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Social and Community Factors Associated With Drug Use and Abuse Among Adolescents

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Standards of acceptable drug use are a function of cultural and societal norms. In the United States, public concern and political response have produced a public policy of "War" on drugs. Yet at the same time, Americans continue to consume huge quantities of alcohol, tobacco, caffeine, over-the-counter (OTC) remedies, and medical prescriptions. Despite the documented social, health, and economic costs of misuse, these drugs continue to be subsidized by the government, produced and promoted by manufacturers, and overused by consumers. In this climate it is not surprising that adolescents in the United States have the highest levels of illicit drug use of any industrialized nation in the world (Johnston, O'Malley, & Bachman, 1991). Nearly all young people (93%) have tried alcohol by the time they graduate from high school, and 41% report occasional binge drinking (five or more drinks at one time). Although rates have declined, 63% of adolescents experiment with an illicit psychoactive drug other than alcohol before they finish high school. Clearly, experimentation with drugs is normative for adolescents, but drug abuse is not.

The purpose of this chapter is to examine three distinctive transitions in drug use among adolescents. The first is the transition from nonuse to drug use characteristic of most adolescents. The second is the less frequent but potentially

more harmful transition from use to drug abuse. The third transition is from abuse back to use or nonuse. These transitions are, by definition, sequenced but not inevitable. An adolescent cannot become a drug abuser without first beginning to use drugs—but the initiation of drug use does not inevitably, or even usually, lead to drug abuse. A host of peer, family, and community factors can either inhibit or facilitate these transitions. These factors serve as the foundation for effective drug-abuse prevention efforts.

These transitions are one aspect of adolescent development and can best be understood in the contexts of normal and abnormal development. The transition from nonuse to use of some drugs is a normative part of adolescent development in American culture. Initial drug use is socially learned, developmentally functional behavior. The transition from use to abuse, on the other hand, is a maladaptive response pattern marked by a failure to achieve successfully developmental tasks characteristic of adolescence.

The analysis of drug use presented in this chapter focuses on the dynamic interaction between drugs, adolescents, and their environment. The patterns of interaction-producing transitions to drug use and drug abuse are best described in behavioral, developmental, and social terms. Common legal and moral definitions of drug abuse are inconsistent with this approach. Drug abuse is indicated when a pattern of consistent drug use is maintained despite of negative social and health consequences. Drug taking assumes an increasingly central role in the abuser's life. Other daily activities become subordinate to drug use. Considerable time and effort is spent raising money for, buying, and using drugs. This investment of effort in drug use supports the development of a drug-centered social network and the emergence of the addict role-identity. Concurrently, adolescent social role function becomes impaired. Effectiveness in family, school, work, and peer roles becomes compromised. The transition from drug user

to drug abuser is complex, gradual, and rarely a conscious choice made by individuals. Critical to our purposes is an understanding of the factors that increase adolescent susceptibility to the drug-abuse process.

THE TRANSITION FROM NONUSE TO USE

In an overview of the literature on risk factors for drug abuse, Glantz and Pickens (1991) conclude that "In general, drug use appears to be more a function of social and peer factors, whereas abuse appears to be more a function of biological and psychological processes" (p. 9). One example of research on risk factors for use and abuse is the three-wave study of drinking behavior among seventh graders conducted by Ellickson and Hays (1991). They surveyed 1,966 students at 30 schools—20 where a smoking and drug prevention program had been conducted and 10 control schools. Students were surveyed at baseline and 3-month and 12-month intervals afterward. At the beginning of the study, 23% of the students reported that they had never tried alcohol. The only significant predictors of alcohol use at Wave 2 were marijuana use by peers and alcohol use by peers and adults; at Wave 3 the most powerful predictor was use at Wave 2. Future heavy drinking among the initial nonusers was best predicted by exposure to marijuana and cigarettes and by expectations of future drug use, but parental drinking and peer approval of cigarettes were also significant if less powerful. Beliefs about the danger of alcohol were not strong enough to prevent heavy drinking. The results of this study make clear that the paths to alcohol use and abuse are complex. Programs that target a single risk factor, such as self-esteem or poor school achievement, are unlikely to have a significant impact.

Kandel and Davies (1991) identified risk factors for the onset of marijuana use. The risk factors identified for both genders were: low attendance at religious services, high educational expectations, participation in delinquent activities,

and parental use of psychoactive drugs such as minor tranquilizers. Risk factors for females were: use of marijuana in their peer group, high level of family education, and lack of closeness to their parents. Male risk factors were: low level of parent education and strong peer orientation. Summarizing their results, Kandel and Davies (1991) concluded that:

In general, young people at risk for marijuana initiation are more deviant than their peers and come from families where the parents appear to experience some form of psychological problems.... Conventionalism is a restraining factor for involvement in marijuana, although high levels of educational aspirations increase the risk. (p. 231)

These and similar studies indicate that a complex web of social factors influence decisions to use drugs. Figure 4.1 illustrates these factors in a model. Peer and parental use appears to provide: models of use, access to drugs, and the motivation and support to initiate use. An adolescent's transition from nonuse to use of any drug may be conceived of as resulting from a combination of three factors: First, the drug must be sufficiently available to the adolescent. Second, the adolescent must perceive some functional value in using the drug. Third, restraints against use must be eliminated, reduced, or neutralized.

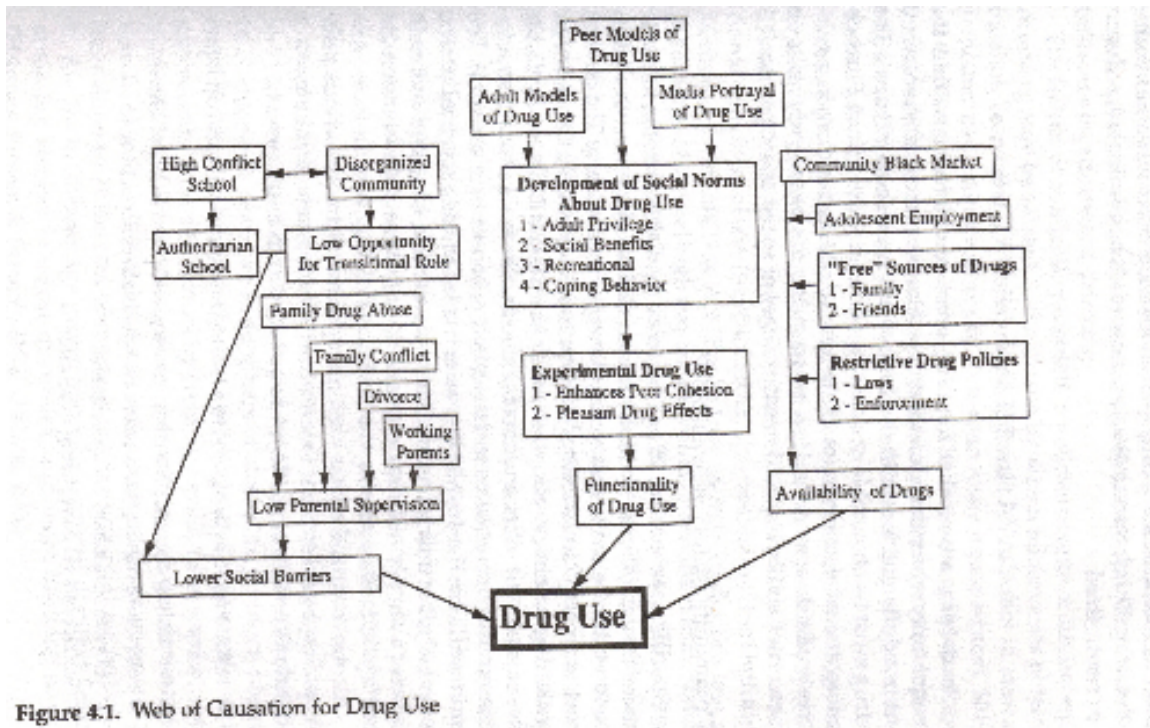


Figure 4.1. Web of Causation for Drug Use

AVAILABILITY OF DRUGS

Availability means that the drug must be obtainable within the community where the adolescent lives. Drugs are most often acquired from adults and peers in the immediate social environment. The drug must be obtainable at a cost the adolescent can afford. Furthermore, the adolescent must know how to obtain the drug in a relatively risk-free manner. Risk assessments are based primarily on perceived ability to avoid negative legal or social consequences.

