©Journal of Drug Issues, Vol. 7, No. 3, pp. 253-262

VALUE FOUNDATIONS FOR DRUG USE

Robert M. Veatch*

This article investigates the relationship of value foundations to the use of drugs. The argument is presented that it is logically impossible to make drug use decisions without evaluating the outcomes of various alternatives and choosing the most highly valued in the circumstances. A map of the major value foundations upon which drug choices might be made is provided, and their relationship to one particular drug category, the anti-anxiety agents or tranquilizers, is explored. The conclusion is reached that a purely therapeutic drug ethic may be problematic as an acceptable basis for drug use.

It is becoming increasingly clear that all drug use decisions, including decisions to use anti-anxiety agents, require some system of values. It is impossible—in theory as well as in practice—to choose to use a drug, any drug at all, without appealing to some set of values, to some *Weltanschauung*. That in practice the value set of the decision-maker impinges on such choices is well recognized. What is more recently being realized is that it is logically impossible to make decisions including drug use decisions without at least implicity evaluating the outcomes of various alternatives and choosing the most highly valued in the circumstances. Drug choices require the interaction between pharmacological information and a value system.

To understand the value foundations for drug use choices there must be some understanding of the major value options. I want, first, to provide a map of the major value foundations upon which drug choices might be made hoping to show in the process that such values penetrate deeply into the decision making. Then, to probe further the relationship of the value foundations to drug use choices, I want to explore more deeply one particular drug category: the anti-anxiety agents or tranquilizers, especially chlordiazepoxide (Librium, Roche) and diazepam (Valium, Roche), two of the three most widely used prescription drugs in the United States. I shall suggest that deciding to use or refrain from using the anti-anxiety agents is often dependent upon a "therapeutic ethic," an ethic of adjustment, and that those who reject the therapeutic ethic will also tend to reject the use of the anti-anxiety agents insofar as their use is dependent upon that ethic. I shall also maintain that the use of other psychopharmacological agents is much more likely to be rooted in other "ethics." Two conclusions follow: First, opposition to use of anti-anxiety agents cannot necessarily be reduced to an anti-drug mentality or the "pharmacological Calvinism," and, second, one might have grave reservations about the use of anti-anxiety agents and still enthusiastically favor other drug use choices.

Because drug choices depend upon the close interaction between pharmacological information and a system of values, it is disturbing to hear it continually implied that more pharmacological research, more data, can reveal if a proper drug choice is being made, or whether we are an overmedicated society. It is a category mistake, a

*Robert M. Veatch, Ph.D., is a Senior Associate of the Institute of Society, Ethics and the Life Sciences at Hastings-on-Hudson, New York.

confusion of facts and values, to assume that the laboratory or clinical research can ever tell us what we ought to do. Pharmacological research may be able to tell us what the impact of a drug will be on the human body, it cannot tell us whether that impact is good or bad, whether we ought to use a particular drug.

It is disturbing to see journals which purport to be scientific regularly using evaluative terms such as "drug abuse," "overmedication," "overuse," "proper and appropriate use," "drug of choice," and "improvement in the quality of life." (See Muller, 1972; Blacknell, 1973: 1641; Lennard et al., 1970). All of these terms are positive or negative evaluations, evaluations superimposed upon the pharmacological data. (See Balter and Levine, 1971: 87; Balter, 1973). An appeal for "rational therapeutics" such as that made recently by Assistant Secretary for Health Charles C. Edwards (1974) is much more complex than it first appears. If by rational therapeutics we mean simply that high levels of scientific information will supply the answers or that they can be derived from "the disciplined application of the physician's full knowledge and training," then no therapeutic decisions can be rational and we ought not to behave as if they could be. If therapeutics can be rational at all they must be rational in that Kantian sense in which an ethic—a system of values—can be rational. Especially in decisions about drugs as controversial as the psychopharmacological agents, we cannot avoid the value judgments which can be, but normally are not thought to be rational. Proper drug choices will depend heavily upon the patient's or the society's system of values. When Dr. Edwards appeals for rational therapeutics and as others have done in the literature, they consistently imply that good scientific information will supply answers. Especially in decisions about drugs so controversial as the anti-anxiety agents, we cannot avoid the value judgments which can be, but normally are not thought to be called rational.

