Encyclopedia of Sociology

Second Edition

VOLUME 1

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Macmillan Reference USA
an imprint of the Gale Group
New York • Detroit • San Francisco • London • Boston • Woodbridge, CT

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DRAMATURGY

See Symbolic Interaction Theory.

DRUG ABUSE

Drug abuse has been a major social problem in the United States for almost a century and we are now in the second decade of a continuing war on drugs. Drug abuse is a health and criminal justice problem that also has implications for nearly every facet of social life. It is a major element in the high cost of health care, a central reason for the United States's extraordinarily high rate of incarceration, and a focus of intensive education and treatment efforts. Substance abuse is an equal-opportunity problem that affects both high- and low-income persons, although its consequences are most often felt by those persons and communities that have the lowest social capital.

Substance abuse, with its connotations of disapproval or wrong or harmful or dysfunctional usage of mood-modifying substances, is a term that was developed in the United States. The more neutral term, *dependence*, is often used in other countries. *Addiction*, which formerly communicated the development of tolerance after use and a physical withdrawal reaction after a drug became unavailable, has assumed less explicit meanings. Whatever terminology is employed, there is intense societal concern about the use of psychoactive mood-altering substances that involve loss of control. This concern is manifest particularly for young people in the age group most likely to use such substances. Society is concerned that adolescents

and young adults, who should be preparing themselves for crucial educational, vocational, and other significant life choices, are instead diverted by the use of controlled substances.

The United States has the highest rate of drug abuse of any industrialized country and, not surprisingly, spends more public money than any other country to enforce laws that regulate the use of psychoactive drugs. Its efforts to control drug abuse reach out across its borders. The United States also plays a critical role in developing knowledge about substance abuse; more than 85 percent of the world's drug abuse research is supported by the National Institute on Drug Abuse.

EPIDEMIOLOGY

Information on incidence and prevalence of drug use and abuse derives from a range of sources: surveys of samples of households and schools; hospital emergency room and coroners' reports; urine testing of samples of arrestees; treatment programs; and ethnographic studies. Such epidemiological information enables us to assess drug abuse programs and decide on allocation of resources (Winick 1997).

Since World War II, the peak years for illicit drug use were in the late 1970s, when approximately 25 million persons used a proscribed substance in any thirty-day period. Overall illicit drug use has been declining since 1985. The yearly National Household Survey on Drug Abuse, which is the most influential source of epidemiology data, reported that in 1997 marijuana was used by 11.1 million persons or 80 percent of illicit drug users (Office of Applied Studies 1999). Sixty percent only used marijuana but 20 percent used it along with another illicit substance. During the 1990s, the rate of marijuana initiation among youths aged twelve to seventeen reached a new high, of approximately 2.5 million per year. The level of current use of this age group (9.4 percent) is substantially less than the rate in 1979 (14.2 percent).

Twenty percent of illicit drug users in 1997, ingested a substance other than marijuana in the month preceding the interviews. Some 1.5 million Americans, down from 5.7 million in 1985, used cocaine in the same period; the number of crack users, approximately 600,000, has remained nearly constant for the last ten years. At least 408,000 individuals used heroin in 1997, with the estimated number of new users at the highest level in thirty years.

Data on incidence and prevalence of use must be interpreted in terms of social structure. Thus, one out of five of the American troops in Vietnam were addicted to heroin, but follow-up studies one year after veterans had returned to the United States found that only 1 percent were addicted (Robins, Helzer, Hesselbrook et al. 1980). In Vietnam, heroin use was typically found among enlisted men and not among officers. Knowing such aspects of social setting and role can help in understanding the trends and can contribute to understanding the use of other substances in other situations. In any setting, the frequency of substance use, the length of time over which it was taken, the manner of ingestion, whether it was used by itself or with other substances, its relationship to criminal activity and other user characteristics (e.g., mental illness), the degree to which its use was out of control, the setting, and whether it was part of a group activity are also important.

