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WHY THE PERVASIVE ADDICTION MYTH IS STILL BELIEVED

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This paper characterises the myth of addiction and considers social mechanisms that may sustain this discourse about substance use problems in the face of counter-evidence. The myth is that substance use is typified by addiction, which is a dramatic, dangerous and chronic condition primarily caused by the biological effects of drugs. This myth is resilient and has been applied to different substances. Among the simple social mechanisms that may sustain the myth are that it provides a clear answer to drug problems and that it is socially-functional for a wide range of social groups (Davies, 1992. *The Myth of Addiction*. Reading, Harwood.). The literature on the nature and functions of myths and legends is briefly reviewed to show that the myth of addiction is of this form. As often with legends, the myth is partly an illustration of how not to behave. It also depicts issues of self-control that may be of central concern to western cultures. Loss of control through addiction is compared with loss of control through possession by deities or spirits, which is the most prevalent alternative source of 'loss of control', and the social mechanisms that surround both phenomena are described. It is also suggested that non-addiction can be an aspect of social identity. It is concluded that there is a need to reconsider substance use as normal behaviour with social causes, without perpetuating the unhelpful morality and unsuccessful solutions suggested by the myth.

Keywords: substance use, myth of addiction

On substance use problems, there is a widening gap between the attitudes and beliefs of many in the research and treatment community and the attitudes and beliefs of policy makers. This gap is exemplified by the UK Government's initial rejection of, then months of silence

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about, the Runciman report (Police Foundation, 2000), despite an unusually favourable media response. Rather than anything more dramatic, the report, which reviews current UK drug legislation, suggests among other things that cannabis and ecstasy should be classified and penalised less heavily, while buprenorphine should be classified and penalised more heavily. Furthermore, the report provides survey evidence that UK public opinion has shifted towards a more liberal and discerning view of drug problems, where, for instance, cannabis and heroin are not considered to be more-or-less the same thing. It is timely to ask why public policy continues to be driven primarily by fear of addiction? The unthinking answer is to invoke the shortcomings of politicians and journalists. A common riposte to criticism of either group is to claim that their actions merely reflect society. In that vein, this paper develops a more sophisticated explanation that may explain the continued persistence and popularity of framing drug problems as 'addiction'. Even within the research and treatment community, many still think about substance use problems within the framework of addiction.

Two books (Finagarette, 1988; Davies, 1992) have specifically proposed that 'addiction' is a myth and similar ideas have been presented by others (Szasz, 1974; Peele, 1985). Addiction research literature suggests the concept of 'addiction' is indeed problematic, requires revision and often muddles social discourse, moral dilemmas, psychological states and pharmacology in an awkward manner. More subtle concepts such as the alcohol dependence syndrome (Edwards and Gross, 1976), controlled drinking (Heather and Robertson, 1981) and client motivation (Miller and Rollnick, 1991) have begun to diffuse from the study of alcohol to other drugs. It has already been suggested that at minimum the concept of addiction requires major revision and the label may no longer be helpful (Akers, 1991). This paper will try and establish why the myth of addiction is so pervasive. It will argue that myths tend to persist because they are functional for the culture and evolve to meet changing needs. This is what is happening with 'addiction' and this paper will explore the roles of 'addiction' as a functional myth in western cultures, the most important of these roles being to do with 'control'. It is first necessary to review the nature of the myth.

THE NATURE OF THE MYTH OF ADDICTION

'I WAS NOT HUMAN SAYS KILLER ADDICT' (Scottish Daily Record, September 2nd, 1986). Whatever the accuracy of this headline, it neatly sums up the myth. That drug use is supposed to cause crime and other antisocial behaviour is a major reason for drug laws and policies. Drugs are illegal because they are supposed to make people do dangerous or wicked things. There is currently some dispute about which drugs are 'addictive' in this sense. Whichever they are, 'addictive' drugs are supposed to have six sorts of undesirable effects.

According to the myth, the biological effects of addictive drugs are such that, if used they:

1. Lead *quickly and easily* to addiction, not merely after heavy use for a number of years.
2. Force addicts to stoop to *any* crime and depravity to finance their addiction, not merely those they were likely to commit anyway due to their life histories, or banal offences to get money and stupid ones while intoxicated.
3. Have psychoactive effects, which *markedly* diminish or eliminate rationality, morality and legal responsibility, not merely distorting sensory and cognitive functioning.
4. Make death and serious health damage *extremely likely*, rather than merely increasing risks.
5. Moreover addictive drugs are supplied by *ruthless* criminals who will *stop at nothing* to attract and enslave new addicts, rather than merely being supplied by people with an eye to a profit, to meet an existing demand.
6. Finally, addiction is an 'all or nothing' condition that is long lasting, if not permanent. One cannot be slightly addicted, or only addicted for a few hours or days.