Five Competing Drug Ethics

I have attempted to construct models of the sets of values of ethics which underlie drug use choices in Western society (Veatch, 1974). It is clear that Western society is re-enacting one of the great value struggles in human history, the struggle over man's proper relationship to nature (Kluckhohn and Strodtbeck, 1973). It is my thesis that it is a radical oversimplification to reduce drug use attitudes to those that are pro-intervention and those that are anti-intervention. Rather some of the crucial elements are the variations especially within those that are in favor of some drug use. I have identified five competing drug "ethics" each of which gives a basis for a different attitude about drug use.

(1) The Wisdom of Nature Ethic. This first ethic for drug use is part of what we might call the "wisdom of nature" drug ethic. It is the view that nature is more clever than man. It is the ethic of a Jacques Ellul (1964) or a Lewis Mumford, (1970), of a Sierra Club or an organic foods cult. The artificial products of man's technology, including the chemicals man has created, are seen as dangerous or evil.

We are in the midst of a battle between the nature nuts and the pill poppers too quick to distinguish between the natural and the artificial. Attitudes about the use of chemicals to control our internal environments tell us a lot about our theologies of nature.

When I was in charge of the Medical Ethics Program at Columbia Medical School I remember seeing a patient who was in excruciating pain from a broken leg. He had fallen in a skiing accident. By evening the pain from the compound fracture was unbearable. He, writhing in agony, pleaded with a young physician for relief. In the staff room I asked this physician what pain medication had been given and why something more could not be done for him.

He had given propoxyphene with instructions to repeat it every six hours if necessary. Propoxyphene is a non-narcotic pain reliever generally thought to be

more powerful than aspirin, but not as strong as the weakest narcotics. "Why can't you give him some meperidine?," I asked.

His response was fascinating. "Meperidine is a narcotic," he said, "and narcotics are dangerous business. Do you want me to risk turning him into an addict when I know that in a day or so the pain will begin to ease? I don't use anything that potent when I can get by with less."

For that doctor, the physician's job is to intervene as cautiously as possible—to stand by and help nature take its course. Later I learned that the patient had become so agitated that the nurse was unable to handle his screaming. She had called the resident on duty who had given an immediate injection of a potent narcotic. The pain eased almost immediately. I asked the resident why he had given the strong pain killer so quickly. "The physician's job is to relieve agony," he said. "If modern medical science has given us the tools to intervene and we don't use them, then why bother becoming a physician?"

At first we think of a broken leg as a simple medical problem raising no important value questions at all. Those two physicians, however, were not just looking at the medical facts and making scientific pharmacological judgments about what to do. They were making choices according to a set of values—according to an understanding of the nature of man and what they think is the correct value system for responding to human need. These two physicians symbolize two radically different world views—two ethics, if you like—about the use of drugs. Every time that a drug is taken to modify body chemistry—whether prescribed by a physician or prescribed by the human being whose chemistry is being modified—we have a small test of our attitude about nature.

Physicians, just like the rest of us, learn an ethic of drug use. In 1932 the great physician and physiologist Walter B. Cannon wrote a book entitled *The Wisdom of the Body* (1932). It is, in a sense, a theological tract for the wisdom of nature ethic. Cannon stands in awe of the body's ability to take care of itself. He summarizes a long tradition of romantic naturalism:

> Only by understanding the wisdom of the body ... shall we attain that mastery of disease and pain which will enable us to relieve the burden of mankind.

Cannon, here, is a preacher for the wisdom of the body ethic. And the current generation of medical school teachers have been trained on Cannon's views as if they were a statement of the facts of human physiology. Cannon may be right—he may be wrong—but he is proclaiming a value system, a world view about man's relationship to nature.

I once conducted a survey of physicians throughout the country (Veatch, 1976). Fifty-five percent agreed with the statement:

> The forces of nature are awe inspiring. The physician best serves his function if he has respect for the complexity of the human body and counts on nature to do its own healing.

