1990) and others have noted, there is no difference in the addictive liability between crack cocaine and cocaine hydrochloride. Furthermore, most people who try crack use it for a relatively short period of time.

The media also presented the image that crack was primarily a drug used by African Americans, which served to demonize it in the eyes of many whites.
However, a study published in the *Journal of the American Medical Association* found that given similar social and environmental conditions, crack use was not strongly related to race-specific individual factors. Once respondents in this study were grouped into neighborhood clusters, the relative odds of crack use were not significantly different for African Americans or Hispanics compared with whites (Lillie-Blanton, Anthony, & Schuster, 1993, p. 996).

More generally, several authors have noted that crack cocaine use never did constitute an epidemic in the United States (Akers, 1992; Reinarman & Levine, 1997). As Alexander (1990) comments, “one could argue that there is an epidemic of having used cocaine at least once, if about 10% of the American population . . . can be taken as constituting epidemic proportions” (p. 187). However, the crack cocaine “epidemic” allowed legislators to shift the blame for many of the social problems of the 1980s, including relatively high rates of unemployment and crime, from the actions (or nonactions) of government to the drug taking and trafficking of individuals. “Crack was a godsend to the Right. They used it and the drug issue as an ideological fig leaf to place over the unsightly urban ills that had increased markedly under the Reagan administration’s social and economic policies” (Reinarman & Levine, 1997, p. 16). We address recent developments in the legislation dealing with crack cocaine in Chapter 11.

**HEROIN**

When the crack cocaine “epidemic” subsided in the early 1990s, government officials and media sources were apparently in search of another drug to demonize. Although heroin never received the same amount of attention as ecstasy and methamphetamine (discussed below), there were several reports in the 1990s and 2000s of an emerging heroin “epidemic.” In 1996, for example, it was asserted that “heroin, once considered the poisonous habit of pathetic junkies, is being reborn as the hip drug of choice among the trend setters of Generation X” (“Ads Show Reality,” 1996). General Barry McCaffrey, drug czar under President Clinton, also weighed in, noting, “heroin is back, and it’s cheaper, more potent, and deadlier than ever” (as quoted in Fields, 1999). Richard Bonnette, President of the Partnership for a Drug-Free America (PFDDA), said heroin was becoming “the drug of the 90s”; another PFDFA spokesperson claimed, “heroin looks like a thermonuclear disaster waiting to happen” (as quoted in J. Gray, 2001).

Employing the tactic of marshaling misleading statistics to indicate the emergence of a heroin epidemic, the media and politicians claimed that heroin use had doubled between 1995 and 1996. The basis for this claim was a National Institute on Drug Abuse survey of 4,500 youth that revealed that 32 admitted to using heroin in 1996; in the previous year, only 14 in a similar survey had acknowledged the use of heroin (J. Gray, 2001). In early 2003, a law enforcement official in Maine was quoted as saying, “Through the state, heroin use is an epidemic, no question” (as quoted in Ferdinand, 2003). In the same year, heroin was also apparently spreading to the Midwest region of the United States, with one article referring to “the rising tide of
small town heroin abuse in the Midwest, occurring in little tidy communities with
town squares, bicycles on front lawns, and American flags” (C. Jones, 2003).

As mentioned above, socially constructed drug epidemics can be made to appear
even more threatening when they involve children. Writing about an allegedly
dealers who target children as young as 12 with free samples and drug packets
decorated with cartoon characters have spawned an epidemic of illicit heroin use in
Massachusetts and New England.”

The heroin “epidemic” has also been attributed to foreign drug traffickers. A
Chicago Tribune article, alleging an increasing problem with heroin in that city,
noted, “in 1985, federal agents dismantled much of the Mexican heroin supply that
dominated the Chicago market. Nigerians quickly filled the void, then were replaced
by Colombians after another federal investigation in the late 1990s” (Bebow, 2004).

**ECSTASY (MDMA)**

Ecstasy is a drug invented by German psychiatrists in 1912. It was tested as a “truth
drug” by the U.S. Central Intelligence Agency in the 1940s (Davenport-Hines, 2001)
and has also been used to facilitate psychotherapy (ONDCP, 2002a). In fact, in the
1950s and 1960s, treatment with hallucinogenic drugs such as ecstasy was seen to
be the cutting edge of psychotherapy (Ehrman, 2003).

As the use of ecstasy allegedly increased in the United States in the late 1990s and
early 2000s, especially at dance parties (“raves”) and similar events, government
officials deemed it necessary to inform the public of the dangers associated with the
substance. During this period, thousands of articles on the topic of ecstasy appeared
in popular magazines, newspapers, and on the Internet. A police officer in Richmond,
Virginia, told a reporter, “it appears that the ecstasy problem will eclipse the crack
cocaine problem we experienced in the 1980s” (as quoted in Cloud, 2000). An edi-
torial written by former drug czar William Bennett claimed, “while the crack
cocaine epidemic of the 1990s has passed, methamphetamine and ecstasy are grow-
ing in popularity, especially among the young” (Bennett, 2001). Although Bennett
did not provide statistics to support his assertion of an increase in ecstasy use, a
survey conducted under the auspices of the Partnership for a Drug Free America
found that the percentage of teenagers reporting use of ecstasy had doubled between
1995 and 2000, from 5% to 10% (PFDA, 2000).

In order to provide evidence of an “alarming explosion” (Rashbaum, 2000) in
ecstasy use, media sources relied on statistics on seizures of ecstasy tablets, reports of
law enforcement officials, and emergency room admission (DAWN) data. The commis-
sioner of the U.S. Customs Service claimed that seizures of ecstasy by his agency had
increased from 350,000 in 1997 to 3.5 million in 1999, then to 2.9 million in just the
first 2 months of 2000. He also predicted that ecstasy seizures would increase to seven
or eight million by the end of 2000 (Wedge, 2000). Hays (2000) indicated that “sei-
zures of the tablets . . . have multiplied like rabbits.” Gullo (2001) noted, “ecstasy, a
drug once used primarily at night clubs, has expanded beyond the club scene and is
being sold at high schools, on the street, and even at coffee shops in some cities.” The source of the claims that ecstasy was being used in contexts in which it had not previously been used was an informal survey of officials in 20 cities in the United States.

