# 2 HISTORICAL PERSPECTIVES AND THE MORAL MODEL

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Substance use and addiction has a long and colorful history in the United States. The alcohol and drug cultural evolution has shifted from attitudes of complacency to demonization, criminalization, and mass incarceration. From the colonial era to the present day, the emphasis has vacillated between treatment and prevention programs to criminalization and harsh punishments for users and offenders. The moral model is one of the key underpinnings found throughout the evolution of the alcohol and drug culture in the United States. Often discussions of the history of addiction and treatment are framed within the context of opposing ends of this moral spectrum: good versus bad, abstaining versus drunkenness, upper class versus lower class, religious versus nonreligious, and disease versus immoral conduct (Thombs, 2006). In this chapter, we explore the historical and cultural perspectives of substance use and addiction in the United States, including the evolution of the moral model.

## COLONIAL ERA (1492–1763)

During the colonial era as Europeans began arriving in the New World, Native Americans were introduced to the use of alcohol. Also during this time, Native Americans introduced Europeans to nicotine and tobacco. Settlers and Europeans began to heavily use tobacco and tobacco products, such as snuff. Over time tobacco became so addictive, people found they could not stop smoking. As a cash crop, tobacco had a huge impact on the New World economy. Tobacco was used as legal tender and was also a contributing factor that led to the slave trade in colonial America (Spurling & Leonard, 1993).

According to Spurling and Leonard (1993), rum was also used as legal tender in the early days of the United States. Because there were no water purification systems, water was often not healthy to drink, so alcohol was used as a form of water purification in colonial America. As a result, almost every person in colonial America drank some form of alcohol. As a matter of routine, most Americans began their day by drinking alcohol with breakfast and continued to drink all day long. Eventually, when the British cut off molasses supplies needed to make rum, the American colonists began making whiskey out of converted grains. Because of the large amount of grain available, whiskey was relatively inexpensive and easy to make. In fact, whiskey was cheaper than coffee. Thus, in colonial America, whiskey became the drink of choice, and there were few moral judgments about its use and the user (Spurling & Leonard, 1993).



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## AMERICAN REVOLUTION AND YOUNG REPUBLIC (1763–1820s)

Despite the widespread use of alcohol and tobacco among the early American settlers, there were those who started to realize the negative impacts of alcohol. Dr. Benjamin Rush, a founding father of the United States and signer of the Declaration of Independence, was one of the first to draw attention to the possible negative effects of alcohol on the human body. Dr. Rush warned that the drinking of alcohol could cause mental and physical health issues that could lead to death (Thombs, 2006). In 1790, Dr. Rush included the "moral thermometer" in his book titled *An Inquiry Into the Effects of Spirituous Liquors on the Human Body*. Dr. Rush's (1790) moral thermometer is a visual scale (represented by a thermometer) showing the progress from temperance to intemperance caused by the effects of liquor on humans. The categories on the temperance portion of the thermometer ranged from water to strong beer and from weak punch to pepper in rum on the intemperance portion of the thermometer. The scale also visually depicts the consequences humans might experience as they move down the intemperance portion of the thermometer. Those consequences ranged from vices to suicide, diseases to death, and punishments to gallows (Rush, 1790). Dr. Rush is known as one of the original advocates for the concept of humane treatment for addicted people (Durrant & Thakker, 2003; Thombs, 2006). The consumption of alcohol continued to increase in the United States, and the dangers of alcoholism slowly began to creep into the American consciousness. In 1791, the "whiskey tax" was passed. Despite the heightened awareness of the excessive use of alcohol, the passage of the excise tax was more about paying down the national debt than it was about curbing the use of alcohol by Americans. This terribly unpopular excise tax was repealed in 1801 (Durrant & Thakker, 2003).

Alcohol was also used as a form of control. According to Spurling and Leonard (1993), slaves were given alcohol to keep them on the plantations, and Native Americans were often provided with alcohol during trade and treaty negotiations in an effort to hinder their negotiation abilities. With alcohol literally flowing through all aspects of American life, public drunkenness was not uncommon. As Dr. Rush had predicted, alcohol-related illnesses and deaths were on the rise. American consumption led to a number of societal issues. One issue was an explosion in the population of debtor prisons. Some estimates show there were as many as 50,000 people per year entering these prisons (Spurling & Leonard, 1993). There was no social safety net such as welfare or social security during this time for those experiencing social and personal ills (Spurling & Leonard, 1993).

## TEMPERANCE MOVEMENT (1826–1919)

Because the use of alcohol was so prominent in early American society and the lack of understanding of what effect excessive alcohol use could have on the human body, there was little concern about drinking or even public drunkenness. Excessive drunkenness led to domestic violence and the abuse of women and children, which resulted in a call for moderation. It was becoming more evident that there was an alcohol issue in America and something had to be done.

The temperance movement was born out of the acknowledgment that the issue of drinking had to be addressed. This movement was originally led by clergy in the United

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States (Spurling & Leonard, 1993). The goal was to curb excessive drinking and public drunkenness through gentle moral persuasion. Originally, the key message of the temperance movement was to view alcohol use through the lens of moderation. This concept was tied directly to linking moderation to the importance of one's personal relationship with God. The key message of the movement was that each individual was a servant of God, and using alcohol often led to becoming a drunk, and drunkards could not serve God well. In other words, drinking prevented the formation of a positive relationship with God and therefore was considered bad (Spurling & Leonard, 1993; Thombs, 2006). A number of organizations were born out of the temperance movement, from the Washingtonians to the Women's Christian Temperance Union and the Anti-Saloon League. As the movement grew, the message soon became one of abstinence rather than moderation (Durrant & Thakker, 2003). According to Hanson (1999), by the late 1830s, there were more than 1.5 million people belonging to more than 800 temperance-related organizations in the United States.

Ironically, one of the fathers of the temperance movement, the Reverend Lyman Beecher, had put himself through school selling alcohol on the side. Unlike the original moderate messaging, Reverend Beecher preached a message of abstinence. Reverend Beecher's work shifted the tone of the message from one of moderation to a message that any use of alcohol was bad. This was the beginning of what became and is still known today as the moral model (Spurling & Leonard, 1993).

