The Pastoral Rehab

Drug Addiction, Therapeutic Discourses and Self-Transformation

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Preface

This is a thesis of people, institutions, events and ideas that constitute addiction treatment in the United States. It is the result of my fieldwork in social anthropology, based at a treatment center in San Francisco, California, from January to June 2013.

My deepest gratitude goes to the clients and staff connected at the rehab I have named Cliff House. I feel privileged and grateful to write this thesis about drug addiction and rehabilitation, and I could not have done so without being entrusted by both clients and staff members.

There are several people I want to thank for making this thesis possible. I am grateful to anthropologist Kelly Knight (UCSF) for providing me with ideas and literature about addiction treatment. I wish to thank Alex Kral (RTI International) who provided me with information about the structural forces surrounding addiction treatment and research in San Francisco. I am grateful to Brad Shapiro (UCSF), who gave me information on methadone maintenance in the United States, and who showed me practices at the methadone clinic at SF General Hospital. At last I would like to thank Adrian Auler and the graduate group ERIE for inspiring me to look into the use of entheogens as a way to cure opiate addiction.

Most of all, I would like to thank my supervisor Professor Andrew Lattas, who has provided me with insightful ways of studying addiction. I would not have been able to connect this story of people, institutions, events and ideas that constitute addiction treatment without his help and guidance throughout the whole process.

Finally, I wish to thank my friends for always supporting me, and especially Andreas Langved, whom I have discussed drugs and subculture with for many years.

I believe that anthropology with its method of participant observation is a good way to provide information of the socio-cultural world of drug users, and I hope this thesis contributes some knowledge on how to approach drug abuse as a complex social problem.

Introduction

Gettin' clean's the easy part. And then comes life.[1]

My research project involves ethnographic work focused on the culture and social relationships of drug addicts and their responses to different treatment practices. My emphasis is on the historical formation of new practices for governing drug addiction and drug addicts. These practices can be understood using Foucault's historical work on the emergence of new practices of governmentality in the West, which were new practices for forming subjects, dispositions and behavior with a view to how these could contribute to the social order and its productivity. Drug addicts, like prisoners, patients and the mentally ill, have to be studied with an awareness of a historical perspective. The use of drugs, tolerated or forbidden, cannot be studied without taking into account the socio-cultural context within which drug use occurs, and this includes a political context made up of complex power relations. In particular, the professionalization of medicine and pharmacy has occurred alongside increased state control over the use of different substances, and I therefore see it as necessary to study efforts to *control* and *manage* the use of such substances. The medicalization of social life has resulted in a growth of therapeutic practices, and I will examine dominant therapeutic discourses in addiction treatment and their central concepts and models of selfhood derive from what has been termed a "therapeutic culture" (Illouz 2008; Madsen 2011).

My thesis also studies the emergence of new juridico-political forms of regulations that characterize contemporary addicts' lives, and this involves new relations to the state, doctors and family. I conducted six months fieldwork in San Francisco, California, where I observed institutional practices at an inpatient residential program for drug addicts. Having experience from working at different drug rehabilitation centers in Norway, I will explore how different understandings of the state and citizenship can underpin different treatment practices and this includes the clinical construction of the drug addict and the addict's own responses to therapy. My goal is to study "*how culturally and historically specific ideas about addiction translate into particular forms of therapy*" (Carr 2011: 232). In particular, I believe that specific political cultures of citizenship and the state can shape drug treatment. Though focused on the Western coast of the U.S., my thesis is mindful of a comparative perspective where for example in Norway and other parts of Europe there is a different expectation of the state's role in the management of social problems and of the citizen's rights.

My thesis draws upon a post-structuralist perspective to study how subjects deemed dependent on the state through their drug use are managed and controlled through the professionalization of medicine, a

[1] Quote collected from the recovering drug addict "Walon", a character from the TV-series "The Wire".

therapeutic culture, social reform movements and personal recovery programs. I will focus on treatment philosophies and practices in relation to wider social structures, where Foucault's famous inquiry into pastoral powers will be used as a central concept in exploring how subjects are influenced by practices of power and knowledge. The goal of self-awareness and self-reflection is central to many therapy programs and can be seen as bound up with a certain way of understanding and privileging the individual in relationship to society and the production of social order.

The increasing impact of drug abuse on society, families and individuals has occurred alongside the increasing criminalization of drug abusers and the professionalization of therapeutic programs. Both require anthropological attention, for what is often lacking is an ethnography of specific drug treatment programs. Drug abusers are affected by structural forces, such as the labor market, housing, social services, the "War on Drugs", pharmaceutical industries, and the illegal market and supply of addictive drugs. The professionalization of medicine, psychiatry, social welfare work and pharmacy is particularly relevant in this thesis, along with a focus on increased state control over the use of both legal and illegal substances by individuals and groups. I will argue that the use and control of substances has been culturally and politically specific, and that it has been changing across time. The practices that oppose and treat drug and alcohol use are targeted both at the individual's behavior as well as behavior that affects the larger society in general. In this sense, because they are often mediating practices for ordering and reordering the dispositions, behavior and social relations of individuals so as to affect the well-being and productivity of groups and society as a whole, they are a form of biopower. These practices are a form of governmentality that seeks to govern both individuals and the larger social order (Foucault 1975, 1979, 1982, 2007; Rose 1996).

Methodological concerns

Research on the use and misuse of drugs is affected by different methodological, theoretical and ethical challenges, and the illegality of drugs can limit access to reliable data (Bourgois and Schnonberg 2009). There is a need for more qualitative research on drug addiction that goes beyond simplistic explanations of human suffering that place moral responsibility on the individual. Instead, this placing of moral responsibility on the individual has to be treated as an ethnographic fact, as a cultural value deployed in the management and production of subjects and subjectivities. Anthropology with its method of participant observation can provide knowledge on the social, cultural, economic and political forces that shape drug users' experience of this culture of individualism. Ethnographic participant observation among drug addicts enables us to study drug addiction within its broader socio-cultural, institutional and historical context where the individual is not treated as a given but as something to be produced. This perspective goes back to the founding grandfathers of the social sciences, such as Marx (1970) and Durkheim (1960) who from different perspectives saw the modern world as bound up with the creation of the individual as a domain of value.

Studies have demonstrated how drug addiction is highly affected by wider social parameters like class, race, gender and ethnicity[2]. These can often overlap and they have often been obscured by the use of moral discourses that emphasize families and individual responsibility as the source or cause of addiction. Looking at the problem from a race perspective, we can find clear structural factors affecting and creating poverty but also drug addiction and punishment. For example, uneducated, blacks in the United States, are more likely to be criminalized for drug use given that sentencing guidelines for crack, which is favored among some Afro-American and Puerto Rican neighborhoods, are far higher than powder cocaine, which is favored as a recreational drug among white drug addicts. The disparity in the sentencing guidelines was reduced in 2007, but there is still a considerable difference, in spite of the fact that crack and powder cocaine contain the same pharmacologically active ingredient – Cocaine (Bourgois and Schonberg 2009). Color or race is an active force despite the cultural emphasis on the individual as agent, and when I use the word race it is to capture cultural constructions of whiteness and blackness, with the latter including Afro-Americans and Latinos. Though they have their own social and cultural differences with each other, they are both marginalized in relation to the social and cultural hegemony of whiteness. These ethnic disparities can be seen in health and employment, where Afro-Americans and Latinos in the United States are seven times more likely to be infected with HIV and more than twice as likely to be unemployed, compared to white men (Bourgois and Schonberg 2009:309).

[2] See Bourgois (2003) on the structural limitations for marginalized Puerto Rican crack-dealers.

In recent years there has been an emphasis on cross-methodological research on drug addiction and anthropology has turned its attention to institutions and their effects on personhood. There has been increasing research on the everyday practice and resistance of the marginalized in relation to the restructuring of the welfare state and an increasing emphasis on punitive states (Bourgois 2000, Bourgois and Schnonberg 2009; Rhodes 2004, 2012). Structural vulnerability and structural violence have become important grounds to study the contextual environment that comes into play with drug addicts experiences in institutional settings. I believe that anthropology and its method of participant observation can provide knowledge on the limits, instabilities and contradictions that are brought on by recent neoliberal policies in contemporary society.

I would like to use Bourdieu's (2000) concept of *symbolic violence* to illustrate this culture of blaming which internalizes and subjectifies forms of social marginalization. Along with resistance and sometimes at the same time, those who are subordinated can sometimes naturalize and individualize the causes of their own inequality by considering their social ranking as something caused by their personal character and failure, and by their inability to operate as a proper citizen. Policy debates and interventions often mystify large-scale structural inequalities and processes because those official practices and institutions often depend on ideological concepts of agency to accomplish their projects of individualization and transformation. In clinics, hospitals and therapy sessions, relations of power are concealed in the everyday life through the personal and individualized nature of the interactions between staff members and clients. This in turn helps to legitimize institutions, for as Bourdieu notes, it is because they seem self-evident and natural that institutions gain their legitimacy. I will look at how dominant therapeutic discourses in an institutional setting bestow authority and power through institutional structures and the symbolic capital of staff members.

Structure versus Agency

I propose to problematize models which treat drug addicts as actors and the institution as structures. This ignores how institutions are never just structures but full of active strategic individuals, and that drug addicts are not just free actors but are structured by wider values, practices, rules and requirements, including the requirement of their bodies. The theoretical distinction between structure and agency is too binary to fit into everyday life, and I find it therefore necessary to study the practices where structure and agency are intertwined and cannot be reduced to one or the other. The question of agency is complicated in regard to drug addicts because of the physical and psychological aspects of addiction, "*diffusing the line between willful actions and triggered responses*" (Brown 2008:4).

Bourdieu's praxis theory with its concept of habitus, has enabled researchers to study the interplay between structure and agency, without reducing social life to mental or social structures (1985). Human agency, according to Bourdieu, is the relationship between habitus and the social field. He uses capital as a concept to illustrate the "*powers that define the chances of profit in a given field*"

(1985:724). An individual's position in a field is based on unequal distribution of cultural, social and economic capital, which in turn determines different degrees of power and authority (Bourdieu 1985). Power and authority are embedded in social relations, which prescribe legitimate ways of speaking from a position within a given field. This is a form of "linguistic capital", which is one's knowledge about the legitimate ways of speaking and these connote cultural and symbolic capital. These social fields should therefore be studied as the relations between "*the properties of discourses, the properties of the person who pronounces them and properties of the institution which authorizes him to pronounce them*" (Bourdieu 1994:111 in Brown 2008:93). I will demonstrate that forms of linguistic, cultural and symbolic capital enabled staff members to speak with "*authenticity*", which was crucial to their authority. In addition, some clients had also internalized these forms of ideological capital and used them strategically to claim authority and authenticity, and a form of metalinguistic awareness developed (Carr 2011) that enabled them to renegotiate institutional practices.

Two Models of Governmentality

I do not wish to avoid the structure-versus-agency debate, but rather to frame the problem around two different models of governmentality, that of a medical model and a judicial model. These are sometimes competing and rival models, and other times they enter into complex overlapping symbiotic relationships with each other. The medical model revolves around a conception of the patient as sick, as trapped in his or her body's desires and irrational cravings. The legal system treats the addict as a rational, responsible subject who needs to be punished for his crimes rather than cured. It is important to stress here that these models are ideal types or polarities, whereas in everyday practices they can interact with each other and reshape each other. For example, the legal system, in its judicial sentencing, has been increasingly using medicine and the desire to cure and transform. On the other hand, the medical model has been influenced by judicial-legal ways of governing and policing society that emphasizes free subjects who need a hierarchy of punishments. Within the field of drugs, these models are combined and problematized.

