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EDITORIAL

Utilising 'new' power strategies for public health education in addiction and dependency: learning from social media influencers

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The traditional goal of work in public health is the promotion of population health (1). Within this very broad definition arise debates about the best way to target health behaviours, what is considered important, and who should be the focus of public health interventions. This paper will examine some of the current issues that arise when considering how to combat addiction and dependency through public health interventions in the context of a world dominated by information communication technologies (ICT). In particular, it will argue that lessons for public health communication on addiction and dependency can be learned from the growth of anti-vaccination sentiment during the global pandemic and that public health needs to embrace the 'new' power of communication to effectively promote healthy behaviours.

Definitions of what constitutes addiction and dependency vary in different social, cultural, and historical contexts, as well as being contested in varying academic debates about the topic. For example, the Diagnostic and Statistical Manual in the current version DSM-5-TR (March 2022), lists nine types of substance addictions in the category of 'Substance-Related and Addictive Disorders': alcohol; caffeine; cannabis; hallucinogens; inhalants; opioids; sedatives; hypnotics and anxiolytics; stimulants; and tobacco. The current version has also included gambling under this category. Other behaviours such as excessive sexual behaviour, compulsive buying, internet use, or stealing, were not included as addictions because the research was thought to be insufficient (2). There are also debates about models of understanding and how they relate to intervention. For example, the use of the disease model and its impact on personal responsibility; combatting stigma; the

biological predisposition model; the possibility of self-medication for other issues (3-6); the relative influence of peers and family; culture and social expectations; the meaning that various substances and behaviours have in different contexts; and of course sociological explanations relating to social capital, poverty, access to healthcare, and social exclusion (7). All these debates add further complexity to those who wish to reduce addiction and dependency and the associated behaviours.

Once the definition debate has been negotiated, if a public health initiative is to be designed, it is then necessary to think about what kind of public health intervention is likely to be effective. Although public health interventions work best when grounded in theories of behavioural change, there is no real consensus about what motivates behaviour. For example, one scoping review found 82 separate theories of behaviour referenced in public health literature (8). The majority of these focused on individual rather than social determinants. Even when we narrow behavioural motivation to the determinants of addiction, the picture remains contested and unclear (9). Despite the complexity of variable definitions, understandings of motivations and theories of behavioural change, public health interventions have managed to have some success in reducing unhealthy behaviours (8). Work on preventing drinking and driving, for example, has operated at various levels with legal changes, enforcement, and monitoring, alongside campaigns to change how people think about the action of drinking and driving, and this has substantially reduced road deaths across the European Union (10). The number of people in Ireland who believe that there is no acceptable amount of alcohol that a driver can consume and be safe to drive has

increased from 61% in 2015 to 73% in 2017 (11).

However, in addition to the absence of a clear uncontested understanding of what motivates behaviour and how to change it, there is another issue. As even the most casual observer of advertising campaigns will attest, the mechanisms for behavioural influence vary according to historical context, which is why the methods of communication used by advertisers change over time. At present, a hugely important source of influence is ICT. One of the lessons that was learned during the pandemic is health advice and methods of intervention are subject to challenge and distrust. Resistance to and refusal of vaccination, for example, has been a growing problem, which escalated substantially during the period of lockdown. Perera et al. (12) claim that the greatest influence on this escalation of rejection of public health advice is attributable to social media. They also note that blocking content on one platform will inevitably cause it to move to another, as people who mistrust advice will share contrary information among their own networks. Such is the scale of this issue that the World Health Organisation (WHO) now lists 'vaccine hesitation' as one of the top threats to world health (13).

Perera et al. argue that ICT influence has changed the narratives that are used to position health advice (12). Medical power is represented as an 'old' power, which is believed by some people to be open to various inaccuracies, dishonesty, corruption, or malice. 'Old' power is regarded as suspect because it is believed to be part of a system of influence and power from which many feel disenfranchised. Social media driven understandings, on the other hand, are perceived as a 'new' power. 'New' power acknowledges that the

powerful use their power and disseminate knowledge to their advantage.

