

## 1.5 *Strategies of order and control: Antabuse medication in Denmark*

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In relation to a follow-up study of patients who went through Minnesota Model treatment for alcoholism ten years ago, I recently talked to a driving instructor in his early forties. He told me that he had not touched alcohol for the past eight years: that is, until last year when he started suffering from fits of dizziness and related anxiety, which in the end prevented him from doing his work. Since he remembered all too well the pleasant experience of calming down with a cold beer or two, he could not resist the temptation. But one became many and after a few weeks of excessive drinking, he ended up in hospital for detoxification and was offered antabuse, the standard treatment for alcoholism in Denmark. Antabuse is a medicine that interferes with the breakdown of alcohol in the body by producing very unpleasant symptoms almost immediately after intake. The drug does not treat alcoholism as such, but is taken as a preventive medicine in order to support the patient's will to stop drinking by providing an automatic physical punishment. This man had used antabuse as a way of controlling his drinking in critical situations many times before, but this time he refused for the following reasons:

I don't like taking antabuse anymore. It seemed to work before and perhaps I needed it just to stop me, but something odd happens when I am on antabuse. I don't know how to explain this, but it is as if it occupies my mind all the time and I start making silly plans. There are so many small tricks you can play with it. As soon as I start taking it, I also start planning when I can stop taking it, and speculate about ways I can control myself again. Antabuse is a reminder. Now, when I don't take it, I know I can go down anytime and buy myself a beer – it takes no planning – and I feel good about that. Then I am in control. When I have taken antabuse, I am so busy with thoughts about when I can start drinking again – as if I have to

test it. I may try out with a light beer – that gives me a slightly unpleasant reaction, flushing and heart-beating – nothing serious. Then I know the antabuse works. I wait a bit, then take another, and perhaps one more of the light ones. If that works all right I'll try with the stronger ones – and step-by-step I can drink through it. Antabuse is a reminder – a challenge.

Since then, I have been struck by the number of stories told to me by patients and health care professionals about the challenges of taking antabuse, and the games of control and cheating that are played in relation to the administration of the drug. Antabuse is sometimes referred to as the family's tranquilizer. Everyday life is often unstable and unpredictable in families with alcohol problems and antabuse may help to stabilise the condition. From the point of view of both the patients, the families, and the medical profession, antabuse provides a fairly simple and discrete solution to a complicated problem, at least for a while. In spite of the good intentions, however, attempts to control the damaging personal and social effects of excessive drinking with antabuse, often seem to create new challenges and uncertainties rather than solve the problems.

In this article, I have been inspired by Gregory Bateson's theory of alcoholism (BATESON G. 1973), and by Sjaak van der Geest, Anita Hardon and Susan Whyte's writings on medicines (VAN DER GEEST S. - WHYTE S. 1989, VAN DER GEEST S. *et al.* 1996, WHYTE S. *et al.* 2002) in my effort to reach some understanding of the social mechanisms and inherent contradictions in trying to manage the uncertainties of excessive drinking with a controlling use of antabuse medication. I suggest, that excessive drinking may be seen as an effort to break out of a cramped living space and that medication with antabuse hardly helps the person in this effort, but rather works as a return ticket.

### *Bateson's Theory of Alcoholism*

Looking at anthropological contributions to research on alcoholism, Gregory Bateson's essay on "the cybernetics of the self" stands out as a classic (BATESON G. 1973). The essay deals with the spiritual and organizational principles for recovery after alcoholism suggested by the fellowship, Alcoholics Anonymous (AA). Clearly enthusiastic over the logic of the programme, Bateson argues that the alcoholic's self-destructive behaviour is an accentuation of characteristic features in western culture, and that the ideas AA lay out for personal development and a sober life represent a more desirable way of being in the world. Furthermore, he suggests that

alcoholism may be seen as a kind of matching between sobriety and intoxication, so that the latter appear as an appropriate subjective correction of the former. Therefore, the causes of alcoholism must be sought in the person's sober life, and as a consequence it is not to be expected that any procedure that reinforces this particular style of sobriety will reduce the person's alcoholism. In other words, if the sober life of the alcoholic drives him or her to drink, then that style of life must contain an error, and intoxication must provide some sense of correction of this error.