Community Factors in Availability

Specific psychoactive drugs are more available in some communities than in others. Alcohol, tobacco, and marijuana are available, to some degree, in virtually every American community. The quality, cost, and ease of availability, however, may vary widely. Other drugs, including cocaine, crack, coca paste, heroin, and LSD, are available in some communities and

unavailable in others. Obviously an adolescent must have access to a drug before becoming a user of it. The more available the drug is, the easier it is for an adolescent to become a user. Kaplan and Johnson (1991) note the role of opportunities in which "a supply of drugs is available and there is an occasion for use" (p. 301) in increasing the likelihood of drug use.

Alcohol availability has been manipulated through various public policy interventions in an effort to moderate drinking on a community-wide basis. This has included such measures as:

1. restricting sales of alcohol to a limited number of state-owned liquor stores
2. forbidding sales in pharmacy, grocery, and "convenience" stores
3. restricting the days and hours on which alcohol can be sold
4. restricted numbers of liquor licenses
5. restrictions on advertising of alcohol

Whether or not such policies have any impact on adult alcohol consumption, Coate and Grossman (1985) found that they had no influence on adolescent drinking.

The failure of availability restriction policies to reduce adolescent drinking may be related to the means by which adolescents obtain alcohol. Teenagers, for the most part, do not buy alcohol in stores (whether convenience stores or state-monopoly liquor stores). Nor do they get most of their alcohol in bars. Their sources are more often friends and older associates as well as thefts from their parents' liquor supplies. These sources are little affected by public policy restrictions on availability.

One public policy that is aimed particularly at restricting the availability of alcohol to adolescents is the minimum drinking age. Minimum drinking age laws are a direct attempt

to keep teens from drinking by force of law. In 1984, the U.S. Congress passed the Uniform Minimum Drinking Age Act (Public Law 98-363). Under this law, a percentage of federal highway funds would be withheld from states that did not make the legal drinking age 21. In response, all 50 states and the District of Columbia have a drinking age of 21. Most studies have failed to show any impact of drinking age laws on adolescent drinking. In a review conducted during the early 1970s, Smart and Goodstadt (1977) concluded that raising the minimum drinking age produced a small reduction in alcohol consumption. Later studies, however, did not support this effect. Coate and Grossman's (1985) analysis of data from the second National Health Examination Survey revealed that a lower minimum legal drinking age was associated with lower rates of adolescent beer drinking. It is possible that minimum drinking age laws have a small effect when first adopted, but effects on availability fade after a few years.

Furthermore, recent initiatives to raise the drinking age from 18 to 21 in many states have been urged, in part, on the grounds that 18- to 20-year-olds often act as suppliers of alcohol to younger adolescents. Raising the drinking age, it has been argued, would restrict early adolescents' access to alcohol by creating a greater age gap between them and legal alcohol purchasers. Evidence suggests that these measures have reduced availability of alcohol to teenagers but appear to have done so at the cost of increasingly deviant drinking behavior in the 18- to 20-year age group: more drinking of distilled liquor, obtaining alcohol in larger quantities, and more drinking in cars (Hughes, Power, & Francis, 1992; O'Hare, 1990).

Prohibition is intended as the ultimate restriction on availability. Outlawing a drug is supposed to make it unavailable to everyone. In reality, however, outlawing a popular drug only drives it into a black market economy. It is in the nature of black markets that they are unregulated. There are no age limits or other regulatory restrictions in a black

market. Anyone who has the cash can buy drugs from black market dealers, who seldom have any hesitation about selling drugs to adolescents.

When prohibition reduces drug availability it tends to inflate the price of the drugs. This may limit adolescent access to drugs to some extent. Less expensive drugs, such as marijuana and crack, are likely to be the first illicit drugs used by adolescents because of their greater affordability. It is relevant to this point that high school students with after-school jobs are more likely to become illicit drug users (O'Malley, Johnston, & Bachman, 1985). Robins and Regier (1991) suggest in this light that "drug use may be promoted by a relative abundance of disposable income" (p. 139). In relation to alcohol, Coate and Grossman (1985) found that adolescent consumption of wine and liquor, but not of beer, was reduced by higher prices. They hypothesized that beer was so cheap that variations in its price did not limit adolescents' access to it. Another way to increase the price of drugs is to increase excise taxes. On the basis of simulations conducted for NIAAA, Grossman (1989) concluded that substantial increases in excise taxes for beer would reduce motor vehicle fatalities among 18- to 20-year-olds by 21%. Grossman asserts that the tax would have greater effect than increases in minimum drinking age because the restrictions on drinking age are commonly circumvented. It is important to note that Grossman's simulations have not been tested empirically.

Skager and Fisher (1989) found—contrary to popular expectations—in a representative survey of 11th-grade students in California public high schools, that the highest rates of drug abuse occurred in rural or small town schools with the highest proportions of white students. Next highest levels were reported by students in large, predominantly white high schools in urban or suburban settings. Lowest levels of drug use were reported in urban, heavily minority schools. One reasonable interpretation of these results is that drug use is

highest in the population of adolescents who are best able to afford drugs.

Social Factors in Availability

Popular media mythology depicts the drug pusher hanging around the schoolyard, trying to entice schoolchildren into trying his illicit wares. Real drug dealers, of course, do not behave this way. Most have a ready market for their drugs and no need to develop new clientele, especially among schoolchildren who have too little disposable income to be an attractive market.

Instead of the pusher, it is usually a friend, older sibling, or parent who introduces adolescents to drug use. Numerous studies show that most illicit drug users received their first dose as a gift from a close friend. As they continue to use, their earliest purchases are likely to be from friends who sell the drug to them at little or no profit. Eventually they learn where and who the drug dealers are, and this, too, they learn from their peers.

Parents can also be a source of drugs for adolescents. In an extensive review of the literature, Blane and Hewitt (1977) found that parents were the most commonly reported source of alcohol for teenagers. Parent supplies appear common in rural areas (Globetti, Alsikafi, & Morse, 1977). Some parents claim they have more control of their child's drug of choice and subsequent risk behavior (i.e., drinking and driving) if they provide the alcohol (McKechnie, 1976). Often parents are not aware that their children are secretly accessing their stores of alcohol or drugs. Baumrind (1985) found that children of illicit drug users are much more likely to be directly exposed to these drugs and even be supplied by their parents.

