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Social constructions of dependency by blunts smokers:

Qualitative reports

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Abstract

Concerns about the risk of cannabis dependence have been renewed in recent years by changing patterns of consumption, including increased levels of use, easier access to high-potency strains of cannabis and the rising popularity of *blunts* (tobacco cigar shells filled with cannabis). Such concerns have been reinforced by a number of studies suggesting that cannabis dependence, as measured by DSM criteria, has indeed increased. However, there are reasons to question these findings. First, the studies may not accurately reflect users' experiences, for a number of methodological and conceptual reasons. Equally important, they do not examine the practice of smoking blunts, which exposes cannabis users to nicotine and has obvious implications for dependence (and other health problems). In this paper we reveal social understandings of dependence by analysing in-depth interviews with 92 users of blunts and cannabis in other forms in New York City. We also discuss ethnographic observations of these users and others that reveal practises and norms relevant to the risk of cannabis dependence. We find that users' experiences and descriptions do not correspond to official dependence criteria and that some use practices, such as smoking blunts in groups, promote moderate consumption rather than compulsive use. Respondents also associated nicotine with dependence, suggesting that research on cannabis dependence should be designed to include blunt smoking.

Keywords

Dependence; Addiction; Blunts; Cannabis

Introduction

Research dating back to the 1970s has shown that use of cannabis is less likely than other drug use to lead to dependence (Johnson & Golub, in press; Grinspoon & Bakalar, 1997; Hall & Pacula, 2003; Mack & Joy, 2001; Zimmer & Morgan, 1997). However, a number of studies have challenged that view in the past decade. Most recently, an analysis of the published results of two national surveys indicates that dependence on cannabis, as measured by DSM-IV criteria, rose significantly between 1991/1992 and 2001/2002 (Compton, Grant, Colliver, Glantz, & Stinson, 2004). The largest increases were observed among young Black men and women and among young Hispanic men. Because overall frequency and quantity of cannabis use did not increase in that same time period, the authors of the survey analysis speculate that the growth in dependence may be attributed to greater use of higher potency cannabis and to higher rates of use among younger age groups (who are consistently found to be at higher risk of dependence) (Compton et al., 2004).

Their explanation of these findings raises a few questions. First, as Compton et al. report, some research has documented increased levels of THC (tetrahydrocannabinol, the main active ingredient in cannabis) in confiscated cannabis in the United States (ElSohly, Ross, Mehmedic, Arafat, Yi, & Banahan, 2000). Others have questioned the representativeness of the historical data in such research (Hall & Pacula, 2003). In addition, the increased potency in the U.S. (rising from 3% to about 5%) is still lower than the 6–8% that has been the norm for many years in Europe (King, 2004). Moreover, it is not clear whether or how much higher potency would raise the risk of dependence. People use cannabis to achieve a desired effect, and if they have access to higher-potency cannabis, they may well need to use less of it to reach the desired state. There is also no available evidence to suggest that young Black and Hispanic cannabis users have had access to higher potency cannabis, although those users had the greatest increases in dependence according to Compton et al. (2004).

Finally, other factors may not have been considered or measured by Compton et al. (2004) or by others researching cannabis dependence (e.g., Chabrol, Fredaigue, & Callahan, 2000; Fergusson & Horwood, 2000; Grant & Pickering, 1998; Swift, Hall, Didcott, & Reilly, 1998). One unmeasured factor is the increased popularity of smoking blunts, the cannabis-filled cigar shells that are typically shared by a small group of users. Because the cigar shells themselves are processed tobacco, users are exposed to addictive nicotine as well as to the THC in cannabis. In addition, users often follow their blunt smoking with a tobacco cigarette, cigar or cigarillo—a blunts “chaser” (Sifaneck, Johnson, & Dunlap, 2005). For both of these reasons, blunts may increase the risk of dependence (and other health problems) among cannabis users (Sifaneck, Kaplan, Dunlap, & Johnson, 2003). Blunts are also more popular among Black cannabis users than with users from other racial/ethnic groups, and that may help to explain the apparently larger increase in cannabis dependence among Black men and women that was noted by Compton et al. (2004) (Golub, Johnson, & Dunlap, 2005).

In this paper we also argue that cannabis dependence is a problematic concept. Cannabis users may understand this phenomenon differently from and largely ignore the way it is defined by diagnostic criteria (such as the DSM-IV) and in clinical research. We present selected findings from an ongoing qualitative study of 92 cannabis users in New York City, most of whom smoke blunts. In addition to users' responses to questions about the addictive potential of blunts, we include analysis from field observations of use patterns and practices as these may be relevant to controlling use.

The social construction of cannabis dependence

Since the 1970s, considerable resources have been invested in researching claims about cannabis, and the construction of cannabis problems has become markedly more sophisticated than it was in the “reefer madness” years of the 1930s, when cannabis was said to drive users to acts of violence (Himmelstein, 1983, p. 121). Today the concept of cannabis dependence is generally defined in clinical terms. Although still heavily promoted by enforcement authorities, the dependence concept is supported by research that analyses behaviour according to diagnostic criteria developed and sanctioned by respected medical authorities: the DSM-IV (American Psychiatric Association) and ICD-10 (World Health Organization). The DSM-IV (1994) and its revision, DSM-IV-TR (2000), list seven factors that may indicate dependence; the ICD-10 lists six (Table 1). Any three or more may be considered to indicate clinically significant impairment or distress from cannabis dependence, if they co-occur within a 12-month period.