In brief, 'addiction' is a dangerous, chronic condition primarily caused by the biological effects of drugs on susceptible individuals, which for some substances may be anybody who takes them. The test of the accuracy of this depiction is not whether the reader believes any of these things, but whether they believe that others believe them. The myth is based on exaggeration and distortion of the effects of certain drugs. For less distorted views see for example Johnson

(1973), Zinberg (1984), Johnson *et al.* (1985), Pearson (1987), Carpenter *et al.* (1988), Hammersley, *et al.* (1989), Kinlock (1991), Waldorf *et al.*, (1991), Hammersley and Ditton (1994), Shewan *et al.* (1998), Gossop (2000) and Orford (2000). Common distortions include the ignoring of counter-evidence, the thrusting forward of individual cases that support the myth as evidence for the most extreme form of the myth, confusing associations with causes and attacking messengers who bring unwelcome messages. Such distortions are standard in human reasoning (Sutherland, 1992). The myth is also perpetuated by the depiction of mythical figures and events that are rare or non-existent. These include:

- The child aged less than 11 addicted to heroin
- The adult drug pusher at the school gates
- The law-abiding youth with no problems, who was corrupted solely by heroin or cocaine
- The user of heroin, or crack cocaine, who became hopelessly addicted after only one or two uses of the drug
- The ex-addict whose problems were solved merely by abstaining from addicting drugs, without any additional effort
- The person high on drugs who acquires inhuman powers, such as superhuman strength, or a destroyed moral sense
- The addict who is so desperate for drugs that he or she becomes capable of any atrocity

From such legends comes the attractive fallacy that addiction is essentially simple. The mythical life history goes something like this: A naïve young person is persuaded to take drugs, becomes addicted to them and turns to a life of crime and depravity that he or she is unable to control. Some ex-users describe themselves like this, but personal life histories are constructed for socially and personally functional reasons and cannot be regarded as factual accounts (McAdams, 1993).

The Myth is Resilient

Every time the myth is debunked in one form, it pops up renewed. For example, in the early years of this century, 'Dope Fiends' were already

popular figures in the American press. But for one or two minor changes of wording, all six aspects of the myth were already in existence: Wicked pushers offered free heroin or cocaine to innocent young people who rapidly and inevitably (or at least with high frequency) became depraved, sick and dangerous (e.g., Kohn, 1992). More recently, in the late 1960s and 1970s it was believed that cannabis use caused immense psychological harm and was being pushed at school gates. Research found no evidence for this (e.g., Johnson, 1973). Meantime, cannabis was relegated to the league of minor evils and by the late 1970s, early 1980s, heroin was believed to cause immense psychological harm. It too was being given away free for unsuspecting teenagers to smoke or fix. Heroin use makes likely but does not guarantee addiction or problems (e.g. Zinberg, 1984; Robins *et al*., 2000; Shewan *et al*., 1998) and most youth obtain drugs on their own volition (e.g., Carpenter *et al*., 1988). More recently the myth shifted onto crack cocaine and research has again failed to find that crack is radically different from other drugs that can be taken for pleasure (Waldorf *et al*., 1992; Hammersley and Ditton, 1994; Akers, 1991).

The most recent wide-scale manifestation of the myth has been for ecstasy. The perplexing aspect of this drug, for the standard myth, is that it does not appear to addict its users. Nonetheless, there is major concern about ecstasy-related fatalities, warnings about possible future brain damage, dangerous mood changes and intoxicated misbehaviour. While there is reason for concern, at time of writing the risks have once again been overstated (Hammersley *et al*., 1999, Grob, 2000). There seems to be considerable morbid enthusiasm for the myth of addiction. A balanced response to future drugs panics would be that there are some things that are too bad to be true. Nonetheless, the myth has vehement defenders everywhere and often appears to be accepted sufficiently strongly by public and policymakers as to deflect any alternative view of drug problems.

Surely the Myth is a Straw Man?

In depicting common beliefs about addicts and addiction, we are not suggesting that people with substance use problems cannot or do not

exist except in this cartoon form. This paper discusses discourse about addiction rather than the facts underlying addiction. The myth is probably a straw man as a credible scholarly account of addiction, but it is a thriving belief system in discourse about addiction. That discourse is primarily about the more florid and dramatic aspects of substance problems. Dependent drinkers or smokers who only ruin their health do not feature much, nor do the many people who are drug dependent but do not cause society problems or seek help. It would be easy to find substance users whose lives fit the myth quite well, but they are a small minority of people with problems and a smaller minority of substance users. Why then are they so influential in discourse about addiction? We *are* suggesting that mythical discourse is widely used and highly influential, even among people who are well informed about substance use problems. We suggest that this implies that mythical thinking is easy to slip into and commonplace. Therefore, its appeal and persistence require explanation in terms of psychosocial processes.

