

# Binarisms, Regressive Outcomes and Biases in the Drug Policy Interventions: A Theoretical Approach\*

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*The golden age of drug policy was characterized by the informal regulation of drug use. Formalization of the control over regulation and its increasingly strict, aggressive character led to the emergence of a binary attitude. The main binarisms: pharmaceutical or drug; ban or tolerance; punishment or treatment; psychopathological or pathopsychological approach; subjective or objective knowledge; traditional or alternative. On the basis of Kuhn's paradigm theory, these binarisms can be integrated. Drug policy interventions based on the binary attitude have had regressive effects. Using the work of Sam Sieber, the author distinguishes nine regressive influences: functional imbalance, perverse diagnosis, ricochet, overload, goal displacement, exploitation, provocation, classification, and placation. The regressive influences have caused the escalation of "the drug problem," which in turn has led to further regressive interventions. This vicious circle could be broken by eliminating the four biases—the paternalistic, elitist, rationalist, and activist biases—underlying the regressive interventions.*

**Keywords** binarisms; traditional and alternative; regressive outcomes; drug policy interventions; biases

## Aspirin Paradigm

There is a period in the development of every discipline when its unity is not yet fragmented by diametrically opposed views; there are more common features binding together its practitioners than there are differences dividing them. This could be called the "golden age" of the discipline if we take the golden age to be a time of harmonious unity and endless possibilities.

This is the case for drug policy too. Indeed, drug policy is not only a discipline where examples can be found to illustrate the different stages in its development as an interdisciplinary science: it is a field of science where the legal status of the chemical substances in the focal point of attention also influences the science itself. As a result the various viewpoints are susceptible to manipulation in the legal and political senses, so that they can become instruments and part of power struggles.

The author attempts to show, in this article, that drug policy has split into many different views with two systems of thinking particularly prominent among them. It will be shown that this state of division did not always exist. The splits in drug policies are the result of a special course of historical development.

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\*This paper was presented at the research meeting entitled "Tensions in drug policy in Western Europe" 12–13th May 2003, Helsingborg, Sweden.

This development is characterized by a slow and inexorable process to move from reliance on informal controls to a complex, rigid, anxious, punitive, and absolute system of formal control. This process becomes circular, and the more we legislate, the greater the number, and the more intense the stringency of formal controls, the more certainly it will inform cultural processes, wither, and fade (Berridge and Edwards, 1981).

What the latter-day epidemiologist has to say about the North Thailand research project of Suwanwela et al. (1978), and on the basis of studies of Westermeyer (1973, 1974a, 1974b; Westermeyer and Bourne, 1977; Westermeyer and Peng, 1977a, 1977b) with opium, a society left to find its natural balances comes to no great harm. So far as large tracts of the East are concerned, suppression of opium use has encouraged its substitution by heroin because lesser bulk means easier surreptitious handling. There can be little doubt that the sudden shock to old balances often contributed to bringing about a worse situation than the original.

Make aspirin a dangerous drug tomorrow, ban it from the supermarket, and make it available only on prescription, and within a generation or two the present traditions of aspirin self-medication will have gone without trace. Moves to put aspirin back in the supermarket would then be certain to give rise to appalled protest.

The binarisms outlined later and the two paradigms deduced from them can be traced back to the mechanisms of transformation through which drug policy interventions can be reversed and have a regressive effect. These regressive outcomes are not recognized, as a result of cognitive dissonance reduction. They are in a way reminiscent of Merton's self-fulfilling prophecy: as a result of the regressive effects of interventions shaped on the basis of faulty assumptions the problem becomes ever greater and demands an even greater "dose" of the faulty interventions as conceived by Watzlawick in his concept of "first-order-change" (Watzlawick et al., 1974). In the second part of the presentation I give an overview of these regressive effects, drawing on international, European, and Hungarian examples.

## **Binarisms**

The best place to start is with the phenomenon itself: division. Fault lines arise along pairs of opposites, often creating such a wide gap between experts and lay persons representing the differing opinions that communication between the opposite groups may cease entirely. Similar pairs of opposites have been found by observers analyzing the development of other disciplines (Rosario, 1996); they can be called binarisms.

### ***Pharmaceutical or Drug?***

One such binarism is the classification of chemical substances influencing the functioning of the central nervous system as pharmaceuticals or as drugs. A special dilemma arising from the confrontation between two opinions of differing content can be found throughout the discipline dealing with drugs and the related areas. One opinion holds that the regular self-administration of drugs is not an accidental process but is, in fact, a necessary one since the acute and chronic drug effect plays a "self-medicalizing" role; in other words, drug users enjoy functional advantages through the drugs. According to the other opinion, the regular use of drugs has neurobiological and psychosocial consequences. Pharmaceutical or drug? This dilemma becomes even clearer if we consider that morphine, one of the most effective pharmaceuticals in modern therapeutic practice, is also a drug: it both heals and destroys.

Or consider the old, and still waged, debate over delta-9-tetrahydrocannabinol, the active substance in marijuana, which is a very favorable therapeutic substance for certain diseases and symptoms such as glaucoma, asthma, or chronic vomiting; but the same drug creates addiction, acting as a posited “gateway drug” to the use of heroin and cocaine; and its users, in an intoxicated state, are often involved in road accidents or other dramatic ends. In the 1950s and 1960s a whole series of research projects began on the therapeutic use of the so-called psychedelic substances, which evoked hallucinations and illusions (their prototype was LSD); but these inquiries were abandoned when the hallucinogens were placed on the drug list in 1968, leaving unsolved the big question of whether their use can be of value in psychotherapy. Are LSD, Ecstasy, or ibogain pharmaceuticals or drugs? Many authors have given many different answers to this question (among the pro-pharmaceuticals side: Grof, 1993; Stafford, 1992; Stolaroff, 1997; Kafkalides, 1995; Zimmer and Morgan, 1997; among the pro-drug side: O’Brien, 1997; Tacke and Ebert, 1991; Ungerleider and Pechnick, 1994).