There is considerable overlap in the criteria for dependence found in the DSM-IV-TR and the ICD-10, along with some shared problems. For example, both see spending large and/or increasing amounts of time obtaining cannabis as a symptom of dependence, without

acknowledging that cannabis is illegal and that it is inherently more difficult and costly, and therefore time-consuming, to procure even small amounts of an illicit substance than it is to obtain legal drugs. For example, after a police “bust,” dealers may become more cautious, so purchasers must invest more time in finding and buying cannabis. In addition, official dependence criteria do not take into consideration the street quality of cannabis and how it may change. Such changes may lead to adjustments in use patterns to achieve desired highs, depending on whether the quality of cannabis being sold at different points in time is high (strong), medium or low. In contrast, those dependent on tobacco or alcohol can easily purchase their preferred brands in standard potencies and prices.

The DSM and ICD criteria have been criticized on several other grounds with respect to their application to cannabis use. It has been pointed out that the three-item threshold for diagnosis is arbitrary, and that it is not reasonable to give equal weight to each criterion when compulsion is over represented on the list. In addition, the criteria do not include some elements of dependence that have been found in research (such as emotional bonding to the substance and attachment to ritual) (Pates, McBride, Ball, & Arnold, 2001; Soellner, 2005; Zinberg, 1984).

Neither the DSM nor the ICD requires that tolerance or withdrawal be among the three criteria needed for a diagnosis of cannabis dependence. This is at least partly because tolerance and withdrawal do not have established clinical significance in the case of cannabis (American Psychiatric Association, 2000). Disregarding this “psychobiological core” (Moore, 1992, p. 460) of the criteria presumably makes the diagnostic scheme more relevant to cannabis use, but it can also facilitate politically inspired or otherwise subjective definitions of cannabis dependence. This change in criteria is consistent with the broader conceptualisation of addiction generally and the consequent use of “disease” to describe compulsive engagement in a wide range of behaviours other than drug use (Earleywine, 2002; Hall & Pacula, 2003; Reinerman, 2005; Room, 1998). Indeed, the latitude is such that one can be diagnosed as dependent without exhibiting impairment or loss of control (Room, 1998). This widening of the conceptual net reveals cannabis dependence as a concept that is socioculturally constructed (Room, 1985, 1998), with meanings that may vary according to whether one consults clinical criteria or user experience.

Cannabis dependence research

Consequences of cannabis consumption are not usually as severe nor as obvious as the consequences of cocaine or heroin addiction (Earleywine, 2002). Clinically significant dependence symptoms are relatively rare even among regular cannabis users, and a number of studies show that most users “age out” of cannabis consumption, either greatly reducing or discontinuing use before age 30 (Hall & Pacula, 2003; von Sydow et al., 2001). Nevertheless, some research indicates that cannabis consumption is not harmless. As a growing number of articles appear in peer-reviewed journals reporting survey findings that support the official descriptions of dependence, the concept of cannabis dependence gains legitimacy.

In a review of research since 1996, Kalant (2004) reports that studies in the U.S. have found that the risk of dependence rises with increased frequency of use and increased quantity of use. Other studies have found that long-term use (defined variously) can lead to dependence (Dennis, Babor, Roebuck, & Donaldson, 2002; Swift, Hall, Didcott, & Reilly, 1998). Chabrol et al. (2000) found that among 256 French students from two high schools with different socio-economic backgrounds, 41.4% of the students used cannabis occasionally or regularly, 51.2% had never used cannabis and 7.4% had used it but had stopped. Of those who had smoked cannabis for three or more years, 63.6% reported dependence, based on DSM-IV criteria. Swift, Hall, & Teesson (2001) documented the prevalence of cannabis dependence among Australians 18 years old and above and found that approximately one-third of users met criteria for

dependence and abuse. Dependent cannabis users were disproportionately between the ages of 18 and 24, unemployed, and showed greater levels of illnesses than non-dependent users.

Some studies suggest that cannabis addiction is both psychological and physiological, or at least that withdrawal symptoms are clinically significant (Budney, Hughes, Moore, & Novy, 2001; Wiesbeck et al., 1996). Cannabis smokers who cease use may have withdrawal symptoms similar to those that are associated with discontinuation of smoking tobacco, such as irritability, appetite change and difficulty sleeping. However, even heavy cannabis use does not seem to provoke physical withdrawal effects that are as clearly defined as those prompted by opiates (Smith, 2002). Support for the notion of cannabis dependence also comes from animal studies (for example, Berger, 2000, p. 979), although these are often controversial.

Other studies have found that cannabis users are *not* at particularly high risk of dependence. Anthony, Warner, & Kessler (1994) contend that approximately one out of 11 people who have ever tried cannabis become dependent. Most cases of dependence are found among young consumers, age 15–25, with peak risk at age 17–18. Between the second and fifth year after first use, risk of cannabis dependence is higher among males than among female cannabis users (Wagner & Anthony, 2002). Fergusson and Horwood's (2000) study of a New Zealand cohort from birth to 21 years old found that most of the respondents' cannabis use did not lead to dependence: approximately 10% were seen as dependent by age 21. However, 20% of the same birth cohort had used cannabis before age 16 and within this sub group, more than 21% met criteria for dependence by the age of 21 (but still less than 5% of the total sample). Rates of dependence rose with increasing reports of positive responses to early cannabis use (Fergusson, Horwood, Lynskey, & Madden 2003).

von Sydow et al. (2001), focusing on patterns in the natural course of cannabis use, also found dependence relatively low in a sample of 2446 German youth age 14–24 years old. Approximately half of the users stopped using the drug in their twenties, with the rest of the sample becoming occasional or frequent users. Poulton, Moffitt, Harrington, Milne, & Caspi (2001) found that cannabis dependence among young adults in New Zealand was related to participation in street subcultures: hard drug use, drug sales, and conviction of a drug-related crime. Yet although the prevalence of cannabis use was found to be about 50%, the rate of cannabis dependence was under 10%.

