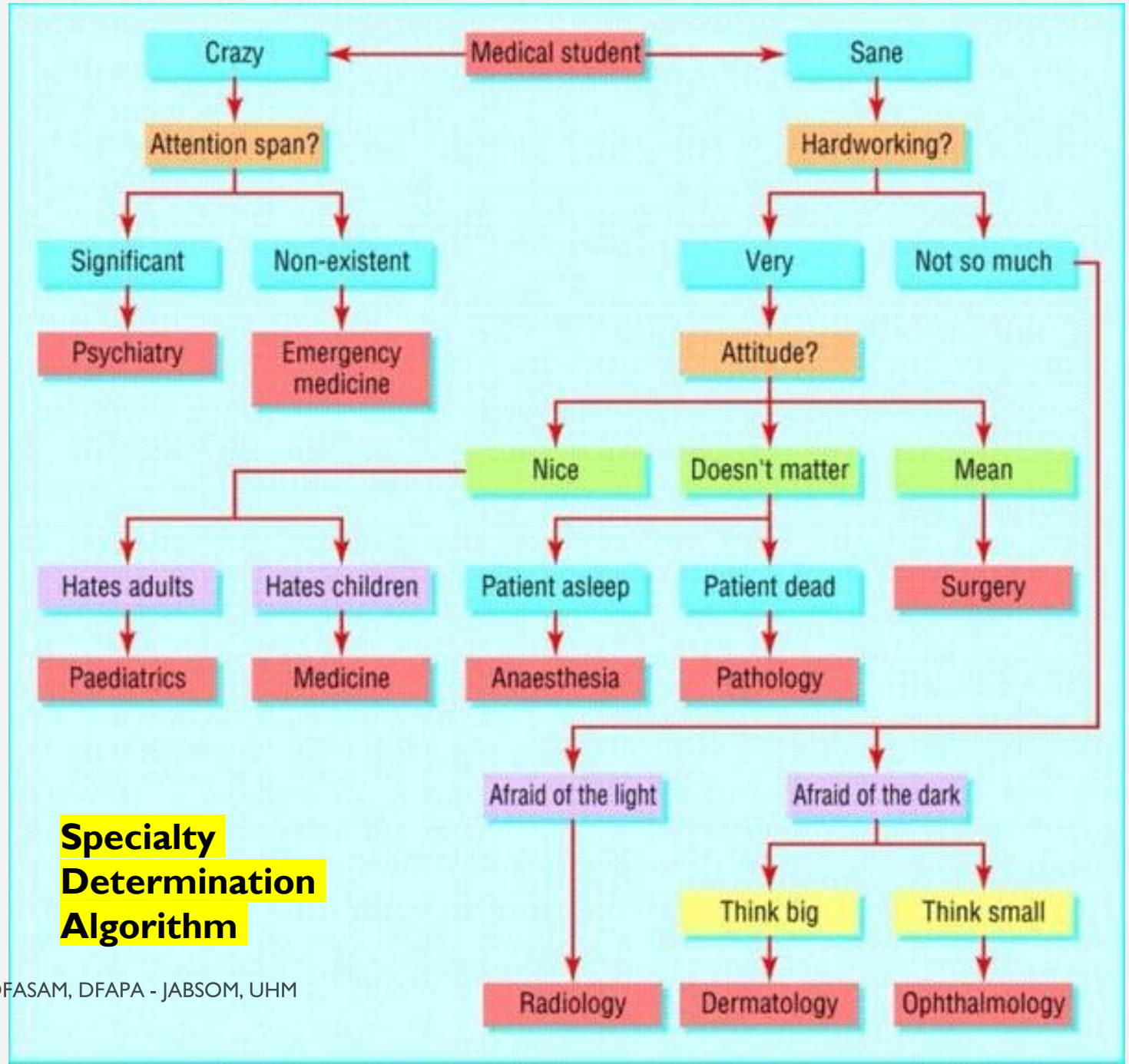

Medical student
Crazy
Sane
Attention span?
Hardworking?
Significant
Non-existent
Very
Not so much
Psychiatry
Emergency medicine
Attitude?
Nice
Doesn't matter
Mean
Hates adults
Hates children
Patient asleep
Patient dead
Surgery
Paediatrics
Medicine
Anaesthesia
Pathology
Afraid of the light
Afraid of the dark
Think big
Think small
Radiology
Dermatology
Ophthalmology
Specialty Determination Algorithm

CULTURES OF ADDICTIONS

W. Haning, MD

Chapter in Streltzer, Cultures and Psychiatry 2nd Ed.

