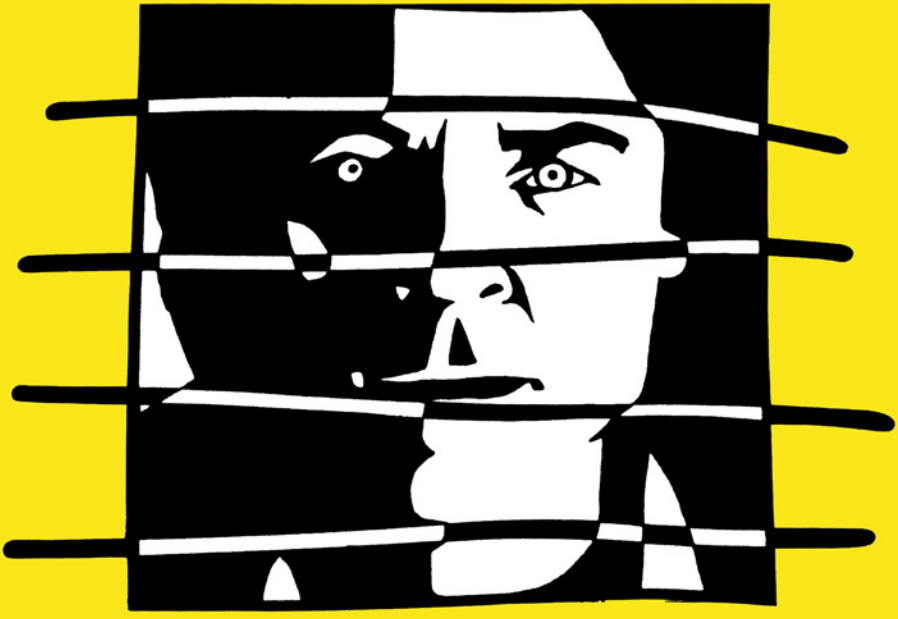
The Psychology of Addiction



Mary McMurran

Contemporary Psychology Series: 10

The Psychology of Addiction

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For
Maureen Walker, my beloved sister; Delia Cushway, my best friend; and Gary Gilchrist, my favourite rock star.

Contemporary Psychology Series

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Series Editor's Preface

The following stories appeared in today's newspaper (*The Guardian,* Wednesday, 8th June, 1994): three tons of cocaine destined for the US were seized at an airstrip in Columbia; a lighthearted article on cannabis, pointing out that there are at least 1.5 million regular users of the drug in the UK; the Marquis of Blandford being placed on probation for eighteen months after pleading guilty to a series of theft and forgery offences, which had been committed largely as a result of his drug addiction; ten teenagers taken to hospital after overdosing on stolen drugs. These stories not only indicate the widespread use and fascination with the use of drugs in contemporary society, but also something more important. This is best illustrated by the last of these four stories, which concerns the ten youngsters in Durham, aged between fourteen and nineteen, who were taken to hospital after becoming violently sick following overdosing on drugs that had been stolen in a house burglary. Fortunately, most of the youngsters were released from hospital shortly after they were admitted, but at least one remained in a very serious condition. The stolen drugs that the youngsters ingested included Valium, methadone and Temazepam. It seems quite unlikely that the young people knew what these drugs were, or what their likely effects would be. However, they were quite happy, indeed paid money, to ingest or inject them into their bodies. One of those who overdosed was subsequently interviewed on the radio, and he said that using drugs was the only way of relieving the boredom of his life.

What is fascinating about this story (and also the story of the Marquis of Blandford) is the blind pursuit of altered states of consciousness without any care being taken as to the user's health or social wellbeing. If we add to the illicit substances that are the subject matter of Mary McMurran's book the other most commonly used drugs, namely alcohol, nicotine and caffeine, it is clear that the pursuit of drug induced changes in mental state is one of the few universals of human behaviour. Looking back over

history and across geographical locations, and across societies and cultures with all kinds of orientations, there seems to be almost always a central place for the use of drugs, especially by men. It is probably safe to say that for all of recorded history most people on this planet have used mind altering drugs in one form or another, and that a substantial proportion of users have been addicted. Often this addiction is socially accepted and, therefore, in one sense 'harmless', but often it results in socially unacceptable levels of dependence and is then, formally or informally, penalized. The point here is that using substances that alter brain processes is a normal part of human behaviour, indeed behaviour that those who are involved in it invest with a great deal of importance. The importance is marked by the willingness to pay substantial sums in money or in kind in order to obtain drugs, and to risk the personal and social effects that are contingent upon addiction.