Even a brief overview of cannabis dependence research indicates that there are difficulties with assumptions, definitions and methodologies employed by cannabis dependence researchers. The larger surveys of young cannabis users described above appear to yield differences in the apparent likelihood of cannabis dependence. The dependence criteria may be applied inconsistently, perhaps as a result of variations in how researchers interpret those criteria. Existing research on cannabis dependence is also limited by the apparent domination of studies done in Australia, New Zealand, the United States and Great Britain. If the tobacco in blunts increases the likelihood of dependence, one might expect to find higher rates of dependence in Europe, where it has long been common practice to smoke cannabis mixed with tobacco (King, 2004). Yet there is little data available about cannabis dependence in Europe, and some studies suggest that rates of cannabis abuse and dependence may be lower in Europe than in the U.S. or New Zealand (see von Sydow et al., 2001)—even though THC potency is higher (King, 2004).

Another problem – and the focus of this article – may lie in the varied ways in which cannabis users themselves understand the concept of cannabis dependence. The restrictive nature of surveys does not allow any exploration of variations in cannabis consumers' social constructions yet these are vitally important, given the subjective nature of cannabis dependence. Most existing research on cannabis dependence relies on clinical criteria that may

not capture actual patterns of use in the community, particularly the social context of behaviour that may be perceived as dependent (Moore, 1992; Room, 1985). Because official dependence criteria have not penetrated deeply into cannabis subcultures, dependence may be better understood through users' descriptions of their experiences. In the rest of this article we investigate those understandings of cannabis/blunts users, based on their own experience and received knowledge, their lifestyles and contexts of cannabis use.

The subjective nature of cannabis dependence is also obscured by the tendency of studies to focus on amount, frequency and duration of use. Many studies also rely on individuals already enrolled in treatment, many of whom use other drugs and alcohol, making it difficult to isolate cannabis-specific problems (see review in Dennis et al., 2002). There has been a marked increase in the number of cannabis users enrolled in drug treatment programs since the early 1990s. This is due in part to the broader definition of dependence but also to the fact that more individuals have been mandated to drug treatment by the criminal justice system (usually for non-cannabis offences) regardless of whether they meet the criteria for cannabis dependence (Earleywine, 2002; Hall & Pacula, 2003; Webb, Burleson, & Ungemack, 2002; Zimmer & Morgan, 1997). Moreover, other cannabis users are mandated to treatment by positive workplace tests, which do not necessarily indicate dependence (Lehman & Simpson, 1992; Zimmer & Morgan, 1997). Finally, there is a tendency to presume that referral to treatment is *prima facie* proof of actual dependence, and to analyse large-scale patterns rather than investigating users' experiences in depth.

In contrast, we argue that a useful way to capture the meaning of cannabis dependence is to speak with users themselves. We do not attempt to say definitively whether cannabis blunts are addictive or not. Rather, we analyse how consumers construct the possibility of cannabis dependence. The power of qualitative data stems from its ability to reveal multiple dimensions of use within consumers' social contexts, a claim that cannot be made by large-scale, quantitative studies. Ethnographic observations and first-hand accounts of the role cannabis plays in users' lives also offer insights into how cannabis differs from other drugs in terms of dependent (and non-dependent) patterns of use. It also allows users themselves to describe addiction and dependence, providing an important means of comparison with quantitative findings and official definitions.

Methods

Data for this paper come from an ongoing study funded by the National Institute on Drug Abuse entitled Cannabis/Blunts: Use, Subcultures and Markets. The study focuses on a wide variety of patterns in the use, sale and purchase of blunts and other forms of cannabis (e.g., joints, bongs and pipes), as well as on the belief systems and conduct norms particular to the subculture of users. We recruited blunts and cannabis users in and around two New York City neighbourhoods: Harlem and the Lower East Side (including the East Village and Chinatown). We conducted in-depth, tape-recorded interviews with 92 focal subjects, following them over a 5-year period by regularly re-interviewing them and observing their various places of consumption and purchase. These focal subjects were selected from a total sample of 120 initial respondents, to represent variable demographic and use characteristics among cannabis/blunt users. The focal sample is 42% female, 43% white, 40% African American, and 15% Asian; 19% of respondents identified themselves as Latino/a. They range in age from 14 to 62 years. Blunts are dominant in the sample: more than 27% of our subjects only use blunts; an additional 62% use both blunts and other cannabis. Of those who consume both, 40% say they prefer blunts. This sample may not be statistically representative of cannabis users, their reports do not provide a basis for a clinical diagnosis of cannabis dependence, and they were not asked questions based on DSM criteria.

In addition to interviews, and over the course of the study to date, we have observed more than 500 individuals during cannabis-smoking sessions in a number of settings: private parties, bars and clubs, small gatherings, stores and public locations such as streets and parks. These observations have yielded rich field notes with thick description documenting rituals and social contexts that shape their behaviour patterns and interpretation of dependence (Geertz, 1973). Investing time in developing rapport with respondents has helped earn their trust as well as facilitate access to respondents' social networks in order to observe their cannabis and blunts use in natural settings.

Findings: field observations

The advantage of supplementing qualitative interviews with ethnographic observations is that field observations provide contexts – personal, economic, social and public – for the information users reveal about themselves in interviews. The field notes summarized here focus on the normative context that emerges from the social and group nature of most blunts use: from the group, respondents develop a sense of what consumption patterns and practices are appropriate or excessive.

