On Board

Many Are Called But Few Are Chosen

T_1 — Primary Deviance [Produce Pleasure]

Variety & pathways or factors
- subcultural
- medical
- occupational
- (upstream) peergroups

T_2 — Secondary Deviance [Prevent Pain]

Motivations for Drug-use Change

Meaning of drug has changed

Increased obj/subj avail.

I'm a junkie

T_3 — Relapse [Social & situational reinforcements]

Usage may become independent of withdrawal symptoms.

"Habit forming"

Esp if other aspects of life are "dismal" and keep drug-using friends

Secondary Deviant:

One whose life & identity are organized around the facts of his deviance, principal factor being the societal reaction.

- eg. compare "doctor" addict to "street" addict

{ Secondary crime
"needle habit"
miss hustling / leaning on others
friendship networks { druggies / other deviants
addict subculture
Health problems { HBV - "clean needle"
malnutrition

1a

Secondary Deviant = one whose life and identity are organized around the facts of his/her deviance, the principal factor being the societal reaction.

Primary versus secondary deviance represents a continuum.

Some Criteria for Distinguishing:

How stabilized or recurrent is the behavior?

What is audience definition – how do others label or define the person?

What is self-definition – does person define self as deviant, criminal, etc?

Are there secondary effects brought on by labeling and legal sanctions?

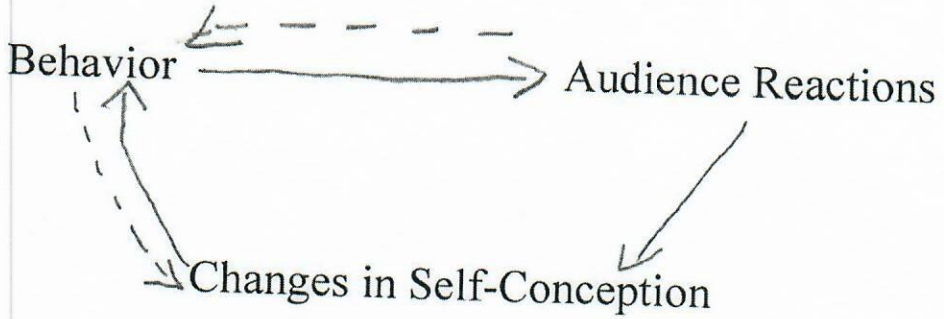
Who is more of a secondary deviant?

- **Pothead (marijuana dependency)**
- **Doctor addicted to demerol (synthetic opiate)**
- **Heroin street addict**

Methadone Addict

Lemert – Labeling Model November 2020

Edwin Lemert reading: Three variables = Labeling Model



Self- conception is a key idea or variable in labeling theory. And *Selves.*

Why important:

1) Define – image/s of self in relation to others

- how see self and how don't want to be seen

2) Product of "Audience" definitions and behaviors
Importance of **Social Audience**

3) Cause of our behavior
Tend to behave consistent with our self-conceptions

Outfit = Witches Outfit

Compare your self-concept with Sam's or Jesse

Girls Study Group – big concern with labeling and stigmatization effects - see in girls "voices"

NARCS – Two Subjective Components:
Self-Conception
Aspirations (Future Selves) – shared with other theories.

Opiate Addiction.soc12H.12-1-2020 (teaching/honors/lectures)

Opiate Drugs

Effects

"narcotic" = a central nervous system (CNS) depressant that produces insensibility & stupor
- designates those drugs & substances with pharmacological properties related to opium and its drug derivatives. All derive from opium poppy plant

= *narkoticos* – "benumbing" or "deadening"

= are effective pain relievers (analgesics) and anticough medications, etc

= physical dependence: discontinue the drug following regular use, then withdrawal symptoms & bodily changes commence

= opium plant also produces *poppy seeds*

Main Opiate Drugs

"Pure" Opium

Morphine & codeine

Heroin — (Heroin Subcutaneous)

Methadone

Synthetic-Pharmaceutical (e.g. oxycontin)

= Purdue Pharma = "magic" drug, did not cause "craving"

= fifth vital sign (circa 2000): creation of *Pain* as 5th sign

= blood pressure; temperature; pulse; and respiratory rate

Legal/Licit use = commercial; harvest opium stock via harvesters, etc.

