

Merging alcohol and illicit drugs: a brief commentary on the search for symbolic middle ground between licit and illicit psychoactive substances

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Note: I corrected some long-lingering typos and made a number of minor adjustments to this text on 5/17/2019. Unfortunately, some infelicities in the prose remain.

An intriguing development in the current history of the American relationship to psychoactive substances is the trend toward merger of the alcohol and drug-problems social arenas. Intimations of such a shift are by no means new--sociologist David J. Pittman (1967) wrote a paper titled "The Rush To Combine: Sociological Dissimilarities of Alcoholism and Drug Abuse" over twenty-five years ago criticizing what he saw as a contemporary trend toward merger-- incidentally citing the "Addiction Research Foundation's" name as one example of the drift toward combining alcohol and illicit drug research (see Popham, de Lint, and Schmidt, 1968, for ARF's spirited defense). There is relatively little scholarly literature on the merger issue specifically (see Weisner, 1992; Rawson, 1990-1991; Dunne et al., 1989), though a somewhat larger literature exists concerning the evaluation of merged alcohol/drugs treatment modalities (e.g., Ottenberg and Rosen, 1971; Cook, 1988; Galanter et al., 1990).

The extent and significance of merger are still unclear and vary according to which aspects of the alcohol-drug domains one has in mind. Schmidt and Weisner (1993:380), for example, recently called the trend toward combined treatment facilities "perhaps ... the most significant organizational development during the 1980s..." and provided impressive treatment system data buttressing their assertion.¹ Yet most of the merging changes so far appear to involve bureaucratic re-organization and name changing, as evidenced, for example: (1) in the emergence of new federal, state, and voluntary agencies defined around both alcohol and illicit drugs -- notably, in the recent creation of the U.S. national Substance Abuse and Mental Health Administration (SAMSHA) and its two major constituent centers, the Center for Substance Abuse Prevention (CSAP) and Center for Substance Abuse Treatment (CSAT); (2) in the rising popularity of such combinative domain-defining terms as "substance abuse," "chemical dependency," and "AOD" ("alcohol and other drugs"); (3) in new journals and journal articles using such terms in their titles; (4) in the development of common protocols for

the diagnosis of drug and alcohol dependence and problems; and (5) in the National Council on Alcoholism's (NCA) 1990 name change to the National Council on Alcoholism and Drug Dependence (NCADD) [(2), (4), & (5) are cited in Schmidt and Weisner, 1993:381-3821]. If the merging tendency continues and becomes fully realized in substantive as well as nominal terms, it would certainly mark a fundamental transformation in the American social management, conceptualization, and moral definition of two formerly quite separate alcohol-problems and illicit-drug domains.

Until very recently, alcohol- and drug-related problems occupied quite separate social problem domains in the U.S. -- and in most respects I suspect they continue to do so. The most important 20th-century historical event shaping their separation was undoubtedly the repeal of national alcohol prohibition in 1933. With Repeal, alcohol resumed its pre-Prohibition status as a lawful commodity, and thus became legally differentiated from illicit opiates and, before long, from marijuana as well (made illicit by the federal Marijuana Tax Act in 1937 [Brecher, 1986]). Following Repeal, alcohol's social problems arena also saw the development of a fundamentally different paradigm for conceptualizing, social managing, and morally defining alcohol-related problems, built around the so-called "disease concept of alcoholism" (Johnson, 1973; Jellinek, 1960).

