

# DRUG PROBLEMS IN THE SOCIOCULTURAL CONTEXT

## A Basis for Policies and Programme Planning

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CONTEXT**

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**CORRIGENDUM**

**Page 9**

In the list of contributors and the acknowledgements, between lines 13 and 14

*Insert:* Mr M. Raw, Department of Psychology, St. George's Medical School, University of London, London, England

**Page 219**

In the footnote indicating authorship of "Controlling the Smoking Epidemic"

*Delete:* By D. Robinson

*Insert:* By M. Raw

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## FOREWORD

*The management of drug abuse provides an excellent example of the types of problem that confront any attempt at comprehensive health action. There is no single—and no perfect—prescription either for dealing with drug abuse or for developing a comprehensive country health programme. Each country must approach such matters in a way suited to its own individuality. Nevertheless, all countries may learn from the experience, from the successes and failures, of others. This book is a contribution to the sharing of some of this experience.*

*Certain things are common to health promotion, whatever may be the specific problems to be solved. Among them are inspired leadership, political commitment, intersectoral cooperation, a sense of timing, availability of knowledge and skills, a sensitivity to sociocultural factors, endurance, and some luck. Rarely, however, do all these ideal factors coincide. Certainly, health workers and others who are concerned with drug abuse must work in far from ideal conditions. Powerful—often criminal—elements commonly strive to thwart efforts to control drug dependence. There is often no tradition of collaboration among the social sectors that should work hand in hand. The research infrastructure necessary to develop techniques appropriate to the sociocultural setting is frequently poorly developed. Funds are notoriously scarce.*

*Yet, this book conveys a message of optimism. In all sorts of circumstances and in the face of every variety of difficulty groups of dedicated people in many countries are achieving remarkable successes. They find in themselves the power to persevere, to transcend frustration, and to fashion highly original effective projects out of apparent impossibility.*

*The contributors to this volume are among the many who have worked with the World Health Organization in its drug dependence control programme, and the editors make their own acknowledgement to them in the following pages. Here, let special tribute be paid to all those persons who have contributed to the success of the projects described in this book but whose names do not appear—the people in many countries who have striven to give hope in an area so often wrongly dismissed as hopeless.*

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# INTRODUCTION

## *Two explicit aims and their interrelation*

This study has two major and closely related aims. The first is to review the sociocultural aspects of drug-taking. These include: how society and culture determine who takes which drug and why, how the drug-taker perceives himself and is perceived and responded to by others, whether a dependent person seeks help, whether and how a population's demand for drugs is kept in balance, and how demand may be deliberately reduced. We are seeking therefore to analyse how social structure and cultures interpret and determine drug-taking, and treat and prevent drug dependence.

The matters we address under this first aim are the proper field of study of the sociologist and anthropologist. However, our purpose is not to analyse these matters academically but rather to consider how sociological and anthropological knowledge and sensitivity may be brought to bear on the solution of a variety of practical problems. There are many excellent books that deal in scholarly detail with drug-taking and drinking practices in many kinds of cultures, but they are concerned more often with patterns of culturally accepted drug use than with deviance or the sociology of help-seeking and treatment.

The second aim is to present a set of guidelines for the formulation of policy and the planning of programmes. A central tenet of this book is that drug dependence is in its every aspect embedded in culture, and that, consequently, it is absolutely necessary in designing such guidelines to maintain a consistent relationship between policies and programmes on the one hand, and, on the other, the sociocultural setting in which any response is being planned. Such emphasis on the need for sociocultural awareness in planning these responses may be seen as doing no more than laboriously stressing the obvious. We believe, however, that in practice the sociocultural context is generally disregarded. That drug dependence is a cultural phenomenon is widely and repeat-

edly ignored in programme planning. A frequent error has been to use imported ideas and technologies either entirely inappropriately or with insufficient thought for the modifications they need for their successful cultural transposition. We do not argue that ideas and technologies should not be exchanged between countries; on the contrary, we believe that such exchanges are vital.