SIMPLE SOCIAL REASONS WHY THE MYTH IS BELIEVED

It Provides a Clear Answer

The simplest reason the myth is believed is because it provides a clear, if impractical, answer to drugs problems. If drugs cause addiction with minimal contribution from the person, or the setting, then the only moral approach to reducing supply is eradication, the only moral approach to treatment is abstinence and the only moral approach to prevention is to insist that drug use should never be initiated. It is tautologous that drugs problems would be solved if drugs were unavailable, everyone stopped taking them, and no one else started. There is no evidence that such a utopia is approaching. In the meantime, the myth proposes that we should all try harder to achieve it. As no claim is made that eradication, abstinence and non-experimentation will work as problem-reduction policies in the meantime, the myth allows society to do something without accepting responsibility for the fact that these interventions fail.

For example, the United Kingdom appears to have experienced a steady rise in prevalence of drug use across nearly twenty years of repeated waves of strong anti-drugs campaigns and harsh laws.[1] Yet somehow, the myth inhibits accepting that this rise suggests that these policies have been ineffective.

In the past hard-liners of various political and religious persuasions have devoted years, sometimes centuries, of unsuccessful effort to stamping out other vices and evils including masturbation, sex outside marriage, undesirable religion, tobacco smoking, alcohol drinking, gambling, usury and teenage delinquency. The harshest of individual penalties, up to and including torture and death, and the most ferocious wars have failed to eliminate these activities. Drugs could only be different if drug use were really an essentially simple biological problem.

It is Socially Functional for a Wide Range of Social Groups

If the myth is true then many groups in society gain something. The media have a good story and politicians a safe issue, but criticising these groups on drugs is rather stale. More interestingly, the increasingly profitable anti-drugs industry has an operational rationale that suggests that it is motivated by science rather than by morality or the desire to make money (see Crow and Hartman, 1992; Akers, 1991; Szasz, 1974). If addiction were a simple biological condition then it might not be unethical to treat it purely chemically, or with simplistic therapy conducted by barely trained counsellors. Acknowledging the psychological and social complexities of the problem is liable to increase the costs of treatment.

Those involved in the production and trafficking of controlled drugs may also enhance their profits by encouraging the myth and keeping their products illegal. As this industry may now be the largest in the world (Castells, 1998, Ch. 3) there is also the potential for it to massively corrupt and penetrate legal social institutions. This is known to have happened in some producer countries. To what extent has it happened also in consumer countries?

[1]One must be cautious in asserting this because accurate population data are not available before the late 1980s.

Law enforcement also benefits. Normally, the causes of crime are poorly understood and attempts to thwart or reduce crime can appear frustratingly unsuccessful (see Pawson and Tilley, 1997, Ch. 1, for discussion about how to decide what works). By arresting drug user-dealers, the police are directly tackling crime (it is not the police's role to decide that drug use, or low-level cannabis dealing, are not crimes). As prisons fill up with drug offenders, it is clear that the police are doing a good job in this regard. If, at the same time, they are actually removing burglars from the streets, or if, by stamping out heroin or crack cocaine, the police are reducing the incentive for burglary and hence the number of burglaries, then this is a major achievement. Unfortunately, it is not clear that getting tough on drugs will reduce the crime rate, for acquisitive crime requires a market for stolen property as well as criminals who want money (Hammersley, *et al*., 1989; 1990). Nonetheless, it is an appealing idea for the police and all others concerned with law and order. Ironically, recent decreases in crime in the USA, which may really be due in part to decreased crack cocaine use, have been credited to simplistic theories of policing that were never actually practised (Bowling, 1999). Similarly, if excessive alcohol consumption is to blame for violence, then the solution to violence might be to curb alcohol consumption. Again, whether or not this is correct – and perhaps it is (Collins and Schlenger, 1988) – such a simple solution has obvious appeal.

There are also global tensions, for the major misused drugs are all primarily produced in developing countries and primarily consumed in the most developed countries (although this is changing). Given the enormous turnover of the drugs market, substantial money must be flowing out of Europe and North America into Latin America, Africa and Asia. This possibility would concern politicians even if drugs were legal. As they are illegal, intervention in the trade is not only allowed, but also congratulated by the international community. In contrast, imagine if the USA tried to pay Korea not to produce electrical goods, or offered military aid to help shut down foreign car factories. Illicit drugs compete with the developed countries' own highly profitable alcohol, tobacco and pharmaceutical industries. One can only speculate about the kinds of pressure that these multinational enterprises exert behind the scenes. In a rare overt example,

in 1990 the USA introduced trade sanctions against Thailand because that Thai health department banned foreign tobacco advertising.