But if 55 percent agreed that leaves 45 percent who did not. The naturalism of the "wisdom of the body ethic" is not the only value orientation brought to bear on decisions about the use of drugs—by either physicians or lay people. The technological mentality of modern society is deeply rooted. In the Genesis story, God commands man to have dominion over the earth and subdue it. Man is a co-creator of his environment, including the experiences of himself and his fellow man. The second physician, the one who was willing to give the narcotic pain killer—who felt he had a duty to give it—believed in a more interventionist ethic.

(2) The Protestant Drug Ethic. Over and against the anti-interventionist wisdom of the body ethic there are at least four ethics justifying drug use. The first I call the Protestant drug ethic. Gerald Klerman (1970; 1971; 1974) and others following him (Manheimer et al., 1973; Parry et al., 1973) see the use of psychoactive

drugs—tranquilizers, anti-psychotic agents, and anti-depressants—as radically opposed to the Protestant ethic. While I do not deny that those who hold to the Protestant ethic in its classical Weberian form oppose certain drug uses, I am convinced that Klerman and others have oversimplified the analysis. Specifically, I believe it is unacceptable to associate the Protestant ethic with an indiscriminate anti-drug position.

The Protestant or Puritan ethic is a moral world view which has dominated Western culture, especially American culture through the modern period. It certainly has opposed the use of certain drugs—such as alcohol and nicotine. Klerman and others, however, seem to have characterized it as the view that "if it makes you feel good it must be wrong;" that is nonetheless an unfair caricature of the ethics of our Puritan ancestors.

The old Calvinists were looking for certainty that they were saved. Later and more corrupt forms of the ethic included the belief that if one worked hard enough and did not deviate from the pursuit of salvation he might earn his way into God's kingdom. The key, however, was that anything that led one astray—that deviated from the path to salvation—must be wrong. If that is the case then while some drugs are to be forbidden as irrelevant to or contrary to the goals of one's life—one's salvation—others may be appropriate or even required. These would include agents used to make man more productive, efficient, and hard-working; the xanthines (including caffeine), the amphetamines used by truck drivers and students, and even the drug, methylpheniate, used to calm hyperactive children are drugs of choice for the Protestant ethic.

Of course, not all drugs will make you productive again. Tranquilizers or anti-anxiety agents are hard to justify on this basis. The Puritan opposes alcohol, but not simply because it is a drug. Consistently he sees it as sinful, because it is a depressant and a very irrational (or non-specific) depressant.

(3) The Neo-Protestant Drug Ethic. A second pro-drug ethic justifies the use of different drugs for a very different reason. It justifies the use of psychotropics including the hallucinogens, euphorics, and marijuana. Some fascinating research is being conducted by researchers from the Maryland Psychiatric Research Center (Kurland, et al., 1973). They are concerned about drug treatment of patients in the final months of cancer. They are particularly concerned about the tortuous increase in physical pain, emotional suffering, isolation, and depression in many of these patients. They have given psychedelic drugs including LSD to a group of these patients and reported remarkable, if not shocking, results. One 58-year-old Jewish woman who had fought breast cancer for 12 years was anxious and depressed. Pressure on nerves had caused numbness and paralysis of the lower half of her bedridden body. After the LSD sessions she said she felt she had left her body, and had been in the presence of God. She had no pain; when her family arrived she radiated a glow of peace and beauty noticed by all her family.

Klerman has called this value set "psychotropic hedonism" and sets it in contrast to pharmacological Calvinism, while I believe it is really very close to the old salvation in some respects. The Native American Church has roots stretching back into the pre-Columbian American Indian culture (Slotkin, 1955-1956). Peyote, a hallucinogen similar to LSD has remained a sacrament of the religious ceremony in spite of the Christian theology and appearance. The religious vision of the modern drug culture is not far removed from the mystical salvation vision of the peyote ritual. An experimental administration of LSD produced the following salvation image (Pahnke, 1967):

> . . . I saw a gleaming, blinding light with a brilliance no man has ever known. It has not shape nor form, but I *knew* that I was looking at God himself. The magnificence, splendor, and grandeur of this experience cannot be put into words. Neither can my innermost feelings, but it shall remain in my heart,

soul, and mind forever. I never felt so clean inside in all my life. All the trash and garbage seemed to be washed out of my mind. In my heart, my mind, my soul, and my body, it seemed as if I were born all over again.