### ***Ban or Tolerance?***

A question closely related to this dilemma is whether the psychoactive chemical substances should be banned or whether, as in the case of smoking or drinking, it should be left to users to decide what they want to use or not use, with or without moderation, accepting all the possible consequences. This brings us to the next binarism, ban or tolerance, which has posed such a thorny problem and is the subject of still unabated debates among experts and lay persons alike. This is the question of the choice of ends and means, of what a rationally thinking society can set as a goal: to be entirely drug-free as regards certain substances or to acknowledge that it is impossible to attain this total goal. The real questions are not raised here and in this way (Nadelmann, 1998). The question of ban and tolerance is in part a question of cultural traditions. In places where wine drinking has traditions reaching back thousands of years or where the cultivation of poppies for seed is deeply ingrained in folk traditions as it is in Hungary, even the approaching European accession and the different European practice does not induce any restrictive measures even when creating Europe’s strictest criminal legislation on the matter. At the same time, the cultivation of poppies has been banned in Ukraine, which is further from Europe, since 1992 (Kótyuk, 1999). It is not only the determining role of culture that can be found in this binarism. Strong economic interests shape the balance of ban and tolerance at any given time for each chemical substance. This is why the tobacco industry and alcoholic products can be advertised in Hungary and why commando units are used to destroy marijuana crops grown on the tiniest plots. There are no powerful interest groups behind the latter and at the same time a strong message can be communicated through the mass media: the police are doing their job.

### ***Punishment or Treatment?***

The dilemma of ban or tolerance restricts or broadens the possibilities of access to drugs but does not affect the question of how the regular, daily user can be brought to give up this use. Some people believe that this can only be achieved through humane methods developing the personality. This approach is generally known as demand reduction. Others consider that the drug user is a criminal since he is using a forbidden substance. And the criminal can be removed from the community by imprisonment (thereby also preventing

others from following his example and beginning to use drugs) and at the same time prison prevents him from continuing drug use. We now know, of course, that the latter is an illusion. Thus the question can also be raised as: punishment or therapy (withdrawal, personality development, rehabilitation), or both, or neither. The both means that if important elements of both approaches are combined to create a system that corresponds to the concepts of both punishment and therapy, a more effective solution can be achieved. This is known as “forced therapy.” In such cases, treatment is given under prison circumstances. But can a procedure be called therapy if the individual does not choose the conditions of his therapy and recovery? The answers given to this question are different for each country, continent, culture, group, and professional trend.

### ***Psychopathological or Pathopsychological Dimension?***

The psychopathological dimension transforms reality through the perspective of pathological phenomena. Here, experiences observed from the clinical viewpoint are projected onto people we do not treat because they do not come to us. Since they presumably display the same symptoms as the patients treated, we attribute the dramatic additional aspects of psychopathology to this invisible population. But could it be that we have a blind spot? Which LSD users seek help in our clinics? Those who have had a problem of some kind while using LSD. For example, someone may have had a bad trip and even after the psychosis was over is unable to cope with the experience. It is practically only with this and similar problems that LSD users come to us. We can conclude from this that all LSD users need our expertise because of unassimilated bad trips. LSD is a terribly harmful substance. If we encounter an LSD user who does not fit into this picture we say that this user is an exceptional case, or this user could have a bad trip at any time and then will realize the seriousness of the problem.

But this may not be true. A significant proportion of LSD users do not regard LSD as a harmful substance. Indeed, some people consider that “LSD is to psychology what the telescope is to astronomy and the microscope is to biology” (Grof, 1993). Many people think they owe the enrichment and development of their personality to LSD. They have no intention of submitting themselves to medical treatment. If they hear of a bad trip in their environment they attribute it to the unpreparedness and prejudices of the user, not to the biological actions of the drug. This opinion could be called the pathopsychological approach, whereby even pathological phenomena are presented as a kind of extreme variant of the healthy.

The question is, where does the truth lie? Should we judge the use of hallucinogens on the basis of the experiences of the psychopathological approach arousing anxiety and even fear? Should we believe the expert clinicians? Or the users? After all, there can be no doubt about their authenticity. Put simply and briefly: should we think in the psychopathological or the pathopsychological dimension when we try to understand the problems of people who have come into contact with drugs?

### ***Subjective or Objective Knowledge?***

Medicine, including addiction science medicine or addiction science for short, focuses on a particular kind of human problems. More precisely, medical science deals with a particular slice of human life problems, namely kinds of human suffering related to disequilibria of the biological organism. Addiction science studies the effects produced on

human behavior and forms of experience by chemical substances acting on the central nervous system. Drug users are a special group of people and are not ordinary patients either. They show exceptional interest in drugs and also in the effects drugs have on their own organisms. Like most patients, they too try to assimilate and make sense of what happens to them right from the development of their illness, with particular regard to the intimate relationship that they form with drugs. In the course of this assimilation and interpretation they may make discoveries that are sometimes in advance of medical science research. Their observations regarding novel effects arising with the combination of different drugs are of particular interest. American drug users, for example, discovered that the combined use of codeine and glutethimide intensifies the euphoria caused by the opiates (Woody, 1991). This was later rediscovered by drug users in other countries. Currently we are witnessing a similar discovery made by when heroin who users are beginning to use clonazepam—too often unjustifiably prescribed by doctors during opiate withdrawal—as a supplement to heroin in order to expand the usual experience of euphoria. In the light of these discoveries, it can be confidently declared that some drug users are brilliant chemists who instinctively experiment with their own organisms and drugs and in doing so make observations from which researchers and clinicians can also learn.

The same conclusion can be reached from a close study of folk customs related to the use of the opium poppy as a tranquilizer. Self-administration of an opium poppy infusion for the purpose of tranquilizing or sedation can be traced from Greek culture to the present, for the most part independently of traditional medicine (where opium was used from ancient times as a medicine) (Kovács, 2000).

The experience of drug users and psychiatric patients in connection with the use of drugs promotes the development of a common language, stock of knowledge, and culture. Since this knowledge is built up by people performing self-observation we cannot speak of the objectivity to which all science aspires. This is why, following Karl Popper, we call knowledge of drug users subjective knowledge (Popper, 1994). As Popper writes, we can speak of objective knowledge when we encounter such statements as: “water consists of hydrogen and oxygen.” Subjective knowledge arises when there is a subjective relationship between the observer and the observed: “he thought that the elementary particles have an internal structure.” We could also say that subjective and objective knowledge are the two poles of knowledge. There is a conceptual continuum between them, along which all kinds of knowledge can be placed according to the degree of objectivity. There can be even more subjective knowledge than subjective knowledge in the Popperian sense, when we hear: “after I shot up, I found out who I really am.” Researchers who perform experiments on themselves as scientists and thereby, or with the help of such experiments, make new discoveries, are balancing on a tightrope between subjective and objective knowledge. The cases of Sigmund Freud, the inventor of psychoanalysis, and Albert Hofmann, a chemist at Sandoz, can serve as examples. Freud’s scientific interest in cocaine was closely related to his experiences gained during his use own of cocaine. Hofmann accidentally discovered the hallucinogenic effect of LSD in the course of using the substance. He then felt the urge to experiment with self-observation of drugs. We will return later to Freud’s study of cocaine. In his essay on subjective and objective knowledge Popper regards a significant part of today’s scientific works as subjective knowledge and draws attention to how far scientists are neglecting objective knowledge.