A similar pattern of constructing an ecstasy epidemic through reference to seizures of the substance occurred in Canada. In May 2000, several Canadian newspapers announced that the largest seizure of ecstasy in the country’s history had occurred at the Toronto airport. Police reported that they had seized 170,000 ecstasy tablets, valued at $5 million. However, it turned out that the police had made a mathematical error in their calculations, weighing the quantity of pills per pound instead of per kilogram. Thus, the actual seizure was 61,000 tablets, valued at $1.8 million. A spokesperson for the Royal Canadian Mounted Police noted, “It’s one of those unfortunate situations. It was an error that we made and we’re only human. So I apologize for that.” (as quoted in Alphonso, 2000)

An additional indicator of the alleged increase in ecstasy use was derived from Federal Drug Abuse Warning (DAWN) data: Mentions of the drug as a factor in hospital emergency room admissions increased from 68 in 1993 to 637 in 1997 (Rashbaum, 2000). However, as we discussed with respect to mentions of marijuana in DAWN data, it is likely the case that the majority of ecstasy users consumed ecstasy along with other drugs, as opposed to ecstasy alone.

Although the popular press and government officials emphasized that ecstasy was a dangerous substance because of claims that it was the cause of several deaths, the causal relationship between ecstasy consumption and death has not been well established. For example, in New York, a study of 20 deaths that had been attributed to ecstasy found that only three were caused by ecstasy alone (Gill et al., 2002). This phenomenon also occurred in Britain, where it was found that 19 of 27 individuals whose death had originally been attributed to ecstasy had other drugs in their system (Boseley, 2002), and Canada, where an inquest into 13 deaths said to be caused by the drug revealed that seven of the individuals has also used heroin, cocaine, and/or methadone (Prittie, 2000).

Consistent with the theme of demonizing drugs by attributing their distribution to foreigners, several media and government sources indicated that the main traffickers in ecstasy were Israelis. One report on ecstasy asserted that “Hasidic Jews” were couriers and that “Israeli organized crime dominates the global trade [in ecstasy]” (Cloud, 2000). This connection was confirmed in another article: “For the most part, Israeli-organized crime syndicates have been implicated as the main source of distribution of the drug in the United States” (Hernandez, 2000). Further, Leinwand and Fields (2000) noted, “The international crime agency Interpol, the U.S. Customs Service, and the Drug Enforcement Administration have tracked Israeli crime groups and Russian mobsters trading in ecstasy.” Even the “official” federal government source of information on ecstasy, an ONDCP (2002a) Fact Sheet, noted “the majority of MDMA comes from Europe and is thought to be trafficked by Israeli organized crime syndicates.”
One of the most prominent themes in government and popular media sources on the topic of ecstasy was assertions that use of the substance causes brain damage. As we have discussed already, and as will be discussed in more detail later in this book, there have been numerous instances of “scientific” studies on the effects of drugs that present misleading and, in some cases, fraudulent information that is then used to justify stringent drug policies. A particularly disturbing example of this phenomenon is seen in research on the effects of ecstasy by George Ricaurte and his colleagues at Johns Hopkins University. One of Ricaurte’s studies, sponsored by the National Institute of Drug Abuse and published in the prestigious journal *Science*, claimed that ecstasy could cause permanent brain damage in human users of the substance: “Even one night’s indulgence [in ecstasy] may increase the odds of contracting Parkinson’s disease” (Ricaurte et al., 2002).

In this study, Ricaurte and his colleagues administered three consecutive doses of what they claimed to be ecstasy to monkeys at 3-hour intervals. When these monkeys were tested after 6 weeks, their dopamine levels had decreased by approximately 65%. Ricaurte and colleagues (2002) concluded,

> These findings suggest that humans who use repeated doses of MDMA over several hours are at risk of incurring severe dopaminergic neural injury. . . . This injury, together with a decline in dopaminergic function known to occur with age, may put these individuals at increased risk for developing Parkinsonism and other neuropsychiatric diseases involving brain dopaminergic/serotonin deficiency, either as young adults or later in life. (p. 2263)

The Ricaurte and colleagues (2002) study was widely reported in the popular media and led to calls for tougher laws to deal with ecstasy. Dr. Alan Leshner, former director of the Drug Abuse Institute, claimed that using the substance “is like playing Russian roulette with your brain” (as quoted in Ehrman, 2003). Perhaps coincidentally, the Ricaurte and colleagues study was published around the same time that Congress was considering a bill designed to control ecstasy (the RAVE Act; see Chapter 11).

However, it turned out that rather than administering MDMA to the monkeys in his lab, Ricaurte and his colleagues, apparently unbeknownst to them, had been administering methamphetamine. The mistake was blamed on a labeling problem; apparently the labels attached to drug containers supplied to Ricaurte’s lab were incorrect. Ricaurte claims he realized his mistake when he could not replicate his own results by administering MDMA to the monkeys orally (McNeil, 2003). Ricaurte further asserted that his laboratory had made a “simple human error. We’re scientists, not politicians.” When asked why the vials of drugs were not checked by those conducting the research, he responded, “We’re not chemists. We’ve got hundreds of chemicals here. It’s not customary to check them” (as quoted in McNeil, 2003). This response seems rather bizarre when we consider that Ricaurte’s research laboratory’s primary activity is to examine the effects of chemical substance on animals (see box).
Once this mistake was revealed, a retraction of the article was published in Science (Ricaurte et al., 2003). However, in issuing this retraction, Ricaurte and his colleagues added, “The apparent labeling error does not call into question multiple previous studies demonstrating the serotonin neurotoxic potential of MDMA in various animal species” (p. 1479). Although Ricaurte and colleagues thus claimed that the wrong chemical (methamphetamine instead of MDMA) had been used only in the study published in Science, of the other journals that published research on the effects of ecstasy written by Ricaurte and his colleagues, including the European Journal of Pharmacology, the Journal of Pharmacology, and Experimental Therapeutics, the only other article retracted was the one appearing in the Journal of Pharmacology. However, Ricaurte was only able to account for 2.25 grams of the 10 grams of methamphetamine that were in the original container that had been labeled as MDMA, suggesting the possibility that other published studies by his research team should also be retracted (Doblin, 2003).

While Ricaurte and his colleagues should be commended for issuing the retraction of the Science article, it is important to keep in mind that their findings of a relationship between ecstasy use and brain damage had already been widely cited in print and other forms of media as evidence of the dangers of ecstasy. It is also possible that scientists and/or journalists conducting research on the effects of ecstasy will continue to cite this study.

