

# Prohibitionism

And its symbolic classification  
of substance consumption

by

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# **Prohibitionism**

## **And its symbolic classification of substance consumption**

**An inquiry  
into the conceptual structures  
of substance consumption classification  
in contemporary Australian society**

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This thesis is my own work containing, to the best of my knowledge and belief, no material published or written by another person except as referred to in the text.

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## **Contents**

1.	Introduction	5.
1.1	Living between desks and some questions that arose	5.
1.2	Methodology	8.
2.	The six dimensions of substance use	9.
2.1	Introduction	9.
2.2	What is a drug?	9.
2.3	Illegal drug use	12.
2.4	Medical drug use	14.
2.5	Legal (nonmedical) substance use	15.
2.6	Performance enhancing drug use	19.
2.7	Herbal substance use	20.
2.8	Spiritual drug use	21.
2.9	Why the last three dimensions can be set aside	23.
2.10	National Drug Strategic Framework 1998-99 to 2002-03	24.
2.11	Classes of substances and dimensions of substance use	25.
3.	Pharmaculture	28.
4.	The concept of addiction	33.
5.	Discussion	38.
6.	A social-scientific vision of pharmaculture	42.
7.	Postscript	44.
	Notes	45.
	Bibliography	48.

I am firmly convinced that effective alternatives are impossible to design if we do not first redesign both our historical perspective on present drug control ideology and our conceptual tools for rethinking about drug use.

--Peter Cohen, 1993

Unless we talk specifically about the symbolic meaning of drug laws, and unless we critique the rhetorical strategies by which that meaning is expressed, drug policy debate will remain largely mired in a quicksand of concealed reference and hidden assumptions.

--Desmond Manderson, 1999

## **1) Introduction**

### **1.1 Living between desks and some questions that arose**

All theses are preceded by a journey and this one was inspired by a nine-year journey through Australia's response to HIV and, in particular, its association with injecting drug use. It began in Sydney in 1993 at the NSW Users and AIDS Association (NUAA) and ended in Perth in 2002 with the West Australian Network of Alcohol and Drug Agencies (WANADA). All up, I worked for five community organisations and one state government primary health care service. I also participated in three national organisations.

When I try to articulate a common thread that links my experiences of these nine organisations, across three states and nine years, what comes to mind are desks. Rooms with desks, people working at those desks, an endless stream of staff and visitors washing in and out each day, and thousands of conversations. The visitors included people for whom the practice of injecting a drug was one, sometimes dominant, sometimes minor, part of their lives. The range of drugs injected was considerable, as was the diversity of people. The former included: heroin, morphine, methadone, pethidine, amphetamines, cocaine, benzodiazepines, insulin, and a range of performance enhancing drugs. The people themselves came from diverse ethnic backgrounds and classes and ranged in age from thirteen to sixty-five. Their life experiences, and the role their drug use played in these experiences, were as varied as the above information suggests.

At the same time I regularly spoke with a range of other people. This included the families of people who used legal and/or illegal drugs, and the people working in the various professional tribes: detoxification staff, needle and syringe program staff, therapeutic community staff, doctors, nurses, educators, and counsellors. Then there were the journalists, police, politicians, social researchers, and foreign dignitaries. I also regularly attended interagency meetings, state and national government forums, conferences, and public meetings. Looking back, I can say I have discussed legal and illegal drug use with a broad range of Australians for almost a decade.

The central concern of this thesis – how drug use is socially constructed in contemporary Australian society – emerged out of these conversations. During these years I found myself becoming more and more dissatisfied with the terminology and concepts used to discuss drug use. This sense of dissatisfaction was heightened through my participation in what can be called the Drug User movement. While even a brief history of this little known social movement is beyond the scope of this essay a few brief comments, will, I hope, enable the reader to better understand both the inspiration for this work and what it tries to achieve.

In the mid to late 1980s a retro virus called the Human Immunodeficiency Virus (HIV) was recognised as the cause of a fatal disease (AIDS) that was infecting people, mainly gay men, in Australia. While the virus affected heterosexual people in Africa and other developing nations, in the developed nations it first spread through networks and communities of gay men, and to a lesser extent, people who injected drugs and sex workers. The virus aroused considerable alarm in our community, and our governments, to their credit, acted swiftly and directed millions of dollars and other resources to combat its spread. So great was the fear of this virus that the then federal and state governments were prepared to employ a wide range of strategies, including a few that were, and still are, controversial.

The two strategies relevant to this essay are the Needle and Syringe Program (NSP) and Drug User organisations. They were both introduced because it was feared that people who injected drugs would act as a bridge along which HIV would pass out of the gay community and into the wider heterosexual community. The aim was to employ people who were currently injecting drugs, train them as peer educators, then send them out into their own and other social networks to educate people on how to inject without contracting or transmitting HIV. It is internationally recognised that our response was politically courageous and successful. (1)

To work in one of the Drug User organisations as a peer educator was, to put it mildly, a very unusual experience. It is not often that a personal history of injecting illegal drugs such as heroin and amphetamine is considered a plus in a job interview. To find yourself being paid well for sharing the knowledge associated with that experience with others is to

live and work within a legal and moral landscape that most Australians would have difficulty understanding. Constitutionally and legally, NUAA is a Non-Government Organisation, but as is often the case with NGOs, it receives almost 100% of its funding from state and federal governments. When people asked me what I did for a living I would reply: I am paid by the government to talk and write about sex and drugs, a noble occupation, wouldn't you agree? Most of the people who learnt of my occupation were incredulous that such an organisation could even exist let alone be government funded. They were also fascinated to hear about the work I did and the moral dilemmas it involved.

At first, questions of terminology and theoretical frameworks seemed irrelevant: we had an epidemic to prevent and lives to save. However, as we came to realise an HIV epidemic among people who injected drugs had been prevented, Drug User organisations began to refocus their attention towards broader social and political issues, in particular, federal and state drug laws and policies. We began to understand ourselves as part of a national and international social movement working towards drug law reform. As with all social reform movements, this involved two interlocking projects: a critique of the existing or inherited way of doing things, and, an articulation of an alternative approach. The aim of this essay is to investigate the first project. It asks: how might we best understand the symbolic and conceptual frameworks we have inherited and which dominate how drug use is currently constructed and understood in Australian society.

My two guiding lights have been the work of Dutch sociologist Peter Cohen and Australian sociologist Desmond Manderson. This essay represents an attempt to take up Cohen's challenge to develop new conceptual tools for thinking about drug use, in particular, conceptual tools that will allow us to illuminate the hidden assumptions and operations alluded to in the preface quote from Manderson. It is an attempt to articulate the dominant symbolic structures operating in the minds of Australians today.

The essay will begin by exploring how I first tried to conceptualise the problem as dimensions of substance use. It will then investigate the multiple definitions of the term "drug" used in the *The Age* newspaper during the period from January 2002 to April 2003.

(2) Having identified three key symbolic dimensions of substance use, a theoretical

framework will be introduced as a way of making sense of how these dimensions have been constructed. Next, the evolution of what will be termed the Prohibitionist pharmaculture during the late 19<sup>th</sup> and early 20<sup>th</sup> century will be explored. The essay will then conclude with a discussion of what a social theory of substance production, trade, consumption, and meaning, might look like, and the future lines of inquiry both illuminated by this approach, and necessary to evaluate its worth.

Before I proceed I would like the reader to understand the limitations of this work. The theoretical approach to substance classification presented is a work in progress. It represents a theoretical map constructed after a brief reconnaissance of the vast landscape of drug use literature. The aim is to construct a framework to guide future work in this area. Thus I have focused on identifying and interpreting key structures. Testing this hypothesis and framework will involve conducting in-depth interviews with Australians to discover how they classify the different substances they and others use. It will also require further analysis of legal, medical, and social scientific discourses.

## **1.2 Methodology**

The approach taken in this work is squarely located within what Robert Alford identifies as the Interpretative tradition of social inquiry. (Alford, 1998: 2) It leaves aside the representation of substance use in epidemiological discourse and takes as the object of analysis, words, concepts and texts. It seeks to read texts in order to articulate the assumptions animating the dominant understanding of substance use in current mainstream media.

As I made the journey from the desks of a social movement to those within a university, I sought to approach the academic traditions of social theorising in a particular way. While I came seeking theoretical frameworks and conceptual tools to assist me make sense of why only some substances, and some substance users, get labelled as “drugs” and “drug users”, I was always very aware that the assumptions I sought to make visible are also embedded within social scientific discourses. For this reason I decided to leave the review of previous sociological theorising till the end of the project.

## 2) The six dimensions of substance use

### 2.1 Introduction

When asked in the first honours seminar what my research would be, the only way I could articulate what I intended to do was to say: there is a riddle I am trying to solve. In our culture there seems to be three separate universes of “drug” use, each with its own distinctive terminology and concerns. I named them *medical drug use*, *legal (nonmedical) drug use*, and, *illegal drug use*. One of my fellow students responded by asking what about drug use for religious and/or spiritual purposes? It was a good point. My response was to signal to the person writing our research topics on a whiteboard that they had better change my topic from “The three universes of drug use”, to “The four universes of drug use” – much to the amusement of those present. Later I would identify another two universes, which brought the total to six. I named these last three *spiritual drug use*, *performance enhancement drug use*, and *herbal substance use*.