*An outline of the study*

The first chapter of this book outlines the work of the World Health Organization and of the other international bodies with which WHO works closely on drug problems throughout the world. The study seeks to break new ground but we freely acknowledge that it builds on the experience and knowledge of many others, all of which has led to an extraordinary growth of international collaboration.

The studies in Chapter 2 present a series of dramatic images of drug use around the world. In a hill-tribe village in northern Thailand men unashamedly smoke opium for pleasure in front of their children; women also smoke but, as the habit carries a certain stigma for them, they may have to go into the woods to smoke. Opium is used widely in this same village also as a potent medicine for a community with no formal medical services: it relieves the symptoms of many physical illnesses, and is the only anodyne at hand for psychological distress. In the slums of Thai cities adolescents inhale or inject themselves with heroin; they are drawn into drug-taking by the disorganization and pains of rapid urbanization. Villagers in the Andes chew coca as they have done for centuries. Coca makes it easier to cut sugar cane; it relieves thirst and hunger; it is a medicine; it has pleasurable and convivial uses; and it may be taken for mystical insights. Coca paste is smoked in the cities.

In the developed world, in any big North American city, for instance, there are subcultures of young slum-dwellers who inject themselves with heroin, and their way of life involves them in crime. Is this picture surprisingly similar to that of slum drug-use far away in Bangkok, or is it very different in that, for instance, there is more alienation from the family and a severance from the mainstream of society? In Chicago, there is not just one pattern of drug-taking: the cannabis smokers or the young multiple-drug-users in the white suburbs have as little similarity to the black heroin street culture as the elder of the family who smokes opium in the Thai village has to the lad who injects himself with heroin in the squalor of the Thai city.

In a Pakistan city, men came quietly to licensed shops and bought the opium they took twice a day in what might be called a low-dose maintenance schedule: all were well-integrated urban workers whose

drug habit began usually as self-medication for illness. In one Pakistan village, opium smoking was so acceptable that at least half the adult males took it in high dosage, while in neighbouring villages it was hardly used at all.

Across the world, in Mexico City, adolescents and even children sniff solvent. This is rapid and cheap intoxication in a setting of poverty and alienation. Alcohol is the more usual medium of rapid and cheap intoxication for men.

In Jamaica, the prevalent drug is cannabis, or *ganja*. Labourers use it for energy to work in the fields; in this respect it is like coca in the Andes. The Rastafarian sect uses cannabis in religious rituals. Young people smoke cannabis in the suburbs of Kingston in a cultural pattern similar to the pattern of recreational cannabis use in Chicago and today indeed in many other parts of the world.

In many countries there are established ways of using a particular drug, which are embedded in custom and manners. Khat is such a drug: a room is set aside specially for its use, and there is the social ritual of the khat party with the segregation of the sexes, the conversation which is part of the occasion, and the "colourful and scented setting". But elsewhere changes in drug use are more usual, associated with rapid socioeconomic change. Old drugs may be used in different ways or new drugs introduced; old and new patterns may mingle. Most of the studies in Chapter 2 describe such change; and the studies from Malaysia, India, Burma, Egypt and Kenya describe important variations on this theme. There is a move away from a single drug-use pattern of a given culture to a plurality of patterns.

The material in Chapter 2, which has provided our illustrations, shows convincingly that drug use can be understood only in the context of the societies and cultures (and the changes that take place in them) in which the users live. It is presented in twelve papers which together give a wide perspective. The range of experiences is described as a basis for the analysis of social and cultural patterns presented in Chapter 3. The range could have been much wider; it could have included, for instance, lysergic acid diethylamide (LSD) used illicitly in a Western city by young people for "expansion of consciousness", and given lawfully to patients by psychiatrists to produce "insight"; wine used in a Christian religious ceremony, and surgical spirit drunk on skid row; the sailor chewing tobacco and the executive smoking a cigar; minor tranquillizers or stimulants used by the urban housewife as modern opiates; a farmer in India, giving cannabis to his oxen to give them strength to plough the fields; in England a favourite horse given a bucket of beer at the end of a hard day's hunting.