Even before the revelations that Ricaurte and his research team had been administering methamphetamine rather than MDMA to the monkeys, other researchers had criticized the study. One commentator noted, “The multiple-dose regimen of injected MDMA administered by Dr. Ricaurte does not simulate human exposure, does not cause cell death, and does not predict anything as a result of MDMA” (as quoted in Drug Policy Alliance, 2002d). Similarly, Colin Blakemore, chair of the British Association for the Advancement of Science, and Leslie Iversen, a British pharmacologist, had communicated with the editor of Science and suggested that Ricaurte’s article should not have been published due to several methodological problems. Interestingly, the very title of Ricaurte’s (2002) article published in Science was misleading, in that it used the phrase common recreational dose regimen. As Blakemore and Iversen pointed out, Ricaurte had administered the drug to monkeys subcutaneously, which would deliver a much higher dose to the brain than the normal amount of ecstasy consumed by humans (Walgate, 2003). An additional issue was the extreme effect on the dopamine system reported by Ricaurte; such effects had not been previously associated with MDMA but were known to occur with methamphetamine (Walgate, 2003). In fact,
well before Ricaurte discovered the mistake, Iversen had suggested that the reported results appeared to be more characteristic of amphetamine than of MDMA (“Retracted Ecstasy Paper,” 2003). This possibility had also been raised in another *Science* article published some 9 months after the Ricaurte and colleagues (2002) publication. Mithofer, Jerome, and Doblin (2003) had noted, “the dopamine changes produced by MDMA [in the Ricaurte et al. study] have long been known as potential effects of d-amphetamine and d-methamphetamine” (p. 1504).

In addition to the alarmist media reports emanating from the findings of the Ricaurte et al. (2002) study, the claim that ecstasy causes brain damage was reinforced through disturbing images showing holes in the brain of an alleged MDMA user—these images were shown on a MTV special documentary about the substance, as well as on the popular *Oprah Winfrey* show. However, these brain images had in fact been graphically manipulated to represent areas of lower brain blood flow as holes and were completely fraudulent. (Doblin, 2003)

Ricaurte’s laboratory has received millions of dollars in funding from the National Institute on Drug Abuse and has produced several studies concluding that ecstasy is a dangerous substance (McNeil, 2003). His earlier studies were cited as evidence of the dangers of ecstasy in the previously mentioned ONDCP (2002a) Fact Sheet on MDMA, which noted, “A recent study sponsored by the National Institute on Drug Abuse showed that monkeys that were given doses of MDMA for four days suffered damage to the brain six or seven years later.” Although, as we will discuss in Chapter 7, federal government agencies that provide financial support for drug research have discontinued the funding of researchers who produce results that do not support the continuation of the drug war, apparently this does not apply to researchers who produce findings such as those of Ricaurte. Despite the documented problems associated with Ricaurte’s research, to the best of our knowledge, the National Institute on Drug Abuse has not discontinued funding his research. As the British pharmacologist Iversen suggested,

> It’s another example of a certain breed of scientist who appear to do research on illegal drugs mainly to show what the government wants them to show. They extract large amounts of money from the government to do this sort of biased work. (“Retracted Ecstasy Paper,” 2003)

The above discussion is not intended to suggest that there are no harms associated with the use of ecstasy. As will be discussed in Chapter 3, ecstasy exerts its effects by stimulating the brain to produce serotonin. Given that the brain can only produce a finite amount of serotonin over a lifetime, long-term heavy use of ecstasy could lead to the depletion of the brain’s serotonin supply, possibly resulting in a higher risk for depression among long-term users (Richburg, 2001). But the most
serious short-term risks associated with ecstasy are related to the fact that many pills are adulterated with other chemicals (Stafford, 2012), several of which are more dangerous to users than pure ecstasy. A study of the composition of seized ecstasy pills conducted by the Royal Canadian Mounted Police found that many contained methamphetamine, MDA, ketamine, and PCP (Leinwand, 2002). Other adulterants included caffeine, cocaine, and a number of over-the-counter drugs. One of the most dangerous adulterants is dexotromethorphan (DXM), a cough suppressant that can produce hallucinations if it is taken in concentrated form (McColl, 2001). And because DXM also inhibits sweating, it can easily cause heatstroke (Cloud, 2000). The problems resulting from unknown and often dangerous adulterants in ecstasy could be alleviated under a system of government regulation of the substance, although we are not necessarily advocating regulation here. But it is also important to note that recent studies indicate that MDMA does not impair cognitive functioning (Halpern et al., 2011), and the Multi-disciplinary Association for Psychedelic Studies has administered the drug to at least 500 people in various clinical trials, with no reports of any adverse events associated with its use (Stafford, 2012).

METHAMPHETAMINE

After the crack cocaine “epidemic” subsided, arguably the most prominent candidate for the “drug of the 1990s” was methamphetamine. Brecher’s (1972) comments in the context of declining rates of methamphetamine use in the late 1960s and early 1970s seem especially prescient in the context of recent developments with respect to the substance:

> If these trends continue, the speed freak may in the not too distant future be merely a historical oddity. Unless, of course, a new wave of anti-speed propaganda campaigns serve to encourage a shift from less dangerous to more dangerous drugs. (p. 3)

Once again, it is important to emphasize that in our discussion of methamphetamine, we are by no means trying to minimize its often devastating effects. Our purpose, instead, is to critically examine the extant information on this drug and to focus on how, as has been the case with other illegal drugs, official government, criminal justice system, and media sources have grossly exaggerated the extent of the methamphetamine problem.

Numerous government, media, and Internet sources in the late 1990s claimed that methamphetamine use in the United States constituted an “epidemic” (a Google Internet search using the words methamphetamine epidemic on December 29, 2005, resulted in more than 246,000 hits). President Clinton referred to methamphetamine as “the crack of the 90s,” and in February 1998, drug czar Barry McCaffrey asserted, “Methamphetamine has exploded from a west coast biker drug into America’s heartland and could replace cocaine as the nation’s primary drug threat” (as quoted in Pennell et al., 1999).
McCaffrey also referred to methamphetamine as “the worst drug that has ever hit America” (as quoted in Nieves, 2001). Some years later, representative Tom Osborne of Nebraska called methamphetamine “the biggest threat to the United States, maybe even including Al Qaida” (as quoted in “My Mistress Methamphetamine,” 2005). In a 1996 publication, the National Institute of Justice asserted that statistics from the Drug Use Forecasting (DUF) program (a program that administers drug tests to jail inmates; see Chapter 5) “may signal an impending methamphetamine pandemic.” The publication noted that approximately 6% of all adult and juvenile arrestees at DUF sites tested positive for methamphetamine in 1996. And while it is certainly true that rates of methamphetamine-positive drug tests for arrestees were significantly higher in cities such as San Diego and Phoenix, the DUF system was developed to examine drug use trends among arrestees and variations in these trends across cities; it was not designed to be a measure of drug use in the general population. We should thus treat these statistics alleging an emerging methamphetamine “pandemic” with skepticism.