AFFILIATIONS AND OBLIGATIONS (DISCLOSURE STATEMENT)

- I have no commercial contacts with pharmaceutical or other agencies who might benefit by or suffer from my presentation. My incomes derive from pensions (Navy, Federal, State) and University (faculty)

- I have been known to prescribe medications, on occasion. I am not taking any, though many believe that I should.

- I shall warn you if I propose any off-label therapies or medication uses.

- ("Did speaker disclose affiliations?" Check "YES" on your evaluation forms, now)

MORPHEUS & MORPHEA

Morpheus & Iris, Pierre-Narcisse Guerin, post 1819

Eugene-Samuel Grasset, *Morphinomaniac, 1897*

ZUNDAP JANUS

METHADONE

Marie Nyswander, 1919–1986

PERSPECTIVE

W. Haning, MD - JABSOM, University of Hawai`i

OBJECTIVES
(CHECK "YES" ON YOUR EVALUATION FORMS, NOW, PLEASE)

- By the conclusion, the attendee will:
  - Be able to identify one therapeutic activity that attempts to repair cultural identity
  - Be able to defend the premise that cultural familiarity is central to effective treatment
  - Identify one or more elements of cultural awareness that can contribute to effective intervention.
- Premises:
  - Cultures and subcultures are largely interchangeable notions
  - Addictions – limited to SUDs, for this presentation
  - What this is not (ethnological discussion)
- Hypotheses:
  - There are true tribal relationships constituting cultures, which are defined by the process and socialization imperatives of addiction
  - It is useful to know these things, if one is to intervene
  - It is useful to know these things, if one is to recover

OBJECTIVES
(CHECK "YES" ON YOUR EVALUATION FORMS, NOW, PLEASE)

- By the conclusion, the attendee will:
  - Be able to identify one therapeutic activity that attempts to repair cultural identity
    - **Milieu, perhaps group therapies**
  - Be able to defend the premise that cultural familiarity is central to effective treatment
    - **Gay groups,. Women's groups**
  - Identify one or more elements of cultural awareness that can contribute to effective intervention.
    - **Language (of the street, names of drugs, etc.)!! Activities (post-meeting fellowship sessions).**
- Premises:
  - Cultures and subcultures are largely interchangeable notions
  - Addictions – limited to SUDs, for this presentation
  - What this is not (ethnological discussion)
- Hypotheses:
  - There are true tribal relationships constituting cultures, which are defined by the process and socialization imperatives of addiction
  - It is useful to know these things, if one is to intervene
  - It is useful to know these things, if one is to recover

IMPORTANT TAKE-AWAYS

- Culture is not a unique province of psychiatry. There are many professionals in other disciplines who have as much or more right to opine, from anthropologists to sociologists to politicians.
- An understanding of the addiction milieu as a culture of its own is essential to effective intervention. Patients may get well *even if* the clinician does not understand or appreciate the cultural context; but the doctor doesn't deserve the credit…
- Not a strict metaphor but a decent one: No more can one hope to be an effective addiction specialist without a cultural understanding, than hope to be of use to *Medecins Sans Frontieres* without knowing the host country's language.
- There are many subcultures within the Big Tent of addiction. The point of overlap, as in anthropology, is at the person under consideration. Some of the cultural contributors to that person are enduring and constructive, and must be employed.

CULTURES OF ADDICTION

- 3 or more possible directions to pursue.
  - Addressing culture-bound behaviors, such as drug usage.
  - Describing the influence of culture upon drug usage in a population
  - Defining a population with a unique culture (shared values, beliefs, behaviors, expectations).

