Opiate of the People? A Case Study of Lahu Opium Addicts

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In the **Communist Manifesto** Karl Marx refered to religion as the "opiate of the people". What did he mean? In his lifetime educated people's opinion of opium changed drastically from one of amused tolerance to real concern: the smoking of opium for pleasure was seen to have a strongly demoralising influence on society. Surely religion provides a strong moral influence on society? We can expect an atheist to show his mistrust of religion but how exactly was Marx using the term?

The image is a weapon of criticism used against religion. Marx sees religion as if it were opium used as a sedative to reduce pain, soothe feelings and dull critical judgement. Is this what opium does for highlanders living on the margins of a modern state which is very much involved in the realities of the twentieth century? What is it that makes people become addicts? Who are those most likely to become victims? How successful are the rehabilitation treatments? Do the highlanders themselves see addiction as a problem?

In this Chapter I shall discuss these questions with reference to three Lahu villages in which I worked as the social science advisor to a project set up principally to identify a better agricultural extension strategy for use in hill tribe villages. I speak Lahu and have worked in other Lahu communities since 1965.

The information presented here focuses on the villages Huai Pong, Huai Nam Rin and Doi Mod located in Wiang Pa Pao district, Chiang Rai but also draws on my field work experience in many other villages. The specific research in this report was carried out by the Tribal Research Institute, the Hill Tribe Development and Welfare Centre, Chiang Rai and the Faculty of Agriculture of Chiang Mai University. Field work was supported by the Royal (Northern) Project and the United States Department of Agriculture and was carried out between 1982-86.

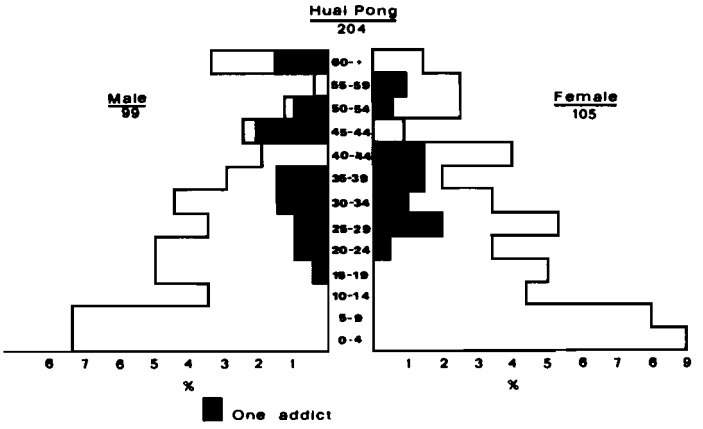
When field work commenced nearly all households in these villages were growing opium (1982/83). By 1985 Huai Pong, which in 1982 had produced a small crop of only 2 kilograms per household, had stopped growing opium altogether. Huai Nam Rin, which also relied on opium production (average production of 1.9 kilograms per household (1982/3)), had stepped back production to approximately 0.5 kilogram per household. Despite this fall in production, addiction rates remained high. None of the villages were self-sufficient in rice and many of the poorer households had to struggle for a living. Although the average gross income per houshold per annum had increased from baht 3,227 to 13,313 in Huai Pong and from baht 9,421 to 12,893 in Huai Nam Rin, small farmers cultivating only 2 rai were, materially speaking, not much better off.

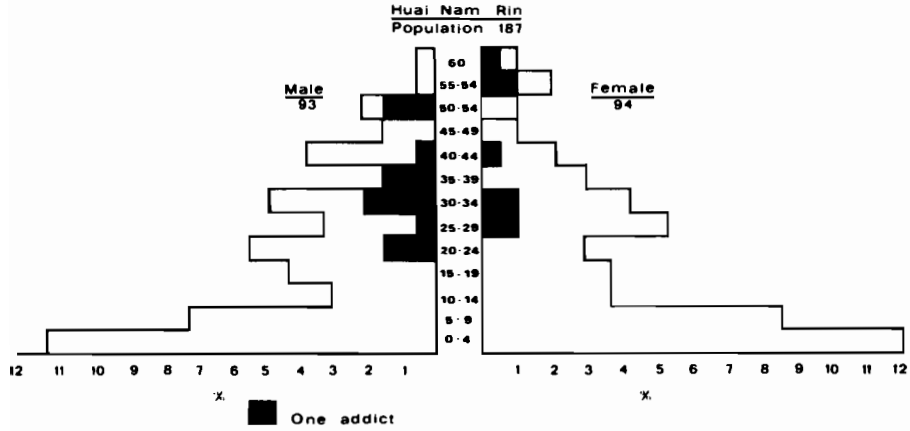
Who are the addicts?