The pharmaceutical industry and the biotechnology research industry also have a lot to gain from the myth. If addiction is a real biological entity that is not determined by complicated psychological and social forces, then there is potential to find a simple (and highly profitable) cure, and in the meantime a programme of basic research can be funded. For example, searching Web of Science from 1997 to January 2001, 13,197 articles had cocaine, heroin, MDMA (or Ecstasy) in their titles. Sampling the most recent 100, only 14 concerned the clinical, social or psychological correlates of drug use at all, while 5 were not actually about drugs. If this small sample can be generalised then there have been 12,537 articles about these drugs in the last 5 years, of which 85% were biomedical and reductionist in approach.

Many religious and moral groups also benefit from the myth. In Judaeo-Christian ethics, there has always been a difficulty in resolving the beliefs in individual free will and a beneficent God with evil behaviour. One can dilute this problem by arguing that drugs (or demonic influences) suspend people's free will. One can then continue to believe that people are essentially good, but are led to do evil by drugs (Blum and associates, 1970). Many who would scorn demons as superstition believe that drugs have equally odd and powerful properties.

Drug users themselves also have something to gain by endorsing the myth of drug use. Few criminals regard themselves as wicked people and they provide rationales and justifications for their antisocial behaviour. No one likes to admit to being bad or stupid and drugs provide a convenient explanation for actions for which one would rather not take personal responsibility (see Davies, 1992).

Last, and often most outspoken in support of the myth, are ex- and 'recovering' drug users themselves. Particularly outspoken tend to be graduates from programs which emphasise help by other ex-users and abstinence, often with 12-steps philosophy or some variation on it. The reason for this may be that many graduates have defined their identities in terms to their ex-addict status. In some cases they have not left drugs behind, but rather have replaced being heavily involved *with* drugs with being heavily involved *against* drugs. Successful graduates of 12-steps programmes have had to accept their powerlessness over the addiction (Keene and Raynor, 1993). In other words they

have had to accept their permanent out-group status, for at any time they might resume their addictive behaviour. The success of 12-steps treatment is often cited as evidence for the truth of the myth. Independent observers have tended to see such treatment as a moral order (e.g., Bateson, 1971; Keene and Raynor, 1993). Accepting the mythical belief system seems to help many people stay off drugs. Nevertheless, what about those who cannot accept those beliefs? Is it sufficient to marginalise them, when they may have as many or more problems? What also about those whose path through drugs or alcohol use does not resemble the myth at all?

A related difficulty concerns drug users who are led to endorse the belief system, although they do not have an addiction problem. They may be chalked up as successes, even though they could have 'recovered' from their non-existent problem without any treatment at all. For example the career of a celebrity caught taking cocaine recreationally may suffer if he or she is brazen about it. Far easier to admit a 'problem' and attend 'treatment' for a while. If caught taking cocaine again, the celebrity can always apologise and admit 'relapse'. There is probably a gradient between this most cynical end of things and people with substantial problems. There is nothing wrong with converting people to temperance and abstinence, but this is not a sufficient solution to the drug problem, nor one based on a purely empirical description of addiction. Consider, for a start, the social damage done by addicts on their way down to 'hitting bottom'.

In short, the myth is to the advantage of all concerned parties and it is no wonder that it is so firmly believed and defended. Many defenders believe that they are defending the truth, for there is some truth to the myth.

IN WHAT SENSE ARE COMMON BELIEFS ABOUT DRUGS A MYTH?

Myths and legends are folk-tales that evolve to make sense of the world and define the group that tells them (e.g., Brunvand, 1981; Glazer, 1987). Although the existing phrase is the 'myth of addiction', it is more strictly a legend, told in the present-day as if it were true. Legends may also function to define a society's moral and social

order by fulfilling wishes or satisfying ideals (e.g., Hobbs, 1987; Ben-Ami, 1980). Part of that order may be the definition of social group (e.g., Hobbs, 1987) and the illustration of moral values (e.g., Ellis, 1987).

> *"Rumour legends (. . .) articulate, and to a great extent validate, wishes and fears. They are told because they express in a succinct and entertaining form what narrators wish to present as a truth about contemporary life and behaviour".* (Boyes, 1984: 64)

In its telling and retelling the drugs myth has evolved to fit easily in with the commonplace ideas of western culture and to justify moral objections to certain types of drug use. It also defines an out-group; people who use drugs, perceived as addicts or potential addicts. So, it is not surprising that it is widely believed.

A brief word about 'western culture'. For reasons to be discussed, the myth appears to be most popular in societies that are capitalist, post-industrial and Judaeo-Christian in ethics: Basically Western Europe, North America, Australia and New Zealand. The international dominance of the myth is probably due to the current dominance of these countries, particularly the USA. For convenience, these cultures will be collectively called 'western'. The debate for and against the drugs myth tends to be most heated in the USA.