During this period, people were asked to take a pledge of abstinence by signing their name and placing a *T* next to their signature. The *T* indicated the individual had agreed to become a teetotaler and had promised to avoid all consumption of alcohol. Not everyone accepted the teetotaler approach. Many within the movement did agree to avoid all alcohol whereas others only agreed to avoid hard alcohol but decided to continue to indulge in drinking wine. As a result of these efforts, Americans were drinking far less than they had in the previous decade (Spurling & Leonard, 1993). By 1840, Americans were drinking roughly 3.1 gallons per person per year compared with 7.1 gallons per person per year in the early 1830s (Goode, 1993).

Whereas there was a focus on the harmful effects of alcohol and ways to stop it, America was simultaneously seeing a dramatic increase in the number of opioids being imported. From 1840 to 1870, opioid imports grew at 7 times the rate of the population (Spurling & Leonard, 1993). The main reason for the increase in opioids was that physicians were using them for a number of medicinal purposes. During this time, opioids were often used as painkillers. With the isolation of morphine and hypodermic medications, doctors began prescribing opioids for all kinds of health issues. The unregulated and seemingly unlimited use of opioids by doctors resulted in a whole new era of addiction. During this era, many doctors and their patients became addicted to drugs. These substances were legal, and many were accessible over the counter. No governmental regulations existed during this time (Durrant & Thakker, 2003). Hypodermic needles were also readily available, and in fact, hypodermic kits were available in the 1897 Sears Roebuck catalog for under $2.00 (Spurling & Leonard, 1993).

Opioids were seen as a "cure-all" and used by most of society. Some ads depicted mothers describing how their crying children would calm down after being given their medicine. Little did they know, their children were probably suffering from withdrawal, so of course, a

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little more medicine would help calm their children down. Because so little was understood about the long-term effects of these medications, many people did not realize they had become addicted until it was too late (Spurling & Leonard, 1993).

Like alcohol, the widespread use of opioids had huge societal implications. Opioid addiction crossed all socioeconomic boundaries. According to Durrant and Thakker (2003), the typical user of opiates by the 1920s was over the age of 30, Caucasian, female, and middle class. Often these women became addicts as the result of being prescribed an opioid to combat some type of medical condition or physical pain. However, no one was immune from the use of and subsequent addiction to opioids. According to Spurling and Leonard (1993), the upper class frequented opioid dens, which were originally viewed as exotic and tended to indicate a certain social status. Simultaneously, the lower classes used opioids to cope with everyday stresses. Cocaine was also widely used as a recreational drug and stimulant. It was during this period that the intersection of drug use and ethnicity in America became visible. For example, African American males who worked as longshoremen often used cocaine as a stimulant to help them get through their long shifts of loading and unloading container ships (Spurling & Leonard, 1993). The Chinese immigrants who came to America to work on the transcontinental railroad and in mining often turned to opioids as a means of escaping their harsh realities. For many Chinese immigrants, opium dens were accepted in their cultures and in fact were seen as a source of cultural and racial identity (Spurling & Leonard, 1993).

By the 1880s, many Americans started to realize there was a problem with drug and alcohol addiction in the United States. Americans began to enter treatment facilities and hospitals for periods of time as they went through the withdrawal process. In 1879, the Keeley Institute opened its doors as one of the first organizations to serve those suffering from alcoholism (Spurling & Leonard, 1993).

Many people who either attempted to treat themselves at home or checked themselves into a treatment center found they were still yearning for drugs and alcohol upon completion of their treatment program. They simply could not seem to wean themselves from the addictive substances. It was during this time that the public, helped by the American media, pushed for assistance in fighting substance use disorders (Spurling & Leonard, 1993).

In 1906, after 27 years of debate, the Pure Food and Drug Act passed in Congress. The law required all manufacturers of patent medicines to place ingredients known to be addictive or dangerous on the product label. The law included alcohol, morphine, opium, and cannabis on the list of ingredients known to be addictive or dangerous. The Pure Food and Drug Act did not prevent these medications from being sold over the counter. However, this act was one of the first steps in the regulation of drugs in the United States. By 1909, the Smoking Opium Exclusion Act was passed. This law made it a criminal offense to be in possession of opium for nonmedicinal purposes (Durrant & Thakker, 2003).

By 1900, there were an estimated 1 million addicts in the United States (Spurling & Leonard, 1993). Even though addiction was prevalent across all socioeconomic levels, how addiction was depicted by social class and race differed tremendously. For example, the African American longshoremen and Chinese laborers were depicted negatively and labeled as drug users. Opium smoking had become associated with the Chinese laborers, and there was a fear among some in white society that cocaine would empower African Americans to

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fight against the oppression and discrimination they were experiencing at the hands of the dominant white leaders (Musto, 1999). It was during this era when the dangers of drug use and the prejudices associated with minorities were linked. It is a connection that still permeates our society today. It was also during this period that messaging about substance use disorders started being manipulated by lawmakers for political purposes.

One of the first bills passed by Congress during the early 1900s was the Harrison Narcotics Act of 1914. It ushered in tighter regulations on opiates and cocaine. After the passage of the law, many doctors came under scrutiny for prescribing heroin and other drugs to addicts (Sharp, 1994; Spurling & Leonard, 1993). In fact, according to Sharp (1994), "There is some evidence that between 1915 and 1938, more than 25,000 physicians came under the scrutiny of federal agents enforcing the Harrison Act and about 5,000 were convicted and fined or jailed" (p. 20). This governmental crackdown was further supported by the Supreme Court ruling in *Webb et al. v. United States* (1919), which stated that doctors could not prescribe opiates to addicts as a form of treatment. This effectively halted the existence of maintenance treatment programs for addicts. The Supreme Court ruled the Harrison Narcotics Act was constitutional and that because addiction was not considered a disease, doctors could no longer prescribe opiates to addicts (Sharp, 1994).

This Supreme Court ruling is often viewed as the beginning of the criminalization of drug users and the basis upon which much of the drug policies of the United States have been built. In one ruling, the Supreme Court in essence criminalized an entire group of people. This ruling also reinforced the narrative that substance users were criminals and deviants simply looking for self-gratification and pleasure (Sharp, 1994; Spurling & Leonard, 1993).

