SCAPEGOATING AND SOCIAL CONTROL IN THE CONSTRUCTION OF A PUBLIC PROBLEM:

EMPIRICAL AND CRITICAL FINDINGS ON COCAINE AND WORK

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INTRODUCTION

If mass media coverage and public policy discourse are any guide, cocaine occupies the same cultural role in the 1980s that LSD and marijuana occupied in the 1960s, that alcohol occupied during the push for Prohibition before 1919, and that opiates occupied just after the turn of the century. Cocaine, that is to say, is the newest root of all evil.

Cocaine can unquestionably be a dangerous drug, one that is often very harmful, and there is little doubt that the incidence and prevalence of both its use and abuse have risen sharply in recent years. There is also little question, however, that cocaine, like the many scourges which preceded it, has been made to shoulder a greater burden of social ills than any one drug can bear. To the usual

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untold "millions" of "addicts," "shattered families," and "destroyed youth" have been added the declining productivity of the American workforce, the loss of competitiveness of the entire U.S. economy, and even our national security. Although little systematic research has been done on cocaine use in and its effects upon the workplace, this has not inhibited treatment industry entrepreneurs, business leaders, politicians, and the media from sounding alarms as if studies had already documented what their anecdotes imply.

This paper attempts two objectives: to present some preliminary empirical findings on the effects of cocaine on the workplace functioning of approximately 60 users who reported using at work; and to place these findings in perspective by critiquing the dominant discourse about cocaine and the workplace. These two goals may well be contradictory, but we feel both are necessary. On one hand, we found substantial use of and deleterious effects from cocaine in the workplace. Yet, on the other hand, because what little research exists on this topic has been so often abused by stretched inferences and overgeneralization, so distorted by hyperbole, and so quickly drafted into the service of propaganda in the war on drugs, we felt a responsibility to present our results alongside our misgivings about the public hysteria of which they would otherwise become part.

Our respondents were drawn from a larger sample of heavy cocaine users interviewed extensively in the course of an ongoing NIDA-funded study of the processes of cessation from cocaine use. While the objectives of this larger study did not include analysis of workplace use, several questions on the impact of cocaine use at work were included in our survey instruments. Upon inspecting the initial frequency distributions of responses to such items, we were struck by the potential importance of work-related issues and so began what analyses we could of those who used at work.

Respondents for the larger study were recruited via the chain-referral (or "snowball") sampling technique (see Biernacki and Waldorf, 1981) from circles of known cocaine users. The subsample of workplace users described below was identified on the basis of remarks about workplace use that were volunteered during the open-ended, tape-recorded portion of our interviews. It must be noted at the outset that the users we will talk about are, by design, probably unrepresentative of the general population of cocaine users. To qualify for inclusion in our study, respondents must have used at least two grams of cocaine per week (approximately $200 worth) for a period of at least six months, or have used cocaine in some amount every day for at least one year. Thus, we are talking about only one part of the cocaine using population here—those at the "heavy" or extreme end of the use/abuse continuum.

COCAINE USE AND WORK: SOME EMPIRICAL FINDINGS

Lest there be any doubt that cocaine use is no longer limited to the high-profile occupations of Hollywood, professional sports, and Wall Street, let us enumerate

briefly the wide range of workers in our relatively small sample who reported using cocaine at work. Among the professional and managerial class, we found respondents in the following jobs: attorneys (immigration, personal injury, criminal, and one who had quit to become a drug counselor); the owner of a diamond business who had been a cocaine dealer in the Air Force; a national sales manager for a multinational corporation; a vice-president of finance for a high-tech, Silicon Valley firm; an executive recruiter; a computer systems consultant; a dentist; a psychology professor; a vice-president of a small holding company; a restaurant owner; and an advertising executive who owns an art gallery where clients and patrons alike have come to expect cocaine as an accoutrement to showings and other social gatherings.

Respondents who worked at other white collar occupations include: a private investigator; two drug counselors; a former bookstore owner; an air traffic controller; a commercial photographer; a computer operator in a law firm; a research assistant; a tennis club manager; a music producer; several secretaries; a real estate office manager; an account billing clerk; and a prop master in the film industry. Among the skilled working class, we found respondents such as: a mechanical inspector in a plastics factory; a machinist who repaired nuclear power reactors; a house painter; two bartenders; a yacht maintenance/repair worker; two carpenters; a limousine driver; two stagehands; a telephone installer; an auto mechanic; an elevator installer; a prostitute; a bus driver; and an oil refinery mechanic.

Comedian Robin Williams once quipped that "cocaine is God's way of telling you that you make too much money." As insightful as his remark was, and without denying that cocaine is very frequently used by the affluent, it is important to note that cocaine use is not limited to those who earn large salaries or high hourly wages. Some of the users in our sample were low-paid, unskilled workers; for example: a cashier in a quick-stop market; a porter for a produce company; a warehouseman; two assembly line workers, one of whom told us that in his factory there were a half dozen low-level dealers on the line who supplied small amounts of cocaine to dozens of night shift workers who enjoyed cocaine because it helped them "get through the shift." We also interviewed various restaurant workers, some of whom bought and used collectively because it reduced fatigue from long hours of standing (often accompanied by drinking), enhanced their productivity and disposition and thus their tips; housewives who valued cocaine for its ability to help them manage a multitude of complex chores simultaneously; and several respondents who were unemployed at the time of their interviews.

Of the 60 respondents, about one-fifth (20.7 percent) fell in the professional-managerial class, one-third in the white collar category (34.5 percent), and one-fourth (24.1 percent) in the skilled or semiskilled group. Their ages ranged from 18 to 53 years, with a mean of 34.4 years. Three in five were male. Nearly 4 of 5 (79.3 percent) were Caucasian; 1 in 10 (10.3 percent) were black; and an equal number belonged to other minority groups, mostly Latino. Three-fifths (60.3

percent) were single (or divorced); nearly a fourth (22.4 percent) were married, with an additional 1 in 6 (17.2 percent) living with a lover. Just over a fourth (27.6 percent) had children living with them. As might be expected from the list of occupations, they were a highly educated group. A total of over half had either graduated from college (24.1 percent) or from graduate or professional schools (another 25.8 percent). An additional 1 in 5 (19 percent) had had some college-level education, although the remaining 31 percent had a high school diploma or less. Fully 3 in 5 (62 percent) grew up in middle-class homes.

Most respondents were seasoned veterans of illicit drug use in the 1960s and 1970s. For example, over four-fifths of the sample (82.8 percent) had used marijuana more than 1,000 times, while nearly that many (72.3 percent) had used LSD more than 10 times. Most had at least tried drugs in all major categories of the American pharmacopia, licit and illicit. Nearly 1 in 4 (24.1 percent) had used heroin intravenously at least once, although only about a third (8.6 percent) of these respondents had moved beyond experimentation to a level of use they felt approached addiction. Only 4 (6.9 percent) had ever been alcoholic, although this has more to do with the fact that we attempted to screen out of our sample anyone who had had a drinking problem within the past 10 years than it does with any actual incidence of heavy drinking among cocaine users generally.