The new paradigm, the brain-child and chief preoccupation of what has come to be called "the modern alcoholism movement," placed the locus of alcohol-related dependency not in alcohol itself but instead in the faulty or anomalous drinker, "the alcoholic." Alcohol, in Levine's apt term, became "the only popularly and scientifically accepted person-specific drug addiction" (Levine, 1978:162). Unlike the prevailing paradigm for opiates, alcohol addiction's source lay somewhere in the constitution or psyche of the aberrant user and not in the drug itself. Alcohol's new paradigm harbored many important implications for research and treatment, not a few of which were realized over the course of the post-Repeal era. For purposes of the present discussion perhaps the new paradigm's most important cultural corollary was that it tended to domesticate, secularize, or de-vilify beverage alcohol's symbolic definition. If a relatively rare disease condition known as alcoholism, rather than alcohol, caused the great bulk of society's alcohol-related problems, then the great preponderance of drinkers (the non-alcoholics) could now enjoy beverage alcohol with impunity (Beauchamp, 1980). In short, the alcoholism paradigm added to alcohol's post-Repeal commercial legitimacy a cultural layer of symbolic legitimacy as well.

The alcoholism paradigm's dual capacity to enhance the moral valence of both the alcoholic and alcohol bears special attention, and marks the most important symbolic divide between the alcohol and drug domains in the post-Repeal era. Commentators have from time to time noted that the drug addict is surely as much addicted to his drug-of-choice as the alcoholic is to alcohol. Therefore, as this argument goes, the drug addict should enjoy equal claim to a "disease conception of drug addiction" and, by extension, equal claim to treatment rather than punishment. This argument is true as far as it goes, but it ignores a crucial symbolic divide between the alcoholic and the drug addict. There is a marked moral divide between the user who becomes dependent upon a tabu substance and the user who becomes dependent upon a substance whose use is

socially sanctioned and, for the great majority of users, is defined as a more or less benign and mildly enjoyable commodity.

The difference between alcohol's and illicit drug's legal status -- licit or illicit -- should not be regarded as a mere legislative incidental but as one aspect and indicator of broad differences in our conceptualization, mode of social response, and symbolic definition in the social construction of these commodities: (1) conceptually, the alcoholism paradigm places the locus of alcohol-related problems in the "faulty drinker" whereas the paradigm for illicit drugs places it in the "dangerous substance"; (2) pragmatically, the alcoholism paradigm emphasizes treatment whereas the illicit-drug paradigm emphasizes enforcing the tabu; (3) morally, the alcoholism paradigm offers a measure of exculpation whereas the illicit-drug paradigm leaves the stigma of addiction virtually unmitigated. As I have noted already, the crucial social fact defining and dividing these contrasting social control paradigms is the moral valence placed on the substance itself: alcohol's post-Repeal definition as a relatively benign and mildly enjoyable "social condiment" (Haggard and Jellinek, 1942) (save for the unfortunate few) made possible the development of a social control system very different from that constructed for illicit drugs. These two distinctively different and separate social control systems, each with its seeming coherence and integrity, may be said broadly to represent the initial state from which the merging trend in alcohol and drug-related social control recently commenced.

I

Notions of merger come at an historical moment when the country also seems to be experiencing a lessening permissiveness, or a "new temperance," in both attitudes and behaviors with regard to alcohol and illicit drugs. Alcohol consumption has been in a slow decline for more than a decade, following nearly two decades of increase from 1962-1980. Alcohol-related mortality rates fell between 1979 and 1988 (Stinson and DeBakey, 1992). Survey data indicate that the same levels of drinking elicit considerably more social friction in 1990 than in 1984 (Room et al., 1991). Illicit drug use has also been in decline since the late 1970s (Harrison, 1992), perhaps more sharply than alcohol use. Public notice of these new shifts began cropping-up in the mass media in the mid-1980s and by now -- though Heath (1987) has expressed reservations that a meaningful change is afoot -- impressions of a new "cultural climate" around alcohol and illicit drugs have become "a commonplace" (Room, 1991).

