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Drug Addiction

Illness or Deviance?

On a cold February morning, a group of ten men and women gather inside the Westview Outpatient Substance Abuse Treatment facility. They sit in a circle in a large room along with the therapist who moderates the group, a white woman in her early twenties. All of the group members are black, ranging in age from about twenty to fifty, with the exception of one white male who looks like he is about twenty years old. The group members take turns "checking in" to the group therapy session, reporting their first name, the drug(s) for which they are in treatment, and the number of "clean days" they have. About fifteen minutes into the group meeting, the door opens and another therapist escorts an additional group member into the room, a black man who appears to be in his early thirties. The therapist hands the group therapist a small piece of paper and leaves the room. After reading what is written on the paper, the group therapist looks at the late group member with exaggerated shock and disappointment. He sits down in one of the open seats, laughing nervously and pulling his knit hat over his face. The other group members start muttering to each other and several say, "Oh, Steve!"

THERAPIST [*looking at Steve*]: Well, I guess we definitely have something to talk about now! Steve, would you like to share?

STEVE [*laughs, pulls his hat over his face again, and says quietly*]: I used last week.

MARTY (black male, about forty): What did you use?

STEVE: Wet [PCP] . . . I was just under a lot of stress and, I don't know . . . I just did. It's not a big deal, though. I don't have to use again. I mean

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everyone uses something to relax, right? Like some people smoke and some people gotta have coffee. It's just my thing.

[*Many people in the group appear agitated.*]

Marty: Whoa, whoa! Wait a minute here. Are you sayin' that you gonna use again then?

Steve: No. I was just . . . I mean, my car . . . I got problems with my car and my girl's been getting to me. And my car was in the shop, and then it got hit by two other cars there. I don't know; I just felt all frustrated. I used it to relax me.

[*Group members appear to get increasingly agitated.*]

Ester (black female, early forties): What?! Oh, you're just in denial. You don't think there's anything wrong with that?

Harrison (black male, probably early forties): You know what they say denial stands for? Don't Even Know I Am Lying! 'Cause that's the truth. I mean, if you don't even think you're an addict.

Steve: I'm just sayin'. I mean, I was just feeling, like my car and my girl getting on my nerves. And I didn't see what the big harm would be.

Bernadette (black female, probably mid- to late forties): Steve, don't you see that you're an addict?

Steve: I don't know.

Bernadette: Do you even know what an addict is?

Steve: Yeah. It's like when someone goes out on the street and has to use and tries to buy drugs.

Sarah (black female, probably mid- to late forties): He don't even know what an addict is!

Bernadette: Is that what you think? Like just someone you see out coppin' on the street?

Steve: Well, no . . . I mean . . .

Bernadette: 'Cause, guess what? You're an addict! And it don't matter what drug. PCP is just as powerful as crack! Let me find the definition of "addict" that NA [Narcotics Anonymous] gives [*pulls out a pamphlet from her purse and begins reading*]. "An addict is a man or woman whose life is controlled by drugs. We are people in the grip of a continuing and progressive illness whose ends are always the same: jails, institutions, and death." [*Turns to Steve*] Steve, are you even working the program? Do you know this stuff?

[*Steve shrugs.*]

Marty: When you're an addict, you're an addict for life!

Steve: See, I don't see it that way.

Harrison: Man, why are you here then?

Marty: Yeah, what are you doing here?

Ester: Is it because of court?

Steve: Well . . .

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Ester: Let me guess. You got picked up and it was either jail or come here. So you chose to come here. Well, until you come to terms with who you are, you just gonna go back out and use.

Marty: See, man. 'Cause once you're an addict, you're always an addict. An addict isn't just that person down there on the street tryin' to buy something. I could be clean for like ten years, never use in ten years. But you know what? I'm still an addict! That's what you don't understand.

[*Several group members agree and nod their heads.*]

Tim (white male, about twenty years old): See, I don't agree with that, about always being an addict. I mean, if you haven't used in ten years, then I don't think you're still an addict.