Most of our respondents had used two or more grams of cocaine per week for an average of over a year (mean = 12.9 mo; median = 8 mo.; mode = 12 mo.; range = 1–78 mo.). Nearly 2 in 5 (39.7 percent) had used cocaine daily for at least 6 months, more than half of whom (24.1 percent of the total) reported daily use for at least one year. Although little attention has been paid to individual level fluctuations in patterns of use, it seems that among this sample such fluctuations were the rule. Most reported periods of very heavy and/or daily use, preceded and/or followed by periods of more moderate and sporadic use. During their heaviest use periods, our subjects reported using an average of 6.3 grams per week (median = 4; mode = 7; range = 1–28). Such heavy use periods—or "runs"—appeared to be common, but lasted an average of less than one year (mean = 9.1 mo.; median = 4.2 mo.; mode = 3 mo.; range = 1–100 mo.); they generally remained only episodes in rather lengthy cocaine careers.

Two-thirds primarily inhaled ("snorted") the drug. Most of the remaining third smoked ("freebased"), although two were intravenous injectors ("shooters"), and a few had used all three modes of ingestion. At the time of our interviews (July, 1985 to July, 1986), more than two in five (43.1 percent) had either quit using entirely or radically reduced their use (from heavy and/or daily use to very rare light use) for at least one year. The remaining respondents (56.8 percent) had not quit and were still using at least occasionally at the time of interview. Those who fell into the quitter category had been either absolutely or relatively abstinent (no more than four instances of use in a 12-month period) from cocaine for about two and one-half years (mean = 29.2 mo.; median = 24 mo.; mode = 24 mo.). Despite the preponderance of very heavy use and the

large proportion who had become quitters, only about one in ten of the total sample (10.3 percent) had ever sought any form of treatment. Interestingly, none of those classified as quitters had ever asked for help from an employer.

Availability and Acceptability

While historical generalizations are exceedingly risky, we have seen no evidence to contradict Weil's (1972) argument that consciousness-altering substances have been used in all cultures during all historical epochs. Indeed, it seems safe to say that when drugs are available they will be used—although not always abused—by at least some substantial portion of the population. Availability of a drug is always an important precondition for use or abuse, and the more illicit and expensive the drug, as with cocaine, the more critical availability becomes. Our earlier research on cocaine use (Waldorf et al. 1977; Reinarman 1979) sensitized us to the importance not only of the availability of the drug, but also of its acceptability within a potential user's social circles. Trusted associates who used cocaine were critical to initiation. Availability without such associates may not lead to sustained use.

In light of this, we asked our respondents both about their sources for supplies of cocaine and the number of their friends who used it, the latter in particular being a crude index of their immersion into cocaine-using circles or scenes where the use of the drug presumably was not disapproved. Their responses suggest that availability was not a problem. While some respondents had only one or two sources, others had dozens. The mean number of sources for this sample was 6.52 (median = 5.15; mode = 5; range = 1–39). On average, more than half of these were formal sellers, although the size of their operations varied from small dealers who sold only small amounts to a handful of friends, to large dealers—or "weight sellers"—who sold to many different smaller dealers and users. Slightly less than half, on average, were friends who were not dealers in the formal sense, but from whom the respondents could obtain supplies.

Our subjects reported a mean number of 8.4 co-users (median = 4.6; mode = 0 [i.e., 12 percent used alone]; range = 1–50), suggesting that the majority of our subjects had a good number of people with whom they used cocaine. In an attempt to get a handle on how such immersion into cocaine circles figures in the cessation process, we asked all quitters about the cocaine use of different kinds of friends. These results, too, suggest substantial immersion into the cocaine scene. For example, nearly half our quitters (48.1 percent) reported that "almost all" their "best friends" and about two-fifths of the friends they saw "most often" (40.1 percent) used cocaine. Interestingly, the proportion dropped to less than one-fifth (18.5 percent) when we asked about their "oldest" friends.

Health Problems

On the assumption that heavy users such as those in our sample would likely have experienced some cocaine-related health problems and that these could well

have an impact on job attendance and performance, we asked a long series of questions on health problems likely to stem from prolonged use or abuse. The number responding "yes" to each item is given in Table 1 in order of frequency.

This list of health problems was compiled from items appearing in the cocaine literature and reported by users in our earlier study. However, in order not to preclude other health problems, all respondents were asked an open-ended question about the "most serious" health problem they had ever experienced by virtue of using cocaine. The modal response was sinus headaches (36.2 percent), followed by a general complaint we have dubbed "nose problems" (20.7 percent). This is probably due to the fact that the vast majority of our respondents were primarily snorters and would therefore be less likely to report the sorts of health consequences some shooters and freebasers have experienced (see Siegal 1984).

However, there were a few subjects who reported more serious health problems due to their cocaine use. One had experienced angina and another had had a convulsion, while two reported hepatitis. Thus, although the data presented in Table 1 suggest that most of our subjects experienced several minor health problems due to cocaine, only a few reported major health problems. The impact on the workplace of even minor problems, however, especially if several were experienced concurrently, could be significant. This question is addressed in subsequent sections.

Table 1. Frequency and Percentage of Respondents "Ever" Experiencing Cocaine-Related Health Problems (n = 58)

	Number	*Percent*
Nervousness	51	87.9%
Grinding teeth	45	77.6%
Nasal bleeding	44	75.9%
Trembling hands	38	65.5%
Insomnia	36	62.1%
Cold sweats	25	43.1%
Diarrhea	23	39.7%
Feeling dizzy	23	39.7%
Feeling faint	20	34.5%
Nausea/vomiting	20	34.5%
Frequent colds	18	31.0%
Frequent sore throats	16	27.6%
Burnt septum	11	19.0%
Urinary problems	8	13.8%
Cysts or boils	3	5.2%

Cocaine-Related Work Problems

Table 2 shows the responses to questions on the effects of cocaine on work relations, absenteeism, and productivity. The items are listed in order of frequency.

For most readers, it may seem that such responses warrant no interpretation or comment. Clearly, by these users own self-reports, cocaine use can have deleterious consequences on the worker and the workplace. It is worth pointing out, however, that these respondents are, by definition, extremely heavy users, and that they were selected from among many others, who probably did *not* use at work, precisely because they *did* mention using at work. Second, we must note that for many of these users, cocaine use did not have unequivocally negative effects on their work. For example, more than one in five (22.4 percent) reported that cocaine use had only a positive effect on their relations with co-workers. Further, a similar proportion (20 percent) reported that cocaine use "enhanced office work," and nearly two in three (64.5 percent) said that cocaine use "enhanced working overtime or late hours."

In mentioning these other, positive responses, we do not wish to imply that they negate or even diminish the significance of the frequency of cocaine-related work problems, which are serious enough by anyone's standards. Rather, we wish only to note that from the point of view of workplace users, cocaine is not merely an unmitigated drain on performance and productivity. Indeed, on the basis of our in-depth interviews, we are led to expect that many if not most workplace users originally ingest cocaine at work in order to improve performance, and that in the early stages of use, cocaine may well have this sort of positive effect. (Cf. Gay et al. 1973; and Washton 1985, for interesting insights on cocaine's appeal to the ambitious and hard-working; and Hauty and Payne 1958, on how stimulants can offset losses of work proficiency due to prolonged work without necessarily producing undesirable effects.)