## PROHIBITION (1919–1933)

The Prohibition era was ushered in partly due to a number of new technologies that allowed for the faster and cheaper manufacturing of alcohol. The amount of grain available in the United States and the ease of making alcohol only led to the continued increase in alcoholism in America. By 1913, many Americans began to consciously acknowledge the impact alcohol abuse was having on society. The temperance movement and Prohibition efforts were a strong political force between the 1840s and the 1930s. The temperance movement had led to over 50% of Americans living in dry counties, which are counties that do not allow the sale or distribution of alcohol (Spurling & Leonard, 1993).

Prohibition really began to take shape during World War I in the years after the United States joined the Allies against Germany in April 1917. During the First World War, it became unpatriotic to drink alcohol in the United States. Grain that had been used for making alcohol was now needed to support the American troops. Ironically, World War I ended before Prohibition was fully enacted across the United States. In 1919, the Eighteenth Amendment of the Constitution was passed, and Prohibition became the law of the land on January 18, 1920. The constitutional amendment banned the sale, production, importation, and transportation of all alcoholic beverages. Prohibition was repealed 13 years later in 1933 (Spurling & Leonard, 1993).

Prohibition is often credited with creating the environment that allowed an entire new class of criminals to be born. Organized crime rings began to pop up, and an entire black

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market was created for the production, sale, and transportation of alcoholic beverages in the United States. Storefronts, which became known as speakeasies, sold cigars and magazines in the front and illegally sold alcoholic beverages at a bar in the back of the store (Spurling & Leonard, 1993).

Enforcing Prohibition was a difficult task for the United States government. During this time, the alcohol produced in the United States was of inferior quality. It was often referred to as bathtub gin because of the poor quality of the homemade spirits. Better-quality alcohol was illegally imported from Canada, which only perpetuated the increase in organized crime (Spurling & Leonard, 1993).

Prohibition had a big impact on American culture. American alcohol consumption decreased by 50%, and overall alcohol-related health problems also saw a decrease (Spurling & Leonard, 1993). However, these two decreases were offset by an increase in violence due to organized crime and accidental deaths from poisoning from black market alcohol. The economic toll on the United States was significant. Originally, approximately $5 million was budgeted by the United States Congress to ensure compliance with Prohibition. By the time Prohibition was repealed, the budget had increased to over $300 million (Spurling & Leonard, 1993). Instead of continuing to increase the budget of the United States to control the production and sale of alcohol, Congress moved toward a regulation and tax model. The repeal of Prohibition gave people access to much-needed jobs during the Depression as well as a much-needed tax base for the United States government. Once again, political forces were at work in terms of how drug and alcohol abuse were being portrayed by the United States government and in the American media.

## WORLD WAR II ERA (1939–1945)

Perhaps one of the greatest influencers on shaping America's drug policy was Harry Jacob Anslinger. He served as the first commissioner of the U.S. Treasury Department's Federal Bureau of Narcotics (FBN), which was formed in 1930. Anslinger was a staunch supporter of Prohibition and the criminalization of drugs. He held office for an unprecedented 32 years, and his impact can still be felt on America's drug policies today (Sharp, 1994). His philosophy was a very simple, straightforward view of addiction—drug and alcohol use was bad. He believed all drugs, users, and pushers should be eliminated from society. Anslinger's efforts resulted in the first American "war on drugs" (Spurling & Leonard, 1993). He was a master of leveraging organized groups like the General Federation of Women's Clubs, the Women's Christian Temperance Union, and the World Narcotic Defense Association to support his cause (Sharp, 1994).

During the early Cold War era, drug sales and use were often depicted as a Communist plot to place fear in the minds of many Americans. The war on drugs only increased during this period and resulted in several significant legislative acts. In 1951, the Boggs Act was passed, which required mandatory jail sentences for marijuana and narcotic trafficking (Sharp 1994; Spurling & Leonard, 1993). The Boggs Act "mandated a combination of fines of up to $2000 and a minimum sentence of two to five years for first offenders and five to ten years for second offenders, with no possibility for probation or a suspended sentence" (Sharp, 1994, p. 22). The Narcotics Drug Act of 1956 further tightened the penalties for selling drugs. Members of Congress who supported this act had sought a mandatory death

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penalty for drug smuggling. However, the death penalty was not included in the final bill. But the act did require the death penalty be imposed for those found guilty of selling heroine to minors (Sharp, 1994).

According to Spurling and Leonard (1993), substance use by African Americans, Hispanics, and Asians was being portrayed as criminal, and the use of alcohol and tobacco by the middle and upper class was at times being portrayed as sophisticated and sexy. Actors and actresses were often seen in movies and on television smoking and drinking in a number of social settings. The use of alcohol and tobacco had steadily increased since the repeal of Prohibition (Spurling & Leonard, 1993).

## NIXON ERA (1969–1974)

The first antismoking warnings started to be published by doctors in the early 1950s (Spurling & Leonard, 1993). By 1964, the first surgeon general warning about cigarette usage appeared. Despite the surgeon general warnings, cigarette sales continued to increase. During the sixties, marijuana and pot smokers became symbols of the peace movement. It was President Richard Nixon who declared total war on public enemy number one—drugs. There was concern about the amount of drug use among Vietnam veterans returning to the United States after such a long and unpopular war. By the 1970s, the perception was that many local law enforcement agencies and police departments were not actively investigating and arresting recreational drug users. To combat the growing concern over the availability of drugs in America, the U.S. government created the Drug Enforcement Administration (DEA) in 1973 under the Department of Justice (Spurling & Leonard, 1993). The DEA was formed by combining two agencies—the Bureau of Narcotics and Dangerous Drugs (BNDD) and the Office of Drug Abuse Law Enforcement (ODALE) (Sharp, 1994).

These agencies and their missions provide another example of the politicization of the American approach to drug users and sellers. Sharp (1994) documented that both agencies were created as a result of an executive order issued by President Nixon. With both agencies under the direct control of the White House, Nixon could control his message about drug use and drug users and hoped to curb the efforts of those resistant to his drug policy goals (Sharp, 1994). Sharp (1994) points out that the mission of ODALE was "simply the escalation of arrests against street-level dealers" (p. 26). The BNDD's mission was to focus on the capture of higher-level drug dealers, which was in direct conflict with the Nixon administration's current approach of focusing on the lower-level street dealers and users (Sharp, 1994). As Sharp (1994) points out, this approach placed an enormous strain on the criminal justice system. Yet there was little disruption to the overall drug trafficking issue it had been implemented to address. As lower-level street dealers were captured and arrested, they were simply replaced by higher-level drug dealers (Sharp, 1994). The increased number of people coming through the criminal justice system "led to coping devices such as plea bargaining, dropped charges, and early release from prison, thus turning the massive-arrest strategy into meaningless 'revolving-door' justice" (Sharp, 1994, p. 27).