COMMUNITY FACTORS IN THE FUNCTIONALITY OF DRUG USE

It is a common observation that ours is a drug-using culture. In one sense this is a meaningless observation. All human cultures are drug-using cultures. The only drug-free people, since the Stone Age, were those whom whites called "Eskimos." Their culture remained drug free only as long as their environment contained no available drugs. Once trade with whites made alcohol and tobacco available, the prevalence of addiction to both drugs rapidly approached 100%. Some archaeologists have suggested that human culture had its beginnings in drug use, with primitive hunter-gatherers first settling down and adopting agriculture in order to raise grapes for wine and/or barley for beer.

In a sense, though, the United States' drug culture may be relevant. Gerbner (1990) suggests that U.S. society promotes the idea that drugs can provide any easy answer to any problem. Berger (1974) calls this the "pain-pill-pleasure" model, in which people with a problem (upset stomach, headache, general stress) take a pill and obtain relief. It is not much of a leap from the notion that small problems can be "fixed" by taking drugs to drugs as a response to most problems. We are exposed to the pain-pill-pleasure model so often that it is probably ingrained in our psyches. Johnson (1974) goes so far as to describe television as a pusher of drugs through the effects of drug advertising. Choate and Debevoise (1976) contend that "children who see over 1,000 OTC commercials each year are picking up a pro-drug message and can be expected to act upon those messages sometime in the subsequent months and years" (p. 91).

Testing this hypothesis, Hulbert (1974) surveyed 990 college students regarding their television viewing and drug use. He found a positive association between the number of nonprescription drug ads the subjects could recall and marijuana use. He also found a negative association between the number

of hours of weekend television viewing and use of marijuana, barbiturates, LSD, and cocaine. Weekday television viewing showed no associations with drug use.

A later study by Milavsky, Pekowsky, and Stipp (1976) found a weak positive relationship between drug advertising and use of nonprescription drugs but no association with illicit drug use. Studies by Robertson, Rossiter, and Gleason (1979) and by Martin and Duncan (1984) found no link between exposure to drug advertisements and illicit drug use. The evidence thus remains mixed as to whether drug advertising and the pain-pill-pleasure model are a factor in promoting drug use.

Some concern has been raised about the effectiveness of alcohol and cigarette advertising in promoting use among young people. A larger concern is the impact of all media portrayals of drug use on the attitudes of youth. Young adolescents are preoccupied with the need to enhance personal attractiveness and social value (Elkind, 1978). As a consequence, it is hypothesized that they are extremely susceptible to the glamorous images of alcohol and cigarette users portrayed in the media. Over time these images may support attitudes toward drug use as a sign of autonomy, competence, attractiveness, maturity, or "toughness." Research on the impact of mass media on children's behavior has focused on preadolescents' retention of commercials and impact on aggressive behavior (Esserman, 1981). Cigarettes and hard liquor are not advertised on television or radio but can be in magazines and on billboards. Beer and wine can be advertised in any medium. Goodstadt and Mitchell (1990) concluded that studies of the impact of alcohol advertising have demonstrated little or no effect on alcohol consumption. This supports the alcohol industries' claim that their advertising focuses on brand selection and not on promoting use among youth. This claim should be viewed tentatively, however, because studies of the advertising/consumption link have not been specific to adolescents.

PEER FACTORS AND LEARNING THE FUNCTIONALITY OF DRUG USE

As social beings, adolescents are heavily influenced by values, beliefs, and social norms acquired through relationships with others. Adults and the peer group play an important role in teaching adolescents to use drugs. Social cognitive theory (Bandura, 1986) provides a useful framework for describing the basic processes involved in learning drug-use behavior. Experimentation with drug use originates from exposure to models in the adolescent's social environment. Influential models tend to hold some desirable status or valued attributes to the observing adolescent. Observed consequences of modeled actions promote the development of outcome expectations. Maturity, independence, attractiveness, and social acceptance are just a few of the personal needs adolescents may associate with drug use. These outcome expectations serve as powerful motivations for experimentation with drug use. Actual drug use is then reinforced through processes of personal attribution, peer response, and parental reactions. For example, if a parent has a strong negative emotional response upon discovering his or her child's drug use, it may serve directly to reinforce beliefs of drug use as rebellion and challenge to adult authority.

Popular conceptions of peer pressure to use drugs imply direct, coercive ploys designed to force adolescents to comply with group norms. In most cases, however, peer pressure to use drugs appears to be a subtle, indirect process of influence. In a prospective longitudinal study, Newman (1984) found that peer groups influence the social meaning of drug use by associating it with images of social recognition, independence, maturity, fun, and a variety of desirable outcomes. Thus drug use often occurs in peer groups because adolescents reinforce each other's beliefs in these images. Peer mutual reinforcement of beliefs regarding the payoffs for drug use provides a powerful social basis for drug use.

LOWER SOCIAL BARRIERS

Our society sets many restraints in the path of becoming a user of illicit drugs. Far more important than the external barriers placed in the path of availability are those internal restraints that society seeks to ingrain in each citizen. In order to become a drug user an adolescent must overcome these internalized restraints to some degree. Internalized barriers often become situational as adolescents discover social and physical environments that are supportive of drug use.

Community Factors That Neutralize Restraints

In every society the use of certain drugs is accepted as normative but the use of other drugs is taboo. Norms also dictate acceptable situations, purposes, and participants. Use of alcohol by adults is widespread and widely accepted in most elements of American society. Tobacco use was widely accepted in the past but is increasingly becoming a taboo practice. "It is noteworthy that the caffeine in coffee is the one remaining psychoactive drug whose regular use is acceptable and encouraged at work in our society" (Lewis, 1993). Gitlin (1990) raises the possibility that "glamorous representations of drugs may well have an added effect of rendering drugs legitimate for some portion of the audience" (p. 47), and "in American society, the likelihood is that the direct and specific images of drugs, whether positive or negative, play an independent part in accelerating drug use, and that the impact of these images, although limited, is not negligible" (p. 49).

The news media play an important role in shaping youth's ideas about drugs—both establishing restraints and neutralizing them. In Canada, for instance, Fejer, Smart, Whitehead, and Laforest (1971) found that nearly 6 out of 10 high school students reported that the news media were their primary sources of information about drugs; next most common (but far

behind) were friends. The same is probably true for American adolescents. This is important because news media reports and antidrug messages in the mass media are frequently distorted and could have a negative impact on rational decision making regarding drugs (Gerbner, 1977,1990).

Both antidrug messages and news reports are dominated by "prophylactic lies"—false or distorted reports of the dangers of illicit drug use. A good example is the famous television spot that shows an egg, declaring, "This is your brain," then the egg being fried in a skillet, to the words, "This is your brain on drugs." Of course, none of the illicit drugs has an effect on the human brain that remotely resembles being fried, nor have any abusable drugs other than alcohol and tobacco been demonstrated to be associated with clinically significant brain damage. Petosa (1992), in a review of drug-use prevention approaches, found that many programs also use exaggerated and obscure dangers as a motivational basis. When adolescents learn through association with drug-using peers that these distortions are lies, they come to mistrust these prevention programs. Thus scare tactics aimed at protecting adolescents from drug use may actually help tear down the restraints against such use.

The school environment plays a major role in the process of developing adolescent drug use. Schools that are rigid and authoritarian in their disciplinary policies tend to promote disrespect for authority. When students are subject to rules that exist purely by the fiat of some authority figure, without need for any rational basis, they can come to doubt the rationality of all of society's rules—including those regarding drugs. The negative attitudes fostered by authoritarian school systems make students more susceptible to drug use. Low perceived peer affect toward school, low academic performance, low perception of freedom in school, and negative attitude toward school have been identified—along with few friendships and low affiliation with children—by Scheier and Newcomb

(1991) as risk factors for experimentation with drug use.