Both the medical model and the judicial model are concerned with the interpretation and management of human behavior. Though they interact and reshape each other, the two models contain two discourses about human nature, behavior and motives that are often in conflict and at other times one is the precondition for the other. This became clear to me after six months of fieldwork, where addicts I had interviewed were sometimes excused for becoming addicts in the first place, but then held responsible for their own recovery. The distinction between addiction-as-a-disease and addiction-as-an-act-of-will, has long been a central concern in the historical reworking of models in treating addiction, with drug addicts being subjected to two different forms of governmentality, that of medicine and law. Both the medical model and the judicial model are concerned with governing subjectivities through disciplining subjects by making them engage in self-imposed reflexive forms of

behavior. I will study how these incompatible discourses of chronicity (addiction as a life-long disease) and choice (the addict as a rational and responsible subject) have moral effects on the addict, and inform how they present their biographies as a condition that is more than theirs alone.

With these two different models of governmentality in mind, I will focus on the medical model and especially what is termed the disease-model of addiction. The medical model developed as an alternative to the imprisonment model, as better able to transform the inmate but also in other institutional contexts - mental patients, the poor and school children. The medical model proposed new transformative interventions into the social body that consisted of new practices and institutions. I will look at how therapeutic drug rehabilitation institutions, working from a medical model, confront and deal with behavior associated with addiction.

The Addicted Subject

There is as Goffman pointed out in *Asylums* (1961), a certain model of the subject that is implied in institutional practices and this is often what is being contested in everyday life at the clinic. A sense of self is shaped and given meaning through everyday practices and interactions, and identity should therefore be seen as a construction process. Goffman offers a classic ethnographic study of nurses, inmates and institutional life that I propose to merge with a more recent study of total institutions and the rehabilitative project as grounded in disciplinary pastoral practices, namely that offered by Foucault. While Foucault's genealogies of power provide a historical understanding of wider structures, I also see it as necessary to combine Goffman's (1961), Illouz's (2008) and Carr's (2011) work to include more of the actual everyday practices involved in institutions; how discourses and technologies of governmentality are used.

The model of "the addicted subject", involves a pastoral project that works upon the motives, desires and self-awareness of the addict who is nowadays defined as a client. There are certain constructions of the drug addict that gives rise to discourses and practices that emphasize self-control, self-discipline and self-awareness. Placing addiction within the self has led to therapeutic interventions that seeks to remove the addict from being a 'slave to instinct' to becoming a rational subject (Coyle 2009). There are certain semiotic processes that are involved in this process of turning people into clients, and I will look at culturally and clinically prescribed ways of speaking from the positions of clients as well as staff members. The increasing influence of the "therapeutic ethos" will be elaborated with a focus on how dominant scripts have been institutionalized in addiction treatment programs, and how clients and staff members make sense and use of the therapeutic language and its models of selfhood.

The Underlife of Institutions

Goffman (1961), Illouz (2008) and Carr's (2011) work complements Foucault's (1975) discussion of the surveillance and control aspects of total institution in modern societies. These institutions cannot be understood by reducing them to their formal structures, rules and practices, for all institutions have their own underlife, their own domains of secondary adjustments that are often necessary for their effective functioning. Goffman emphasized that no institution can be practiced only according to its own formal logic, but has an informal underlife which complements, supplements and diverts from the formal policies and goals of the institution. I have attempted to understand interactions between staff members and clients at an American rehab, and I believe it is important to present both clients and staff members' views and practices, so as to avoid a binary opposition between power and resistance. Indeed, resistance, as Foucault and within anthropology - Abu-Lughod (1990:42) points out, is never in a position of exteriority in relation to power.

Staff members

Those employed in an institution are supposed to work upon people, upon their motives, character, desires and other personal qualities. The staff members must have some implicit assumptions about those they are working upon, and these assumptions may interpret the patient's everyday behavior (and especially their resistances) as symptomatic and as evidence for why they are in treatment, and as further justifying the treatment accorded to them. As Goffman notes: "*Given the inmates of whom they charge, and the processing that must be done to them, the staff tend to evolve what may be thought of as a theory of human nature*" (1961:87). This informal staff theory of human nature is not always identical to the official views of what behavior is expected and what motivates and causes behavior. However, these expectations serve as generating assumptions about the drug addict and imply and impose a conception of his or her identity.

Staff members at an institution do not just follow formal rules, but have developed their own categories, strategies and practices to be able to work with drug addicts, and sometimes these can be a mixture of formal and folk models of illness, motivations, identity and human nature. Both the official and unofficial theories about human nature imply assumptions about the drug addict and offer a conception of his identity that can be accepted, contested and renegotiated in everyday interactions.

In line with John Schwartzman's (1975) study of a methadone clinic, I will look into the distinction between what he calls *paraprofessional* and *professional* staff members. The *paraprofessionals* use their own personal problems and struggles with drugs as a primary therapeutic tool, while the *professionals* are hired based on their academic qualifications. These two different groups of staff members draw upon different forms of knowledge: the *paraprofessionals* use personal experiences and often the folk wisdom of Alcoholics Anonymous, while the *professionals* use

academic theories such as behavior modification models. However, as will become clear, that this is not a clear distinction, for as staff members combined both formal and informal folk models of illness, identity and human nature.

Clients

When the drug addict enters the rehabilitation clinic, he begins a shift in his moral career, with new significant others and a new role as a patient (Goffman 1961). Since every organization to some degree has a regime of activities, obligations and rules, this also contributes to a disciplining of the drug addicts being. I will study how this transformation is experienced by the drug addict, and how he or she must draw upon new vocabularies and concepts to articulate his or her identity. I want to focus on how the drug addict both assimilate and accommodate themselves to the drug clinic and its categories which define and create their identity. I will examine the biographies of addicts to document their successes and failures in rehabilitation, and how addicts understand this process and necessity to work upon the self. This thesis studies the effect of practices, laws, rules and classifications on addicts and how they respond back with their own practices, understandings and classifications.

Process

My initial project started out as a comparative analysis of drug-assisted rehabilitation, where I would compare the Norwegian national drug rehabilitation program LAR (Legemiddelassistert Rehabilitering) with a methadone clinic in San Francisco. After several visits to methadone clinics in San Francisco, I came to the conclusion that without connection to a research group and approval from HIPAA (the protection of confidential information about research subjects in the United States), it would be difficult to get access to clients. While I was still looking for clinics to conduct my fieldwork, I explored different approaches to drug addiction rehabilitation. I attended several lectures and events organized by the graduate group ERIE (Entheogenic Research, Integration and Education) from the California Institute of Integral Studies (CIIS). These lectures inspired me to look into the use of psychedelics like ayahuasca and ibogaine as a way to treat opiate addiction. This is an interesting development in psychedelic research, and I would like to devote more time and space to the healing effects of entheogens[3]. Unfortunately, the illegality of these drugs makes it difficult and I would not have been able to gather enough information and informants because of time-limits and lack of connections.

Although my goal was to present a clinical ethnography, I was still interested in studying the subculture of drug addicts so as to capture the street culture of poor drug users in San Francisco. The socio-cultural role of the state does not just affect drug treatment programs, but also the lifeworld of addicts. To what extent do drug addicts internalize a political order into their everyday understanding, categories and negotiations with institutions, and how does this in turn affect their relationship with each other in their own subculture? To understand the drug addict’s perspective in an institution, required that I also gave attention to important outside arenas of the addict’s life, such as church, family, welfare organizations, employers, and friends. The drug addict’s subculture is shaped by a world of meaning and solidarity, with the sharing of drugs, goods, housing, music and companionship.

During my fieldwork, I also became involved with the San Francisco Drug Users’ Union (SFDUU), which is a group of active drug users that created an organization with the purpose of working for better rights and conditions for poor drug users in the city. I attended some of their events and meetings in the Tenderloin District in Downtown San Francisco. One memorable moment was when I joined them for a hearing on the consequences of the so-called ‘War on Drugs’ in front of the Human Rights Commission at City Hall. This was at the same time as the San Francisco Ballet Opening Night Gala. It was kind of surreal to pass by all these rich, well-dressed people on the stairs. They were walking on the red carpet being served champagne, and we were walking up on the side with a mission to create safe injection sites, needle exchange programs and less police brutality. It presented a

[3] Entheogens are substances that may be synthesized or obtained from natural plants, and they induce altered states of consciousness which are used in religious, shamanic or spiritual contexts.

striking picture of inequality in the United States, where class poverty and suffering can take racial and ethnic forms – that can also involve unequal medical access and health effects.

Early in my fieldwork I became involved with the everyday life of a clinic and was introduced as a member to the group sessions. This was unfamiliar to me because I had mainly worked one-on-one with clients in Norway. In the United States on the other hand, group sessions are a central component in the treatment setting. In my initial exposure to group sessions, I felt a bit intimidated. I guess in some ways, I shared new clients' initial experience with being a new member to the group, in that I was unfamiliar with the formal rules and group dynamics. I also felt uneasy because of my role as a researcher. I was a foreign stranger taking notes in the corner while clients shared stories of traumatic events of physical and emotional abuse. As time went by, and I got to know both clients as well as staff members, I grew more comfortable at doing participant observation at the clinic. Although I became more confident in this new clinical setting, I continuously had ambivalent feelings about my role and responsibility as an independent researcher. For instance, what was my part when clients told me that they broke the rules, like using drugs, engaging sexually with each other or something simple such as using their phones without permission? Clients' activities were discussed during the staff meetings that I attended, but I did not reveal these secrets to staff members because I knew that this would get clients discharged from the rehab. When I work as a counselor myself, clients do not share secrets like that because they know I have to act upon the information and report it to others, it is a part of the job. As a researcher, however, you develop trust between you and your informants, and in this case, my informants were both staff and clients. It was necessary for me as a researcher to follow the procedures required for data and informant protection as well as the ethical rules of conduct stipulated by the American Anthropology Association. In addition, given the trivial nature of these offences, in that they did not harm others, I did not report such clandestine activities which are part of the social life of all institutions.

Representation of the material

Most of my information comes from observing practices and everyday life at the clinic that I have named "Cliff House". I observed group sessions and conducted interviews with clients and staff connected to this clinic, but also with other addicts I encountered who were not a part of the program. The majority of my informants at the clinic came from middle-class families, were educated, had jobs, and were covered by insurance. Clients at Cliff House had used a wide range of substances such as alcohol, crystal meth, ecstasy, GHB, cocaine, opiates and prescription drugs.

I decided to analyze dominant therapeutic discourses using personal narratives and public rituals of speaking at an American rehab. To focus just on narratives is undoubtedly useful but it should not be at the expense of recognizing other non-verbal mediums of communication, for instance body language: "*Oral discourse is a performative art, and written transcriptions lose the inflections and body language that punctuate speech*" (Gates 1988 in Bourgois and Schonberg 2009:12). However, I was struck by the sophistication of my informants' statements about themselves and addiction, which contributed to my emphasis on language discourses. Many clients at Cliff House were not poor or uneducated, and can be said to have "one foot in each camp" – meaning they were involved and engaged in the mainstream society and their respective families, but were also involved in a drug culture with an oppositional value structure. This I believe made secrets, shame and fears even more relevant, because there was a constant need to hide these two worlds from knowing each other. Although most clients were middle-class white educated individuals, there were also a few Latinos and a few that had been homeless and more involved with the street-culture of poor drug addicts. A female client I have named Laura, for instance, was one who came from a good family but had an unstable life on the streets without financial security for almost a decade. Laura, and my experience with other active drug users from San Francisco Drug Users' Union, gave me some access to the subculture of poor drug addicts in San Francisco.

At the rehab I observed different group sessions each week and attended staff meetings. The latter proved very useful in providing me with different staff perspectives and opinions regarding clients' statements and group session activities. Group sessions at Cliff House primarily revolved around educational lectures followed by a group discussion or process groups where either clients or staff would present a designated theme which would then be elaborated.