Moreover, the nature of the effects of cocaine on work and the workplace are

Table 2. Frequency and Percentage of Workplace Problems Due to Cocaine Use (Number Responding "Yes"; n = 58)

"Did you . . . as a result of your cocaine use?"	*Number*	*Percent*
Ever feel you weren't working well?	36	62.1%
Ever take days off?	35	60.3%
Ever have strained relations with boss?	16	27.6%
Ever have negative effects on relations with co-workers?	13	22.4%
Ever lose a job?	7	12.1%

very likely contingent upon many things, including: the stage in the career of use (e.g., early, regulated use vs. late, uncontrolled use), which does not inevitably pass beyond controlled use to abuse (Murphy, Reinarman, and Waldorf 1986); the drugs used in conjunction with cocaine (e.g., alcohol used to "come down" from cocaine produced more absenteeism and reduced productivity and work quality than did cocaine used alone according to most respondents); the nature of the work (e.g., manual labor at a deadline vs. complex, creative problem-solving in a group setting); the style of use (e.g., incidental or occasional workplace use vs. routine use during work hours); and the mode of ingestion (our respondents reported far fewer troubles associated with snorting than with freebasing). Some of the possibilities for such variation in consequences can be seen in the following vignettes. They illustrate the possibilities for serious negative consequences with long-term use, but also suggest that such consequences are not inevitable and that some workers have managed to use cocaine to enhance their productivity for several years prior to the occurrence of cocaine-related workplace problems.

"Bill" is a 23-year-old, white concert producer who had used cocaine for several years before getting into trouble. In his heaviest use period, he snorted three or four grams per week for about three months. While at first cocaine added to his productivity and allowed him to keep the late hours required by his work, it later got the better of him. "I would go to the meetings but I just couldn't think of anything. You need to do a lot of things and your mind is not working. You think you are really creative when you're high, [but] people can tell after a while that you're on blow. . . . I've lost a lot of money in this business. . . . I'm not proud of myself about that. . . . I was ready to expand . . . but drugs screwed me up. It [cocaine] just crept up on me . . . all the stress." He also noted that this was more or less an occupational hazard: "Nine out of ten promoters if not more go out of business. They get involved in the entertainment industry too much and they get involved in drugs. . . . You party too much and people offer you drinks and give you coke. That's what happened to me and I wasn't strong enough and I didn't have enough will power to say no. I didn't realize what it was doing to me, and that was my biggest downfall."

"Harry" is a 38-year-old machinist and union organizer who was introduced to cocaine by his foreman. He has used cocaine for nine years, the last few being problematic as he began to drink heavily to moderate the effects of pressure and cocaine. "I worked the second shift in a big factory. There was lots of speed around . . . people were trying to stay awake. Cocaine was the royalty of speed." When Harry was promoted from machinist to union organizer, he received a major increase in income, a boost in ambition, and more work pressures. His cocaine use escalated. "When I was doing it, I'd do it everyday because I was afraid to stop. . . . I used to think I'd fall apart if I stopped because I knew how tired I was. I used to use that as an exucse, 'Oh, I've got so much work to do, I can't stop now.'. . . Being an organizer is kind of an insane

job. Most burn themselves out.'' Although his motives for using cocaine to work were drawn from a quintessentially American work ethic (i.e., to further ambition, achievement, and accomplish more in a limited time) rather than from any deviant value system, the results eventually fell far short of the success story he had hoped for. Harry went from being one of the very best organizers to being ''real unhappy'' and developing a drinking problem on top of whatever damage he did to himself with cocaine.

''Archie'' is a 30-year-old white male who works as a mechanical inspector in a plastics factory. He had used cocaine several years ago for over a year at the rate of more than two grams per week for nine months. ''I'd do it during break. The amount I'd do would be just enough to get me through to the next break. It was assembly line work, so you had to be real fast. It wasn't very detailed at all, but there were safety factors involved. So, you know, cocaine made me more alert and more aware of what I was doing.'' Asked whether he meant that cocaine use enhanced his performance and actually allowed him to get more work done more safely, Archie replied, ''Definitely, definitely.'' He never used it only at work, but rather at friends' houses and parties. He never experienced any problems associated with his cocaine use at work or in his private life. He did note, however, that he ''got bored'' with the extra energy from cocaine and so stopped using entirely in 1977.

''Melvin'' is a 33-year-old white male attorney-turned-drug-counselor who used cocaine almost daily for over five years. During his heaviest use period, he ingested 25 grams per week for about 6 months. During the last of these months, just prior to seeking hospital treatment and quitting altogether, he freebased up to 50 grams per week. Throughout most of the 5 years, however, he found snorted cocaine to be an important aid to his work. ''When I was studying for the bar exam I used cocaine. . . . Then when I was taking the bar exam I used cocaine. When I passed the bar exam it sort of confirmed all of my beliefs that cocaine was a wonderful drug because I didn't think that I had the capability of passing the bar. So, the fact that I passed it and was using cocaine could only be attributed to the cocaine; it couldn't have been attributed to the fact that I was smart enough to pass. There was a lot of deep psychological stuff behind that.'' In his fourth year of trouble-free use, Melvin built a successful business. This too tended to confirm his sense that cocaine was a positive aid to his productivity. However, in the fifth year he stopped snorting and began freebasing. That is when his use became extreme and dysfunctional. He ''couldn't enjoy it'' anymore and ''hit bottom.'' He entered a hospital, cleaned up, and has been abstinent from cocaine for a year and a half. He attends Cocaine Anonymous meetings and now works as a drug counselor.

Although three of these four subjects eventually experienced work problems due to cocaine use, their accounts suggest that such problems vary in severity,

length of use before their onset, and their actual impact on the worker and the workplace. In an effort to learn more about the relationships between cocaine use and workplace problems, we analyzed the associations among the extent of use (highest use in grams per week, and length of use at two or more grams per week), acceptability or immersion in social circles where cocaine was consumed (number of friends with whom they used cocaine), availability (number of sources from whom cocaine could be purchased), and work problems that respondents attributed to their cocaine use.

The variable of "cocaine-related health problems" was also construed as a user characteristic rather than a dependent variable for two reasons. First, there were no correlations of any significance between health problems and the independent variables measuring user characteristics. Second, there was a correlation coefficient of .417 between health problems and workplace problems. Thus, we treated health problems as a user characteristic or independent variable so as to