The Durham youth who said that he used drugs in order to escape boredom was perhaps also revealing a near universal human truth. Now, my cat does not get bored I presume, but if it is in a state where there is not much to do it lies down in the sun or goes to sleep. This does not seem an option for many human beings. Our brains are constantly active while we are awake (and indeed while we sleep), and we need a certain level of stimulation in order to maintain a comfortable equilibrium. Where the level of stimulation required falls below the optimal, then there is either a search for increased stimulation, or the general level of arousal of the brain is damped down by taking some substance which alters its normal functioning. It has been suggested by eminent theorizers, such as Arthur Koestler, that the capacity for computing inherent in the human brain is too great for our own good, and leads to all kinds of personal and social problems. If we have more brain power than is needed for everyday functioning in our well ordered social world, then this additional power will find an outlet in non-essential activity, which may be socially valued (such as artistic endeavours), or socially devalued (such as the search for thrills, gratuitous violence, vandalism and drug use).

It is, therefore, necessary to approach drug use as a normal behaviour in which ordinary and well-adjusted people engage, as well as looking at the extreme end of the continuum of behaviour which results in severe personal addiction and social paralysis. Dr McMurran's book reviews the major psychological models of addiction and looks at the functions that addictions serve for those who suffer from them. It points out quite clearly that whether or not addictive behaviour is judged as problematic

depends upon the circumstances and social context. It is clear that biological determinants of addiction play only a small role in the overall experience of the problem and, indeed in the case of many drugs, may be largely irrelevant. What the person who uses a drug expects to gain from its use and the consequences of that use is largely, if not entirely, socially determined.

Dr McMurran is one of Britain's leading experts on the role of drugs in the aetiology of criminal behaviour, and this expertise is evident throughout the book. The link between drugs and crime is, of course, a major concern of the media and the general public that often appears to be more important in the public mind than the use of the drugs themselves. Many of the attempts to introduce more stringent penalties for drug use are in fact indirect attempts to reduce the rate of criminal activity associated with the need to finance drug habits. I suspect that many people would be reasonably content to let addicts use their drug so long as they did not need to engage in all kinds of anti-social behaviour in order to be able to do so.

The final chapter is in some ways the most important as it tackles the very difficult topic of how to reduce the risk of addiction occurring. Prevention based upon disseminating knowledge does not work. This much is clear from many evaluation studies in health promotion. Even if people have all the information available about the harmfulness of certain substances or other behaviours, they will still engage in them if their motivation is strong enough. Dr McMurran suggests a model of prevention based upon inhibiting initiation and escalation by restricting access and changing the culture in which drug using occurs. In addition, she recommends a focus on harm minimization rather than complete prevention, which offers a more realistic chance of success, and is more likely to engage the experienced and inexperienced drug user alike in attempts at reducing the harmful effects of drugs in our society.

As with other books in this series, the reader will find this an accessible introduction to the concepts necessary to understand issues around drug use, and also will find, as they progress through the text, an increased familiarity with basic psychological concepts.

Ray Cochrane
Birmingham, June 1994

Preface

My favourite statement 'about the author' in any book I have read so far is in Jim Hankinson's *Bluff Your Way in Philosophy*. It says, 'At school he was widely held to be too clever by half; but these days, by dint of persistent intake of alcohol he is only too clever by about 10 per cent.' Being too clever by any degree was never one of my credentials, and does not explain how I came to write this book. I feel, however, that it is necessary to present some account of how I developed an interest in the subject of addiction and consequently came to write about it.

I have worked with offenders since 1980, first as a prison psychologist in a young offender centre, and more recently as a clinical psychologist in a secure psychiatric hospital. My main area of study over the years has been that of alcohol-related crime. I have made attempts to understand the link between drinking and offending, and to apply interventions to reduce both drinking and alcohol-related crime. My knowledge of addictive behaviours has, up to now, focused upon this one specific angle, and although I have written about alcohol and crime, I have not previously set out to summarize the psychological perspective on addictive behaviours. Writing this book presented me with the opportunity to broaden and clarify my own thoughts on the subject.