My analysis draws upon participant observation, 27 formal and informal interviews with clients and staff members, written documents, conversations with researchers in the field, and literary sources. Both clients and staff members were informed that participation was voluntary and that it would not interfere with their course of treatment. I have not engaged in detailed descriptions of actual spaces such as the rehab, the A.A.-meetings we attended and intimate details about clients or staff that might have exposed them. To be able to protect my informants I have used pseudonyms, and followed the

procedures required by the Norwegian Social Science Data Services (NSD) for data and informant protection as well as the ethical rules of conduct stipulated by the American Anthropology Association.

Structure of the thesis

The first chapter will present theoretical perspectives I have used to understand the rehab practices at Cliff House. The main theorists I have chosen are Michel Foucault, Nikolas Rose, Erving Goffman, Eva Illouz and Summerson Carr. These theorists are concerned with the rise of modern institutions devoted to the breaking and remaking of the self.

The second chapter will present historical developments in the addiction field, for the present has to be understood as part of a genealogy of practices for the caring for the self. It is necessary as Foucault's puts it to "*write the history of the present*", and as Michael Agar has pointed out, what appears to be radical changes in a field like addiction treatment, can "*be merely a cosmetic alteration of traditional ideas and practices held together with newly formulated 'political cement'*" (1990:1165 in White 1998:330). Addiction treatment in the United States has undergone processes of moralization, criminalization, medicalization and commercialization, and I will explore how these processes and cycles have been combined as well as problematized.

Chapter 3, 4 and 5 will present practices at the clinic, with both personal stories of clients and staff members, and the interaction between these two roles. Chapter 3 and 4, will present the female addict Laura, who has been in a variety of institutional settings in her life course. I have chosen to devote two chapters to Laura, because her life history so clearly illustrates how addicts are subjected to both the medical model and the judicial model. In chapter 3, I will present her life history, with both her engagement with different forms of institutions as well as her involvement in a subculture. Here I will focus on her movement between institutions which in different ways have attempted to manage her "addicted self". In chapter 4, I will write about her exposure to treatment at Cliff House, and I will analyze how addiction is assessed and the technologies and practices involved in individual and group counseling. In chapters 3 and 4, there will be an emphasis on therapeutic modalities such as "Cognitive Behavioral Modification".

Chapter 4, will focus on Justin, a former drug addict turned counselor, who has modified and adapted the philosophies and practices of Alcoholics Anonymous in ways that serve to create and offer him to clients as an exemplary model of an individual addict able to transform himself into a healthy citizen.

Chapter 5 will revolve around Michael, a client in his sixties who witnessed how the drug subculture changed after the 1970s and who later became addicted to prescription drugs. In this chapter I introduce the concept of "*the melancholic subject*" borrowed from the anthropologist Angela Garcia (2010) as part of my theoretical analysis of how practices at the clinic, work to manage and transform "the addicted self".

Chapter 1: Theoretical Perspectives

In the 1950s anthropologists started to investigate the comparative cultural context that was associated with alcohol use (Berreman 1956; Heath 1958; Mangin 1957; Sayres 1956; Simmons 1959; in Wilcox 1998:14). These studies revealed that the consumption of alcohol was determined by custom, which meant that both normal and abnormal drinking behavior was learned and defined by cultural expectations. In 1970, James Spradley's ethnography of urban, alcoholic nomads was published, which contributed to the anthropological understanding of alcohol use in relation to wider structures such as the legal system in the United States. Since the 1980s there have been many anthropological contributions to the alcohol and drug addiction field. After the discovery that intravenous drug use was a major mode of HIV transmission in the United States, ethnographic drug research increased (Feldman and Biernacki 1988; Wievel 1988 in Campbell and Shaw 2008:697). There are numerous ways one can analyze drug addiction, whether it be through key concepts such as structural violence (Bourgois and Schonberg 2009), labeling (Becker 1963; Spradley 1968; Stephens 1991), biopower (Foucault 1979; Agamben 1998) or governmentality (Foucault 2007; Rose 1996; Campbell and Shaw 2008). The complex nature of drug addiction makes anthropology with its method of participant observation an important empirical tool that overcomes as Bourgois notes, some of the limits and misinformation that can be collected in quantitative approaches.

Indeed, the empirical and theoretical work on drug addiction offered by Bourgois has inspired me to look into how intimate violence interfaces with various forms of structural violence. Like Bourgois, I also see the value of a theoretical approach combining Marx, Foucault, Bourdieu and Scheper-Hughes. I will mainly focus on Michel Foucault and Nikolas Rose in relation to their understanding of how discourses are part of wider regimes of power which I will apply to understand American "rehab" practices.

Michel Foucault

Michel Foucault's famous study of the relationship between power and knowledge argues that "governmentality" is the development of a set of technologies for controlling and disciplining subjects, for forming subjectivities and behaviors that are the basis of a particular kind of social order. These technologies have been changing but they involve individuals being advised, urged and coerced into adopting and exercising certain technologies of the self that align their behaviors, motives, opinions and desires with wider disciplinary and regulatory ideals that comprise these technologies of governmentality. Governmentality is the development of a set of institutions, practices and knowledges that interrelate and form apparatuses that functions as relations of power (1979).

In "*Discipline and Punish*" (1975), Foucault traces the history of new forms of intervention that shifted from punishing the body to rehabilitating the person, to transforming the soul, that is, the thoughts, subjectivity and dispositions of individuals. Whereas Machiavelli's Prince acquired his principality either through inheritance or by conquest, and his bond to his territory was external (Foucault 1979:130), the new form of governmentality became dependent upon knowledge about the population that has to be managed and produced in a qualitative manner. The population was a potential workforce in the industrial society and was therefore the perceived source of society's productivity and social order. In his historical survey of changing governmental practices, Foucault identifies three major changes in the economies of power. First, the state of justice in a feudal system where society is organized around customs and written law, with an interplay of commitments and litigations. In the second phase he speaks of an administrative state that is corresponding to a society of regulations and disciplines. The third is a state of government, a state that is no longer defined by its territory but by the mass of the population inherent in it (1979:145). Foucault identifies a major change from a logic of "*sovereignty*" to a logic of "*biopower*", which shifted obedience from physical force to one that promotes the well-being of its citizens (Foucault 1979). When population as a thematic category entered into political thought, new forms of disciplinary power emerged that were designed not just to punish the offence but rather to "*supervise the individual, to neutralize his dangerous state of mind, to alter his criminal tendencies*" (Foucault 1975:18). "*Biopolitics*" is aimed at treating the "population" as human beings with particular biological and pathological features, which can be augmented or shaped using specific institutions, practices and forms of knowledge. Governmentality depends upon these specific techniques and it became dependent upon new secular and professional forms of knowledge, such as science, medicine, economics and psychology. Foucault's work on knowledge and power illustrates that social control increasingly came to depend on non-corporeal technologies that focused not on violence but internalized forms of discipline and control that turned the self back upon itself in relationships of self-truth and self-observation.

Pastoral Powers

Max Weber defined power as the ability to control people, events or resources, and distinguished different forms of power (charismatic, traditional, and rational-legal); he also distinguished between legal and illegal power. Weber viewed power as something to be held, seized or taken away. In contrast, Karl Marx's concept of power was in relation to social classes and systems of exploitation rather than individuals, who for Marx emerge as an important organizing domain in relationship to capitalism and its ideological emphases. Michel Foucault has a similar understanding of the individual as an effect of modern regimes of power, but for him this includes modern regimes of surveillance, evaluation and discipline linked up to secular professional bodies of knowledge. Power, according to Foucault, is not a commodity or something that results from the choices or decisions of an individual subject, but is "*exercised from innumerable points in the interplay of nonegalitarian and mobile relations*" (1990:94 in Knight 2008:74). Power is everywhere, it comes from below and cannot be exercised without a series of aims, projects, techniques, practices, forms of knowledge and institutional sites. Power is not a thing but something to be produced in different ways at different times, and in the West it has shifted from regimes of punishment aimed at torturing the body in spectacles of pain, to regimes of surveillance and discipline that seek to produce forms of self-inquiry, which seek to pastorally manage the soul of the sick, the mentally ill, prisoners, school children and workers.

Foucault's study of pastoral powers is presented in his lectures "*Security, Territory and Population*" from 1978-79. Modern society, according to Foucault, consists of a very particular set of techniques, rationalities and practices that seek to govern individuals conduct in a similar way as a shepherd who cares for his flock: "*The modern Western state has integrated in a new political shape an old power technique which originated in Christian institutions. We can call this power technique the pastoral power*" (1982:782). Foucault explores the social uses of this metaphor of a shepherd's care for his flock that was originally religious, originating in the Mediterranean East, and above all in Hebrew cultures (1979:169). Pastoral powers are the relationship between the shepherd and his flock, where the shepherd's power is not over a territory but over the flock in its movements from one place to another. The essential objective of pastoral powers is the salvation of the flock, and it is therefore a form of care: "*It looks after the flock, it looks after the individual of the flock, it sees to it that the sheep do not suffer, it goes in search of those that have strayed off course, and it treats those that are injured*" (Foucault 1979:172). Foucault points to the important fact that pastoral powers are an individualizing power, by according as much value to a single sheep as to the whole flock. The shepherd directs the flock but must ensure that no single sheep is left behind. The shepherd is someone who takes responsibility for the sickness and salvation of each soul. Foucault claims this religious project has been secularized into the pedagogic goals of the psychiatrist, doctor, social welfare worker, teacher, warden, etc. This is a regime of power that lies in its purpose, in a project, for those upon

whom it is exercised. It is not power over a territory like a city, state or sovereign (unlike the Greek Gods who protected the city). The pastorate leads individuals and communities on their way to salvation, to improve their morality, dispositions, thoughts, skills, mental health, happiness and other such qualities of subjectivity. These techniques are connected to the law because for individuals and communities to be able to earn their salvation, their greater happiness and well-being, are through submitting to an order, a command, or the will of God that is now more secular and organized around professional authorities like the doctor, psychologist, social welfare worker and I might add the drug therapist.

The pastorate is connected to the truth, because salvation and submitting oneself to the law, are conditions of acceptance and belief in a particular truth (Foucault 1979:224). The pastor must teach by his own example, and by his own life because this is where his power lies. He gives directions with regard to daily conduct and this involves observation, supervision and control over every moment of the sheep flock's total conduct. "*The pastor must really take charge of and observe daily life in order to form a never-ending knowledge of the behavior and conduct of the members of the flock he supervises*" (Foucault 1979: 236). We will see in this thesis that many drug therapists operate in the same way, using their experience and history with drug problems to propose themselves as exemplary models of self-scrutiny and self-discipline.

Foucault's study of pastoral powers as a way to govern individuals is highly relevant in institutions, and especially those organized around medical knowledge and practices: "*We can say that medicine has been one of the great powers that have been heirs to the pastorate*" (1979:266). In addition, the production of truth in the pastorate is intrinsic to the emergence of a new rationality and a new art of governmentality. Foucault's concept of pastoral powers can illuminate how therapy seeks to work upon the motives, thoughts, desires and other subjective aspects of the psychic being of addicts. These pastoral powers are dependent on confession and "*cannot be exercised without knowing the inside of people's minds, without exploring their souls, without making them reveal their innermost secrets. It implies a knowledge of the conscience and an ability to direct it"* (Foucault 1982:783). Religious aims (salvation in the next world) has been replaced by "worldly" aims and expanded into the social body and this transformation found support in institutions such as medicine, the family, psychiatry and education (Foucault 1982:784).