In addition to government claims of a methamphetamine “epidemic,” a number of popular media sources made similar assertions. Thus a 1996 article in the Spokane, Washington, Spokesman-Review with the headline “Meth Turning Kids Into Monsters” claimed that methamphetamine was “exploding through the Inland Northwest and the nation.” An official from the city of Spokane claimed that half of the young people booked into the juvenile detention center in the city had used the drug (Sitamariah, 1996). Methamphetamine was also said to have “ravaged the state [of Missouri] for more than a decade, ensnaring young and old, businessmen, housewives, and entire families” (Pierre, 2003). A detective in Franklin County, Missouri, argued, “It used to be big news to find a meth cook. Now everybody is cooking meth” (as quoted in Pierre, 2003; italics added). An official from the Bureau of Alcohol, Tobacco, and Firearms stated “[meth] has literally spread like dermatitis. . . . It’s like trying to fight a water balloon. You fight it and it goes somewhere else” (as quoted in Pierre, 2003).

A 2005 Newsweek article (“America’s Most Dangerous Drug”) made questionable use of the U.S. National Household Survey on Drug Use and Health statistics to bolster claims of a methamphetamine epidemic. The article claimed that in 2004, there were 1.5 million “regular users” (equivalent to approximately 0.6% of the population aged 12 and older) of meth in the United States (Jefferson, 2005); however, it is important to note that this figure was based on survey respondents who reported that they had used methamphetamine at least once in the previous year. Gillespie (2005) questions whether use of methamphetamine in the past year is equivalent to “regular use”; “Are you a regular user of liquor if you’ve had one drink in the past year?”
The same 2005 *Newsweek* article also included data from a July 2005 telephone survey of 500 law enforcement agencies conducted by the National Association of Counties; 58% of those responding to the survey said methamphetamine was their “biggest drug problem.” However, as Gillespie (2005) notes, the law enforcement officials’ responses to the survey may have been influenced by the preface to the survey, which stated, “As you may know, methamphetamine use has risen dramatically in counties across the nation.” In addition, there are questions surrounding the methodology of the National Association of Counties’ survey because it provided no information regarding response rates or how representative the sample of 500 counties was of all counties in the United States (Gillespie, 2005; see also Shafer, 2006).

Newspaper reports documenting the methamphetamine phenomenon often made rather questionable statistical comparisons in order to underline the extent of the alleged problem. An article in the *Spokesman-Review* noted that the number of methamphetamine addicts in Spokane County treated in publicly funded clinics rose “nearly 2,200 percent” between 1993 and 1999 (Martin, Rourke, & Gaddy, 2002). While this may appear to be an alarming increase, it is perhaps less so when we realize that in terms of actual numbers, there was an increase from 22 individuals being treated for methamphetamine in 1993 to 503 in 2000 (the population of Spokane County in the year 2000 was 417,939). A related media strategy is to report on large percentage increases in methamphetamine cases and/or methamphetamine-related crime without providing the raw figures on which the percentage increases were calculated. For example, an article on the topic of methamphetamine in *Newsweek* magazine noted, “In North Dakota, where meth cases have quadrupled since 1994, a Northeastern University study estimates that the teen murder rate jumped by 320 percent. Across the river, in Clay County, Minnesota, crime is up 500 percent over five years” (Bai, 1997). However, the actual numbers of murders and crimes were not provided in this article. A *USA Today* article reported that there was a “144 percent rise in meth-related deaths from 1992–1994—deaths were up 222 percent in Los Angeles and 510 percent in Phoenix” (Davis, 1995). Again, no raw data were provided.

There have also been allegations that in comparison to other substances, methamphetamine has properties that make users more susceptible to addiction. Several sources emphasized that the “high” from methamphetamine lasts longer than the psychoactive effects of other drugs, although the actual length of time the high is alleged to last varies widely depending on which source is consulted. Thus Durbin (2003a) asserts that a methamphetamine high can last 14 hours or more; Brandon (2001) suggest that it lasts 12 hours, while a National Institute of Justice Report claimed that “the high can last up to 24 hours” (Pennell et al., 1999). Apparently, these longer highs are partial contributors to meth users being more susceptible to addiction. A sheriff’s lieutenant in Spokane, Washington, claimed that “nearly 95% of all meth users are addicted to the drug six months after using it” (as quoted in Blocker, 2001a), and an *Associated Press* article asserted, “smoking it provides a high so intense and long-lasting that addiction can be instant, withdrawal is excruciating, and brain damage is often permanent” (“Meth Threatens Hawaii’s,” 2003).
Another article suggested “just one hit, and meth can take over a life” and that “even two binges scorch the pleasure center of the brain, causing lifelong depression” (Martin et al., 2002).

The Drug Enforcement Administration’s website (www.justthinktwice.com) included a link to “Meth is Death,” a site sponsored by the Tennessee District Attorneys General Conference, which claimed that “one in seven high school students will try meth”; “99 percent of first-time users are hooked after the first try”; “only five percent of meth addicts are able to kick it and stay away”; and “the life expectancy of a habitual meth user is only five years.” Sullum (2005) encourages a critical consideration of these statistics:

Do the math . . . and you will see that 13.4% of Americans die as a result of methamphetamine abuse within five years of graduating from high school. According to the U.S. Census Bureau, there are more than 20 million 15- to 19-year olds in the U.S., so we are talking about hundreds of thousands of deaths a year, and that’s not even counting people who start using meth after high school.

Clearly, there have been nowhere close to this number of deaths caused by methamphetamine, which underlines the absurdity of the “information” contained on the Tennessee District Attorneys General website.

Linked to the idea that methamphetamine is more addicting than other psychoactive substances is the assertion that users of the substance are less amenable to treatment. However, scientific research suggests that methamphetamine addicts are not necessarily more difficult to treat. A study conducted by the California Department of Alcohol and Drug Programs reported that treatment of individuals addicted to the major stimulant drugs, including methamphetamine, was just as effective as treatment for alcohol problems and somewhat more effective than treatment for individuals who had heroin as their primary drug of addiction (cited in Pennell et al., 1999). Similarly, a study in Washington State found that methamphetamine addicts were just as amenable to treatment as individuals addicted to alcohol or other drugs, and that methamphetamine addicts who completed treatment had a reduced likelihood of involvement in criminal activity (Washington State Department of Social and Health Services, 2003). More generally, outcome measures of treatment programs in 15 states indicate that methamphetamine users are amenable to treatment (King, 2006).