Another quotation comes to mind here. I have a book called *The Macmillan Treasury of Relevant Quotations*. A friend of mine once spotted this book on my shelf and asked the pertinent question 'Relevant to what? One citation is relevant to the subject of this book. It is by Frederick Goodyear, who mentioned in his letters, 'It is really very curious that people get more muddled in their heads by thinking about intoxicants than by drinking them.' I do not actually know who Frederick Goodyear was, or to whom he was writing, but I think he has a point. In writing this book, I learned a great deal about the topic of addiction. Having to think about intoxicants forced me to defuzz my woolly thinking and straighten

out my crooked logic. I hope that I have managed to make some sense of addiction for the reader.

Of course, this is by no means the first book on the subject. There are important texts about the addictions on which I have relied for information and critical comment. Being an addictions enthusiast, I belong to a number of fan clubs. My favourite stars are Nick Heather, Jim Orford, John B. Davies, Bill Miller, and Alan Marlatt. (There is a minor luminary called Harold Rosenberg, but I mention him only because he teaches at Bowling Green State University in the USA, and I expect him to recommend this book to his students.)

I benefited also from the help of colleagues and friends, who kindly read drafts of the manuscript and gave me invaluable advice. I am indebted to Professor Ray Cochrane, Series Editor, for reading the entire manuscript and providing helpful comments and encouragement to keep going. My friends and colleagues in the Psychology Department at Rampton Hospital were also keen advisers and supporters. Ray St Ledger deserves my thanks, and possibly even some tangible reward, for the considerable amount of time he spent reading drafts and giving advice. He was more generous still in supporting me when I got frazzled trying to write a book while also trying to keep abreast of my other work in the hospital. Mark Gresswell gave me the benefit of his extensive theoretical knowledge (self-reported), not to mention taunts about the book as a whole, which he retitled *All I Know About Addiction by Mary McMurran*. John Hodge disagreed with me, as usual, about dependence; I do not like to admit it, but I have learned a considerable amount from him during our debates on the subject. Finally, Mike Coogan, an organic chemist, provided a different perspective altogether. His trenchant comments and sound advice were extremely helpful to me, and he will be long remembered for his query Is talking bollocks in pubs a symptom of alcoholism?'

Mary McMurran
January 1994

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Chapter 1
Addiction:
Misconduct and Disease

Addiction is a term used in everyday language, usually without much reflection upon precisely what the construct means. Addressing the question 'What is addiction?' opens a Pandora's box of troublesome concepts which take some effort to define and understand. Informally, addiction may be defined as a degree of involvement in a behaviour that can function both to produce pleasure and to provide relief from discomfort, to the point where the costs appear to outweigh the benefits. Heavy involvement in an addictive behaviour is often accompanied by the recognition on the part of the 'addict' of the physical, social or psychological harm that he or she incurs, and an expressed desire to reduce or cease the addictive behaviour, yet, despite this, change is no easy matter.

The aim in this book is to explore the meaning of addiction to understand why some people continue to engage in a behaviour to the degree where the costs apparently exceed the benefits. As a first step in understanding what addiction is, we need to look at the historical development of the construct of addiction. Tracing the history of addiction shows that definitions of and responses to overindulgence have changed over time, depending not only on scientific knowledge but also on public attitudes and beliefs prevalent in any given place at a particular time.

Two important approaches to understanding behaviour, including addictions, have prevailed at different periods of time: the moral model and the disease model. The *moral model* of human behaviour is based on the notion of free will; people are presumed to be able to choose what they will do in a variety of situations. Behaviour which contravenes social norms is, therefore, seen as sinful, weak-willed, or simply a social nuisance (and perhaps a combination of all three). Based on the moral model, logical responses to undesirable behaviour are religious counselling, legislative controls and punishment. The moral model of behaviour prevailed in Britain and the United

States in the eighteenth century, and the term addiction was at that time used simply to mean a bad habit or vice.

The *disease model* or *medical model* of human behaviour became prominent in the nineteenth century, the conditions for this change being created by developments in the natural sciences. Physicians borrowed the concepts employed in the new physics and chemistry and applied them to human behaviour. The notion of free will gave way to determinism; that is, every event, including human thoughts and actions, must have a cause, and we must look to science to provide information about the factors that determine that event. The most significant development was the application of medical concepts to problems that had previously been regarded as within moral or spiritual domains. Thus undesirable behaviours came to be viewed as the symptoms of physical malfunctions and, where no physical cause was apparent, the notion of 'mental illness' was evoked. When undesirable behaviour is thus construed as a disease, treatment rather than punishment is indicated.