Table 3. ANOVA of Cocaine User Characteristics by Cocaine-Related Work Problems

	USER CHARACTERISTICS									
WORK PROBLEMS	*Availability (# of cocaine sources)*		*Acceptability/ Immersion (# of Co-Users)*		*Highest Use (g/week)*		*Length of Heavy Use (# mos. @ 2 g/wk)*		*# of Health Problems*	
"EVER. . . "	*N*	$\bar{X}$	*N*	$\bar{X}$	*N*	$\bar{X}$	*N*	$\bar{X}$	*N*	$\bar{X}$
Lose Job	58	6.52	58	8.41	57	6.29	55	12.95	58	5.95
No	51	6.67	51	8.08	51	6.06	49	12.51	51	5.47
Yes	7	5.43	7	10.86	6	8.25	6	16.50	7	9.43**
Strain With Boss	58	6.52	58	8.41	57	6.29	55	12.95	58	5.95
No	42	7.14	42	8.62	41	6.35	40	11.85	42	5.52
Yes	16	4.88	16	7.88	16	6.16	15	15.87	16	7.06
Strain With Co-Workers	58	6.52	58	8.41	57	6.29	55	12.95	58	5.95
No	40	6.95	40	8.48	39	5.78	39	12.18	40	5.23
Yes	18	5.56	18	8.28	18	7.42	16	14.81	18	7.56*
Poor Performance	58	6.52	58	8.41	57	6.29	55	12.95	58	5.95
No	22	6.14	22	7.04	22	7.86	22	11.23	22	5.73
Yes	36	6.75	36	9.25	35	5.31	33	14.09	36	6.08
Absenteeism	58	5.76	58	8.41	57	6.29	55	12.95	58	5.95
No	23	3.54	23	8.30	23	7.22	22	14.32	23	5.70
Yes	35	6.88	35	8.49	34	5.67	33	12.03	35	6.11

*p=<.01; **p=<.001.

be able to examine its association with workplace problems. It was constructed as a simple continuous variable, with a value of 1 added for each "yes" answer.[1]

The relationships between selected cocaine user characteristics and cocaine-related work problems are explored by ANOVA comparison of means and Pearson correlation coefficients in Tables 3 and 4, respectively. Only two statistically significant differences in means were found, both having to do with the extent of reported health problems. First, those who reported "ever" losing a job in part due to their cocaine use reported a higher number of cocaine-related health problems. Second, those who reported that their cocaine use had "ever" caused strain with co-workers also reported a higher average number of health problems. The correlation coefficients in Table 4 tell the same story.

The fact that there were no other significant associations may have to do with small sample size or measurement error. Our sample was, after all, drawn from a larger group of cocaine users on the rather ad hoc basis of whether they volunteered reports of workplace use in the course of a depth interview about cessation from cocaine. Further, our study was not designed to examine workplace use per

Table 4. Pearson Correlation Coefficients: Cocaine Use Characteristics by Cocaine-related Work Problems

	WORK PROBLEMS				
User Characteristics	*Lose Job*	*Strain With Boss*	*Strain With Co-workers*	*Poor Performance*	*Absenteeism*
Availability	−0.0707	−0.1776	−0.1131	0.0522	0.0858
(# of cocaine sources)	(58)	(58)	(58)	(58)	(58)
	P=0.299	P=−0.091	P=0.199	P=0.349	P=0.261
Highest Use					
(g/week)	0.1013	−0.0131	0.1151	−0.1878	−0.1146
	(57)	(57)	(57)	(57)	(57)
	P=0.227	P=0.462	P=0.197	P=0.081	P=0.198
Length Heavy Use					
(# mos. @ 2+/g/wk)	0.0916	0.1318	0.0881	0.1034	−0.0826
	(55)	(55)	(55)	(55)	(55)
	P=0.253	P=0.169	P=0.261	P=0.226	P=0.274
# of Health Prob's	0.4614	0.2461	0.3859	0.0618	0.0733
	(58)	(58)	(58)	(58)	(58)
	P=0.000	P=0.031	P=0.001	P=0.322	P=0.292
Acceptability/					
Immersion	0.0772	−0.0284	−0.0078	0.0913	0.0076
(# of Co-Users)	(58)	(58)	(58)	(58)	(58)
	P=0.282	P=0.416	P=0.477	P=0.248	P=0.478

se, so our questions were neither exhaustive nor ideal for examining the issue of the effects of cocaine use on work. Thus, these data must be seen as preliminary and interpreted with caution until more rigorous measures can be used on larger and better defined samples.

That said, however, we think it is at the very least interesting that the availability and acceptability of cocaine use and, more importantly, the extent of use showed no direct association with either health problems or workplace problems. Indeed, the tables show some non-significant differences in means and weak correlations which ran quite against our expectations. For example, those who reported having lost a job due in part to cocaine use—arguably a proxy for the most extreme cocaine-related work problems—did report having more co-users, higher peak use, and longer heavy use than those who had not lost a job. But, contrary to expectation, they had fewer sources for supplies of cocaine. Those reporting cocaine-related strain with the boss also had fewer sources.[2] Similarly, those reporting poor work performance due to their cocaine use had a somewhat longer career of heavy use but a lower level of highest use. And among those who reported cocaine-related absenteeism there was both lower highest use and shorter heavy use periods than among those who reported no absenteeism.

While it is important not to read too much into such apparent anomalies, we think that taken together they suggest the need for greater analytic attention to a whole host of variables—individual, occupational, and other factors having to do with the workplace itself—which may well complicate the relation between the use of cocaine and workplace problems.[3] Should such anomalous findings recur in larger samples with more rigorous measures, then policy makers, EAP counselors, business, and the media will have to cast their nets more widely—beyond drug abuse as individual deviance—if they are to catch valid explanations of workplace troubles now so often attributed to cocaine alone.

DISCOURSE ABOUT COCAINE AND WORK

The analytic complexities needed to understand cocaine use in the workplace are rarely found in the dominant discourse about such problems. In fact, this discourse is more noteworthy for what it leaves out than for what it puts in to the drug use/work problems equation. One would never imagine, for example, that for nearly a century social scientists have studied workplace organization, the labor process, and the structural sources of worker alienation and oppositional practices, or that for decades the core issue was what working conditions had to do with employee substance abuse, rather than what such abuse was doing to the workplace.

Also largely missing with respect to drug use issues is the social constructionist sensibility. Research in this vein demonstrates that social problems come to exist not merely because there is some "objective" level of human suffering going on, but because some group makes viable claims that such suffering should

be publicly constituted as a problem. We think that the ontological skepticism of the social constructionist tradition is important—especially when "everyone knows" what the problem is, and doubly so when the putative problem is some form of consciousness alteration.

Historically, every single drug scare or war on drugs has been shown to consist of political, economic, racial, class, or cultural matters which had little to do with drug use or its consequences. Musto (1973) has shown this to be the case for opiates and cocaine at the turn of the century. Gusfield (1963) brought out the same dimensions of the temperance movement. Becker has made similar points about the first crusade against marijuana (1963) in the Depression and about LSD (1967) in the 1960s. And we should not forget that alcohol, always America's greatest "drug problem," was blamed not merely for industrial accidents, declining productivity, and higher medical costs, but also for marital dissolution, poverty, crime, mental illness, wayward youth, unwed mothers, and general moral degeneracy (see, e.g., Levine 1984; Baumohl 1986).

If history is any guide then, we ought to be alert to the ways in which the "crisis" or "epidemic" of cocaine use in the workplace is both more and less than what it seems. One way to do this is to examine critically the evidence invoked to support claims that an "epidemic" of drug use at work exists as an empirical phenomenon, and that its course and consequences are uniformly what they are claimed or assumed to be. Even a cursory examination suggests that, despite repeated cover stories in every major newspaper and magazine and on every news show, very little solid research has been done on cocaine use in the workplace. Most of what we hear are anecdotes and opinions from public officials, treatment professionals, law enforcement officers, and consultant experts, each with their own axes to grind, and tales from reformed drug abusers who have been redeemed and whose horror stories are tacitly taken as typifications of the indubitably disastrous ends to which drug use inevitably leads.

