Dependence and Society

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Summary
The connections between sociocultural factors and alcohol dependence may be approached in several ways. Sociocultural factors can be treated as predictors and correlates extrinsic to dependence, viewed as a disease entity. The concept of dependence can be reexamined in terms of its presumed "seating" -- in the individual's psyche or body -- and expanded to include the possibility of seating at supraindividual sociocultural levels. And the idea of dependence can be reinterpreted as "culture-bound", that is, as depending for its existence and meaningfulness on sociocultural characteristics specific to particular times and places. The paper focuses on the latter two approaches, with particular attention to the development of sociological "constructionist" thinking that views the concept and experiential reality of addiction or dependence as a product of particular cultural conditions rather than as a transcultural universal.

This paper is concerned with sociocultural factors in dependence, and particularly alcohol dependence. There are at least three ways in which this topic can be understood. The first way is the most comprehensible for those outside the social sciences: it is simply to take dependence or addiction as a given -- whether it is defined in biological, psychiatric or psychological terms, and whether it is defined as a disease or as a moral failing or as an erroneous product of social learning -- and to consider psychosocial among other factors in its occurrence. The second way is to take apart the "given," the disease or condition or dependent variable, and to consider to what extent sociocultural factors can be part of the essence of what is to be explained. The third way is to distance ourselves from the disease or condition or dependent variable, and to shift to the question of how such conceptions as the disease concept of alcoholism or addiction arise -- regarding the addiction concept, in other words, as a sociocultural creation that tells us as much about structures of thought in a given social order as about the nature or reality of individual experience. This paper will consider all three of these ways of interpreting the topic of dependence and society, but I will spend less time on the easy ground and more upon the harder ground of the sociocultural construction of alcoholism and other concepts of alcohol problems.

The most usual meaning in considering sociocultural factors in dependence -- the way it is usually considered in textbooks and compilations -- is to consider interrelations with or the causative role of sociocultural factors in the occurrence of dependence. Kissin and Begleiter's recent edited volume on "psychosocial factors" in "the pathogenesis of alcoholism", for instance, includes chapters on gender, on ethnicity and nationality, on religion, on social class, on occupational factors, and on region and urbanization as factors in the occurrence of alcoholism (1)

In this perspective, the existence and nature of addiction is usually treated as a "given" which exists outside the purview of the sociocultural, although its prevalence is affected by sociocultural factors. It is in this spirit that textbooks of epidemiology give great importance to the triad of environment, host and agent as factors in the etiology of disease, but do not normally include within their scope discussions of the meaning, definition and nature of what is to be explained -- the disease.

The second way of understanding sociocultural factors in dependence is to look at the sociocultural dimension in the "dependent variable" -- that is, within the disease or condition under study itself. As commonly used in medical discussions, in fact, the term "etiology" subsumes this second meaning of factors intrinsic in the disease entity, along with the first meaning of extrinsic "causal factors". Thus theories of the etiology of a disease have included, along with the specification of "causal" or "risk" factors, a presumption or assertion about the seating of the disease -- that is, where the disease process itself is seen as located and operating (2). In the case of dependence, conventional discussions define the seating of the disease as being in the body or in the mind or in the soul -- or in some combination. Thus, for Alcoholics Anonymous, an alcoholic is "not only mentally and physically ill", he or she is also "spiritually sick" (3). Whether the conception is psychiatric or psychological or for that matter religious, the seating is usually defined as being in the individual -- potentially also in the family or in a dyadic relation, in some conceptions -- and the possibility of group or societal level seating is not contemplated.

In the professional literature, there has been considerable wavering back and forth over the years between a physical or a psychological or a combined "seating". For Norman Kerr, at the inaugural meeting of what is now the Society for the Study of Addiction, the seating was dual: while the disease of inebriety involved the drinker being "driven by an ungovernable impulse" or "pursued by a constant desire to fly to intoxicating liquors", there was also "a physical influence in operation, a physiological neurotic effect, the tendency of which is to create an appetite for more of the intoxicating agent" (4). The enthusiasm for degenerative genetic theories of alcoholism around the turn of the century tended to tip the scales towards physical causes and "seating" (5), while Berridge notes that, for the leadership of the Society, the scales tipped again around 1915 "away from a purely physical emphasis towards that of 'disease of the will'" (4).