The use of drugs was one type of behaviour which lent itself well to reconstruction from a moral failing into a disease: the disease called addiction. The disease model was seen as especially fitting to the explanation of behaviours that involved taking into the body substances that could be presumed to interfere with the body's natural chemistry. However the transition from the moral to the medical model was neither abrupt nor complete. Approaches to dealing with undesirable behaviour even today contain both moral and medical elements: legislation, punishment and religious exhortation coexist with medical interventions. In tracing the development of the construct of addiction, it is instructive to examine how the moral and medical models have applied differentially over time. It would be simple to launch straight into the history of responses to drug use, but first there is an important question to be asked: What is a drug?

What is a Drug?

Many substances, from aspirin to heroin, are classified as drugs; only some of these substances are called 'addictive' drugs. There is, in fact, no intrinsic characteristic that distinguishes drugs from non-drugs. We cannot look to chemistry to help us define a drug—there is no uniting chemical feature. Nor can we look to pharmacology for an answer in terms of effects on the human body—substances classified as drugs variously stimulate, sedate, cause hallucinations, alleviate pain, prevent infection, or

anaesthetize. The concept of a drug is, in fact, a social artefact (Gossop, 1982). How a substance comes to be classified as a drug is a fascinating topic, the essence of which seems to be the determination of powerful social groups to control the use of particular substances for a variety of reasons. From some angles, it is clear that control over the use of some substances is imposed out of concern for the individual's physical well-being. From a different aspect, it is apparent that control over the use of certain substances is imposed because using them makes people troublesome. From yet another perspective, it may seem that controls are designed to aid the manufacture and distribution of substances that contribute to a nation's economy, and eliminate competition. Looking at the issue a different way, it may be that certain professional groups—doctors and pharmacists—wish to enhance their status and security in the world by keeping to themselves the powers of prescription and sale of specific substances.

The types of control exercised reflect one or more of these aspects of the need to control, thus we have legislation controlling possession, use and sale of drugs; taxation; mandatory public health warnings; and codes of practice for advertising. Where the control of substances called drugs is operating effectively, we tend to see those substances as good, or at least good if used appropriately or sensibly. Thus, tranquillizers are good drugs as long as a doctor prescribes them appropriately, and alcohol is beneficial as long as drinkers do not overindulge. Where controls are not operating effectively, the drugs concerned are labelled bad, for example with heroin, crack and ecstasy.

Szasz (1974) suggests that to call a drug 'addictive' is erroneously based on the notion that addiction is a condition caused by the chemical properties of the drug; he thinks that we call drugs 'addictive' because we see that people like to use them, particularly where the people involved belong to groups that readily lend themselves to social stigmatization. People seem to like to use the species of drug known as 'psychoactive drugs', that is 'any chemical substance, whether of natural or synthetic origin, which can be used to alter perception, mood, or other psychological states' (Gossop, 1982, p. 2). Davies (1992) notes that it is beyond doubt that certain substances have psychoactive effects, but that the notion of 'having to have' a drug cannot be explained by its pharmacology. He goes on to point out that, in the final analysis, there must be a physiological basis for *all* action, so the notion of 'having to have' a psychoactive drug simply on the basis of its effects on the body's physiological processes does not

distinguish drug use from any other behaviour. Indeed, we shall see later on that non-substance-based behaviours, such as gambling and sex, have recently been admitted to the addictions field of study as a consequence of reducing the emphasis on the biological element of addiction.

Szasz (1974) defines drug abuse simply as 'socially disapproved pharmacological behaviour' (p. 9) and he goes on to say that the study of *drugs* is quite rightly within the domains of chemistry, pharmacology and medicine, however the study of *drug use and drug avoidance*— what Szasz calls 'ceremonial chemistry'—does not fit within these domains. He illustrates his point well when he suggests that pharmacology is to drug use as gynaecology is to sex, or as mathematics is to gambling.

Primed with this knowledge that the classification of certain substances as drugs is a social convention, and not a natural, inviolable truth, and that the basis for addiction is not readily located within the pharmacology of any substance, let us turn now to the history of responses to drug use.

Bad Habits and Vices

If we look back at life in eighteenth-century Britain, the situation in relation to drug use was obviously quite different from that which pertains today. Alcohol was consumed in enormous quantities, and opium could be found on sale at the corner shop and was widely used as an analgesic.