In view of all this we can ask whether subjective or objective knowledge is needed to gain suitable information on the effects drugs have on people. Do we need one, or both, or something else?

### ***Traditional or Alternative?***

We might not be using the right concepts. For want of a better word we use the term traditional for everything which, in keeping with the current scientific rules, asks questions, sets up hypotheses, confirms or refutes, disputes or agrees. The kind of thing Kuhn (1970) must have meant when operationalizing the concept of *paradigm*. For what else is science in a given period but a system of rules framed by some kind of written and unwritten agreements, where the collection and processing of data have consensual traditions? If someone departs from these traditions it is highly likely that the person cannot be a successful scientist, even if it turns out that in a future period of its development science will follow such a line of thinking and procedures. In essence we use the concept of addiction science to mean the addiction science engraved in textbooks and handbooks. Addiction science may be defined as all the knowledge taught in universities and meeting the following criteria:

- striving for objective knowledge in the Popperian sense;
- grounded in the results of clinical and laboratory research using objective measurement methods to learn the effects of drugs;
- inclusion solely of the psychopathological dimension in the concept of illegal drugs to the exclusion of the pathopsychological dimension;
- emphasis on the harm caused by drugs rather than on their functional advantages;
- respect for the current legal regulation regarding access to drugs. It is worth taking a closer look at this last point.

The latter criterion is far from inevitable. What do we expect of a scientist if not objectivity? Loyalty to the authorities is very far from the criterion of objectivity if the authorities do not make their decisions on the basis of scientific facts. And in drug affairs, this is quite often the case. It is a well known fact, for example, that many substances were placed on the drug list before research on the substance was completed. In the majority of cases the decision was quite clearly of a political nature. It is not surprising then if the political decision results in a regressive action (Sieber, 1981), that is, it increased rather than reduced use of the banned drugs or the severity and extent of harm related to their use. A separate subsection will be devoted to the legal regulation of drugs.

The term alternative is a somewhat more straightforward expression since its opposition to traditional condenses all trends into one. In contrast with traditional addiction science, the system of knowledge of alternative addiction science hardly appears in written form. It is a kind of hidden underground science in which knowledge and information passed on through personal contacts plays a much bigger role than does knowledge that has been screened repeatedly through the various disciplinary layers and in this manner becomes impersonalized. In alternative addiction science, publication, the impact factor of the scholarly medium has hardly any subcultural value. It is only personal experience that counts. One's own experiences or those of close relatives are of greater significance than is learning acquired at the addiction science faculty of a major and prestigious university. This is why the Alcoholics Anonymous (AA) movement can be regarded as a part of alternative addiction science. In AA experience with alcohol gained personally or through a relative (from a position of co-dependency) is the *sine non qua* for addiction science work of any kind. The followers of alternative addiction science do not regard certain groups of drugs as harmful (nor does AA!). In fact, they consider that the use of some chemical substances is advantageous for personal development. They approach natural drugs as medicinal plants that are closely related to folk medicine and naturopathy (Table 1).

**Table 1**  
Traditional and alternative: similarities and differences

Goal	Traditional	Alternative
Setting	Objective Knowledge Clinical setting: Laboratory	Subjective Knowledge Every day life settings
Relationship to powership	Loyal	Autonomous
Access to psychoactive drugs	Prohibitive	Differentiated; use of any drugs is permitted, even suggested
Access to natural psychoactive drugs	Rejected	Accepted
Bad trip	Biological Problem	Psychological problem; is it based on the inexperience and prejudice of the users
Access to synthetic psychoactive drugs	Rejected	Rejected
Relationship to natural medicine	Negative	Strong
Health-illness view	Psychopathological approach	Pathopsychological approach
Self-experiment	Rejected	Accepted

### Data of the Alternative Approach and Their Interpretations

This study is not the place to give an overview of all the theses, research findings, and manifestations of the traditional and the alternative. In view of the fact that the traditional has appeared in far more documents than has the alternative, we can make a more detailed examination only of the alternative.

#### *Cradle of the Alternative: Freud's Cocaine Study*

Sigmund Freud has been noted among our examples. A number of his letters show that in April 1884 Freud communicated his scientific interest in cocaine. Well before his discovery of psychoanalysis, and with a frustrated professional success behind him (gold chloride procedure), he felt that cocaine could finally bring him fame. His biographer, Ernest Jones, cites the letter containing the following passage: I have read about cocaine, the most important constituent element of coca leaves which the members of some Indian tribes chew to tolerate the deprivations and vicissitudes. A German doctor experimented with it on soldiers and reported that cocaine heightens the soldiers' energy and endurance. I intend to obtain some cocaine and I will try it on patients with cardiac problems and nervous exhaustion, especially in the pitiful state that occurs when the administration of morphine is terminated (Dr. Fleischl). Perhaps others are also working on this problem and perhaps they are not reaching any result. However, I will definitely try it and, as you are well aware, if someone is persevering he will sooner or later succeed. (Jones, 1961)

Freud began to study the effect of cocaine in two directions. He ordered a gram of cocaine from Darmstadt and immediately tried 50 milligrams of it. He found that his depressed mood ended and he became increasingly cheerful. He felt as though he had eaten

a sumptuous supper and instead of becoming drowsy it greatly increased his zeal for work. He decided to recommend cocaine to his friend Ernst von Fleischl-Marxow (1846–1891), who was seriously ill. Fleischl, who was also a doctor, had contracted a serious infection while experimenting and his right thumb had to be amputated. Neuromas then developed, causing him intolerable pain and he became addicted to morphine as a pain-killer. Freud thought that a less harmful substance should be given in place of morphine; cocaine came at the most opportune time because he considered it less harmful. Fleischl succeeded in breaking the morphine habit. In another case, Freud effectively eased the pain of gastritis with cocaine. In the meantime, he took the substance himself in small doses in order to combat depression and digestive disorders. He was satisfied with the effect. He trusted so much in cocaine and was so unaware of its danger that he sent some to his fiancée Martha, “to strengthen her and bring color to her face.” In addition to the clinical (self) tests, Freud perused the literature on cocaine in the library of the Medical Federation. The study he completed on June 18, 1884, shows what complex and extensive research he carried out on cocaine at that time (Freud, 1884).