Myth and legends are also widely believed to be true (Hobbs, 1987), are modified to fit with current local culture (Glazer, 1987) and sometimes have had a basis in fact at some point, although this becomes irrelevant as they are retold in different forms (Brunvand, 1981). Indeed, those who believe the drugs myth often insist that it is fact, not belief, theory or explanation (see Stutman, 1989). But, the facts of the matter do not speak for themselves. Similarly, oral legends are often reported as factual history or personal – if often second-hand – experience (Glazer, 1987; Hobbs, 1987). This appears to apply to the mythical addiction figures listed earlier, who tend to be reported as 'known of' rather than known from direct experience. If such cautionary figures exist at all, they are certainly much rarer than the number of times that their stories are retold.

Because the myth is supposed to be fact, little attempt is made to explain how drugs are supposed to have these terrible effects. For example, it is difficult to obtain a detailed explanation of *how* drug

use might cause crime because that is taken to be self-evident that the need for drugs forces people to commit crimes. Issues such as that most drug 'addicts' were criminal prior to addiction, that both behaviours develop concurrently in adolescence, or that extent of crime is only weakly related to extent of drug use, are regarded as academic hair-splitting. The broader criminological issue of economic crime requiring a demand for the stolen goods is swept aside. Similarly, oral legends *are* explanations or judgements (e.g., Hobbs, 1987). In terms of the myth, asking why drugs are bad is rather like asking why the mysterious killer in the well-known modern legend 'The boyfriend's death' (Glazer, 1987) should kill the boyfriend and hang him above the car in which his girlfriend is waiting (or decapitate him in other versions). To demand explanation in terms of causes or motives is to reject the legend; yet in the real world it is very reasonable to ask 'Why would he want to do that?' It is equally reasonable to ask how drugs have their mythical effects and to read the evidence that they do not.

There may well be some truth in the myth. There are addicts (although one may debate the validity and helpfulness of this label), drug related crimes, strange and terrible behaviours and drug-related diseases and deaths. The question is, are the drugs the main causes of these problems and if so under what conditions? Similarly, oral myths that have no connections with contemporary reality die out or are modified (Horton, 1993), only leaving those that somehow continue to be relevant. For drugs, we now forget the considerable concerns over the moral and medicinal properties of tea and coffee when they were first introduced (e.g., Barr, 1995: 4–6). If the idea that drugs are extremely dangerous were completely wrong then it would have been discredited long ago. It is much harder to discredit a myth. Any cautious suggestion that there is some truth behind it will be taken as support for the myth, rather than some more moderate explanation, while any suggestion that the myth is exaggerated or inaccurate will be attacked. Critics of the myth are often set up as advocating an unreasonably extreme position. Perhaps the best example of this being the recent visit to the Netherlands by the American 'Drugs Czar' General McCaffrey, prior to which he systematically misdescribed the Dutch situation to fit his professed beliefs (Reinarman, 2000).

Although the concept of addiction began as a reasonable scientific theory that allowed medicine to engage with problems of drinking and drug use, the concept has escaped into popular use where 'addiction' is now the answer, not the question. To understand why the myth of addiction is still widely held, one must ask not, 'Is it true?' but 'What functions does it serve?'.

CULTURAL FUNCTIONS OF THE MYTH OF ADDICTION

As an Illustration of How Not to Behave

Oral legends are invoked to explain new events and to illustrate the value of traditions to the young or naïve (e.g., Horton, 1993). For the myth of addiction, one salient tradition is a reverence for physical and mental health: People should be able to cope with their problems and avoid behaviours that damage their health. People are supposed to be responsible for and able to influence their own health. People should also not infringe on the persons or property of other people. 'Addicts' cannot cope, damage their health, are irresponsible and fail to respect others. It is important that the traditions we revere are often those that we fail to attain. As the typical daily time spent cooking has declined to less than 15 minutes, cookery shows on TV have become more popular. As obesity rises, a fascination with fitness and leanness rises. As drugs are used more widely, addiction stories are told and re-told to illustrate our reverence for health. Telling the myth does not mean living up to the standards illustrated and in reality people's health consciousness may be part-time and coexist with substance use (Parker *et al.*, 1998; Mullen, 1993).

The Issue of Self-Control

Richard Blum wrote of 'The New Demonology', (Blum and associates, 1970) referring to society's increasing willingness to blame any variety of bad behaviour on drugs. Like a demon, a drug is supposed to be able to possess a person and make the do things that the person themselves would not do.

Modern western cultures seem to have a fascination with issues of self-control. Perhaps this is not surprising in cultures that have come to value individualism so highly. Not being in control of oneself is regarded as a serious problem. In more fatalistic and/or co-operative cultures, not being in control is the norm and, in some, phenomena like being possessed by spirits, demons or deities are not regarded as deviant (e.g., Suryani and Jensen, 1995). Control may lie with the gods or with social rules and the person may not be perceived as an agent who has free choice.