The relationship between the "new temperance" drift and the alcohol/illicit drugs merging tendency is notable. Alcohol's symbolic definition appears to be moving toward that of drugs. Drugs on the other hand, seem also to be moving toward greater proscriptiveness, and perhaps even more markedly than alcohol. Therefore, negative sentiment -- though it may be increasing for both alcohol and drugs -- may not be in fact converging. Yet a purely linear conception of changing popular sentiment regarding either alcohol and drugs is simplistic. The prevailing sensibility seems roughly that alcohol is somewhat too legal whereas drugs, on the other hand, are somewhat too illegal. The reasons for these two tendencies differ. Alcohol is being re-

problematized. The enforcement dimensions of the "War on Drugs," on the other hand, have become regarded as too heavy a burden for the nation to bear. Therefore, whereas alcohol's symbolic definition seems to be drifting toward illicit drugs, the drift associated with illicit drugs -- toward the enhancement of "demand reduction," "prevention," and "treatment" -- is driven by economic and pragmatic considerations. Yet the alcohol side of the merging trend is not without its economic motives as well. For example, the flood of new funding for drug problems that devolved from the 1986 and 1988 "War on Drugs" legislation moved the alcohol field to stress alcohol's fundamentally drug character. In effect, alcohol attempted to ride the coattails of a boon in anti-drug funding.

Though drug legalization has enjoyed renewed interest in the great drug debate, the current anti-drug drift in popular sentiment augurs against this likelihood. On the alcohol side, alcohol's re-problematization has evidenced a complex and intriguing character and history. The fundamental dilemmas are these: prohibition will not return to alcohol -- the country's recollection and image of the great experiment are too fresh and too negative, even despite a current, revisionist trend in prohibition's historiography (see Weisberger, 1990). At the same time, alcohol's re-problematization seems to be straining at the symbolic boundaries of licitness, thus giving rise to a hazy symbolic and policy territory lying between licit and illicit. In symbolic terms, a new social control agenda is asking both (1) what are the limits of degrading alcohol's licitness while conceding that alcohol will remain licit, and (2) how can the social handling of illicit drugs be pushed in a more preventive and treatment-oriented direction -- i.e., toward greater symbolic benevolence -- as popular sentiment continues in a trend toward a greater negative valence on drugs?

II

It may be noted that there is a big symbolic divide between licit and illicit, legal and illegal. The sociocultural grant of licitness brings with it broad and important rights, as the designation of illicitness brings equally broad and important controlling potentials. Legal vs. illegal is a fundamentally dichotomous social structural fact: the commodity is either legal or illegal, the prisoner is either guilty or not guilty. A great deal may hang on whether the plastic sandwich bag that the police discover in your car's trunk contains oregano or marijuana, talcum powder or cocaine. There is, in this formal sense, no middle ground between a matter that is assigned to the province of the legal/police/criminal justice realm and one that is not thus assigned.

The broad symbolic significance and power of the formal licitness is visible in a number of ways. When, for example, pro-beverage interests argue against further restrictions on alcohol advertising, the point may be made that imposing special limits on alcohol's advertising is incompatible with its licit status. In U.S. House of Representatives' hearings on alcohol and tobacco advertising and marketing in 1990, Dan Jaffe, representing the Association of National Advertisers, argued that, "If a product can be legally purchased and used by every segment of the adult population, then society should not create 'second class' citizenship with regard to commercial speech about that

product" (quoted in *Alcoholism Report* 18[8]:6, 1990). Similar rhetorical motifs occur with respect to earmarked or increased taxation, abstinence-oriented prevention education, and so on. In each case, licitness symbolically lodges alcohol in a broad class of socially sanctioned commercial objects -- thus affording pro-beverage interests the rhetorical leverage of both a claim to symbolic legitimacy by virtue of commercial legitimacy and a claim to the right to parity or equitable treatment with respect to other licit commodities.

III

If the alcohol/drug merging trend were to continue, four merging scenarios suggest themselves: (1) a shift toward the "drug-ification" of alcohol problems, (2) a shift toward the "alcoholization" of drug problems, (3) the emergence of some sort of moral/pragmatic middle ground, defined by melding the two domains' social paradigms, or (4) the development of a new social paradigm whose structure somehow redefined and accommodated the requirements of both formerly distinct problem areas.

