

The Social Psychology of Drug Dependence

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This paper is concerned with particular contributions which analyses of the interaction of individuals with their social environment can make to the epidemiology of drug dependence. These contributions can take two forms. One is the traditional form of the elucidation of psychosocial factors in patterns of occurrence in the population. The other, to which we turn first, is the illumination and specification of the nature and meaning of the phenomena under study.

Drug dependence is an essentially clinical concept, that is, an interpretation of a set of phenomena as constituting symptoms of an underlying disease entity. The set of phenomena which the drug dependence concept seeks to organize under a clinical rubric is repeated behaviour; specifically, the "repeated administration of a drug on a periodic or continuous basis" (World Health Organization, 1964, p.4). The concept is applied to only a limited portion of this field - excluding, for instance, insulin use by diabetics - and in an explicitly evaluative fashion: it is used to refer to repeated drug ingestion in spite of harmful sequelae, or the risk of them, or to a degree which is felt to be intrinsically excessive.

There are a number of possible alternative definitions of a particular kind of repeated behaviour. The situation may be defined differently by different observers: the harm is unreal, or unfelt, or improbable, or less than that from the likely alternative behaviours. Or the field of behaviour may be viewed as part of a more general pattern of mental defect, social dysfunction, etc., or as composed of a number of essentially disparate phenomena. Drug dependence as a concept, then, does not have exclusive jurisdiction over the behavioural territory it covers, and is especially characterized by its negative connotation and its claim to constitute a separate entity. But we will not attempt here an evaluation of its strengths and weaknesses relative to those of competing concepts. Instead, accepting for present purposes the utility of a concept of drug dependence, we will propose that this concept needs to be expanded beyond its conventional definitions if it is fully to comprehend the field of behaviour it seeks to cover.

In directing attention towards the repetition of drug taking behaviour, the concept of drug dependence seeks to provide an explanation in terms of a "glue" which holds a drug user to a repeated pattern of behaviour. In the traditional view, the "glue" has been viewed as seated in the individual's body (tissue tolerance, abstinence syndrome, etc.) and/or in the

individual's mind (compulsion, loss of control, etc.) (see World Health Organization, 1969, p.6). Until recently the general presumption has been that a physiological dependence is inherently more compelling and less tractable; if both physiological and psychological dependence seemed to be present, the psychological dependence was usually taken as a symptom of the underlying physiological dependence.

The assumption that the "glue" is a property of an individual and that the physiological level is controlling have been due in part to the clinical origin of the concept of drug dependence. Clinicians have a lively awareness, of course, that the causes of the complaints that are presented in the clinic often lie outside the individual experiencing them, but have been reluctant to accept the idea that the seat of the disease-like entity might lie in a supraindividual aggregation.

The assumption that the "glue" lies in the individual also reflects a prevalent Hobbesian view of the relationship between the individual and his social environment: social norms and contracts are assumed to exert an influence only as society's way of controlling undesirable behaviour, so that the positive tendencies toward deviance must be rooted in the individual. If socio-cultural influences are seen as acting only to contain or extinguish harmful or excessive behaviour, they cannot also be the source of the "glue" which holds the individual to such behaviour. Thus in general sociological discussions of alcoholism, high deviance rates are commonly attributed to an absence of social constraints ("permissive norms"), while the term "prescriptive norms" is used to characterize the so called "Jewish pattern" which favours light drinking but strongly condemns drunkenness (Mizruchi and Perrucci, 1970).

In our view, some of the phenomena covered by the term drug dependence are best understood as "seated" at aggregate levels. The criteria for choosing between alternative possible "seats" of a set of phenomena viewed, in the clinical style, as symptomatic manifestations, are not as clear as the criteria for choosing between alternative possible causes. As a rough guide, however, it would seem useful to insist that factors at the possible level of seating should be present when the symptoms are present, and should disappear when the symptoms disappear. By this criterion, in some cases of drug dependence the "glue" holding the individual to his behaviour seems to be a property of a social situation rather than of the individual, in that the behaviour appears and disappears as the individual moves into and out of the situation. There is explicit recognition of this in some of the literature on drug dependence, under such rubrics as "reactive addiction" (Ausubel, 1958, pp.49-54), but it has often not been reflected in general formulations of the nature of drug dependence.