During this time, the depiction of the use of marijuana and cocaine continued to be seen in popular culture. Many upper- and middle-class Americans were often portrayed as indulging in the use of these substances in movies and on television. It was as if the collective

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memory of America had faded and the issues of addiction experienced a generation ago were front and center again in American culture (Spurling & Leonard, 1993).

President Nixon did not focus only on the law enforcement aspect of substance addiction in the United States. Sharp (1994) suggests that perhaps one of the most interesting aspects of Nixon's war on drugs was his focus on drug treatment. In June 1971, in a Special Message to the Congress on Drug Abuse Prevention and Control, Nixon asked Congress to amend his 1972 budget and to provide an additional $155 million (bringing the total designated for drug control programs to $371 million) (Woolley & Peters, 1999). Even though Nixon was asking Congress for money to support drug treatment, he continued to describe America's drug problem as a national emergency and framed drug addicts as less than and often as the dregs of society (Woolley & Peters, 1999).

## CARTER ERA (1977–1981)

President Jimmy Carter deviated from Nixon's very public depiction of drug users as criminals who must be dealt with swiftly and harshly. For example, the Carter administration's drug policy was based on a wellness rather than a criminal approach (Sharp, 1994). The drug policy during the Carter years was rooted in prevention and treatment programs and focused on improving existing policies and programs. One of the leaders of Carter's new drug policy was Peter Bourne. Bourne, a physician who had worked in the field of mental health and substance use, was a longtime supporter of Jimmy Carter. After Carter's election in 1976, Bourne became his chief drug policy adviser and was named director of the Office of Drug Abuse Policy (ODAP) (Sharp, 1994).

Peter Bourne's work experience and educational background brought a very different perspective regarding how to approach the nation's drug policy (Sharp, 1994). There were three main themes to Carter's drug policy agenda: (a) a balanced approach to the drug issue, (b) a focus on research and less focus on creating a public frenzy around drug use in America, and (c) a reorganization of the nation's approach to creating drug policy (Sharp, 1994). The Carter administration's more balanced approach shifted the focus onto the problem of prescription drug use and abuse as much as the Nixon administration had focused on illegal drug use.

Perhaps the largest shift in drug policy during the Carter years was the push for the decriminalization of marijuana (Sharp, 1994). In March 1977, the U.S. House of Representatives Select Committee on Narcotics Abuse and Control heard testimony on the topic of the decriminalization of marijuana. The Carter administration supported reviewing the potential medical uses of marijuana and addressed the harsh penalties imposed on marijuana drug offenders.

A number of changes were made to existing laws from 1967 to 1970 (Sharp, 1994). According to a summary of the House Select Committee on Narcotics Abuse and Control hearings, there were stiff federal penalties already in existence for certain federal drug offenses. For example, some first offenses carried from 5 to 20 years in prison, and second offenses resulted in 10 to 40 years in prison (U.S. House of Representatives, Select Committee on Narcotics Abuse and Control, 1977). However, when the Controlled Substance Act was passed by Congress in 1970, it repealed all prior federal legislation and allowed for reduced penalties for federal drug offenses. The new federal penalty for a first offense of simple

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possession and/or distribution was a maximum 5 years in prison and a fine of no more than $15,000. For a second offense, the penalties were doubled. Also, a first offender could be placed on probation for 1 year for simple possession without a guilty verdict (U.S. House of Representatives, 1977).

Despite these reductions in federal penalties that had taken place prior to Carter's election and the focus on medicinal uses of marijuana, the Carter administration failed to decriminalize marijuana (Sharp, 1994). A number of contributing factors led to Carter's failed drug policy. One factor often cited is that of the resignation of Peter Bourne as Carter's chief drug policy adviser under a cloud of controversy. He was accused of using cocaine at a Washington, DC, party, and he was also accused of writing a prescription for a colleague under a false name. As a result of these two incidents, Bourne's credibility was shattered, and along with it, so was the credibility of the Carter drug policy (Sharp, 1994). The Carter administration found it difficult to overcome all the years of portraying drug use and abuse in such a negative light. The grip was so tight that public opinion could not be changed as quickly and easily as some in the Carter administration had hoped (Sharp, 1994).

## REAGAN ERA (1981–1989)

After the failed attempt of the Carter administration to shift the drug conversation away from one focusing on criminalization to one focusing on treatment and prevention, the Reagan years ushered in a reemphasis of criminalizing drug offenders (Sharp, 1994). Even though the drug problem in America was not a key issue debated in the 1980 election, President Ronald Regan began his presidency with a renewed interest in America's drug policy focusing on public awareness and law enforcement (Sharp, 1994).

Several issues drew the American public back into the conversation about drug use. The introduction of a new form of cocaine, crack cocaine, really changed the conversation (Sharp, 1994). By 1986, cocaine was often thought of as the drug of choice among the upper class. Numerous stories appeared in the media describing cocaine use by athletes and celebrities. Because crack cocaine was less expensive than regular cocaine, the use of cocaine crossed all socioeconomic boundaries because it was more readily available to the masses (Sharp, 1994; Spurling & Leonard, 1993). The media images of drugs being used by the wealthy, athletes, and celebrities were replaced with images of "impoverished black and Hispanic individuals" (Sharp, 1994, p. 53). Like the Chinese and African American laborers of the 1920s and 1930s, drug users were once again being depicted as criminals and ethnic minorities (Sharp, 1994). By the mid-1980s, when Americans were polled about their concerns about the biggest threats to America, drug use often polled as the number one concern (Spurling & Leonard, 1993).

Another contributing factor to Americans' increased fear of drugs and drug use was the spread of the newly identified disease acquired immune deficiency syndrome (AIDS) (Sharp, 1994). Because so little was known about the spread of this deadly disease, a lot of fear and social stigma was associated with it. The fact that AIDS was known to spread among intravenous drug users only fueled the growing fears of drug use in America (Sharp, 1994). These fears became interwoven into the overall drug narrative of the late 1980s.

