EDITORIAL

New Deviancy Theory and the Healthcare System's Role in Creating, Labeling, and Facilitating Unauthorized Prescription Drug "Abuse"

Although the "new" deviancy theories are now more than 50 years old, they continue to inform our understanding of contemporary patterns of illicit drug use.[1] The lines between licit and illicit forms of drug use have become increasingly blurred as the "new" deviancy theories were developed: the "misuse" of prescription opiate analgesics and the expansion of marijuana prescribing have pulled much of the discussion surrounding these activities into the medical sphere. It is our contention that the application of classic sociological and criminological theory lends valuable insights into contemporary patterns of unauthorized prescription drug "abuse."

Deviance is a sociological concept that refers to behaviors and beliefs that deviate from the norms, standards, and expectations of a given society.[1] It is a broader concept than crime and is distinct from the notion of "difference" in that it contains the implicit likelihood of authoritative intervention or sanction: that is, it refers to behaviors and beliefs that are stigmatized. "New" deviancy theories challenged established ways of thinking about such phenomena by rejecting the idea that there is a distinct, unambiguously deviant minority whose behavior can be explained as a result of individual pathology or social dysfunction. In place of the traditional "correctionalist" orientation, an "appreciative stance" was advocated that is committed to faithful understanding of the world as seen by the subject. Viewed from this perspective, it was argued that deviance is meaningful behavior involving choice and that there is an underlying continuity between normalcy and deviance.[2] Such continuity is evident in the use of prescription medications, which is deemed legitimate when it is authorized by a physician to treat a medical ailment, but is likely to be deemed deviant if patients continues to use when there is no longer a medical need to do so—either for pleasure or because they have become dependent.

Howard Becker provided the most famous statement of the "new" deviancy position when he noted that "deviance" is *not* a quality of the act the person commits, but rather a consequence of the application by others of rules and sanctions to an "offender": deviant behavior, in other words, "is behavior that people so label."[3] In his seminal work, *Becoming a Marihuana User,* Becker describes a series of learned steps that he deemed necessary for someone to become a regular drug user:

> . . . No one becomes a user without 1 - learning to smoke the drug in a way which will produce real effects; 2 - learning to recognize the effects and connect them with the drug use (learning, in other words, to get high); and 3 - learning to enjoy the sensations he perceives.[4]

Due to the illegality of marijuana use throughout the United States at the time, would-be users had to contend with powerful forces of social control. It was, Becker noted, by being a part of a user group that participants could gain access to supply, keep their use a secret, and gain access to justifications and rationalizations.

Use of prescription medications has many interesting contrasts and similarities with the processes Becker describes in relation to marijuana use. Marijuana and opiates have the potential to create both euphoric and dysphoric sensation. Physicians may spend considerable effort educating patients about the risks and benefits of

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the drug—helping them to perceive the effects and to make sense of the experience. In this way, the informed consent process replaces the role of the drug user group described by Becker. As part of the process of guiding patients and helping them to learn how to use prescription drugs, we might infer that physicians might inadvertently facilitate the transition to "abuse." From an ethical perspective, two major principles of medical practice seem at odds: the principals of *primum non nocere,* or "do no harm," and "patient autonomy." In respecting one of these principles, the physician violates the other. How such principles are understood might influence the way clinicians frame instructions for use, side effects, and the risk profiles of prescription drugs.

The role that rationalizations and justifications play in supporting deviant behavior was famously highlighted by David Matza and Gresham Sykes.[5] Insisting that "juvenile delinquents" do not subscribe to an oppositional morality, these authors argued that delinquency is motivated by exaggerated adherence to widely held subterranean values, emphasizing excitement and hedonistic leisure over formal values and work. Matza and Sykes also highlighted the role that neutralization techniques play in sustaining deviant behavior by warding off the guilt associated with such activities.[5] These techniques include denial of responsibility, denial of injury, denial of the victim, condemnation of the condemners, and appeals to higher loyalties. It follows that neutralization techniques only need to be applied when behavior is deviant, and always when it is illegal. During the initiation of prescription medications, these techniques are unnecessary, but are likely to be activated if use progresses beyond the point of medical need. Based on this perspective, one can assert that prescription use becomes deviant once the user needs to employ neutralization techniques: the use of such techniques signifies an implicit recognition that the behavior falls outside of what is considered legitimate or acceptable and is moving toward recreational use or dependency. Drawing on these insights, clinicians might consider assessing the use of neutralization techniques to diagnose "inappropriate" drug use. Addressing patients' assumptions and beliefs is already a core part of psychotherapy in the addictions. Further, understanding the patient's value system can help direct the informed consent discussion to explicitly confront the sensation of feeling high as part of the side effect profile of these drugs, especially with regard to opioids.