Rates of use by subgroup can vary greatly. Thus, for example, prevalence rates of drug use are higher among males than females and highest among males in their late teens through their twenties. Over half the users of illicit drugs work full time. About one-third of homeless persons and more than one-fourth of the mentally ill are physically or psychologically dependent on illicit drugs. The first survey of mothers delivering liveborns, in 1993, found that 5.5 percent had used illicit drugs at some time during their pregnancy. A survey of college students reported that in the previous year, 26.4 percent had used marijuana and 5.2 percent had used cocaine. National Household Survey data indicate that use of illicit drugs by persons over thirty-five, which was 10.3 percent in 1979, jumped to 29.4 percent by 1991 and was 33.5 percent in 1997.

Rates of cigarette smoking are of interest because of their possible relationship to the use of other psychoactive substances. Approximately one-eighth of cigarette smokers also use illicit drugs. In a typical month in 1997, 30 percent of Americans, or 64 million, had smoked cigarettes and one-fifth of youths between the ages of twelve and seventeen, were current smokers. Almost half of all American adults who ever smoked have stopped

smoking. Drug abusers may also be involved with alcohol.

POLICY

A central contributor to current American policy toward mood-modifying drugs was the Harrison Act of 1914, which prevented physicians from dispensing narcotics to addicts (Musto 1987). The Marijuana Tax Act of 1937 and strict penalties for sale and possession of narcotics that were imposed by federal legislation in 1951 and 1966 expanded punitive strategies. An important change took place in 1971, when President Nixon—who had campaigned vigorously against drug use—established a national treatment network. Nixon was the only president to devote most of the federal drug budget to treatment; his successors have spent most of the budget on law enforcement.

In 1972, the Commission on Marijuana and Drug Abuse recommended a dual-focused policy that is both liberal and hard-line. The policy, which continues to the present, is liberal in that users who need help are encouraged to obtain treatment. But it is hard-line because it includes harsh criminal penalties for drug possession and sales. As a result, nearly two-thirds of the federal resources devoted to drug use are now spent by the criminal justice system to deter drug use and implement a zero-tolerance philosophy.

President Carter's 1977 unsuccessful attempt to decriminalize marijuana was the only effort by a national political leader to lessen harsh penalties for drug possession. Between 1981 and 1986, President Reagan doubled enforcement budgets to fight the "war on drugs." Politicians generally have felt that the traditional hard-line policy served their own and the country's best interests and there has been limited national support for legalization or decriminalization (Evans and Berent 1992).

Originating in several European countries, the policy of *harm reduction* has, during the last decade, generated growing interest in the United States as a politically viable alternative to legalization (Heather, Wodak, Nadelmann et al. 1998). It attempts to understand drug use nonevaluatively in the context of people's lives and to urge that the policies that regulate drug use should not lead to more harm than the use of the substance itself causes. A representative harm-reduction initiative is the establishment of needle exchanges, for injecting users of heroin and other drugs, in order to minimize the possibility of HIV transmission resulting from the sharing of infected needles. The use of needles to inject illegal substances has been linked to one-third of the cumulative number of AIDS cases in the United States. In the United States, the use of federal government money for needle exchanges is prohibited, although there are approximately 1.3 million injecting drug users. Critics of these programs believe that such exchanges increase heroin use and send a latent message that it is acceptable to use drugs like heroin. Harm reductionists disagree and argue that needle exchanges lead to a decline in rates of HIV infection without encouraging use.

Another policy disagreement between America and other countries involves marijuana. In the United States many federal benefits, including student loans, are not available to those convicted of marijuana crimes. In contrast, marijuana has been decriminalized in a number of Western European countries, including Italy, Spain, and Holland. It is openly available in coffee houses in Holland, where officials believe that its use is relatively harmless and can deter young people from using heroin or cocaine. In America, marijuana is viewed by federal authorities as possibly hazardous and a potential "stepping stone" to heroin or cocaine use, and approximately 695,000 persons were arrested for its possession in 1997.