It uses different ways to transmit information, most notably peer to peer sharing. This means that certain populations are more likely to trust information from this source.

Pintado and Sánchez (14), suggest that ICT social networks engage in two main areas of activity that maintain their influence: the creation of new content and development of social relationships. Content is then shared among a social network. One example of the influence of this kind of 'new' power is in relation to the circulation of positive marijuana messages, which has been to increase the likelihood of marijuana use among young people exposed to the information (15). Leaving aside debates about the veracity or otherwise of information on marijuana, or about abuse of power for the gain of a small elite, what is clear is that internet memes and information are influencing what potentially addictive substances mean to people and how they feel about them.

For this reason, Garcia del Castillo et al. argue that ICT should be used for prevention and promotion of health (16). Calling for a public health agenda for social media, they argue that preventative promotional material should be disseminated for a range of public healthy lifestyle initiatives, in particular in relation to legal activities such as smoking and alcohol but also for illegal drug use. Perera et al. make three suggestions about how we can learn from the so called 'new' and use it for health promotion (12). Firstly, they argue, we need to create a context rather than specific content. Using the example of the growth of anti-vaccination sentiment during the pandemic, they note that despite the disavowal of Andrew Wakefield's

retracted research on MMR vaccinations (17), numerous groups abound on social media that discuss vaccines together (12). Wakefield did not organise these groups, but he created the context for their formation. Secondly, they suggest we should not attempt to use facts over narratives, as it is counterproductive to pit 'old' power against 'new' and make people choose between them. Their third suggestion is that we spread narratives that resonate with a target audience and will be passed from peer to peer.

The idea of counter narratives which challenge power relations are by no means new. For example, Shen argues that Irving Welsh's 1993 novel and 1996 film *Trainspotting* offered representations of heroin addiction which provided a counter narrative to the individual choice discourses in post Thatcherite Britain, by representing heroin use as an existential choice (18). It offered a counter explanation for why people become addicted to heroin. Furthermore, in the academy there have been sustained critiques of the notion of moral panic (19); the notion that the behaviours of certain people, like for example the young, indulge in substance use and misuse, and are inherently dangerous and are thus the subject of, often unjustifiable, public outrage and concern. Moral panic, in this context can be regarded as a tool to justify the eradication of rights of the oppressed by the powerful.

A more sustained critique of the ways in which the medical model has obtained and sustained power by the special knowledge it holds and the ability to problematize certain groups has come from Foucault (20). This critique which has been extended to what Rose (21) describes as the 'psy' disciplines. He argues that psychology, psychiatry, psychotherapy and other 'psy' disciplines have played a key

role in 'inventing our selves', changing the ways in which human beings understand and act upon themselves, and how they are acted upon by politicians, managers, doctors, therapists, and a multitude of other authorities. These mutations are intrinsically linked, he claims, to recent changes in ways of understanding and exercising political power. In this tradition using Foucault's genealogical approach, Johansen et al. (22), for example, trace the construction of the 'addict' in 19th Century policy and its relationship to drug reforms and social regulation attempts and argue that the 'addict' was brought into being as a result of various forms of social and political power. As Sedgwick (23) has observed the addict seems to be a perfect candidate for a list of identities that emerged at the end of the eighteenth century and intensified throughout the nineteenth: the hysterical woman; the Malthusian couple; the masturbating child; and the perverse adult. All of these are thus argued to be identities that have been brought into being to regulate and control the populace.

Furthermore, the medical model itself has been subject to criticism in relation to the validity of the claims it makes when diagnosing illness (24-26). On a more prosaic level, attention has also been drawn to the relationship between academia and the alcohol industry and to who funds research and the implications of this (27), as well as the development of an addictions industry (28).

So, while discussion and challenge in relation to the influence of medical power is not a new phenomenon, it has certainly been taken up enthusiastically by users of ICT to the extent that ICT represents a 'new' power that must not be ignored or dismissed when designing public health interventions. Those who wish to work

with reducing dependency and addiction by means of public health education, would be wise to take cognizance of the advice of Perera et al and create context rather than content, avoid challenging 'new' power with 'old' power, and use online peer to peer networks for dissemination (12).

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