At first I was very unsure what I meant by “universes” of drug use or whether it was the most appropriate term. Later on I changed it to “dimensions” which will be used for the rest of the essay. I was also unsure of whether to articulate these dimensions as forms of behaviour, as in *medical drug use*, or, as categories or classes of drugs, as in *medical drugs*. As the project continued, I came to understand what terms I needed to use, and why it was I had been so confused to begin with. This slow process of understanding began with an investigation of the key term “drug”. This chapter will begin with an analysis of this term then document the six major ways in which it used (and not used) to describe substance consumption in contemporary Australian society.

### 2.2 What is a drug?

The best explanation I have found of what a drug is occurs in a text for North American college students by K. Liska titled: *Drugs and the human body* (2000). Drugs he says, are:

substances used to modify, maintain, or enhance an existing condition in order to alleviate or prevent a state of illness or to relieve symptoms. (Liska, 2000: 3)

He notes that foods can be covered by this definition, as can vitamins, then explores this a little further:

If our body responds in some way to a substance, either physically, biochemically, or mentally, then that substance can be said to have a drug effect. This leads us to this general and very broad definition: A drug is any absorbed substance that changes or enhances any physical or psychological function in our body. If we accept this definition, and recognizing that body functions include mental activity, digestion, metabolism, blood circulation, sexual function, growth, wound repair, etc., then we must conclude that ALMOST ANYTHING CAN ACT AS A DRUG.” (Liska, 2003: 3-4) [capitals in original]

Liska then summaries:

we [can] conclude that just about everything has the potential of being a drug. Whether a substance is or not may depend on the patient, the dose given, environmental circumstances, the illness, prior treatment, and the effect desired.” (Liska, 2000: 4)

A “drug”, then, is a substance that is used in a particular way or for a particular purpose, namely for its “drug effect.” By this Liska means a drug is a substance that is used to influence our state of being by direct interaction with our internal chemistry. A substance becomes labelled and understood as a drug when we use it for this purpose. This understanding, however, does not gel with how the term is currently used in Australian society. Vitamins are not thought of as drugs, and in many social contexts neither are coffee or tea. At the same time, we think of cannabis and heroin as drugs because of their perceived pharmacological properties and we perceive these properties, and the definition of these substances as drugs, as being independent of social context. There is a

contradiction here. It seems that whether a substance is defined as a drug depends upon the social context, however it is commonly believed that substances are defined as drugs solely because of the pharmacological properties they possess and that this definitional process is independent of social context. This paradox is an important one.

The belief that substances are labelled drugs purely upon their perceived pharmacological properties is part of a conceptual framework that American sociologists Craig Reinerman and Harry Levine have termed *pharmacological determinism*. Pharmacological determinism, they write, is the belief that the effect and outcome of drug use is caused by the pharmacological properties of substances alone, independently of individual psychological differences or social context. [Reinerman and Levine, 1997: 8]

One outcome of this belief is a conviction that the decision to legislate certain substances as illegal drugs during the 20<sup>th</sup> century was based purely on pharmacological grounds. Thus: the currently illegal drugs are substances that contain pharmacological properties that make them too dangerous to be used for nonmedical purposes. This pharmacological and legal status is said to be independent of any and all individual and social considerations. As will be discussed later which substances did and did not get legally prohibited was very much influenced by other factors. [Musto, 1987; Manderson, 1993]

Norman Zinberg, an American researcher, conceptualised this new understanding with his model “drug, set, and setting”. (3) [Zinberg, 1984] The importance of this model will be explored later, but is important here is note that what we have are two opposing conceptions of substance use which can be used to understand and interpret all discourses about substance consumption whether the topic is use, policy, law, theory, or history. On the one hand, we have pharmacological determinism that uses a linear cause and effect model: drugs pharmacologically cause effects in humans that are independent of individual variation and social context. On the other hand, we have a theory that uses a three-factor model: the outcome of drug use is the result of an interaction between the pharmacological properties of the substance, the individual’s physical, emotional and mental condition, and the social and cultural context in which the substance use occurs. All texts about substance use employ one of these models either explicitly or implicitly. One of the defining features of the dominant framework in Australian society is its dismissal of the social or cultural

dimension and its insistence on the validity of a pharmacological determinist theory of substance use.

The limitations of this pharmacological determinist approach quickly become apparent when we consider vitamins and other substances commonly called *herbal substances*. Under the definition outlined by Liska above, vitamins and herbal substances are clearly drugs: we consume them because of pharmacological properties we believe them to have, in order to change or enhance our physiological and biological condition. Despite this, *herbal substances* are often defined as not being “pharmaceutical” or “medical” drugs. As we will also see, in some contexts, alcohol, coffee, tea, and sometimes tobacco, are also understood as not being drugs.

To clarify the situation, I will replace the term *drug* in Liska’s definition for the term “pharmaco-active substance”, and then abbreviate it to “substance”. Thus a (pharmaco-active) substance is a substance consumed in order to interact with our internal chemical structure for a stated purpose. One difficulty with this definition is that foodstuffs clearly come under this definition. I actually think this is good, for on a very basic level the substances we call drugs are foodstuffs with particular properties. Further, all the foods we eat are broken down by the body and used in chemical processes just like the substances we call drugs. Finally, in relation to alcohol and caffeine, despite them usually being consumed in fluid form, it is their association with foodstuffs that plays an important role in them not being labelled as drugs. The value of using (pharmaco-active) substance as the basic term is that it allows us to articulate the social construction of the term “drug”. For this essay, a “drug” is a substance that has been labelled a “drug”. This means the words I used to describe some of the six dimensions above will have to be reconsidered. All of this should become clear when we describe the language used to delineate each of the six dimensions.

### **2.3 Illegal drug use**

The most commonly understood use of the term *drug* in contemporary Australia is in relation to what are called *illegal* or *illicit* drugs. A recent article in *The Age* newspaper titled

“Indonesia is dancing with death,” discussed substance using behaviour by young adults in Jakarta. The author Tom Hyland begins by describing a nightclub in Jakarta:

The relentless techno beat is so loud your insides vibrate. Strobe and laser lights flash out across the crowd of maybe 5000 that surges in waves across the vast dance floor. It’s 2am on a Saturday and amid the noise and crush, the mood in this north Jakarta nightclub is a strangely mellow mix of joy and energy. [B02 NAA 04jan03]

One of the themes of this article is out-of-controlness, thus the music is “relentless” so loud it “vibrates” your insides while the crowd “surges in waves”. We learn that Indonesia “faces a national health disaster”, that the country is “a nation of addicts”, and that injecting drug use and HIV is a “national emergency” that “could kill an entire generation”. Figures on the number of injecting drug users “paint an alarming picture” of what is “being called a hidden epidemic”.

Shabu-Shabu, which is what Indonesians call methamphetamine, “makes users fearless and prone to risk-taking” and “is said” to be “popular” in Indonesia’s “massive” sex industry. Despite “massive” drug seizures, illicit drug use is “increasing” in this “most corrupt country”. Hyland cites a report by the Melbourne based Macfarlane Burnet Institute for Medical Research stating that it is “estimated there ...[are]... between 1.3 million and 2 million drug users in Indonesia, with up to 1 million of these injecting”. He adds, “Some local estimates put the number of users at 4 million—about 1 in every 50 Indonesians”.

Very clearly Hyland uses the term “drug” to refer only to certain substances. Apart from methamphetamine, heroin and ecstasy, cocaine and cannabis are the only other substances named. Alcohol, caffeine and tobacco are not mentioned. Nor are any substances used for medical purposes. The terminology of this article identifies drug use as being the use of illicit or illegal substances, but not legal ones. It identifies young people and associates them, via their drug use, with prostitution and drug dealers. It identifies corruption and disease (HIV) as associated with a behaviour perceived to be a “problem”, a “threat”, a “crisis”, an “emergency”, a “disaster,” and involving “killing”, “weapons”, and “victims”.

Interestingly, the article begins with the observation of the “mood” in the Jakarta nightclub as being a “mellow mix of joy and energy”, which the author attributes to ecstasy, ignoring other substances that might be being consumed (alcohol), as well as other factors (youth). It ends with the observation that a “lot of people want to take drugs” to “have fun” as well as to “escape the pressures of life”. This acknowledgement of a beneficial side to the use of these substances appears overwhelmed by the overall weight of negativity. The use of these substances is constructed as both a cause and symptom of serious individual and social harm. “Drug users” are people who “use” “illegal drugs” which are “trafficked” by “drug dealers” with assistance from “corrupt” officials. The use of these substances causes “disease”, “crime” and “death”.

#### **2.4 Medical drug use**

The second most commonly used meaning of the term drug is in relation to the use of substances for medical purposes. A recent article in *The Age*: “Horror drug a winner in cancer fight”, by Tom Noble has the subheading “Thalidomide, the anti-nausea drug that once deformed babies around the world, is proving effective against a blood cancer”.

The article begins by outlining the situation of Ray Modystack. Three years ago his “persistent cough and chest pain” was diagnosed, and “it was bad news”. He had “multiple myeloma” a cancer of the blood that, if not treated, “usually kills within six months”. Despite treatment with chemotherapy, his symptoms persisted and he is quoted as saying: “it was basically the end of the line for me”. Thus the scenario has been set: we have a person who, despite first world medical treatment, is facing death. Next we learn that his stepdaughter “discovered” a trial was occurring at Melbourne’s Peter MacCallum Cancer Institute using the “pharmaceutical” Thalidomide: “Two years later, signs of Mr Modystack’s cancer have disappeared”. His “case” is “one of the success stories” we are told.