Therapist: It doesn't even have to be drugs. You can be addicted to other things, too, right? Like John . . . He tells me how he feels when he sells drugs. Like that feeling he gets is the same feeling as other people get from *using*. So I tell him, selling drugs for you is an addiction!

Bernadette: Steve, you better go to a meeting. There's one here right after group.

Therapist: Yeah, we'll make it part of your treatment schedule. Now you *have* to go!

Steve: Oh . . . [*doesn't sound enthusiastic*]

Harrison: Yeah, man . . . you gotta start going to meetings and workin' the program.

Ester: You first got to realize what you are!

What is drug addiction? Is it a disease that can be treated or is it a crime that should be punished? Is it a temporary condition or an incurable illness? What causes it—bad genes or a bad upbringing, a lack of responsibility or a lack of spirituality? While most Americans agree with the notion that drug addiction is a disease, these questions still have no clear answers. Decades of research and an ongoing war against drugs have not brought us any closer to a definitive method of defining and dealing with drug addiction. Just as the previous scene illustrates how those in drug treatment have varied perspectives about addiction, we have myriad ways of handling it. Some drug users will go to treatment while others will go to jail. Some drug users will be labeled lifelong addicts while others will never receive or accept such a designation.

The opening scene highlights the confusion and contradictions about labeling addiction that I observed during my fieldwork in two institutions designated as authorities in managing drug users: a drug court and an outpatient drug treatment facility. The scene comes from my observations of group therapy meetings at the drug treatment facility. Many of the interactions between those in treatment had to do with negotiating what the "addict" label means. As the scene shows, most subscribed to the notion that addiction is a lifelong disease with no

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cure, the view promoted by twelve-step groups like Alcoholics Anonymous and Narcotics Anonymous. This definition was even extended to behaviors that did not include drug use, like selling drugs. Others, however, were skeptical about this definition. Ultimately, individuals in both institutions had to accept the definition of "addict" that was assigned to them in order to progress through the programs. Steve, the individual in the scene who was reluctant about labeling himself an addict, was ultimately discharged from the drug treatment program. Because he was referred into treatment by the criminal justice system, his failure to complete treatment also likely resulted in his being sent to prison. While his continued drug use certainly contributed to that outcome, his resistance to accept the "addict" label also played a role in the clinic deciding that he was not progressing appropriately in treatment. If he had accepted that he was an addict and articulated his relapse as a sign that his addiction problem was out of his control, he likely would have been sent to a more intensive treatment program, such as inpatient, rather than to prison.

While I initially expected to find a lot of variation in the construction of addiction across these settings because of their different underlying orientations (the criminal justice system versus treatment), there was instead a great deal of consistency. Everybody in both settings tended to enforce the disease label of addiction, yet their management tactics overlapped treatment with punishment. This overlap of therapeutic and punitive approaches to managing addiction, a practice I term "therapeutic punishment," occurred in both drug treatment and drug court. In the drug court, the staff viewed the client as a criminal with an addiction problem. In treatment, counselors often had the same view of those in the program, especially if they had been referred to treatment by the criminal justice system. Even if they were not explicitly viewed as criminals, addicts were thought of as untrustworthy and immoral. This view justified the use of punishment in both treatment and the court, although it was framed as therapy, a way of "helping" clients come to terms with their addiction problem and their lack of socially appropriate values. Those going through these programs, however, viewed the sanctions as purely punitive.

It is not a surprise that the "managers" of drug addicts viewed the drug users they encountered as immoral, irresponsible, and often criminal. I offer two main reasons for this, both of which relate to the ongoing stigma that surrounds drug use and abuse.