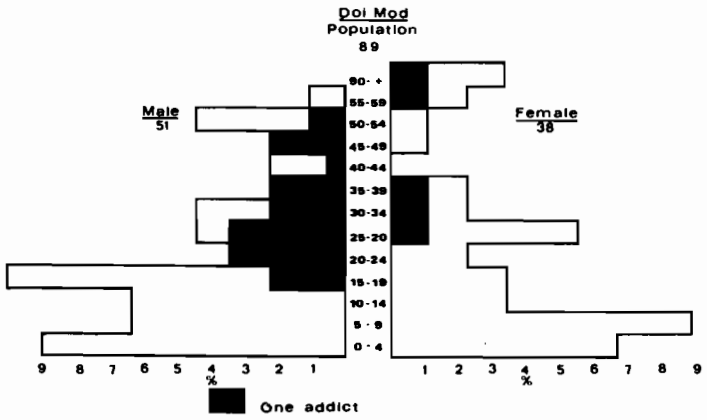
Out of a total population of 480 living in 87 households I counted 79 addicts: 16.5 percent of the total population. Addiction was determined on the criterion of habitual and compulsive smoking of at least one pipe daily (3.3 grams). Sixty three percent of addicts were men (50 individuals) and 37 percent women (29 individuals). In Doi Mod all of the men between the ages of 20-24, some three individuals, were addicted and all save one individual in the 25-29 cohort (again three individuals). By far the most vulnerable were not the older people who could claim to have earned the right to be self-indulgent and to have chosen to spend the last years of their life in a drugged state (as might

be true of the Hmong) but those who had just entered into their majority and were in the prime of their lives. In my sample villages, males between the ages of 20 and 39 made up nearly 30 percent of all addicts (24 individuals) and females in this same age group made up over 21 percent of the total (17 individuals). The impact on both the reproductive and the productive capacity of the community is considerable.

A better idea of the distribution of addicts can be gained from an examination of the population pyramids on the opposite page. If addiction rates are any indication of the morale of a community, then Doi Mod was the most demoralised village. Out of a total population of 40 above the age of twenty years nearly 50 percent or 19 people smoked opium everyday. In this village two men under the age of 20 smoked, surely a clear indication of the pessimism with which this community faces the future.




Huai Nam Rin
Population 187
Male
93
Female
94
60
55-59
50-54
45-49
40-44
35-39
30-34
25-29
20-24
15-19
10-14
5-9
0-4
12 11 10 9 8 7 6 5 4 3 2 1
1 2 3 4 5 6 7 8 9 10 11 12
%
%
One addict


Doi Mod
Population
89
Male
51
Female
38
90- +
55-59
50-54
45-49
40-44
35-39
30-34
25-29
20-24
15-19
10-14
5-9
0-4
9 8 7 6 5 4 3 2 1
1 2 3 4 5 6 7 8 9
%
%
One addict

On average most smokers were married (over 60 percent) and had been addicted for 9-10 years. I did not find any unmarried females who smoked but 14 percent of all male addicts had not been married. Those who had suffered marital trauma by death of a spouse, been abandoned or divorced were more highly represented in the addicted group than the general population. Table 1 below summarises the data from which I have drawn these observations.