Of 73 “patients” who “took Thalidomide”, “80 per cent were helped”, with “younger patients doing the best”. This “new study” sought to establish how “beneficial” and “effective” thalidomide was. The author then talks about how the effects of the

“pharmaceutical” were established when it was “prescribed” for a “patient” a few years ago, after which the “search was on for the best way to use the drug”. Mr Modystack, we learn, “used the drug in combination with injections of interferon”.

The author then describes how there are “new drugs” which “look much less toxic”. Associate Professor Prince is quoted as saying, “they certainly work, but whether they are as good as thalidomide we don’t know yet”. The article ends by returning to Ray Modystack: “The side-effects, tiredness, constipation, numb feet and fingers, were worth it for his extra lease on life. “I’m over the moon,” he said””.

The term drug is used in this article to describe a very different type or class of drugs to the one described in the first article by Tom Hyland. These drugs are “pharmaceuticals”, are “prescribed” by “doctors”, studied by “associate professors”, and given to “patients” to “treat” life-threatening conditions like cancer. These drugs are “new”, “beneficial”, “effective”, and “good”. They “help” people, and “doctors” search for the “best way” to use them.

## **2.5 Legal (nonmedical) substance use**

With this dimension of substance use the term *drug* is used very infrequently. Another difference is that while there are hundreds of medical or pharmaceutical drugs and quite a few illegal drugs, this dimension is characterised by a very limited almost fixed number of substances. Further the four main substances in this dimension – coffee, tea, alcohol and tobacco – are usually understood as unique and unrelated to each other. Each substance is understood as existing in its own right and as not being part of any class or category. Their embeddedness within mainstream Australian culture has made them resistant to, though not immune from, conception as a drug. This means individual variation and social context are understood as playing a role in the value of each substance and the outcome of its use. Thus problems associated with their use are understood as being the result of individual and social factors as well as the pharmacological properties of the substance. The challenge to tobacco’s acceptability has involved a shift in its definition, from simply being itself, tobacco, to being an “addictive drug”. It has also involved discussions of the outcomes of

its use shifting from the use of the drug-set-setting model to a pharmacological determinist model.

- **Tea and coffee**

Tea is rarely discussed in *The Age*, and only one major article was found during the data collection period: “The great brew-haha” by Phillippa Hawker. It was subtitled: “Behind the story of a simple cup of tea is a tale of espionage and intrigue captured in a documentary by Melbourne filmmaker Diane Perelsztein,” and it began with:

The cup that cheers has a complex, often dark history. The story of tea is a tale of politics, economics and spirituality, of espionage, and the drug trade.

[B01 NAA 28feb03]

The article concerns itself exclusively with the social history of the substance, a history it describes as “closely guarded,” “a mystery”, and “little known”. It talks about “skilled tea workers”, “hillside plantations”, “methods of cultivation and preparation”, of a substance being “grown, harvested and dried”. The substance is a “cup that cheers”, a “drink”, and its use termed “drinking”, a practice once “regarded a patriotic duty by Queen Victoria”. We learn of the British “thirst” for the substance and the “profits” of the “industry”, how it became “incorporated into spiritual and contemplative life”, as well as “art and culture”. We learn about “rituals”, “celebrations”, “innovations”, “tea dances”, and “tea parties”.

While this article focuses upon the production, trade and cultural meaning of this substance, coffee tends to be treated a little differently. In “Caffeine conundrum” by Jamie Talan, the most significant feature is a willingness to discuss both benefit and harm. Further this understanding is stated as a well-known and accepted “fact”:

Balancing caffeine’s pleasure versus its harm is something every coffee or tea drinker knows well. [B04 NAA 16dec02]

Talan notes that caffeine, the “ingredient” in coffee, tea, and cola, “delivers the buzz”, and that “recent studies” have “reported” “potential health benefits” while other studies have

“found it can be unhealthy”. The important question is “what’s a coffee drinker to do” with the conflicting information. Unlike *medical drugs* where doctors control use, with *legal substances* people are allowed to manage their own use. Unlike *illegal drugs*, it is understood that beneficial use is possible and controlled use a possibility.

Talan then goes into the research: “two cups of caffeinated beverage—perhaps 300 milligrams—can nudge the brain’s arousal system” and “bring on alertness”. Coffee “may have a protective effect on the cognitive decline associated with aging”, and “may reduce the risk of gallstones” while other studies “have hinted at possible benefits at protecting against Parkinson’s disease and diabetes”. At the same time, the author notes, caffeine “has also been linked with miscarriages, infertility, cancer, birth defects and heart disease”. What is interesting here is that a substance that many Australians use because it tastes good and they like the mild stimulant effect, is linked to so many potential health benefits and harms. One of the commonalities of the substances in this dimension is that they constantly attract claims regarding possible positive and negative effects on health.

In terms of language people who use coffee or tea are “drinkers” who “drink” a “product” or “beverage” as a daily “ritual”. With substances classed as *medical drugs*, the health benefits are understood to outweigh the health harms, while with substances classed as *illegal drugs* the harms are understood to far outweigh any, if there are said to be any, benefits. With the *legal substances* the question is undecided and constantly contested. This is especially so with the last two substances in this dimension.

- **Tobacco**

Tobacco is currently the most contested substance in this dimension. A recent editorial in *The Age* titled “Enforcement may be smoking’s fag end” and subtitled “tougher penalties against those who ply cigarettes to children may not be the answer”, begins with:

Breaking down society’s tobacco addiction was never going to be an easy task. For hundreds of years smoking was seen to be normal as breathing. The jury is no longer out on smoking, at least not on the essential link between tobacco and ill health. [A10 NAA 23dec02]

Tobacco we learn is not an “illegal substance” but rather a “product”. The editor’s concern is with “restricting tobacco sales” particularly to “minors” and the need for “warnings” at the “point of sale”. “Cigarette retailers” he argues, need “training” in “responsible service,” and the “glamour” needs to be removed so “young people” no longer find tobacco “cool”. A study “suggests” that there is a “small but persistent smoking sub-culture among the young”. At the same time we also learn that “96 percent of all drug-related deaths are attributed to tobacco and alcohol...about 80 per cent [of which] are directly attributed to tobacco use”.

While this editorial is concerned about the harms to health associated with the use of this substance, when compared with the article on *illegal drug use*, one important difference is that the term “drug” is only used once. Despite the clear dangers, including the accurate and startling statistic that 80% of all drug-related deaths in Australia each year are associated with tobacco use, (4) the editorial is focused upon responsible commercial activity as the appropriate response. To present the harm associated with its use the editor turns to the language associated with illegal drug use, “addiction”, “drug-related deaths”, and concern with “young people”. However he still calls tobacco a “substance” and rather than “drug” and describes the people as “smokers” rather than as “drug users”, and sellers “retailers” rather than “dealers”.

- **Alcohol**

In *The Age* newspaper, alcohol tends to be discussed in three main ways. The first is as a commercial product, as when Robert Gottliebsen, in an article titled “Tough calls for Southcorp suitors,” and subtitled “The sums are getting harder as the wine market grows more complex,” talks about a “dramatic power shift” from “manufactures” to “retailers”. [Weekend Australian 8-9/3/03, p.34] The second way is when it is mentioned in passing in articles about other topics. In the article “It’ll be a big night in town”, journalist Stathi Paxinos describes how farmers in drought affected northwest Victoria intend to celebrate recent rainfall with a “big night in town”. Alcohol is not mentioned by name, but it is very clear what the quoted farmer Mick Foott means by a “big night”. [A05 NAA 22feb03] The

third way is when the harm associated with the substance is addressed. The article “Tobacco, alcohol ‘do most damage’” by Ruth Pollard, begins:

Tobacco and alcohol account for 83 per cent of the cost of drug abuse in Australia, dwarfing the financial impact of illegal drugs. [A08 MEA 21jan03]

In the second paragraph, however, we are told that the “illicit drug toll is fast catching up with alcohol”. The author then notes, “tobacco” is “still the greatest killer by far” before saying that while the costs of “drug use” are “high”, the problem of “alcohol use” is more “complex” because of the “beneficial effects” of “moderate drinking” but “harmful effects” of “binge drinking”. Thus it is implied that unlike alcohol use, there are no beneficial effects associated with illegal drug use. This article also contains a very common phrase: “alcohol and drugs”. The phrases “alcohol and drugs” and “tobacco, alcohol, and drugs” are commonplace in *The Age* and imply that alcohol and tobacco are not drugs. Yet as other quotes above suggest, when harm is being discussed, they are considered drugs. Further, very rarely are people who use alcohol or tobacco described as “drug users”. Instead they are “drinkers” and “smokers”.

When an editorial in *The Age* newspaper appeared titled “Keeping kids out of the drug culture”, its subheading was, “There may be no causal link between marijuana and hard drugs: it’s still not a good habit to start”. [B06 NAA 25jan03] There was no mention of alcohol or tobacco in this article. The “drug culture” is understood as referring to the culture around the use of illegal substances. The cultural beliefs and attitudes around the use of alcohol, coffee, tea, and tobacco, are not understood as constituting a “drug culture”.