In order to address what was being dubbed a drug epidemic, the Just Say No campaign was born. First Lady Nancy Reagan began to make a number of public appearances with the

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sole purpose of bringing an awareness of illegal drugs and drug use to the American public (Sharp, 1994). In September 1986, President Reagan and the first lady gave a nationally televised speech during prime time to reach as many Americans as possible. The speech was intended to increase the public's awareness of the current drug issues facing America (Sharp, 1994). Excerpts of the speech were printed in the *New York Times* the following morning. Nancy Reagan was quoted as saying, "Drugs take away the dream from every child's heart and replace it with a nightmare. . . . There's no moral middle ground. Indifference is not an option. . . . Our job is never easy because drug criminals are ingenious" ("Excerpts From Speech," 1986).

Despite the increased emphasis on public awareness, critics of the Reagan administration point out that no new funding was sought to develop treatment and prevention programs during this time. The emphasis had once again shifted to abstinence, law enforcement, and criminalization of users (Sharp, 1994). To boost the law enforcement portion of the approach, harsher laws were passed in Congress, including the Anti-Drug Abuse Act of 1986. This law required minimum sentences for the distribution of cocaine and crack cocaine. First-time offenders for possession or intent to sell were to receive a minimum of 5 years in prison. These harsher penalties continue to contribute to the high incarceration rates found in the United States (Capuzzi & Stauffer, 2016).

## THE 1990s AND 2000s

Despite all the Just Say No efforts, by the 1990s there was a sharp increase in drug use among 13- and 14-year-olds (Spurling & Leonard, 1993). The most popular drugs of choice were still marijuana and cocaine. Often the experimentation with marijuana by teens led to more frequent use and a desire to explore other, more dangerous drugs over time (Spurling & Leonard, 1993).

One of the tangible results of the war on drugs that has gained national attention in recent years is the issue of mass incarceration. By the early 2000s, and after 9 decades of trying to combat drugs, the United States had one of the highest incarceration rates related to drug use in the world. According to a press release from the Department of Justice, Bureau of Justice Statistics (2003a), the "growth in the federal system from 1995 to 2001 (up 61 percent) is attributed largely to the increase in drug offenders (accounting for 48 percent of the growth)" (p. 1). The 2002 statistics are staggering in that "1 in every 143 U.S. residents were incarcerated in State or Federal prison or a local jail" (Department of Justice, Bureau of Justice Statistics, 2003b, p. 2). And the high rate of incarceration has continued throughout the mid-2000s. The latest Bureau of Justice Statistics report, *Prisoners in 2014*, shows that "6% of all black males ages 30–39 were in prison, compared to 2% of Hispanic and 1% of white males in the same age group" (Department of Justice, Bureau of Justice Statistics, 2015, p. 1). As of September 2014, 50% of all males and 59% of females serving time in federal prison are there because of a drug offense (Department of Justice, Bureau of Justice Statistics, 2015).

As America's war on drugs continues, now more than ever, the statistics show that those belonging to lower socioeconomic and minority ethnic groups represent those feeling the effects of the criminalization of substance use offenders. According to the United States Sentencing Commission (1998), possession of powder cocaine is a state offense. However,

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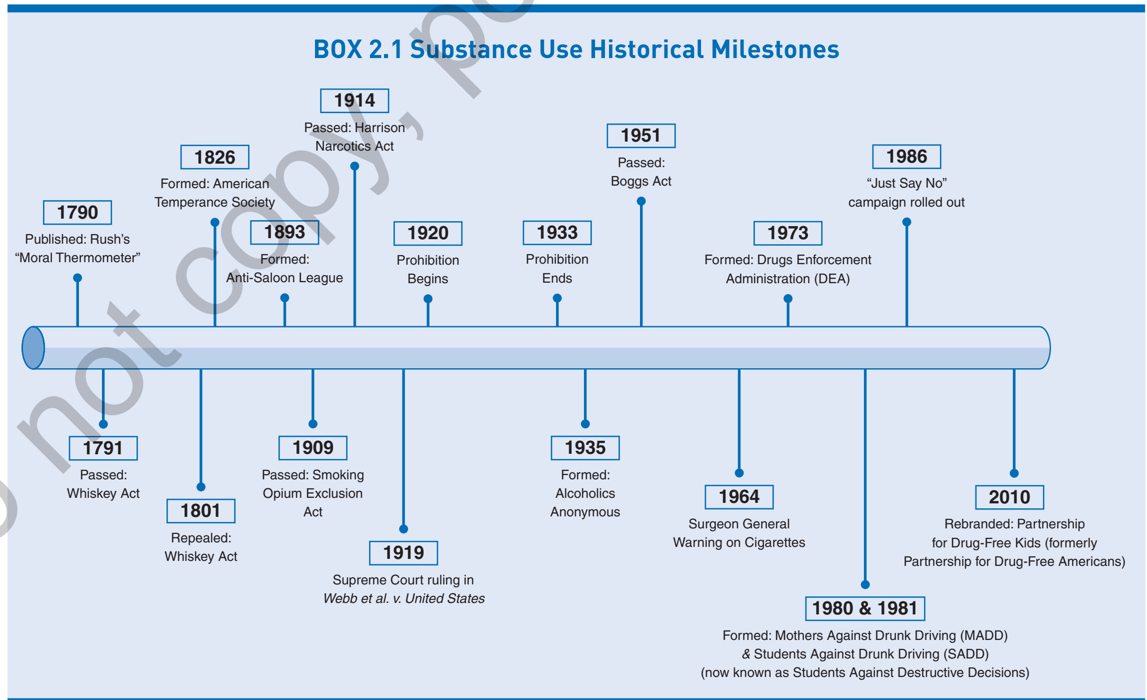
possessing an equal quantity of crack cocaine carries a minimum of 10 years in federal prison if convicted. Ever since this distinction was first made in 1988, 95% of those sentenced for crack offenses have been African American (Caulkins, Rydell, Schwabe, & Chiesa, 1997). These conviction rates are despite the fact that according to the nonprofit human rights organization Human Rights Watch, illegal drug use is proportionally higher among whites than blacks. One of the key areas of focus on the war on drugs has been the possession and sale of crack cocaine by African Americans (Human Rights Watch, 2000, p. 2). According to Human Rights Watch (2000), "Crack cocaine in black neighborhoods became a lightning rod for a complicated and deep-rooted set of racial, class, political, social, and moral dynamics" (p. 2).