Although some individual blunts smokers may be heavy users overall, blunt smoking is often a communal activity with conduct norms and rituals that tend to discourage excessive consumption and/or dependent behaviour (Dunlap, Johnson, Sifaneck, & Benoit, 2005a). Analysis of ethnographic field notes suggested three ideal types of blunt-use groups – session, cypher and party – each with its own rules. A *session* generally includes three or more people who pool money to buy cannabis and a cigar, roll the blunt and smoke it. Sessions tend to last for several hours and involve other activities not related to smoking (e.g., movies, playing cards). The group rules of smoking enforce sharing: each member of the group is expected to take only a couple of puffs before passing the blunt to the next person. If other acquaintances come along, they may smoke, but only those who have contributed money may light the blunt and offer it around. A *cypher* is somewhat different: the group usually remains smaller, involving just a few persons who gather inconspicuously to smoke, usually outdoors. Cyphers are less likely than sessions to be planned in advance. Participants do not pool resources; rather, each brings his or her own blunt. Newcomers must contribute their own blunts, unless they are invited to smoke by a cypher member. The goal of cypher participants is to get high as quickly and discreetly as possible; thus members meet, smoke and disperse without engaging in any other activities. At a *party*, alcohol is the main substance consumed and blunts users are expected to separate themselves from the rest of the party when they wish to smoke (Dunlap et al., 2005).

These use settings tend to foster controlled, purposeful consumption. We observed specific occasions in which smoking is considered appropriate and in which peer pressure discourages individuals from consuming more than what is seen as a fair share. These norms are enforced by the implicit threat of ejection from the group and by an argot of informal social control. Thus, one who will not pass the blunt when expected risks being ridiculed as a “hedgehog,” and one who takes more than two puffs at a time may become known as a “steamer” (Johnson, Bardhi, Sifaneck, & Dunlap, 2005). (The earlier term for this behaviour – “bogart” – dates back to the late 1960s.) It is possible that these group norms also minimize consumption when people smoke blunts alone. The vast majority of the focal subjects who use blunts (88.6%) said they prefer to smoke blunts in groups. The few who reported occasionally smoking blunts alone said that when they did so, they tended to replicate the group practice of taking a few puffs and then putting the blunt out. Whether the conventions of restrained blunt smoking also influence cannabis use in other forms, however, is open to question.

Findings: in-depth interviews

The same rapport and trust that give ethnographers access to blunts users' social networks also encourage respondents to talk openly about illegal and potentially stigmatising behaviour such as drug use. Field observations of use patterns provide context for in-depth interviews in which cannabis consumers share their opinions about the dependence potential of blunts. Their responses suggest the extent to which they have internalised both cannabis subculture norms and public discourse related to drug use and the risk of addiction.

We posed the following question to our focal subjects: "Tell me whether you think smoking blunts is addictive. Explain your answer." Respondents were not asked questions designed to determine whether they fit clinical criteria for dependence. Asking about addiction or dependence in an open-ended fashion has three advantages over questions based on clinical criteria. First, an open-ended query is more likely to elicit subjective insights. It also avoids "presumptive entitativity" with respect to cannabis dependence. Finally, the fact that blunts actually involve two substances – cannabis and tobacco – is likely to confound conclusions about cannabis dependence that would be drawn from responses to standard diagnostic questions. As the responses below will indicate, the open-ended question illuminated the significance of tobacco's role in the dependence potential of blunts.

Out of 89 usable responses, we found that 45% ($n = 40$) said they think blunts are addictive, 45% said they did not think so, and 10% ($n = 9$) said "maybe" or that they did not know. However, the difference between the "yes" and "no" groups is less clear than it first appears, for many of the responses are qualified. Those qualifications have to do with the widely known addictive nature of tobacco, beliefs regarding the role of personality in addiction and the differences between cannabis and "harder" drugs. The responses also demonstrate that although many users seem to think of addiction and dependence in a fairly clinical sense, most also employ conceptions or social constructions that differ significantly from the official definitions constructed in the DSM-IV and the IDC-10. It is also important to note that most respondents do not distinguish between "addiction" and "dependence." In part, this is because they were specifically asked if they think blunts are "addictive." That wording was chosen because when the question was pilot-tested, respondents did not seem to recognize or understand the term "dependence," although they were familiar with the concept of addiction. It is likely that their conceptualisation of addiction has been shaped by expanded popular usage of the term and by the anti-drug rhetoric they have heard virtually all of their lives in school and through mass media. (This public context of self-reported drug-related behaviour warrants further investigation.)

The role of tobacco in cannabis dependence

It is significant that subjects were asked specifically whether they thought that *blunts* were addictive, as opposed to joints or other forms of cannabis. Knowing that blunts are made with cigars prompted many respondents to identify the role of tobacco in the risk of cannabis dependence, regardless of whether they answered "yes" or "no" to the question of whether they believe smoking blunts is addictive. The fact that these blunts consumers invoked tobacco in their responses highlights a need to focus on blunts specifically in research on cannabis dependence. Comparing blunts users with those who smoke cannabis in other forms (i.e., without tobacco) could yield significant insights into the nature of cannabis dependence.

Generally, subjects who invoked tobacco gave one of two responses: (1) Yes, blunts are addictive, because they include tobacco, or (2) No, blunts are not addictive but the tobacco in them is addictive.

Blunts are addictive because of tobacco

Of those who believe smoking blunts *is* addictive, 17% said it is most likely because tobacco is used in making blunts.