WHAT IMPELLED THIS PRESENTATION

- Listening to patients, but much more the result of attending community-based recovery meetings, I realized that folks went through decreasing identification with a previous lifestyle.
- Some cultures are reasonably stable (LGBT, Swamp People), possibly unstable or variable (immigrant nationalities), or transitional and residual (military).
- Cultures have foundations: mutual support/survival, obtaining goods/food, ease of communication, other attributes to be mentioned.
- Was this not also true of those with SUDs? And if so, how might this realization be useful?

WHAT IS A CULTURE?

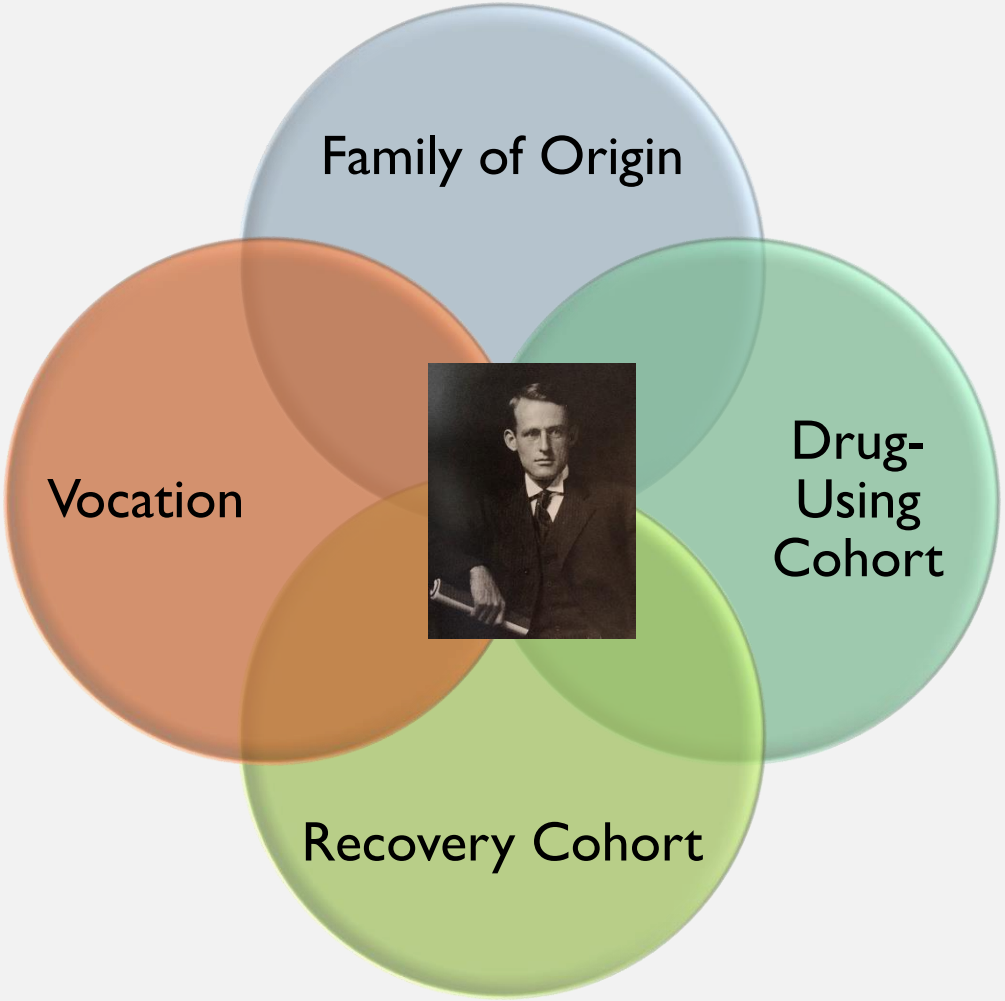
- A collection of common customs and beliefs of a particular society or group
- We are accustomed to thinking of cultures in geopolitical terms, in conjunction with cuisine and language; but the attributes of different cultures may overlap, allowing one individual to subscribe to more than one culture simultaneously.