## **2.6 Performance enhancing drugs**

“Warne’s drug hearing to be held tomorrow” was the title of an article by Jacquelin Magnay and Roy Masters in *The Age*. [D01 MEA 20feb03] At issue was cricketer Shane Warne’s use of a “banned diuretic”, banned in the sense of its use being prohibited for professional

athletes. There is no suggestion that harm is the issue, rather it is the “cheating” as the title of another article in *The Age* made clear: “Warne is no drug cheat: Sutherland” by Alan Brown. [D02 MEA 25feb03]

The first article, like the article about substance use in Indonesia, is remarkable for the number of times the term drug is used in an article of 17 short paragraphs. Rather than describing Warne or other athletes as “drug users” the terminology tends to be “drug cheats”. The prevalence of the term drug seems to be because, firstly, the substances involved are understood to be *medical drugs*, and secondly, because the moral disapproval of “drug use”, as in *illegal drug use*, fits the moral view of this form of substance use. Thus athletes become “drug cheats” if they use a “banned” or “prohibited” “drug” to enhance their performance.

## 2.7 Herbal substance use

One of the selling points of substances that are termed herbal is that they are said not to be drugs as in *medical* or *pharmaceutical* drugs. “Mad cows and infertile hamsters, the anti-herbal hysteria grows”, an article by John Macgregor in *The Age*, begins with the paragraph:

Since ancient times, herbal medicines have been used to treat a range of human ailments and the interest in herbal cure-alls across the world is no less today. [B04 NAA 02dec02]

“Herbal medicines” are then spoken of as “herbal remedies”, “natural therapies”, “vitamin supplements”, “herbs”, “natural medicines”, and “complementary medicines”. The author’s aim is to address fears about the health dangers associated with the use of these substances by contrasting and comparing these substances with another class of substances which he terms “modern pharmaceutical medicines”, “pharmaceuticals” and “pharmaceutical drugs”. He quotes a Dr Alan Tillotson who says:

Herbal critics...seem unable to mathematically calculate the vast numerical difference between the thousands of victims of modern pharmaceutical medicine and the handful of victims of natural medicines. For example, the worst estimates of ‘dangerous herbs’ is that they may kill 50 Americans a year, while pharmaceuticals routinely kill 140,000 (according to the *Journal of the American Medical Association* in 1997), making herbs approximately 28000 times safer than pharmaceuticals. [B04 NAA 02dec02]

While John Macgregor is clearly discussing the use of substances for health purposes, he goes out of his way to define these substances as different from *medical* or *pharmaceutical* drugs. Why he and others do this is a question that falls outside the scope of this essay. What we can say is that how people define and label substances plays an important role in how they are perceived and legally regulated. The definition of these substances as *herbal substances* has meant that their production, trade, sale, possession, and use falls outside the legal controls imposed on medical or pharmaceutical drugs. (5)

## 2.8 Spiritual drug use

During the data collection period, I came across only two articles that discussed what I have identified as *spiritual drug use*. The first “Taking a trip up the river”, subtitled “About Us: Shamans of the Amazon”, by Brian Courtis, was a review of a documentary to be screened on the television station SBS that night. It began:

At a time when our view of the world is again taking on distinctly hallucinogenic qualities, Dean Jefferys’ journey up the Amazon doesn’t seem so strange. We clearly need whatever help we can get from those tribal medicine men he has been visiting. [B08 NAB 28mar03]

Courtis here sets up an expectation and understanding that he believes his readers will relate to: The use of substances for spiritual purposes is something that occurs in far away tribal cultures and that there is a knowledge and wisdom associated with their use that may

help us make sense of our “crazy” world. Courtis writes that, “tribal medicine men” have a “knowledge” of the “mysteries” of the “ancient ayahuasca ritual” which “takes” a “participant” on a “psychedelic-type trip” into “other dimensions”. In ways that are not explained, this experience, if done “under the shaman’s guidance”, “allows” the shaman (but strangely not the participant) to “be involved” in “complicated healing, clairvoyance, ancestral links and communication with plants, animals, and spirits.”

Courtis notes that a “Brazilian” in “Amsterdam” “speaks” of her “attempts” to use ayahuasca to “help” “heroin addicts”. He also notes that an ingredient of ayahuasca, “dimethyltryptamine (DMT)”, is “extracted” in Australia from the “native acacia or wattle”. Having begun with the suggestion of benefits for us to be found in ayahuasca and its use, it is enough to note of “attempts” to use it with people who are heroin dependent. There is no claim of treating dependence, just that it may “help”. The second reference to DMT is equally vague. It “is” extracted. For what purposes and by whom is left a mystery.

The second theme of the article is about the way the documentary “hints” about “international drug companies” who “aim to patent” the “rain-forest’s natural medicines”. The two themes come together in the last paragraph:

What does become clear on screen is that, beyond ayahuasca, these tribal medicine men hold a knowledge the world would be foolish to let slip away to any “bio-pirates.” With their trips up the river, the shaman faces a natural enemy. [B08 NAB 28mar03]

It seems that the use of substances for spiritual purposes is something done by ancient people and by contrast not something done by modern people like Australians. The language used to describe what we are dealing with is that of the 1960s, the period of time in our own cultural memories that we associate with this form of substance use. Thus ayahuasca has “hallucinogenic properties” leading to a “hallucinogenic experience” which is like a “psychedelic-type trip”. However, it is not this actual practice that should interest us readers. The use of ayahuasca is an indication of the existence of other substances that might benefit us—if we keep the “bio-pirates” at bay.

The second article “The freakiest trip” by Kate Hamilton, begins with the introduction:

William S. Burroughs loathed it, Timothy Leary loved it, but most people scarcely know it exists. It's DMT, a powerful hallucinogen that offers a mind-blowing and sometimes terrifying high...as well as a possible explanation for everything from schizophrenia to alien encounters. [Good Weekend, *The Age* magazine, 29-3-03, pp.42-45]

Again we get the term “hallucinogen” but never the term “drug”, however, we do get the more social scientific term for hallucinogen: “entheogen”. These are, we learn, special substances, “powerful” is a frequent adjective. Again we get a promise of a substance-induced understanding of complex phenomena that both concern and scares us, this time schizophrenia – in the last article it was heroin dependence. Like that other substance that we fear so much, heroin, this one, DMT, is also said to have the potential to induce experiences of heaven and hell, ecstasy and madness.

## **2.9 Why the last three dimensions can be set aside for this essay**

As outlined earlier, the aim of this essay is to uncover the foundational structures of the dominant substance classification system currently operating in Australian culture. Initially I set aside *herbal substances* (and their use), *spiritual drugs* (and their use), and *performance enhancement drugs* (and their use), simply on the hunch that they were not central to the puzzle I faced. Later on this hunch was vindicated. This will become clear to the reader a little later, so at this point I will just make a few quick observations.

*Herbal substance use* is a form of *medical drug use* in that, like the latter, it is directly focused upon the healing and maintaining of health. *Performance enhancement drug use* is a recent dimension that emerged long after the basic drug classification symbolic structure became embedded in Australian culture. Originally it was part of *legal substance use*, the change coming after sport became a job and the use of performance enhancing substances for work purposes was transferred over to this new area of work. *Spiritual drug use*, in the main, involves the trade, possession and use of substances that are currently legally prohibited

and thus it comes under *illegal drug use*. If, however, the conceptual framework this essay constructs is to be of any value, it will need to accommodate and address these three dimensions. I believe it can, but that will have to wait for a later time.

## **2.10 National Drug Strategic Framework 1998-99 to 2002-03**

Having spent considerable time trying to identify language that indicated the existence of different dimensions of substance use in Australian culture, I had meant to pay close attention to the drug policies of the Commonwealth and Victorian governments. I didn't happen. However towards the end of the project I thought I had better have a glance at them and I looked into the *National Drug Strategic Framework 1998-99 to 2002-03* (1998).

The contents page listed an introduction followed by a section titled "The harm caused by drugs in Australia". This section sought to outline our national strategy by first articulating the harm associated with different dimensions of drug use. It contains seven subsections:

- 2.1.1 Tobacco
- 2.1.2 Alcohol
- 2.1.3 Pharmaceutical drugs
- 2.1.4 Performance- and image-enhancing drugs
- 2.1.5 Illicit drugs
- 2.1.6 Inhalant and Kava use
- 2.1.7 Polydrug use

[p.iii]

I am struck by how closely these distinctions made by the strategic framework's authors match the ones I identified and then corroborated in *The Age* newspaper. Leaving aside inhalant and Kava use, as well as polydrug use, the five left do suggest that policy makers also identified the dimensions I found. Alcohol and tobacco get their own section acknowledging their unique status while caffeine is left out because of the perception that it is not a drug and does not cause harm. "Pharmaceutical drugs" matches' *medical drug use*,

“illicit drugs” matches’ *illegal drug use*, and “performance- and image-enhancing drugs” matches’ *performance-enhancing drug use*. The most important difference is the articulation of each of these as categories or classes of “drugs” whereas I chose to identify them as dimensions of behaviour. This dual status as classes of objects and dimensions of behaviour provides an important key to conceptualising how we understand substance consumption in Australia.