The "new paradigm" option has come forward in the broad idiom of a "public health" model or approach. The significance and prospects of this paradigm are difficult to assess at this point (see Beauchamp, 1990; Erickson, 1990; and Mason et al., 1992 for good articulations of this new perspective). One reason is that it has been presented in several different and even incompatible forms: as a classic agent-host-environment model, as a risk-factor model, as a demand-reduction model, as a "problem-minimization" model, as a single-distributionist model, as a community organization model, etc. This sort of multiplicity of conception is not surprising, coming at a time of seeming ferment and change in the field. Moreover, as Christie and Bruun (1969) sagely pointed out many years ago, multiple and fuzzy meanings may well be one of the assets and even requirements of viable social problems paradigms, given that such paradigms must serve to integrate thought, feeling, and action across many institutional planes, diverse interest groups, and changing historical circumstances.

Yet, and despite this new paradigm's legitimate claim to offering a (several?) new conceptual frameworks for understanding and responding to society's substance-abuse problems, the public health paradigm's major pragmatic implications seem to date merely to devolve back to the drug-alcohol merging options (1)-(3) (see above) -- i.e., by "drug-ifying" alcohol, alcoholizing drugs, or somehow averaging the two domains. So far, at least, the public health idiom has been employed primarily (a) to promote a re-problematization of alcohol and alcohol use, (b) to de-emphasize punitive approaches to drug problems (favoring instead preventive and treatment efforts), and (c) to promote a general emphasis on primary prevention with respect to both alcohol and drug problems, particularly focusing on youth. It follows, therefore, that even from within the new conceptual offerings of a public health approach, the current merging trend can rely on little more than a melding or averaging of the alcohol and drug domains in defining policy design.

IV

Can the alcohol and drug arenas truly be merged or melded given their formerly sharply different symbolic definitions, or can a socially meaningful "average" be defined between them? Or does the symbolic plane not lend itself to averaging? More than one sort of response is possible. Advocates of the new public health idiom have, for example, tended to downplay or reject the moral/symbolic dimension. This disposition is nicely reflected in the often heard public-health argument that (licit) alcohol and tobacco impose far greater tolls of death, sickness, and disruption for society than do (illicit) heroin, cocaine, and marijuana. The central rhetorical value of this contrast is that it frames and advocates an ostensibly more "rational" and objectivist approach to setting society's "substance abuse" problem priorities. Society misjudges the comparative suffering and social costs of licit and illicit substances, the argument suggests, because it is misled by irrational factors. That heroin, say, may have acquired a symbolic definition -- for whatever reasons -- that makes its use and users more threatening and loathsome than the three-pack-a-day cigarette consumer is utterly disregarded in this formulation. So also is the symbolic significance of the licit/illicit divide. Indeed, the licit/illicit divide seems reduced the status of an arbitrary and archaic holdover from a bygone mentality.

Nothing seemingly stops society from shortening the symbolic distance between illicit drugs and licit alcohol by simply making it tougher to produce, sell, buy, consume alcohol. These approaches are evidenced nowadays in a great variety of strategies that both promote and devolve from alcohol's re-problematization: for example, limiting or reducing the number alcohol sales outlets, reducing days/hours of sale, restricting advertising, increasing tax levels, raising minimum age, imposing warning labels, and even monitoring the use of alcohol in entertainment media such as television. The irony of these control measures is that though they may be justified and explained in terms of an abstract, statistical relationship between (say) per capita alcohol consumption and society's burden of alcohol-related problems, they are more likely to be embraced because they provide valuable and ostensibly authoritative ammunition in the symbolic redefinition of alcohol, alcohol producers, alcohol sellers, and even alcohol users. What is offered as a technical contribution is embraced for its symbolic utility.