While he was writing the cocaine study, Freud was taking cocaine daily. He never gave it to himself parenterally, always taking it orally. We do not know exactly when and why, but he stopped taking it in that same year, 1884. According to the data available Freud, who had not yet created psychoanalysis at the time, did not become addicted to the substance. For him cocaine was primarily an intellectual, therapeutic problem despite the fact that, as Jones clearly shows, he could not avoid the positive reinforcing effect of cocaine: “in this study he struck a tone that never again occurred in his writings: the objectivity is intertwined with subjective fervour, as though he were in love with his subject.”

This study was written in the historical (golden) age when no trace can be seen of the split in drug policy issues (Gerevich, 1999). The interest of the specialist was guided solely by a healthy curiosity about the subject. Society had not yet qualified drug use as deviance and the judicial authorities did not regard it as a crime. Public opinion had not yet developed rigid prejudices (which could also influence scientists). Moral considerations were not encountered either. It was a moment like that when Albert Hofmann discovered LSD. Both the traditional and the alternative can be found in the cocaine study. Traditional in that the scientist attempts to collect information objectively on the properties of cocaine using the traditional approach of medical science, drawing on clinical experiences, and to evaluate the data. Alternative in that the scientist takes for granted that to be properly informed personal experience is necessary.

### ***The Cognitive Model of Drug-Induced Experience***

One of the most influential thinkers, whose train of thought can be recognized throughout the manifestations of alternative addiction science is the American sociologist Howard Becker. In the 1960s he already expounded the model that can also be regarded as one of the precursors of cognitive psychology. According to Becker the subjective drug experience is determined by a number of factors.

1. We select among the objective effects. Often important effects are not attributed to the drug. The grosser the objective (physiological) effects the harder they are to ignore.
2. The appearance of the effect is relative. The same drug may be experienced quite differently by different people or by the same people at different times. Aberle found that Indians and experimental subjects have quite different experiences with peyote (Aberle, 1966).

3. Greater emphasis is placed on extraordinary experiences. Users who take drugs in order to achieve some subjective state not ordinarily available to them expect and are most likely to experience those effects that produce a deviation from conventional perceptions and interpretations of internal and external experience: distortions in perception of time and space and shifts in judgements of the importance and meaning of ordinary events, to mention only the most common effects.
4. A particular effect may be singled out as particularly desirable. Even effects that seem to the uninitiated to be uncomfortable, unpleasant, or frightening can be defined as a goal to be sought.
5. How a person experiences the effects of a drug depends greatly on the way other (initiated) users define those effects for him, but at the same time, in some cases, the opinion of the uninitiated (nonusers) about drugs can also be determining.

According to George Herbert Mead, objects have meaning for the person only as the person imputes that meaning to them in the course of interaction with them. The meanings of objects—including drugs—are not given in the object but arise in the course of social interaction. Objects derive their character from the consensus participants develop about them (Mead, 1934).

With the growing intensity of the drug-induced experience we reach the most extreme form, the experience of drug psychosis. According to Becker (1967), all societies form notions of sanity and insanity. The users too, qualify their own state in keeping with the social consensus. As a result, the user may regard it as a kind of mental disorder or psychosis. An excellent example of this is Burroughs' *The Naked Lunch*, a novel published in 1959, which is full of psychosis experiences. In his descriptions, published later and based on his own experiences, the symptoms of psychotic regression decline and then disappear, subsequently confirming Becker's train of thought. If the user perceives confusion, the experience may be identified with a whole series of preconceptions. The user may think, for example, that "I will never get out of this state," or "this drug use will kill me." These thoughts can induce panic and anxiety. The panic can predominate in the drug experience without actually being directly related to the drug. Burroughs' book is full of descriptions of this kind of panic.

Becker (1967) gives the example of a user who is deluded into thinking that a second-story window is only a few feet from the ground. This phenomenon can be interpreted in two different ways. One is that the drug has caused a severe distortion in perception. This distorted perception indicates the existence of psychosis. The second interpretation is simply that the user has failed to correct the distortions caused by the drug. According to Becker this can be learned.

In this way, the untoward mental effects produced by drugs depend in part on the physiological action but to a much larger degree they may have their origin in the definitions and conceptions the user applies to that action.

The functions of the drug-using culture can also be understood in this context. The members of the culture prepare the novice for the measures that are essential if the undesirable effects of the drug are to be avoided. The novice learns from experienced users how to interpret the given perception. One of the most important interpretations is that the experience the novice is undergoing is temporary and will not last forever. In this way, the unusual perception no longer appears frightening.

Becker (1967) considers that the following conditions are needed for such a culture to function.

- The drug must not produce, quite apart from the user's interpretations, permanent mental and physical damage.
- On this basis, the given culture cannot be organized around a few chemical substances, such as alcohol, barbiturates, and heroin.
- Users must share a set of understandings. In addition to material on how to obtain and ingest the drug, as well as definitions of the typical effects, the typical course of the experience, the permanence of the effects, and the methods of dealing with any problems that may arise.
- Finally, the drug should be used in group settings where the definitions and interpretations of this culture can be passed on.

These conditions apply mainly to the use of marijuana and the psychedelic substances.

### ***The Psychedelic Culture***

Users of plants having a pure psychedelic action express the conviction that these substances (mainly the indoles: LSD, psilocibin, harmalin, and the triptamines, as well as the phenethylamines: mescaline, MDA, DOM, and others) constitute a separate pharmacological group and characteristically stimulate the central and sympathetic nervous system and act on the serotonergic and/or dopaminergic systems. These drugs also differ from other drugs in that their use is far safer from the medical point of view. This is true especially for the indoles. There is no fatal dose and they have no serious physical toxicity either. Their users nevertheless face dangers. According to the members of the psychedelic culture, these dangers are mainly of a psychological nature. Often preconceptions are reproduced in the course of drug use; if someone expects horrors he will get them in a "bad trip." This state of anxiety can recur from time to time without the person having the experience while taking a new dose of LSD. This is the flashback phenomenon. The bad trip is the result of a vicious circle leading to panic and is not related to the neurobiological action of LSD. Drawing on their experiences, the proponents of alternative addiction science claim that the bad trip psychosis can be avoided if the user is prepared, without prejudice, before taking the drug for the expected happenings and experiences, is warned of the possible dangers, and told of the importance of a friendly human environment in order to avoid panic and feelings of hostility. Users of psychedelics consider that the textbooks published by traditional addiction science mislead potential users. They express beliefs about dangers that lead to false expectations. These act as self-fulfilling prophecies in novice users and do, in fact, evoke panic-like states. The clinical perception of these states then confirms what is written in the textbooks.