If patterns of drug use and motivations for drug use are embedded in society and culture, so too is every aspect of treatment. For, as drug use can be understood only in this context, it is equally true of a person's wish to stop taking drugs and to stay off drugs, and of measures that stimulate and encourage this wish. This argument is set out in Chapter 4, which starts with a study from London that suggests that heroin users give up drugs mainly from their own efforts, because of changes in their self-image and motivation, and in their life circumstances and relationships. They see treatment as something that reinforces these changes. This kind of evidence must be taken into account when considering formal treatment and its results. The word "treatment" is used here to include all forms of treatment and rehabilitation, with emphasis on its social and community dimensions. Treatment never affects an individual separately from all other influences: it is an extra and often transient factor that reinforces other immensely potent forces. This theme returns in Chapter 5. One of the most important questions to be faced at present is how treatment can be made to reinforce rather than interfere with a natural process of recovery. Chapter 4 contains a number of examples of treatments which are in this way sensitive to their natural settings: a community-based voluntary programme in Hong Kong; treatment at a Buddhist temple in Thailand; treatment by detoxification of opium dependence in Sri Lanka; a community clinic in a mosque in Egypt; care in hospital casualty departments in London; a Japanese approach to the treatment of alcoholism that draws on traditional religious and cultural values; and a series of three studies of the role of the general practitioner, in different settings. A brief critical review then considers whether methadone maintenance programmes are transferrable from the North American setting, where this approach was pioneered, to the circumstances and needs of various developing countries. This same theme is exemplified in a study of Alcoholics Anonymous, which deals also with the very important issue of self-help.

Chapter 5 considers certain themes that must be identified when the sociocultural influence on treatment is examined; it extracts some important generalities from the diverse case material of Chapter 4. For instance, what does "alliance" between treatment and sociocultural setting mean? To what extent is it useful to exchange ideas about treatment between East and West? What determines whether such transfers are successful?

Chapter 6 considers prevention through reduction of demand. The case studies bring together a number of approaches that are not often seen as being related or as instances of strategies that have demand reduction as a common factor. The first paper considers the growing

world problem of the large-scale prescription of psychotropics, the social and economic factors that underlie these patterns of prescribing, and the expectations—and sometimes the demands—of patients. A case study from Thailand describes an imaginative experiment in which primary health care workers are recruited from traditional opium-using communities and trained to give types of socio-medical help that may relieve the demand for opium as a panacea. The example of the use of benzodiazepines shows that the heedless import of Western medicine is not the answer. Work from the USA is then described which shows that in parts of Chicago it was possible to reduce demand by intervening in an epidemic of heroin use. The strategy employed, that of case-tracing coupled with an energetic methadone programme, is outlined.

A study of opium use in nineteenth century England gives an historical perspective: the similarities between opium use in the industrial cities and the Fens in England at that time and some patterns of drug-taking in developing countries today deserve note. The paper explores the various preventive strategies employed in England at that time and also raises the question whether one way of dealing with the demand for drugs would be to wait for drug problems to disappear with socio-cultural change. This might at first seem dangerously like complacency, but it could also be seen as an argument for the advantages of a longer-term view of the drug problem than the perspective that our current concern about it permits us.

What would have happened in the Britain of the industrial revolution if a law had been enacted that sought overnight to eliminate the endemic use of opium and that treated as criminals those who persisted in taking it? Stringent control legislation was not enacted in the United Kingdom until the 1920s, well after the slow processes of change had led to decline in demand for the drug. It is clear that in recent times it was exactly this sort of upset in ecological balance that was risked when, after the Second World War, various countries prohibited opium smoking. It is with this story and its lessons for demand reduction that the paper on “Blunt approaches and beyond” is concerned, drawing on material from South-East Asia.