There are, it seems to me, at least two drawbacks to this alcohol-re-problematizing approach. First, the various control measures themselves afford society no clear sense of their theoretical limits. If public health considerations were absolutely to govern the degree, manner, and subsequent enforcement of these control measures, would hours of sale go to zero, or taxes go to infinity, or outlets to nil, etc.? If alcohol is a "risk factor" with respect to a great many illnesses, injuries, and causes of death, is the best level of alcohol consumption no alcohol consumption at all? And if alcohol in the hands of television actors legitimizes and glamorizes alcohol to youth, should alcohol be flatly prohibited from appearing on television? Public health advocates might readily concede that these objectives go too far. My point, however, is that the logic of such advocacy does not convey what the theoretical limits to control should be. One byproduct of the absence of theoretical limitation is that such measures are readily equated with a temperance-like or prohibitionist objective for public policy.

The second drawback is that the symbolic character and symbolic consequences of alcohol's re-problematization are in effect dismissed or rendered nil. Who hears anymore of the competing (and antagonistic) "cultural integrationist model" in the explanation of aggregate level alcohol-related problems? If, for example, re-problematizing alcohol were to undercut alcoholism treatment's symbolic legitimacy, would anybody care? Is such a concern a "technical" matter that belongs in the discussion when hours of sale or taxation levels are up for debate? The champions of the modern alcoholism movement regarded themselves as having fought a long and important cultural battle on behalf of improving alcoholic's social standing and moral definition. If their advocacy and social accomplishment (Schneider, 1978) is in effect degraded by the current public health paradigm, does that sort of symbolic "correlation" belong in the political forum? A prevention enterprise aimed at alcohol-related problems cannot be regarded in quite the same terms as, say, a prevention enterprise aimed at reducing heart disease. An HMO's (say) new heart prevention effort may simply be regarded as a welcome addition to heart-related services -- save in minor ways, the promotion of prevention would not equivalently imply the symbolic degrading of direct treatment. Not so regarding alcohol-problems prevention: if society's duty to proffer alcoholism treatment is linked to the prevailing moral valence on alcohol, per se, then re-problematizing alcohol implies also marginally reducing society's duty to provide alcoholism treatment.

V

The general territory defined by alcohol-related or drug-related problems comprehends a great host of included problems -- call these "subproblems" -- thus allowing advocates and researchers in a social problems arena the flexibility to shift their gaze from one subproblem to another as circumstances may warrant. Such "subproblem shifts" may involve new attention to new problem categories, to new circumstances, or to new categories of victims. As it happens, the recent trend toward re-problematization of alcohol has involved a number of subproblem shifts. These, to the extent they have lessened the symbolic distance between alcohol and illicit drugs, have figured in the current tendency toward merger. In other words, one of the mediums through which the symbolic distance between the alcohol- and drug-problems domains have been reduced is a shifting gaze with respect particularly to alcohol-related subproblems.

Four subproblem shifts particularly have characterized recent history: (1) to drunk driving, (2) to fetal alcohol syndrome (FAS), (3) to youth, and (4) to criminal justice populations. All four cases involve a re-emphasis on alcohol, per se, (not alcoholism); all four also reflect problem areas where the alcoholism paradigm's utility is limited; drunk driving and FAS define victims other than the drinker him/herself, thus evoking social responses on behalf of the victim's protection; all four may also be said to involve statuses in which abstinence from both alcohol and illicit drugs is the ideal norm. To the extent that the alcohol problems domain has become preoccupied with these four subproblems particularly, the wider alcohol arena is commensurately better suited to nudge alcohol's symbolic definition in the direction of illicit drugs.

VI

The modern alcoholism movement sought the improvement of the alcoholic's social standing -- which, perhaps inadvertently, also helped redefine alcohol itself. Now -- and for the past decade or so -- alcohol has been undergoing a process of re-problematization. Why did the domesticating inclination of the modern alcoholism movement in turn give way to the re-problematizing drift of a "new temperance" shift in sentiment? Has a new linkage of alcohol with drugs served as a symbolic medium and instrumentality for the alcohol re-problematizing tendency? How will the historians and sociologists of the future explain this remarkable, and unexpected, shift of American sentiment and conceptualization? The literature on the new temperance has cited a number of factors: the growth of healthism, consumerism, the new conservatism of the 1980s, the seemingly self-destructive tendencies of the modern alcoholism paradigm (Roman, 1991), the emergence of polydrug abusers, the emergence of the parents movement, the growth of criminal justice alcoholism treatment clients, the development of the public health perspective, the development of a federal preoccupation with prevention, and more. I should like to note two background factors that have undoubtedly contributed to the current shift: the freestanding character of the alcohol problems field after over the post-Repeal period and the remarkable persistence of a substantial abstaining and very infrequently drinking segment of the U.S. population over the same period.