Lack of church involvement also appears to be a factor in the initiation of drug use. Fors and Rojek (1983), for instance, found in a survey of 6th- through 12th-grade students that the greater the regularity of church attendance, the lower the use of alcohol, tobacco, and marijuana.

Peer Factors That Neutralize Restraints

Association with drug-using peers is a powerful influence promoting adolescent drug use (Kaplan & Johnson, 1991). The importance of peer pressure urging the adolescent to use drugs may well have been generally overestimated. Although direct pressures to use drugs may be substantial in some cases, this is probably less often the case. Drug use may be a condition for acceptance as a member of some peer groups, but many drug-using peer groups contain non-using members who are well accepted into the group. Homogeneity of drug use in peer groups is often motivated by pressures or support toward conformity to expectations, but it is also common for members of a peer group to be chosen on the basis of possessing similar attitudes and behaviors. The extent to which each of these two forces explains shared drug-use patterns is not clear.

Far more important than direct pressure is the effect association with drug-using peers has on social restraints against drug use. As mentioned above, the adolescent learns from these associations that much of what school and media have taught the adolescent about drugs is false. The drug-using peer group teaches the adolescent that drug users as a group are no more sick or evil or weak or dependent than the rest of their peers.

Perceived drug use by peers may be as important as actual peer drug use. Adolescents who believe that drug use is common among their peer group are likely to accept the

idea that drug use is normative behavior. Drug users tend to overestimate the proportion of their peers who also use drugs (Bowker, 1974; Duryea & Martin, 1981). This distortion in perceived norms may influence students' motivations to use drugs. The adolescent inclination to think in exaggerated terms (i.e., "everybody does it") contributes to this tendency.

Sheppard (1989), however, has challenged this view. He found, in a study of 2,319 elementary and secondary school students in Ontario, that there was no significant association between perceived drug use, either at their own school or generally among Ontario students, and students' self-reported intentions to use cannabis in the next 2 years. The weakness of this study is its use of behavioral intentions that may or may not be closely related to actual future use.

Peer influence on the neutralization of restraints is not limited to drug-using peers. Association with peers who are socially deviant reduces the impact of social restraints on adolescent behavior. Cadoret (1991), for instance, identified "bad friends"—friends not approved of by the adolescent's parent—as a risk factor for initiation of drug use. Downs and Rose (1991) likewise found that identification with delinquent peers was associated with the highest levels of alcohol and drug use, the most positive attitudes toward such use, the lowest levels of perceived harm due to such use, and the highest levels of other psychosocial problems such as depression, low self-esteem, and alienation. Brook, Cohen, Whiteman, and Gordon (1991) found that adolescents who associated with deviant peers were 2.66 times as likely to use drugs; peer drug use showed a positive but nonsignificant association with adolescent drug use in their study.

THE BENEFITS OF EXPERIMENTAL DRUG USE

It is often assumed that psychoactive drug use among adolescents is always negative. Newcomb and Bentler (1989)

suggest that "infrequent, intermittent or occasional use of drugs by a basically healthy teenager probably has few short-term and no long-term negative or adverse consequences" (p. 246). Baumrind (1985) perceives adolescent experimentation of various types as being more "health-enhancing" than are risk avoidant behaviors that are phobic or sedentary. As evidence, Baumrind points to studies that show that experimental use of marijuana in nondelinquent populations is associated with positive attributes including independence, friendliness, self-confidence, and intelligence. Newcomb and Bentler (1989) found that in the quantities typically used by normal adolescents, cigarettes were more harmful to health than alcohol, marijuana, or most other drugs used over a 4-year period.

It is apparent that for most healthy adolescents there are clear social benefits and minimal perceived negative health consequences of experimental drug use. The social milieu of American adolescence clearly defines social benefits of the experimental use of psycho-active drugs. Simultaneously, adolescents have difficulty estimating drug-use risk or accepting personal susceptibility to negative outcomes. In addition, most adolescents will use drugs with little or immediate health consequences. These experiences simultaneously increase the functional role of drugs and reduce social barriers to drug use.

THE TRANSITION FROM USE TO ABUSE

Glantz and Pickens (1991) state that "In general, drug use appears to be more a function of social and peer factors, whereas abuse appears to be more a function of biological and psychological processes" (p. 9). Although we agree in part, we believe that peer and community influences do play an important role in the transition from use to abuse. An adolescent's transition from use to abuse of any drug may be

conceived of as resulting from an interaction among three factors: First, genetic or biological predisposition; second, use of drugs becomes a central element in the user's life; third, the user's identification with the addict role and fear of withdrawal (see Figure 4.2).

The genetic or biological predisposition is outside the scope of this chapter. Excellent reviews of the literature on genetic predisposition to alcoholism are to be found in Sher (1991) and Anthenelli and Schuckit (1992). A genetic predisposition to alcoholism does seem to exist, but it appears to be much less important than nonbiological factors in the etiology of alcoholism. There is far less evidence to tell us whether such predispositions exist for any other drug of abuse.

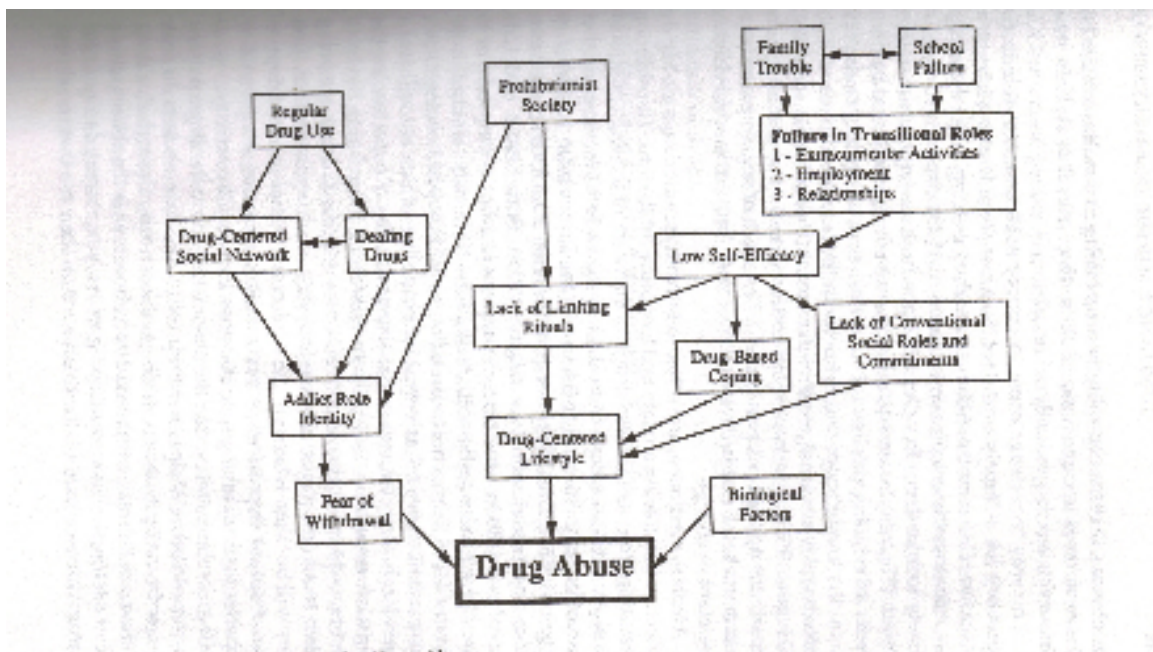


Figure 4.2. Web of Causation for Drug Abuse

CENTRALITY OF DRUG TAKING IN THE ABUSER'S LIFE

One reason why the abuser persists in drug taking despite negative consequences is that the drug has come to hold a central place in the abuser's life. Drug taking has entered into a