The racial divide continues as black males in urban areas are often targeted for drug offenses. This marginalized population is often an obvious target of law enforcement because it is easy for police to find offenders on the streets in urban areas, and it is easy for the media to capture footage of these types of arrests compared with drug offenders living in suburban, predominately white neighborhoods (Spurling & Leonard, 1993). These specific drug issues are often more visible in predominately poor urban minority neighborhoods than they are in middle- to upper-class white neighborhoods (Human Rights Watch, 2000).

Whereas so much focus has been given to the selling and use of illegal drugs in the United States, the two most legal drugs are still arguably the most lethal—alcohol and tobacco. Despite stronger driving while intoxicated (DWI) laws, and the ongoing focus on prevention and awareness programs about the dangers of tobacco use, it must not be

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forgotten that these two legal drugs still account for large numbers of deaths each year in the United States. From 2005 to 2009, smoking was responsible for more than 480,000 premature deaths annually among Americans 35 years of age and older (U.S. Department of Health and Human Services, 2014). According to the Centers for Disease Control, there were approximately 87,000 deaths from 2006 to 2010 that can be attributed to the excessive use of alcohol (Centers for Disease Control and Prevention, 2013).

This historical journey of drug use and addiction within American culture has been reflective of changing attitudes and social constructions across various eras. It is clear that there has been no essential truth about what addiction is and about how we as a culture should treat the problem. When one considers the tapestry of cultures that make up American society, this epistemology of addiction becomes even more complex.

## CULTURAL VIEWS OF ADDICTION

Cultural and ethnic views regarding alcohol and drug use are interwoven with cultural and ethnic identities. Alcohol and drug use are often associated with specific racial groups, and these stereotypes can be difficult for these groups to overcome. For many cultures, alcohol and drug use is a part of normal social activities that often bind a group of people together.

Alcohol was introduced to the Native American culture by Europeans coming to the New World. For many Native Americans, alcoholism has had long and devastating effects on their population. According to Porter and Teich (1995), the alcoholism rate among Native Americans is "5.4 times higher than it is for all races in the United States" (p. 133). There are several theories regarding why alcoholism is so high among Native Americans, and most of those theories focus on the significance of drinking in social settings. For example, many older Native American men have incorporated drinking as part of traditional ceremonies as well as during parties held in Native American homes (Porter & Teich, 1995). Another often-cited reason for high rates of alcohol use by Native Americans is that the rates are due to their acculturation process and are a result of their way of dealing with stressors such as poverty and other social issues (Porter & Teich, 1995).

The impact of alcohol on Native American culture should not be underestimated no matter what the root cause. Also, the diversity that exists between Indian people in terms of age, gender, tribal culture, and social organization must also be considered when looking at the use of alcohol among Native American population subgroups (Porter & Teich, 1995; Straussner, 2001). Even though alcohol use among Native Americans should not be associated with old stereotypes, the use of alcohol in this population has become a part of the Native American cultural identity, and those associated stereotypes are difficult to overcome (Heath, 2000).

Alcohol also plays a key role in Jewish culture. Drinking is largely done at home with family and as part of family celebrations. For many Jewish people, one's ability to use alcohol in moderation is often seen as a form of self-control and is not necessarily considered a vice (Thombs, 2006). According to Heath (2000), for many Jewish people, part of celebrating the traditional Sabbath involves having a glass of wine before and after the Sabbath meal. Heath (2000) suggests that within the Jewish culture, "we have a population with no abstainers but also one with virtually no problem drinkers" (p. 90). Perhaps this can be explained due to the fact that often drunkenness within the Jewish culture is viewed as negative and

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inexcusable (Thombs, 2006). Straussner (2001) found that in fact, "Jews appear to have a lower rate of alcoholism or alcohol dependence than is found among the general population in the United States" (p. 302).

According to Vaillant (1983), of all the ethnic groups, the Irish are almost 7 times more likely to suffer from alcoholism than people from Mediterranean cultures. Thombs (2006) suggested that "although on one hand drinking is viewed as the 'curse of the Irish,' on the other it is seen as the quintessential Irish act, one embodying all that is 'Irish.' In a symbolic way, drunkenness connects the Irish to all of their similarly anguished ancestors" (p. 239).

According to Heath (2000), alcohol consumption varies from culture to culture as does the type of most desired alcoholic beverage. For example, the countries of Russia, Portugal, Spain, France, Italy, and Greece can be classified as "wet" cultures based on the annual alcohol consumption and the social norms associated with drinking in those countries. "Dry" countries include India, Israel, and Saudi Arabia as well as some Hopi and Cantonese cultures.

Heath (2000) also suggests that based on a culture's predominant beverage, certain countries can be classified as wine, beer, or hard liquor (spirits) cultures. Beer cultures include England, Australia, Austria, and Germany. He suggests that Portugal, Chile, Argentina, and France are wine cultures. Japan, Russia, some Scandinavian countries, and the Gaelic and Eskimo cultures tend to drink spirits. Heath (2000) also states that people in any culture may partake in all three types of alcoholic beverages or none at all depending on the social and cultural context in which they live.

Similar to the way drinking is often associated with the Irish culture, opium smoking is often associated with the Chinese culture (Durrant & Thakker, 2003). As discussed earlier, opium smoking among Chinese immigrants in the United States had a large social aspect to it. The cultural aspect of Chinese opium usage was often "at odds with the American orientation toward productivity, action and settling the West" (Thombs, 2006, p. 241). As a result, even though opium smoking was considered acceptable by Chinese Americans, it was frowned upon by the dominant American culture and viewed within the racist context of foreigners who were corrupting American culture (Durrant & Thakker, 2003).

Substance use and abuse cannot be viewed solely through a historical lens but must also be viewed through the lens of what is considered acceptable cultural and social norms within unique populations. As has been discussed here, what some cultures consider immoral, other cultures consider to be perfectly acceptable.