Some of these quasi-religious uses of psychotropic drugs are just as single-minded in the pursuit of salvation as the old Calvinists were. Granted it is a different, more present-oriented, more aesthetic salvation, but it is equally single-minded. It is a kind of value commitment that takes great risks—medical, legal, genetic risks—in order to pursue a particular kind of salvation.

Max Weber and others have demonstrated that this single-minded, activist, worldly pursuit is the really unique characteristic of Calvinism (1958). The conversion from one goal to another has taken place before in modern Western history. The current drug culture can be seen as a radical conversion of that goal-oriented behavior to a new kind of salvation. We might call it the Neo-Protestant drug ethic. It is not surprising that the contemporary drug culture emerges in middle-class youth who have been trained by their parents into this single-minded, goal-oriented moral stance. The interchangeability of the drug culture and radical religious movements like the Jesus freaks makes perfect sense in this light.

(4) The Protean Drug Ethic. A third pro-drug ethic radically abandons this single-mindedness. Proteus, that fascinating sea god of the Greeks, was capable of assuming many forms. The love of change, of variety for the sake of variety, has become a kind of goal for some in modern society. There is a drug ethic which grows out of this world view. Following Robert J. Lifton (1971) I call it the Protean drug ethic. It is the ethic of the pill party where variety of chemical experience is valued in itself. Coffee in the morning, martini for lunch, sedative to get to sleep, perhaps marijuana on the weekend. This is the ethic of pluralism. It is a peculiarly American ethic making necessity the mother of virtue. Change and variety become valued in themselves. The drive to unify, to integrate, to make sense of one's life, is abandoned in favor of a quest for diversity. Drugs expand the possibilities of that diversity beyond the wildest hopes of the pre-pharmacological pluralist.

(5) The Therapeutic Drug Ethic. Finally, there is the therapeutic drug ethic, the view that the goal of drug use is simply to produce happiness, contentment, accommodation, or adjustment. Elimination of conflict has itself become a goal rather than a means to a goal. The therapeutic drug ethic, a name taken from Rieff (1966) depends upon both the goal-oriented activism of the Protestant ethic and the pluralism of the protean ethic. Action is called for, but with a goal which is substantively rather contentless. A sense of well-being itself replaces the commitment to an eschaton—whether that eschaton be communal, as in the classical Judeo-Christian and recent Marxist visions, or more individualistic, as in the Platonic, the capitalistic perversions of Calvinism, or the Neo-Protestant's new pharmacological perversion. The result of the removal of cathectic dissonance may indeed be pluralistic for each may have his own well-being. Pharmacological agents used in accord with the therapeutic drug ethic may well produce great variety, but in contrast with the protean ethic, in each individual, variety itself is no longer the objective. To the contrary, it is an integration of emotion with few questions asked about the legitimacy of the contentment or accommodation attained.

Values and Anti-Anxiety Agent Use

The anti-anxiety agents provide a good example of the implications of these five value foundations of drug use. While two or more of these ethics may give similar answers to the use of a particular agent for a particular purpose, it is important to realize that they will be doing so for different reasons.

The holders of the wisdom of nature ethic would tend to oppose the use of

chlordiazepoxide, diazepam, or any of the other anti-anxiety agents. Their opposition, however, is derivative from a general suspicion of chemical or other "artificial" interventions into the human body. Citing the experience of thalidomide, DDT, diethylstilbestrol and other agents which were belatedly found to be harmful often in producing very remote effects, the defenders of the wisdom of nature ethic would doubt man's or the FDA's ability to adequately understand the implications of the use of these drugs.

The opposition is not one that can easily be combatted through rational argument or accumulation of more data. Since knowledge is never perfect, one who is inherently suspicious of intervention logically need never be convinced. Opposition to the wisdom of nature ethic, such as it is, must be theological or philosophical. It must rest on an understanding of an appropriate degree of skepticism. These are arguments which cannot be taken up here. It should be clear, however, that the wisdom of nature ethic is a very romantic view of the awesomeness of nature and the natural processes, and a terribly low view of man. Man is so weak, so fallible, that he should gamble on nature's luck rather than man's ingenuity and planning. Carried to an extreme, it logically defeats all attempts at medical intervention.