First, our cultural discourse about drugs and addiction overlaps therapeutic and punitive perspectives. For the past twenty-five years, we have been inundated by federally funded drug "prevention" announcements on television and school programs like D.A.R.E. (Drug Abuse Resistance Education). The messages are clear: drugs turn ordinarily good people into immoral, bad addicts. The only way not to become a low-life addict is to *choose* not to use drugs in the first place. Drug users, often portrayed as scary (and poor racial minorities), should be avoided at all costs and essentially removed from society. One individual in drug treatment that I interviewed discussed the impact these messages had on his

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own family. The day before our interview, his daughter had come home from elementary school and when he asked her what she had done in school that day, she mentioned attending a program where they learned about "bad people who use drugs." The father felt horrible and reluctant to reveal his drug problem to his daughter because of this message. These "educational" messages also conflate any drug use with abuse; all drug users become bad drug addicts. This leads Americans to the conclusion that the only possible solutions to our drug problems are treatment (for those who deserve it) or incarceration (for most everyone else), or some overlap of the two. That drug treatment facilities in urban areas are often in poor neighborhoods populated by racial minorities furthers this moral perception of drug users and addiction.

Second, the criminal justice system has essentially colonized drug treatment. The criminal justice system has become the largest referral source for those in treatment (more so than doctors, self-referrals, or any other source). The majority of adults in treatment for using stimulants (including methamphetamine) or marijuana are there because of the criminal justice system (SAMHSA 2010a). Initiatives like drug courts have institutionalized the relationship between the criminal justice system and drug treatment by putting a judge at the forefront of both the client's criminal offense and his or her drug problem. This relationship has been effective because of our cultural discourse about drug users (sick people who need to be punished) and Americans' sense that while drug addiction might be a disease, at the same time, drug users need to be punished. As a result, any alternative approach to drug policy becomes silenced; any "new" initiative is about diverting offenders into treatment rather than reforming our drug laws. Our drug policy solidifies the notion that any drug use is abuse that requires treatment. As my research shows, even those who do not meet traditional diagnostic criteria for drug abuse or addiction are labeled addicts in need of drug treatment.

I began this project with a very open-ended question: What frameworks for defining and managing addiction operate in two settings that, on the surface, appear to represent competing authorities of addiction management (medical and criminal)? In these settings, is addiction framed and managed primarily as an illness, a criminal problem, or a moral issue? To represent those competing authorities, I chose an outpatient drug treatment facility and an adult drug court as my research sites. Both were located in the same large city, which I have given the pseudonym "Capital City." While I was aware that overlapping frameworks could exist in one setting (and they did), I chose sites that at least institutionally reflected different authorities. That is, in the court, a judge was the ultimate authority in handling the drug-addicted clients; in the treatment facility, a psychiatrist or therapist was the ultimate authority in determining treatment success or failure. Because of this institutional focus, the findings illuminate the institutional arrangements of labeling and managing drug users, in a sense, the "production" of addiction. Therefore, it is more a study about organizations than about individuals.

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To answer such a broad research question, I utilized a "grounded theory" approach (Glaser and Strauss 1967). I had no preconceived hypotheses; the study began as largely exploratory. I wanted to hear how people in these settings talked about addiction, how they revealed their views of addiction in their daily actions and written materials, and how they thought it best to manage people diagnosed as addicts. I attempted to learn the "natural language" of the organizations (Manning 1970: 256). Because I focused on how these institutions communicated definitions of addiction to their clients, my research fits into the paradigm of "institutional ethnography" (Smith 2002, 2006a, 2006b). Institutional ethnography is not incompatible with a grounded theory approach; it just directs the focus to social processes that influence individual behavior. Observations and open-ended interviews were the primary tools I used to gather data. In addition, to connect these discrete settings to larger institutional processes and meanings, I examined national data about drug treatment and drug courts along with documents from national organizations related to drug treatment and drug courts. Themes emerged from the data and helped guide my subsequent data collection, which occurred between June 2005 and May 2007. See the appendix for a more detailed discussion of my methodological approach.