Self-Control and Substance Use

Self-control is certainly a central issue in drug use. Revealingly, one phrase to describe normal alcohol consumption is 'controlled drinking' (e.g., Heather and Robertson, 1981). The implication being that 'uncontrolled drinking' is self-evidently abnormal or undesirable. Similarly, drug users may avoid certain drugs because they believe they would not be able to control their effects (Parker *et al.*, 1998).

The opposite side of this control issue is that some drug users take drugs for the adventure of trying to master something that is difficult to control. In America, since the late 1960's it has often been competent, if unemployed and uneducated, street-wise young men who became heroin users, or, more recently, crack smokers. Being able to handle an expensive heroin (or cocaine) habit was a sign of social status. It requires skill at obtaining illicit funds and the ability to retain one's composure and function under difficult conditions, such as being stoned on heroin or while suffering withdrawal symptoms (Preble and Casey, 1969; Weppner, 1982). Most recently, the newest generation may be turning back to heroin (Jacobs, 1999), believing that crack cocaine is uncontrollable, although it may be armed crack dealing, rather than crack smoking, that is difficult to control (Jacobs, 1999).

It is also possible that some people take drugs in order to abandon their self-control. This possibility is taboo – literally not for speaking about – for the drugs myth assumes that wanting to lose self-control is a demonstration of having an addiction problem – bingeing – which suggests out-group membership and the need for treatment.

But, some degree of bingeing, on food at least, appears to be quite common (Palmer, 1987). Many drinkers sometimes set out to get drunk; most have probably experienced at least one hangover. Such behaviour is not so much losing self-control, as temporarily abdicating it (Orford, 2000). Being able to abdicate self-control can also serve important social functions, which will be explored by examining the phenomena of possession.

Possession and Drugs as Means of Relinquishing Control

In societies where spirit possession is an accepted phenomenon, 'spirits' can say and do things that are forbidden, or at least awkward, to people possessed by them (Lewis, 1989). For example, among the Hopi in Arizona, ritual clowns criticise people's behaviour in ways that are normally impolite and might lead to acrimony. These criticisms help to regulate Hopi society (Geertz, 1994: 292–294). The clowns can only fulfil this function while everyone more-or-less accepts that the person beneath the costume is not responsible for their comments. If sanctions could be taken against the person, then it would be harder for clowns to be outspoken.

Interestingly, a range of cultures utilise various drugs to achieve fantastic religious transformations, often via a shaman (Lewis, 1989: 34). This would include – in a modest way – the transformation of wine into blood in Christian ritual. Prior to the globalisation of licit and illicit drug markets, the religious use of drugs could aften exist without the drugs diffusing out and being used for recreation as well.

Turning to non-religious behaviour, in western culture being drunk allows one the freedon to be relatively outspoken (Alasuutan, 1992; MacAndrew and Edgerton, 1969). Going out for a drink after work can allow one to criticise the boss in a way that would be embarrassing, or even dangerous, in the worksplace. Declarations of passion are also easier when one is drunk. After all, one can always apologise in the morning. As with Hopi clowns, this mechanism only works while people more-or-less accept that drunken behaviour is not entirely within the control of the drunken person. So, the idea that one can be out of control on drugs can serve an important social function.

Abdicating control is often confused with losing it. Many clients have difficulties in controlling their use. They may have intended to merely abdicate control for a while, have a good night out, but they instead lose control in some sense and wind up with problems. In Bali, trance states can also get out of control and lead to suicide attempts and amok, where a person suddenly behaves with extreme violence (Suryani and Jensen, 1995, Ch. 7), but most trances are seen as benign possessions by deities.

It is also interesting that according to Lewis (1989) possession most often occurs among socially disadvantaged or excluded groups, particularly women in many cultures. Based upon what the spirits say, possession can be interpreted as a means of making demands on the advantaged – men or those in power – without completely violating social norms. Lewis (1989) concludes that most cases of possession cannot be reinterpreted as occurrences of serious mental illness. Could loss of control through drug addiction be manifest similarly in cultures that do not believe in spirits? Littlewood (1994: 91–94), describes an interesting case where a girl from Bangladesh who had been in the UK for only two years was showing signs of hysteria that read very like possession, unacknowledged within a UK medical framework. Having been prescribed tranquillisers, this young woman went on to an overdose attempt.

Similarly, is heroin or crack cocaine addiction a form of pardonable rebellion against the social exclusion of large numbers of poorly educated young working class men? A broader possibility is that addiction represents a typically masculine response to the stereotypical demands society places upon men (and many women) to be in control of themselves and be autonomous, responsible, healthy wage earners (Reid and Burr, 2000). Entertaining this possibility suggests that substance use problems will not all be readily classifiable as mental illness and this applies more so as drug use becomes more widespread.