Confession

Although Foucault did not examine illegal drug use, he did study very closely related institutional groups such as prisoners, the mentally ill, and patients. Foucault's concepts are clearly worth taking into consideration since substance abuse is affected by how subjects are created and regulated by knowledge and power, and more especially by pastoral regimes that have a religious origin. Foucault's extensive historical inquiry into the kinds of knowledge and power that are deployed within

Christianity are relevant for they are borrowed and transformed within the drug therapeutic context. In particular, Foucault's analysis of the confession as a technique of self-disclosure that folds the self back upon itself so as to create the modern subject, is of particular relevance to my thesis. "*A particular discourse of truth on the self will be formed through the examination of conscience. Starting from oneself, one will extract and produce a truth which binds one to the person who directs one's conscience"* (Foucault 1979:238). Foucault claims that western man has become a confessing animal. There is an obligation to produce words that are true to an inner reality, and this is fundamental to the contemporary project of individualization. Foucault's genealogies of confession can be viewed as a cultural history of inner reference, of self-reflection, that seeks to govern and transform the self by shaping the kind of relationships of self-scrutiny, discipline and knowledge that the self forms with itself through the intermediary of others; a priest, a congregation or in my case a social worker, a psychologist and a therapy group. Confession is highly present in therapeutic communities, as addiction is viewed as a disease characterized by the denial of inner truth that can be relieved and cured through verbal articulation. In this model, the removal of evil from the self comes through self-truth, because it is self-deceptions which prevent the self from controlling itself.

We can analyze confession not just as a discourse, but as a set of techniques that are connected with power that is grounded in the desire to know and express inner truths. Foucault's concept of "*games of truth*", explores relationships of power that exists in institutions like prison systems or medical establishments. These games of truth are regimes that determine what is good or evil, true or false, and what is valid or invalid (Foucault 1988:15 in Ning 2005). The biomedical discourse is concerned with controlling the human body to ensure proper functioning in the social world. In his concept of biopower, Foucault explores how institutional forms of social control, discipline the human body through "normative" rather than power through physical force. Bodies are therefore disciplined through everyday practices, rules, norms and forms of surveillance and evaluation that create invisible nonviolent forms of power, which can often function more effectively than through physical force.

In his lectures "*The Birth of Biopolitics*" (1979), he claims that neoliberal forms of governance created a new subject, which he terms "homo oeconomicus" – "the entrepreneur of himself". "Homo oeconomicus" is a rational and self-interested actor: "*Being for himself his own capital, being for himself his own producer, being for himself the source of [his] earnings*" (Foucault 1979:226). Foucault's conceptualization of power/knowledge, governmentality and techniques of self, is particularly relevant to my thesis, as the drug addict is viewed as failing to be "*the entrepreneur of himself [or herself]*". The various links between the "*techniques of self*" (1988) and the disciplinary practices and ideals of contemporary regimes of governmentality, create new expert relations that seeks to manage individuals and their conduct. In other words, you are free if you can obey, and you can have your autonomy if you follow the rules. In the neoliberal era, there is a new relationship between the techniques of governing others and the government of self and this is situated within the

community of mutual obligations (Rose 1996). I will revisit Nikolas Rose's ideas about governmentality and moral community, and later use both Foucault and Rose to illustrate how language, authority and social relations in a therapeutic setting are used as a tool to restructure the subjectivity of the marginalized.

Nikolas Rose

The British Foucauldian scholar Nikolas Rose has paid attention to the genealogy of subjectivity, governmentality and the rise of what scholars such as Beck (1992) call a "risk society". This involves discourses and institutions that define individuals or populations at risk so as to "*ground calls for ever-expanding regimes of vigilance, surveillance, and control.*" (Castel 1991 in Campbell and Shaw 2008:699). Rose claims that a recent restructuring of the welfare state has triggered a change in practices and techniques of governmentality, with the state adopting a new relationship to welfare recipients. Conservatives, neoliberals but also politicians to the Left such as the Labor Party in the UK and Democrats in the U.S., claimed that welfare and health services were overused and creating individuals who were over-dependent on the state, and this had led to unnecessary institutionalization and high costs for tax payers. Subjects were now conceived of as needing to become active members in their own government, as moral subjects with new duties and responsibilities. In his work "*The Death of the Social? Re-figuring the territory of government*" (1996), Rose emphasizes the importance of community as a concept that was used to refigure and produce the new relationship between the government and its subjects. The relationship between citizens and the state acquires a new moral framework, with the state being less obligated to its citizens and more on them becoming obligated and responsible through their belonging to a community – ethnic, gender, territorial or local. '*Government through community'* deploys a wide range of strategies and logics that emphasizes the neoliberal view of individuals as active and responsible for their own self-government. One example that Rose considers is the development of health initiatives and policies for HIV and AIDS aimed at making the gay community responsible for its sexual practices. It was in response to the activism of the gay community that national governments funded research and implemented new policies for HIV and AIDS (Ballard 1992 in Rose 1996). These governmental interventions led to the formation of an identity that was defined "at risk". Local support groups, activists, and political authorities created a demand for a community that had secure rights and benefits. The community of gay men responsible for the spread and control of HIV created new ways of governing subjects according to a logic of risk minimization.

Government increasingly operates not through the wider category of "society" but through positing and creating communities that can become self-policing. For Rose, these are the new and expanded governmental technologies in the neoliberal era. Community is therefore a *means* of government through our affiliations and moral obligations to the community that we belong to. This has

transformed our understanding and classification of the subjects of government, who are required to govern *themselves*.

The Marginalized

Rose draws a fundamental distinction between what he terms "*the affiliated*" and "*the marginalized*". Those who are affiliated are included as active citizens in their responsible communities. The affiliated successfully 'invest' in themselves by active choices that are in line with the government of self-responsible conduct. "*The marginalized*", on the other hand, are "*not considered as affiliated to any collectivity by virtue of their incapacity to manage themselves as subjects or they are considered affiliated to some kind of 'anti-community' whose morality, lifestyle or comportment is considered a threat or a reproach to public contentment and political order*" (Rose 1996:340). The drug addict has emerged as a "*risky subject*", who is affiliated to a kind of "*anti-community*" and who is resilient, and perceived as a threat to the neo-liberal project of "*government through freedom*" (Coyle 2009).

Neoliberal policies have often involved the privatization and the dismantling of public institutions for many of those who were considered marginalized. The result was that many of them such as the mentally ill, physically handicapped, homeless, racially disadvantaged and others, became more visible in the urban landscape. This worried many middle- and working-class families who saw around them growing urban poverty accompanied by illegal drug consumption and crime. There was a widespread fear of the growing "underclass" in the United States in the 1970s, fuelled by the dystopia of self-imprisoned poverty presented in academic texts such as Oscar Lewis' "*Culture of Poverty*" from 1966. This so-called underclass represented a shift in the classification of marginalized subjects, where "*a continuous **quantitative** variability in levels of civility becomes re-coded as a **qualitative** distinction*" (Rose 1996:345 my emphasis). This means that the claims of people speaking "*in the name of community*", implies a psychology of identification.

The identification of a community requires the work of educators, activists and campaigns to make people aware that such a community exists and therefore legitimately can make demands on behalf of this community. "*Within such a style of thought, community exists and is to be achieved, yet the achievement is nothing more than the birth-to-presence of a form of being which pre-exists*" (Rose 1996:334). Community activists, politicians and government officials often refer to a community that pre-supposedly already exists, whether it be gay men, drug addicts, psychiatric patients, or members of an ethnic group. However, community is partly created and imposed so as to disseminate self-policing and self-governing practices. For Rose, under neo-liberalism there has been a movement from self-governing individuals to more reliance on self-governing communities and this is part of an economy of power, of supposedly minimalizing the state and its interventions through passing the obligation to police onto others – onto individuals and groups.

The role of categories, funding, institutions and state personnel in creating communities and groups is related to a wider point that identity is implicated and emerges out of a dialogical relationship with wider structures, even when that identity assumes itself to be authentically given and constituted. This is also the point in Carr's (2011) work, where dominant ideologies of personhood serve to generate assumptions about clients. As one of her informants at the rehab proclaimed "*You got to be abused there, or they start thinking' there be somethin' wrong with you*" (115). Such a statement points to the normalization of certain models of deviancy and its social production.

The Expert Society

The marginalized will have to be equipped with tools so they can have an "*identity, choice, consumption and lifestyle*" that is compatible with the neoliberal "*empowered*" subject. The marginalized have either refused the responsibility and moral order or they don't have the capacity or skills for the management of themselves. Individuals that are viewed as marginalized, as belonging to the underclass or the excluded, lack the skills to take this personal responsibility for managing themselves, and this gives rise to an "*expert society*" of professionals, who seek to "*empower*" individuals so they can function as responsible citizens. "*The expertise of subjectivity*" is a whole family of new professional groups that classifies and measures the self, determines its troubles and prescribes remedies (Rose 1996). Psychotherapies and the "*expert society*" are connected to the obligations of the modern self. The modern self's moral obligations to society is to be less obligated, to not construct him or herself in terms of society and what it owes, but rather to adopt the obligation to construct a life from different available choices so as to realize and perfect the self - and in doing so contribute to society. Individual responsibility is constructed as the perfect realization of social responsibility. Life is therefore measured by personal fulfilment which is determined by acts of personal decisions and personal responsibility. There is a need to work on the self so one can achieve autonomy and liberation. This individualization process has led to the growth of psychology, social sciences and various philanthropic professions that seek to manage and assist the poor and marginalized. For instance, during the 1960s the National Institute of Mental Health (NIMH) spent more money on psychological theories and studies of behavior than on medical research on the biological aspects of mental disorders (Illouz 2008:163). Its psychological theories of human nature serve to rationalize neoliberal theories of governmentality. One counselor at Cliff House told me she was very fond of using Maslow's hierarchy of needs in her therapy sessions. Theories derived from Maslow concern individual personal growth and seek to realize and maximize each individual's potentialities, and only by doing so, can the individual live a truly authentic and free life. Maslow's theorization of self-actualization, led many counselors at Cliff House to view their work as building up an awareness of psychic structures with clients: "*Maslow's hierarchy means a lot to me because I genuinely believe that everyone is aspiring self-actualization. We want that, we want to connect more – spiritually, communally, inter-personally*".

The view of the addict as lacking morality and self-awareness is a view that implies a deficiency in psychic faculties. Yet many addicts are trapped in the pain of moral failure and a heightened self-awareness. Though therapy constructs itself as creating moral values and self-awareness, it is actually producing new forms of these. It is not operating quantitatively to add extra aspects to these faculties but changes the qualitative nature of morality and self-awareness. In particular, therapy uses particular kinds of narratives to produce new versions of identity and experience. Ironically, the realization of individual needs is what will free the individual from the need for drugs by catering and prioritizing other needs – spiritual, communal and interpersonal. Needs are invented and imposed to create a psychic reality that can be managed. Psychological theories such as Maslow's are part of the naturalization of pastoral powers.

Therapeutic Communities

Therapeutic communities (TCs) started to grow and be developed in new ways in the 1960s. This was a part of a milieu of experiments in therapy where patients were formed into groups and encouraged to take responsibility for themselves and their fellow members. In the therapeutic communities one had total responsibility for one's actions and this was produced through constant feedback from one's peers. Rose (1996) has paid attention to how such therapeutic models such as behavior modification are today increasingly consonant with the liberating theologies of self assertion. The profession of clinical psychology developed after the 1950s, when personality disorders such as addiction, anxiety or anorexia were increasingly not seen as "illnesses" but rather as maladaptive behaviors. This resulted in a model which was more about education and acquisition of new skills, rather than a 'disease' model. These developments led to an expansion of power, of the socio-cultural interventions of psychiatry and medicine.