Table 1 Addicts by Sex, Average, Age and Duration of Addiction; Marital Status

Village	Number	Sex		Average		Marital Status (%)				
		M: male F: female		Age	Years Addicted	Married	Widowed	Divorced	Separated	Single
1. Huai Pong	36	M	20	36	9	83	4	4	–	9
		F	16	35	4	92	–	4	4	–
2. Huai Nam Rin	22	M	14	42	8	76	5	–	–	19
		F	8	42	11	37.5	37.5	12.5	12.5	–
3. Doi Mod	21	M	16	38	14	40	13.3	20	20	13.3
		F	5	41	8	50	33	–	–	–

Source: Field survey 1983/84

Why do people smoke?

There can be no doubt that the principal reason why people smoke is not only that opium is available but that a general sense of malaise and hopelessness pervades much of the highland world. Broad structural issues that define their precarious position in wider society exert an overall negative influence on their daily existence, making it more likely that in a crisis, they will choose this self-destructive alternative, even where their own cultural values caution them against making this choice. Endemic poverty, high infant mortality (40 percent of children die in their first year), low life expectancy (36-39 years) all contribute to this malaise. It is not surprising that so many turn to opium as a way to forget troubles.

Is it specifically because they are poor? This is a much more difficult question to answer. The short answer must be that it definitely helps. If your hold on land is precarious, if you do not have citizenship, if you do not feel strong and do not have access to health services when you are unwell, it must be a comfort to give up, forget your troubles and become a smoker.

When I ask the poverty question and review my data a clear correlation emerges: the poor are much more likely to become addicts. Only 13 percent of my sample village smokers could be considered well off, the remainder are rather poor. Beside this, the better-off addicts manage their habit rather more carefully than those who are determined to seek oblivion. They are more likely to smoke unadulterated opium. They are less likely to lace their opium with chemical analgesics like aspirin which distend the blood vessels, enhance the absorptive capacity of the lungs and stimulate circulation.

The question then arises, "Have I posed the question the wrong way around? Are people poor because they are addicts?" It is extremely difficult to state with any confidence a response which would hold true in all cases. A vicious circle of poverty and addiction provides a much more realistic explanation. To identify the cause as one or the other is to hopelessly simplify the issue.

In Table 2 the socio-economic situation of the two groups, addicts and non-addicts is summarised; It provides a crude measure of industriousness. Clearly, on average, non-addicts cultivate larger fields of all crops including opium, commit more labour to agricultural tasks and get higher yields. Non-addicts are more likely, on average, to engage themselves for longer periods in off-farm work. The non-smoking population also secures a higher average income, 133 baht as against 104 baht per month.

Table 2 Comparison of the Agricultural Effort and Production of Lahu Non-addict and Addict Farmers (1983/84)

Activity	Non-addict		Addict	
	Ave.	Households involved (%)	Ave.	Households involved (%)
Opium Poppy				
Area Cultivated (rai)	1.6	67	1.4	71
Labour input (man/days)	90		70	
Yield (grammes)	1,334		889	
Dry-rice				
Area Cultivated (rai)	4.5	86	5.0	76
Labour input (man/days)	200		128	
Yield (kilogrammes)	240		108	
Maize				
Area Cultivated (rai)	3.0	77	2.6	84
Labour input (man/days)	140		120	
Yield (kilogrammes)	768		500	
Red Kidney Bean				
Area Cultivated (rai)	1.7	79	1.2	76
Labour input (man/days)	79		46	
Yield (kilogrammes)	210		104	
Wage and Forest Employment				
Number of working days	129	56	97	74
Income per household (per month in baht)	133		104	

Note: Total number of non-addict households surveyed was 52, and addict households 38.
Source: Field survey 1983/84

This is not to say that addict households do not try. A larger proportion of such households establish opium fields, cultivate maize and enter wage labour. They also tend to be more unrealistic about maintenance work. What is not shown in the Table is that they are ambitious starters, clearing larger fields than their available labour can cope with. They start on a large scale but finish with lower yields from poorly managed fields.

This background information to the problem does not enter into hill tribe responses when asked why they took up smoking. Their answers are quite specific to their personal

experience. Professor Charus Suwanwela in a review of the reasons why people start with opium lists these as the principal causes: release from pain, as a medical sedative and for pleasure. To these I might well add, as a result of my study of the Lahu, imitation of elders and escape from depression. Table 3 summarises responses I was given.