## **2.11 Classes of substances and dimensions of substance use**

This brief content analysis of a few articles from *The Age* newspaper published between January 2002 and April 2003 shows that different dimensions of substance use are conceptualised and thought about quite differently. This is clearly seen in the language used to describe each dimension. In relation to the first three dimensions we can say that:

*Medical drug use* involves doctors giving drugs to patients to treat illness and cure disease. It is understood as causing beneficial outcomes and is thus good drug use. *Illegal drug use* involves drug dealers selling drugs to drug users who use them for fun and to escape. It is understood to cause harm to individuals and society and is thus bad drug use. *Legal substance use* involves people drinking tea, coffee and alcohol or smoking tobacco. These behaviours are understood as causing both good and bad outcomes, thus there is ambivalence towards them.

As stated, this analysis has been brief, using only a few articles – with one exception – from one newspaper. I do not wish to imply that all newspaper articles employ language that conforms to these distinctions, nor that all Australians accept and use them. However, as the framework for Australia’s national drug strategy suggests, these distinctions do enjoy some formal acceptance. It is my belief that these distinctions express what is the dominant classification system of substances and substance use in Australian society at present.

In this dominant classification system the categories of *medical drugs*, *legal (nonmedical) substances*, and *illegal (nonmedical) drugs* are thought of as distinct separate classes based upon empirically observed pharmacological properties. This belief rests upon pharmacological

determinism. We can further demonstrate this view and the value of Zinberg's drug, set, and setting model by investigating the examples of morphine and amphetamine.

While morphine is understood as a *medical drug*, heroin is understood as an *illegal drug*. What most of Australian's do not realise is that "heroin" is the brand name given to a drug called diacetyl-morphine by the German pharmaceutical company Bayer in the late 1890s. (The last "e" in heroine got lost sometime during the first two decades of the twentieth century) Most people find this piece of information disturbing, especially if they, or a family member, has been prescribed morphine, for they interpret it as meaning that they are being told that morphine is like heroin and everything they have heard of heroin is true of morphine. It is actually far more accurate to say heroin is like morphine and everything you know about morphine is true of heroin, for heroin is a version of morphine or more precisely, it is morphine that has been tweaked a little. The changes this brings about in morphine are quite minor. It increases the strength by 2-4 times, it suppresses the histamine reaction (itching sensation) associated with morphine, and makes the drug slightly less dreamy for the user. In many ways it is a superior drug, a fact recognised by the British who refused to cave into the US led pressure to totally prohibit the drug, and who still use it medically.

At the same time, for a sociologist this situation has provided us with an amazing "live" experiment that has run now since the early 1950s. In Australia we have people who are prescribed morphine for chronic pain conditions who use the drug for years, becoming physically dependent in the process. We also have heroin dependent people who also use that drug for years, and whose experience of what is basically morphine dependence, is very different. Thus, the same drug used daily in different social contexts leads to very different outcomes and is described and understood in very different terms.

We also have a similar situation with amphetamine. On the one hand amphetamine is an illegal drug said to be too dangerous to allow it to be sold legally to people who wish to use it for recreational purposes. At the same time, in a version called dexamphetamine, it is prescribed to children with Attention Deficiency Hyperactivity Disorder (ADHD) to take daily.

The conclusion I draw from these examples is that the classification of pharmaco-active substances in terms of their pharmacological properties into three classes *medical*, *legal*, and *illegal*, is not as clear-cut as we like to think. The distinction between medical, legal, and illegal substances is important to us, not so much because it recognises important pharmacological differences between the three classes of substances but because there is actually so little that does distinguish them. This is also why the question of whether the distinctions are classes of pharmacological properties or dimensions of behaviour is so unclear: They *are* dimensions of behaviour, but they are understood as, and represented as, classes based solely upon pharmacological properties. The important influence of social context is erased and its contribution is attributed to pharmacology, and to a lesser extent individual psychology.

This leads me to think that the main reason the drug law reform movement, and any suggestion of reclassifying any of the currently illegal drugs, is so fiercely resisted, is because it is never a question of one substance only. Rather we have a substance classification system, which we have inherited, that is largely symbolic, despite its claims to an empirical basis. To question the classification of even one substance is to question the system as a whole. It is for this reason that I have found the almost exclusive focus of the drug law reform movement, and social theorists, on illegal drug use unhelpful. To put it a little simplistically, this focus blinds us to the role of the symbolic category of illegal drugs within the larger social process of substance use classification.

The rest of this essay will outline what I call a pharmacultural approach to substance consumption. It is an attempt to construct a theoretical framework for understanding how we understand and explain to ourselves the diverse ways in which we use substances, the contradictory outcomes we experience, and how the dominant classification system evolved in response to a range of other social issues.

### 3) Pharmaculture

The major argument of this essay is that existing approaches to “drug” use bracket out areas of human substance consumption resulting in theoretical and historical accounts that fail to address all substance use and fail to articulate the relationships between the different dimensions/classes of substances and their use. The second argument is that focusing upon the relationships between the different classes of substances, and dimensions of use, will enable us to develop something we sorely lack: a comprehensive theoretical conception of substance consumption. The third argument is that this alternative approach will enable us to more fully understand the symbolic frameworks and policy-law structures regarding substance use that we have inherited. This approach requires the deployment of some new concepts and this part of the thesis will introduce these concepts.

Australia’s official and dominant approach to substance use can be termed *Prohibitionism*. Prohibitionism is a type of pharmaculture. A pharmaculture is a set of beliefs, knowledges, and practices concerning all aspects of pharmaco-active substance consumption. This includes: techniques of farming, production, and preparation; beliefs about the different purposes, properties and outcomes of substance use; and, practices concerning trade, supply and use. Put more simply, pharmaculture is that part of a society’s culture that deals with pharmaco-active substance production, trade, use and meaning. Pharmaco-active substances are all those substances that humans use to interact with their internal chemistry. Pharmaculture, like pharmaco-active substance use, especially when food is included, appears to be universal.

The concept of pharmaculture is an attempt to redress the separation of human substance consumption into distinct de-linked discourses. The belief that the three main classes of substance use are unrelated and constitute qualitatively different phenomena needs to be overcome if we are to develop a social scientific approach to substance consumption as part of the human condition. For this essay, the focus will be upon the dominant symbolic classification structure in contemporary Australian society. The important project of bringing together and synthesising economic, political, historical, legal, sociological and

anthropological discourses with the currently dominant discourses of medicine, psychology and epidemiology will have to wait.

While contemporary Australian society is pluralistic in many ways, there is often a dominant perspective in each area. In the area of pharmaculture, the dominant approach, prohibitionism, became embedded in legislation and culture during the late 1800s. Desmond Manderson traces this process in his 1993 book *From Mr. Sin to Mr. Big: A history of Australian drug laws*. The first drug laws (6), introduced during the 1880s and 1890s, concerned the trade in and use of opium prepared for smoking. They did not concern themselves with other forms of opium then readily available from a range of sources including medical practitioners, pharmacists, homoeopaths, sellers of patent medicines and grocers. (Manderson, 1993: 38) These were the first laws that sought to prohibit the use of certain substances. In the first decade of the 20<sup>th</sup> century the new nation of Australia enacted laws to control the distribution of medicinal substances. These laws began the legal recognition of *medical drugs* as substances whose supply and use should be managed by trained professionals, doctors and pharmacists. (Manderson, 1993: 81) These two types of laws created the foundations for the two major classes of substances that currently dominate the thinking of Australians. The adoption of new substances for nonmedical purposes during the 1960s was responded to with a revitalisation of this approach.

I have termed this pharmaculture Prohibitionism rather than prohibition for a particular reason. Adding the “ism” evokes the ideological dimension, and not being a commonly used variation, foregrounds the attempt to broaden the way prohibition is defined and understood. Most importantly, it seeks to extend the commonly understood meaning of this term to include a recognition that prohibitionism is a pharmaculture that comprehensively classifies and regulates all substance production, trade, use, and meaning. For instance Kevin Zeese, Professor of Epidemiology and Social medicine at the Montefiore Medical Center in New York writes in his 1999 essay *Drug Prohibition and Public Health*:

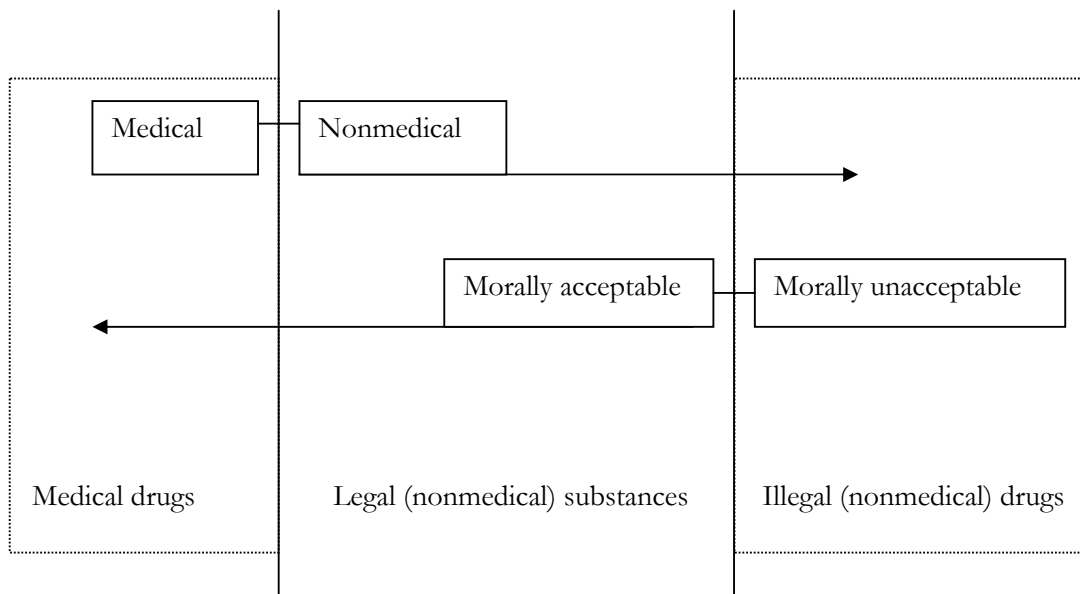
Drug Prohibition and Public Health  
Synopsis

For the past 25 years, the US has pursued a drug policy based on prohibition and the vigorous application of criminal sanctions for the use and sale of illicit drugs. The relationship of a prohibition-based drug policy to prevalence patterns and health consequences of drug use has never been fully evaluated. (Zeese, 1999: 1)

In this statement prohibition refers only to the currently illegal substances and our laws, policies and practices regarding their use. This common exclusive focus upon *illegal drug use* results in the bracketing out of all other pharmaco-active substance use. To make sense of our dominant pharmaculture of prohibitionism, we need to explore how the different classes of substances have been constructed.