The modern era has seen a similar history of shifting back and forth on the "seating" of dependence. In WHO Expert Committee discussions of addiction and dependence, a strong commitment to a physiological seating in the 1950s was succeeded in the mid-1960s by a shift to dual concepts of physical and psychic dependence, with psychic dependence seen as "the most powerful of all the factors involved in the chronic intoxication with psychoactive drugs" (6); thus in his acceptance speech for the Browning Award in 1972, Nathan Eddy took the view that "we had been wrong all those years in regarding physiological dependence as the primary phenomena" (7). More recent formulations under WHO auspices have emphasized the interrelatedness of levels -- thus the report adopting the designation "alcohol dependence syndrome" specified that it included a "triad" of an "altered behavioral state", an "altered subjective state", and an "altered psychobiological state" (8) -- or have adopted a rather metaphysical view of dependence as "essentially located within a system" of "phenomena" and "relationships", taking "account of the interaction between drug, person, and environment" -- a model which is contrasted with views of dependence which see it only "in terms of what is going on within the individual, either physiologically or psychologically, or strictly in terms of behaviour alone, or in terms of the social role that the drug-user assumes" (9). In U.S. research psychiatric circles, there is currently a strong tendency to tip the seating of alcohol

dependence back to the physical level. Meanwhile, Griffith Edwards appears to be reverting, in a recent article, to a bifurcation between phenomena at the "psycho-social" and the "psycho-biological" levels -- with the discussion of the latter level actually limited to biological dependence phenomena (10).

In the second meaning of "sociocultural factors in dependence", the issue can be raised whether some part of the phenomena covered by dependence concepts should rather be seen as seated at social levels, outside the individual's psyche or body (11). If dependence is a concept which is invoked to explain the repeated occurrence of apparently intrinsically harmful or aversive behavior, then it must be acknowledged that there are social mechanisms -- for example, customs of "treating", "shouting" or "standing rounds" -- which can sustain such behavior even in the absence of physiological or psychological dependence. Bruun's classic small-group drinking studies (12), in which there were plenty of exhortations from one group member to another to drink up, but never a single suggestion to slow down, might thus been seen as reflecting a dependence "seated" at group or cultural levels, rather than at psychic or physical levels. As Jellinek implied, the French concepts of "alcoolisation" and of the "economic origin" of alcoholism can be seen as conceptions of the seating of alcohol dependence at a societal level (13).

If the first way of understanding sociocultural factors in dependence is to treat dependence as a clinical "given" for which sociocultural correlates or causes are to be found, the second way thus extends the reach of sociocultural factors into the domain of the "dependent variable" itself, pointing out and examining the sociocultural dimensions in what is to be explained. A third way of understanding sociocultural factors in dependence departs even more radically from the textbook views of social epidemiology, and takes one step further back from the comfortable platonic positivism involved in most discussions of the etiology of disease. In this third view, the dependence concept itself is viewed as a sociocultural construction, located in a particular time and place and sociocultural circumstances. This third perspective goes by such terms in the social sciences as "constructivist" and "historical social constructionist". It is a view which has been gaining prominence in sociology, somewhat to the puzzlement and indeed disapproval of many working in a clinical research perspective (14). The remainder of this paper attempts a tentative synthesis of work in the tradition of this third meaning of sociocultural factors in dependence.

Let us start from some observations about dependence and addiction concepts and their intellectual and social history. Here I am paying attention not only to professional literatures but also to popular conceptions of the drunkard. I am also lumping together, without fine distinctions, the related concepts of "alcoholism", "alcohol dependence" and "alcohol addiction". In this, I have some distinguished company from among those in the mainstream of American thought in the field; Mark Keller recently offered the opinion that the 1960s WHO Expert Committees moved "to eliminate the word addiction from the expert lexicon in favor of the euphemism dependence for no other reason than that some members felt that addiction was a very severe word" (15), while Donald Goodwin has waxed quite sarcastic about the efforts of WHO committees to distinguish between "alcoholism" and "alcohol dependence" (16). In popular thought in the U.S., and indeed apparently in some other countries, the heart of an addiction or dependence concept -- its "pathognomic symptom", in Jellinek's famous translation of the 1950s U.S. version of the concept into scholarly terms (17) -- is "loss of control". As is explicit in the formulation which forms the "first step" of Alcoholics Anonymous, the loss of control is twofold; AA members must admit "that we were powerless over alcohol -- that our lives had become unmanageable". The loss of control is

not only over one's drinking behavior, but also over one's life because of the drinking.

> With the alcoholic illness . . . goes annihilation of all the things worth while in life. It engulfs all whose lives touch the sufferer's. It brings misunderstanding, fierce resentment, financial insecurity, disgusted friends and employers, warped lives of blameless children, sad wives and parents. (3, p. 28.)