Time's recent cover story on drug use in the workplace illustrates the paucity of hard evidence and the plethora of soft inference in such stories. The title, "Battling the Enemy Within," conjures up images of the Red Scare and wartime idioms like "loose lips sink ships." It is rife with anecdotes about private security forces cutting padlocks on the lockers of 400 workers at a utility plant and drug-sniffing dogs searching the grounds of an oil company, each recounted as if the grounds for such social control mechanisms were self-evident. There are quotes like the following, which are routinely offered without the usual supporting evidence required by journalistic canons:

> Illegal drugs have become so pervasive in the U.S. workplace that they are used in almost every industry, the daily companions of blue- and white-collar workers alike. . . . Their presence on the job is sapping the energy, honesty, and reliability of the American labor force even as competition from foreign companies is growing even tougher. . . . The costs of drug abuse on the job are staggering. . . . Drug abuse cost the U.S. economy $60 billion in 1983 (*Time*, 3/17/86, pp. 52–53).

This passage is no better nor worse than others of its ilk, and the gist of this paragraph may pass inspection. Clearly drugs are used in all sorts of industries by some workers in most occupations, and it is no doubt true that this use entails some costs. However, the phrase "*the* U.S. workplace" (emphasis added) seems to gloss over dozens of occupational, organizational, technological, professional, cultural, and regional differences that obviously figure into patterns of workplace drug use. And "daily companions"? Not even a majority of our most extreme cocaine abusers used at work every day; the vast majority who ever used at work did not do so throughout the entire span of their use, and they were in most cases in a distinct minority at their workplaces. Further, to say that it is cocaine that is "sapping the energy, honesty, and reliability of the American labor force" is to imply that nothing else had affected workers' productivity and integrity before cocaine came along, and that the problem exists in the entire labor "*force*" rather than among what may be a small minority of workers.

In the eight-page article there is only one qualifying phrase: "No one knows precisely how pervasive drug use on the job is" (p. 53). But this is immediately followed by: "Federal experts estimate [who? on what evidentiary grounds?] that between 10 percent and 23 percent of all U.S. workers use dangerous drugs on the job. . . ." Readers might want to know whether it is one in ten or one in four; which drugs; how often; and whether this use, if in fact it exists, *by itself* automatically entails the dangers and costs assumed throughout by the reporters.

Then we are told of a study conducted by counselors from the 800-COCAINE hotline which showed that 75 percent of callers used cocaine at work and that 69 percent "regularly worked under the influence of cocaine." We are not told what "regularly" means, what the consequences of this are assumed to be, or, more important, that those who call the hotline are likely to be in more desperate straits than the twenty million cocaine users who do not call. In fact, an utter absence of information on what sorts of samples are being talked about is a clear problem with such articles, and worst-case scenarios are routinely and uncritically presented as if they were the norm.

The paragraph quoted above did offer, perhaps inadvertently, the unusual and intriguing notion that foreign economic competition has heightened the concern of U.S. businesses about drug use, although there was no hint that this is only one of many reasons why business is worried about declining productivity and is seeking more and better social control over workers. Beyond this possible exception and the one qualifying phrase, the article maintained a theoretical impoverishment and a fact-starved ideological consistency worthy of *Pravda*. (Indeed, no less than the "most humiliating defeat (46–10) in SuperBowl history," that of the New England Patriots to the Chicago Bears—a loss which virtually every football fan and even Boston bookies had predicted—was attributed by *Time*'s reporters to the *purported* use of *marijuana* by *some* Patriot players at *some* point "during the season.")

Nor are respectable journals immune from the sorts of simplistic stories seen in

media accounts. For example, a conservative Republican Senator was given space in *American Psychologist* in which to attribute the nation's economic woes to "the devastating effect of alcoholism and drug abuse" (Quayle 1983, p. 454). After giving a narrative nod to the tax, investment, and other economic aspects of declining productivity, the Senator went on to quote "experts" (although not evidence that might be examined independently) whose testimony "showed" that drugs such as cocaine were "at the root of the [productivity] problem" (*Ibid.*, p. 454). He made a series of factual assertions—all without a single reference—such as the following:

> Employees with a drinking or drug problem are absent 16 times more than the average employee, have an accident rate that is 4 times greater, use a third more sickness benefits, and have five times more compensation claims while on the job. Forty percent of industrial fatalities and 47% of industrial injuries can be traced to alcohol abuse. These impaired workers function at slightly more than half their normal capacity. With 3 million alcoholics in the United States and up to *53 million people using drugs occasionally, we are looking at almost 60 million workers performing at significantly less than their normal capacity* (Quayle 1983, pp. 455–56).

With such statistical and semantic sleight of hand, the decline of America's economic might is laid at the door step of 53 million occasional, not necessarily workplace-using drug users, 90 percent of whom, according to the Senator, principally use marijuana. Leaving aside his severe underestimation of the number of alcoholics and his severe exaggeration of drug users, the extrapolations are inexact and unsupportable in the extreme. In fairness, however, it must be noted that the Senator's figures, wherever he may have gotten them, are treated with genuine circumspection compared to those casually bandied about elsewhere.

There are, for example, these entries in *EAP Digest,* one of the principal sources of information on employee drug problems for businesses:

> [N]ot enough attention has been given to the problem of employee theft. It is reported [no citation] that "stealing from the boss" results in losses of $5 to $100 billion to employers each year. . . . Of the five million employees who are said [no citation] to have tried cocaine at least once, about 25% are regular users . . . perhaps one-third of a million can be described as "hopelessly" addicted [no citation]. . . . The regular user spends an average of $33,000 a year on cocaine alone [no citation]. . . . Cocaine purchases, it again has been estimated [*sic;* no citation] can exceed $500 a day or up to $200,000 a year for one user. . . . As a result of these figures [literally] it can be said that regular users must generate at least $33 billion each year to support their cocaine habits. . . . How much do cocaine-dependent employees steal from the boss? Obviously we have no way to tally the actual losses. But let's assume that only one-half of the $33 billion is raised through theft from all sources. It seems safe to further assume that at least one-half of that—or more than $8 billion ($8,000 for each user)—may be due to theft from employers (Silvan 1984, p. 27).

Atop this statistical house of cards rest second-order inferences and estimates

that are at best seriously misleading. Moreover, in addition to the two assumptons the author makes explicit, there is the implicit assumption of pharmaco-economic determinism; i.e., that cocaine users are like depraved dope fiends who would steal their own mothers' TV sets for a fix, a stereotype that may well not even apply to many heroin addicts (see Hanson et al. 1985). While the author smuggles into her narrative the assumption that cocaine users use 365 days a year, there is no evidence that even a majority of the estimated five million so-called "regular users" of cocaine use it on the job at all, much less everyday—to say nothing of the other 17 million who have, according to NIDA reports, tried it (see, e.g., Adams and Durell 1984). There is also the systematic omission of any link between, on the one hand, declining productivity and employee theft, and on the other, factors such as managerial practices, declining investment in productivity—enhancing technology, capital flight, union busting, stress, the loss of craft and control over work processes and products, alienation, exploitation, or any of the other ingredients in workplace conflict that sociologists have studied for years.