Behavior modification is a therapy of normality which is about learning new techniques to develop social skills. The therapist educates the client according to desired or undesired behavior and the techniques of self-scrutiny and discipline that are to be used. Therapy involves constant self-analysis and self-help, so one can choose a lifestyle as an autonomous and responsible self. The therapist is concerned with developing new skills for the client with the principles of reward and punishment offered by the institution and the community of peers where the addict is asked to find and ground his or her identity. The system of rewards and punishments offered by the therapeutic community serves as a re-socialization process, and is evident in group sessions where for example clients can gain "points" by attending sessions. Some clients told me they could get cigarettes or other treats by working in groups. I was also present at staff meetings where counselors would discuss holding clients' phones back if they did not present within a week the first of their twelve steps – a program derived from Alcoholics Anonymous. Clients were also given rewards that were not part of the formal structure of the institution, though they served its purposes. For example, I witnessed one

counselor who used his personal connections to help a client get a job after he finished the program, because he wanted to reward him for making such good progress in his recovery.

The Therapeutic Ethos

"*We have no idea what a self is. So how can we fix it*?" (Schulz 2013 in Madsen 2014:101)

There have been many contributions to the study of the emergence of a therapeutic culture and its effect on selfhood (Lears 1983; Rieff 1987; Rose 1996; Jansz and van Drunen 2004; Illouz 2008; Madsen 2011). Lears (1983) has postulated that the therapeutic ethos has become a dominant ideology in our contemporary society, or in Gramsci's words, a form of "cultural hegemony" (Madsen 2011). Psychological knowledge has spread throughout society because it is considered to rest mainly on scientific and value-free knowledge which will benefit individuals and society as a whole. Various sociological contributions have from different perspectives studied the effect of the spread and influence of the concepts and models of human nature derived from psychology. Therapeutic narratives have been applied to nearly every aspect of modern life, which contributes to the forming of our self-understanding and interpretation of others. Today, almost half of the American population has consulted a mental health practitioner and therapeutic discourses have been implemented in various institutions (clinics, schools, prisons, the workplace etc.). The therapeutic culture has become dominant according to Illouz as the result of several factors; "*the internal changes in psychological theory; the institutionalization of the therapeutic discourse in the state; the growing social authority of psychologists; the role of insurance companies and pharmaceutical industries in regulating pathology and therapy; and the use of psychology by various actors in civil society*" (2008:156).

Rose (1996) has argued that psychology is consonant with the modern project of making individuals engage in self-reflexive projects of becoming autonomous and rational subjects. The therapeutic ethos with its emphasis on self-knowledge is both an epistemological (a particular conception of the knowing subjects to be governed) and moral act (Illouz 2008). It provides individuals with systematic forms of self-surveillance and introspection that promotes honesty, openness and willingness to articulate emotions and behaviors so as to be able to guide and transform these towards the realization of ideal socio-cultural interests and goals. In this sense, the individualizing nature of therapeutic discourses should not be viewed as opposed to the State and power, but rather as adopted and propagated by the State (Illouz 2008). In addition, the therapeutic language also blurs the distinction between public and private spheres, as it mixes both subjective experiences (behaviors, emotions, desires) with public norms and techniques of introspection.

Foucault's historization of systems of knowledge has been influential in exposing forms of power that are concealed in the implementation of therapeutic discourses in institutional settings. These "technologies of self" (1988) are used to control and discipline individuals in subtle ways by and

through dominant therapeutic discourses and often in the name of freedom; of freeing those individuals from self-captivity. I agree with Foucault that the therapeutic ethos with its concepts, narratives and systematic use of introspection and self-discipline, has concealed power in that is has produced more subtle and invisible ways of influencing and managing individuals. Psychology is at the heart of contemporary subjectivity, where Foucault's concept of governmentality can be applied to understand how self-governing individuals are connected with political objectives. The perceived autonomy of the self, which was based on the idea that introspection and self-examination would lead to freedom, should therefore not be viewed as an antithesis of power but rather as what constitutes it. I therefore see it as necessary to approach the therapeutic ethos as part of deeply ingrained moral and normative discourses and practices which shape how individuals are advised to adopt various techniques of introspection to re-create themselves and that which should constitute a good life. Identity in all societies is not something that is given but is something to be produced and developed. Self-regulation and self-control takes a particular form in contemporary society as a means to achieve an ideal normative form of life where individuals gain and use a certain "therapeutic capital" in the management of oneself.

In various institutions, the techniques of introspection derived from Christianity that were re-coded and re-articulated within psychology were both cognitive and emotional, and they were grounded and mediated through professionalized linguistic communicational practices. A self-reflexive selfhood emerged which internalized powerful forms of self-control as well as new communicative interactional styles with other individuals. Illouz has argued that we have seen the emergence of individuals being cast by psychologists as "Homo Communicans", "*who reflexively monitors his words and emotions, controls his self-image, and pays tribute to the other's point of view*" (2008:95). In other words, it is not just sufficient to master one's own life but to do so in ways that offer new social relations with others. Illouz further argues that this introduces a sociological puzzle: "*it fosters a form of sociability based on communication; it encourages a strong individualism based on enlightened self-interest, but always with the aim of maintaining the self within a network of social relations*" (2008:103). The practices of self-inspection and examination are also the process by which individuals are advised to change or develop new social relationships, based on shared truths, shared experiences of self-reflection, of moral failure and success. The cultural model of communication in therapy session became successful in that it combined description and prescription, diagnosis and healing of psychic struggles (Illouz 2008).

The therapeutic ethos is an instance in Ian Hacking's (1986) words of "making up people" according to value systems that are constituted by representatives of expertise knowledge (e.g. psychiatrists, psychologists, social workers, counsellors). The psychological discourse has been interpreted as consonant with the neoliberal project of making individuals govern themselves. Psychology is part of the individualization *and* social management of our neoliberal era, and has come

to shape the modern self by cultural codes used to express and transform selfhood. The neoliberal subject is not determined by traditional bonds and duties, but rather by an individual obligation to construct a life among different choices so as to realize and perfect the self. Although the modern era has been characterized by increased freedom as a result of the abolishment of former social ties and obligations, I will argue that the fundamental individualism in the United States with its core values of individual well-being and self-realization, paradoxically has led to more depression and forms of drug abuse.

Although Foucault's concepts are clearly worth taking into consideration when discussing the therapeutic ethos, I will take up Illouz point that if the therapeutic discourse has "triumphed", we still don't know why and how it has triumphed, which calls for a thick and contextual cultural analysis that can capture actors' understanding and use of such therapeutic practices and scripts (2008:4). To study the therapeutic culture in a rehabilitation program for drug addicts, I have combined the work of Foucault, Goffman, Illouz and Carr to study both the larger social structures as well as the everyday life to examine how drug addicts make sense and use of the therapeutic language in the exercise and performance of selfhood. My thesis is an attempt to contribute to Illouz's work of combining the specialized body of knowledge and cultural frameworks, where she argues that it has become impossible to disentangle "knowledge" from "culture", so a dual approach to the therapeutic discourse is necessary (2008:12).

Language and its effect on personhood

"*There is a distinct clinical logic to the theorization of addiction as a disease of insight, the topographical modeling of subjectivity, and the implementation of a linguistic program of inner reference*" (Carr 2011:123).

The therapeutic ethos has shaped our understanding of ourselves in which language is central in constituting and expressing selfhood. Anthropologist Carr's inquiry into the making of clinical roles and the effect of language on its users has been very useful for my own analysis. There is an economy of self-awareness in clinical rehabs in the United States that informs these narratives and the therapeutic practices. Here people often act according to their expected roles, and language is used as a tool to discover clients' so-called inner truths as a way to attain sobriety.

Language discourses are important in analyzing the historical construction and transformation of personhood because it is not simply a reflection of our reality, but a form of social action which constructs and creates reality. Examining the "*special language of the helping professions… can help us understand more profoundly than legislative histories or administrative or judicial proceedings how we decide upon status, rewards, and controls for the wealthy, the poor, women, conformists, and nonconformists*" (Edelman 1974:297 in Carr 2011:225). To study language discourses in an institution

can provide us with knowledge on institutional practices and positions as well as their effect on selfhood.

Professional discourses shape individual narratives, and especially in addiction treatment because there is a strong belief in a transparent language to overcome addiction[4]. Modern therapeutic interventions in drug rehabilitation centers in the United States hold a firm belief in the linguistic regime of inner reference: "*Since the late 1980s, narrative therapists and scholars alike have lauded the instrumental potential of talk, suggesting that linguistic interaction with skilled and sensitive therapists allows people to experiment with new or possible selves*" (e.g., Anderson and Jack 1991; Borden 1992; Bruner 1990; in Carr 2011:122-123). Modern psychotherapies claim that language enables the patient to distance him-or herself from their addiction so they are able to objectify it and therefore rework it.

Many addiction counselors at Cliff House believed in the patient developing an honest language that would reflect their true inner state of being and in doing so it would motivate the patient. They were as much concerned with producing clean words as producing clean bodies, because honesty, openness and willingness are essential towards a successful recovery. A quest for authenticity leads to a quest for honest mirroring and for honest words. One counselor who had a firm belief in the A.A. program was adamant that rigorous honesty was a fundamental component of a successful recovery: "*I try to help them with how rigorous honesty relives them of the burden to protect whatever it is they don't want to talk about, in a way that they really achieve ultimate freedom, because transparency means you have nothing to hide*".

The linguistic program of inner reference evaluates clients' statements about their inner states as either true or false. There is a challenge among addiction counselors to verify or falsify inner states, as clients could use it strategically and only tell them what they wanted to hear. Carr (2011) in her study of the linguistic regime of inner reference in the U.S., reveals that clients could *perform* acts of inner states, which she terms "*flipping the script*". Flipping the script becomes a way of performing the therapeutic self by the strategic use of therapeutic knowledge. It is a form of metalinguistic awareness that develops as clients participates in verbal practices in group or individual counseling. Clients will flip the script partly because basic goods and services are connected to the linguistic regime of inner

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[4] Stromberg (2008) argues that the "*referential ideology*" of meaning in language in American culture has a strong hold, which means that we often assume that language transparently reflects our inner thoughts and emotions, and that the words we use point to an independently existing reality. However, "*the pointing to a separately existing reality assumption is wrong in part because language always shapes the reality it describes*" (2008: 2).

reference. This means that although honesty, openness and willingness are of the highest cultural value in addiction treatment, the use of this language of authenticity also determines whether one can receive welfare payments or have custody over one's children. Addicts can *perform* being rehabilitated to get help from relatives, friends or doctors. One client told me that he went to an out-patient rehab a few years ago, where he could not manage to stay clean. He wanted to make his parents happy and was also living with them at the time, and one of their conditions was that he would quit doing drugs. This client described the double life that some addicts live, in his case he "*flipped the script*" partly as a way to keep his apartment:

"*I continued to smoke crystal every day in that [out-patient rehab], you know, telling people how to stay sober like high as fuck. It's kind of fucked up, me telling people how to stay sober when I've been up for days, I was just really fucking high in that place".*

Another client told me he was "5150" (the code for involuntary psychiatric evaluation) when he came down from the drugs and was having major anxiety-attacks. He went to the hospital and told them he was suicidal even though he wasn't because he needed to be locked up, and he knew what to say to make it happen. The patient did need therapy and treatment for anxiety but needed to overdramatize it as suicidal to get treated seriously. This is also evident in Bourgois and Schonberg's work where one of their informants threatened to jump of the Golden Gate Bridge, which led to a required twenty-four-hour psychiatric evaluation that again guaranteed him a dose of methadone (2009:98).