When I review my field notes a qualitative profile can quickly be built up.

The relief of pain was given by 29 percent of my sample as a reason for starting. A young man, Leh Kui, of 20 told me that two years ago he first took opium to cure a bad stomach-ache and although his father had forced him to give up smoking on three different occasions, his friends insisted that he join their smoking parties as a non-paying guest. A well-to-do married man of 30, Ai Lu, addicted for four years told me that he had once taken some medicine from which he suffered a bad reaction. This caused him so much discomfort he started smoking to relieve the symptoms. Although he knows he cannot afford to smoke and often complains about the high price of opium, because of a serious skin disease he has tried to give up without success. As addicts lose their appetite and spend money on opium in preference to food, various form of malnutrition appear. Deteriorating ill health often provides a rationale for addiction.

Table 3 Reasons for Smoking Given by Addicts

Village	Number	Causes Given (%)				
		Imitate Elders	Join Spouse	Group Pressure	Sickness	Depression
– Huai Pong	36	25	30	10	31	4
– Huai Nam Rin	22	18	27	12	26	17
– Doi Mod	21	31	28	4	31	6
Total 3	79					
1	26	25	28	9	29	9

Source: Field survey 1983/84

Many start smoking as a consequence of emotional trauma. A widower fifty years old told me he began when his wife died early in their marriage. A young woman reported that she had taken up the pipe to relieve her sorrow on the death of her husband. Another because she was deserted.

Most gave the reason that they simply followed their spouse or parents. Over 50 percent of those questioned reported that they were either subject to peer pressure or copied others because it seemed to be the thing to do. Only 9 percent stated that they started simply for the pleasure it gave them.

More often than not it is combination of circumstances which leads to addiction. Ca Ku is a typical case. He comes from a family which smokes but avoided opium until after he was married. Following a domestic dispute with his wife,he sought the comfort of friends who were smokers. Within a short time he had become an addict. This story is repeated by many.

Opium treatment: does it work?

Over 70 percent of the addicts interviewed have undertaken cures. Most treatments currently in use do not work. Some 23 percent of those interviewed were not interested in considering treatment. As far as they were concerned opium gave them the strength to work and they felt that their indulgence was not a problem. Table 4 summarises their answers.

Table 4 Opium Treatment Experience

Village	Number	Treated	Never	Place of Treatment							Totals	
				Lam Pang	Chiang Mai	Tham KraBok	Chiang Dao	Fang	Village	Others	Treatments	Cost (baht)
Huai Pong	36	31	5	9	26	4	1	1	23	2	66	16,950
Huai Nam Rin	22	16	6	5	16	4	4	2	20	1	47	13,000
Doi Mod	21	14	7	8	14	–	4	–	18	1	45	13,620
Totals	79	61	18	22	56	8	9	3	61	4	158	34,570
Average											2.6	567
											1	218

Source: Field survey 1983/84

Treatment has been available since 1967 when a special facility was set up at Lampang public hospital. Many went many times. In 1970 an additional servicing clinic was set up at Suan Dok hospital in Chiang Mai. Many of those who had undergone treatment at Lampang tried Suan Dok. Again many went many times. Eight of those in my sample are veterans of such cures and have gone as far afield as Tham Kra Bok in search of the perfect cure. They are still awaiting a guru with the magic answer. Some have even attempted a cure by running away into the forest and providing their own treatment. My small sample has tried an average of 2.6 cures at an average personal cost each time of 218 baht.

It is widely reported by veterans of curative courses that although they stop while in hospital as soon as they return to the village it is extremely difficult not to take up where they left off. Some say that the physical discomforts which they relieve by smoking, such as stomach ulcers, persistent headaches, bad backs and the like are not taken seriously while they are undergoing treatment and as soon as they leave the hospital reassert themselves. Many do not like the way they are treated by medical staff and say that returning to the pipe is a way of forgetting their humiliation.