Media sources discussing methamphetamine also claimed that the substance was related to increases in the commission of property and other crimes. An attorney in Butler County, Missouri, claimed that criminal cases accounted for 75% of his practice, and that 75% of those cases were meth related. The same attorney also claimed that one in four of the divorce cases he handled involved situations in which the husband or wife used methamphetamine (Pierre, 2003). Similarly, a prosecutor in Spokane, Washington, claimed that “most property crimes are committed by people addicted to meth” (as quoted in Blocker, 2001b). Going even further, a detective in the Spokane County Sheriff’s office asserted, “in all the stolen property cases, meth has been at the
center” (as quoted in Martin et al., 2002; italics added). In Oregon, the Governor’s Public Safety Advisor asserted that methamphetamine was the “driving force in 80 to 90 percent of the property crimes committed” (as quoted in Esteve, 2003).

Even "environmental crime" has been attributed to methamphetamine addicts. For example, in the Olympic National Forest in Washington State, it was alleged that methamphetamine addicts were funding their daily drug habits by chopping down trees and selling the wood. (“Addicts Blamed,” 2001)

An analysis of the Portland Oregonian’s coverage of methamphetamine noted that the newspaper had published at least 261 stories on methamphetamine over the one-and-a-half-year period ending in March 2006, and that the statistic that the drug “fuels” 85% of the property crime in Oregon had appeared in at least 14 articles between 2002 and 2006, without any attribution (Valdez, 2006). However, as Scott Moore (2006) pointed out, if methamphetamine was responsible for 85% of the crimes, one would expect that the property crime rate in Oregon in the early 2000s would be close to double the rates in the “pre-epidemic” years. However, in 1990, the property crime rate in Oregon was 521 per 10,000 population; it decreased to 478 per 10,000 population in 2003. Further evidence that estimates of the relationship between methamphetamine use and involvement in crime are inflated is provided by data from the Arrestee Drug Abuse Monitoring (ADAM) Program (see Chapter 5). In 2003, 25.4% of arrestees subject to drug tests in Portland, Oregon, tested positive for methamphetamine use (ADAM, 2003). While this is by no means an insignificant figure, it is a far cry from the 85% figure cited by law enforcement and government officials. In short, while scientific research generally confirms that users of some illicit drugs are more likely to be involved in property crimes than those who do not use drugs, we need to ask if methamphetamine (or any other illegal drug, for that matter) were eliminated, would all property crime also be eliminated?

As discussed above with respect to other drugs, a useful rhetorical device used to demonize a substance is to report anecdotal cases of bizarre acts committed by individuals allegedly under its influence. Several media sources recounted the story of a man (Eric Smith) in New Mexico who was high on methamphetamine and beheaded his 14-year-old son and “tossed the head from his van window onto a busy highway” (D. Johnson, 1996). This particular incident was also recounted in a USA Today article, which added, “Smith’s grisly act last July was just another bizarre outburst blamed on methamphetamine, a powerful stimulant known on the street as ‘crank’ or ‘ice’ that’s fast becoming the top choice of Americans buzzing in life’s fast lane” (Davis, 1995). Quoting UCLA pharmacologist Ron Siegel, the article further noted, “[the Smith case] is pretty mild compared to the kind of case we’re seeing in California. . . . We’re seeing everything from serial killing to necrophilia.” This article also noted that abusers of methamphetamine included Adolf Hitler and recounted another incident to emphasize the dangers associated with the substance:
A California woman, who fueled her long days cleaning houses with meth, sat down to watch the *Ten Commandments* [movie] with her kids after work. By the end of the movie, she’d killed her first born child in a ritual way that was a copycat of the movie. (Davis, 1995)

In Oregon, it was reported that

Jeffrey Cooper was high on meth when he helped kidnap Elizabeth Gumm at an ATM machine and then watched as his friends beat her and threw her down a hill to die. How did he go so wrong? The answer is methamphetamine, a highly addictive powder with a jolt more powerful and longer-lasting than cocaine. (N. McCarthy, 1995)

This article also quoted a drug treatment center caseworker, who said,

I guess the thing that alarms me about this drug is that it literally turns people into animals. They don’t eat, they don’t bathe. They don’t take care of their children. The live in filth, and they just become subhuman. (N. McCarthy, 1995)

In Fargo, North Dakota, a “meth addict who burned his house down while hallucinating, killing his own mother, pleaded guilty to manslaughter” (Bai, 1997). A report on methamphetamine use in Washington State even went so far as to attribute animal abuse to the effects of the drug, noting “there were tweakers [methamphetamine users] who clubbed to death 17 newborn calves” (Solotaroff, 2003). Apparently, the connection between methamphetamine use and killing animals is not a uniquely American phenomenon. When a 37-year-old businessman in Sydney, Australia, killed 17 rabbits and a guinea pig in 2005, he claimed to be in a “drug-induced psychosis caused by ice.” A forensic scientist’s report on this individual noted that meth use caused him to have hallucinations and to “communicate” with rabbits (C. Munro, 2006). While we are not denying that the incidents described above occurred, does it make sense to attribute them to methamphetamine alone, or could other factors be involved?

Accounts of bizarre acts engaged in by individuals allegedly under the influence of methamphetamine have not been restricted to the popular media. A 1999 National Institute of Justice report on methamphetamine recounted the case of “[an individual] in San Diego who commandeered an army tank and wreaked havoc on people before being shot down by the police. . . . The individual was an acknowledged meth user.” The same report noted, “In Riverside, California, a 40-year-old mother killed her children, ages one, two, and three, when she was using her kitchen to cook meth, and an explosion occurred” (Pennell et al., 1999).

In the previous example, we also see another consistent theme in drug demonization: an emphasis on how drugs threaten children. In an example of this theme, Swetlow (2003) noted,

Hazardous living conditions and filth are common in meth lab homes. Loaded guns and other weapons are usually present and often found in easy-to-reach
locations. Living and play areas may be infested with rodents and insects, including cockroaches, fleas, ticks, and lice. Ashtrays and drug paraphernalia are often scattered within a child’s reach, sometimes even in cribs.

Swetlow (2003) further commented,

Dangerous animals trained to protect illegal meth labs pose added physical hazards, and their feces contribute to filth in areas where children play, sleep, and eat. Many children who live in meth homes are also exposed to pornographic materials or overt sexual activity.

While all of these assertions may, in fact, be true, is it logical to imply that the drug is the cause of the children’s exposure to danger in general, and pornography and sexual activity in particular?

In 2005, two additional issues surrounding the alleged negative consequences of methamphetamine use surfaced: “meth-mouth” and “meth-addicted babies.” Pictures of methamphetamine users “whose gums are pus-streaked and whose rotting teeth . . . are blackened and broken” (Shafer, 2005) appeared in several popular media articles in 2005. These articles implied that methamphetamine was the sole cause of tooth decay and loss and gum disease. However, as Shafer (2005) notes, it is by no means clear that methamphetamine is the only cause of these conditions. Methamphetamine users suffer from dry mouth, which is associated with tooth decay and gum disease, and many users try to refresh their dry mouths with soda that contains sugar, which further contributes to tooth decay. Perhaps even more importantly, many methamphetamine users neglect proper dental care, including brushing, flossing, and visiting dentists on a regular basis.