The concept is thus implicitly an explanation of perceived personal failure: the affected individual has failed to carry through on significant role expectations in his or her life; this failure is ascribed to a personal failure to control behavior in accordance with expectations; and this loss of control is in turn ascribed to loss of control over drinking behavior.

Over thirty years ago, Edwin Lemert pointed to the potential cultural specificity involved in rooting the concept of alcoholism in the presumption of personal self-control. Collecting a number of statements of American attitudes toward the alcoholic, he noted that the "general theme underlying" them "has to do with lack of self-control on the part of the drinker. This societal symbolism of the deviation as a sign of character weakness is one of the most vivid and isolating distinctions which can be made in a culture which attributes morality, success, and respectability to the power of a disciplined will." At a more general level, he proposed that

> in a given society, . . . in order for chronic alcohol addiction or compulsive drinking to develop, there must be strong disapproval of the consequences of drinking or of drinking itself beyond a certain point of intoxication, so that the culture induces guilt and depression over drinking and extreme drunkenness per se. (18)

Somewhat later, Mairi McCormick noted that, as viewed in the English novel, alcoholism first appears on the historical stage in the early 19th century: "it seems probable that the gamma alcoholic made his appearance in society with the industrial revolution. . . . When we look at fiction about 1830, when the industrial revolution was in full swing, we find that the same drinking may be described as existed 80 years before but that a new and more desperate kind of solitary, tragic and inexplicable drinking has come into existence beside it." (19) Mike Russell (29) has indicated where we can see an analogous change in process today, in the shifting definition of the smoker; one result of the education and agitation about smoking in the last 30 years, he comments, has been to convert happy habitual smokers into unhappy and guilty ones, increasingly defined in terms of addiction.

Behind the fictional debut of the alcoholic in the early 19th Century, Harry Levine has argued, lay a new concept of addiction, a "new paradigm or model" which "defined addiction as a central problem in drug use and diagnosed it as a disease, or disease-like. The idea that alcoholism is a progressive disease -- the chief symptom of which is loss of control over drinking behavior, and whose only remedy is abstinence from all alcoholic beverages -- is now about 175 or 200 years old, but no older." (21) Drawing on the work of Foucault and Rothman, Levine argues that "the rise of middle-class society was . . . a precondition for the new way of seeing the drunkard."

> Grounded in the optimistic Weltanschauung of the Enlightenment, the middle class assumed that evil need not exist -- social problems were solvable or curable. However, the conditions of a "free society", meaning individual freedom to pursue one's interests, required shifting social control to the individual level. Social order depended on self-control. . . . In the Jacksonian era, the 1830s, Americans troubled by the disorder they perceived in their society built almshouses, penitentiaries, orphan asylums and reformatories to administer "moral treatment" to the dependent and deviant. The idea, in all cases, was to build up the

> dormant or decayed powers of self-control through discipline, routine and hard work. . . . Like asylum advocates, temperance supporters were interested in helping people develop and maintain control over their behavior and actions. Temperance supporters, however, believed they had located, in liquor, the source of most social problems. . . .
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> In the 19th century, the concept of addiction was interpreted by people in light of their struggles with their own desires. The idea of addiction "made sense" not only to drunkards, who came to understand themselves as individuals with overwhelming desires they could not control, but also to great numbers of middle-class people who were struggling to keep their desires in check -- desires which at times seemed irresistible (pp. 163-165).

In the context of American and British societies, then, it can be argued that both the idea of addiction and the existential experience of loss of control to which the idea refers are historical creations of a particular epoch, reflecting a particular organization of the society. In American society, in particular, the idea of a disease entity marked by a loss of control over behavior and thus over one's life, first worked out for alcohol, has been applied in many other contexts, at both lay and professional levels. It can be seen in the proliferation of "Anonymous" groups on the model of Alcoholics Anonymous. Compulsive Overeater, by Bill B., published by a major corporation in the field of treatment of alcoholism and other disorders, rigidly applies the twelve steps of AA for those who may be considered to have lost control over their eating behavior (22). A recent article in the "Science" section of the New York Times applies the addiction concept to sexual behavior:

> Some types of excessive sexual activity have all the hallmarks of an addiction and can be treated in a fashion similar to other addictions, such as alcoholism and gambling, a growing number of sex therapists believe.
>
> People with this problem, who are now being called "sexual addicts", typically use sex as a psychological narcotic. They are driven to find relief through sex from feelings of agitation and worthlessness. But once the sexual high ends they are again overwhelmed by those same feelings, and once again feel driven to sex. And so the cycle starts over once more.... Sex becomes the all-consuming focus of life, an overriding passion that is pursued at the cost of living a normal life, at the expense of career, family or marriage. (23)

According to the article, there are now hundreds of groups throughout the country organized under such rubrics as "Sexaholics Anonymous" and "Sexual Addicts Anonymous". These examples show that addiction conceptualizations extend in a society like the U.S. far beyond their original realm of psychoactive drug use, to cover any behavior which is defined as problematic and yet which is recurrent. For such behaviors, there is a cultural expectation of self-control, and the recurrence of the behavior in contravention of this expectation often is viewed as prima-facie evidence of addiction (24).