Members of the psychedelic culture are prepared to make "pilgrimages" of thousands of kilometers simply to obtain special hallucinogenic fungi (Stafford, 1992). In recent years growing numbers of Hungarian drug users have joined this culture. Making use of the possibilities of the Internet, a number of addiction science studies in Hungary have been published presenting the attitude and knowledge of this psychedelic culture (Ruzsa, n.d.; Grof, 1993).

### ***Consequences of the Legal Regulation of Drugs***

A study of what happens to drugs after they are permanently removed from the allowed and tolerated category to the list of banned drugs produces interesting findings. In their highly influential book on opium use in nineteenth century England, Berridge and Edwards (1981)

show that as long as mankind exercised informal control over drug use, problems arising with the use of drugs could be handled very effectively. According to the drug historians we can speak of drugs as becoming a social and even world-wide, global problem since the introduction of formal control of drugs (Berridge and Edwards, 1981). The details of the picture are no brighter. Drugs that are forced into illegality deteriorate in quality, people begin to fake them, and so they become polluted and infected. A great number of the somatic complications of use can be attributed to the additives used for faking or the toxic agents used as solvents. When a drug previously used as a pharmaceutical is placed on the black list and so moves out to the street, its active content can fall by as much as 40%–60%. It becomes entirely uncertain whether it actually contains what the sellers claim. It is certain that there is a sharp increase in harm related to its use (Weil and Rosen, 1983).

The other consequence of a ban is that use of the given (banned) drug also soars. This happened after marijuana, LSD, and amphetamines were banned (Miller, 1991; Galanter and Kleber, 1994). Many observers attribute this to the “forbidden fruit” phenomenon while others call attention to the provocative aspect of the ban. There is also a considerable increase in the danger of stigmatization. The lives of drug users move “underground”; they are forced to hide and lie. They can and do become marginalized “invisible,” and therefore, out of reach of the helping services and epidemiological research. The disproportionate growth in the price of drugs forces some to resort to criminal means to find the high sums, i.e., theft, prostitution, and drug pushing. The mass media present this image to public opinion.

If we reverse the question and examine how use of the given drug changes following decriminalization we find the opposite result in the case of marijuana (there are no on decriminalization for the other drugs). According to both Dutch and American decriminalization data (Model, 1991; Kleiman, 1992; Spruit, 1998), marijuana use declined when punishment was removed.

### ***Drugs and Psychotherapy***

As mentioned earlier, after the discovery of LSD psychiatrists and psychologists began to use the substance in the treatment of psychiatric patients. When LSD was banned, after 1968 most of these therapeutic procedures were interrupted or continued illegally. Textbooks and handbooks published in the 1990s make brief mention of these experiments. What they have to say is essentially that LSD therapies were abandoned in the 1970s because LSD did not prove successful as a pharmaceutical or as a substance promoting the effect of psychotherapy (Hollister, 1986; Tacke and Ebert, 1991; O’Brien, 1997). The proponents of traditional addiction science hold the same opinion of marijuana, Ecstasy, ketamine, ibogain, and mescaline. It should be added here that these eminent authors are probably right because there is still no methodologically sound general study of these experiments, which unequivocally confirms their positive effect.

However, the psychedelic literature gives a more differentiated and detailed picture. Three periods can be distinguished in LSD psychotherapy.

- The first was from the second half of the 1940s to the end of the 1950s. During this period LSD was tried in a wide spectrum of psychiatric illnesses. In the first experiment 20–30 mcg was given to 16 healthy persons and six schizophrenic patients. In some cases the LSD was combined with Ritalin, Librium, dramamine, and amphetamine.
- From the late 1950s onward the diagnostic spectrum of patients involved was narrowed (psychotics and the mentally retarded were excluded from treatment).

Substantially larger single doses were used, and the LSD was not combined with other substances. *The Journal of Psychedelic Drugs*, which covered this topic specifically, reported on the methodology, aims, and results of the treatment. Later the journal was renamed the *Journal of Psychoactive Drugs*.

- The third period of psychedelic therapies extends from the 1970s to the present: this is the underground period when therapeutic activity has been forced into illegality with the ban on the use of hallucinogens. This illegality was temporarily ended with the prompt use of a few rediscovered substances (Ecstasy, ibogain, ketamine). These substances were then banned too.

The most professionally competent survey of LSD therapy can be found in the book of Stanislav Grof: *LSD Psychotherapy* (1980) Kafkalides' (1995) book, which first appeared in Greek in 1980, described the psychedelic treatments that the author used with pregnant women. This book became widely known only after it was republished in English in 1995. A book of interviews with Jacob, the legendary LSD and later Ecstasy therapist, also appeared recently (Stolaroff, 1997). The reader learns from this book that despite his illegal activity, Jacob never had any brushes with the authorities. This was probably because no event occurred during his treatments that went beyond the frames of his clinic, even though he conducted close to 3000 psychedelic psychotherapies and trained around 150 specialists.

Grof's (1993) book gives the best account of the theory of LSD psychotherapy. According to Grof, the western science that grew out of the Newtonian–Cartesian, or materialist culture, which roughly corresponds to what we have called traditional addiction science, deals only with the individual's biological endowments, experiences after birth, or the Freudian individual unconscious. With the use of LSD, manifestations originating from the perinatal and transpersonal levels of the psyche can be grasped. Such manifestations include the psychological experience of death and rebirth, encounters with archetypes, visits to the world of mythological beings of different cultures, extrasensory perception, and out-of-body experiences. These are experiences of the kind we can read about in the documents of various shaman rites, initiation ceremonies, and death-rebirth mysteries. The expression “psychedelic” means literally making manifest the psyche. This concept aptly reflects the fact that LSD is principally a nonspecific catalyst of psychic processes since it raises the energy level of the psyche and the body, thereby manifesting or making perceivable psychological processes that are otherwise latent.

Reports of psychedelic therapies are of an anecdotal nature. However, there can be no doubt that those who have successfully treated many patients in this way still have unfaltering faith in this therapeutic method, nor do we have any information about malpractice suits irrefutably demonstrating the harmfulness of the procedure. Nevertheless, alternative addiction science has still to give a scientific account of the healing process and its therapeutic efficacy.

## **The Splits in Drug Policies**

### ***Conflict or Peaceful Coexistence?***

At present there is a state of warfare. The frontlines are quite clearly demarcated and wide. The theory and practice of the alternative camp are scarcely present in the media and are not present at all in the universities. While the Internet, as the latest electronic medium, at first appeared to be a reliable space for publication, it is now doubtful whether it is suitable for

presentation of the alternative. New criminal regulations are being drafted that will make it possible to prosecute anyone using the Internet to encourage drug use. In our opinion it is not open conflict or witch hunts directed at the alternative that will lead to resolving the differences between traditional and alternative models and to an end of the splits in drug policy and addiction science too.