Hungry children sat quietly in a darkened room, terrified of their abusive father. In the kitchen, maggots and rotting food filled the fridge. With the electricity out, cooking was done on a propane stove. The furniture was repossessed. The welfare check was already spent. The family was being evicted. None of this mattered to Wayne and Dina Tamura. As long as the couple from the tiny town of Kau was high on crystal methamphetamine, they were happy. (“Meth Threatens Hawaii’s,” 2003)

Several popular media articles on the topic of “meth babies” also appeared in 2004 and 2005. Similar to the portrayal of crack babies (see Chapter 11), these articles alleged that there were numerous negative outcomes for children whose mothers used methamphetamine while pregnant. For example, an article in the Minneapolis Star Tribune stated “[meth] babies can be born with missing and misplaced body parts. [She] heard of a meth baby born with an arm growing out of the neck and another who was missing a femur” (McCann, 2004). A commentary signed by several prominent medical and psychological researchers in response to these portrayals noted that there was no scientific evidence for the alleged connection between mothers’ methamphetamine use and negative outcomes in their children.
We are deeply disappointed that American and international media as well as some policy makers continue to use stigmatizing terms and unfounded assumptions that not only lack any scientific basis but also endanger and disenfranchise the children to whom these labels are applied. Similarly, we are concerned that policies based on false assumptions will result in punitive civil and child welfare interventions that are harmful to women, children, and their families. (D. Lewis, 2005)

A deputy sheriff in Scott County, Tennessee, attributed an increase in methamphetamine lab arrests in his county to prayers by residents. "We have seen a 600% increase in drug arrests, specifically with meth, since we have had the prayer vigil. . . . We have used every tool that we could to slow down the drug problem that we have here and prayers have been the answer." (as quoted in Lake, 2011)

Finally, as has been demonstrated with the other illegal drugs discussed in this chapter, methamphetamine has been demonized through assertions that in recent years, trafficking in the substance is primarily engaged in by members of minority groups. Prior to the late 1990s, most reports indicated that biker gangs (who also constitute a pariah group) were the main traffickers in methamphetamine. However, in the late 1990s and early 2000s, several articles on the substance asserted that Mexican organized crime groups were becoming involved in the methamphetamine trade (Nieves, 2001). Thus Swetlow (2003) referred to the “expansion of Mexico-based traffickers,” and a report on the arrests of nine individuals for methamphetamine trafficking in the central region of Washington State noted, “most of the accused smugglers were illegal aliens” (Morlin, 2003). Similarly, a newspaper report on the situation in Oregon examined the surnames of those appearing in federal court on what were described as “major methamphetamine cases” in order to demonstrate a Hispanic connection. Despite the obvious problems with respect to the reliability of measuring ethnicity in this manner, the report noted, “in 1990, of the 34 persons charged with methamphetamine cases in federal court, none had a Hispanic surname. In the first 7 months of 1995, 56%—41 out of 73—have Hispanic surnames” (Ortiz, 1995). Illicit imports of pseudoephedrine, a main precursor substance used in the manufacture of methamphetamine, have also been attributed to foreigners. Thus, one article attributed these imports to a “loose network of people of Middle Eastern origin” who may have had ties to “terrorist groups in the Asian world” (Eisler & Leinwand, 2002).

In an opinion/editorial published in the Los Angeles Times, Kleiman and Satel (1996) make the important point that “in the case of methamphetamine, there is no need for the exaggeration that has created a credibility problem for other drug campaigns.” It is certainly important that we not underestimate the very real problems substance abuse in general, and the use of methamphetamine in particular, cause in society. At the same time, our ability to effectively deal with these problems is not helped through overstatement and misrepresentation of facts.
DRUG “EPIDEMICS” OF THE 2000s AND 2010s

Not surprisingly, several socially constructed drug “epidemics” have emerged in recent years. Although we focus on salvia divinorum, K2/Spice, bath salts, and prescription drugs below, several other drug scares, focusing on a variety of consciousness-altering substances, have emerged. For example, in the spring of 2012, it was reported that the California Poison Control Center had received 60 reports of teenagers drinking hand sanitizer, and public health officials said the cases could “signal a dangerous trend” (Knox, 2012). Also in 2010, it was reported that in the first 3 months of 2012, Poison Control Centers in the United States had received 139 calls seeking help and information about the “intentional misuse of cinnamon” (Healy, 2012). In 2010, newspapers and television broadcasters reported that youth were consuming nutmeg to achieve highs, that the substance was (obviously) cheap and readily available, and “hence the end of the world has come” (Shafer, 2010; see also Curtis, 2012). There were also reports of teenagers inhaling air from mothball bags in order to achieve a high (“Teenagers ‘Bagging,’” 2009). In Britain and Australia, there were allegations of a “mephedrone” (also known as “meow meow,” an ecstasy-like drug and an analogue of methcathinone, related to bath salts in the United States—see below) epidemic (Laurance, 2010a; Travis & Weaver, 2010). Similar to what has happened with several other drugs, this drug was further demonized after allegations that it caused the death of two British teenagers. After toxicology tests revealed that the youths did not take the drug, David Nutt, former chair of the British Advisory Council on the Misuse of Drugs (see also Chapter 12), commented, “This news demonstrates why it is so important to base drug classification on the evidence, not fear, and why the police, media, and politicians should only make public pronouncements once the facts are clear” (as quoted in Laurance, 2010).

SALVIA DIVINORUM

Another emerging drug in the 2000s was salvia divinorum (known on the streets as “Sally D” and “Magic Mint”), which is regarded as the world’s most potent hallucinogenic herb (Sack & McDonald, 2008)—among the “prominent” alleged users of this substance were Miley Cyrus (Hall, 2011). The federal government estimated that approximately 1.8 million people had tried salvia in their lifetime, and similar to what we have seen with other drugs, stories of atrocious acts committed by those allegedly under the influence of this substance proliferated in the media. For example, it was reported that a 42-year-old restaurant manager in Yonkers, New York, shot himself in the face 10 minutes after smoking salvia. Another 17-year-old boy committed suicide in Delaware at a time when he was apparently smoking the drug several times a week (Sack & McDonald, 2008). It was also alleged that Jared Loughner, who killed six people and injured 14 others (including U.S. Representative Gabrielle Giffords) in Tucson, Arizona, in January of 2011, was under the influence of salvia when he committed these acts. A New York Times article noted,
No one has suggested that the use of a hallucinogenic herb or any other drugs contributed to Jared Lee Loughner’s apparent mental unraveling. . . . Yet it is striking how closely the typical effects of smoking the herb, salvia divinorum . . . matched Loughner’s comments about how he saw the world, his oft-repeated assertion that he spent most of his waking hours in a dream world that he had learned to control. (Sulzberger & Medina, 2011)