In recent years, evidence has accumulated from the anthropological literature to support the view of addiction concepts and loss-of-control experiences as socioculturally specific. It has been a common observation in the literature on drinking in tribal and village societies that alcoholism is generally rare in these societies. This has often been taken at its face value, as one would interpret, for instance, a statement that measles or cirrhosis mortality were rare. But recently there has been a more explicit recognition that the rarity may reflect something else: that alcoholism as an idea and as a way of behaving may be seen as "culture-bound" (25), that habitual drunkenness does not become alcoholism without a specific underlying pattern of general cultural beliefs and norms. Thus, for

instance, Leland's careful review of the evidence on the applicability of alcohol addiction concepts to North American Indian drinking includes a substantial questioning of whether "loss of control" is a meaningful concept in the context of traditional Indian cultures. "If controls over drinking are culturally determined, and if Indians have never socially or culturally internalized such controls, we might be tempted to conclude that their absence in the group should not be interpreted as loss of control, i.e., a symptom of alcohol addiction." (26) Kunitz and Levy (27) interpret the changing beliefs about alcohol they observe among contemporary Navahos in terms very like Levine's interpretation of the changes in American society in the early 19th century: traditionally among the Navahos, heavy drinking and associated health and social problems certainly occurred, but the heavy drinkers did

> not for the most part define themselves as sick in the same way as healtrh professionals do. As the society changes, however, these behaviors increasingly come to be seen as maladaptive to the new world where people are expected to be at work on time; where no network of kin is available to help when a husband is out drinking; where bills must be paid; and where all sorts of obligations the dominant society takes for granted must be fulfilled.... In the new society that is emerging, older patterns of behavior are increasingly defined as in some way deviant. The drinker's behavior comes to be defined as sick. He is no longer a man who drinks a lot; he is an alcoholic. (pp. 254-5)

Kunitz and Levy add the strongly constructivist comment that "the process whereby that redefinition takes place tells us more about the society which is doing the defining and undergoing the change than it does about the phenomenon known as alcoholism" (p. 257).

The concept of "culture-bound" or "culture-specific syndromes" exists uneasily at the interstice between transcultural psychiatry and medical anthropology, referring to diseases -- particularly but not only mental diseases -- that only exist in a particular cultural context (28). Developing-country psychiatrists have called it a "somewhat unfortunate term" as it has usually been applied, "to denote a heterogenous group of disorders" linked only by the fact that they were encountered outside the cultural framework of European psychiatry (29). But, as the same paper demonstrates, in a wider perspective the classical disease categories of European psychiatry can also be viewed as culture-bound. For example,

> the tendency to classify psychiatric phenomena on the basis of intrapsychic processes is the result of a development strongly influenced by philosophical trends and a particular school in psychology and psychiatry. This has led to the now axiomatic "underlying" causes even in the absence of overt manifestations.... The division of mental functions into thinking and feeling has further contributed . . . to the establishment of a dichotomy in classificatory systems which may not be justified.... Modern psychiatry has selected a few emotions like anxiety and depression to the exclusion of a whole range of other emotions like anger, greed, jealousy, hate, eroticism, etc. The excessive emphasis on two emotions appears unjustified. This emphasis is perhaps reflected in the 19 different classificatory categories for depression.

In suggesting that alcoholism can be viewed as a culture-bound syndrome, I am not of course denying the transcultural reality of the withdrawal syndrome or other physical accompaniments and sequelae of heavy or prolonged drinking -- although even here different cultural patterns of drinking can shift the meaning or implications of particular symptoms (30). Attention is directed rather to the aspects which have usually fallen under the rubric of

"psychological dependence". In my view, looked at in a cross-cultural perspective, it is questionable whether these necessarily covary with the physical accompaniments or sequelae of heavy drinking. In such a perspective, therefore, it would be unwise to assume that the various elements described as the "alcohol dependence syndrome" constitute a single "psychobiological reality" (8, p. 9); rather, variations in the sociocultural construction of drinking behavior -- dependence concepts and experiences, as well as other concepts and experiences -- should be made the subject of empirical investigation, along with studies of the sociocultural patterning and biological concomitants of drinking. Even in societies with many similarities, we may find significant differences in conceptualizations. Thus Raul Caetano has pointed out (31) that the recent operationalizations of the alcohol dependence syndrome differ in the U.S. and in Britain, with U.S. researchers including and British researchers excluding social consequences of drinking from the definition.