While the research in this book focuses on one particular city's drug court program and an affiliated treatment facility, the findings have a broader application to the institutional arrangements of drug treatment and the criminal justice system. While drug courts vary by locale, they have many components in common (NADCP 1997). Thus, examining one program in great detail can help readers better understand drug court programs as a whole, even if all of the findings do not apply to every drug court program. Capital City's court also had served as a "model court" for those who were planning drug courts in their own communities, indicating that its practices were promoted by the preeminent national organization of drug courts. For similar reasons, the outpatient treatment facility that I studied in Capital City offers crucial insight into treatment programs across the United States. Outpatient drug treatment is now the most common treatment modality in the United States and these programs are governed by a similar set of state and federal guidelines, ensuring a high degree of similarity. While the interactions in Capital City's drug court and treatment facility undoubtedly reflect some degree of local peculiarities, this study transcends the local by exploring issues related to drug courts and treatment programs throughout the United States.

Other scholars have discussed the deviance-versus-disease contradiction of drug addiction, but most focus on the macro level, tracing policy developments over time or placing them in a historical context (for example, Conrad and Schneider [1980] 1999; Reinarman 2005; Tiger 2013). One of the strengths of this book is its "microsociological" focus on how this contradiction gets worked out in the day-to-day activities of institutions that label and manage drug addicts. It is a qualitative study of the front line of addiction work. Research on drug courts and drug treatment has been overwhelmingly dominated by quantitative

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evaluation studies. Even the relatively few qualitative studies of drug treatment and drug courts (for example, Nolan 2001; Paik 2011; Shavelson 2001; Tiger 2013; Whiteacre 2008) do not typically investigate the coordination between treatment and the criminal justice system. This is a serious gap in the research on drug addiction, considering that the criminal justice system and drug treatment are so intertwined. This book serves as an important contribution to filling that gap and to better understanding the treatment and punishment overlap.

This book also adds a new perspective to the existing literature by contextualizing the findings within theories of medical sociology as well as criminology. I specifically draw on the ideas of two broad sociological areas that have been used to study deviance: medicalization and the labeling perspective. The medicalization of deviance thesis argues that many of our definitions of deviant categories have shifted from moral conceptions to medical ones, especially in recent years (Conrad and Schneider [1980] 1999). It is a macro sociological perspective in that it attempts to trace social processes over time to identify larger cultural patterns of how we define and manage deviance. While the case of drug addiction somewhat fits into this medicalization thesis, I also show how medicalization falls short at explaining the lingering moral frameworks that still exist to describe drug users. Our current view, in terms of both cultural discourse and established drug policy, is that drug addicts are both diseased *and* deviant. That is, they are on the one hand sick individuals in need of treatment, but on the other hand still immoral outsiders who require punishment and resocialization. Additionally, this overlap of both medical and moral frameworks for describing drug users is reinforced by policy and discourse so it appears to be a stagnant designation; as a result, we are not necessarily moving toward further medicalization despite the millions of dollars spent annually to test and develop various pharmaceuticals to treat addiction.

I also frame my research findings from a labeling perspective (Becker 1963; Scheff 1999; Szasz 1974). A labeling perspective of deviance emphasizes the microsociological processes involved in the application and enforcement of deviant labels. Because my research focuses on the interactions between those in the court and the treatment programs to understand how addiction is defined and managed, a labeling perspective is appropriate. The rest of this chapter briefly reviews these attempts to understand deviance and integrates them to explore the use of therapeutic punishment in the drug court and drug treatment facility.

Medicalization and Deviance

> A disease is no absolute physical entity but a complex intellectual construct, an amalgam of biological state and social definition. (Rosenberg 1962: 5)

The previous quotation is from Charles Rosenberg's book *The Cholera Years*, which documented the various explanations people gave for the causes of cholera

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during three nineteenth-century epidemics. During the 1832 and 1849 epidemics, the disease was framed in very moralistic terms; those who contracted it were seen as sinners who indulged in vices because of their weak moral character. By the 1866 epidemic, however, the general consensus on how diseases were contracted and how they manifested within the body had changed markedly. By the time of the third epidemic, most people believed disease to be an entity that could be distinguished from both the individual sufferer and other diseases. Disease was no longer a judgment from God, but often environmental in origin, and could be isolated and treated (Rosenberg 1962). While changes in scientific understanding certainly contributed to this shift in how people thought about disease, they were not the only factors. Rosenberg focused on these cholera epidemics to illustrate how concepts of disease reflect larger social and cultural values. Indeed, disease categories are never stagnant; they are constantly being negotiated within the medical establishment, within other institutions in society, and between the medical establishment and other institutions. This process, along with the historical forces that shape it, is called the "social construction" of disease (Aronowitz 1991).