Bateson picked up a concept from AA called "false pride". False pride is characterised by an obsessive acceptance of challenge, a pride in willpower as expressed in the proposition 'I can...' When the alcoholic is confronted with his or her drinking, this principle of pride will be mobilised in the proposition 'I can stay sober'. However, success in this achievement destroys the challenge, since the contextual structure of sobriety changes with its achievement, and thus is no longer the appropriate context for pride. It is now the risk of the drink that is challenging and calls out for the 'I can drink', as illustrated by the example at the beginning of this chapter. Thus, the challenge component of alcoholic pride is linked with risk-taking, and the alcoholic is caught in a compulsive pattern of pride-in-risk.

False pride presumes a relationship to a real, or a fictive, "other". This other may be experienced as part of the alcoholic self or may be represented by the alcoholic's family, other important relations, or society in general. Such relationships may be expressed in either symmetrical or complementary patterns. The alcoholic's relationship to himself, as well as his relationship to the world around him, becomes a compulsory fight of challenges and defeats, and, since both symmetrical and complementary relationships are liable to escalate, the situation develops into what Bateson calls a schismogenetic pattern: the alcoholic is caught in a game of challenges and control no matter whether he drinks or not.

### *Antabuse and Controlled Drunkenness*

Antabuse (disulfiram) has been used substantially for more than fifty years in Denmark. The effect of the medicine was discovered in 1947 by two Danish researchers, Jens Hald and Erik Jacobsen, from the biological laboratories of Medicinalco in Copenhagen (HALD J. - JACOBSEN E. 1948). Until the introduction in 1985 of Minnesota Model treatment in Denmark and the following spread of AA groups to all corners of the country, antabuse totally dominated Danish alcoholism treatment. The somewhat rigid and

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controlling character of the Danish welfare system, stressing collectivism and sameness, combined with a cultural preference for “controlled drinking” rather than abstinence, provided fertile soil for the use of antabuse (STEFFEN V. 1997: 101).

Antabuse is routinely offered to anyone who gets in touch with the public health care system for problems with alcohol, whether this contact goes through general practitioners, outpatient clinics or hospital wards. Research from 1988 shows that antabuse was used in more than 90 per cent of all cases in the public out-patient wards, often under quite coercive circumstances, with one third of the patients claiming that it had no positive effects on their drinking problem (SKINHØJ K. 1988: 23). A report from the Link’s outpatient clinics based on data relating to 1736 users in 1992-93, states that 75 per cent of them were taking antabuse at the beginning of treatment (LANDSFORENINGEN LÆNKEN 1996). These findings are confirmed by a recent study showing that antabuse medication still dominates Danish treatment for alcoholism (JÄRVINEN M. 1998). With all of the general emphasis on positive reinforcement being more effective than painful punishment, it is surprising how antabuse treatment has been left out of that larger understanding. Most professionals agree, when asked, that antabuse should only be used with the explicit consent of the patient and in combination with other forms of therapy. In practice, the prescription of antabuse is seldom discussed and supportive activities are only utilized to a very limited extent, because the initiative depends a great deal on the individual patient.

Considering the extensive use of antabuse, one might expect some enthusiasm or at least satisfaction among the users of the drug. In fact, neither the patients who take the drug, nor the doctors who prescribe it, are very optimistic. Most of them would probably agree with the administrative director of the Link Outpatient Clinics in Denmark, who laconically calls antabuse «a chemical extension of good will» (ORBE D. 1996: 11). Usually, the effect of antabuse can be maintained by a dose twice a week and the idea is, of course, that the fear of unpleasant reactions should prevent the person from drinking. According to this logic, the will-power to resist drinking only has to be mobilised twice a week, instead of every time the temptation of a drink comes up. Thus, in contrast to most other medicines, antabuse is meant to work by anticipation and serves its purpose best, when the actual effect is left out, *i.e.* exclusively as a placebo. To some patients, antabuse does indeed seem to have that effect, and some actually manage to stay sober on antabuse for many years. But more commonly, antabuse medication falls into a periodic

pattern of three to six months of abstinence, followed by rather dramatic binges of escalating character.