In the eighteenth century, alcohol was seen as a good thing, but drunkenness and social disorder were not. Amongst the less elevated members of society, beer and gin were the common tipple. English brewers had learned to distil gin in the late seventeenth century and the populace took to the spirit with gusto, leading to what became known as the 'gin epidemic', which peaked around 1750. Much of the poverty and lawlessness amongst the working classes was blamed on excessive alcohol consumption. Taverns and gin palaces were meeting places for criminals and prostitutes, and habitual drunkenness became associated with crime, vice and public disorder (Shaw, 1982). Drunkenness was seen as a social problem and efforts were made to control the distillation and retail sale of gin through taxation and licensing (the Gin Acts of 1736 and 1743). Drunkards were controlled by punishment, including fines, whippings, stocks and imprisonment (Heather and Robertson, 1985).

In the same era—the eighteenth century—opium use in Britain was widespread and the drug was readily available from chemists,

druggists, pharmacists, village shops, grocers, general stores and corner shops, usually in the form of laudanum—a mixture of opium and alcohol—but also in its raw form (Berridge, 1977). East Anglia in particular was noted to be an area of prodigious opium consumption, the main consumers being agricultural labourers and not the educated classes. In this damp, poorly drained region, neuralgia, rheumatism and the ague were commonplace and opium was the source of physical comfort (Orford, 1985). Opium use was readily tolerated because the drug was a panacea for the relief of many chronic ailments. Because people who used opium were not troublesome, as were many alcohol users, there was relatively little concern about the habit.

Industrialization

It is clear that in the eighteenth century, drug use was viewed as a social problem, if it was seen as a problem at all. Using opium was seen as a harmless means of managing ailments for which there existed no cure. Drinking alcohol, even in large quantities, was acceptable as long as the drinker did not get drunk and make a nuisance of himself or herself. But attitudes to drug use changed and to explain this we should acknowledge wider social changes occurring around this time.

The beginnings of the medicalization of alcohol and drug use must be seen against the background of the increasing industrialization of society. Prior to this, when the workforce was largely engaged in agricultural labour, the effects of drinking and drug use could be tolerated, but with the transition to industrial labour, drink and drugs were seen to interfere with work performance and safety. Progressive urbanization of the work force also increased the need for social control. Kohn (1987, p. 53) suggests that the affluent classes were

> coralling the poor masses, organising them into streets, mills and factories. Yet inside those alleys and workshops, a class was taking shape which its masters could not understand. Its way of life, its conditions of existence, and above all its morals were therefore objects of fervid investigation.

In the early days of the Industrial Revolution when foundries, factories and mills were rapidly increasing in number, the typical employer was intent on accumulating capital to plough back into his business so that it could expand and develop; he did not spend his money on sumptuous living (Cole and Postgate, 1971).

Because he made a virtue of moderation, he regarded it as a desirable characteristic in his employees. All of these issues— control, curiosity and middle-class values— combined in the expression of concern for the health and welfare of the working classes. The time was right for the advent of temperance.

Temperance

In the colonial US, the situation with regard to drink had been much the same as in Britain. Drink flowed freely and was considered the 'Good Creature of God'; drunkenness, however, was considered a sin. As industrialization progressed, the problems connected with alcohol use became more obtrusive, and the Quakers transformed the 'Good Creature' into the 'Demon Rum' (Keller, 1976). The hazards of alcohol became the focus of the temperance movement, whose proponents emphasized moderation for the greater good of society. A feel for the nature of temperance can be gained from the old joke about the temperance preacher who, in his lecture to the crowd, dropped a worm into a glass of whisky to illustrate the dangers of alcohol. The worm died and the preacher turned to the crowd and posed the rhetorical question, 'What does this tell you?' From the back of the hall, a cockeyed optimist responded, 'If you've got worms, drink whisky.'

The American Temperance Society was formed in 1826. The message of temperance spread to England, carried by seafarers to the port of Liverpool, where the Liverpool Temperance Society was formed in 1830. However, temperance had already been brought to Scotland by a Greenock magistrate, John Dunlop, who had visited France and been impressed by the moderation of the working classes there (Longmate, 1968). Dunlop founded a moderation society in 1828 or 1829, which spawned many branches throughout the west coast of Scotland. The foremost English crusader, however, was Joseph Livesey, a cheese merchant of Preston, who was the founder of the British Teetotal Temperance Society.