## BASIC TENETS OF THE MORAL MODEL

As we can see, the moral model of conceptualizing addiction evolved from historical use/abuse and attempts to remedy its impact on society. The moral model assumes that addicted people refuse to abide by ethical or moral proscriptions of conduct and that their behavior is freely chosen. Excessive drinking or other drug use is viewed as an expression of irresponsibility, sinful behavior, and even evil possession. The addict is defined as a transgressor who is engaged in morally wrong behavior. Because this position assumes that people are free to choose their behaviors, addicted people are not seen as being literally "out of control" of their addiction as in other models. They instead are seen as choosing to create suffering in themselves and family members and can therefore be justifiably blamed for

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their behavior. Because the behavior is seen as freely chosen, the most logical way to treat the problem is to punish the transgressor. Therefore from this perspective, the best remedy is to create legal sanctions, provide stricter jail sentences, and increase fines to control and punish the user. Punishment is preferred over providing care or help to the addicted person. Relapse is considered evidence of the enduring evil and sin present in the person and a sign that further, more intense punishment is needed.

## STRENGTHS AND WEAKNESSES OF THE THEORY

There are several advantages and disadvantages of the moral model perspective on addiction. One positive aspect of this theoretical perspective is that it is straightforward, simple, and clear. There is little ambiguity or complexity about the causes or nature of addiction, and the remedy is clear. There is no need to examine social, biological, psychological, or spiritual factors related to the epistemology of addiction. Addiction is not seen as a complex issue with many influences and underpinnings. The behavior is seen simply as wrong or sinful, and the application of punishment can be clearly applied. From this perspective, increases in rates of addiction throughout our society are attributable to widespread "moral decay," and calls for a return to "traditional family values" are made to remedy the problem.

One of the disadvantages of the moral model is that scientific research has shown that addiction is an extremely complex problem with multiple contributing factors. In many ways we have just begun to understand the complex nature of addiction from biological, social, psychological, and spiritual perspectives. Scientific evidence suggests that contributing factors to the development and maintenance of addiction are apparently related to genetic predispositions, environmental factors such as family structure, and biological changes in the brain after use over a prolonged time. Another disadvantage to the moral model is that it is not clear at all that addictive use is freely chosen and a matter of free will. In fact, many models discussed later in this book take opposite positions and offer evidence that addictive behavior is out of the control of the individual and that the brain is actually hijacked by the introduction of chemicals. Likewise, in terms of sociological factors, various social policies in U.S. history have contributed to the systemic addiction of populations such as the use of alcohol to control slaves and Native Americans to make them more compliant. In contrast to the freely chosen tenets of the moral model, these external contributing factors to the onset and maintenance of addiction are outside of the control of individuals. Another disadvantage to the moral perspective is that punishment has not been shown to decrease rates of addiction. In fact, an emphasis on societal sanctions and prohibitions against drug use and drug users have historically resulted in increases in organized crime, created lucrative and dangerous underground markets, and overloaded prisons at significantly higher costs than providing treatment.

Whereas the moral model is not an organized and officially adopted model for addiction treatment, it is present in our history and our belief systems both culturally and personally. This makes it difficult to research as a treatment model, but the evidence mentioned earlier does not support its usefulness. Despite questions about the efficacy of this model, this view of addiction as immoral conduct has tremendous influence over social policies.

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## INFLUENCES ON SOCIAL POLICY

The moral model emerges during each political season and can be seen in political campaigns of conservative groups who attempt to appeal to public sentiment by proposing tougher penalties to stop the moral decay and widespread impact of addiction. This sentiment appeals to the general population likely because many still view addiction and drug use as sinful, and many have been personally harmed by addicts. Any promise to control what feels out of control morally is attractive despite repeated failed attempts by the government to eliminate addiction with legal crackdowns (e.g., Chinese opium smokers of the 1800s, Prohibition). Richard Nixon called drugs "public enemy number one" in the 1970s, which eventually influenced the creation of the Just Say No campaign of the 1980s. In the mid-1980s, polls showed that the American people believed that drugs and drug use was the biggest problem in the country. The Just Say No campaign has been seen as a contributor to the prevalence of the moral model in that drugs were framed as bad and drug users were framed as bad people. The message was clear that addictive behavior was seen as a choice and a problem to be punished. It was actually another oversimplification of the problem that insinuated that if people were morally strong enough they could avoid addiction. Ronald Reagan kept saying "we are going to take back America." From this view, addiction has nothing to do with social context, growing up in poverty, being raised by addicted parents, or the effects of oppression; it is just a matter of having the moral fortitude to say no. Those who cannot say no become one of "them" or the "other," and you do not want to be one of "them."

It is important to acknowledge that our history heavily influences modern-day policies. In terms of public drug policy, our history has brought us to vacillating and often contradictory assumptions involving morality and disease. As a society we believe on the one hand that addiction is a disease, but we punish the addict for the behaviors associated with the disease. Peele (1996) called this the "disease law enforcement model." For example, the temperance movement created a combined disease-moral model that can be seen in the way punishment is given by drug courts to DWI offenders (Thombs, 2006). Offenders are often forced to participate in treatment or 12-step groups in addition to fines and incarceration depending on the number of offenses. Further, employers require addicted employees to

### BOX 2.2 Activity—Self-Exploration

1. What was the first reference to addicted people you ever remember hearing?
2. What do you remember about the first person you ever saw or met whom you identified as addicted?
3. What messages did you get from your parents or family about addicted people? How have those messages influenced your beliefs?
4. Some things about addicted people that concern me are ________________________.
5. Morally I think addicted people are ____________________________________________.
6. Some things I anticipate I might struggle with when counseling a person who is addicted are ________ _______________________________________________________.

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attend treatment under the threat of job loss. As a society, we are left with a confusing conceptualization about the nature of addiction and how we must treat it, as well as social norms about what is acceptable and unacceptable substance use.

## INFLUENCES ON CLINICIANS

Clinicians often bring their own experiences with addiction into their work. Many have been either directly or indirectly affected by addiction. Some are adult children of alcoholics, some have struggled with their own addictions, and some have had relatives and friends who have suffered with addiction. Most of us carry some preconceived ideas about addicted people, and many of those perceptions come out of painful feelings associated with those we know. We are naturally judgmental beings, and those judgments can closely resemble the notions at the core of the moral model. How we view addiction and its causes directly affects how we choose to treat it. If we have witnessed someone close to us struggle with addiction, we may judge them based on our personal feelings. If you have unfinished business around an addicted person in your life, you may project those feelings onto your addicted clients. We may believe that they are just not trying hard enough or that they should have more willpower.