It is important to note that it is not just penal or medical institutions that produce dominant scripts, but also ethnographers who become co-producers of discourses. This is evident in Campbell and Shaw's (2008) work on harm-reduction discourses among injecting drug users (IDU's), where drug ethnographers' own concepts becomes a mode of "making people up" as ethical subjects (Hacking 1986 in Campbell and Shaw 2008). Since IDU's were perceived as a "hidden population", ethnography with its active participant observation method became a well-suited approach. Drug ethnography works with concepts such as harm reduction, risk minimization, which may create sanitary messages that can be seen as "*normalizing judgments*"[5] (Bourgois et. al 1997:161). Ethnographers circulate stories about risk that inform public health interventions: "*As it did so, it became an alternative governing mentality and a set of normative practices that drug users knew they should adopt* (Singer 1992 in Campbell and Shaw 2008:696). This is evident when ethnographers

[5] "Normalizing judgments" is described by Foucault as one of the mechanisms of disciplinary powers (the other two are "hierarchical observation" and "examination"), where individuals are measured by degrees of "normal" behavior, which makes it possible to measure differences between individuals. Normalization specifies a general norm that can be recognized and standardized, where individuals are characterized and corrected according to a norm (1975).

report of addicts repeat mantras such as "*I always use bleach*" and "*I never share needles*". Drug addicts therefore learn what to say in response to ethnographic interviews. This means that the social role of the state as well as research affects the lifeworld of addicts. They internalize a political order into their everyday understanding that affects their relationship with each other in their subculture. Risk for instance, is now part of the lexicon of how drug addicts describe themselves. Risk is a category in everyday culture that has many meanings that draw upon wider official discourses, but addicts also reinvent and remake the hegemony of these discourses.

It is impossible to tell whether clients use language to tell the truth or use it strategically, or both sometimes believing in their strategies and other times strategically using their truths. This is also the case with my own ethnographic interviews. Flipping the script can illustrate anthropology's methodological concern: Whether anthropologists have access to the "*native's point of view*" (Geertz 1974). In my own clinical setting I discovered that clients could probably present an alternative script to me during our interviews simply because I did not hold a power over their life course. Since I did not hold the position of a staff member, I did not make any decisions regarding their course of treatment, their finances or whether they had custody over their children. I did not take any urine analysis, which is also important because the use of urine analysis can identify the truth state of clients, for supposedly this scientific medicated body never lies. The addict's body is made to hold his truth and this truth is surveyed and claimed by science, by the newly authorized and empowered counselors who can use urine analysis to validate or falsify clients' claims to abstinence and reformation. Urine analysis reveals not just the drug use of clients but also their inner states of being, their deceptions and lack of commitment to change, for this is also what is being measured.

Chapter 2: Developments in Addiction Treatment in the United States

This chapter uses a historical perspective to study changing forms of treatment in the United States from the late nineteenth century and into the early twentieth century. These changes in therapeutic strategies and technologies are related to changing government policies, practices of institutional care, medical treatment philosophies and wider cultural assumptions about the self and power. I will use a brief genealogical approach to trace certain historical and cultural ideas about addiction and focus primarily on how these have affected the current addiction treatment system in the United States. In order to do this, I have used literary sources to present historical developments, and sometimes have supplemented these with my own interviews with addicts and counselors who have witnessed and experienced what they see as various successes and failures in rehabilitation from the 1960s up till today. I conclude this historical outline by studying the rise and influence of neoliberal forms of governance after the 1980s. In terms of my overall approach, I will in this chapter explore the addiction treatment system as a contested site in which different actors (clients, care providers and institutions) utilize, accommodate and resist dominant ideologies and treatment philosophies about addiction.

A Brief Presentation of Addiction Treatment from the 19th century to the 1930s

I will now explore different institutional and grassroots movements which sought to rehabilitate and redeem the addict. I will look at the growing influence of social movements and how they have affected welfare practices in the United States and in particular the culture of therapeutic institutions and their desire to restructure the subjectivity of the addict. My project directs attention to the relationship between the state and welfare practices which are often private and which in their early origins were religious. I will use a discursive analysis in order to show how moral puritanism and projects of individualization have been present in efforts to rehabilitate and redeem the addict from the Washingtonian movement and up until the emergence of Alcoholics Anonymous.

In 1784, Benjamin Rush, the so-called "*Father of American psychiatry*", published his book "*An Enquiry into the Effects of Spiritous liquor Upon the Human Body, and Their Influence upon the Happiness of Society*", where he proclaimed that "*A nation corrupted by alcohol can never be free*" (White 1998:2). Prior to being defined as a disease, alcoholism was viewed as a moral failure that led to sinful behavior which threatened the public order of society. Before the development of institutions specializing in addiction, addicts were subjected to "treatment" in all kinds of institutions – the almshouse, the jail, the workhouse, the charitable lodging home, and the lunatic asylums (White 1998). Although alcoholics and addicts landed in different types of institutions, they were met with hostility and viewed as not being morally worthy of receiving treatment for their condition. For

instance, hospitals were not accessible for addicts because they were considered unworthy of community care. In 1870, the American Association for the Cure of Inebriates was created, which led to the creation of six institutions specializing in treating inebriates (White 1998:23). This resulted in heated debates about which institution bore responsibility for treating alcoholics and addicts, and conflicts rose between the newly created inebriate institutions and the psychiatric asylums. Addicts and alcoholics were people who showed symptoms of both inebriety and insanity, and the psychiatric asylums hesitated over accepting alcoholics and addicts because mixing these two subject populations would prove "*prejudicial to the welfare of those inmates for whom the institutions were designed*" (Parish 1883 in White 1998:25). These disagreements between the inebriate asylums and psychiatry about where to place alcoholics and addicts, are still highly present in the field today, because addicts are trapped by both their mind and bodies.

Inebriate Homes, Asylums and the Washingtonian Movement

Psychiatric asylums created structures to exclude alcoholics from receiving treatment and this coincided with the rise of temperance societies like the Washingtonian movement. It was not initially a social reform movement but was directed at morally and physically saving individual alcoholics. The Washingtonian movement was created in 1840 by six alcoholics in Baltimore and its goal was redemption through experience sharing and tales of personal reformation (White 1998). It preceded Alcoholics Anonymous by about a century. Their solution was total abstinence from alcohol through confession and the strength of the fellowship of alcoholics, where they would swear an oath of abstinence in front of their fellow members. The temperance movement emphasized pledges, bonds and oaths, and they involved a ritual of confession and renunciation of past sinful life. As such the temperance societies were heavily steeped in a religious approach to moral conversion. Foucault has been concerned with studying the history of different pastoral technologies for governing individuals and communities. The Washingtonian movement's emphasis on confession, creating self-awareness and guilt, was part of the movement of pastoral practices outside of the church so as to be deployed by a community of concerned citizens interested in creating their own self-policing congregations. The development of largely non-state, personal and informal movements of recovery, was also the development of new forms of social control where the movement as a group works to police and articulate a confessional culture with the obligation to be self-reflexive and self-disciplined. The confessionary "drunkards tales" that dominate the conversion practices of these movements seek to craft subjectivities by providing individuals with a shared language of experience and shared practices for managing desires, self-deceptions and relationships with others. This sharing of intimacy in recounting tales of weakness and fallenness, often involved narratives that shared and objectified personal truths of human fallibility; that cravings could not be controlled and that served to alienate the self from itself and others. This sharing of home truths and personal experience continues to create intimate and strong bonds between the members of therapeutic groups, which allow their congregation

to function as a moral policing community that watches over its members. What was different from earlier rehabilitation efforts before the personal recovery movements, was that the confession of truth was no longer just shared with a moral superior like a priest, but with a congregation of fellow sufferers who used a common language to break and remake the addicted self. This shared language is part of a process of narrativization where words are used to reflect on the past to vitalize the present. The use of language to express personhood is typical of a certain moral crafting of the self that is especially strong in the United States, "*which insists that fully formed selves exist prior to their speech acts, that a person's words should be valued primarily as signs of selfhood, and that language is a window to the psyche if not the soul*" (Carr 2011:218). Self-reflection in a moral community therefore becomes the central strategy of reclaiming one's body and mind to craft a moral subject. Sobriety then, is not just about abstinence from alcohol and other drugs, but rather about discovering a pure and natural inner state without the need of external remedies. Recovery is about guilt and the cultivation of insight which is expressed and evaluated in verbal tales. The Washingtonians therefore sought personal self-reform instead of social prohibition to achieve sobriety.

The Washingtonian movement paved the way for the creation of inebriate homes, which often relied on religion to reform alcoholics and addicts. One of these homes was the San Francisco Home for the Care of the Inebriate. These inebriate homes were the result of "*that Victorian marriage of a disease concept of alcoholism and the idea of asylum treatment*" (Baumohl 1987:396). The ideological conflict continued over which institution would be best suited for the treatment of drunkards. Some saw the disease concept of alcoholism as an excuse for sinful behavior, and the conflict also revolved around whether "drunkards" were to be involuntary treated for long periods of time in large asylums or voluntarily treated for short periods of time in small, rural homes. The Washingtonian movement proved to be an alternative to prohibitionist efforts at controlling alcohol, for it espoused a "*humanist perfectionism which emphasized overcoming man-made problems with manly exercises of will. At the same time, however, this "moral heroism" was guided by an abiding Paulinism which stressed the spirit of divinity in man and the power of brotherly love to create a truly moral community based upon reciprocal obligations among its members*" (Baumohl 1987:402-403). Drunkeness was viewed as a lack of will-power and reason, where the tyrant appetite for alcohol destroyed the control of intellect and will. The central idea was the mastery of self, and inebriety was to be defeated through faith and religious exercise. In this historical period there was an increasingly interest in the nature of subjectivity, which contributed to an inward turn in the form of confessional autobiographies, diaries and letters, that have been described as the century of the "*discovery of the self*" (Illouz 2008:48).

It is important to remember that the temperance movement is part of a moral puritanism that is deep in American society, and the use of religious-like conversion experiences in addiction recovery continues in many American therapy programs. The use of religion as a framework in addiction recovery uses an emphasis on the submission of individual will to a higher power, to a higher moral

and intellectual authority – God, the priest, the congregation, family and other social obligations, but also the individual's own mind and conscience, his or her duty to care for themselves: "*The three-part story style – the past, the turnaround experience and life since then – was modeled on a similar story that Christians had evolved to qualify themselves as converted*" (White 1998:71). This is part of a focus on confession and moral rebirth, and functions as a narrative of salvation. The complete abstinence from alcohol and drugs purifies the body and its corruption of mind and this allows a reconstruction of identity and social relationships and partly through the supportive moral care of other alcoholics and addicts who have also undergone this spiritual conversion. Former addicts' are encouraged to carry the message to the unsaved, in other words, acts of service to other alcoholics and addicts. Moral puritanism is a prominent part of America's individualism. A moral discourse underpins processes of individualization whereby social problems are to be resolved through pastoral confessional projects undertaken by private institutions that have individuals as their focus (Foucault 1979).

The inebriate homes of the late nineteenth century sought to morally reform the character and lifestyle of alcoholics, whereas inebriate asylums generally emphasized the genetic, biological and psychological aspects of alcoholism. However, patients in the inebriate asylums were exposed to religious services and many of the inebriate homes used medical and psychological knowledge in their moral "treatment" (White 1998). The San Francisco Home of the Care of the Inebriate was later turned into a private prison in 1898 because of heated debates about the proper treatment of alcoholism and as financial support declined during the economic depression. Opponents of the inebriate homes claimed their quasi-religious treatment was insufficient and inebriate asylums instead sought "*the business of correcting habits, not curing souls*" (Baumhohl 1987:434). The Washingtonians sought a spiritual transformation through moral treatment, while the inebriate asylums were essentially behavioral where the patient was forced to adapt to the rules and values of the institution. Thus, the institutional response to alcoholics turned from private, specialized facilities like inebriate homes to public psychiatric facilities.