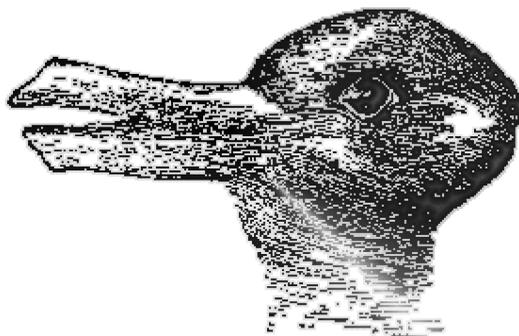
### *One or Two Paradigms?*

First of all, we would like to clarify whether traditional and alternative are a paradigm and if so, whether they represent one or two paradigms.

In his paradigm theory Thomas Kuhn uses an example from gestalt psychology to throw light on the relationship between paradigms and reality, the “rabbit-duck” dilemma. This dilemma is condensed in a single image. The picture is of a shape that can be seen or interpreted in two ways. Applying the example to the relationship of traditional and alternative it could be said that the representatives of the paradigm of the traditional see a rabbit, while the proponents of the alternative see a duck. The same phenomenon (the shape or the drug problem) reaches the level of conscious processing in two different ways (Figure 1). If this is so, it is evident that on this basis we evaluate the two approaches as two separate paradigms. And if there are two paradigms behind the traditional and the alternative it is very difficult to imagine some kind of integration to bridge the differences.

Does it change the conclusions we have drawn so far if we consider the question from the viewpoint of whether the proponents of the traditional and the alternative are thinking about the same reality? If it is the same reality, then it appears certain that addiction science is divided along two paradigms. But are we really speaking about the same reality?

It can be concluded from the facts outlined here that it is not the same reality they convey but two different slices of reality. Serious cases with clinical harm that can be attributed to the use of drug(s) come to the attention of the proponents of the traditional. In contrast, the representatives of the alternative form their opinion on drugs among users who have not reached the clinical level and even, if we consider the LSD psychotherapy, on the basis of observations made on a nondrug-using clinical population. This means that the traditional and the alternative are not two paradigms. Therefore, it is not two separate paradigms that can be held responsible for the present divided state of drug policies.



**Figure 1.** The rabbit-duck dilemma.

## Regressive Outcomes of Drug Policy Interventions

As I stressed in the introduction, the binarisms and splits that can be observed in drug policy are in reality related to mechanisms that are the cognitive formations of generally unconscious, hidden, and unexpected mechanisms that can transform good intentions into their reverse. The following section gives an overview of these mechanisms, it is illustrated with international and Hungarian examples.

### *Terminological Definitions*

Human helping intervention can be regarded as the intentional, planned efforts directed at changing or solving a situation or problem (Sieber, 1981). According to their consequences, interventions can be classified into three groups:

- An intervention is *progressive* if it brings the goal set closer and the initial problem moves towards a solution.
- We can speak of *zero intervention* if the goal remains just as distant as it was at the start of the intervention.
- Finally, intervention is *regressive* if the goal becomes more distant and the initial problem deteriorates. Regressive intervention should not be confused with side effects that may detract from the overall effect of the intervention, but if the original goal (symptom reduction) is successfully attained the side effect is not regressive despite all its unpleasantness.

The processes (traps, false assumptions, beliefs, faulty calculations, unexpected events, etc.) that change the direction of interventions, disrupt them, and in the final analysis reverse them, are known as converse mechanisms (Sieber, 1981).

### *Converse Mechanisms*

Converse mechanisms can be of many kinds. Most converse mechanisms appear during the disruption of states of equilibrium, when imbalance and tension arises among the functional consequences of the system. In this presentation I describe nine converse mechanisms from the viewpoint of drug policy interventions.

*Functional Imbalance.* The economic basis of the drug problem is the balance of the “demand and supply” of drugs (Carstairs, 2003). If a political decision places a legal substance (e.g., amphetamine) on the blacklist, the demand for amphetamine seeks a new object. In Hungary in the 1980s, to replace amphetamine, which had been banned, drug-using youth “invented” codeine and “poppy tea.” They combined both with glutethimide, a very dangerous pharmaceutical. These opiate-glutethimide combinations caused more serious health problems in users than did amphetamine (Gerevich and Bácskai, 1995). The same processes can occur when any drug is prohibited (e.g., alcohol prohibition), although this is not inevitable.

The economic principle of substitution and complementarity is among the basic principles of all drug policies. A few fatal substitution practices arose in the course of nineteenth century drug policies: e.g., opium smoking was treated with morphine, morphinism with heroin, heroin and morphine addiction with cocaine.

The pendulum effect is also a variant of functional imbalance. In such cases a lasting imbalance generates opposite needs and at a critical point the pendulum swings in the

opposite direction (Carstairs, 2003). A good example is the decriminalization in a number of states in the United States in the 1980s; the inadequate preparation and lack of harmony with federal drug policy led to the swing of the pendulum in the present direction, to the “war on drugs.”

It also frequently happens that the pendulum is shifted not by organic development processes but by arbitrary political decisions. It seems to me that this is characteristic mainly of the countries of Eastern Europe. In Hungary, in 2000, in the wake of a political decision, penal policy was made stricter without any professional arguments whatsoever and this year the new government liberalized policy, again without any sound foundation.

*Perverse Diagnosis.* In this case the demand targeted is illusory because the intervention is based on a faulty definition of the situation. The intervention further disrupts the system. The results of a famous United States (Chicago) criminological investigation serve as an example. The Chicago police increased the number of raids on the basis of the assumption that easy access to drugs was behind the deteriorating crime statistics. The confiscation of drugs led to a rise in their prices. With this the drug dealers’ profits increased. Users had to steal to pay the higher prices, leading to an increase in crimes against property. It follows that the more efficiently the police work, the more the illegal drug trade flourishes.

Another important example of faulty analysis of the situation is that most bans on drugs are introduced before the scientific research on which the ban is based is completed and without making use of the results. This tendency feeds on a moralizing attitude that rejects the need to understand the requirements of the system. According to the cognitive structure appearing in this moralizing attitude, some kind of “intentional evil” is manifested in drug use.