Drinking periods may be more or less consciously planned and arranged with due respect to holidays and feasts, or they may be subject to more subtle and unconscious mechanisms. To some people relapses appear totally unpredictable and immune from personal control, and the uncertainties of the consequences are so incalculable that they seem to prefer any kind of control to prevent it from ever happening again. Nevertheless, most patients first consult a clinic with a deeply felt wish of being helped to achieve some level of moderate drinking, and they consider antabuse a regulatory means in that direction. Professionals, in general, find moderate drinking an acceptable first goal, but many think that abstinence is probably more realistic in the long run. The attitude seems to be, that each individual should learn by his own personal experiences. Gradually, hopes of recovery in terms of moderate drinking fade or disappear with repeated experiences of relapse. Antabuse becomes a pragmatically installed mechanism of self-control, and regular binges an abreaction, perhaps triggered off by the very constraints of control.

### *The Charms of a Medicine*

Examining medicines and therapies as forms of social control is a common approach in medical anthropology (VAN DER GEEST S. - WHYTE S. 1989). Periods of illness are occasions of dependency, when ideas of obligation and morality are mobilised, and therapy is always embedded in various forms of social relationships such as kinship, community, and social institutions. The sick role is associated with both privileges and obligations, just as the role of caretaker is embedded in certain moral demands. One of the primary obligations of the patient is to become well and therefore to comply with the treatment offered by professionals (PARSONS T. 1951). In fact, one of the main purposes of taking antabuse might be to confirm the patient's consent to the unspoken rules of compliance. In that sense, antabuse may be better understood as a ritual treatment rather than a purely medical treatment. The ritual provides the professional with the symbolic power of controlling the patient's intake of the drug, and the patient demonstrates his will to comply with the rules of the game by accepting this external control (ORBE D. 1996: 12).

Normally, medicines are defined by their capacity to change the condi-

tions of a living organism. They are expected to solve problems in undramatic ways and are valued for their effectiveness in alleviating ill health by removing the symptoms. Their concreteness as substances enhances the perception of illness as something tangible, and permits therapy to be separated from social relations. As such, medicines may be an attractive alternative to other kinds of therapy, a treatment that focuses on the individual body, which can be carried out privately – a fact that is particularly important when sickness is associated with shame and might reflect poorly on the patient or family. Thus, one of the charms of medicines is that they allow private individual treatment, and diminishing dependence on practitioners, experts, and kin (VAN DER GEEST S. *et al.* 1996: 154-156).

Antabuse, however, provides a challenging example to these notions of medicines. On the one hand, it fits in very nicely with the need for discretion and privacy in relation to a problem that is considered highly stigmatising. On the other hand, the administration of the drug is embedded in a huge system of public institutions and social control. Firstly, antabuse is a prescription drug and thus requires the interference of a doctor. Secondly, the drug is administered in ways that urge the patient to show up in public to take the medication. Finally, the actual intake is carefully surveyed and registered by representatives of the social system. Such public administration and strict surveillance prevent many, especially women, from seeking treatment at all. A former nurse tells how she secretly developed a substantial alcohol problem over a couple of years and then, desperately needing help, eventually went to see her general practitioner:

«I went up to my doctor and simply shouted to his face, that if he did not help me right here and now, I would drink myself to death! He instantly gave me some drugs for detoxification and suggested antabuse treatment. But no, no – not for me, thank you! Showing up at the clinic twice a week to take my antabuse, oh no – the secretary would soon find out, and in a small town like this people talk»!