This view returns us fairly close to the position adopted by Jellinek towards the end of his life, with a view of drinking problems ("alcoholism", in his late terminology) as a "genus" with many "species", differentiated according to the presence or absence of such features as "psychological vulnerability", "physiological vulnerability", "sociocultural elements", "economic elements", and "type of damage incumbent upon drinking" (32) This typology alerts us to the necessarily multidisciplinary nature of an approach to understanding and preventing alcohol problems -- without a hegemony for any particular discipline's operating model. What our societies have defined as addiction and entrusted to the hands of self-help groups, professionals, or moral politics, reflects heartfelt experiences which encompass many different levels of seating. Jellinek's late typology is a long distance away from the unilinear, progressive model of a single disease entity, organized around loss of control, to which Jellinek had adhered in the late 1940s and early 1950s. Between the two conceptualizations had lain for Jellinek a rich international experience of the very different things "alcoholism" denoted, even in the professional literatures, in different sociocultural contexts. The 100th anniversary of the Society for the Study of Addictions seems an appropriate moment to pick up the implied challenge of Jellinek's late formulation, and to add the comparative study of addiction models and other interpretations of drinking behavior in different sociocultural contexts to the already full agenda of research on sociocultural variations in drinking behavior and problems.

We may ask what practical difference is a comparative constructionist approach to concepts and definitions of alcohol likely to make. In the first place, it helps to liberate us from the weight of interpretations and allows us to get back to the actual presentation of alcohol problems, not only in terms of objectively verifiable symptoms but also in terms of the deeply felt experiences of men and women in a particular time and place. Secondly, it alerts us to the possibility of differentiations within a given society in the definitions of alcohol problems. The addiction concept, with its emphasis on self-control, has been especially a middle-class way of defining and looking at behavior. This is true also of controlled drinking strategies, as the rubric of "controlled drinking" itself implies. The concepts of drinking problems of those not in the middle class and without middle class aspirations remain to be explored.

Thirdly, it helps us to evaluate critically the applicability of new treatment fashions to a particular time and place. In the International Study of Alcohol Control Experiences, we found that there had been a remarkable and parallel growth in treatment systems in the postwar era in countries with very different political traditions and alcohol cultures; to us it seemed that "common solutions were adopted for very different problems" (33). Whether with respect to temperance

thought, to alcohol control models, or to treatment regimes, the history of ideas about alcohol has been marked by an unusual internationalism. There are many benefits from this, but we can also observe cases in which professional enthusiasms led to the application of models in inappropriate circumstances. Getting away from the idea that there is one condition that is the same everywhere allows us to take a more critical view of the applicability of treatment modalities across cultures.

Lastly, the approach raises the issue of the possible contribution of attempts to alter professional or popular understandings about alcohol in the prevention of alcohol problems. As we can see from the example given by Michael Russell of the newly emergent category of unhappy and guilty smokers, dependence concepts carry a burden for those identified by them as well as offering benefits and redemption; along with defining certain patterns as deviant, they tend to locate the seating of the problem at individual rather than at societal or cultural levels. Dependence concepts also attribute great power to the psychoactive substance -- again we can see this in Russell's eloquent presentation of nicotinism as a dependence, for instance in his comparisons with heroin and alcohol. This attribution of power in popular understandings of dependence is why we are uneasy applying the concept to banalized substances like tea, coffee and chocolate. And it is why to talk of sexual behavior or overeating in formal terms as an addiction is to raise the stakes on the behavior, to turn it from the everyday to the potentially tragic or heroic.

To attribute great power to a substance, as the cultures with significant historical temperance movements have tended to do with alcohol, is a two-edged sword. As we are learning from the balanced-placebo designs and other studies of the effects of expectations on behavior after drinking (34), it is these socially and culturally conditioned expectations which are a large part of the explanation of alcohol's association with violence and crime. For this, we should not necessarily blame the temperance movement: it may have been strong precisely in those societies where the cultural association of drinking and violence was already deeply entrenched. While they point to no instant solution, constructivist approaches alert us to the power of ideas as well as material circumstances, and offer us a way of envisaging and considering alternatives to our present conceptualizations of alcohol and drug problems.

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