M. Norwood: Um, yes. I think it's addictive because you've got the tobacco in there too. So, it adds a different flavour that you may like a little bit more; and you may get addicted to that particular form of smoking the weed, because it's got a little extra something. But also because of, you know, obviously, the nicotine in the wrap is gonna make you have a nicotine addiction. (White female, age 25. First used marijuana and blunts at age 15. Has BA, is employed. Smoked marijuana in blunts 5 times and in other forms 29 times in past 30 days)

For some users, dependence on smoking blunts was seen as an extension of addiction to tobacco:

Airhead: Well, joint paper, you really just smoking weed [marijuana]; you're not smoking nothing else. If you roll it in a Dutch, or a Philly paper, or White Owl [cigar shell] it lasts longer. You get more of the high. I guess you get more high. The paper is addictive, smoking it out of the Dutches. [Is it because of the tobacco?] Yeah ... once you keep on smoking it, you can't stop smoking it. ... Yeah, I can't stop smoking. (Hispanic female, 25. First used blunts at 13, marijuana at 16. Dropped out of school in 11th grade, is employed. Smokes blunts twice a day, marijuana in other forms daily)

For respondents like these, the question of whether or not cannabis is addictive was not salient. The presence of tobacco in blunts is enough to cause dependence, even though blunts typically contain more cannabis than tobacco. Other subjects considered cannabis separately, but they did not always agree on its dependence potential. For example, one user said, "Marijuana is habitual. And tobacco is addictive. So, I would think that the combination would classify as addiction." On the other hand, another respondent clearly exonerated cannabis when asked whether smoking blunts is addictive: "It probably is addictive because there's nicotine in the outer wrap ... but not because of the weed."

Tobacco is addictive but blunts are not

Of those who answered "no" to the question on blunts dependence, 15% were careful to qualify their answers by discussing the known addictive properties of tobacco:

Coach: I never thought of blunts as being addictive but I suppose it would be because of the tobacco skins. But at the time that I used to smoke them, when I was younger, I didn't think about that at all. [So you would think that it was the tobacco skins and not the marijuana that was addictive?] Definitely. ... I've been smoking marijuana off and on ... since I was thirteen and if I don't wanna smoke, I don't smoke. (African/Caribbean male, age 30. First used marijuana at 13, blunts at 18. Has BA, is employed. Has not smoked blunts since 1994, smoked marijuana in other forms 15 times in past 30 days)

A variation on this theme is to explicitly distinguish blunts from tobacco cigarettes:

Jesus: Nah, it's not addictive because you can quit at any time. It ain't like cigarettes. Cigarettes are addictive. (African American male, age 17. First tried blunts at 15, does not use marijuana in other forms. Is in 11th grade, does not work. Smoked blunts 16 times in past 30 days)

For these respondents and others like them, it may be that there is simply not enough tobacco in blunts to make them addictive. This is an empirical question, but it is true that blunts smokers in the United States mix much less tobacco with cannabis than is common in other countries, especially in Europe (Jones, 2003; King, 2004).

It is clear that many respondents interpreted “blunts” as a proxy for cannabis, whether or not they believe blunts smoking is addictive. Even among those who said blunts are addictive, many cited nicotine as the primary source of dependence potential. The addictive properties of nicotine are well known by smokers and non smokers alike, but it is also worth asking how many respondents use tobacco at times other than when smoking blunts. Just under half of the focal subjects (48.3%) said they smoke tobacco cigarettes; 43.8% said they did not, and 7.9 % said they do so rarely or on occasion. Less than half of those who smoke tobacco cigarettes said they believe that blunts are addictive (44.2%), but even fewer felt that blunts are not addictive (39.5%). When asked if they felt addicted to tobacco, however, 76.7% of them said yes. Non smokers (of tobacco) were evenly divided between those who think blunts are addictive and those who do not. Among the small group of occasional smokers, more than half said they do not think blunts are addictive.

Yes: blunts can be addictive

Psychological dependence

The response that came closest to matching any clinical criteria for dependence was the belief that one can become psychologically, but not physically, dependent on cannabis. Of those who felt that blunts can be addictive, 7.5% made the abstract statement that such dependence can be mental or psychological. Another 30% described their own feelings of craving or “need,” nearly always to relieve anxiety or stress.

Javier: Yes, it is addictive. It's very habit-forming. Um, it becomes like a crutch. It's like another human being. It's something that's always there, regardless of good times, bad times, whatever you're going through. ... I smoke twenty-four hours a day. I wake up two o'clock in the morning, and I take a couple of drags. I wake up first thing in the morning; I have a cup of tea and a couple of drags. Um, whatever I'm doing, before I go to work, I smoke. When I come home, I smoke. Whatever I'm doing, I always smoke. ... I take a couple of drags; I put the blunt out, and I put it in my pocket, I put it in my ashtray. I put it anywhere. (Male Black Hispanic, age 32. First used marijuana at age 11, blunts at 14. Left school in 9th grade, is not legally employed but sells marijuana. Smokes blunts daily, marijuana in other forms occasionally)

Javier describes a compulsive pattern of use in which he invests a great deal of time smoking, and which he believes is addictive behaviour. What he does not address is whether he thinks he could or should stop smoking blunts. As a 9th-grade dropout who is not legally employed, Javier seems to have little incentive to quit; he lacks the involvement in school or work that tends to moderate use (Dunlap, Johnson, Sifaneck, & Benoit, 2005b).

Several other users said they believed they or others they knew were psychologically dependent because they smoked blunts or other cannabis to relieve anxiety. Very few subjects claimed to have experienced any physical changes as a result of not smoking, and only one described unequivocally physiological symptoms:

Sharp Shooter: I smoke a lot and I think that my body feels differently if I don't smoke. My stomach is a little off and I get home and I wanna smoke again and I don't think it's just psychological. It affects my body. (White female, age 22. First used marijuana and blunts at 13. College education, employed. Did not smoke blunts in past 30 days, but used marijuana in other forms 100 times)

A few others, such as Renegade, reported feelings more consistent with possible psychological dependence:

Renegade: I don't think it's something where if I don't get it, it's gonna be, I'm not gonna be able to stand it. But when someone's passing around a blunt, like I definitely

want to smoke it, you know ... like it allows me to stop thinking about stuff that may be on my mind ... So it provides, like, I guess, a way of escape ... Now I notice like from day to day like if I don't smoke, how it impacts me. Sometimes, it makes me more irritable or moody or cranky, you know. Or sometimes it's better because I'm not as foggy or fuzzy, you know like I would be. Like my head is much clearer if I, than if I had smoked. The difference is like physically on the body. (Asian-American female, age 28. First used marijuana and blunts at 17. Has BA degree and is employed. Smoked blunts 4 times and marijuana in other forms 25 times in past 30 days)

It is worth noting that although Renegade describes effects that are largely psychological, she also says she feels them physically.