The Protestant drug ethic would often oppose the use of the anti-anxiety agents, but would do so for a quite different reason. To the extent that a chemical agent interferes with, or is irrelevant to, pursuit of one's goals, such an agent ought to be opposed. Much, but not all use of tranquilizers is diversionary from the ultimate salvation of the holder of the Protestant ethic. Some uses, however, would be acceptable. For instance, if a researcher who depended upon his vision for the reading of texts central to his livelihood suffered an eye injury requiring surgery, and if the anxiety produced from anticipating the surgery seriously jeopardized the performance of the operation, the individual might rationally choose restricted, single time use of the anti-anxiety agent as a means to achieving his life's work. The justification is, however, very restricted, applying to short term, self-limiting use where the anxiety to be overcome is not an integral part of his work, but rather a well-defined and short-term obstacle to it. Were he to use the anti-anxiety agent to relieve the tension of worrying about his scholarly pursuit and were that relief of anxiety to thereby diminish his productiveness, such use would be clearly contraindicated for the holder of this set of values.

The justification of the use of anti-anxiety agents for the holder of the Neo-Protestant ethic is somewhat more difficult. The hallucinogens are central paraphernalia for a holder of this view. He is in no way opposed to drug use in principle. But, it is even more difficult to hypothesize a plausible case where the anti-anxiety agents would be used for the Neo-Protestant than for his Puritanical forefathers. It would have to be a use where the anti-anxiety agent was a means to increase cathectic, aesthetic experience interpreted as salvific. Since most of the anti-anxiety agents tend to have sedative properties or at least do not have hallucinogenic properties, their rational justification would be difficult to establish.

The Protean drug ethic proponent would be more open to the use of the anti-anxiety agents. When variety of experience is valued, it is the sequencing that is important as well as the substance of the pharmacological effect. Anti-anxiety agents would have their place when one has been "up" and wants to come "down," when one is prepared to shift mind sets from the business world to before dinner relaxation, or when mood shift or variation is desired for some other reason.

While all the other pro-drug use ethics including the Protestant ethic are able to justify the use of anti-anxiety agents in special, limited circumstances, the therapeutic ethic stands in a special relationship with them. The anti-anxiety agents are the sacrament of the therapeutic ethic. With a set of values where the objective is to relieve tension or eliminate cathetic dissonance, the anti-anxiety agents are evaluated favorably by their very definition.

In the practice of medicine the use of the therapeutic ethic in making drug use decisions is complicated by the physician/patient relationship. In many cases the physician holds a set of ethical principles that lead him to the position that he should choose what he thinks will be best for his patient. When this is combined with the therapeutic ethic he is led to choosing the course which he believes will be most likely to produce adjustment or relief of anxiety. In this form the therapeutic ethic of adjustment is a direct descendent of the controversial Hippocratic ethic that the physician should do what he thinks is for the benefit of the patient. It is controversial because it is paternalistic and individualistic, but also because it sees the patient as something with needs to be satisfied, rather than as a responsible autonomous individual with a set of moral obligations and a destiny. The therapeutic ethic robs man of his destiny, substituting instead an accommodation designed to squash tensions and incongruities.

Use of anti-anxiety agents will often be justified, at least implicitly, with the therapeutic ethic. In contrast with stimulants, the anti-anxiety agents are often used to avoid the realities which are the human condition. Serentil (mesoridazine) has been advertised as being "for the anxiety that comes from not fitting in." It is to be used by the "newcomer in town who *can't* make friends, the organization man who *can't* adjust to altered status within his company, the woman who *can't* get along with her new daughter-in-law, or the executive who *can't* accept retirement." The objective is "adjustment," "fitting in" without concern about whether the patient ought to become adjusted or fit in. The tone is one of smoothing over incongruities and of assuming the problem is in the complainer, "the disordered personality," rather than in the social conditions or the objectives pursued. Milpath (meprobamate and tridihexethyl chloride) has been advertised "to keep the constant complainer from becoming an office fixture," the assumption being that if the complaining is eliminated the goal is achieved. The classic central nervous system depressant, ethyl alcohol, the most commonly used of all the accommodation enhancing drugs, is well understood for its ability to reduce anxiety, at least in the short run.