Table 4 lists "village" as the venue most often used for treatment. This is misleading in two ways. First in a general sense because treatment in situ is uncommon; and second, because the two courses of treatment conducted, although they attracted many participants, were superficial and too brief to be ranked as serious attempts at amelioration. The in-village treatments, presided over by a monk, Phra Pricha Atiwatano, lasted for only three days. These were sponsored by a well meaning group of the Bangkok National Womens Association of Thailand who could only afford to subsidise the cost of treatment for a total of ten days for each of the two sessions. In the seven days after Phra Pricha's departure one can only assume that the addicts were supposed to consolidate the cure that had already been

achieved. Those who are addicted to another socially approved drug, tobacco, and have experienced the strength of dependence in the withdrawal symptoms will readily concede that neither three nor ten days is enough to effect a cure.

This is not to say that the village is the wrong place in which to attempt treatment. With community support, a well run programme could enjoy a much higher rate of success.

From this brief review of my Lahu data it can be stated with confidence that there is a close relationship between poverty and addiction. A more careful study conducted by a true master of social science could argue a strong case like Durkheim in his classic study of the close relationship between alienation and suicide. The problem of establishing causative factors is naturally different. There can be cumulative cycle of social events which lead to the final solution of suicide whereas addiction to opium can be viewed as part of an attempt to adapt to intolerable conditions.

As such, opium addiction must be seen in a category of drug dependence alongside alcoholism. If medical arguments that alcoholism is a physiological as much as a psychological illness hold true, perhaps the same argument can be used for opium addicts. In fact, many reformed opium addicts resort to alchohol as a substitute panacea and in doing so exchange one type of addiction viewed unfavourably by a dominant world culture for another just as damaging to those who are unable to manage it, but which happens to be culturally condoned. After all, what government would dare to deny the Russian proletariat their shot of vodka or insist on urine alchohol tests for State Department diplomats expected to attend what most Moslems and Hindus consider to be barbaric cocktail parties. In an anthropological sense, "drug addiction" must be seen for what it is: a culturally defined value judgement. The negative value judgement is muted in the case of socially accepted drugs of addiction such as tobacco and alcohol on the increasingly

suspect grounds that those who habitually ingest them do not endanger the well being of the community at large.

It is not possible to state unequivocally from my small sample that material poverty is the sole cause of opium addiction. Nor is it possible for me to assert that addiction is a cause of poverty. Clearly though these two causative factors are related in more than a casual way. It appears that a relationship of mutual dependence does exist but is difficult to establish because more than a simple measure of material wealth ought to be examined to evaluate the case properly. The highlanders environment also contributes to a general malaise which makes it more likely that people will become addicts. This perhaps has just as much to do with the problem of working class alchohol abuse in the USSR and the USA as it does with the specific situation of the highlanders. It has a great deal to do with their relative social position, lack of control over their own destiny and their subject status in modern, bureaucratic state systems. This then extends the concept of poverty to include mental health in the wider sense of the term. We should not be surprised that the members of minority cultures subject to powerful pressures and demands to conform to a new world order feel fundamentally threatened.

It is personal fortunes and mostly misfortunes which best account for addiction. It is those who are least able to cope with the circumstances of daily life who are most likely to become victims. The sample study also has something to tell us about opium cures. So much attention is given to detoxification and suppression that the socio-economic and psycho-social context in which the problem occurs is virtually forgotten. In a broader sense a balanced development policy such as that suggested by Chupinit in this book would do much to alleviate the situation. But unfortunately such an approach seems a long way off. Although it would be unrealistic to expect anything to be done about the wider political context, the local setting should not be ignored when attempting cures. Treatment within the village

has much to recommend it, especially if it is mounted in such a way that it addresses underlying and endemic problems of poor health (stomach ulcers etc).

Highlanders, like people all over the world, use drugs to lighten the drudgery of their daily existence. Modern Thailand has deemed that smoking be stopped but because of the availability of opium and the depressing nature of life in the mountains, it continues to be widely used. This opiate of the masses is a medication which has retained its popularity as a cure for the malaise of modern times, the need for which is usually reinforced by quite specific pyschological and physical injuries.

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Further Reading

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