Medicalization is one specific mechanism that may operate in the social construction of disease. Medicalization refers to the process by which conditions not previously considered to be illnesses become redefined as such. Medicalization can occur at a conceptual level, where medical language is used to describe a behavior or condition, or at an institutional level, where treatment of the behavior or condition becomes more firmly placed within the realm of the medical community (Conrad 2007). Medicalization could include the redefining of a moral problem into a medical one. An example of this would be the emergence of attention deficit disorder (ADD) in the 1970s and 1980s to replace the notion of "bad" or unruly children (Conrad and Schneider [1980] 1999). Medicalization could also involve the movement of issues previously seen as "natural" or nonclinical into the realm of medicine. An example of this would be the increasing medicalization of women's bodies and processes, the view that menstruation, childbirth, menopause, and premenstrual syndrome are pathological conditions and/or require medical intervention (Markens 1996; Martin 1999; Riessman 1983; Wertz and Wertz 1989).

Medicalization would not be as widespread without the success of the medical profession in increasing its power and prestige, thereby enforcing its expertise over all areas that can be perceived as medical in nature (Freidson 1989; Starr 1982). Medicine's expert control over technologically advanced procedures and treatments, as well as its increasing use of genetic research to trace the possible causes of certain diseases and behaviors, has fueled further interventions by medical professionals into treating more contested areas (Conrad 2000; Ragoné and Willis 2000).

Medicalization, however, is not always a top-down process, where the medical profession imposes a new medical label on a behavior or event without the consent of the general population. Ballard and Elston (2005) argued that the earlier

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descriptions of medicalization overemphasized the medical profession's desire to expand its own dominance and underplayed the benefits of medicine that people perceived. Indeed, there are many instances in which patients themselves demand that a medical label be attached to their condition. For example, Vietnam veterans actively persuaded psychologists to diagnosis them with posttraumatic stress disorder (PTSD) and those suffering from chronic fatigue syndrome (CFS) sought the medical label to legitimize their illness (Aronowitz 1992; Mechanic 1995; Scott 1990).[1] Alcoholics Anonymous (AA), founded in 1935, promoted the idea that alcoholism was a progressive disease even before the medical establishment had universally agreed that it was a medical problem (Schneider 1978). Many of the subsequent notions about addiction as a progressive disease have come from this early definition proposed by AA. Similarly, the disease view supported by AA has resulted in the development of other twelve-step programs, including Narcotics Anonymous, Cocaine Anonymous, and most recently, Marijuana Anonymous. These examples show that the medical profession is sometimes only marginally involved in the process of medicalization. That is, Americans value a disease explanation and will often seek out a medical label themselves if none exists.

Medicalization has both positive and negative consequences. Certainly, some conditions become less stigmatized when they are framed as medical problems. The individual is no longer at fault for having a disease, as they were perceived to be during the early nineteenth-century cholera outbreaks. Viewing a problem in a medical way relieves the individual of blame, although not entirely. Some will still view the person as responsible for contracting the disease, such as in the case of lung cancer or HIV/AIDS. However, even if they view the person as responsible, most will acknowledge that the individual still deserves treatment for the condition. Medicalization also draws attention to issues that we may have neglected in the past, like PTSD. However, medicalization has the drawback of further individualizing and depoliticizing social problems. That is, medicalization contributes to the increasing neglect of the social, economic, or political context that may be related to certain problems (Conrad and Schneider [1980] 1999; Fox 1989; Lee and Mysyk 2004; Zola 1972). Instead of looking within the social structure or culture, medicalization ensures that we attempt to isolate the cause of the problem within the individual.