ADDICTION AS A CULTURE

- Central to the discussion of drug-using groups as cultures is an assumption that there are parallels in legitimate society
- Groups or tribes of people engaged in drug usage or drug-transferring transactions fulfill the requirements of a culture
  1. Provide for each other's needs
  2. Set norms for behavior, attire, ceremonies, diet
  3. Protect each other (or protect the drug sources, amounting to same thing)

CULTURAL OVERLAYS, EXAMPLE

Robert Holbrook Smith, MD, 1910



MULTI-GENERATIONAL EXPERIENCE; AND CULTURAL OVERLAP

WHY IS CONSIDERATION OF CULTURE EVEN REMOTELY IMPORTANT TO THIS AUDIENCE?

- Enculturation, from the 1st and 2nd Editions, Culture and Psychopathology, Tseng & Streltzer, Wen-Shing Tseng Ch.1 (p.14).
- It's Learning Theory, writ large: immersion in and acceptance of patterns of behavior can change the brain's hard-wiring:

- Castillo RJ. Culture, trance, and the mind-brain. *Anthropology of Consciousness*. 1995;6:17–34.

- Thompson RF, Donegan NH, Lavond DG. The psychobiology of learning and memory. In Atkinson RC, Herrnstein RJ, Lindzey G, Luce RD (Eds.), *Steven's handbook of experimental psychology*. Second edition. New York: John Wiley and Sons; 1986.

- Sperry RW. Structure and significance of the consciousness revolution. *Journal of Mind and Behavior*. 1987;8:37–65.

CULTURE = (MILIEU + CONSTITUENTS)/TIME

$$Cult = \frac{(M + B)}{t}$$

ENCULTURATION AND INFLUENCE, IMPLICATIONS

Acceptance that the milieu over time – the culture – can organize the architecture of the brain leads to several useful implications:

- The earlier the intervention or the modification of milieu, the earlier the response.
- The milieu can be reconstructive. It is not simply a setting or a background to group/individual therapy. It ***IS*** therapy.
- The therapeutic effects can be enduring: the longer the enculturation, the more resistant to deviance from the cultural norms.

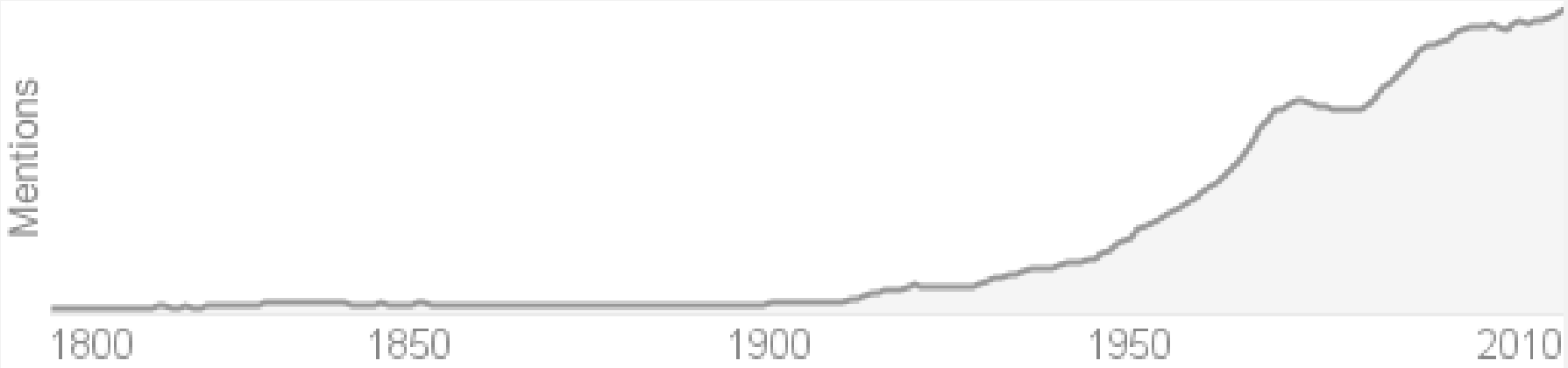
WHAT IS AN ADDICTION?

- ASAM: https://www.asam.org/resources/definition-of-addiction
- DSM5: (slides x 3, below) 11 criteria, 2+ = Dx
- ICD10 : Coding, not criteria-based
- AA: Look in vain; examples only.
- NA: "Many books have been written about the nature of addiction. This book primarily concerns itself with the nature of recovery."