One strategy for reducing demand that has been much favoured in recent years in the West is “drug education”. Vast sums have been expended on it although the premises on which it is based are seldom clearly explained. Neither has its relation to the general body of social and psychological knowledge on change in attitude and behaviour been properly explored. The drug user is usually regarded as a passive object divorced from society and culture. The problem is individualized. Outcome is seldom adequately measured. However, it would be wrong to

discount all the experience of recent years, and a study in Chapter 6 reviews critically the experience of the USA in this regard.

Also in Chapter 6 there are two studies of the multiple strategies that have been used to control consumption of socially used drugs: one from Canada on reducing demand for alcohol and one from the United Kingdom on multiple strategies for controlling the smoking epidemic.

Chapter 7 sums up and analyses the case studies of Chapter 6, as Chapter 3 does for Chapter 2, and Chapter 5 for Chapter 4. The aim is to extract from the case experiences the general principles of a model of preventive action that would be sensitive to societies and cultures and would reduce the demand for dependence-producing drugs. No single master-strategy can be proposed for all situations: the aim must be to design a balance of strategies and to keep the response flexible.

Chapter 8 seeks to bring the study to a practical focus and deals with questions of policies and programme planning. The essential principles for the design of policies and programmes that should constitute an integrated national response to drug problems are set out and explained. This is intended to show the practical application of socio-cultural awareness to national and local planning, and to offer explicit, rational, feasible and economical guidelines.

In the final chapter (Chapter 9) current trends in thinking on drug issues are considered, as well as their implications for national and international policies.

### *Thinking across the chemical boundaries*

There is a tendency for experts on drug problems to dwell exclusively on the problems associated with particular substances or groups of substances. Thus papers, whether on drugs or alcohol or cigarettes, seldom quote from the literature on the other two subjects, and scientific conferences and international meetings are usually organized on a similar basis. People who are interested in the legal prescription of psychotropics usually do not move in the same circles as those who study the illicit use of drugs. Similarly, policies and programmes of governments, and official reports, tend to be concerned only with specific substances. Studies and policies on different forms of health-related behaviour rarely take account of the relation between such behaviour and the misuse of drugs, alcohol and tobacco. Nevertheless, communication of ideas across substance boundaries would seem to be of tangible benefit to both science and control measures.

We have sought therefore in this book to cross freely some of those conventional boundaries, selecting case studies that exemplify important and diverse sociocultural themes, and have welcomed contributions

that illustrate these themes irrespective of the substance discussed. In the process, the book has, in part, built itself on studies on a wide range of substances conventionally classified as drugs, which include cocaine, khat, psychotropics, opiates, cannabis and solvents. Alcohol use has also been taken to illustrate a number of important themes, and cigarette smoking is used to illustrate multiple strategies for controlling a socially approved drug.

The space given to illustrative material drawn from experience with any particular drug should not be regarded, therefore, as an indication of the relative importance of the drug to the world's health problems. That sort of representation would have elicited very different choices from the different countries: for many, tobacco and alcohol would then deserve much more space. This book must not be seen as reinforcing the general and serious disregard of the health implications of the use of these socially accepted substances.

What is acceptable in one place is not at all acceptable in another. It seems that no substance that can be said to be the one favoured and accepted drug of one culture or one time is not, or has not been, the subject of vigorous suppression in another culture or another time.

#### *Definition of terms*

Drug issues have long been beset by a confusion of terms, and, despite several attempts by WHO to set up an agreed terminology, different words still have very different meanings for different people. If the idea of sociocultural awareness is to be respected, what may be needed rather than any effort towards universally agreed definitions (an effort which undoubtedly would be futile) is a sensitive and consistent habit of examining how all of us continually use terms in this field and of being aware of the hidden implications of word choice and of the assumptions that we do not readily acknowledge but that our choice of words indicates.

One might usefully take the word "problem", which carries many kinds of assumptions. It is only over the last few decades that the phrases "drug problem" and "alcohol problem" (or "alcohol-related problem") have become common usage; the term "smoking problem" has not yet fully arrived. The word "problem" implies that "something has to be done"; it indicates deviance and legitimizes intervention. This is not to say that the "problem" label and its connotations are always inappropriate, but only to argue for more awareness of the circularity of the process: once something is called a problem, it continues to be seen as one, with all the consequences this implies. The word "problem" therefore is a loaded one and it illustrates the general point that we must be careful about words and terms that carry hidden implications, of which there are many in the drug context.