The same journal in the same year contains another article on drug abuse in the workplace that is full of similarly slanted speculations. After a string of unreferenced "startling statistics," the authors cite an unreferenced "study" showing that one of six drivers "responsible for fatal [auto] accidents was high on marijuana when the accident happened" (Masi and O'Brien 1984, p. 24). Then they scale new "heights" of unsubstantiated speculation:

> A great deal of attention has been given to alcoholism, the very roots of the EAP field. On the other hand, expertise with drug abuse in the workplace is virtually unknown. . . . However, evidence [uncited] shows that marijuana is at least as threatening to physical health as tobacco and alcohol . . . and potentially more damaging to the respiratory system than tobacco and [*sic*] a significant threat to the reproductive system. . . . Although the physical manifestations of drug abuse often remain undetected, they will inevitably be recognized by a deterioration of work productivity. . . . The state of the art in case-finding employees [*sic*] with drug abuse problems affecting the job is in its infancy. Due to low case reporting, data to help employers develop appropriate methods for reaching such employees is based on sheer speculation (Masi and O'Brien 1984, pp. 24–25).

Here the authors start out strongly by asserting that the expertise needed to understand drug abuse in the workplace is nonexistent, and then proceed to prove the assertion with their own unsupported and unsupportable assertions about marijuana. After stating that signs of such drug abuse often remain undetected, they then assert that such signs will "inevitably" be detected in deteriorating productivity, only to note in the end that despite efforts at "case-finding," there is no good data to go on because of "low case reporting." It will not do to claim that a huge problem exists and then to add that it cannot be found because we don't know how to look or what to look for. The very real risks from drug abuse at the workplace will end up being confused and camouflaged by such distortions

and exaggerations when they are presented as fact by the very "experts" businesses rely upon for knowledge of such issues.

Although these articles cite no references, many of the stories in major news magazines do cite the one piece of research that seems to provide the basis for estimates of how many billions of dollars drug use costs U.S. businesses. This federally-funded study by the Research Triangle Institute (Harwood et al. 1984), in contrast to the articles in which it is quoted, is an island of cautious scholarship in a sea of suspect data. The authors make use of copious qualifications and spell out all of their procedures for estimating the total national costs of alcohol abuse, mental health problems, and drug abuse in the workplace. They are at pains to note the weaknesses in their assumptions and the ways in which missing or vague data make theirs a precarious exercise. Interestingly, although the costs of alcohol problems are estimated to be double those of all other forms of drug use and abuse combined, and while mental health problems are also more costly, the costs believed to be linked to illicit drug use are what make it into mass media reports (see, e.g., *Newsweek* 8/22/83).

The researchers who pulled together the estimates cannot fairly be held accountable for the uses to which their work is subsequently put. Nonetheless, it is instructive to examine how their figure of $46,936,000,000 worth of "costs to society" from drug abuse was estimated (Harwood et al. 1984, p. 4). Alongside treatment costs, deaths, auto accidents, crime, welfare programs, and more miscellaneous cost categories, there is one called "reduced productivity," estimated to be $25,716,000,000, which is of greatest interest here. It is the largest category (by a factor of five) in the entire list of drug abuse costs, comprising 55 percent of the total national costs attributed to drug abuse. Moreover, they report a trebling of total drug abuse costs between 1977 and 1980, 72 percent of which increase was attributed to reduced productivity (Harwood et al. 1984, p. 10). Yet they emphasize—curiously, given the epidemic of attention given to the "epidemic"—that such "major increases . . . are due primarily to changes in methodology, or to inflation . . . and population growth," and that they "do not attribute any of the growth in costs to changes in the incidence, prevalence, or severity" of workplace drug abuse (p. 11). Indeed, even more curious, the authors show a statistically significant ($p = <.05$) *decline* in cocaine use between 1979 and 1982 (p. 31).[4]

Perhaps most interesting here are the measures used to estimate the dollar amounts of reduced productivity attributed to drug abuse. We quote the authors directly:

> Drug abuse is hypothesized to impair productivity of workers in a manner similar to the impact of alcohol abuse. . . . It was found that individuals who reported that they had *ever used marijuana daily for at least a month had household incomes 27.9 percent lower than those of persons with similar characteristics who had not used marijuana. The prevalence rates reported in Table III–22, which indicate 7.8 million young men and women aged 18–34 had used marijuana at that level.* [*sic*] The number in each age/sex group of Table III–23 was

> multiplied by the (1) labor force participation rate (to adjust for persons unlikely to pursue employment), (2) age/sex productivity rates, and (3) impairment rate (27.9 percent) to obtain a value for reduced market productivity of $25.7 billion (Harwood et al. 1984, p. 70; emphasis added).

After re-reading this section of the report to ensure that we had not missed something important, we turned to the appendix for a more detailed explanation of such methodological choices. Frankly, we found it difficult to believe that sophisticated researchers, who had obviously done a tremendous amount of work, could have used household income differentials as a proxy for lost productivity in the workplace, much less lifetime prevalence of daily marijuana use for one month as the sole index of drug abuse. Given the pre-eminent place accorded cocaine use in the headlines, we were quite surprised to find *absolutely no* measure of its use or abuse in the model used to estimate its purported costs to American business and society. Even if one were to accept the exceedingly dubious and untested hypothesis that drug abuse (particularly of a central nervous system stimulant such as cocaine) drains productivity just as alcohol (a depressant) does, there are a host of questions that need to be asked about using a calculus in which the two principal variables (household income and marijuana use) are so far removed from the actual behaviors they are purported to measure: work productivity and cocaine use.

Far from assuaging our anxiety, the appendix raised still more doubts. There, readers are told that the analysis was performed using models derived almost exclusively from studies of disease behavior *on* humans rather than deviant behavior *of* humans; that only one person was interviewed per household, and that it was *this* person's drug use, but the *household's* income that was used; that the income data took the form of $5,000 ranges, which were "of poor quality for analysis such as this" (Harwood et al. 1984, p. A-20); and, finally, that "the statistical analysis of the impact of consumption of drugs other than marijuana yielded *no significant results relating abuse of the drugs to household income . . . [and that] the failure to find relationships was true for variables reflecting recency and frequency of current consumption, lifetime consumption of the substances, and abuse of substances in combination with alcohol or other drugs*" (*Ibid.*, p. A-20–21; emphasis added).

We wish to note that by calling attention to such egregious extrapolations we are not picking on the RTI researchers for poor work. On the contrary, we are using their work precisely because it is perhaps the best of such estimation studies. Indeed, in contrast to "experts" quoted in the media, and treatment industry spokespersons who generalize from the tiny fraction of drug users who seek treatment (without telling us that they are doing so), the authors of this report are to be congratulated for their methodological and theoretical candor. Although their core measures would be unlikely to slip past peer review and appear in a social science journal, the authors did as good a job as is possible with what data were available.