It should be clear that other psychoactive drugs will be much more compatible with the other drug legitimizing ethics. As the goal changes so does the chemical. Alcohol is very different from coffee. Antipsychotics, which if used properly can be reality enhancers, are very different from anti-anxiety agents. One antipsychotic agent (Navane, Roerig) even advertises "The goal: A working schizophrenic,"—the ultimate in Protestant drug ethic appeals. If, indeed, different psychoactive agents serve different drug ethics, then it should be clear that disapproval of one may be quite compatible with strong support of others. It is an oversimplification to distinguish only between pro- and anti-drug positions. Even if the anti-anxiety agents are suspect because of their foundation in a therapeutic ethic, the disapproval need not extend to the other psychoactive drugs.

In the end the patient and the patient's society have to reach a decision. They must evaluate the legitimacy of the anxiety to be treated. There are indeed anxieties which are understandable and legitimately treated according to an ethic which has more than accommodation as its goal. The death of a spouse, the tension accompanying public performance or risky surgery, and phobic anxieties, all of these are anxieties which cannot be attributed to corrupting social conditions. But these situations certainly cannot account for the entire use of anti-anxiety agents. The patient must distinguish these from other uses.

I emphasize "patients" because if it is a set of values which ultimately justifies anti-anxiety agents use, then the therapist's values are of only tangential importance. They are relevant to the drug use decision in two ways. First, the therapist's values will inescapably be communicated to the unsuspecting patient and therefore both patient and therapist had better be aware of them. Second, since the therapist is also a moral agent who is the possessor of a drug ethic of his own, he in

the end must retain his own conscience, refusing to use those agents when the ethical basis for the use is unacceptable to him.

The solution to the value conflict dilemma must be two-fold. First, this is a society which strongly values freedom. The individual must retain a right to choose those values which are the basis for drug use choices. In this sense self-medication is the ideal. Relatively safe anti-anxiety agents should be at least as freely available as alcohol, the ultimate drug of the therapeutic ethic. In a technologically complex society, however, self-medication will not always be possible. Until the day when more self-medication is possible the consumer ought to at least have maximum information on which to base his drug use choices. It ought to be required, for instance, that the package insert be included with every prescription.

Pluralism and freedom of choice in the end, though, are not enough for a policy on drug use choices. At least three reasons require moving beyond this freedom of choice ethic. First, there are limits to what is tolerable in society. At least freedom of choice to use agents which are potentially dangerous to others must be limited. Second, we must have guidelines for proper drug use for those who cannot choose and consent for themselves: children, mentally retarded, and the senile. And third, and I think this is perhaps the most significant reason for going beyond freedom of choice, we have to know what we as drug consumers ought to do, not simply what we are free to do.

I conclude that the therapeutic drug ethic is problematic as an acceptable basis for drug use. That does not mean that one should oppose drug use, or even anti-anxiety agent use. Drug use may be legitimated by goals beyond production of happiness, contentment, accommodation or adjustment. Anxiety may not always be the worst evil in the world. Often it is a warning, a symptom of more systemic social wrong.

Drug use when its purpose is to make the consumer more creative, sensitive, compassionate may be based on the Neo-Protestant ethic. When its purpose is to make him more responsible, efficient, and even productive, the old Calvinist ethic may be the justification. Both have been defended as humanizing foundations for drug use choices.

Not everyone will share a particular system of values. It does seem reasonable, however, at least if we are to have a "rational" therapeutic, to expect that all who are in a position to make drug use choices ought to come to grips with the value foundations of those choices. To do so requires a vision of man and his relation to nature.

FOOTNOTES

[1] Portions of this paper were originally presented in an earlier form at a National Institute of Mental Health Psychopharmacology Research Branch conference on Prescribing and Use of Anti-Anxiety Agents in Outpatients: Clinical, Pharmacological, and Social Considerations, Bethesda, Maryland, May 2-3, 1974.

REFERENCES

Balter, Mitchell B.
1973 "An Analysis of Psychotherapeutic Drug Consumption in the United States." *Etiology of Drug Abuse* I (April 17): 57-68.