Other countries have experimented with ways to make drugs such as heroin legally available, albeit under control. Thus, in Switzerland, heroin addicts have been legally maintained. In England, methadone (a heroin substitute) can be obtained by prescription from a physician. In the United States, by contrast, an addict must enroll in a program to be able to receive methadone.

In the United States prevention of drug abuse has never been as important a policy dimension as treatment or law enforcement, in part because it requires legislators to commit resources in the present to solve a future problem. Prevention has, thus, accounted for less than one-seventh of the drug abuse budget. Because of the variety of prevention approaches and because of the American local approach to education, there are many viewpoints on how to conduct programs that will prevent young people from becoming drug users and

abusers. An information-didactic approach, often with the assistance of law enforcement personnel, has been traditional. A role-training, peer-oriented, values-clarification, alternatives, affective-education approach emerged in the 1970s, along with psychological inoculation. Addressing the social structure and family in which young people live, and targeted community action, attracted substantial support in the 1980s and 1990s.

National policy toward drug use is systematically promulgated by the Office of National Drug Control Policy (1999). The office has established the goal of reducing drug use and availability by 50 percent and reducing the rate of related crime and violence by 30 percent by 2007. It is proposed that these goals will be achieved by expanding current approaches.

Although drug abuse has been called "the American disease," physicians have had little impact on policy. Between 1912 and 1925, clinics in various states dispensed opiates to users. More recently, however, the federal government has opposed making marijuana available for medicinal purposes, even to treat persons with terminal or debilitating illnesses. Nevertheless, eleven states decriminalized marijuana possession in the 1970s and others, by referendum vote in the 1990s, have permitted physicians to recommend and patients to use marijuana medically.

CONTROL

In the United States, programs to control the supply of mood-modifying substances are intended to interdict the importation of illicit materials, enforce the laws, and cooperate with other countries that are interested in minimizing the availability of controlled substances. In addition to illicit substances (such as heroin, that has no established medical use), prescription products can be abused. These include substances such as barbiturates, that are used without medical supervision in an inappropriate manner. The problem also includes over-the-counter drug products that are not used for the purpose for which they were manufactured. Some nondrug substances like airplane model glue and other inhalants that can provide a "high" and are difficult to regulate, are also considered part of the country's substance abuse burden.

Preventing illicit drugs from entering the United States is difficult because of heavily trafficked, long, porous borders. Large tax-free profits provide incentives for drug entrepreneurs to develop new ways to evade customs barriers, process the drug for the market, and sell it (Johnson, Goldstein, Preble et al. 1985). For example, approximately seven-eighths of the retail price represents profit after all costs of growing, smuggling, and processing cocaine for illegal sale in the United States. The increasing globalization of the world economy further facilitates the international trade in illicit substances.

A key component in efforts to reduce the supply of stimulants, depressants, and hallucinogens is the Comprehensive Drug Abuse and Control Act of 1970, which established a national system of schedules that differentiated the public health threat of various drugs of abuse. This law, which has been modified over the years, classifies controlled substances into five categories, based on their potential for abuse and dependency and their accepted medical use. Schedule I products, such as peyote, have no acceptable safe level of medical use. Schedule II products, such as morphine, have both medicinal value and high abuse potential. Schedule III substances, such as amphetamines, have medical uses but less abuse potential than categories I or II. Also acceptable medicinally, Schedule IV substances, such as phenobarbital have low abuse potential, although the potential is higher than Schedule V products, such as narcotics that are combined with non-narcotic active ingredients. Conviction for violation of federal law against possession or distribution of scheduled products can lead to imprisonment, fines, and asset forfeiture.

Ever since it assumed a major role in promoting the Hague Opium Convention of 1912, the United States has been a leader in the international regulation of drugs of abuse. The United States convened the 1961 Single Convention on Narcotic Drugs and the 1971 Convention on Psychotropic Substances. Some countries, like England and Holland, subscribe to the treaties but interpret them more liberally than does the United States. The United States has also provided technical assistance, financing, and encouragement to other countries to minimize the growth of drugs such as cocaine and marijuana. Programs have been conducted in Mexico and Turkey to eradicate these