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Cultural Aspects and Responses to Addiction

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Abstract

Use of psychoactive substances, and our interpretations of the effects of the substances, are affected by culture, defined broadly to include social worlds and subcultures as well as tribal, societal and linguistic groupings. Prototypical patternings of use include medicinal use; customary regular use; and festival and other intermittent use (where the psychoactivity is most attended to). A fourth pattern, addictive or dependent use, was a conceptualisation arising after the Enlightenment. Cultural norms may both encourage and discourage use and heavy use, and may make the use more or less problematic. Cultural factors also shape responses to substance use, including the social handling of problematic situations and persons. Thus there are characteristic differences between cultures in the institutional and professional location in the handling of substance use problems. In the modern world, there is substantial diffusion of practices and understandings between cultures, and in multicultural societies drinking or drug use patterns often serve as markers of cultural distinctions. Despite all the diffusion, there are persisting cultural differences in thinking about, patterns of use of, and responses to psychoactive substance use.

Introduction

This chapter is concerned with cultural factors in addiction. In discussing cultural aspects, we are referring to shared beliefs, norms and patterns of behaviour, both about use of psychoactive substances and about how the use should be interpreted and responded to. "Cultural" is used to mean pertaining to a variety of kinds and levels of collectivity. This can range from a small tribal group, for instance the traditional inhabitants of Easter Island in the Pacific, to a large multinational aggregation, as in a discussion of how English speakers understand addiction, in contrast, say, to French speakers.

Often in discussing cultural factors we are dealing with multicultural situations, with a diversity of cultures or subcultures. In such situations, the particular norms and behaviours of a group may serve as markers differentiating between groups; where most people drink alcohol, for instance, abstaining from alcohol may become a mark of difference for Muslims or Mormons (Room, 2005).

We also use "cultural" here to refer to "social worlds" (Shibutani, 1955; Unruh, 1980) within a society in which understandings, norms and behaviours are shared, but in which the cultural boundaries are less marked. For instance, one can speak of a social world of heavy drinkers who know what is expected behaviour at the bar in a tavern in a particular society (Cavan, 1966). Are male drinkers expected to buy drinks for each other, or does each always pay just for himself? What signals are being sent between a man and a woman when he buys a drink for her, and she accepts?[1] Among young adults in Oslo, Norway, for instance, "when men buy drinks for women, this may be interpreted as a negotiation for further intimacy" (Træen & Hovland, 1998). Answers to such questions will be obvious to those within the social world, but may not be to outsiders.

Cultural Expectations About and Definitions of Psychoactive Substances and Their Effects

By definition, psychoactive substances change our mental state. But how we interpret that change, and how we behave under the influence, is strongly influenced by "set and setting" (Zinberg, 1986) – including our expectancies about the effects, which in turn are influenced by cultural factors as well as previous experience. Although the psychoactive effect of tobacco may not register in the consciousness of a habituated cigarette smoker, in other circumstances the effect of tobacco use may be so strong that the user is rendered unconscious, as early Spanish observers reported in describing tobacco use among native South Americans (Robicsek, 1978). How those under the influence of a given dose of alcohol behave differs widely between cultures, as MacAndrew and Edgerton (1969) argued in their landmark work on *Drunken Comportment*. Whether or not someone taking LSD experienced a "bad trip" in the US in the 1960s and 1970s, Bunce (1979) argued, was strongly influenced not only by subcultural expectations but also by the extent of sociopolitical controversy at that particular historical moment concerning the drug.

Three social patternings of psychoactive drug use can be distinguished as prototypical: medicinal use, customary regular use, and intermittent use. In many traditional societies some drugs or formulations have been confined to medicinal use, that is, use under the supervision of a healer to alleviate mental or physical illness or distress. For several centuries after the technique for distilling alcoholic spirits had diffused from the Arab world to Europe, for instance, spirits-based drinks

[1] See "Buying and accepting drinks" thread on http://forums.plentyoffish.com/datingPosts8464582.aspx (accessed 16 June, 2013).

were regarded primarily as medicines (Wasson, 1984). This way of framing drug use has been routinized and made subject to official control in the modern state through a prescription system, with physicians writing the prescriptions and pharmacists filling them. Drugs included in the prescription system usually are forbidden for nonmedicinal use (Babor, 2010), although the modern international drug control system has been fighting a losing battle to enforce this rule.