The Impact of Psychoanalysis and the Unfolding of the Therapeutic

The psychoanalyst Sigmund Freud is considered to be one of the most influential figures in the late nineteenth and twentieth century. In Jürgen Habermas' words: "*The end of the nineteenth century saw a discipline emerge [psychoanalysis], primarily as the work of a single man [Freud]*" (in Illouz 2008:23-24). In his theory of psychoanalysis, Freud developed a new language to describe and manage the psyche, and offered new cultural codes that produced new narrative models to make sense of the modern self. Freud provided a new way to understand and manage human suffering, and connected the modern self to "*ideals of autonomy, self-knowledge and the pursuit of happiness*" (Illouz 2008:25). His theory of human nature contained both cultural concepts of pathology and normality, and the

conscious and unconscious nature of the human psyche. Freud presented techniques of introspection and self-examination which through verbal articulation could overcome conflicts and lead to autonomy and self-mastery. His theory of psychoanalysis provided a way to interpret unconscious behavior (instincts, fear, fantasies, dreams etc.) and to use introspection and self-analysis as a way to control desires and transform them into rational behavior. Concepts derived from Freudian theories like emotions, rationality, self-interest, self-esteem, authenticity and the like were promoted by psychologists and offered a language through which individuals have now increasingly come to understand their selfhood. Freudian ideas became very popular in the United States and his psychological theories spread throughout American society in both academic and institutional settings as well as popular culture. The psychoanalytical model gained a foothold in American society because it addressed contemporary modern problems of selfhood and "*expressed them in a hybrid language that combined the tropes of popular healing and myth with the legitimizing language of medicine and scientific rationality*" (Ilouz 2008:36).

Criminalization of Addiction

By the mid-1920s, most institutions specializing in inebriety disappeared and during this period drunkenness was increasingly portrayed as contagious to society in general which led to a greater emphasis on punishment and legal action to treat the alcohol problem. Increased public intoxication and public disorder created concerns about the contagious effects of alcoholism on civic society, where for instance a study conducted in 1916 revealed that a sample of 100 people arrested for public drunkenness had 1,775 prior arrests (White 1998:79). Many articles were published on the growing "*tramp problem*" which led to a "*rising fear that a shrinking able population would be responsible for growing hoards of the mentally defective, the insane, the criminal, the infirm, and the chronically drunk*" (White 1998:89). When the Harrison Anti-Narcotic Act was implemented in 1914 (the first national antidrug-legislation), the alcoholic was redefined from a patient to a criminal. This led to an increasing number of alcoholics committed to federal penitentiaries, and the character of the alcoholic was again framed in a language of moral failure. The prohibition era did not only affect alcoholics, but also their caregivers and community providers. Doctors were now perceived of as contributing to the narcotic problem, and federal agents harassed and prosecuted both doctors and their clinics. It was a "*powerful intolerance for the drug user as well as the drug supplier*" (Morgan 1981:124). Between the implementation of the Harrison Anti-Narcotic Act in 1914 and 1938, more than 25,000 physicians were indicted for dispensing out opiates. This was part of intensified forms of regulation and policing of medicine. Many opponents of the Anti-Narcotic Act saw it as unconstitutional, since it tried to control or restrict the physician's pledge to serve their patients. In fact, in 1925, the Los Angeles County Medical Association protested these legal actions because "*any physician who attempts to devote his time to the treatment of narcotic addiction disease – no matter how conservative he may be, or conscientious, or careful, no matter how humanitarian his purpose, will invariably come into*

conflict with the laws" (Williams 1938:227 in White 1998:120). The Anti-Narcotic Act led to federal prisons being filled with alcoholics who could not be treated appropriately, which led to the Porter Act of 1929 that was created by the Congress to construct two "Narcotic Farms". These farms, the Lexington Narcotics Farm and Forth Worth, were designed as prisons and would function to rehabilitate addict offenders who would stay there between one and ten years: "*The farms isolated addicts, in the belief that such isolation checked the contagious spread of addiction into communities*" (White 1998:125).

Alcoholics Anonymous

The rise of Alcoholics Anonymous has had an enormous impact on how we treat addiction treatment today for it took religious pastoral practices of conversion and re-systematized them for a specific target population and purpose. Alcoholics Anonymous also influenced other therapeutic practices which increasingly drew on psychology and secular modern medical understandings of subjectivity and personhood. A.A's core philosophy and its twelve step program is central in the remaking of the alcoholic and today often the addict. Indeed, what is sometimes called twelve-step facilitated treatment (TSF) has become a nearly universal approach in alcohol and drug treatment in the United States. Cliff House was a TSF rehab and was heavily influenced by the philosophy of Alcoholics Anonymous.

Addiction as a Physical Allergy and an Obsession of the Mind

With little or no support for alcoholics and drug addicts from the government in the early 1900s, Bill Wilson, the founder of Alcoholics Anonymous, started a movement involving self-help groups with the publication of the Big Book in 1939. The book outlines the twelve steps for recovering from alcoholism and the book has provided the framework for curing other forms of addiction, and has been estimated to having sold 30 million copies. The spiritual and social strategies of A.A. were derived from the early Oxford Groups[6] (a Christian community) and were developed into a program of self-inventory, confession and restitution. A.A. was founded in Akron, Ohio in June 1935 when Bill Wilson met a surgeon named Robert Smith for a conversation about their common problems with alcohol. Bill W. and Dr. Bob, as they are often called in A.A. folklore, described addiction as a physical allergy and an obsession of the mind (A.A. 1976). Dr. Bob's emphasis on addiction as a vulnerability instead of a will or choice, became the cornerstone of the modern disease concept of alcoholism. Bill Wilson became a charismatic leader who offered new social strategies to cope with the suffering resulting from alcoholism. A.A. was founded on the idea of the folk wisdom of recovering individuals with an emphasis on spirituality and moral accountability as a way of attaining sobriety. This produced a rehabilitation system run by people in recovery themselves that were autonomous and separated from

[6] The Oxford Groups had four principles: Absolute honesty, absolute purity, absolute unselfishness and absolute love (White 1998).

the mainstream medical and mental health system. Wilson was influenced by the psychoanalyst Carl Jung who emphasized spirituality as a way of experiencing transcendence, and saw the potential of using shared vulnerability and pain to guide and support individuals in their recovery.

A.A.'s philosophy shared several common characteristics with earlier mutual-aid groups of alcoholics. It saw the etiology of addiction as multilayered, with both physical, mental and spiritual dimensions. The central focus was on self-inventory, self-reflection, confession and mutual support. Total abstinence was the ultimate key to recovery and the ultimate goal of recovery. What's more, the care for other alcoholics became a way to strengthen one's own sobriety. One of the main differences however, was that earlier mutual-aid groups placed an emphasis on self-will which was demonstrated through the pledging of abstinence in public. A.A. on the other hand, saw the road to recovery as something that occurred outside the self, in other words, that sobriety could not be attained alone. It emerged from "*the shared honesty of mutual vulnerability openly acknowledged*" (Kurtz 1982:44 in White 1998:163). This vulnerability openly acknowledged contributed to a new construction of alcoholism that did not abolish or deny previous religious and moral constructions, but reformulated them by merging them with more secular forms of knowledge. In doing so, the modern disease concept has increasingly normalized the alcoholic, it moved the formerly deviant Skid-Row alcoholic into mainstream society and our own families.

It is interesting to note that the disease concept that was set forth by A.A. did not rely on scientific evidence to support its claim. In fact, there is no discussion about the etiology of addiction as a disease in the first 164 pages of the Big Book (White 1998:197). Medicine treats the body, and psychiatry treats the mind, but A.A. views alcoholism as an affliction of the mind, body, and spirit. The strength of A.A. is that it is partly a community of self-healers who help other alcoholics by virtue of their own experience, and who offer practical social advice and help for achieving abstinence. I interpret A.A. and its discourse as part of a popular appropriation of the disease concept. It was partly medical discourse moving out of the hands of middle class medical professionals so as to be used in new ways by others who had an interest in illness and cures. Healing came under the control of the alcoholics themselves who could come from all kinds of social backgrounds.

The cultural anthropologist Victor Turner, known for his extensive work on rituals and symbols, states that "*the healing rite in 'folk' or 'tribal' medicine is seen to be more than the typing and labelling of diseases and symptoms and the restoration of health. It is rather the mobilization of efficacy through symbolic action for restoring internal integrity to the patient and order to his community*" (1975:159 in Wilcox 1998:110). Members of A.A. still come from a diverse set of social groups, but they share their common experiences with alcoholism within a shared language to foster radical change within the self so as to create a common fellowship with its worldview that combines religion with medicine. A.A. has a distinctive referential system of meaning in recovery, with concepts such as surrender,

powerlessness, resentments, control and higher power. The personal narratives and symbolisms in A.A. have a spiritual power in themselves as they are infused with the moral rebirth themes of sin and redemption and death and resurrection.

Members of A.A. have reported that they still live their lives as a "dry drunk", which means that they continue their destructive behavior even without the use of alcohol. Counselors at Cliff House often told clients that there is a difference between sobriety, which is the choice not to drink or use, and their recovery, which is reclaiming their lives by adapting to a new set of challenges and the opportunity for self-development offered by the 12-step program. There are therefore said to be no recovered alcoholics in A.A., only *recovering* alcoholics. Recovery can only be achieved through a spiritual awakening through the symbolic action of the steps and ongoing vigilance over oneself and also in relationships to others. The fellowship functions to police self-vigilance and self-deceptions.

Public campaigns and the growing popularity of A.A., led to increased funding for the treatment of alcoholism and a rise in hospital-based alcoholism treatment units. For instance, the number of alcoholics receiving treatment in state-sponsored programs rose from 473 in 1948 to more than 26,000 in 1960 (White 1998:192). A.A.'s philosophy was quickly adopted as the main therapeutic approach in the early 1950s after the prominent rehab Hazelden developed its Minnesota Model: "*Thousands of community representatives traveled to observe Hazelden's program – this movement shaped public and medical conceptions of alcoholism*" (White 1998 in Fletcher 2013:223). The Minnesota Model puts greater emphasis on the treatment community, and values participation and support among the members of the community. This also led to the incorporation of the family in addiction treatment, as Hazelden views addiction as a family disease. Hazelden's philosophy adopted the A.A. message about the chronic and progressive nature of the disease, and the transformative power of fellowship by employing group sessions among clients in addition to one-to-one-counseling. The Minnesota Model uses psycho-education to re-build addicts' awareness about addiction, and here recovered addicts are often used as counselors with a reliance on group counseling to confront and overcome self-denial. Today, more than 90 percent of treatment programs in the United States follow the basic principles and practices of the Minnesota Model (McLellan and Meyers 2004 in Willenbring 2010).

The Minnesota Model affected care-givers as well as clients, and it developed less formal relationships between counselors and their clients. This was a sharp contrast from earlier state-assisted programs which often subjected alcoholics to the same treatment as psychiatric patients. These treatments had often involved "*degradation rituals*" (Goffman 1961) and a hierarchical relationship between care-giver and client. The authority of institutional psychiatrists, doctors and social workers had been emphasized but it was no longer self-evident in the Minnesota Model: "*earlier authoritarian forms of interventionism and behavior regulation were superseded by humanistic techniques of counseling and*

advice, characterized by cooperation between professionals and clients" (Jansz and van Drunen 2004:38). The growing popularity of this democratic model also resulted in the dismantling of public institutions in the same era, where community-oriented therapy became the preferred model. The heated debates about the proper nature of treatment for addicts and alcoholics continued during this period, and both state psychiatric facilities as well as A.A. expressed ambivalence about mixing addicts with psychiatric patients. Moore and Buchanan conducted a survey in 1966 where they revealed that staff at state psychiatric hospitals expressed a concern because they had a pessimistic view of the alcoholic's ability to change, whereas A.A. members resisted having alcoholics treated in psychiatric facilities because of the implication that the alcoholic was mentally sick (White 1998:217). However, A.A. groups increasingly became the dominant treatment program, and by 1957 they had been established within 265 public and private hospitals and 336 prisons (AACA 1957:6 in White 1998:170).