great many arenas of the abuser's life. The adolescent abuser goes to school under the influence of drugs, plays sports under the influence, socializes under the influence, works under the influence, and so forth. Discontinuing drug taking would disrupt the abuser's entire life. Drug taking becomes one of the major life activities of the abuser. For the dependent abuser, or addict, drug taking has become a major end in itself and much of the adolescent's life comes to be organized around the need to obtain and use his or her drug of choice. At this stage it is obvious that the centrality of drug taking to the abuser's life has become more symptomatic of abuse than causal of it. This state, however, is only gradually achieved.

The way that drugs come to occupy such a central role in the abuser's life is largely a result of the principle of learning known as negative reinforcement. Although the drug user typically takes drugs in order to achieve a pleasant state of mind, the drug abuser is more likely to take drugs in order to escape from an unpleasant state of mind. When any behavior, such as taking a drug, is followed by relief from an ongoing unpleasant condition, such as anxiety or depression, the frequency of that behavior in the future is increased. This process is known as negative reinforcement (Holland & Skinner, 1961; Skinner, 1953), a concept often confused with, but actually more nearly the opposite of, punishment. The result of negative reinforcement is a habit that is likely to occur very frequently and is highly resistant to change.

Alcohol, marijuana, and other sedative-hypnotic drugs are highly effective in relieving anxiety and loosening inhibitions. The oblivion resulting from using these drugs to the point of losing consciousness provides an escape from any negative affect. Heroin and other narcotics are particularly effective in the suppression of sexual or aggressive impulses. They also provide relief from feelings of alienation, depersonalization, or fragmentation. Both heroin and LSD have been used in some cases to suppress psychotic symptoms or to give them a more

acceptable attribution—"I'm only 'seeing things' because I took a drug, not because I'm crazy." In any of these instances, drug use becomes negatively reinforced. The adolescent will feel a need for the drug whenever there is a possibility of experiencing the negative emotions. A negatively reinforced behavior is likely to become a part of every aspect of a person's life. If drugs are being taken to avoid a negative emotional state, such as depression, then they will be taken whenever the adolescent wishes to avoid depression. Because depression is not something anyone ever wants to experience, drug taking soon becomes an everyday activity.

Cocaine abuse seems to be the major exception to the abuse pattern described above. A significant minority of cocaine abusers do seek escape from depression or feelings of inferiority through this drug of choice. A far more common pattern, however, is the abuser whose cocaine taking is a means of coping with high-pressure demands for performance -- at school, in athletics, or on the job -- that the abuser has difficulty in meeting. For reasons that are primarily a function of price structures, the first pattern is more often found in crack users, and the second pattern is more common in users of cocaine powder (cocaine hydrochloride).

Another principle of learning that plays a part in the growing centrality of drug taking in the lives of some abusers is that of *state dependent learning*. State dependent learning takes place under the influence of a psychoactive drug and is only fully remembered when the learner is again under the influence of the same drug. Through this process, drug taking may become inseparably linked with other aspects of the adolescent's life. For the abusing adolescent in particular, having fun may become a state dependent behavior, with the adolescent actually finding difficulty performing in the drug-free state certain behaviors, such as dancing, socializing with the opposite sex, or playing pool, that have habitually been done under the influence of drugs.

Peer Factors in the Growing Centrality of Drugs

The transition from drug use to abuse is partly due to the lack of internalized rules and rituals that make the controlled use of potentially abusive drugs a possibility (Duncan & Gold, 1985; Zinberg, Harding, & Winkeller, 1977). For the controlled user these rules define how, when, and where the drug is to be taken. The controlled user has learned to use the drug in a minimally hazardous fashion, to recognize a safe level of intoxication and not exceed it, and to take the drug only at times and places where it will be safe. Perhaps the most common such rules are time limits—not drinking alcohol before noon (or some later hour); using marijuana only on the weekend; or not using drugs during school hours or before driving. Abusers lack such limits, using drugs indiscriminately at nearly any time, place, or circumstance.

Keeping drug use within limits is also partially made possible by drug-use rituals. Rituals are stylized and predictable ways of doing something that are characteristic of a group. Always eating food with alcohol or mixing distilled spirits with soda or fruit juices are rituals that help keep alcohol use within bounds. The custom of passing a "joint" around a circle of friends serves a similar role in limiting marijuana intoxication. The drug-using peer group is the main source of the rules and rituals that help the controlled user to avoid abuse. Young (1971) was among the first to note that drug-users' lore provides prescriptions for keeping drug use in check as well as prescribing informal sanctions against going beyond those bounds. The drug-using peer group brings sanctions such as rejection or ridicule to bear on the adolescent who takes too much or indulges under the wrong circumstances or too often. These sanctions help prevent a transition from use to abuse.

One way that the abuser may have failed to learn such rules is because of isolation from a drug-using peer group. This

may be a major factor in the high risk of alcoholism in children of non-drinking parents and members of churches that forbid alcohol use. Such persons have had less opportunity to learn rules and rituals for safe alcohol use.

Alternately, the abuser may have learned abusive patterns of drug taking through association with a peer group of abusers. Association with abusers results in learning norms that are antithetical to the rules and rituals that sustain controlled use. By criminalizing drugs and driving their users underground, our society increases the likelihood that the novice user will be thrown into association with abusers and may come to learn abuse-promoting rules rather than use-promoting rules.

Involvement in a delinquent peer group is another peer factor that can contribute to a lack of conventional commitments. As Duncan and Gold (1985) have said, "The usual concern in our society is with drug abuse leading to crime, but there is reason to believe that crime leads to drug abuse" (p. 182). Of course, any use of illicit drugs is criminal behavior in itself and use of alcohol by adolescents is also a crime, but we are talking about criminal involvement that precedes that. Likewise, we are referring to delinquent activity that precedes any crimes committed in order to obtain money for the purchase of drugs.

A number of studies have shown that antisocial behavior beginning in childhood is highly predictive of later abuse of drugs (Robins & Ratcliff, 1978; cf. Robins & Wish, 1977). One such study, by Lukoff (1974), found that the younger the age at which the delinquency began the more intense and committed the addictive career that followed. Surveys of two samples of heroin addicts revealed that 36.6% of a group of imprisoned addicts and 21.0% of a group of methadone patients had their first experience of illicit drug use while in a jail or detention home (Duncan, 1975). The same study found that more than 75% of the methadone patients reported having been arrested

at least once before their first illicit drug use.

The stigma of being labeled a delinquent cuts an adolescent off from many legitimate opportunities (Duncan, 1969). For instance, expulsion from school or loss of job may result from being labeled a delinquent. Social isolation may also result—even if the adolescent's peers are not unwilling to associate with a "delinquent," their parents may forbid such associations.