DICTIONARY DEF ADDICTION – FROM 1800 FORWARD

Cambridge English Dictionary - the need or strong desire to do or to have something, or a very strong liking for something:

- His addiction began with prescription drugs.
- I have an addiction to mystery stories.



ASAM – ADDICTION – SHORT FORM

- Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.

- Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

SUBSTANCE DEPENDENCE (ESSENTIAL)

- **Organization around acquisition, use, recovery from effects, of the drug**
- **Dosage and frequency not the issue**
- **Consequences are the issue**
- **Adaptation and deterioration are hallmarks**
- **Ambivalence is the psychodynamic (two voices, simultaneous, contradicting)**
- **Alterations in relationships (gravitation toward destructive relationships)**

SUBSTANCE Use Disorders, DSM5 #1/3

Criteria for Substance Use Disorder

1. Substance is often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control substance use
3. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
4. Craving, or a strong desire to use the substance
5. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.

SUBSTANCE Use Disorders, DSM5 #2/3

Criteria for Substance Use Disorder

7. Important social, occupational, or recreational activities are given up or reduced because of substance use.
8. Recurrent substance use in situations in which it is physically hazardous.
9. Substance use is continued despite having knowledge of having a persistent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Tolerance, as defined by either of the following:
    a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect
    b. A markedly diminished effect with continued use of the same amount of the substance.

SUBSTANCE Use Disorders, DSM5 #3/3

Criteria for Substance Use Disorder

11. Withdrawal, as manifested b either of the following:
    a. The characteristic withdrawal syndrome for the substance.
    b. The substance (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.

- Early remission: >3 mos., <12 mos. (no criteria other than craving/desire)
- Sustained remission: >12 mos. (no criteria other than craving/desire)

- Mild: 2-3 symptoms
- Moderate: 4-5 symptoms
- Severe: 6+ symptoms

IMPACT OF SUBSTANCE USE

- Centrifuging off of other cultural identities.
- The first to go is the one with least personal affinity or which places onerous burden on the individual Church, meditation, exercise.
- Family, professional affiliations follow.
- The last one to go is vocation (Why? No food bank for drugs/alcohol).

THERAPEUTIC IMPLICATIONS AND ORIGINS OF THIS FOCUS OF INQUIRY

- Cultural reaffiliation or new affiliation needed in order to treat (Carlton re adolescents, Hawai`ian identity)
- Corrective action on schisms: the current client of adversarial politics, splits us. Thus there is no cultural norm to which to return, if there ever truly was. Countries with well-integrated identities suffer less disorganization (both by definition and in conjunction with substance use): Japan, Denmark, W. Samoa.
- *Professionally, where did the experiences come from to enable examining this?*
  - Adolescents
  - My own cultural affiliations (military, gay, medical, high school. AA/NA, institutions – ASAM, alumni, etc.)
  - Departmental emphasis (6 texts published by DoP on culture & psychiatry, dating back to 1974 & Jack McDermott/Wen-Shing Tseng, subsequently Jon Streltzer).
- *Where is enculturation accomplished?*
  - Individual, Group, Milieu therapies (Stephanie Brown – the evolving patient)
  - Family
  - Peer group, vocational setting, others

Starch/glucose

Tryptophan

SETS AND SETTINGS

- Settings – families, domiciles, locations, proximity of drug-using community
- The drugs (Set) - list

THE DRUGS

• Ethyl alcohol (all brands and forms, and ethyl ether gas). Use characterized by disinhibition and sedation, social shared consumption validates legitimacy. Overarching culture determines acceptable limits and styles of use.

• Sedative-hypnotics (benzodiazepines such as diazepam and alprazolam, barbiturates, chloral hydrate). Use in conjunction with either alcohol or opioids is more common than use alone; used to ameliorate side effects of stimulants or hallucinogens.

• Stimulants (e.g., cocaine, amphetamines such as methamphetamine). Performance and study enhancement eff ects create considerable overlap with occupational roles (those jobs requiring long hours awake, tedious or exhausting labor; and those associated with creativity and the arts [17]).

• Opioids (e.g., heroin, morphine, meperidine, oxycodone, tramadol). The acuity of withdrawal symptoms fosters exchange of information between users of the sources of supply, venues.