**SPICE/K2**

Spice/K2 (synthetic cannabis) also emerged in the 2000s and was similarly connected to the commission of deviant and/or bizarre acts by its users. This drug, whose active ingredients are synthetic cannabinoids, was developed by Clemson University chemist John Hoffman (Gay, 2010) and, up until 2011, could be purchased in head shops in several jurisdictions in the United States. Similar to the construction of other drug epidemics, one strategy is to present data on adverse events connected to the use of a substance. Thus it was noted that in 2009, Poison Control Centers in the United States had 13 reports of K2/Spice poisonings, but in the first 6 months of 2010, there were 766 such reports (Havrelly, 2010). K2 was also demonized through reports of the commission of deviant acts by users of the substance: For example, 18-year-old “athlete and band standout” David Rozga “got high on fake pot” and “though he had never suffered from depression . . . went home, found a shotgun, and killed himself” (Salter & Suhr, 2011). Detective Sergeant Brian Sher of the Indianola police department, who led the investigation into Rozga’s death, commented, “I’ve seen it all. I don’t know what else to attribute it [Rozga’s suicide] to. It has to be K2” (as quoted in Gay, 2010). Similarly, “Charlie Davel, 19, was killed after he fled police and went the wrong way on a highway in Mukwonago, Wisconsin. Friends told authorities he had smoked K2 several hours before the crash” (Blum, 2011). In Seattle, it was reported that an individual who crashed his vehicle into several pedestrians had been smoking K2 before driving (Sullivan, 2010). This substance was also apparently being widely used by individuals in the Armed Forces (at least partially because it cannot be detected in routine drug tests), with 113 members of the Navy and 260 Air Force personnel being disciplined for use or possession of the substance in 2011 (deVise, 2011). K2 is also apparently popular with individuals who must submit to drug tests, such as firefighters, police officers, and individuals on probation (Zagier, 2010), again, because it cannot be detected in routine drug tests.

Of course, as anecdotal accounts of the use of Spice proliferated, it was alleged that this drug too was a candidate for epidemic status. Ward Franz, the state representative who sponsored legislation in Missouri to ban Spice, stated, “it’s like a tidal wave. It’s almost an epidemic. We’re seeing middle school kids walking into stores and buying it” (as quoted in Gay, 2010). In 2010, bans on Spice were implemented by legislators or public health officials in Alabama, Arkansas, Georgia, Hawaii, Iowa, Illinois, Kansas, Kentucky, Louisiana, Mississippi, Missouri, North Dakota, and Tennessee (Leinwand, 2010; Zagier, 2010). Several other states followed suit, and in 2012, the Drug Enforcement Administration placed K2/Spice under a Schedule I classification (Cohen et al., 2012). However, in the proverbial game of the dog chasing its tail, such
bans have little effect, as manufacturers of psychoactive substances circumvent the bans by making slight changes to the chemical formula. Dr. Nora Volkow, director of the National Institute on Drug Abuse, commented, “the moment you start to regulate one of them, they’ll come out with a variant that is even more potent” (as quoted in “Bath Salts Ban,” 2012). Similarly, an owner of a shop who sold K2 commented, “You can’t prohibit something that hasn’t been invented yet” (as quoted in Zagier, 2010). Interestingly, some have argued that laws criminalizing cannabis have been partially responsible for driving people to the use of Spice/K2 (Savage, 2010).

**BATH SALTS**

Perhaps the most prominent emerging drug “epidemic” of the 2010s was related to “bath salts.” “These are not the Epsom salts that aunt Ethel used to sprinkle in a warm tub, nor are they soothing, fragrant bottles you pick up at the aromatherapy store” (T. Wilson, 2011). Instead, this is a stimulant drug whose active ingredient is methylenedioxyxypovalerne (mdpv), which, similar to K2/Spice, could be purchased at smoke and head shops and even some convenience stores. Users of this substance (which also goes by the names ivory wave, red dove, vanilla sky, super coke, cloud 9, pevee, ivory snow, ocean magic, white dove, white knight, and white lightning, among others), typically snort it, similar to cocaine, but it can also be injected, smoked, or even eaten. It was reported that during the January to June 2011 period Poison Control Centers in the United States received 3,470 calls about bath salts, compared to 303 such calls in all of 2010 (Goodnough & Zezima, 2011a). An emergency room physician in Virginia, in reference to the “epidemic” surrounding this drug commented, “If cocaine and methamphetamine were tropical storms, bath salts was a hurricane” (as quoted in Fischer, 2012).

Despite widespread coverage of bath salts drugs in the media, apparently there is still some confusion in the general public regarding the nature of these drugs. For example, in Toronto, Ontario, it was reported that a teenage boy attempted to purchase bath salt drugs at a beauty/bath shop. When the proprietor showed him a section of Epsom and dead sea bath salts, the youth indicated that he didn't want these, but instead wanted “the kind that can get you high” (Donkin, 2012). It was also reported that “truckloads” of (actual) products such as bubble bath and shower gel were being intercepted at the border after investigations found boxes that were labeled as bath salts.

As is typical of the characterization of almost all emerging drug “epidemics,” the popular media are fed stories from law enforcement officials regarding the bizarre behaviors of individuals consuming these drugs. For example, Indiana state police claimed that a 42-year-old woman who was high on bath salts trashed a hotel room. Police said when they arrived . . . Tammy Winter was sitting on a bed, rambling about evil spirits and needing to write on the walls of the room to protect her from the spirits. A relative who was present told police that Winter was an abuser of bath salts. (T. Wilson, 2011)
In Kentucky, a young woman driving on a highway after consuming bath salts “became convinced her 2-year-old was a demon. She allegedly stopped the car and dropped the child on his head” (Salter & Suhr, 2011). In Mississippi, “a man who hallucinated after taking bath salts used a hunting knife to slit his face and stomach” (Salter & Suhr, 2011). A sheriff in Mississippi reported, “we had a deputy injured a week ago. They were fighting with a guy who thought they were two devils. That’s what makes this drug so dangerous” (as quoted in Byrd, 2011). In Washington State, the drug was linked to the death of an army sergeant, his 5-year-old son, and the boy’s mother. “[Stewart] raced past a trooper on I-5, refused to pull over, shot his wife, and then shot himself. Bath salts were found on his person, in one of his pockets, inside the interior of his car, and in his house” (Estaban, 2011). One of the most widely recounted cases involving this drug was that of a man in Florida who chewed off the face of another man in May of 2012 in a “zombie-like cannibal attack” (Martinez, 2012) and was initially alleged to have tested positive for bath salts. However, subsequent drug tests revealed that this individual had used marijuana, not bath salts.