Being in Control as a Social Phenomenon

It is difficult to address the nature of phenomena such as possession by spirits or loss of control after drinking within a reductionist framework. According to reductionist materialism, these phenomena must

be linked to some measurable change in the nervous system, or they are 'not real'. Reductionist thinking about addiction often reverses this causal chain, so that if a substance is linked to a measurable change in the nervous system, then that is taken as evidence that the change is a cause, even a sufficient cause, of the substance's effects. Possession is much more obviously problematic, as indeed are non substance based addictions such as gambling (Orford, 2000).

A more realistic view is that such mental phenomena do not have to map onto a unique physical state of the nervous system in any simple one-to-one fashion. One plausible possibility is that they are social events, sustained by people's need to keep the social mechanism operating. For drug use, belief in loss of control may help to maintain the phenomenon.

Two examples: first, it is possible that drunkenness causes violence in part via a social mechanism of this kind. Suppose that (a) everyone knows that alcohol makes you violent and (b) violent behaviour is the accepted and expected response to some social events. Amongst some young Scottish males, if you are insulted in certain ways then you are supposed to hit the insulter. After alcohol, there may be more risk of such a violent response. For, someone who is *not even violent when they are drunk* may be perceived as cowardly, unmanly or insufficiently jealous of other men's attentions to his girlfriend. Conversely, someone who is as readily violent sober as others are drunk may be perceived as dangerous and unpredictable; 'mental' in local slang. The context of having drunk alcohol enables and permits, even demands, violent behaviour (e.g., Wight, 1993), while the drug may cause a cognitive 'alcohol myopia' that facilitates violence in some circumstances (Steele and Josephs, 1990).

Secondly, Glaswegian drug injectors have a scornful label 'Giro Junkie' which refers to drug injectors who spend much of their benefit cheque on drugs, then more-or-less abstain until the next cheque. 'Real Junkies' scorn Giro Junkies because they are obviously not really addicted, they can go without drugs and are not even addicted enough to have to steal. Researchers in Glasgow have also encountered injectors who are proud of their scars and collapsed veins, which demonstrate their status as veterans. Perhaps, in the local culture around drug injecting, people seek out and cultivate signs and behaviours which indicate that they are 'out of control' and 'mental'. In

a subculture that can be extremely violent and exploitative, the benefits of being thought 'mental' are obvious (see also Bowling, 1999).

Most people have had experience with alcohol and realise that, for alcohol, there are degrees of control. It is not difficult, then, to imagine that supposedly stronger drugs would have correspondingly larger and potentially more dangerous effects, which would include losing control. The concept of loss of control may be both necessary and frightening in many western cultures. Drugs are seen as dangerous because of loss of control, but, inverting this, the addiction myth may also serve to define what 'being in control' consists of. As an individual supposedly in control of oneself, it may be difficult to gain power, become wealthy or make fully autonomous decisions about one's life, but at least one can avoid using drugs. Looking at it another way, junkies, in their drug use, do not have to struggle with social and economic success. They have an explanation for their failure that may actually enhance their self-esteem, compared to their neighbours who have progressed little further in conventional society (see Davies, 1992).

Behind the myth of addiction lies an example of the fundamental attribution error; to assume that things that have powerful effects on people must be caused by clear changes in their brains. This underestimates the power of the social. More research and thought are needed about how social forces create both substance use problems and depiction of those problems as 'addiction'.

Drugs and Social Identity

Another important contribution of the addiction myth is that is serves to structure our culture. A traditional tribal culture may have included several hundred artefacts and conceptual entities, which changed only gradually over the centuries. In contrast, the number of artefacts and entities in an industrialised culture is uncountable and ever changing. Basic cultural dividing lines, like choice of food, dwelling or clothing have become eroded. Even the decision to build in 'local style', or cook the recipes of one's ancestors have become choices rather than cultural imperatives.

Given these conditions, grand simplifying concepts like 'Not using drugs because they are dangerous' are thus attractive as methods of

making one's identity distinct. It does not matter that the majority of people in western cultures do use drugs – if caffeine, alcohol and medicine are included – or that the dangers of 'drugs' are often distorted. Jenkins (1996) describes how social identity is constructed in part by conflict at the edges of identity boundaries. One example of such conflict is what substances one consumes and how one characterises that consumption. Most people define their own behaviours by virtue of their 'not' being addicted, or 'only' drinking within safe limits, or avoiding 'addictive' drugs like heroin. This has been explored in more depth specifically for cannabis (Hammersley *et al.*, 2001).