Illegal/Illicit = harvest liquid latex or gum (dried latex) via "active" opium bulbs or poppy ("scoring" once or twice a day)

Methods of Use

Smoke

Chew-Eat

Snort

Inject

Skin-popping

Id

Withdrawal & Body-Physical Change When Use is Discontinued

Re-use of opiate stops/alleviates withdrawal symptoms

Opiate Drugs Vary in Effects:

Potency/Strength of opiate

Duration of Effect

[Tolerance]

Demographic Features

Gender Age Social Class Race

Turn of 20th Century (19th Century)

20th Century -1930s to about 2000

21st Century

Pathways

Medical

Occupational

Subcultural (lifestyle)

Peer-Friendship-Family/Kin

Who is more of a *secondary deviant?*

Macrolevel "Sociological" Factors

- structural disadvantage
- subcultural
- medical practices
- subjective & objective "risk" factors that apply to drug use & "crime" more generally

Theories = See Diagram & Who Is More of a Secondary Deviant

What is cause "craving" – strong desire/compulsion to re-use the drug

Pleasure-Euphoria (druggies as "losers" – weak, escape from reality)

"These drugs—principally heroin, cocaine, and crack—are, for many people, powerfully reinforcing. The pleasure or oblivion they produce leads many users to devote their lives to seeking pleasure" (James Q. Wilson, cited in Zimring & Hawkins, 1995, p. 97).

Medical – a "disease"

- cellular, metabolic change
- brain change – change in brain tissue
- brain change (including withdrawal?)

Cognitive & Self Change (Lindesmith)

- change in *meaning* of drug for user via recognition of withdrawal & reuse to prevent.

Stage 1: Experience (first) withdrawal symptoms. Re-use & symptoms go away.

Stage 2: Recognize withdrawal as due to lack of drug.

Stage 3: Take active part in ingesting opiates to relieve and/or avoid-prevent withdrawal symptoms.

Stage 4: Relapse & other adaptations (e.g. "gets into one's skin")

= even after weaning, has the memory of it

= experience of taking drugs changes the individual's behavior, definitions, attitudes toward the drug & self in relation to it

= change in *meaning* of the drug & its relation to one's body & to "self"

= becomes more subjectively acceptable & objectively possible

- use can become independent of initial craving . . . habituation & "get into one's skin"

Test of Addiction: What happens <u>after</u> or when drug use is stopped. How disturbing vs what goes on while using the drug.

after stopping

Original causes give way to sustaining or effective causes = processual.

Some Combination of Above

- what is the "hook" or the source of the *craving*?
  - "pleasure" "euphoria" "escape"
  - cellular or biochemistry or brain tissue change
  - cognitive-symbolic: avoid/prevent "pain" via recognition of withdrawal, etc.

Some Facts Supporting Cognitive-Self Theory:

- cannot anticipate withdrawal & act to avoid it; need linquistic ability for this

Grossly insane persons . . . mentally cognitively impaired individuals

Babies & those under age 10

Babies born to addicted mothers

Animals - can get them to relapse if reinforcement is strong enough; but can't anticipate & avoid

Medical patients using large amounts of morphine or synthetic if "unaware" & weaned off

Methadone – blocks pleasurable sensations (mostly), but holds off withdrawal
- just as addictive as heroin or morphine

Doctors – high addiction rate
- understand & not fooled by the effects of the opiates
- drugs are highly objectively available

<u>Recidivism-Desistance</u>

- most/many "mature out" -- e.g. tired of wear & tear,

- high relapse during first year off the drug – circa 60% (similar to offenders overall)

<u>Relationship between Opiate Dependency & Crime</u>

<u>Other addctive "drugs"</u>

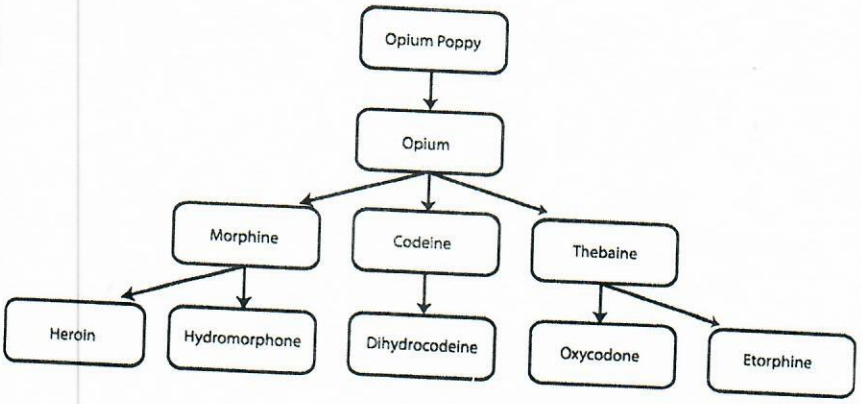
= stop use, then withdrawal symptoms emerge

= nicotine addiction

= alcohol

= barbiturates

= marihuana??



The Opiate Family

concentration in the natural plant. Now, commercial opium is standardized to contain ten percent morphine.