Having made that general point, and having argued in effect that what looks like a muddle in need of tidying is often, on closer inspection, exactly what people mean to say (their words loaded with meanings that have to be sought out), we were faced with the problem of what to do about the very diverse ways in which terms have been used by authors who have so generously contributed material for the many case studies in this book. One solution would have been to insist pedantically on, for instance, substituting "dependence" for "addiction" or "misuse" for "abuse". We have preferred, however, to respect the choice of words of the original authors in the belief that their choice of words about drugs (in a book that is concerned with drugs, society and culture) very often usefully reflects sociocultural assumptions.

However, in the review chapters (Chapters 1, 3, 5, 7, 8, and 9) we have as far as possible used WHO terminology. In the context of those chapters, some of the more important terms may be defined as follows:

*Drug.* "Any substance that, when taken into the living organism, may modify one or more of its functions."<sup>1</sup>

*Drug dependence.* "A state, psychic and sometimes also physical, resulting from the interaction between a living organism and a drug, characterized by behavioural and other responses that always include a compulsion to take the drug on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its absence. Tolerance may or may not be present. A person may be dependent on more than one drug."<sup>2</sup>

*Psychic dependence.* "A condition in which a drug produces a feeling of satisfaction and a psychic drive that require periodic or continuous administration of the drug to produce pleasure or to avoid discomfort."<sup>2</sup>

*Physical dependence.* "... an adaptive state that manifests itself by intense physical disturbances when the administration of the drug is suspended... These disturbances, i.e. the withdrawal or abstinence syndromes, are made up of specific arrays of symptoms and signs of a psychic and physical nature that are characteristic for each drug type."<sup>2</sup>

*Dependence-producing drug.* "A drug having the capacity to interact with a living organism to produce a state of psychic or physical dependence or both. Such a drug may be used medically or non-medically without necessarily producing such a state. The characteristics of a state of drug dependence, once developed, will vary with the type of drug involved."<sup>1</sup>

*Drug abuse.* This term does not appear to have been given the same type of precise definition as those listed above. We take it as meaning "use of a drug which is viewed as a problem by the society concerned". The society's view is based on its assessment of the physical, mental or social harm caused by the use of a drug, or on ethical or religious disapproval. Deviance from the norm is another criterion.

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<sup>1</sup> WHO Technical Report Series, No. 516, 1973.

<sup>2</sup> KRAMER, J.F. & CAMERON, D.C., ed. *Manual on drug dependence*, Geneva, World Health Organization, 1975.

*Drug use.* We use this neutral term in the text without judgement on whether the behaviour concerned is or is not a "problem", believing that a two-stage analysis is often useful, i.e., an objective and empirical description of a society's pattern and determinants of drug use, and a social process which determines what part of the total spectrum of use is to be viewed as abuse.

*The intended audience of this book*

This book is intended particularly for people who are responsible for programme planning for any aspect of drug dependence. This does not mean only a small specialized readership of professional planners at national level. While it is intended to be useful for central planning, it is meant to be of equal value for planning at many other levels, e.g., the province, the city and the community. Responsibility for programmes and policies is, however, in an important sense, very much more than a matter for administrators and official committees: if culture is not to be impoverished, all concerned citizens must contribute to the ideas that properly influence official responses. In that sense, this book is intended for anyone who cares to read it critically; it may, for instance, be of interest to students and other young people who have the responsibility of carrying ideas forward into the future.

Frequent reference is made to the needs of developing countries, and we hope that the study has special relevance for their problems. But they are not the only intended audience: sociocultural insights are needed as much for the planning of methadone clinics in Europe as for the setting up of a culturally relevant programme in South-East Asia. An examination of the situation in a country very different from one's own is likely to lead to a better awareness of the social realities so easily overlooked at home.