MOVING BEYOND THE MYTH

This paper has examined discourse about addiction critically. When scrutinised in this way, some other widely believed and talked about social phenomena come to seem like rarities, or vanish entirely. But in addiction, real, common problems are clearly associated with substance use. It is essential to avoid taking the reality of these problems as evidence for the myth of their causes and consequences. Because the myth is sustained by such a variety of social mechanisms, there is a large pontential for thinking about addiction to regress towards the myth in order to increase consensus. This occurs in subtle ways even within the addiction research community, whose primary rationale is to understand the problems caused by substance use. This can contribute to thinking that tends to take the links between substance use and problems as self-evident. Yet, it is highly unlikely that identical explanations for the development and prognosis of substance use and the related problems will apply to all substances, all people and all social conditions.

It should not be controversial to recognise that some drugs can be used without harm, by some people, in some conditions. Indeed, a major objective of addiction research should be to understand how and when this occurs. To design safe airplanes, engineers need to understand how and why they crash, just as addiction research wants to understand how addiction occurs, but engineers also need to understand how and why airplanes fly safely, which they do most of the time. The study of normal or non-problematic substance use is

underemphasised in addiction research. The myth of addiction promotes a climate of thought that is the equivalent of every air crash – however caused – leading to all the planes of that model being permanently banned from the air with no right of appeal. There is a need for an improved understanding of normal substance use, rather than the presumption that non-problematic use is either 'experimental' or the early stages of a potentially problematic career. Without understanding how normal use is not pathological, it will be difficult to understand how use can become problematic.

However, there is a moral dimension to substance use that is largely absent from aviation. People do not have value free views of substance use, but generally have strong moral opinions about the merits and harms of intoxication, about what is appropriate or inappropriate intoxicated comportment, about the kinds of people that one should or should not associate with, and about how much harm is 'too much' where drugs are concerned. There cannot be purely scientific or rational resolutions of these issues. Here again, the myth clouds the issues because it obscures the fact that in western societies drug use is the norm; including alcohol, tobacco, over the counter medicines, caffeine and other performance enhancing drugs. The myth also prevents reasonable discussion of the extent to which there is or should be a common morality about substance use and intoxication. Everyday morality tends to favour traditional drugs such as alcohol and traditional consumption patterns that are engrained into society, regarding non-traditional ones with hostility. But modern societies also contain a vanguard of people who ardently favour new things over traditional ones – ecstasy rather than alcohol being a recent example – so hoping for a return to tradition is generally wishful thinking. The myth that there are some biologically harmful drugs and some relatively harmless ones shuts down dialogue between these two tendencies in society. It also does the disservice of medicalising morality (Szasz, 1974).

The myth also inhibits discussion of what drugs we want, how, when, at what cost and consumed by whom? According to the myth, we don't want evil addictive drugs, but perhaps we do want harmless ones. Abandoning the myth, there is no such distinction. At this point, many readers with be thinking 'Ah, but *except* for...' and they will go on to insert their least, or most, favourite drug. Common beliefs

include that all drugs are harmful except marijuana, or that all drugs are harmless except opiates and cocaine. All drugs in common use can have dreadful effects, but none necessarily do so. For example, suppose heroin were legal; should people in severe chronic pain take it, what about 12-year-old children, what about long-distance coach drivers? Now suppose it illegal; does this alter the main issues about use for these groups? Now suppose a different drug – similar specific problems remain.

Society could try and eliminate all psychoactive substances, but it is doubtful if this could be accomplished. Anti-drug measures have become more and more severe, to no obvious effect. Rather than fighting a war on drugs, we should be considering how to cope with them, which will require research that does not underestimate social influences on behaviour. Drugs are here to stay and, with global pharmaceutical research, even if better chemical interventions are developed, it is also likely that the variety of substances that people could take for pleasure will increase. Even if heroin, other opioids and cocaine could somehow be eliminated, it is likely that other substances would come to replace them. Or, people would carry on drinking. In the war on drugs, the enemy is ourselves.

Coping with drugs requires the consideration of other options that are currently met with hostility, anger and ridicule. For a start, the use of the blanket term 'drugs' is unhelpful, for drugs vary widely in their effects and the problems they can cause. A modern utopia might well have no mind-altering substances. But, like it or not, there is a great demand for them and they are unlikely to be eliminated. Before the war on drugs goes any further – the USA and UK have been involved in military action in foreign countries and British and American prisons are bursting with drug users – it is time to set the myth aside and consider if there is some less violent and more permanent method of coping with drugs. This method is unlikely to consist of any simple medical, social, economic or legal panacea. But, as described, the power of the myth is that it offers a basically simple and appealing solution that can never be shown to be failing and which fits well into our culture's ideas. Left unchecked, it will continue to worsen the social problems surrounding drugs, both by hindering the necessary compromises and by directly ostracising and persecuting minority drug users. It will also continue to neglect the less dramatic

but more considerable problems associated with alcohol and tobacco. To tackle drug use we need a different discourse about drugs. It may seem simpler to tackle the problems of a minority out-group of 'addicts' with some sort of biological problem but this is largely displacement activity in the face of a daunting task.

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