Depending on our background, we may believe that the addicted person can find a cure for his or her problems in the context of religion. If you are in recovery yourself and religion or spirituality helped you, you may impose that same path on your clients. Regardless of your beliefs in what causes and maintains addiction, it is difficult not to feel judgmental when someone with eight arrests for DWI kills an innocent college student on the way home from school. Likewise, it is difficult to work nonjudgmentally with a recidivist client who has attended several rounds of treatment without any success. An angry client in extreme denial who proclaims his drinking is not affecting his children may bring up frustration and anger in a clinician. Just as racism, sexism, and homophobia are internalized in us all, the moral model is all around us and in us. Acknowledging and embracing this potential is the only way for these biases to not have undue influence on our interactions with addicted clients. It is important to be able to separate the person from the problem. Examining their own personal vulnerabilities to the negative effects of addiction can help clinicians focus on what is best for their clients. Being politically correct and claiming not to operate from the moral model can in the end be detrimental to our work as addiction counselors.

**BOX 2.3 Activity—Common Myths About Addicted People**

As a group, brainstorm a list of common myths that you have heard about addicted people. What does society generally believe about addicted people? What are the stereotypes? After making the list as a group, deconstruct some of those myths to discover the underlying beliefs or assumptions. For example, if "addicted people lack willpower" is on your list, what is the underlying assumption? It may mean that the myth is based on the idea that addiction is a choice. It may be particularly useful to explore conceptions of denial and resistance in this discussion as well. Discuss how these myths are connected to how we might prescribe treatment for addicted people.

Additionally, clinicians who are working with addicted clients with legal involvement may need to educate probation and parole officers to mediate the influences of the moral model as a form of advocacy for clients. Clients may have their legal status and recovery compromised by a system that may not perceive addiction as a disease or be educated about

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the effects of drugs on the brain. For example, many probation officers are unaware that marijuana stays in the system for 30 days so any drug screens administered during this time would produce a positive result and place the client in violation of probation. The more clients can be treated from an educated perspective and not a judgmental one, the more likely recovery efforts can be supported.

## CASE STUDY RESPONSES

Gabriel seems to be struggling with addiction because of guilt and shame associated with his infidelities and his confusion about his sexual orientation. His irresponsible behavior of dating multiple women while being in a committed relationship reinforces his guilt and shame. Because he was raised in a home that lacked strong family values, he was never afforded the benefits of a strong moral foundation. He seems to struggle with the notions of right and wrong and lacks the personal values to help guide his life choices. Although we don't know much about his childhood, his parents did not appear to provide a religious or spiritual environment to help guide his decision making. The cultural backgrounds of his parents (Native American and African American) may help him find a moral compass through tradition and find support from church and cultural communities. Gabriel lacks the personal willpower to stop using for long periods of time and has not fully grasped the implications of his use and illegal behavior. His legal punishments have apparently not been significant enough to keep him from further transgressions. The penalties have not been harsh enough to convince him to make the choice to change. He also does not fully understand that his misbehavior has impacted his family and his ongoing deliberate use of drugs is out of control, causing the suffering of his family members. His actions are being controlled by evil forces in his life, and his salvation may lie in his acceptance of God's help and a church community. He should stop choosing to use.

The moral model treatment approach to working with Gabriel is very straightforward. It would emphasize a return to traditional or family values and a strong religious component. We would recommend to Gabriel that he find a religious community that would provide a peer mentor and an environment that could guide him in creating a more morally just lifestyle. Daily prayer, devotion, and meditation would be crucial to his recovery. It would also emphasize stronger punishment and legal consequences for his behavior. We would also emphasize his need to find and keep a job to support his family. He would need to place his relationship with God above all else in his life. He needs to explore the relationship between his drug use and his sexual promiscuity, which separate him from serving God well. His confusion about his sexual orientation will be resolved as he becomes stronger in his faith and finds his moral compass.

From the moral model perspective, Gabriel would benefit from more severe punishments for his poor decisions and misbehavior with substances. Through counseling he would be encouraged to place his family first in his priorities and return to the traditional values of his culture. He would also be encouraged to take full responsibility for his misbehavior and immaturity, acknowledging and accepting that his troubles are of his own making. He would be guided to incorporate structures in his life that would provide a moral compass for his behavior.

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From the moral model perspective, no attention is given to the biological, psychological, or social contributing factors in Gabriel's life. For example, from this perspective his many attempts to stop using are not attributable to changes in his brain chemistry, and his predisposition to addiction genetically may be seen as an excuse rather than a factor in his struggles. Likewise, the environmental factors present in his childhood and in his family of origin relationships would not be viewed as contributors to his issues, nor would they be seen as an important part of treatment. The oppression he likely experienced as a biracial person of color would not be perceived as relevant to his psychological issues but rather as an excuse for his bad behavior. Another weakness of the moral model is that there is no scientific evidence that supports the notion that addiction is the result of freely chosen or willful misconduct. Additionally, punishment has not been shown to be an effective means of curtailing substance use.

Some of the strengths of viewing Gabriel's substance use problems from the moral model perspective include that his problems are straightforward and clear. There is no need to overphilosophize or theorize about the causes and maintenance of his issues. His misbehavior and moral deficits are all that need to be addressed if he is willing to address them. He must choose a better life for himself by stopping his use of substances, accepting the consequences of his behavior, and perhaps finding a faith community that will guide him in living a life centered on strong moral values.

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## SUMMARY

The moral model perspective of drug use and addiction has a long and complex history. Early Americans used alcohol regularly and were complacent about its impact on individuals and society. Attitudes have shifted in extremes from this complacency to demonization and criminalization of users and addicted people. Social and political controls aimed at curbing abuse have contributed to the strength of the moral model and resulted in oversimplification of a very complex problem. Addiction counselors may carry internalized biases that reflect moral model attitudes and should work to increase their awareness so that they do not influence their work with clients. Whereas public sensitivity to the struggles of addicted people has increased, many challenges and barriers continue to prevent some from accessing needed treatment.

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