The delinquent label not only may cut the adolescent off from nondelinquent peers, but it increases involvement with antisocial peers. The jail or detention home provides a meeting place in which the first-time offender is introduced to a new peer group of delinquents (Duncan, 1969; Gold & Williams, 1969). With increasing rejection by prosocial peers, the adolescent becomes more intensely involved with antisocial peers.

Yet another peer-related factor, identified by Jacobson and Zinberg (1975), is that serious dealing in drugs is a major factor in moving some drug takers toward abuse. Nearly all drug users engage in occasional dealing for little or no profit, but serious dealing is associated with a greatly increased risk of abuse. Professional dealers have made dealing their work, so work can no longer be a factor mitigating against abuse. Drugs necessarily become a central factor in the life of a dealer. Furthermore, dealing is a stressful occupation with high risks of being cheated, robbed, or arrested. Such stress can contribute to negative affect states and the dealer-user has a ready supply of drugs with which to medicate that negative affect.

Community Factors in the Growing Centrality of Drugs

The failure to learn limiting rules and rituals is not just a matter of which peer group the user associates with. It also

involves, in part, the larger society. Waldorf, Reinerman, and Murphy (1991) have pointed out that in American society, "such controlled use norms and other informal social controls remain anemic; they have not been allowed to become part of public discourse and culture" (p. 276). Waldorf et al. make the point that criminalizing drugs makes it less likely that such rules and rituals will be developed and disseminated. What one user, or group of users, has learned to do in order to minimize drug-related risks cannot readily be passed on to others when use must be surreptitious.

Societal rejection and scapegoating of illicit drug users contributes to the transition to abuse by cutting the identified user off from competing conventional involvements. When a student is expelled from school for using drugs or alcohol, he or she is closed off from a conventional involvement and potential route to achievement. The same thing happens when a user is fired for taking drugs. When parents, frightened at learning their child is a drug user, react with rejection or "tough love" they too contribute to the transition to abuse by reducing their child's participation in family activities and values.

ADDICT ROLE AND FEAR OF WITHDRAWAL

Another major factor is the acceptance of the role of abuser. Our society has developed certain shared images of what a drug abuser is like. If the user comes to accept those images as elements of self-identity, then the role prescribed by those images will increasingly come to shape the user's life. The addict lifestyle is a role that is learned in the course of the transition from user to abuser. Fear of withdrawal illness is another influence that can keep the abuser taking a drug despite negative consequences.

Community Contributions to Addict Role Adoption

Where the illicit drugs are concerned, our society recognizes only two possibilities—abstinence or addiction. Under these circumstances, "the idea that one can and should exercise control can atrophy" (Waldorf et al, 1991, p. 277).

Some years ago a drug education slogan in use on the West Coast was "Heroin, it's so good, don't even try it once." Just consider the implications of that message. How many of us could resist anything that was made to sound that good? In fact, wasn't this antidrug slogan remarkably similar to the old potato chip advertising slogan declaring, "I bet you can't eat just one." Did the one sell as much heroin as the other did chips? The worst part of this message was that anyone who believed it and yet did try heroin was convinced that they could not stop.

The myth of instant addiction is less common than it once was. We no longer see movies and television dramas in which a character is given, unknowingly or against their will, an injection of heroin and as a result becomes an addict. Such plots were once common in the media. Not too long ago drug educators and law enforcement officials seriously warned of drug pushers putting marijuana in tobacco cigarettes or tea to recruit marijuana addicts. More recently there have been claims that drug pushers were putting heroin or cocaine in marijuana to turn marijuana users into cocaine or heroin addicts. Ridiculous though such stories are, they contribute to a belief in the overwhelming power of addiction. Belief in that power makes the abuser feel powerless to stop or limit drug use.

Although the instant addiction myth maybe less widely promoted than in the past, our mass media and much of our drug education still exaggerate the power of drugs to control, rather than be controlled by, the user. The stereotypical image of drug withdrawal illness has been presented in innumerable

movies and television shows. Such media images may make for good drama, but they are grossly exaggerated portrayals of a real phenomenon. Persons addicted to heroin or other opiates do suffer physical illness when they are unable to take their usual dose, but the illness is nothing like the famous performance by Frank Sinatra in *The Man With the Golden Arm*. The severity of withdrawal symptoms experienced by a narcotics addict varies greatly but at their worst they are no worse than a fairly severe case of influenza and are not life threatening. Withdrawal from addiction to alcohol or sedative hypnotics such as Seconal® or methaqualone can be much more severe and potentially life threatening, but because these drugs are legal little attention is paid to their withdrawal effects. Controversy still exists over whether or not cocaine or the amphetamines produce a withdrawal illness, which shows that any withdrawal illness produced is too minor to be unequivocally identified.

By teaching adolescents that addiction follows inevitably on the use of illicit drugs and that once addicted the user must continue taking the drug or suffer severe illness, our society promotes abuse. Such exaggerations may scare some adolescents away from drug use, but they can also make those who have tried using drugs believe that they cannot stop.

The "Just Say No" approach to drug education also contributes to the transition from use to abuse. This approach not only confounds use with abuse but implies that all that is necessary to prevent drug abuse is a simple act of will. That being the case, then anyone who uses drugs must simply be weak willed. If adolescents are given this message and then do try drugs, their self-esteem is likely to suffer. In the words of one middle school student: "You say to yourself when you're younger, 'I would never use drugs.' And so, then if you do, some part of you always hates yourself" (quoted by Nora L. Ishibashi, personal communication, April 14, 1993).

Many of our society's efforts to prevent drug use and

abuse seem to contribute, instead, to the transition from use to abuse. Outlawing drugs may have such an abuse-promoting effect. The impact on alcohol use of Prohibition from 1920 until 1933 is still debated. Per capita consumption appears to have decreased, but this may only be due to the difficulties in estimating the size of an illicit market. Drunkenness may have increased or it may only have become more notable due to the illegality of alcohol.

McCord (1991) examined the effects of Prohibition on alcohol use and abuse through a study of two cohorts of men. One cohort was composed of men who were over 21 at the time Prohibition began. The second cohort experienced Prohibition during their adolescence. McCord found that the second cohort experienced significantly higher rates of alcohol problems and non-traffic criminal offenses. The reasons for such an effect are open to debate, but it does appear that living through Prohibition as an adolescent raised the risk of alcoholism and crime.

Another abuse-promoting factor related to societal prohibition of certain drugs or of adolescent use of others (such as alcohol) is the impact of negative consequences. A number of studies have shown that severe punishment or harsh rejection by parents after being caught using drugs increases the chances of an adolescent becoming a drug abuser (cf. Kaplan & Johnson, 1991). This is particularly true if the negative consequences occur early in the adolescent's drug-use experience.

Peer Contributions to Addict Role Adoption

Although the community gives broad shape to the addict role, it is in the addict peer group that the role is refined and learned in detail. Just as a peer group of controlled users may teach limiting rules and rituals, an abuser peer group may teach norms that contribute to abuse.

Participant observation research by Eckert (1983) reveals that adolescents often draw very sharp distinctions in social role affiliation. A typical high school will have three or four clearly identified groups. In this context drug use is part of a complex symbolic process of social stratification. For some adolescents, group affiliation becomes a fundamental aspect of personal identity. For the adolescent drug abuser the reciprocal reinforcement of group affiliation and personal identity tends to reduce behavioral options. This situation makes it more difficult for the abuser to disassociate from the addict role.