Such a situational dependence may be seen as located at a number of different levels. Stivers (1971) has recently described an "ethic of hard drinking," referring to traditional norms at the cultural level among the Irish. A culturally-prescribed pattern of intermittent "explosive drinking," whether at fiestas, weekends, or times of liberty for isolated occupational groups, can be found in some cultures or subcultures on each of the

continents. Subcultural norms mandating drinking in particular circumstances despite the probability of adverse consequences have often been described for the tight little world of Skid Row "urban nomads". More diffuse subcultural entities in the general population - what we may call "social worlds" of heavy drinking, following Shibutani (1961, pp. 127-136) - also show patterns of norms requiring drinking which risk harm or seem intrinsically excessive. Such norms often come under official scrutiny in time of national crisis, as with the prohibition of the reciprocal buying of drinks during the First World War. For another example, we may suspect that the motives for the heavy drinker's driving after drinking often have more to do with maintaining his social standing as a man who can "hold his liquor" than with an inherent compulsion to drink. A situational dependence may also be a matter of implied understanding among particular face-to-face groups - marital partners, workmates, drinking companions, etc. - which can hold the individual, under penalty of ostracism, in a pattern of drinking against his private inclinations and even in the absence of cultural or subcultural supports.

As we have re-defined it, then, a drug dependence may be located at any of five very general analytical levels: the physiological, the psychological, the level of interaction in face-to-face groups, the levels of subcultures and "social worlds", and the cultural level. In practice, of course, the occurrence of repeated behaviour which derives its "glue" from several levels at once may be expected; in this case, the extinction of the dependence at only one level will not necessarily cause the behaviour to disappear. We may also expect to find that a dependence seated at one level is frequently a cause of dependence at another level: physiological dependence may result from a dependence located in face-to-face interactions, psychological dependence may drive an individual into subcultural dependence, and so forth. While the crucial cases for establishing the utility of defining dependence at several analytical levels are those in which the dependence is at a single level, cases with sequenced and multiple dependence may often be more typical.

It should be noted that the five levels referred to are intended only as a starting point. Further distinctions can be made at will within each of the levels; for instance, physical diseases may be seen as seated at a number of different levels within what we have called the physiological level. That three of the five levels used here are supraindividual simply reflects our primary concern in this discussion with supraindividual factors.

For the remainder of this paper, we will turn our attention to the possible contribution of psychosocial factors to the epidemiology of drug dependence, in the more traditional sense of the elucidation of patterns of occurrence of drug dependence as we have defined it. Etiological factors in drug dependence, at whatever levels the dependence is seated, may also be found at a number of analytical levels, e.g., in the pharmacology and means of administration of the drug, in the physiology and personality of the individual, in characteristics of the individual's social situation and cultural milieu. In epidemiological discussions of dependence,

primary distinctions are often made on the basis of the drug involved, and a heavy emphasis is correspondingly laid on pharmacological factors. There are indeed often markedly different epidemiological patterns for different drugs, but it appears that social and cultural factors often override or modify pharmacological factors. MacAndrew and Edgerton (1969) have re-emphasized the striking cultural differences in the effects of a given amount of alcohol on behaviour. Conversely, in many countries, patterns of initiation into drug use - a necessary but not sufficient condition for dependence - show marked similarities across many drugs. In these countries, the cultural norms restrain children from the recreational use of psychoactive drugs - including even coffee and tea, for which there is no general public image of risk or excess. For teenagers in this milieu, drug use involves both a claim to adult status and a symbol of emancipation. The current typical US pattern of the age at which various drugs are first used - in order: sniffing of chemical solvents, tobacco smoking, alcohol drinking, marijuana smoking, other drugs - seems to be a reflection primarily of the socially-conditioned ease of access for teenagers to the various drugs. Adult disapproval excludes the behaviour from the official worlds of school and home; thus the drug use is confined to the teenager's third world of sociable peer-group interactions, as part of a whole semi-furtive complex of behaviours symbolizing autonomy and adulthood, including sexual experiences, "joy-riding", etc. - behaviours which are labelled as "delinquency" if official notice is taken of them. Although a studied inattention to restrained and discreet versions of such behaviour is common (Reiss, 1970), the official adult morality limits the frequency - though not necessarily the intensity - of the behaviour and makes a dependence involving steady use likely to occur only in conjunction with de facto emancipation from the official adult world - dropping out of school, leaving home, etc.