When a drug becomes a regular accompaniment of everyday life, its psychoactivity often is muted and even unnoticed, as is often the case for a habitual cigarette smoker. Similarly, in southern European wine cultures wine is often differentiated from intoxicating "alcohol"; wine drinkers are expected to maintain their original comportment after drinking. This may be called a pattern of *banalized use*: A potentially powerful psychoactive agent is domesticated into a mundane article of daily life that is available relatively freely in the consumer market.

Intermittent use—for instance, on sacred occasions, at festivals, or only on weekends—minimizes the buildup of tolerance to a drug. It is in the context of such patterns that the greatest attention is likely to be paid to a drug's psychoactive properties. The drug may be understood by both the user and others as having taken control of the user's behavior and thus to explain otherwise unexpected behavior, whether bad or good (Room, 2001). As in Robert Louis Stevenson's fable of Jekyll and Hyde, normal self-control is expected to return when the effects of the drug wear off. In light of the power this framing attributes to the substance, access to it may be limited -- in traditional societies by sumptuary rules keyed to social differentiations, and in industrial societies by other forms of market restriction, including outright prohibition.

In modern societies a fourth pattern of use is commonly recognized: addicted or dependent use that is marked by regular use, often of large doses. Where such use for the particular substance is not defined in the society as banalized, addiction tends to be defined as an individual failing rather than a social pattern. Conceptualising repeated heavy use in terms of addiction means that the categorisation becomes an explanation – an explanation of why the pattern of use continues, despite problems resulting from the use for the individual and often for others. The concept thus focuses not on the pattern of use in itself, but rather on an apparent inability to control or refrain from use despite adverse consequences.

The addiction concept became established for alcohol in general understandings of European societies in the period after the Enlightenment. Particularly as temperance movements sprang up in response to the waves of very heavy alcohol consumption that accompanied the Industrial Revolution, the addiction idea came into common use as an explanation of why backsliding was common among temperance members who had pledged to give up drinking (Levine, 1978; Room, 2003). In the late 19th century, the concept was extended by doctors to cover other psychoactive

substances, and more recently popular and professional discourse has commonly applied it also to other behaviours (Marks, 1990; Saïet, 2011), though not without dispute (Jaffe, 1990). Though the concept has diffused into many cultures, there are substantial differences in cultural understandings of what it characterises and implies (Room, 2006).

Norms Concerning Use and Related Behaviour

The use of psychoactive substances in any society or cultural group is structured by norms concerning use, and behaviour while and after using. Laws and regulations on these matters, such as laws forbidding sales to or use by those under a certain age, or prohibiting driving after use, or regulations such as a church denomination's rubric specifying how left-over consecrated wine from a communion service is to be handled (it is to be "reverently" consumed; Blunt, 1871:198), may be described as formal norms. At least as important in structuring use are informal norms concerning use, which are often highly differentiated according to the social context (Greenfield & Room, 1997) and to the user's demographic and social position. Bruun's division between controls at the phases of use, of pattern and of consequences (Bruun, 1971b) – whether use at all is disallowed, or there are controls on the pattern of use, or controls aiming to insulate the use from adverse consequences – describes the main strategies of both formal and informal norms in limiting the damage from substance use.

It is important to note that norms may encourage use – and indeed heavy use – as well as discourage it, and may make the use riskier or more problematic. Taking alcohol as an example, heavy drinking or drug use is not always a matter of individual choice, but in particular social contexts may be a strong expectation. For example, in cultures where buying rounds is customary, once the round has been established, a man drinking with a group of friends will face a strong expectation to stay and drink as many drinks as there are men in the group. In a Mongolian cultural group in China, competitive drinking is a norm: "a refusal to drink signifies a refusal to engage the other on equal and respectful terms. Drinking partners take turns challenging each other to drain the cup, and the cups are inverted immediately afterward to prove the liquor is gone" (Williams, 1998). Among young adult Italians, as also elsewhere in Europe, drinking games, enforced as a group ritual, serve the function of "becoming drunk quickly so as to amplify the effects of drinking: less shyness and disinhibition" (Beccaria and Guidoni, 2002). Cultural expectations may thus facilitate heavy drinking and even enforce it, so that in some circumstances addiction or dependence might better be described as located at collective levels rather than in the individual's mind or body (Room, 1973). This idea is carried by the French term *alcoolisation*, used concerning a society such as France when alcohol consumption was at its highest there in the 1950s (Jellinek, 1954).

Cultural Factors in Responses to Substance Use

Intoxication and habitual use of psychoactive substances can be problematic in many ways for those around the user, and societies and cultures respond in many ways in efforts to limit or prevent the problems. Informal responses by those around the drinker, smoker or drug user are very common (e.g., Hemström, 2002; Hradilova Selin et al., 2009) – at levels ranging from a spouse's raised eyebrow to strenuous retribution.