*Ricochet.* In other cases the diagnosis is correct but the intervention ricochets. There is no need for intervention in the group targeted. An example of this is the institution of diversion in Hungary (I note in parentheses that I am not familiar with the practice of diversion in Western Europe; there could be similar tendencies there too). Most of the users diverted from punishment to therapy are casual users who have practically no need of medical or even of psychological treatment. This has been confirmed by a clinical investigation. We divided 650 drug users presenting for outpatient treatment into two groups according to how motivated members of each group were for therapy. We examined the characteristics of the two groups. We found that 86% of those in the group not motivated for treatment came from those who had been diverted. Diversion, as a legal intervention in Hungary, targets the group that does not need treatment.

*Overload.* The diagnosis is correct, the target group of the intervention is the right one (no ricochet), but, due to lack of the necessary conditions, the system chosen is unable to carry out the task set; even more, it becomes overloaded with the additional task and is unable to perform even the tasks it had handled earlier. There have been numerous examples of this regressive effect in Hungary. The primary prevention tasks given to the underperforming school system placed teachers in an impossible situation. Some teachers solved this situation by organizing peer support groups among the students and passing the task of prevention to these students, who had not been properly prepared for it. It was a case of the blind leading the blind.

Another current example is the institution of diversion created on the basis of the recently amended penal code, referring tens of thousands of marijuana-smoking youth

to the competence of drug-user treatment units. The drug-user treatment institutions in Hungary are at present underdeveloped, underfinanced, and overburdened. It is not difficult to predict the regressive effect.

*Exploitation.* Groups involved in the intervention—on either side—use the resources of the intervention for their own purposes, consequently the aim of the intervention is not attained or becomes even more distant. A very old example of this converse mechanism is the “petard effect.” The fuel tanks of the planes that crashed into the World Trade Center on September 11, 2001 produced a petard effect: the resources of aviation blew up the building. The provocation discussed in the following section is also a variant of the petard effect.

Drug policy examples of the petard effect:

- Drug dealers are admitted as patients to hospital departments treating drug users where they use the hospital’s infrastructure to sell drugs. This happened recently in Budapest.
- The Viridiana phenomenon: taken from Bunuel’s best film: social workers doing charity work among drug users are “crucified”; they are reported to the police for drug dealing. Recently a young minister of religion was shot and killed by the people she was helping.
- The police resell confiscated drugs, for their own profit; police corruption. There have been a number of cases of this in Hungary in recent years.

Another example of exploitation is when, due to the rigidity and unrealistic nature of the existing legal regulation, all of the actors in legal regulation conspire, as it were, to sabotage implementation of the law. Dutch drug policy can be regarded from this point of view as sabotage by the entire nation. More and more examples of partial or total sabotage regarding drug users can be observed in Europe. This will sooner or later lead to a reconsideration of the United Nations conventions (Room, 2003).

*Goal Displacement.* In these cases, values of a means nature become goal values; the means becomes an end in itself, divorced from the goal for which it was created, even making the goal impossible to attain, that is, evoking the opposite effect.

Spraying marijuana crops with paraquat, a poisonous weedkiller, in Mexico in the 1970s contributed to the poisoning of youth in California with paraquat, causing serious harm to their health. The weedkiller as a means gained priority over the aim of the intervention and evoked a regressive effect (Sieber, 1981).

In Hungary the strict rules of penal policy were elaborated in 1999, before the aims of the national drug strategy, thereby gaining priority over the aim of intervention. The instruments of penal policy became incompatible with the goals set later, leading to great confusion in the area of drug policy.

Although these strict rules were eased in 2002, bringing the goals and instruments into closer harmony, the systems requirements for the easing were neglected and, as a result, the effect of the easing has been predictably compromised.

The centralization of drug policy in a situation where resources are lacking can contribute to placing drug affairs in an impossible situation. This is what we are witnessing now in Eastern Central Europe and particularly in Hungary.

*Provocation.* Provocation can mean both explicit and implicit threat and temptation directed at different groups of people. This threat or temptation can generate a striking back by the

object of the provocation and can thwart the intention of the provocation: it can lead to the emergence of a more unstable situation. With the forbidden fruit effect, the object of the ban becomes attractive and thus the provocation has a regressive effect through the ban and temptation. It not only draws attention to the object of the ban but also suggests that there are people somewhere who can indulge freely in the forbidden action.

Impact studies following decriminalization in the United States revealed the regressive nature of provocation (Sieber, 1981; Model, 1991; Kleiman, 1992; MacCoun, 1993; MacCoun and Reuter, 1997). According to the report of the Oregon Drug Abuse Council (1975), 40% of those who smoked marijuana before the liberalization declared that they smoked less often in the first year after the law was amended and 35% smoked less in the second year; 5% increased their use.

These data, in harmony with other clinical data, indicate that the criminalization of marijuana has a provocative effect for a substantial proportion of potential marijuana smokers, triggering the forbidden fruit effect. This effect ceases to operate with decriminalization. It seems likely that neither the ban or its lifting have any effect on the self-medicators struggling to cope with psychological problems. An insignificant, conformist group of smokers can be diverted away from marijuana smoking or diverted towards smoking with the legitimization of use.

*Classification.* Individuals can be classified in groups through various mechanisms. This generally facilitates orientation among the groups and helps to meet the special needs of the given group. But it can also have the opposite effect, especially if the classification is derogatory, stigmatizing, and discriminatory for certain groups, increasing social prejudice against the group and, thereby, contributing to the social exclusion of the group. This is especially true for drug users and all groups that belong in the concept of victimless crime (Sindelar and Fiellin, 2001). With this labeling, victimless criminals can be given the attributes of victim-criminals. This projection can lead to the negative Pygmalion effect, to the vicious circle of devaluation of the group (Rosenthal and Jacobson, 1968). This classification process can cause inequalities in access to care, too (Burnam et al., 2001).

In Hungary discrimination against drug users is manifested in a number of specific facts. The treatment of drug-using patients is financed to a lesser extent than that of psychiatric patients and even less than that of somatic patients. They are able to obtain modern relapse preventive, craving reducing, and maintenance pharmaceuticals only without social insurance support, for the full, high price. The same discrimination affects the doctors and social workers who deal with drug users: they are paid low salaries in a service with a low level of infrastructure. The detoxification of drug users is carried out not as a part of the general emergency care but in so-called “sobering-up stations,” which the ombudsman has found seriously violate the human rights of patients, the protection of their data, and their right to self-determination of information (Bácskai and Gerevich, 2002).

In the countries of Western Europe the signs of negative discrimination can be observed more rarely and they are much more advanced in the respect of human rights than are the former socialist countries.

*Placation.* Those in a position of power always have many ways of placating society’s conscience and silencing the spokespersons for drug affairs if tension grows because of unsolved problems. They can set up structures (committees, Commissions of Inquiry, etc.)

seeking ritualistic pseudo-solutions, creating the impression that they want to do something to advance the cause. In reality, nothing happens.