I know people who are addicted

Seventeen percent of those who think blunts are addictive attribute their belief to the fact that they see other people exhibiting dependent behaviour. However, all of these respondents also said they were not dependent themselves. Door's response is typical:

Door: I don't really feel like I'm addicted to it. If I needed to stop then I would stop ... but I know people that really have to have it in the mornings when they wake up. They are really addicted. I don't really know how to describe it. (African American male, age 37. First used marijuana at 9, blunts at 25. Has 1 year of college, is employed. Smoked blunts 20 times and marijuana in other forms 5 times in the past 30 days)

Subjects who gave this response saw the dependent behaviour of others as evidence that smoking cannabis blunts can be addictive, although some added that they believe dependence and/or addiction is determined by the user's personality.

It is a pleasurable habit

Of those who said they believe smoking blunts is addictive, 17% went on to explain their answers in terms of pleasure and habit rather than need. However, at least one older respondent used "habit" almost synonymously with "addiction" (which is also how heroin users in New York City use the term). Note that she compares cannabis with a caffeinated soft drink:

Trish: Only if you let it. It's just like a Pepsi-Cola or something. I mean ... it gives you a relaxed feeling so they get in the habit of smoking to get that relaxation. ... Yeah they like it, but it's addictive. Not like heroin or something like that, but it's addictive to the point where it's a pleasure thing and they just keep doing it. That's what it is. And it becomes addictive. ... Yeah, I would say that because they get in the habit of using it to relax all the time. (African American female, age 62. First used marijuana at 14, blunts at 60. Has some college and is employed. Did not smoke blunts, but used marijuana in other forms 30 times in past 30 days)

In other cases, as with the young user cited below, the concept of addiction seemed to be conflated with that of routine:

John Doe: Yeah. Because when you do it, it's like, oh, you feel nice. And then the next day you're gonna want to do it again. Because you know, people do it every day. (African American male, age 15, in 11th grade. First used marijuana and blunts at 12. Smoked blunts 30 times in past 30 days; does not use marijuana in other forms)

In a similar vein, one respondent said he believes smoking cannabis is "kind of" addictive, because "I don't *want* to stop." In contrast, when asked if he felt addicted to tobacco cigarettes, he replied, "Yes ... Because I *can't* stop." (Emphasis added.)

These responses and others from the same group recognize the likelihood that individuals will want to repeat an enjoyable experience enough to become habituated, but it is less clear how much compulsion they attach to the practice of repeated blunt smoking.

The ritual is addictive

A few (5%) of the subjects who affirmed the notion that blunts can be addictive emphasized the specific rituals involved in preparing and smoking them:

Dakota: Definitely because it's about the ritual, and there's a different way to smoke, but it's one that is, um, there's a whole process to it and anything that has a process to it makes something more appealing or less appealing to most people. For me it makes it more appealing, take like a procedure and go through it. (White female, age 27. First smoked marijuana at 11, blunts at 25. Has two years of college, is employed. Smoked blunts 15 times and marijuana in other forms 22 times in past 30 days)

This recognition of ritual is similar to the concept of habit, in that the driving motivation is pleasure and that the level and target of compulsion are somewhat ambiguous. As Renegade suggests, users may become more attached to the ritual processes than to the blunt itself:

Renegade: The whole process of smoking blunts, I think, is addictive for a lot of people. Like the actually, um, making a blunt, like taking a cigar and like filling it up with weed and rolling it back up again I think is addictive. Sometimes that is actually more enjoyable to people than actually needing to smoke the blunt itself. Kind of like cigarettes, like having a cigarette, the process of lighting it up and smoking it, and having it in your fingers, is actually more compelling than having the cigarette itself. (Asian-American female, age 28. First used marijuana and blunts at 17. Has BA degree and is employed. Smoked blunts 4 times and marijuana in other forms 25 times in past 30 days)

In describing the process of preparing materials for smoking that is familiar to all users, these respondents seem to be invoking the social context documented in the ethnographers' field notes. Yet unlike other group rituals that serve to moderate consumption, rituals of preparation are seen as promoting compulsive use, at least to some consumers.

No: blunts are not addictive

Feel no craving or need

Among the subjects who said they do not believe smoking blunts is addictive, by far the most common reason given – by 43% – is that they do not develop a craving or need for cannabis. Generally, the idea was that if one did not have a blunt it was not a major problem:

Joseph: Nah. ... Because I smoke when I want to smoke. I don't got to smoke all day or all night. (Hispanic male, age 17. First used blunts at 13. Has 8th grade education, is unemployed. Smoked blunts 30 times in past 30 days)

Joseph's comment is typical. One could go without cannabis if it was not available and it would neither harm the person physically nor psychologically. Similarly:

Smokey McPott: I don't think [smoking blunts is] addictive. I mean I think it's just another way to smoke pot. I don't think pot is really addictive. I think it might be psychologically addictive, I don't think it's physically addictive. I don't find myself waking up in cold sweats craving weed. But, um, you know, I'll smoke when I wanna smoke. I'll smoke out of whatever is available. It's more of, I wouldn't say a luxury *per se*, but it's more of just a, you know mixing it up. It's just something else to do. (White male, age 25. First used marijuana at 17, blunts at 18. Has BA, is employed. Smoked blunts once, marijuana in other forms 30 times in past 30 days)

It stands to reason that users who do not crave a drug will not go to extraordinary lengths to obtain it and use it. These respondents reported smoking only when they want to do so.