In Britain, temperance fitted well with the aim of educating the working classes, embodied in the Society for the Diffusion of Useful Knowledge. The creed of this society was that ignorance, idleness and debauchery were the enemies of the working man and that his asset— his labour—could be improved in value through education, hard work and temperance. Until its demise in 1847, the society published books and pamphlets on a variety of subjects, a tradition continued in the 1850s and 1860s by Trades Union publications, with the typical message to 'get intelligence

instead of alcohol—it is sweeter and more lasting' (Cole and Postgate, 1971).

In the USA, the temperance movement, in alliance with Protestant religions, gained political momentum and it became a prohibition movement. The Reverend Howard Hyde Russell was one person responsible for changing the emphasis of the movement towards prohibition, by identifying the saloon as the centre of drunkenness, vice and corruption (Paredes, 1976). Soon, all alcohol use came to be seen as dangerous and no one was exempt from its damaging effects. A Prohibition Party emerged, whose manifesto was the total ban on the manufacture, sale, transportation and importation of alcoholic beverages. In 1919, success was achieved with the Eighteenth Amendment to the US Constitution that made these acts crimes. Prohibition was successful in reducing alcohol consumption and alcohol-related problems, yet it was an unpopular law since prohibition was difficult to enforce and gave rise to nationwide gangsterism that we associate with the USA of the 1920s. Public opinion against enforced abstinence swelled and Prohibition was repealed in 1933.

Where opium use was concerned, the man who precipitated public concern in Britain was Thomas De Quincey (1785–1859) who began publishing his essays *The Confessions of an English Opium Eater* in 1821 in the *London Magazine*. In the preface to his collected edition of *The Confessions* (reproduced in the 1907 edition), De Quincey extolled opium as 'the one sole *catholic* anodyne which has hitherto been revealed to man' and he also considered it to be a powerful counteragent to 'the formidable curse of *taedium vitae*' (p. 5). As an opium eater, he was in the prestigious company of the Romantic poets of that age—Coleridge, Byron, Keats and Shelley. However, De Quincey's writings gave rise to some concern about opiate use among the working classes, particularly for recreational rather than medicinal purposes (Berridge, 1979). He commented, for example, on Manchester cotton workers who crowded druggists' shops on Saturday evenings to buy opium because their low wages would not stretch to the purchase of ales or spirits. De Quincey thought that wage increases would not change matters: 'I do not readily believe that any man, having once tasted the divine luxuries of opium, will afterwards descend to the gross and mortal enjoyments of alcohol' (p. 5).

Medical interest in opium use was fuelled by the death of the Earl of Mar in 1828 (Berridge, 1979). The Earl died of jaundice and dropsy two years after taking out a life-insurance policy. The

insurance company at first refused to pay out on the grounds that the Earl was a regular opium eater and that this habit would have shortened his life. This case, along with the high number of infant deaths attributed to the practice of sedating babies with opium, led to investigations into opium use by the medical profession. This eventually resulted in the 1868 Pharmacy Act, which placed restrictions on prescription and sale of opium. Berridge (1977) places this legislation in context when she points out that public health considerations were only part of the force leading to the control of opium; the increase in the organization of professional groups at this time meant that physicians wanted to control prescribing and pharmacists wanted to control sales.

While opium eating and drinking were arousing concern about public health, a different type of opprobrium was directed toward another form of opium use: opium smoking. In both Britain and the US, immigrant Chinese were seen as proprietors of sinister opium dens where vice and debauchery were rife. This may have been an overdramatic view. It has been suggested that smoking opium was simply part of the Chinese way of life and to call the venues where smoking opium occurred 'opium dens' would be akin these days to calling places where people smoke cigarettes 'tobacco dens' (Kohn, 1987). Nevertheless, the anti-opium smoking attitude was common in England where the Chinese population amounted to a few hundred; in the US, there were thousands of Chinese immigrants and the fear of 'drug fiends' was intense (Kohn, 1987). Szasz (1974, p. 76) suggests that the Chinese immigrants were 'exceptionally hard-working and law-abiding people' and therefore their peculiar habit of opium smoking became the focus of the persecution simply because 'Americans could not admit that they hated and feared the Chinese because the Chinese worked harder and were willing to work for lower wages than they did.' Animosity toward opium smoking, undoubtedly with its roots in racism, may be seen as the origin of social ostracism of the 'drug addict'.

Disease of the Will

As has been shown, public concern about alcohol and drug use originated variously from needs to control the work force, stamp out lawlessness and keep immigrants in their place. It is also true that concern for the health of the population was important and members of the medical profession were therefore engaged in the study of alcohol and drug use. Trained in the management of disease as they were, it is hardly surprising that they looked at