THE DRUGS

• Hallucinogens (e.g., LSD, peyote). Difficulty of detection causes strong crossover with occupations for which drug-testing is a requirement.

• Cannabinoids (e.g., cannabis/marijuana, hashish; synthetic cannabinoids/ "spice"). Increasingly occupying the sphere of usage enjoyed by alcohol, employed to disinhibit and promote a shared experience.

• Arylcyclohexylamines (e.g., phencyclidine (PCP), ketamine). Mixed eff ects; generally these are agents with access limited to the medical and veterinary communities.

• Methylenedioxy-methmphetamine (MDMA) variants (synthetic cathinones or "bath salts"). "Rave" participants, youth-centered use.

• Miscellaneous regional stimulants (e.g., khat, betel, kava). Geopolitical specificity.

• Nicotine (tobacco derivatives, including extract for vaporizer inhalation). At one time a social mediator with usage by the majority of the population; usage interestingly now defines a group of social outliers.

DRUG-USING SUBCULTURES

- A recurring theme in Erving Goffman's classic, *Stigma*, is the development of clusters or tribes around shared values that are regarded negatively or as aberrations by the community: an early study of California paint-inhaling youth describes a non-treatment-seeking cohort who are disengaged from the primary culture, and for whom the paint provides relief from a sense of isolation.
- Similar group cohesion effects are seen within groups as disparate as inner-city cocaine and heroin users around their religious and spiritual experiences, and female injection drug users in Georgia.

DRUG-USING SUBCULTURES

- Drug-using subcultures can prove unexpectedly willing to be studied. A survey of Iranian students in 2007 indicated a full third of the sample having used drugs or alcohol.
- The remarkable aspect of the study was not as much the level of substance use, as the degree of self-disclosure, within a culture which has developed a sophisticated program of recovery facilities yet which provides harsh punishment for drug use (personal communication, R. Rawson).

RECOVERY SUBCULTURES: COMMUNITY-BASED MUTUAL ASSISTANCE

- Recovery groups, 12-step (AA, NA, Al-Anon Family Groups)
- Specificity of common grounds (e.g., NA vs. Meth Anon)
- Culturally-anonymized (e-Recovery: *In the Rooms*)
- Smart Recovery (Oahu/Maui), others non-12-Step
- Malignant cultures – Narconon, some Therapeutic Communities

ADVOCACY CULTURES

- NCADD
- Shatterproof
- Partnership for Recovery
- National Association for Children of Alcoholics
- Join Together
- Legal Action Center
- Faces & Voices of Recovery
- A New Path
- Drug Policy Alliance
- …Others in References, "Links"

VIGNETTES

1. Mac, senior Marine, EtOH, Medal of Honor
2. Julio, USMC 1st Sergeant, PTSD Iraq (OIF1)
3. MDMA Pod, Judith et al.
4. Sheri, pregnant methamphetamine user
5. Mixed young military, EtOH+, Sam et al.
6. Opioid-dependent doctor

VIGNETTE 1: MAC

- Hispanic male USMC CSGM, veteran

VIGNETTE 2: (HIGH SCHOOL) JUDITH, HARVEY, BEN & MARY,

- Senior high school students, "pod"; MDMA, cannabinoids.

VIGNETTE 3: SHERRI ("SHERRI-GIRL")

- Woman (self-identifies as "local girl"), gravid, multi-generational using household

VIGNETTE 4:
SAM, DEXTER, ANNETTE & JUDY, USMC

- Active-duty military cohort sharing a domicile; "adult family" vs. work-group. EtOH. Frequent UDS monitoring.

VIGNETTE 5: BARTON WONG, MD

- NA text case on MD IVDU, NA Big Book p.200, "Physician-Addict."
- Dr. Paul O. from AA, barbiturates, old PP. 449 ff

CLINICAL GUIDELINES

- The case the vignettes make for addiction culture
- Utility of understanding the cultures
  - For interventions (speaking the language) – Individual Therapy
  - For treatment (identifying groups) – Group Therapy
  - For Family Therapy (Allies; Network Therapy [Marc Galanter]) – Milieu Therapy
  - For legislative and policy action (Patient advocacy groups) – Resource Development

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