Blunts use can be controlled

There is a difference between smoking blunts only when opportunities arise and actively controlling one's use. One measure of control is whether a user can stop smoking at any time and without difficulty, and it was cited by 7.5% of the respondents who rejected the notion of blunts as addictive. For example:

How High: If I wanna stop I can stop. You know. But if I don't choose to stop then I won't stop ... I did it [stopped] before ... And I just felt normal like I always feel when I'm smoking. (Jamaican male, age 30. First used marijuana at 11, blunts at 15. Dropped out of school in 11th grade, is employed. Smoked blunts and marijuana in other forms 30 times in past 30 days)

Another measure of control is deliberately limiting one's use to times when responsibilities are not pressing:

Sammy: Uh, no [blunts are not addictive]. Not really. I mean, I think that, like I know when I finished school ... for the, you know, basically the next week afterwards, all I did was smoke weed. But that was just cuz I knew that I really didn't have any other responsibilities. But, you know, now that I'm in school, it hasn't really been so frequently. (White male, age 21. First used marijuana at 17, blunts at 18. In college and employed. Smoked blunts once and marijuana in other forms 4 times in past 30 days)

Other respondents talked about only smoking on weekends or after they came home from work.

Cannabis is not like harder drugs

About 20% of those who did not feel smoking blunts is addictive based their assessment on a comparison of cannabis and "hard" drugs such as cocaine and heroin.

Arlos: It is not actually addictive, but you do actually get the urge and you feel depressed and somehow, somehow you just want to do it eventually. It's not officially [physically] addictive like crack or all that other stuff. (Chinese male, age 19. First used marijuana at 14. Pursuing GED [General Education Diploma], is employed. Smoked blunts 25 times but no other marijuana in past 30 days)

Arlos went on to say that he wondered if cannabis "might be" mentally addictive. Another respondent, Sheeba, also thought physical dependence might be possible but ruled out physical addiction:

Sheeba: I know it affects your physical chemistry. But from an addiction standpoint ... I think that you have a little bit more agency and control than you would have if, um, you're on heroin or on, you know, and you certainly don't have the withdrawal kind of situation. (African American female, age 32. First used marijuana at 13, blunts in her mid-20s. Has BA, is employed. Smoked blunts once and marijuana in other forms 6 times in past 30 days)

Interestingly, some respondents who said they do not believe cannabis is addictive also said that they know other users who seem to be dependent on the drug. About 7.5% made this observation; they saw the behaviour of others as evidence that addiction is driven by personality rather than the drug. This is in contrast to those who saw the dependent behaviour of others as proof of cannabis' addictive potential (see above).

It should be noted that several users also spoke of tobacco as if it were a “hard” drug in comparison with cannabis, mainly because of nicotine's addictive potential, as reflected in the first few quotations above. These cannabis/“hard” drug distinctions may reflect a conceptualisation of addiction and/or dependence that is associated with well known withdrawal symptoms and loss of control—criteria that these cannabis users do not experience or see happening to fellow users.

Discussion

For the most part, respondents did not assess the possibility of blunts dependence in terms that clearly correspond to clinical criteria. Several users described smoking with increased frequency, but none of them reported developing tolerance, or smoking larger amounts to maintain desired effects. As noted above, many users suspected that they or others had a psychological need to smoke, but only two people reported being unable to cut down or stop using. Rather, it was more common to hear users say they could easily stop smoking cannabis/blunts, although this claim may warrant scepticism because not all of those users had actually done so. It is also significant that only five users described even minimal feelings of discomfort (withdrawal symptoms) when cannabis was unavailable to them; the vast majority reported that doing without cannabis at any given time was not a problem.

If respondents associate blunts with group settings, they may be less likely to see blunts as addictive. Certainly the group norms observed by our ethnographers present the blunt as something to be shared with others rather than consumed alone, or if used alone, to be consumed gradually (stop after two hits, for example). Most of our respondents consumed blunts in groups, but the sample was split on the question of whether they feel blunts are addictive. This suggests counter-vailing forces, which may need more investigation. One that does emerge from the data is attachment to ritual. Although only a small number of respondents said they found the rituals of preparing blunts to be addictive, this should be investigated in light of existing literature on attachment to ritual both as a factor in dependence and as an impediment to recovery from addiction to other substances. Another factor that influences respondents' views of blunts and dependence is the presence of tobacco, but that is not necessarily related to the group setting.

Although most users did not distinguish between “dependence” and “addiction” when explaining their answers, there was widespread agreement that dependence on cannabis requires a sense of craving or need, compulsion as opposed to simple want or desire. In this respect blunts dependence is seen as similar to other kinds of addiction. Indeed, a number of subjects reported smoking to relieve stress or anxiety, and suggested that blunts dependence would be of a psychological nature. Even some of those who clearly said blunts are not addictive were willing to consider the possibility of psychological dependence. A different take comes from the several respondents who cited pleasure rather than need as the motivation for continued smoking; these users tended to describe this behaviour as a “habit” rather than a dependency. In contrast, a large number of those who do not see blunts as addictive specifically said they felt no cravings and were able to forego cannabis use without any negative consequences.

Respondents frequently noted that although they were not dependent on blunts themselves, they knew others who were. This claim was made both by users who believe blunt smoking is addictive and those who said it is not. In both cases, the implication is that personality rather than the substance used determines whether or not one will become dependent. This implication is particularly strong in the responses of those who do not believe blunts are addictive. It is possible of course that seeing dependence in others but not in oneself represents denial, and some of the users who expressed this view might meet clinical criteria for dependence.

However, that conclusion cannot be drawn from the data available here. Rather, it is safe to say that users define dependence using different criteria from that found in clinical definitions.