Submitting to the forms of surveillance and publicity involved in the administration of antabuse is felt as shameful and humiliating by many patients. But then, antabuse treatment can still be limited to the intake of a substance, in contrast to counselling and group therapy that involves other people and reveals more sensitive knowledge about the person. Using a medicine has the advantage of making the problem seem concrete and disease-like, it offers a mechanical solution and it clearly demonstrates the patient's compliance.

### *Cheating*

Most patients end up accepting the control associated with antabuse medication, and some will even claim that external control is exactly what they need. Nevertheless, cheating plays an important role. Innumerable stories about how to cheat with antabuse are told, and although some professionals doubt that the stories are in accordance with reality, they do indeed reflect the patients' preoccupation with the subject. Some stories focus on situations in which the patient is subjected to so-called "voluntary coercion" – a self imposed constraint accepted due to the pressure of significant others. Although compulsory treatment with antabuse is not allowed, various forms of motivational pressure certainly take place, particularly when the Prison Service or the Social Security authorities are involved. Agreement to enrol in controlled antabuse medication can play a central role in the negotiation of conditional release from prison, of the commutation of sentence in cases of drunk driving, of parental rights to have access to their children in cases of neglect, of conditions for social security payments, or even of a demand for participation in treatment programmes. Considerable pressure may also be put on the patient by family, friends or employers, and antabuse may provide a visible and simple solution to such pressure. Under these conditions, the patient is often more influenced to take the medication by the prospect of future gains, than by a genuine wish to stop drinking.

When possible, antabuse is given under strict surveillance. Even when legal authorities are not involved, intake is noted down on a small yellow card carried by the patient as documentation of treatment (ironically referred to as a "driver's licence" or "the yellow card"). The medicine is preferably ingested as a tablet dissolved in water, which reduces the number of very simple methods of cheating available, such as hiding the tablet under the tongue and spitting it out later. Another common method is that of sticking a finger in the throat and vomit. Medical secretaries tell stories about patients pretending to drink the liquid, but instead, trying to let it flow unnoticed down their chin and into the jacket. Others try to chat with the secretary until the tablet settles at the bottom of the cup, in order to reduce the concentration of the drug, and then throwing the rest out. More inventive strategies include a patient who hid a wad of cotton in his mouth, to absorb the liquid so that he could spit it out afterwards. A more negotiable way of avoiding antabuse is through complaints of side effects, though most doctors seem to doubt the seriousness of such complaints. or through medication with drugs that counter the effect of antabuse.

Stories about cheating are, of course, well known by patients as well as professionals, and it makes one wonder why they all engage in this game. In his classic study of play, Johan Huizinga notes that society is often more lenient to “the cheat” than to the “spoil-sport”, because the cheat, by pretending to be playing the game, acknowledges the basic framework or the premises of the play, in contrast to the spoil-sport who threatens the very existence of the play-community by his non-compliance (HUIZINGA J. 1955: 11). Although it lies at the heart of play that rules should be kept, many examples from popular lore let the cheat win by fraud, as for example in the fable of the hedgehog and the hare (HUIZINGA J. 1955: 52). Perhaps something similar is at stake in antabuse treatment.

### *Testing*

According to the professionals, patients subjected to “voluntary coercion” are a minority at the clinics and attempts to cheat with antabuse are not so common. Listening to the patients, however, another sort of cheating, or rather testing, appears to be very widespread. This testing takes place among patients who have voluntarily agreed to take antabuse, but who nevertheless engage themselves in various forms of self-imposed testing or experimenting with the drug and its effects. A man in his early fifties recounts how he was escorted to an outpatient clinic by his neighbour, after a long period of time with a slowly escalating drinking problem. He had a consultation with a doctor and was prescribed antabuse, which he willingly took. He actually liked coming to the clinic in the mornings to chat with the other patients, and even went there on mornings when he did not have to take antabuse. Anyway:

«... of course, I had to test it – just to see if it really worked. It was after a while in treatment. A couple of days after taking my antabuse, I felt like having a beer at home. My wife was there, but she didn’t say anything – or perhaps I thought it was none of her business – so I drank a plain lager at first. That was okay, nothing really happened. It was near Christmas, so I continued with one of these with a throttle, you know, a Christmas brew. That was it! I simply dropped out on the floor, fainted. My wife got terribly scared of course and called an ambulance, what else could she do? I got into the emergency unit and was checked for all sorts of ills – my heart, blood pressure, and whatever. At least I got a full check-up – usually that is reserved for the car – and fortunately, there was nothing wrong with me. That’s nice to know, if I take the positive view on this whole event. Well, then I could say to myself, that at least I tried it. I guess, I am the kind of person that has to learn by his own experiences – and now I don’t have to try that



again! To be honest, it was quite scary, my eyes were swimming and I couldn't control my body – not least for my wife it was scary. I could have dropped dead, if I had had a weak heart for example ».

Others have less dramatic experiences and simply manage to drink through the unpleasant effects by tolerating the symptoms until they eventually stop. For people with weak hearts this method is considered life-threatening, but it is not uncommon and often talked about with a touch of pride. A carpenter in his late thirties told me how he simply 'forgot' that he was on antabuse after a detoxification and the next day went to the local bar, for a beer after work:

« My heart started beating very fast and my face turned extremely red. It was scary for a while. But you know, it passes and then I don't care. The first time I drank on antabuse the effects were much worse, but now I know that after a while it's over – it's no hindrance, if I want to drink, I drink »!

*Strategies of Order and Control: Antabuse as Transformation or Return Ticket?*

In families dominated by alcohol abuse every day is a struggle to gain control over lives that have become unmanageable. With alcoholism basically understood as a loss of control as such, a condition that seems immune to the exercise of personal willpower, quotidian life becomes unpredictable and full of uncertainties. In this situation, neither the alcoholic nor the family knows what to rely on or what to expect from day to day. They are also uncertain about how to solve the problem. For many people the prospect of giving up drinking altogether is almost unbearable, even when moderate drinking turns out to be extremely hard or even impossible to manage. To a wide extent, the uncertainties and the ambiguities of the alcoholics about treatment options are shared by the medical profession. Both sides know very well, that the effort to control the intake of alcohol by inflicting a mechanical physical punishment, is an uncertain strategy in the long run. Antabuse is not a drug that cures a disease, it hardly removes the symptoms. But at least it gives the impression that something is being done. It may even provide a placebo-like sense of control and order that can help both alcoholics, their families, and the professionals to manage the uncertainty for a while. This effect may explain why many patients seem to comply with the drug, at least for a while. On the other hand, the attempt to control the situation by the prescription of antabuse also creates new uncertainties by challenging the very means of control itself. The various ways patients try to contest the effect of antabuse

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by cheating, testing, and experimenting with the drug, show how control often results in strategies to counter the restraints of control. Finally, the way professionals tacitly accept the state of affairs, shows that they are not too interested in giving up the impression that they are in control; that they know what they are doing. Cheating does not spoil the game as such, but it blurs the outlines of the current state of play, apparently, in the interest of many parties.

For most people in western societies drinking alcohol is a normal social and recreational activity. Although we tend to think of intoxication as a breakaway from more formal behaviour, alcohol researchers have argued that drinking patterns in general are governed by ritual rules leading towards feelings of transformation and redemption (ELMELAND K. 1996). This suggests, that excessive drinking may be seen as a personal development process, an effort to break out of a cramped living space. The effort is rarely successful, partly because the goal is too vague, and partly because the means are not appropriate. Antabuse, however, will hardly help the person in this effort, but will rather work as a return ticket sending the person back empty-handed (ELMELAND K. *et al.* 1990: 74). Bateson stated, in one of the premises of his theory of alcoholism, that if the sober life of the alcoholic somehow contains an error, it makes no sense to send the person back to this previous condition. This is exactly what antabuse seems to do.

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