Jock Young drew attention to the socially constructed nature of deviance in his book *The Drugtakers.*[6] Adopting a relativist position, Young argued that the same activity might be labeled as simultaneously deviant and normal depending on whose standards are being applied. It is, in other words, the context surrounding the action as well as the larger societal norms that constructs the definition. This type of subjective assessment of deviancy has direct parallels with the interplay between physician and patient. It underscores some of the largest practical difficulties when labeling/diagnosing use, "misuse," and "abuse" or, in the sociological rhetoric, deviancy. There is a dynamic context for drug use: at one moment, it can be to treat pain alone, and another to enjoy the high or to meet a dependence, while many times it achieves all three. As with deviancy, the diagnoses of pain and/or dependency are subjective and context specific.

Edwin Lemert's[7] distinction between primary and secondary deviance is pertinent here. Highlighting the importance of social reaction, Lemert notes that primary deviance is commonplace and managed within a socially acceptable identity, while secondary deviance is internalized and becomes part of the core definition of the self. An example of secondary deviance would be when somebody who uses drugs comes to define themselves as an "addict." Interaction with significant others is an important influence and may lead to the normalization or acceptance of the deviation as peripheral to identity or may stimulate a symbolic reorganization of the self around the deviant act. The distinction between primary and secondary deviance parallels exactly the transition from authorized use of medication to treat pain to viewing the use of the drug or the addiction as the pathology in and of itself. Furthermore, Lemert describes secondary deviance as, "Adjustment to the overt and covert problems created by the consequent societal reaction to him," which corresponds with the way modern welfare systems give social support to chronic patients due to their disability.[8] The chicken and egg debate about whether welfare support incentivizes/creates long-term disability remains contentious.[9]

Harold Finestone showed how addiction is shaped by the broader social context in his influential ethnographic study of black heroin users in 1960s in Chicago. "With little prospect of achieving or identifying with status positions in larger society", he argued, "the Cat [heroin user] is the personal counterpart of an expressive social movement."[10] According to Finestone, this form of secondary deviance was an expressive, productive adaptation to cope with systemic racism, segregation, and exclusion from the formal economy. The heroin

scene provided the basis of a countercultural identity built around "cool" and "kicks" as well as the need to "hustle" (to maintain the lifestyle). For the Cat, the taboo and the desire to put himself beyond the comprehension of the "square" were motivating and unifying.[10] The development of subcultures around prescription medications requires an ethnographic study of its own.

"New" deviancy theories developed in opposition to the prevailing dogma that there was a deviant minority whose behavior could be explained as a result of intrinsic pathology or social dysfunction. Modern medical research tends to emphasize inherent pathology, neurochemical pathways, and social determination in much the same way as the very earliest deviancy theorist. Applying "new" deviancy to this modern phenomenon can generate a novel understanding of the topic. The main contribution of the "new" deviancy theories was to draw attention to the counterproductive nature of stigmatizing and exclusionary forms of social control: far from eliminating "deviance," such responses often serve to entrench it. This does not mean that social control is necessarily a bad thing, however, and we would do well to heed the distinction Braithwaite draws between shaming that is stigmatizing and counterproductive and that which is reintegrative and crime reducing.[11] Young made a similar distinction when he claimed "the subculture of drugtaking" has "the only viable authority to control the activity of its members" (p. 221). Rather than harassing and undermining existing drug subcultures, he advocated a policy of maintaining such cultures and encouraging users to adapt their habits by providing them with what he called "positive propaganda"—accurate, credible information about the effect of drugs. Physicians treating patients whose use of prescription medication is blurring into recreational or dependent use are well placed to fulfill such a role. These lessons can guide policy makers seeking to address the larger issues contribution to this problem.

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