Perceptions of blunts' dependence potential vary somewhat with some user characteristics, but the strength of the relationships is unclear. Among those who think blunts *are* addictive, slightly less than one-third use blunts more than daily, just over half are between the ages of 14 and 24, and 17.5% are over 35. One half are Black, nearly one-third are White and they are as likely to be male as female. The profile of those who think blunts are *not* addictive is somewhat different: They are less likely to use blunts more than daily, and more likely to be White and male and between the ages of 14 and 24 (see Table 2). These findings suggest that the likelihood of perceiving blunts as addictive may rise with consumption level and possibly with age, and may be more common among Black users, but no meaningful pattern can be attributed to race or gender with these qualitative data.

The question of whether tobacco contributes to the dependence potential of blunts clearly warrants further investigation. Of those respondents who think blunts are addictive, 52.5% smoke tobacco cigarettes (including those who smoke cigarettes only rarely or occasionally). As reported above, the vast majority of tobacco cigarette smokers said they felt addicted to cigarettes, but as a group these cigarette smokers were only slightly more likely to think blunts are addictive than not addictive. By virtue of personal experience, tobacco users might be expected to be more familiar than non smokers with the concept of addiction, but it does not necessarily follow that they would find blunts addictive. First, because they meet their nicotine needs with cigarettes, the amount of extra nicotine they consume in blunts is likely to be marginal. Second, it may be that tobacco smokers know what addiction feels like, and they simply do not feel it with blunts.

Regardless of whether they said they felt blunt smoking is addictive or whether they smoked tobacco cigarettes, several respondents (15% of the total sample) said that nicotine is addictive and recognized it as an important component of blunts. They also made distinctions that implied an understanding of the pharmacologically active ingredients of opiates and tobacco as addictive.

By contrast, none of these blunts consumers ever expressed or implied awareness of the pharmacology of cannabis. The words tetrahydrocannabinol and/or THC were never mentioned by any of these ethnographic subjects, nor were they implicitly identified as a possible contributor to cannabis dependence. Indeed, the argot and social constructions being widely used and understood by blunts and cannabis users *do not* include awareness of THC as the primary psychoactive ingredient that gets one "high" or that might contribute to cannabis dependence (Johnson et al., 2005). Yet many blunt users quite clearly understood that nicotine was the pharmacologically active ingredient in tobacco, whether in cigar shells or in cigarettes. The absence of THC in the social construction of cannabis dependence among these cannabis subculture participants suggests that the numerous drug prevention and education messages they have received have not mentioned THC as the active ingredient in cannabis, while anti-tobacco messages have clearly identified nicotine as the addictive drug in tobacco products. An alternative explanation may be that THC and other scientific terms mentioned in anti-drug messages (dependence was also relatively unknown) have been ignored by these cannabis consumers and by the cannabis using subcultures in which they participate.

Our findings suggest that published clinical research and public-health drug prevention efforts may define cannabis dependence in ways that may be unknown or irrelevant to the lived experiences of users themselves. For example, quite a few respondents mentioned the rituals associated with blunts smoking – including the processes of rolling the blunt and passing it around the group – and described smoking blunts as an inherently social activity. A few said

these characteristics make blunts addictive to some people, but most cited the rituals and the social nature of the behaviour as simply enhancing the appeal of blunts. It may be that the need to relieve anxiety described by many users is met by the social interaction with friends as much as by the cannabis that is in the blunts. In other words, their self-identified psychological dependence may be grounded in social support rather than in the pharmacology of cannabis. Indeed, in pharmacological terms, these respondents revealed a deeply entrenched distinction between cannabis and harder drugs – including nicotine – that are known to be addictive. Their perceptions of dependence may also reflect their internalisation of anti-drug messages and the public discourse of addiction. These examples demonstrate how ethnographic research can reveal the social context of cannabis/blunts use, context that permits a deeper understanding of actual patterns of use that cannot be captured by large-scale surveys or measured by official dependence criteria. Indeed, social settings and ritual practices involved in smoking blunts and using cannabis in other forms may be of central importance in limiting the consumption of cannabis.

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Table 1

DSM-IV-TR criteria for substance dependence

- (1) Tolerance: a need to increase the amount used to achieve desired effect, or diminished effect from the same amount;
- (2) Withdrawal: the characteristic withdrawal syndrome for the substance, or the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms;
- (3) The substance is taken in larger amounts or over a longer period than was intended;
- (4) Persistent desire or unsuccessful efforts to cut down or control use;
- (5) A great deal of time is spent in activities necessary to obtain and/or use the substance, or recover from its effects;
- (6) Important social, occupational, or recreational activities are given up or reduced because of substance use;
- (7) Continued use despite knowledge of a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (American Psychiatric Association, 2000)

ICD-10 Criteria for Cannabinoid Dependence Syndrome

- (1) A strong desire or sense of compulsion to take cannabinoid;
 - (2) Difficulties in controlling onset, termination, or levels of use;
 - (3) Withdrawal: the characteristic withdrawal syndrome for cannabinoid; or use of the same (or a closely related) substance to relieve or avoid withdrawal symptoms;
 - (4) Tolerance, such that increased doses are required in order to achieve effects originally produced by lower doses;
 - (5) Progressive neglect of alternative pleasures or interests because of cannabinoid use, increased amount of time necessary to obtain or take the substance or to recover from its effects;
 - (6) Persisting with use despite realizing overtly harmful consequences (World Health Organization, Geneva, 1992)
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Table 2

Characteristics by beliefs about whether blunts are addictive

	Yes (%)	No (%)
Use more than daily	32.5	15.4
Age		
14 to 24	55.0	70.0
25 to 34	27.5	27.5
35+	17.5	2.5
Race		
Black	50.0	21.5
White	32.5	50.0
Asian	15.0	15.0
Other	2.5	2.5
Male	50.0	70.0
Female	50.0	30.0
Tobacco smokers	52.5	52.5
Non smokers	47.5	47.5