Prohibitionism can be understood as being constructed upon the interaction of two binary distinctions: medical substance use—nonmedical substance use; and, morally acceptable substance use—immoral substance use. The interaction of these two binary distinctions occurred during the late 19<sup>th</sup> century in a range of Western-European societies as medical and religious institutions sought to maintain or strengthen their control over the definition of, and use of, pharmaco-active substances, and, the meaning of that use.

**Diagram 1.** The two foundational binary distinctions within contemporary Prohibitionism



As diagram 1 suggests the institutionalisation of these two distinctions into legislation created the three main classes of substances within Prohibitionism. These two distinctions, that create the three classes, operate on several different levels.

Firstly, they delineate three classes of substances. *Medical drugs* are pharmaco-active substances that have properties that make them useful for medical purposes. *Illegal drugs* are pharmaco-active substances that are said to have dangerous properties and often no medical value. The third class, *legal (nonmedical) substances*, is actually a space between the two other classes. It exists as a liminal zone rather than a bounded class as evidenced by several of its characteristics: the substances within it are not understood as a class with shared characteristics, they have resisted classification as drugs, and they have escaped the tightness of legislative control associated with the other two classes.

On a second level, these three classes operate as three separate moral dimensions each with its own language, moral concerns and explanations for why benefit and harm occur. Thirdly, they act as a symbolic framework for addressing other social fears and expectations, often to do with race, gender, class, health and disease, foreigners, sex, and moral virtue and vice. (Musto, 1987; Manderson, 1993) The main social purpose of this classification of substances is to make the management of substance related harm easier. As will become clear, harm is the key theme. Explaining why it happens and how to prevent, or minimise it happening is the central project of each society's pharmaculture.

The Prohibitionist presentation and understanding of these categories as empirical classifications based upon chemical properties is hard to justify. Opiates, amphetamines and cannabis all appear in both medical and illegal drug categories. There is an intimate connection between medical and nonmedical substances. All of the most commonly used *illegal drugs* were first used as *medical drugs*. The liminal zone acts as a cover over this relationship. In the minds of Australians who can be described as being prohibitionists, the three categories outlined above do not exist. For them there are two classes of "drugs", *medical drugs* and *illegal drugs* and these two classes are perceived to be distinct and separate from each other. Coffee, tea, tobacco and alcohol on the other hand are understood not as drugs but simply part of our general culture.

By including all areas of substance use in our focus, some things become clearer. Firstly, during the 20<sup>th</sup> century the type and range of substances used by Australians has increased fairly consistently with each decade. Secondly, substance use is a widely practiced and accepted part of Australian culture. Thirdly, it is inaccurate to argue that the use, after 1970, of the substances currently classified as *illegal drugs*, represents something new and foreign in our culture. Instead we can say that what really happened was a new generation of adults decided to expand the number of substances they used for nonmedical purposes. The use of these new substances only made sense to them because substance use for nonmedical purposes was an accepted and understood form of behaviour.

While Prohibitionism has enforced a fixed number of acceptable substances for legal (nonmedical) use and legally prohibited the attempted introduction of new substances into this dimension of pharmaculture, it has allowed a consistent flow of new substances for medical use. It has also allowed the medical profession to redefine more and more areas of the human condition as suitable for, if not requiring, treatment with *medical drugs*. Thus the increase in substances used for nonmedical purposes occurred in parallel with a similar process in the area of medical drug use. This increase in the use of *medical drugs* can be understood as the most significant change in substance use during the 20<sup>th</sup> century however the almost exclusive focus on *illegal drugs* and their perceived separateness has shielded from us how the claim “drug use is morally wrong” has accompanied a continually growing catalogue of available substances, and reasons for their use.

Having outlined what I have called a pharmacultural approach to substance use and identified a dominant pharmaculture and termed it Prohibitionism, I will next investigate its key animating concept. My aim is not to prove my case once and for all but rather to demonstrate that it does seem to fit with the data and does provide us with way of making sense of the symbolic classification structure we have inherited.

#### **4) The concept of addiction**

Addiction is generally understood as a disease that can be empirically verified and which has been scientifically studied, described and explained by medical and other scientific and social scientific disciplines. This essay argues that while there is an identifiable experience that can be described theoretically, the concept of addiction needs to be understood as only an attempt to understand this experience, not an empirical theory of it. Furthermore, the concepts of addictiveness and addiction have operated independently of scientific research and medical practice as symbolic resonators of human fears, desires and expectations. It will be argued that addiction operates as the key signifier of an illegal drug: the key identifier of why some substances are said to cause harm.

To put it very simply, humans, like other mammals, are able to develop an altered equilibrium through interacting with some substances, a process that we call addiction but which can most usefully be understood as neuro-adaption. If neuro-adaption is used to describe the physical or pharmacological and biological processes of habitual substance consumption, then we can reserve addiction to describe a psychological-social process that is actually independent of substance use, though often entwined with it.

A person consuming morphine daily over an extended period of time for a chronic pain condition experiences the same neuro-adaption as a person consuming diacetyl-morphine (heroin) daily over the same period of time. However we usually only describe the latter as having an addiction. Addiction in this sense is the relationship a person develops with a substance, or range of other activities or behaviours. The most common experiences of addiction are with: sex, fame, food and pharmaco-active substances and this should not surprise us. They all represent ways in which humans experience powerful emotional attachments and relationships. In other words, it is not that some substances are addictive, it is that some substances are very good reinforcers of addictive behaviour and relationships.

If we want to understand how our current Prohibitionist pharmaculture evolved then we need to excavate the social construction of addiction and its later role in the 20<sup>th</sup> century

legislation of morality. Harry Levine traces the emergence of the modern conception of addiction to America, England and other European societies between 1750 and 1800. He reads the well-publicised and accepted conception of addiction in the work of an American physician Benjamin Rush. Rush studied what he called “addiction to habitual drunkenness” and identified four themes: the substance was the cause of the phenomenon, the phenomenon is a disease, the disease is a loss-of-control, and the only effective treatment is abstinence. (Levine, 1979) We can also add a final theme: the medical profession should provide the treatment. In its entirety this list operates as a narrative: addiction is a medicalised description that narrates and explains the downfall of a human being. The key element of the narrative is the phenomenon of loss-of-control. This always-contestable phenomenon of loss-of-control is the key concept.

Levine notes that Rush, having explained the cause of addiction and outlined a straight forward treatment process, turned to the social problems that he believed were caused by addiction to distilled alcohol. Looking at American society, leading up to and after independence, he identified the outcomes of addiction as “disease, poverty, crime, insanity and broken homes.” (Levine, 1979) Because Rush located the source of the problem in the chemical properties of the substance, he saw the availability of the substance as key to the problem. Levine argues that before this new paradigm of substance use was developed, traditional views understood alcohol use, depending on the context, as sometimes pleasurable, and sometimes sinful, but never beyond the will, and thus the responsibility of the individual. (Levine, 1979) Rush’s conception of addiction represented a new paradigm in which the chemical properties of alcohol were said to cause individuals to lose control over, and thus responsibility for, their use of the substance and their lives. This conception, Levine argues, has continued to operate through to today. (Levine, 1979)

One way of assessing this last argument is to read a 2001 essay by Alan Leshner, the then head of the American National Institute on Drug Addiction (NIDA), the largest and dominant drug research institution in the world. Leshner states that addiction is a “brain disease expressed in the form of compulsive behavior.” (Leshner, 2001) His arguments can be expressed as a narrative that exactly follows the one outlined by Rush 200 years before: the use of “addictive drugs” hijacks the brain’s reward circuits, causing a brain disease that

manifests itself as compulsive substance use, the only treatment for which is abstinence. (Leshner, 2001) “Compulsive” has replaced “loss-of-control” as the key term however the concept itself has not changed. While there *have* been attempts to build in new dimensions – psychological, sociological and genetic – the narrative structure and theory of causality remain the same. What *has* continually changed is the substances which are defined as addictive and therefore which people get defined as addicts or users of addictive substances.

Levine notes that it was mainly puritan protestant ministers who ran with Dr Rush’s new concept of addiction. It proved to be an influential concept inspiring two key social movements of the 19<sup>th</sup> century: the Temperance movement and the Anti-Opium movement. Towards the end of the century, the aims of these movements began to coincide with the aims of the emerging medical profession. The medical profession sought to gain control over the distribution of substances used for medical purposes while others lobbied for legislation controlling which substances could be used for nonmedical purposes.