THE TRANSITION BACK FROM ABUSE TO USE OR NONUSE

A third transition that may be seen in adolescents is a transition back from drug abuse to drug use or nonuse. Data from the National Institute of Mental Health's Epidemiologic Catchment Area (ECA) Study (Helzer, Burnham, & McEvoy, 1991) indicate that alcoholism has a mean duration of 9 years, with a majority (54%) of cases running their course in 5 years or less. The ECA data for illicit drug abuse (Anthony & Helzer, 1991) show a mean duration of 2.6 years, with 75% of all cases ending within 4 years.

In some cases this transition is a result of treatment for drug abuse, but Regier et al. (1993) have found that less than one of every four persons with an addictive disorder receives treatment for that disorder. In a majority of cases the transition takes place without formal treatment (Davies, 1992; Hammersley, Morrison, Davies, & Forsyth, 1990; Stimson & Oppenheimer, 1982). On the basis of the ECA data, Helzer et al. (1991) conclude that, "Many [alcoholics] appear to be able to reduce their drinking sufficiently to terminate their difficulties quite early in the course of their disorder. It is those who try and fail that appear for treatment" (p. 98).

In his study of treated and untreated ex-addicts, Biernacki (1986) found that the experience of recovery from heroin addiction varied by level of immersion and identification with the addict lifestyle. Street addicts had a very hard time kicking the habit because so much of their lives hinged on the addict lifestyle and because they were excluded from conventional society. They usually had to hit "rock bottom" or some existential crisis before quitting. They remained stigmatized and had a hard time finding a new social identity or place in society after quitting. Addicts whose immersion and commitment to the junkie lifestyle was tenuous or fleeting found it easy to quit; some just walked away from heroin and simply resumed their conventional lives.

MOTIVATIONS FOR QUITTING

A 1982 research conference sponsored by the National Institute on Drug Abuse concluded that studies of the motivations of youth who stopped using marijuana should be given high priority because of their potential value in guiding future interventions (Cohen, 1982). Despite this, recommendation's focus on young abusers, the few studies that have examined motives for quitting drug abuse have all dealt with adults. How far these results can be applied to adolescents is uncertain.

The earliest such study, by Martin, Duncan, and Zunich (1983), surveyed college students who had quit abusing any of a variety of illicit or prescription drugs. Health reasons were the most frequently reported reason for quitting. Mental and emotional problems related to the drug was the second most frequent reason. This was followed by a dislike for effects produced by the drug -- a category that often overlapped with the preceding two. Fourth was a simple loss of interest in the drug and its effects.

A survey of 61 Central European athletes who had quit using hashish produced similar results (Duncan, 1988). The most frequently reported reason for quitting in this group was a dislike for the drug's effects. The second most common reason in this group of athletes was that quitting was necessitated by their training regimen. Health reasons and mental/emotional problems were tied for third most common reason.

Brooke, Fudala, and Johnson (1992) surveyed 20 subjects from the subject pool of two treatment studies and found that the most frequently reported reasons for seeking treatment were related to what might be called the hassles of being addicted—"being out of control . . . needing drugs every day and suffering from a longstanding problem" (p. 40). Next came mental and physical problems related to drug use, inability to afford the drug, and difficulty in obtaining the drug.

Fears that had discouraged the subjects from seeking treatment were also examined in the Brooke et al. study. The most frequently reported fear was that of failing in treatment or that their problem was incurable. Fear of their drug use becoming known to friends, family, and so forth was the second most common fear discouraging treatment seeking. A third fear, expressed by a minority of subjects, was that the police would learn about their drug associations if they sought treatment.

Waldorf et al. (1991) found that the most common reason for quitting among adult cocaine addicts was health problems, given as a reason by nearly half (47.2%) of their subjects. The next most frequent was financial problems (40.6%). This was followed by work-related problems (35.8%), pressure from spouse or lover (33%), decision to stop selling (29.2%), fear of arrest (28.3%), pressure from friends (27.3%), and pressure from family (26.4%).

They found differences in reasons for quitting between 30 subjects who quit after receiving treatment and 76 who quit on

their own. For the untreated quitters, health problems remained the most common reason (reported by 46.1%), followed by financial problems (31.6%), pressure from spouse or lover (25%), and work problems (23.7%). For the treated group the same reasons were in the top four but their order and frequency were different. For these subjects the most common reason was work problems (66.7%), followed by financial problems (63.3%), pressure from spouse or lover (53.3%), and health problems (50.0%).

Waldorf et al. (1991) found that few of the quitters in their study had experienced a state of despair or had hit rock bottom. Shaffer and Jones (1989), who also studied recovery from cocaine abuse, identified two types of quitters: Those they called "rock bottom quitters" had become increasingly immersed in cocaine use until virtually all aspects of normal life disintegrated and they were moved to quit. "Structure builders," on the other hand, were people who did not necessarily experience dislocation because of their cocaine use but who set about finding activities to take its place. The former were more likely to require formal treatment, whereas the latter seem to be candidates for natural recovery.

NATURAL RECOVERY

The term *natural recovery* has come to be used for any transition back from abuse to nonuse or controlled use that occurs without treatment. As the ECA data (Anthony & Helzer, 1991; Helzer et al., 1991) have indicated, most drug abusers experience recovery after relatively few years and most do so without treatment. Furthermore, as Waldorf et al. (1991) observe, "Those who underwent natural recovery processes were as likely to succeed as those who went through formal treatment" (p. 216).

Shaffer and Jones (1989) found three ideal-typical phases

of natural recovery: first, "turning points," when addicts begin consciously to experience negative effects; second, "active quitting," when they take steps to stop using; and third, "maintaining abstinence" or "relapse prevention." Klingemann (1991, 1992) reached very similar conclusions, describing the three stages of natural recovery as being a motivational stage, a stage of decision implementation, and a struggle for maintenance characterized by the negotiation of a new identity or meaning in life.

Recovery always involves some degree of abstinence from drug taking, but it does not necessarily mean total abstinence. Describing both natural recovery and recovery with treatment, Waldorf et al. (1991) state that "rigid abstinence from all consciousness-altering substances is not a prerequisite for recovery. Among both our groups of quitters, occasional drug use (sometimes called 'slips') was common, but for most this did not appear to be particularly consequential" (p. 217).

In fact, recovery can mean the return to controlled use of the drug in question. Ever since Davies (1962, 1969) reported cases of alcoholics whose drinking had returned to normal levels, the idea of controlled drinking as a successful outcome for recovered alcoholics has been a subject of controversy. Despite widespread opposition to the idea by treatment professionals and by Alcoholics Anonymous, the accumulating evidence clearly shows that such outcomes not only do occur but occur frequently. Vaillant's (1983) longitudinal study, for instance, showed social drinking and abstinence to be about equally common outcomes of recovery from alcoholism.

Controlled use of illicit drugs as a positive outcome has been less frequently discussed. Davies (1992) suggests that this is because our society labels all use of illicit drugs as abuse, regardless of the consequences (or lack of them) for the drug user.

All use of illicit drugs is illegal and therefore "abnormal," and public perceptions cannot at the present time entertain concepts such as "normal heroin use" or "normal cocaine use." Consequently, the idea of returning to normal levels of drug use from levels that are abnormal cannot be demonstrated, primarily on account of the linguistic and moral contexts surrounding the words "drugs" and "normal."
(p. 42)

Natural recovery seems largely to involve two processes: (a) displacing drugs from their central place in the abuser's life, (b) learning different ways to deal with stress and other underlying problems.