Morphine is one of the most effective drugs known for the relief of pain and remains the standard against which new pain-relieving medications are measured. It also has a number of medical applications beyond pain relief, with important use in emergency medicine. Morphine is available in oral solutions (Roxanol), sustained-release tablets (MS-Contin), suppositories, and injectable preparations. The injectable form can be given subcutaneously, intramuscularly, and intravenously.

Despite this very widespread use, especially in medicine, most of the morphine derived from opium is not used directly but converted into codeine and other opiates.

CODEINE

Codeine was isolated from opium soon after the discovery of morphine. However, most codeine used in the United States is not refined from opium but synthesized from morphine.

Codeine produces less analgesia, sedation, and respiratory depression than morphine. It also has good absorption if taken by mouth—unlike morphine, which is largely inactivated by the liver if taken as an oral preparation. Codeine is usually marketed in tablets or liquid, either alone or in combination with acetaminophen (for example, Tylenol #3) and other medications. This versatile drug is a particularly effective cough suppressant. It is by far the most commonly used narcotic in the world.

Table 1.2: Past Year Substance Use, Past Year Initiation of Substance Use, and Met Diagnostic Criteria for a Substance Use Disorder in the Past Year Among Persons Aged 12 Years or Older for Specific Substances: Numbers in Millions and Percentages, 2015 National Survey on Drug Use and Health (NSDUH)

Substance	Past Year Use or Misuse[v]		Past Year Initiation Among Total Population[vi]		Met Diagnostic Criteria for a Substance Use Disorder[vi,vii]	
	#	%	#	%	#	%
Alcohol	175.8	65.7	4.8	1.8	15.7	5.9
Drinking Pattern						
Binge Drinking[i]	66.7	24.9	da	da	da	da
Heavy Drinking[i]	17.3	6.5	da	da	da	da
Any Illicit Drug[ii]	47.7	17.8	nr	nr	7.7	2.9
Cocaine/Crack	36.0	1.8	1.0	0.4	0.9	0.3
Heroin	0.8	0.3	0.1	0.1	0.6	0.2
Hallucinogens	4.7	1.8	1.2	0.4	0.3	0.1
Marijuana[iii]	36.0	13.5	2.6	1.0	4.0	1.5
Inhalants	1.8	0.7	0.6	0.2	0.1	0.0
Misuse of Psychotherapeutics[iv]	18.9	7.1	nr	nr	2.7	1.0
Pain Relievers	12.5	4.7	2.1	0.8	2.0	0.8
Tranquilizers	6.1	2.3	1.4	0.5	0.7	0.3
Stimulants	5.3	2.0	1.3	0.5	0.4	0.2
Sedatives	1.5	0.6	0.4	0.2	0.2	0.1
Alcohol or Any Illicit Drugs[ii]	182.3	68.1	nr	nr	20.8	7.8
Alcohol and Any Illicit Drugs[ii]	41.3	15.4	nr	nr	2.7	1.0

Notes: Past year initiates are defined as persons who used the substance(s) for the first time in the 12 months before the date of interview. The "nr = not reported due to measurement issues" notation indicates that the estimate could be calculated based on available data but is not calculated due to potential measurement issues. The "da" indication means does not apply.

i. Binge and heavy drinking, as defined by SAMHSA, are reported only for the period of 30 days before the interview date. SAMHSA defines binge use of alcohol for males and females as "drinking five (males)/four (females) or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days" and heavy use of alcohol for both males and females as "binge drinking on each of 5 or more days in the past 30 days."

ii. Illicit drug use includes the misuse of prescription psychotherapeutics or the use of marijuana, cocaine (including crack), heroin, hallucinogens, inhalants, or methamphetamine.

iii. As of June 2016, 25 states and the District of Columbia have legalized medical marijuana use. Four states have legalized retail marijuana sales; the District of Columbia has legalized personal use and home cultivation (both medical and recreational). It should be noted that none of the permitted uses under state laws alter the status of marijuana and its constituent compounds as illicit drugs under Schedule I of the federal Controlled Substances Act.

iv. Misuse of prescription-type psychotherapeutics includes the nonmedical use of pain relievers, tranquilizers, stimulants, or sedatives and does not include over-the-counter drugs.

v. Estimates of misuse of psychotherapeutics and stimulants include data from new methamphetamine items added in 2005 and 2006 and are not comparable with estimates presented in NSDUH reports before 2007. See Section B.4.8 in Appendix B of the Results from the 2008 NSDUH.

vi. Estimates of misuse of psychotherapeutics and stimulants do not include data from new methamphetamine items added in 2005 and 2006.

vii. Diagnostic criteria for a substance use disorder is based on definitions found in the Fourth Edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV).

Source: Center for Behavioral Health Statistics and Quality, (2016).[3]