Peter Cohen argues that the concept of addiction arose from the need of post-Reformation individuals to morally steer themselves. Acceptance of the Reformation ideals meant that individuals were now considered more responsible for their actions and lives, and in a far more personal way. It was up to the individual, through the application of their will, to manage their desires and fears, actions and relationships. (Cohen, 2000) The process of industrialisation, the expansion of markets, and the economic relationships constituted by capitalist exchange, all contributed to a landscape in which individuals managed their desires and fears within rapidly changing social conditions animated by new seemingly all-powerful technological and economic powers.

With this situation in mind, the concept of addiction can be understood as an attempt to articulate a rational explanation of a behaviour that appeared, and was experienced as, being beyond reasoned comprehension and control. Its capacity to resonate symbolically came from it being used to articulate a fear of losing control over one’s desires and behaviour and of society being overwhelmed by destructive forces. The coincidence is uncanny. Just at the time when European and European settler societies were being

transformed by the forces of industrialisation and modernisation, physicians, and protestant ministers began to loudly proclaim that distilled alcohol contained properties that could lead individuals, and if not stopped, entire nations, to destruction. Just when people's lives were being shaped profoundly by social and economic forces that must have seemed overwhelming and mysterious, the medical profession, backed by religious institutions "discovered" another force said to be capable of profoundly and disastrously altering a person's wellbeing and life. However, unlike the forces of industrialisation and modernisation, this force was located in an identifiable object, something that could be pointed to.

If addiction became, through the Temperance movement and the Anti-opium movement, the reason why alcohol and opium were dangerous, it also provided the inspiration for a journey that was understood as a morality tale. Alcohol and opium seduced people with a bliss that robbed them of their senses and self-control. Once seduced, the person no longer controlled their own behaviour, instead they were enslaved to the substance, sometimes until death. Salvation required a renunciation of the "demon drink" and conversion to sobriety. In this sense addiction was understood as a form of possession that required a possessed individual to renounce their chemical idol and convert to a state of chemical and spiritual purity.

It is as if this acceptance and deployment of the concept of addiction was a communal or collective attempt to construct a physical explanation for what was understood as a form of possession. The history of scientific investigation and conceptualisation of addiction since can be read as an attempt, by writer after writer, to strip the concept of any and all magical and moral elements, and to provide, in their place, a materialistic explanation. This required interpreting the narratives of "addicted" individuals as demonstrating that they were no longer in control of themselves. This finding, once established, meant that what such people actually felt or said could be ignored for they were no longer in control of themselves, and if they said anything that contradicted the addiction narrative, then that was just the drug talking.

In spite of attempts to construct a scientific concept of addiction, people, even 200 years later, refuse to accept a strictly scientific definition. An addicted individual is both sick and

immoral and addiction both a disease and a moral perversion. As Valverde has pointed out, addiction has always evaded rhetorical and conceptual capture by one discipline or profession. (Valverde, 1998: 33) This tug of war has seen a re-emergence of term addiction during the last 30 years of the 20<sup>th</sup> century despite attempts to replace and redefine the term as drug dependence, alcoholism, and drug abuse by the World Health Organisation and other expert committees and organisations.

The most interesting aspect of the application of the concepts of addictiveness, addiction and addict, is the inconsistency. Why was it applied to alcohol and then removed? Why was it not applied to tobacco until the second half of the 20<sup>th</sup> century well after the legal and symbolic classes were constructed and institutionalised? These questions have been explored by a number of different writers, most notably by David Musto in his 1987 book *The American Disease: origins of narcotic control*. Behind the myriad reasons of race and class what stands out is that the substances classed as *illegal drugs* were said to be addictive while *legal substances* were said not to be. During the 1960s and 70s when cocaine and cannabis were found to not fit the definition of drug addiction/dependence, a new vaguer form “drug abuse” was coined to explain their harmfulness and justify their continued criminalisation.

In summary we can say that humans are able to develop an altered equilibrium with a range of pharmaco-active substances but not all of these substances are currently understood to cause addiction in contemporary Australia. The evolution and application of the concept of addiction has played a key role in the construction of a prohibited class of substances in the late 19<sup>th</sup> century and early 20<sup>th</sup> century. The advances in neurology and pharmacology in the last three decades of the 20<sup>th</sup> century has brought into question this earlier classification and with it, the entire symbolic classification structure we have inherited. We now live in a situation where the dominant classification system of prohibitionism with its three main classes has become the site of continual debate and struggle.

## 5) Discussion

As stated at the beginning of this essay, the aim has been to construct a theoretical framework that would address the challenge articulated by Peter Cohen. As an undergraduate honours student returning to social theory after 12 years away, I have been painfully aware of my ignorance of both contemporary social theory and the major contributions in the area of substance use. Still, I arrived with an insight, one I felt had potential, and through out the research process the goal has been to evaluate whether this insight was worth anything. Could it be used to illuminate a way of making sense of the hard to grasp complexity of human pharmaco-active substance use and the way we have conceptually constructed it in our various discourses? For me the answer is yes. A larger aim of course is to persuade readers of this. From the beginning, I have had two readers in mind: social theorists with an interest in the area and drug policy-law reform activists. With these two readers in mind I will outline how I intend to use the concept of pharmaculture to pursue my research in this area.

The empirical research for this work was brief and perfunctory. I read *The Age* to see whether the substance classification system that I believe exists in many Australian's minds left footprints in a major metropolitan broadsheet newspaper. From these footprints I extrapolated a conceptual framework that could explain the main structures glimpsed in the newspaper texts.

The next step is to find out whether in-depth interviews with a range of Australians support my thesis. I believe that I will find this symbolic classification system, but not evenly spread. It will be most prevalent in Australians over the age of 55, who came of age before the introduction of cannabis, cocaine, amphetamine, LSD and heroin into Australian culture during the 1960s. Amongst people aged 20 to 45 I suspect I will find that many people will conceptualise the boundary between *legal (nonmedical) substances* and *illegal drugs* quite differently. There will be a far greater variety of classification systems used and they will contain far greater sophistication. At the same time I think the older prohibitionist classification system will lie buried if modified within them as the template that their classification system is a rejection of, or adaption of, or reconfiguration of.

With people who believe in the prohibitionist classification system I have found that when it is challenged they often react with horror. They experience a rejection of it as implying that all substances are the same, and, as a call for a total free for all where all substances are to be made available at milkbars to all people of any age.

This is not the case. This thesis does not seek to promote legislative change but rather to deepen our understanding of the substance classification system we have inherited and use. What drug policy-law reform activists seek is to replace prohibitionist policies with policies based upon a consistent consideration of the pharmacological properties of all substances. However these activists (including myself) have made the mistaken assumption that an “evidence based” approach is common sense and that once this is pointed out people will accept it. This I believe will not work because it fails to comprehend what it is we are actually dealing with.

Pharmaco-active substance production, trade and use, are some of humankind’s most ancient technologies which came of age during the Neolithic agricultural revolution, but probably predate us becoming human as research with primates suggests. (Siegel, 1989) The current conception of drug use meaning illegal drug use as a minority activity is a significant misrepresentation of the phenomenon of pharmaco-active substance use in our society. We can accurately present this by saying: all humans use pharmacoactive substances, but only some of us are labelled drug users, or, in a form that would bring it home to most Australians: We are all use drugs, but only some of us are labelled drug users.

The ability of some substances to affect consciousness has always quite rightly been understood as magical, religious, dangerous, powerful, and requiring careful management. To interact so directly with our internal chemistry and consciousness has always been, and will always be, dangerous, and its outcomes ambiguous and unpredictable. Intellectual, religious and political elites have always understood this.

We can also say that pharmaco-active substances and their use will always be the subject of powerful desires and fears. They will always provide powerful symbolic resonators for

channelling other fears and desires and thus control over their availability and meaning, hotly contested. The social construction of some substance use as (illegal and immoral) drug use, and these substances as addictive, by definition unable to be controlled, has become a culturally embedded symbol used to channel not only fears concerning the ambiguities of substance consumption, but also wider fears concerning free will, freedom and the wellbeing of society.

Articulating the distinctions at the heart of the prohibitionist classification structure, making the invisible and taken-for-granted, visible and clearly debatable, is only the first step to understanding pharmaculture. The concept of addiction is embedded within a diverse range of institutional discourses, structures and processes. These include, but are not limited to: the legal system (courts, corrections, law enforcement) the medical system (doctors, nurses, pharmacists) substance production industries (pharmaceutical, legal substances, illegal substances) politics, education, pawn shop industry, sex industries, financial institutions, casinos and other gambling organisations, and the full range of mass media.

In another sense, prohibitionism can also be understood as one of the last moral battles about the body still unlost by organised Christianity. During the 20<sup>th</sup> century we saw the slow re-evaluation and repeal of laws that defined: women as unable to vote, homosexuality as a crime, abortion and prostitution as illegal. There was also a slow erosion of moral injunctions against sex before marriage and interracial sexual relationships. The “Drug legalisation debate” is, in many ways, another battle in the ongoing cultural struggles over each individual’s right to control what they do with their own body. Prohibitionism is animated by a belief that human adults are not capable of exercising control over their consumption of substances, and that therefore, the range of substances they have access to for nonmedical purposes must be controlled for them.