Although the rhetoric of the modern alcoholism movement was ostensibly committed to integrating the treatment of alcoholism into the mainstream of American medicine -- a rhetorical corollary of the "disease conception" -- in fact the treatment system that emerged in the nation was instead freestanding and primarily nonmedical in character. What first evolved in the nation was a treatment system divided between a voluntary, self-help wing and a parallel, publicly financed wing employing the same basic conceptual paradigm and treatment approach but applying these to alcoholics who had one way or another disdained, avoided, or failed AA's program in the past. The freestanding character of the alcohol arena, in turn, implied that a resurgence of dry sentiment across the country -- whether in the form of a grassroots movement or a campaign urged on by public health professionals -- would find a social arena in which to articulate their perspective and advance their action agenda.

Although the modern alcoholism movement's paradigm provided the rhetorical/conceptual basis for de-problematizing or domesticating beverage alcohol, in fact the nation's population subgroups of abstainers and infrequent or light drinkers remained remarkably unchanged in the years and decades following Repeal. When Riley and his colleagues conducted the first survey of drinking patterns in the national population in 1946 (Riley and Marden, 1947), they found that 35% of the adult population abstained and another 13% drank less often than once a month -- a total of 48% either abstained or drank less than monthly. When Cahalan et al. (1969) conducted their national survey in the mid-1960s, their findings were virtually identical to Riley's: 32% abstained and 15% drank less than monthly -- or 47% either abstained or drank less than monthly. Much the same pattern were observed in the several

surveys conducted in national population over the course of the 1970s and 1980s (see Hilton, 1991:126-128). In 1990, the most recent year for which national survey data are available, 35% abstained and 17% drank less than monthly (Bocian, 1993) -- or 52% either abstained or drank less than monthly.

In short, the long sweep of such findings suggests a national population divided roughly equally between abstainers and infrequent drinkers, on the one hand, and a broad array of more frequent drinkers, on the other. Though the nation's apparent per capita consumption of alcohol has enjoyed periods of unchanged constancy (1946-1961), gone up (1962-1980), and gone down (1981-1990) over the historical period covered by modern national surveys, changes in consumption are due primarily to variations in the consumption practices of more frequent drinkers and not due to either great expansions or great contractions in the nation's proportions of abstainers and infrequent drinkers. The country has never become "wettened" in either popular sentiment or behavior in the sense that more frequent drinking -- here, defined very broadly to include drinking "at least once a month" and more frequently -- has expanded greatly beyond roughly half the national adult population. Aside from its significance as a measure of the remarkable stability of the nation's abstaining and infrequently drinking population segment, these findings suggest that about half of the U.S. adult population would be inconvenience little or not at all were alcohol controls greatly increased. It remains to be seen how a newly re-politicized alcohol-and-drugs-limiting campaign would play out in this semi-arid clime.

"National Drug and Alcohol Treatment Utilization Survey" (NDATUS) data show remarkable growth in combined alcohol/drug treatment facilities between 1982 and 1992: combined alcohol/drug facilities rose from 26% of all facilities (i.e., 74% of all facilities offered either alcohol-specific or drug-specific treatment but not combined treatment) in 1982 to 76% of all facilities in 1990; combined facilities saw a six-fold increase in absolute numbers of clients seen 1982-1992 (from 83,677 to 508,789) whereas alcohol-only facilities underwent a significant decline in clients (from 199,492 to 132,493) over the same period (from Schmidt and Weisner, 1993:Table III, p. 381).

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