Societies also respond to alcohol and drug problems at more formal levels. In the modern world, there is considerable uniformity across societies in the general roster of agencies and professions with responsibility for the social handling of problematic situations and persons. In most societies, there are hospitals and other health services and medical professionals; courts and police and judges; welfare institutions and social workers; and churches and other faith institutions and clergy. But none of these sets of agencies and professions have clear and unchanging custody of alcohol and drug problems. Typically, all of them handle some part of drug and alcohol problems, but drug and alcohol problems are not central to the jurisdiction of any one of them. The result is a diversity of competing models of how alcohol and drug problems should be handled (Bruun, 1971a). As an eminent addiction doctor, Norman Kerr, put it already in the late 19th century: "in drunkenness of all degrees of every variety, the Church sees only the sin; the World the vice; the State the crime. On the other hand the medical profession uncovers a state of disease" (Kerr, 1888).

There are characteristic cultural differences in the location of the handling of alcohol and drug problems. For alcohol problems, for instance, the welfare system has been the traditional central location in several Nordic countries; liver clinics within the medical system have played a major role in France and Italy; psychiatry has had a principal role in Switzerland and Austria (Baumohl & Room, 1987; Klingemann et al., 1988; Klingemann & Hunt, 1992). But it is also true that, in a given society, the handling of alcohol and drug problems has often changed over time -- particularly because these are "wicked problems" (Wittel & Webber, 1973) where whatever solution is in effect will seem inadequate. As Bruun (1971a) remarked about the Finnish history of the social handling of alcohol problems, "the consistent frustrations concerning the relative lack of success in fighting alcoholism made [Finland] move compulsively from one model [of response] to another".

The responses to alcohol and drug problems, both informal and formal, are thus just as subject to cultural definitions and norms as are the substance use and related behaviours. The responses are influenced both by the cultural definitions and norms concerning the substance use, and by cultural beliefs and practices concerning appropriate responses. For the formal responses, general cultural and societal understandings and practices concerning the social handling of social and health problems also come into play.

Intercultural Influences and Diffusion

No man is an island, and no cultural group in the modern world is completely on its own. A particular solution to a set of problems worked out in the cultural conditions of one society may travel far. Thus there is much about the ideas and organisation of Alcoholics Anonymous that reflects cultural understandings and practices in a particular society, the United States (Mäkelä et al., 1996; Room, 1993). But AA has diffused widely across the world, into cultures with considerable differences from US society. Even so, it is clear that the patterns of diffusion of AA show some regularities in terms of which societies it has flourished in, and these regularities tell us something both about core characteristics of AA and about patterns of culture (Mäkelä, 1991). And to some extent AA practices have been adapted to the local culture (Eisenbach-Stangl & Rosenqvist, 1998). Furthermore, even where AA was seen as culturally alien in some way, the news of its existence stimulated adaptations seen as more culturally congenial – and often the outcome has been AA and the adaptation coexisting side by side (Room, 1998).

We have already mentioned above the tendency of cultural groups in multicultural societies to define themselves in distinction from each other, with drinking or drug use practices fairly often used as markers of the distinctions. On the other hand, it is clear that there is also some assimilation: immigrant groups take on practices from the receiving society, often forming a new cultural bricolage (Room, 2005). Influences and diffusion are also common between societies and cultures. Such influences are carried by four major forces: mass media, producers and other economic actors, intergovernmental bodies and agreements, and the professions. News reports, television and film entertainment, and now also internet channels, convey information and images between cultural groups, perhaps particularly between youth cultures in different societies. In an increasingly globalised world with diminishing trade barriers, global corporations and other economic actors (and their equivalents for illicit drug markets) actively and tirelessly try out promotion methods and materials which have worked elsewhere in new cultural settings. Dissemination and influence also flows through the international drug and tobacco treaties and the agencies which implement them, as well as increasingly through other agencies such as international non-governmental organizations in a cross-national policy community. And doctors, police and other professionals, through professional societies, journals, newsletters and meetings, diffuse ideas, evidence and practices internationally.

Despite all the dissemination, cultural differences persist. In terms of cultural differentiations in psychoactive substance use and problems, and in the societal and cultural responses, it is possible to point to trends both of change and of stasis, both of convergence and of divergence, depending on where one looks. In thinking and acting across cultures concerning alcohol and other drugs, it is wise to take into account that even matters that are taken for granted in a given society or culture, or

that are assumed to be universally valid in a profession's thinking, are often understood differently in different cultural traditions.

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