That is just the point. Apparently none of the legions of journalists, editors, and fact-checkers at *Time, Newsweek, Business Week, The Wall Street Journal,* or the *New York Times,* to say nothing of lesser publications, bothered to look at the appendix, or even to cast their usually critical eyes upon the report that formed the primary evidentiary basis of their front page stories about the "drug crisis" or the "epidemic" of cocaine use in the workplace. Having accused others of speculation, we must note that the inference we draw from this state of affairs is a speculative one: that the social construction of the cocaine crisis has been allowed to snowball into a giant news theme on the basis of very shaky evidence largely because tales of the crisis filled so many needs for scapegoats and fit too well the prevailing biases.[5]

In speculating on the socially constructed dimensions of this issue, we do not mean to imply that there is not a "cocaine problem" in this country, nor that this takes no toll on businesses. We are suggesting rather that if rational public and private policies are to be enacted in response—particularly when, like drug testing, such policies may impinge heavily on the lives and liberties of millions of citizen-workers—then such policies cannot be based on what appears to be mis- if not dis-information.

It will be difficult at best to obtain the more accurate sorts of data we think are needed for rational responses. There are many obvious reasons for this. For one, people who use illicit drugs are quite naturally reluctant to talk about it—particularly when their livelihoods are increasingly at stake, whether or not their drug use actually affects their work performance. This makes data collection difficult, but not impossible. Researchers have managed for years to get good data—both ethnographic and survey—on heroin users, criminals, and other deviants. And the data reported in the first part of this paper were obtained from respondents who had every interest in privacy. We think there are other reasons why so much bad information or so little solid evidence is available.

The social constructionist perspective calls attention to what Becker (1963) called moral entrepreneurs. There are many, many dedicated professionals who have made drug problems their life's work, and we do not mean to impugn their integrity. However, it is apparent that a treatment industry exists which has little interest in problem deflation and a potentially substantial interest in problem inflation. This growth industry should not be understood as just an institutional aggregation of sincere individuals who are simply responding to existing need. It is true that public sector alcohol and drug treatment programs have waiting lists, but if anything, the reverse is true for private programs, which spend hundreds of thousands of dollars annually advertising for clients and otherwise marketing their services in newspapers and magazines and on television and radio. Most of the "experts" quoted in journalistic articles or interviewed on talk shows represent such programs. Yet they are not billed as professionals who have interests, but as "objective experts" who have their fingers on the pulse of the problem.

We think it is essential to remember that these programs have arisen in part for

structural reasons that are not directly related to the "epidemic" of cocaine use. First, in the early 1970s, the fiscal crisis (O'Connor 1973) led state and local governments to "contract out" services which theretofore had been part of the public sector. This created a new market niche for alcohol and drug treatment professionals (see, e.g., Weisner and Room 1985; and Weisner 1986, for insightful analyses of how this affected alcohol treatment). In California at least, this policy shift put the state in quasi-partnership with an emerging private sector treatment industry. For example, a 1982 report from the California Department of Drug and Alcohol Programs noted that the intent of their certification of such programs was to ensure "sufficient marketing of provider services . . . [and to] demonstrate market demand" for them such that they would "meet the requirements of insurance purchasers." Part of the Department's work that year entailed "a market analysis" to "develop promotional strategies for service providers" (California Department of Drug and Alcohol Programs 1982; cited in Morgan 1984).

Second, after the National Institute on Alcoholism and Alcohol Abuse (NIAAA) and other treatment interests succeeded in getting insurance coverage for alcohol and drug treatment, and when drug abuse spread through the middle classes who held such insurance, drug users became a profitable "market." There are now billboard advertisements for Cokenders (for which clients or their insurance companies pay $2,000–3,000 for a weekend retreat), and full-page ads in national magazines and regular television spots for chemical dependency hospitals (where costs range from $8,000 to $28,000 per month for inpatient therapy).

The growth of this treatment industry is *not* simply a response to existing "demand," however great that demand may or may not turn out to be. Chemical dependency "units" have become a profitable way for hospitals to utilize excess plant capacity. In response to the booming general health care market, many private hospitals built additional bedspace which, in response to overbuilding and to Medicare cuts and cost-containment efforts, soon lay empty. In 1985, for example, the California hospital occupancy rate averaged 59 percent, and by 1990, there will be some 18,000 excess beds—a 28 percent oversupply, according to a state study (Office of Statewide Health Planning 1985). Thus, many hospitals are either starting their own drug and alcohol treatment programs, or franchising out part of their excess capacity to national corporations who have chains of such programs (e.g., Comprehensive Care Corp., the largest, has over 400 such franchises in the U.S. at this writing).

It is from this new industry that many of the "experts" who define the cocaine "epidemic" for reporters are drawn. The directors of the 800-COCAINE hotline, for example, are omnipresent in both print and electronic media. They are no doubt skilled clinicians and researchers. But when they tout their startling statistics they tend not to convey to mass media audiences that they are talking

only about people whose troubles with cocaine have led them to call a national hotline. They also do not say that while they render a needed and presumably good-quality public service, they are at the same time performing marketing functions ("outreach" and "visibility," for example) for their owner—Psychiatric Institutes of America, a subsidiary of National Medical Enterprises, Inc.—which operates a chain of for-profit treatment facilities catering to middle class alcohol and drug abusers who have health insurance or can otherwise afford inpatient treatment costs of up to $20,000 per month.

Again, we are not saying that hotline directors are necessarily prone to any impropriety. On the contrary, they are among the more well-known and respected of such private programs. There are countless others who have leapt into this new market, whose previous experience in the drug and alcohol problem field is meager. Some for-profit management consulting firms now do what amounts to road-shows: giving one- or two-day seminars on workplace drug abuse to corporate executives in cities across the nation at rates of $250–350 per person per day (e.g., *New York Times* 8/5/86). Like treatment programs, drug testing, and private security, such consulting expertise has become a growth industry.

By raising such issues, we do not intend to minimize the cocaine-related work problems which this paper helps to document. Our intent is simply to note that current discourse on such problems seems to us clearly skewed toward problem inflation and mystification. By virtue of the social organization of the media and the emerging treatment and control industries, a variety of incentives exist for maximizing and distorting most every aspect of the problem. If what we have said about the nature of the evidence and the perspective of those collecting and framing it for public consumption has any merit, then drug researchers ought to watch for the supply-side production of this new social problem, as well as watching the problem itself.

This seems to us particularly critical in a political epoch in which the Right has made it national policy to induce structural myopia with respect to human problems (recall, for example, that the U.S. Attorney General publicly claimed that homeless people "choose" to eat in shelters because the food there is free), and to attempt to blame a cornucopia of institutional problems on individual deviance and personal immorality. In such an ideological context, scapegoating cocaine as the main cause of declining productivity, lost economic competitiveness, and compromised national security becomes part of an utterable vocabulary, whether or not it has any empirical basis.

In the face of clear evidence that there is *some* kind of a serious cocaine problem in the United States, it is a fair question to ask whether any of this social constructionist skepticism really matters. We think it does, because discourse matters; public perceptions of what the crises or issues are is shaped by what politicians and the media say and do (see Edelman 1964). Some workers in some

of our workplaces have used some drugs at some time, and some of them have been affected adversely. It will take more and better research to know what such "some's" mean empirically. But it takes little research to know that nearly a third of the Fortune 500 companies now have drug testing programs for all job applicants and for most employees.[6] Such economic deterrents provide a powerful supplement for flagging legal deterrents. The problem is that workers, qua citizens, are supposed to be constitutionally protected from unlawful searches, from testifying against themselves, and to be considered innocent until proven guilty.