Thus, Prohibitionism represents a remaining way in which humans are denied control over their own bodies and what they do with them. This means that drug law-policy reform activism can be seen as one social movement in a long line of ongoing emancipatory social movements that evolved out of the European enlightenment. What I hope this essay demonstrates is that to adequately understand and assess prohibitionism will require, first

and foremost, reconceptualising “drug use” as only one dimension of pharmacologically active substance consumption. By refocusing our understanding in this way, those areas of substance use that currently lie submerged and unseen in public discussions and debates about drug use, will come into view and in doing so, will unsettle the simplistic dichotomies and assumptions that currently carry so much taken-for-granted weight.

## **6. A social-scientific vision of pharmaculture**

The use of pharmacoactive substances to achieve human goals is one of humankind's most ancient technologies. The knowledges, techniques, and practices that have developed around this practice can be termed pharmaculture. Powerful substances including morphine, nicotine, THC, cocaine, and others have attracted considerable sustained attention from religious, political, economic, medical, and cultural elites throughout human history.

Before the advent of maritime exploration and trade in the late Middle Ages, alcohol was the most significant substance in European societies. It was used daily for nutrition and fluid, as part of Christian religious ritual, for medical purposes, and in a great range of cultural contexts. Maritime expansion led to the introduction of a range of new substances into European culture: tobacco, cocoa, cannabis, coffee, tea, and opium. At first each of these substances was expensive, restricted to the elites, and used mainly for medical or religious purposes.

Over time as methods of farming and production were industrialised and capitalist markets and economies developed, these substances became more available and applications for their use broadened outside purely medical and religious contexts. These processes led up to the beginning of the 20<sup>th</sup> century and a slow dawning that the completely unregulated production, trade and consumption of many of these substances was too dangerous for individuals and societies as a whole to continue.

The regulation of substance consumption through legislation led to the institutionalising of two dimensions of substance use: *medical drug use*, and *legal (nonmedical) substance consumption*. At the same time, three substances, opium (and diacetylmorphine), cannabis and cocaine were designated as too dangerous for nonmedical consumption which led to the construction of a third dimension: *illegal drug use*.

Several processes played a significant role in shaping, in the lead up to the 20<sup>th</sup> century, substance consumption in Australia and other European derived societies: the

development of industrial chemistry and the pharmaceutical industry, the institutionalisation of medicine and pharmacy, the medicalisation of human life, and increased international trade.

Between 1960 and 1970, a significant shift in the slow continual evolution of substance use practices occurred: new generations of adults in Western countries, accepting the expanded pharmacopeia of substances for medical use, decided to expand the range of substances used for nonmedical purposes.

This process of expansion in range of substances used for nonmedical purposes has been conceptualised by all major institutions as the emergence of “drug use” but as this brief vision suggests, we must reject this view. The conception of *illegal drug use* over the last thirty years as a distinct phenomenon foreign and new to Australian culture represents an attempt to manage substance use in a moralistic way through the re-enactment of distinct symbolic classes of substances. It constructs its correctness and validity by using pharmacological determinism to present two 19<sup>th</sup> century binary distinctions as empirical observations when in fact the initial classification of particular substances as addictive drugs occurred well before the modern sciences of pharmacology and medicine emerged.

The decision by young adults between 1960 and 1970 that the limitation to three substances: alcohol, tobacco and caffeine, was an unnecessary and old fashioned restriction, looks all but inevitable given the social forces within Western democratic capitalistic societies. At the same time the resistance to any change in the inherited symbolic classification structure, while confusing to some younger people, also appears inevitable. This resistance also challenges our understanding of secularisation, and the influence that religious institutions have on our management of moral problems. In other words, our need to manage substance consumption runs far deeper than religious dogma. Pharmaculture can provide a framework for researching and understanding how and why each of the moral dimensions of substances use are experienced and how people experience them being challenged.

## **7. Postscript**

In Australia at present most substance use and conversation about it occurs at and around tables and chairs whether it be the kitchen table, a work desk, pub bar or café table. This is so regardless of whether the substance is defined as medical, legal or illegal. Just as substance use patterns are always evolving so are the classification systems we use to conceptualise and understand them. Currently the dominant pharmaculture I have called prohibitionism is coming under sustained challenge which will only increase during the next few decades. Regardless of how fierce these debates become change will be slow and evolutionary.

There is an opening here for sociologists to make a contribution, an important one. It will require us to develop theoretical models that embrace and connect the social, psychological, biological and pharmacological dimensions of human social experience. I hope this thesis makes a small contribution to this challenge.

So let us charge our cups, mugs, glasses, cigs, straws, pills, herbs, joints, bowls, spoons and syringes, clear our desks, cock our chairs, and proceed.

## Notes

(1) The Commonwealth Department of Health and Aging has recently published a commissioned report: *Return on investment in needle & syringe programs in Australia* (2002). This study repeated an earlier study of change in HIV prevalence in cities with and without NSPs. (p.4) By the year 2000, 453 people had acquired HIV via illegal drug injecting practices in Australia. (p.79) In contrast the study estimated that 25,000 HIV infections among people who inject drugs had been prevented in the period 1988 to 2000 by the introduction of NSPs. (p.85)

(2) During this period, from the 19<sup>th</sup> of January 2002 to the 20<sup>th</sup> of April 2003, 113 articles were collected. Of these, 66 discussed *illegal drug use*, 25 *medical drug use*, 12 *legal substance use* (6 alcohol, 3 tobacco, and 3 caffeine), 8 *performance enhancement drug use*, 2 *spiritual drug use*, and, 2 *herbal substance use*.

(3) In *Drug, Set, and Setting: The basis for controlled intoxicant Use* (1984) Zinberg outlines his research over more than twenty years. An early study trip to England confronted him with a perplexing puzzle: why did people's experience of nonmedical heroin use differ between England and America. Up until this trip he had worked with the assumption that it was impossible for any person to ever use cannabis, LSD or heroin in a controlled and functional manner. In England he studied people who, while heroin dependent, received their heroin from a doctor, and who seemed to be able to lead normal family and work lives. He states that by 1969:

It was becoming obvious that in order to understand the drug experience, I would have to take into account not just the pharmacology of the drug and the personality of the user (the set) but also the physical and social setting in which use occurred. [x]

This insight has become known as the: drug, set, and setting model of drug use. In many ways it can be understood as a sociological theory of substance use because its most important aspect is the inclusion of the social or cultural dimension to theorising about substance use.

(4) Miller M, Draper G (2001) *Statistics on drug use in Australia 2000* AIHW cat. No. PHE 30 Canberra: AIHW (Drug Statistics Series no. 8). The authors note that during 1998, there were 19,019 deaths associated with tobacco use (p.20), 3,271 deaths associated with alcohol use (p.26), and just over 1,000 deaths associated with all the illegal drugs taken together (p.33). While 46% of Australians had used one or more of the illegal drugs at least once in their life (p.33), 22% of Australian currently use tobacco and another 40% had in the past (p.9). With alcohol, 59% were regular users (p.26).

What these figures hide is the level of experimentation with alcohol and tobacco that did not lead to regular use and more importantly, the hidden generational difference in use of one or more of the illegal drugs. The 1998 Household study revealed that 91% of Australians had used alcohol, 80% within the previous 12 months, and that 66% had used tobacco. Regarding the use of any illegal drug it found that while 30% of people 40 and over had, 52% of 14-19 year olds had, 68% of 20 to 29 year olds had, and 62% of 30 to 39 year olds had.

My suspicion is that if 40 to 49 year olds had been separated from those over 50, we would have found that those over 50 and who came of age before the emergence of cannabis, LSD and other drugs in the mid to late 1960s, would have an extremely low prevalence rate. In 1998, those over 50 years of age represent around one-third of Adult Australians and this skews and hides the most significant divide in nonmedical substance use in Australian society: that between those aged over 50, and those aged between 20 and 50. This divide is not between those who use drugs for nonmedical purposes and those who do not but rather what substances people use for nonmedical purposes. I also suspect that adherence to a prohibitionist pharmaculture is largely, but far from exclusively, an over 50 phenomenon.

(5) The recent legal proceedings against Pan pharmaceuticals support my arguments in two main ways. Firstly, many of the companies involved in the herbal substance trade are also involved in the pharmaceutical drug trade. Secondly most of the media who followed the story chose to use the term “drug,” particularly in the titles and/or introductions to heighten the stories emotional impact while also employing a distinction between “prescription drugs” and “alternative” or “herbal” or complimentary” “medicines” “remedies” or “products” in the stories to articulate exactly what substances they were referring to.

(6) This is not exactly true. Around the middle of the 18<sup>th</sup> century, Victoria and New South Wales enacted laws to control the production and sale of substances such as arsenic that had been used to deliberately poison people. I am confident this area can be left aside without compromising my arguments.

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More than once I have witnessed conversations where a person will repeat in their own words something another person has said a few minutes ago as if the first person had never spoken. It used to puzzle me until I realised that putting something into your own words is how we integrate an insight or new understanding. Simply repeating another person's words is not enough.

One of the important skills of scholarship I have just began to learn is how to splice another's words and ideas with your own. It's bloody difficult, especially when you use the compost method of writing: devour books, let it ferment, then follow the little shoots of inspiration that sprout. Each narrative sprout is made of the composted material of other writers, but which molecule came from which?

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