It has a placating effect if the government sets up a committee to define or solve a problem. Firstly the committee can appropriate the resources available for solution of the problem (appropriation), secondly it can build up its proposed strategy on perverse diagnoses, and thirdly it can become so out of contact with the real situation that the proposed solution is either misguided or becomes insufficient for lack of the appropriate conditions.

Europe has a strong culture of pseudo-solutions in the form of committees. This is especially true for the former socialist countries where the historical traditions (Patomkin effect) of eastern Bolshevism (Byzantinism) favour pseudo-solutions.

Since December 2000 Hungary has had a National Drug Strategy that orders priorities among the actions to be taken in drug affairs. This strategy has no system of evaluation and, consequently, there is no way of determining what has been attained from the goals set and what has not.

A special form of placation is when new regulation is needed as a consequence of the failure of a compromised regulation. This is carried out for the penal code, but in the absence of coordination with other legislation related to drug use (Police Act, Health Act, Data Protection Act, Act on Legal Procedure, etc.) the otherwise honest intentions of the legislators cannot be realized. This has happened in Hungary, too, in the case of the present amendment of the penal code.

## Biases

It is not because it lacks a suitable theoretical foundation that international drug policy devotes little attention to reverse effects. It rarely happens that experts do not notice the foolishness of their measures because they cannot see them. It is much more likely to happen because of biases. I would like to draw attention to four kinds of biases:

The paternalistic bias that automatically excludes the possibility that international conventions directed at promoting the solution of the drug problem, especially the United Nations convention on drugs, will be effective and, in reality, aggravates the drug problem. In particular this arises when more and more countries in Europe adopt legislation which, somewhat along the lines of Dutch drug policy, sabotages the UN conventions.

The elitist bias that leads to taking the messages of the drug policy elaborated by governments at face value and the failure to examine the background mechanisms that can throw light on the shortcomings of these drug policies. In the case of the countries of Eastern Central Europe there are substantial counterforces working—at government level—to impede the adequate handling of the drug problem.

The rationalist bias that regards a drug policy measure as the product of enlightened thinking and not of emotions, feelings, self regard, or chance. The Municipality of Budapest, dominated by Liberals—by accident—joined not the Frankfurt Resolution of liberal cities, but the Stockholm Resolution of prohibitionist cities. Despite the fact that this has since been discovered, no corrective measure has been taken.

The activist bias that considers that doing something—no matter what—is better than doing nothing. In most cases in Hungary the constraint to action is politically motivated. The left wing government eases the strict legislation because it was introduced by the previous, right wing, government. And in the meantime both have failed to take the basic preparatory steps—elaboration of a policy proposal, commissioning background studies by experts, conducting impact studies, etc., that would serve as the basis for legal intervention.

## Conclusions

The formal regulation of drug use and the globalization of this regulation have led to the emergence of a binary attitude. Parallel with this, the accumulated knowledge on drugs has disintegrated: a dichotomy has arisen between traditional and alternative knowledge.

Some of the helping interventions arising from the binary attitude have had regressive consequences, creating a vicious circle that further deteriorates the drug situation. In turn, the deteriorating indicators of drug use and drug trafficking have provided and continue to provide grounds for planning and implementing further regressive interventions.

This vicious circle will only be broken if a synthesis of traditional and alternative knowledge is achieved. For this, the globalization of drug policy must be ended. If global control is replaced by local regulations adapted to the different regions, eliminating regressive elements and continuously adapted in the light of the efficacy of the regulation, it is possible that the demand for drugs will decline.

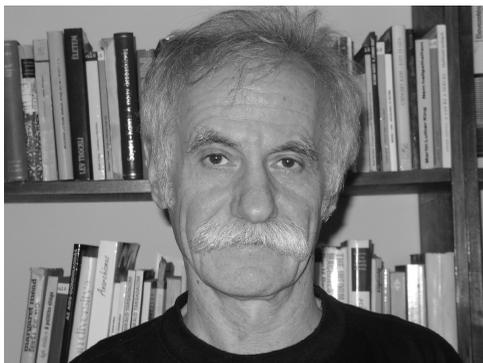
## RÉSUMÉ

L'âge d'or de la politique de drogue était caractérisé par une réglementation informelle de la consommation des drogues. La formalisation du contrôle de réglementation, et le caractère de plus en plus rigide et agressif de celle-ci ont entraîné une approche binaire de la problématique. Voici les binarismes principaux: pharmaceutique ou drogue; interdiction ou tolérance; punition ou traitement; approche psychopathologique ou psychologique; connaissance subjective ou objective; traditionnelle ou alternative. Selon le paradigme Kuhn ces binarismes sont intégrables. Les interventions de la politique de drogue basée sur l'approche binaire entraînaient des effets régressifs bien repérables. D'après Sam Sieber, Kuhn distingue neuf effets régressifs, notamment déséquilibre fonctionnelle, diagnose perverse, ricochet, surcharge, exploitation, provocation, classification, apaisement. Dus aux effets régressifs, la problématique de la drogue est devenue de plus en plus pesante, ce qui avait pour effet l'apparition de nouvelles interventions régressives. Ce cercle vicieux pourrait être surmonté par l'anéantissement des quatre parti-pris, notamment paternaliste, élitiste, rationaliste et activiste, qui se cachent derrière toute intervention régressive.

## RESUMEN

La edad de oro de la política antidroga se caracterizó por una reglamentación informal del consumo de drogas. La formalización del control de la reglamentación y el carácter cada vez más rígido y agresivo de la misma ha dado como resultado un abordaje binario de la problemática. Los binarismos principales son: fármaco o droga; prohibición o tolerancia; castigo o tratamiento; abordaje psicopatológico o patopsicológico; conocimiento subjetivo u objetivo; tradicional o alternativo. Según el paradigma de Kuhn, estos binarismos son integrables. Las intervenciones de la política antidroga basada en el abordaje binario producían efectos regresivos bien identificables. De acuerdo con Sam Sieber, Kuhn distingue nueve efectos regresivos, desequilibrio funcional notorio, diagnóstico perverso, rebote, sobrecarga, explotación, provocación, clasificación, aplacamiento. Debido a los efectos regresivos ha habido una escalada de la problemática de la droga, y esta escalada ha tenido como efecto la aparición de nuevas intervenciones regresivas. Este círculo vicioso se podría romper neutralizando los cuatro prejuicios, claramente paternalista, elitista, racionalista y activista, que se esconden detrás de toda intervención regresiva.

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