It was once axiomatic in American culture that what one did on one's own time was one's own business; that is no longer the case. Although the time span during which drugs affect consciousness and behavior is a small fraction of the time span during which traces of the drug will show up in urinalysis, employers, politicians, and the testing industry are making the presumption that the two intervals are identical. In the current crisis atmosphere, they will be able to hire, fire, discipline, and control on the basis of this dubious presumption.

The social control implications of all this are approaching Orwellian proportions. Literally millions of workers who have never even tried an illegal drug will be subjected to supervised urine testing in 1987 alone. These implications do not stop at the workplace door, but extend into culture and political life. The commissioners of all major professional sports have all tried to implement such testing, not merely for purposes of checking performance, which is obvious enough for all fans to see, but explicitly to get chemical proof of players' moral purity as cultural role models (see, e.g., *New York Times Magazine,* 10/6/86). The President's Commission on Organized Crime has recommended drug testing for *all* U.S. businesses. Drug-sniffing dogs are becoming fixtures not merely in workplaces across the country, but in schools as well. Searches and seizures which constitutionally could not occur under law enforcement auspices are now routine occurrences in the private sector and in public schools. No less than the President and his Cabinet have undergone urinalysis—one member of which has gone so far as to introduce the term "narco-terrorism" (*New York Times,* 7/20/86, p. 1) into the linguistic arsenal of the war on drugs. And the mayor of New York has called for special narcotics courts and prisons, and for giving the death penalty to drug sellers (Koch 1986).

After cutting funds for drug programs for most of his six years in office, the President has introduced a new "crusade" against illicit drugs, which he claims will be a "Pearl Harbor for the drug traffickers" (*San Francisco Chronicle* 8/5/86). Although his 1987 budget proposed further spending cuts, the President's rhetorical increases seemed to be prompted by election year fear that Democrats might somehow construe him and the members of his party as insufficiently antidrugs. In fact, drug-baiting may come to compete with red-baiting among vote-hungry politicians, with those who are "soft on drugs" vulnerable in the same way Senator McCarthy made those he labeled "soft on communism."[7]

CONCLUSION

It has often been said that truth is the first casualty in war. If the questions we have raised about the current crisis of cocaine in the workplace have value, this old saying may come to extend to wars on drugs as well. Whether or not that turns out to be the case, we believe the research agenda with respect to cocaine and work could fruitfully be broadened to include the ways in which that problem has been and is being constituted in public discourse. Cocaine use that affects work may well be a serious problem, but we won't really know if we continue to take for an existing fact what has yet to be even adequately described.

In the first part of this paper we offered some preliminary data on the possible effects of heavy cocaine use on workplace performance. These data suggest both that such effects can have serious consequences for some users in some workplaces at some stages of their using careers, and that a great deal of analytic complexity is required if we are to understand all the contingencies involved. Such findings notwithstanding, it is clear that a host of workplace and cultural problems with little or no demonstrated causal link to cocaine or other drug use are now being hung on that hook. By suggesting some of the other ingredients in this scapegoating process, we hope to push this discourse a step or two away from ideological passions. There are, we think, sound scientific reasons for doing so.

First, the development of a distinguished body of research on the social construction of social problems over the past two decades has made it abundantly clear that we ignore the political, economic, and ideological dimensions of such problems at the peril of policy failure. In the current cocaine-in-the-workplace "crises," the appeal of an available demon seems to have eclipsed other pertinent questions about the nature of work and corporate decision making in a conservative epoch obsessed with international competitiveness and social control, and about why, in just such an epoch, so many millions of Americans choose to ingest consciousness-altering substances in the first place. It is at least arguable that policies which do not take into account such questions will thereby court the same tragic fate as every other effort to control drug and alcohol abuse. Second, if discourse is rooted in the claims of self-interested groups who have many incentives to abdicate analysis of causal complexities, then the public is being misled and democratic influences on law and policy formation thwarted. If history is any guide, public policies that are based on such flimsy foundations will serve no victims well—be they companies or co-workers, children or parents, or cocaine users themselves.

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NOTES

1. We treated health problem variables this way because they showed weak scale reliability (alpha = .73) and because factor analysis revealed no significant clusters of symptoms. Our five variables on workplace problems were also treated individually rather than as part of a scale or regression equation. They did not scale reliably (alpha = .63), whether weighted for seriousness or excluding the weakest item (strain with co-workers) (alpha = .66), although we felt each item had sufficient face validity to warrant inclusion as an individual outcome measure. If these items are not frought with additional measurement error, these frequencies suggest that there are apparently a variety of discrete ways in which cocaine use can be associated with problems at work.

2. It may be that the number of sources from whom a user may purchase supplies of cocaine is not a valid index of availability. A user may have only one or two suppliers, but these may be particularly "good" connections, i.e., have high quality supplies readily available at low prices. Several respondents lived with dealers and would thus not need other sources. If a large number of sources is found in other studies to be a valid measure of availability, then the relationship between supplies and levels of use or abuse must be re-examined to take account of other, intervening factors which may explain why available supplies may or may not increase use or abuse.

3. See, e.g., Goldenberg 1972; Mangione and Quinn 1975, on the importance of job dissatisfaction in the start of drug use; Trice and Roman 1972, on the role of job-based risk factors; and Erikson 1986, for a useful review of the nature and sources of alienation in labor processes which have undergone technological transformation.

4. They also state in a footnote that such cost estimates for alcohol, drug abuse, and mental health are "not comparable" and that "the estimate of reduced productivity" is "one partially complete for drug abuse" (Harwood et al. 1984, p. 4). See also Johnston et al. 1986, pp. 41–45; 172–175; 178–185, for the best national data showing that the actual incidence and prevalence of cocaine use leveled off or declined some five to seven years prior to it's becoming a "crisis" attended to by the media and political officials.

5. We are reminded of the *Washington Post* story about an eight-year-old heroin addict by Janet Cooke (10/1/80), which won a Pulitzer Prize. The youngster was reportedly given heroin and injected by his mother's boy friend, an addict. Despite the fact that any addict could have told editors that the story was phony, since only a fool would have given away precious, expensive dope, even if vile enough to do so, no one suspected anything until the Pulitzer was awarded. The embarrassed editor printed an apologetic retraction which nonetheless failed to note that the story slipped by both editors and the Pulitzer jury precisely because it played upon long-standing prejudices toward "dope fiends." The reporter/writer resigned after admitting that the story was concocted.

6. The *Chronicle of Higher Education* (1/7/87) reports that drug test results have become the sixth leading criterion for hiring among a national sample of industrial companies. After verification of education and past employment, etc., one-third of the 230 corporations verify chemical-moral purity with urinalysis.

7. For example, California Senatorial candidate Ed Zschau, seriously trailing in the polls, recently charged incumbent Senator Alan Cranston with being "a concombatant in the war on drugs" (*San Francisco Chronicle*, 8/12/86).

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