Balter, Mitchell B., and Jerome Levine
1971 "Character and Extent of Psychotherapeutic Drug Usage in the United States." *Excerpta Medica International Congress Series No. 274.* Psychiatry (Part I) Proceedings of the V World Congress of Psychiatry. Mexico, D.F. (November 25-December 4): 80-88.

Blackwell, Barry
1973 "Psychotropic Drugs in Use Today: The Role of Diazepam in Medical Practice." *Journal of the American Medical Association* 225 (September 24): 1637-1641.
Cannon, Walter B.
1932 *The Wisdom of the Body*. New York: W. W. Norton Co., Inc.
Edwards, Charles C.
1974 Statement Before the Subcommittee on Health, Senate Committee on Labor and Public Welfare (February 25).
Ellul, Jacques
1964 *The Technological Society*. New York: Alfred A. Knopf.
Grof, Stanislav, Walter N. Pahnke, Louis E. Goodman, and Albert Kurland
1973 "Psychedelic Drug Assisted Psychotherapy in Patients With Terminal Cancer." Part II. In Goldberg, Ivan K., Sidney Malitz, and Austin H. Kutscher (eds.), *Psychopharmacological Agents for the Terminally Ill and Bereaved*. New York: Columbia University Press: 91-133.
Klerman, Gerald
1971 "A Reaffirmation of the Efficacy of Psychoactive Drugs." *Journal of Drug Issues* 1: 312-319.
Klerman, Gerald
1970 "Drugs and Social Values." *International Journal of the Addictions* 5: 312-319.
Klerman, Gerald
1974 "Psychotropic Drugs as Therapeutic Agents." *Hastings Center Studies* 2 (No. 1): 81-93.
Kluckhorn, Florence and Fred L. Strodtbeck
1973 *Variations in Value Orientations*. Westport, Ct.: Greenwood Press, Inc.
Kurland, Albert A., Stanislav Grof, Walter N. Pahnke, and Louis E. Goodman
1973 "Psychedelic Drug Assisted Psychoterapy in Patients With Terminal Cancer." Part I. In Goldberg, Ivan K., Sidney Malitz, and Austin H. Kutscher (eds.), *Psychopharmacological Agents for the Terminally Ill and Bereaved*. New York: Columbia University Press: 86-90.
Lennard, Henry L. and Leon J. Epstein
1970 "Hazards Implicit in Prescribing Psychoactive Drugs: Mystification in Drug Use and Models of Drug Action are Reviewed." *Science* 169 (July 31): 438-441.
Lifton, Robert J.
1971 "Protean Man." *Archives of General Psychiatry* 24: 298-304.
Manheimer, Dean I., Susan T. Davidson, Mitchell B. Balter, Glen D. Mellinger, Ira H. Cisin, and Hugh J. Parry
1973 "Popular Attitudes and Beliefs About Tranquilizers." *American Journal of Psychiatry* 130 (November): 1246-1253.
Muller, Charlotte
1972 "The Overmedicated Society: Forces in the Marketplace for Medical Care." *Science* 176 (May 5): 488-492.
Mumford, Lewis
1970 *The Myth of the Machine: The Pentagon of Power*. New York: Harcourt, Brace, Jovanovich, Inc.
Pahnke, Walter N.
1967 "LSD and Religious Experience." In DeBold, Richard C. and Russell C. Leaf (eds.), *LSD, Man, and Society*. Middletown, Ct.: Wesleyan University Press: 71-72.
Parry, Hugh J., Mitchell B., Glen D. Mellinger, Ira H. Cisin, and Dean I. Manheimer
1973 "National Patterns of Psychotherapeutic Drug Use." *Archives of General Psychiatry* 28 (June): 769-783.
Rieff, Philip
1966 *The Triumph of the Therapeutic*. New York: Harper & Row.
Slotkin, J. S.
1955-1956 "The Peyote Way." *Tomorrow* IV (3): 64-70.

Veatch, Robert M.
1974 "Drugs and Competing Drug Ethics." *Hastings Center Studies* 2 (No. 1): 68-80.
Veatch, Robert M.
1976 *Value Freedom in Science and Technology*. Missoula, Montana: Scholars Press.
Weber, Max
1958 *The Protestant Ethic and the Spirit of Capitalism*. New York: Charles Scribner's Sons.