Given the anecdotal cases surrounding the use of bath salts recounted above, it is perhaps not surprising that this drug was nominated as the worst drug ever. For example, a spokesperson for the Carolinas Poison Control Center described bath salts as “like being on cocaine, but ten times worse” (as quoted in Salter & Suhr, 2011). Similarly, Mark Ryan, Director of the Louisiana Poison Control Center, commented, “if you take the worst characteristics of LSD, PCP, ecstasy, cocaine, and methamphetamine and put all those together, you’ve got one big, bad thing” (as quoted in Halladay, 2011; see also Goodnough & Zezima, 2011b). And, in further revealing displacement effects, a sheriff from a county in Northern Mississippi noted that the problem with bath salts in his rural area grew after a law restricting sales of pseudoephedrine was passed in Mississippi (Byrd, 2011).

**PRESCRIPTION DRUGS (SYNTHETIC OPIATES)**

Prescription drug abuse has also been labeled an “epidemic” (including by Obama’s drug czar Gil Kerlikowske; Nano, 2011) and, arguably, the supporting data on this problem are more reflective of a serious problem than data on the use of the illegal substances presented above. Nationally, emergency room visits related to prescription drug overdoses doubled over the 2004–2009 period (to 1.2 million), and between 2000 and 2007, overdose deaths from painkillers increased from fewer than 4,000 per year to more than 11,000 (Fagan, 2010); it was also estimated that 80% of Americans between the ages of 12 and 20 had used a controlled drug that was prescribed for someone else at least once (Holmes, 2012). One of the more prominent deaths related to prescription painkillers was that of actor Heath Ledger (Nano, 2011). In reference to the trafficking in oxycodone, the Staten Island New York District Attorney commented, “we are equating this now to the epidemic we saw when crack cocaine was first introduced to New York City” (as quoted in Eligon, 2011). This quest for prescription opiates has led to increases in robberies of vehicles transporting drugs, drugstores and pharmacies (Goodnough, 2010), and also warehouses—in 2010, $75 million in pharmaceutical
products was stolen from an Eli Lilly warehouse in Connecticut (Perrone, 2010), and an estimated 686 pharmacies were held up in 2010 (Colliver, 2011).

Although some reports have made reference to an increase in newborn babies being dependent on painkillers (Goodnough & Zezima, 2011a; Leinwand-Leger, 2011; Patrick et al., 2012; Ungar, 2012), what is conspicuously absent from media reporting on this alleged prescription drug epidemic is accounts of bizarre behaviors committed by individuals under the influence of these substances that we have seen for illegal drugs.

It is also notable that, due to the higher cost of prescription painkillers, a significant proportion of individuals who became addicted to these drugs apparently shifted to heroin. For example, referring to a “tidal wave” of heroin use in Oregon, the state medical examiner noted that in 2011, 143 people had died of heroin overdoses in that state (Tomlinson, 2012).

CONCLUSION

This chapter has addressed how, over the past 100 years, government and criminal justice system officials, with the assistance of media sources, have used a number of tactics to demonize certain drugs and to socially construct drug epidemics. While we have not claimed that drug problems do not exist in the United States, socially constructed epidemics tend to exaggerate and distort the nature and magnitude of drug problems, making appropriate prevention, treatment, and drug control responses more difficult.

Psychoactive drug use is ubiquitous across time and cultures/societies, and this has led some to assert that intoxication is not unnatural or deviant, but, rather, that absolute sobriety is not a natural or primary human state (Davenport-Hines, 2001; Weil, 1986). Drug use remains widespread in society despite the fact that the use of all forms of drugs—legal and illegal—involves some level of risk. As we will discuss in more detail in Chapters 3 and 4, the risks associated with drug use are diverse, but fatalities associated with use are one important measure of harm. Data on drug-related mortality indicate that the number of deaths annually caused by the use of alcohol, tobacco, and prescription drugs is roughly 30 times the number of deaths attributed to all illegal drugs combined (Mokdad et al., 2004). Given the substantial level of harm posed by the use of legal drugs, we find it interesting that psychoactive drugs are typically dichotomized into those that are considered to be “good” and those that are considered to be “bad.” We consider how legal and illegal drugs are similar and different and how certain drugs have been demonized in order to justify their illegal status.

Drug use is not only widespread in society; it fills an important role for a number of constituencies. Government officials and politicians create “heroes” and “villains” that resonate with voters, and drugs provide a common “enemy” that can unite an otherwise divided public. In many cases, the attention directed to drugs acts to divert attention from policies that may have contributed to drug use in the first place. Similarly, criminal justice system officials need psychoactive substances as drug problems because “epidemics” justify increases in financial and other resources devoted to their organizations. Finally, the media emphasize and exaggerate the negative consequences of drug use because moral panics sell newspapers and advertising.
A variety of strategies have been employed to emphasize the dangers of (illegal) drugs over the past century. These include claims that illegal drug use is responsible for the majority of crime that occurs in society and that drugs possess unique powers that encourage otherwise normal people to engage in bizarre and often violent behavior. Illegal drug use has also been demonized through claims that minorities, immigrants, and foreign nationals are the primary users and traffickers of illegal drugs. Through this strategy, both the external cause and internal problems associated with drug use can be attributed to something that is foreign and clearly “un-American” (Musto, 1999). Finally, illegal drugs are demonized by claims that they pose a unique threat to the health of children, often through a misrepresentation of the scientific evidence on the effects of these drugs.

**REVIEW QUESTIONS**

1. In terms of the annual number of deaths in the United States related to drug use, how do legal and illegal drugs compare?

2. How does the United States compare to other Western countries in terms of incarcerations for drug violations?

3. What techniques have been employed to demonize particular drugs? What themes have been emphasized in this demonization?

4. What are the propositions of the “gateway drug” theory as it applies to marijuana? Of those who have ever tried marijuana, what is the probability that they will become regular users of heroin or cocaine?

5. What alternative explanations have been provided to account for the fact that hard drug users are likely to have tried marijuana?

**INTERNET EXERCISES**


2. Using an Internet search engine, type in one of the following terms: methamphetamine epidemic, ecstasy epidemic, Oxycontin epidemic, bath salts epidemic. Note how many “hits” are obtained, and examine the content of five of the sources you identify. What themes are emphasized in referring to the issue as an epidemic?