Typically in these countries, the patterns of use - and in a related fashion the patterns of dependence - of the different drugs diverge in young adulthood, in line with very different norms for adult usage. Coffee and tea drinking is encouraged in almost all situations, except where any eating is a profanation, and the rare adult who does not drink either tea or coffee suffers frequent mild embarrassment. The extraordinary measures taken by governments in wartime to preserve morale by assuring supplies or at least substitutes are evidence of the intensity of the dependence we would be faced with if caffeine proved to entail a substantial medical risk. The pattern for smoking cigarettes has been changing to a tea and coffee model, where use is appropriate for all adult ages and both sexes in most situations, so that Hamilton Russell notes of Britain that "there are not many places where smoking is not freely permitted. Cigarettes are perhaps the most readily available of all commodities" (Russell, 1971). Usage and heavy usage remain less than universal among adults, however; the medically-based campaigns of the last decade have at least reinforced nicotine's old image as a risky substance and a destroyer of will-power.

Previous attitudes to smoking still apply for alcohol. Use, even heavy use, is at least tolerated by society as a whole, as part of the risk-taking and aggressive behaviour of young men in particular (Knupfer and Room, 1964). Heavy smoking, drinking and drug habits are often

cultivated during military service; and it is doubtful that a society that still wants its young men to fight wars will act very strongly to eliminate risk-taking and aggressive behaviour. The well-documented relationship between alcohol and violence and traffic casualties may be as much a matter of their association in the pattern of violent behaviour by young men as it is a direct result of the pharmacological effects of alcohol.

There is no doubt that there is an "official morality" (Warriner, 1958) which frowns on risky and harmful behaviour, and questions about general attitudes to drunkenness in sample surveys will usually bring this forth. But within the official morality there is an institutionalized pattern of exceptions, where heavy drinking is tolerated or encouraged in particular situations, notably in sociable interaction rather than during the performance of work or family roles (Watson, 1958). Such behaviour is acceptable in young men in particular, although increasingly also for young women. Loosely contained within this framework is a relatively open "social world" of heavy drinking, with its own norms which frequently encourage hard drinking, and its own haunts, including the tavern. Not everyone eligible will be members of this world, although for some ethnic and occupational groups in the USA entry is almost automatic. This world is likely to encompass a number of more closely defined sub-worlds, as Blumer and associates found in studying the worlds of drug use among young people in big cities in the United States (Blumer, 1967).

In US general population surveys, heavy drinking behaviour and its social consequences are most commonly reported by men in their early twenties (Cahalan and Room, 1972). Heavy drinking is expected to taper off as the man settles down, gets married, and gets a steady job. The roles of work and family normally come to occupy an increasing part of the middle-aged individual's daily round, and commitment to the roles of sociable interaction is correspondingly reduced. Middle-aged heavy drinking often takes on an air of nostalgia, as at college and military reunions. The institutionalized alcoholic and Skid Row inhabitant are, of course, predominantly phenomena of middle age, and part of their etiology may be the gradual rejection by society of those who maintain their youthful commitment to pure sociability at the expense of work and family. Their dependence, whether it is on the alcohol or on the "good times" with which the alcohol is associated, is no longer supported by broader cultural norms, but is seated in the individual, in particular small groups of friends, or in a tightly enclosed "contra-culture" (Yinger, 1960).

For drugs which are not generally accepted by society, as is traditionally the case with opiates in the United States of America, sustained use tends to occur in a "contra-cultural" situation, and at a relatively early age, apparently as an alternative to settling down in the "straight" world. The heavy social costs to the individual seem to be often sufficient to overcome an individually and contra-culturally based dependence at a relatively much earlier age (Winick, 1964) than the age of 60 or so at which institutionalized alcoholics often appear to "mature out".

In this paper we have been concerned with both conceptual and empirical issues posed by viewing drug dependence in the light of the study of the interactions of individuals and their social milieu. Our discussion seeks to reflect the altered perspectives on drug dependence which result from expanding the field of vision beyond the characteristics of clinical cases to include patterns of drug use in general populations, and the social processes involved in the definition of particular kinds of drug use as social and health problems. Although the limits of space have imposed an almost propositional form, our discussion is intended not as a definitive summary, but as a way of raising some questions and posing some hypotheses which may prove fruitful in future work on drug dependence and its social psychology.

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