Community Factors in Natural Recovery

An important element in the recovery process is what Duncan (1975) called "environmental restructuring," removing the abuser from the sources of the problem and the environments associated with drug taking. In its most extreme form this would include what were once called "geographic cures"—moving to another city or traveling to another country. This effectively removed abusers from their usual sources of drugs and the places in which they were accustomed to taking drugs, as well as the peers they were used to taking drugs with.

Obviously such geographic cures are not generally practical for adolescents. They can, however, avoid the specific places where they bought and used drugs in the past. Shaffer and Jones (1989) found that "energetic attempts" to avoid drug users and places where the drug was being sold or used played a key part in the success of cocaine users who quit without treatment.

Waldorf et al. (1991) found that "the most frequently used strategies for quitting cocaine were what we call social

avoidance strategies" (p. 205). More than two thirds of the quitters reported that they had stopped going to specific places—parties, bars, and so forth— where they knew cocaine was likely to be used.

Peer Factors in Natural Recovery

As mentioned above, the avoidance of drug-taking friends was also a part of a typical natural recovery. In the Waldorf et al. (1991) study, 62.3% of the cocaine quitters reported making conscious efforts to avoid cocaine using friends, and 41.5% reported seeking new, non-drug-using friends.

Finding a new peer group is often a major part of natural recovery for adolescents. This may be a conscious choice by the adolescent. On the other hand, the adolescent's parents may have arranged this change by sending the adolescent away to a boarding school or by moving the family to a new neighborhood. In either case, a new peer group is often a vital part of an adolescent's natural recovery.

RECOVERY THROUGH TREATMENT

It appears that treatment is necessary for those abusers who have become most deeply involved with drugs. In the Waldorf et al. (1991) study the treated group reported a higher frequency of drug-related problems in general. This could be interpreted as indicating a more serious drug-abuse problem. That in turn could explain the need for treatment in order to quit cocaine. Of the treated quitters in that study, 80% had tried to stop at least once prior to their last successful attempt. One abuser estimated that he had tried to stop at least 40 times. Only 32.9% of the untreated quitters had experienced a previous attempt to quit. Although some users, especially those who wound up undergoing formal treatment, found it

very difficult to quit using cocaine, roughly half of the untreated quitters had no difficulty quitting.

Community Factors in Recovery Through Treatment

Historically, treatment programs have often made use of the principle of the geographic cure by taking the addict out of the community in which drugs had been obtained and used in the past. The "drying out farms" of the 1920s and 1930s (along with dubious treatments) mainly kept the patients away from their usual community and peers. The same principle continues to be used by many therapeutic communities. Patients applying for admission to the Cenikor Community through their center in Houston, Texas, would be admitted to treatment at their center in Denver, Colorado, and vice versa.

Relapse following treatment is often the result of exposure to environmental stimuli of persons and places with whom drug use was associated in the past. Such stimuli that have been repeatedly associated with drug use may become discriminative stimuli tending to elicit further drug use. They may even become conditioned stimuli eliciting conditioned responses that mimic the drug effects themselves. Wallace (1989) found that such environmental stimuli were causal factors in more than one third of the relapses in her study of crack cocaine relapses.

The therapeutic community attempts to be literally a community—a group of persons who are drug free and committed to a common set of values. Those values typically include an emphasis on openness and honesty. The adolescent is subjected to intense group pressure for conformity to the community's values in a process that attempts to break down the abuser personality and to rebuild a healthy personality through a process of resocialization.

The larger community may also impact in important ways

on the adolescent in treatment. For one thing, many treatment services rely on public funding for their continued existence. Political factors may determine whether services are even available for the adolescent.

If the adolescent faces stigmatization and rejection from the larger community, advances achieved through treatment may be quickly lost. For instance, adolescents under treatment for drug abuse are often unwelcome in public schools. This cuts them off from their natural nonabusing peer group and may deprive them of the opportunity to get an education.

Peer Factors in Recovery Through Treatment

Peer support can be an important element in treatment as well. Booth, Russell, Soucek, and Laughlin (1992), for instance, studied 61 consecutive admissions for alcoholism treatment at a Midwestern medical center. They found that friends' reassurance of worth predicted greater time to readmission in survival analysis.

Therapy groups and self-help groups can be highly effective elements in drug-abuse treatment, at least in part, because they serve as a substitute peer group. Abusers, who have become socialized into the "addict culture" by drug-abusing peers, can be resocialized by this new artificial peer group. Supported by these new peers, they can learn the needed new skills for interpersonal coping (Duncan, 1975). On the other hand, peer pressure to resume drug taking can be a major cause of relapse. Marlatt (1985) found that direct and indirect social pressure to use drugs was a factor in one of five relapses. Such pressures, of course, are a problem only if the adolescent's reference group is composed of drug-abusing or at least drug-using peers.

SUMMARY

Adolescent drug use is heavily influenced by community, family, and peer factors. Three transitions are useful for understanding the development of drug use among young people. The first transition is from nonuse to use, which is made by almost all adolescents. The transition from use to abuse is made by 10% to 20% of young people. Contrary to popular belief, the transition from abuse back to use or nonuse is successfully made by most young drug abusers. This developmental model clearly illustrates the importance of social factors in the acquisition, shaping, and maintenance of drug-use patterns. For adolescents, drug use is a socially learned pattern of behavior.

Keys points made in this chapter include:

- Experimentation with drugs is normative for adolescents; abuse of drugs is not.
- For most healthy adolescents there are many social benefits and minimal negative health consequences of drug use.
- Typically a friend, older sibling, or parent introduces the adolescent to drugs.
- Rarely are adolescents exposed to coercive peer pressures to use drugs. Peer influence is most often a subtle, indirect process of modeling and social support.
- Maturity, independence, attractiveness, fun, and social acceptance are just a few of the social needs adolescents may associate with drug use.
- The transition from nonuse to use is facilitated by
 1. the local availability and affordability of drugs.
 2. the adolescent's learning the functional and social value of drug use.
 3. the neutralization of restraints against drug use.
 4. drug-using peers who tend to neutralize restraints against drug use.
 5. school environments with rigid, authoritarian

policies. This approach tends to neutralize restraints against use.

6. the use of scare tactics and "prophylactic lies." This approach tends to neutralize restraints against use.
- Although drug use is primarily a function of social influences, the transition from drug use to abuse also involves elements of genetic/biological factors.
 - The transition from drug use to abuse is gradual and rarely a conscious choice.
 - Drug abuse is characterized by
 1. drug use taking on a central role in the adolescent's life.
 2. the adoption of an addict role-identity,
 3. fears of withdrawal symptoms.
 - The drug user typically takes drugs to achieve a pleasant state of mind; the abuser is more likely to take drugs to escape an unpleasant state of mind.
 - The transition from drug use to abuse is facilitated by
 1. rejection by the non-drug-abusing community.
 2. increasing involvement with drug-abusing and delinquent peers.
 3. societal myths about the powerful addictiveness of drugs.
 4. severe punishment and parental rejection of the teen caught using drugs.
 - Only one of four drug abusers ever receive treatment for their abuse.
 - Most drug abusers recover within 4 years and do so without treatment.
 - The transition from drug abuse to use or nonuse is facilitated by
 1. establishing a nonabusing peer group.
 2. avoiding social and physical environments associated with drug abuse.
 3. some degree of abstinence from drugs but not necessarily total abstinence; half of recovered abusers return to controlled use.

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