One cannot underestimate the influence that Alcoholics Anonymous (and now Narcotics Anonymous), has had on the treatment industry in the United States, where TSF (Twelve-Step-Facilitated Treatment) has become a nearly universal approach to treating drug addiction. It is important to note here that TSF is not the same as A.A. or N.A., where A.A./N.A. is an independent self-directed program without ties to institutions or political organizations. Alcoholics Anonymous is not 'treatment', it is rather a spiritual community grounded in sharing experiences. In fact, some have argued that the original principles of A.A. are not consistent with the current use of TSF because the original voluntary aspect has been violated by court-directed patients who are forced into accepting TSF practices (Fletcher 2013:222). For instance, one of the clients at Cliff House was forced into treatment by his new employer after a urine analysis showed evidence of cannabis. He told me that he only smoked pot every other weekend but was forced to accept treatment. He had moreover to accept a definition of himself as powerless over his "addiction" and had to adopt the identity of an addict or else he would lose his job.

Methadone Maintenance

While A.A. increased in popularity and power in the 1950s, public institutional treatment declined, and prohibitionist efforts led to increasing incarceration of drug addicts. President Dwight D. Eisenhower declared a "*new war on narcotic addiction*" and in 1951 the Congress passed the Boggs Act-legislation that increased penalties for drug violations and introduced mandatory minimum sentences (White 1998:234). Drug addiction treatment and rehabilitation underwent further transformations in the 1950s when large numbers of alcoholics were seen in medical screenings for the armed services after World War II. It was the result of the high levels of repeated relapses in programs funded by the government, which led to placing alcoholism and drug addiction within the general health system. The American Medical Association changed the concept of alcoholism to a disease in 1957 (Jellinek 1960 in Taite

and Scharff 2013). This new definition of drug addiction created different approaches to the existing problem and led to the discovery of the opiate drug methadone by the two doctors Nyswander and Dole. The practice of psychoanalysis declined during this period as it was seen as a costly and time-consuming therapy, and many criticized the "talking-cure" as more suitable for middle-class patients instead of poor drug addicts living in urban areas. Nyswander and Dole proclaimed that heroin addiction was a chronic biological condition, and that methadone maintenance was the only viable alternative to reduce the high incidences of relapses among addicts.

Methadone maintenance has been promoted as a cure for opiate addiction since the 1970s[7]. By 1973, more than 80,000 addicts were enrolled in methadone programs in the United States, many of them returned soldiers from Vietnam (White 1998:254). Methadone was promoted as a better alternative to heroin, and a drug that could be controlled by physicians. This was also a part of an attempt to reduce heroin-related crime in urban areas. Methadone maintenance, along with the therapeutic communities, replaced the federal treatment programs in the 1970s. The Lexington Narcotic Farm was closed in 1974 and transferred to the Bureau of Prisons (White 1998:260).

The birth of the methadone clinic has caused controversy over its similarities with illicit drug[8]. Bourgois, following Foucault, has analyzed methadone as an example of an "*intradiscursive conflict*" (2009:284). Biomedical science declares methadone as medicine, but critics consider it a dangerously addictive substitute. This controversy serves as an interesting example of the competition between medical and judicial models, and the methadone clinic can be viewed as a sort of compromise between these two models. The state and medical authorities have created new distinctions between legal versus illegal substances, and this is aimed at controlling and disciplining the uses of pleasure (Bourgois 2000). Patients on methadone have become physically dependent on this substance, and Bourgois claims that this is a form of discipline because methadone dependency makes it too physically painful for them to misbehave. Methadone maintenance programs disciplines addicts by often requiring them to be exposed to other forms of therapy such as counseling so as to continue to receive their dose of methadone. Compulsory urine samples are also important in this treatment program, which seeks to monitor and control the use of other illegal drugs.

The state and medical authorities have created distinctions between heroin and methadone, with individuals using heroin being constructed as drug addicts, whilst those on methadone are patients in rehabilitation: "*The 'dope' became 'medication', the 'addict' became a 'patient', 'addiction' became*

[7] Statistics collected from the national guidelines for drug-assisted rehabilitation in Norway (2010).

[8] Methadone and heroin have similar characteristics, such as stimulating the same neurotransmitters in the brain. One argument favoring methadone maintenance is the decline in death rates, for the death rate of heroin addicts is "*more than 3 times greater than the experienced by those engaged in MMT* (methadone maintenance treatment)" (NCDP 1998:1939 in Bourgois 2000:174).

'treatment'" (Agar 1977:176 in Bourgois 2000:169). In the United States, where the judicial model is more pronounced, there are dramatically different practices deployed regionally[9]that reflect the struggle between these models of addiction, and also models of personhood. In San Francisco where it is legal, it was still difficult for poor drug addicts to participate in methadone treatment from the 1990s through the 2000s, because it was administered primarily through private for-profit clinics that charged about three hundred fifty dollars a month (Rosenbaum et.al 1996 in Bourgois and Schonberg 2009:284).

In comparison, there are about 7000 LAR-patients in Norway, who either receive methadone, buprenorphine or suboxone.[10] The political system in Norway is based on a welfare model that supposedly gives less responsibility to the drug addict and it favors a medical model over the judicial model in handling and treating drug addicts[11]. However, drug addiction is still a major problem since Norway has one of the highest rates of overdoses in Europe (SIRUS 2010)[12]. I have personally witnessed that although methadone is considered medicine, patients can inject it, mix it with other substances such as alcohol, methamphetamine and benzodiazepines, or in some cases sell their doses on the street to other addicts. There has recently been a heated discussion in Norway about developing heroin-assisted rehabilitation for addicts who don't comply with methadone maintenance. Heroin-assisted rehabilitation can function as an example of biopower, where addicts are redefined via medicalization rather than criminalization. Studies from Switzerland, where they have established heroin maintenance since the mid-1990s, show that clients on heroin may be more functional when it comes to health status and social compliance than methadone maintenance clients (Uchtenhagen 1997 in Bourgois 2000:186).

At Cliff House, there were a few clients on suboxone (an opioid antagonist) which was considered as a better alternative than methadone because it reduces cravings and withdrawal symptoms, and the opiate receptors are blocked so they cannot achieve a euphoric high. However, it is also criticized in the treatment community because it is incompatible with the drug-free ideology of A.A. [13]

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[9] Eight states have declared methadone treatment as illegal (Bourgois 2000:74).

[10] Statistics gathered from the presentation of the LAR-conference in Oslo 2012.

[11] The prison system in Norway has been termed as "*Scandinavian Penal Exceptionalism*" (Pratt 2007).

[12] In Oslo, ten percent of the overdoses between 2006 and 2008 were caused by methadone (SERAF 2011)

[13] The National Survey of Substance Abuse Treatment Services (Office of Applied Studied, 2007) revealed that only 3.6 percent of residential treatment settings had opioid treatment programs. In addition, the Institute for Behavioral Research from 2005 found that less than 10 percent of therapeutic communities (TCs) used methadone (Sorensen et. al. 2008).

The Managed Care Model of Health Services

In the 1980s and 1990s, the United States adopted a managed care model of health services. This model dismantled public institutions in favor of corporate-managerial techniques for managing alcoholics and addicts. It transferred the federal responsibility to local state governments and created a welfare restructuring which reformed and privatized social services. Conservatives and neoliberalists claimed that behavior health services were overused and created dependency and a client mentality among individuals. The former U.S. President George W. Bush claimed that a "*culture of dependency was born*" and that "*people became less interested in pulling themselves up by their bootstraps and more interested in pulling down a monthly government check*." (1999:229-230 in Carr 2011:23). In the 1980s there was a cultural panic about dependency. "Empowerment" and individual responsibility therefore became the central strategy in the neoliberal era in the 1990s, which promoted cost-effectiveness and limiting the supposedly overuse and abuse of health care services. The managed-care model seeks to transform dependent subjects into more responsible and productive members of society. In 1996, the passage of "the Personal Responsibility and Work Opportunity Reconciliation Act" (PRWORA), further restructured the welfare state, and forced welfare recipients into the workforce. This resulted in a reconfiguration of welfare recipients from passive clients into self-empowered health care consumers. The restructuring of the welfare state was especially harmful for active drug addicts, because they could not fulfill workfare requirements because of severe heroin withdrawal symptoms (Bourgois and Schonberg 2009:171-172).

"*Out of broken dependencies, the dependency on drugs grow*" [14]

The concept of "*co-dependency*" was developed in the 1980s, where not only those who were dependent were seen as a problem, but also those who enabled or supported other people's dependency. "*In a series of published works in the mid-1980s, Dr. Timmen Cermak conceptualized codependency as a "disease", proposed criteria for its medical diagnosis, and advocated that the treatment of this disease be paid for by major insurance carriers*" (1986 in White 1998:296).[15]

Fraser and Gordon (1994) have deployed a Foucauldian geneology approach to study the connotations and assumptions about the concept of dependency using a historical perspective. They argue that dependency is an ideological term, and that in the postindustrial era, welfare dependency has been associated with pathology. Terms like alcohol-, drug- and chemical dependency were re-defined in the 1980s, when the pathology associated with drug dependency became infected with new fears and critiques of welfare dependency.

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[14] This is a quote from Justin, one of the counselors at Cliff House.

[15] Co-dependency was not included by insurance companies, however, because they saw it as financial suicide (White 1998).

Although co-dependency as a concept has been criticized, it was still present at Cliff House. Family members were educated on how they might have supported or enabled addiction in their family and were told that addiction is a family disease which leads to undesired behaviors for the entire family system. Each weekend there were family groups at Cliff House where family members were introduced to the concept of co-dependency:

"A specific condition that is characterized by preoccupation and extreme dependence (emotionally, socially, and sometimes physically) on a person or object. Eventually this dependence on another person becomes a ***pathological*** *condition that affects the co-dependent in all other relationships"* (my emphasis).

Such discourses seek to make families responsible for addiction and that remove all other considerations of class, race and ethnicity from the equation. In line with Carr's (2011) analysis of American rehab practices, I would note that although many staff members at Cliff House were critical of welfare reform and the limits of the health system in the United States, they still used the various moral languages of dependency. Psychological discourses about dependency have often individualized dependency as a personal pathological trait or disorder, but they have also sought to empower other moral policing communities such as the family or counseling groups. Here notions of dependency and personal failure could take unusual forms with the client being constructed as having failed to discover authentic relations with others - with addiction emerging as a failure in relationships of dependency.

Coercion and Consent in the Neoliberal era

In the 1980s and 1990s, in-and-out-patient treatment centers increased, and these were supported by insurance money for alcoholism and drug addiction treatment. In the mid-1980s there was a decrease in accessibility, intensity and duration offered from residential rehabs for alcoholics and addicts. These developments happened at the same time as the Federal drug-control budget rose from $1.5 billion in 1981 to $13.2 billion in 1995 (White 1998:305), which means that addiction once again was re-framed in new moral discourses. The number of offenders committed to the criminal justice system exploded in these two decades, and paved the way to the newly created drug courts, which were used to divert non-violent drug offenders from prison to treatment. These drug courts involved a reworking of the medical and the judicial models of governmentality. Alcoholics and addicts were subject to both a technology of personal transformation and coercion. Addicts assigned to the drug courts are both patient and prisoner, for the court can imprison the addict if he or she doesn't comply with treatment. In 2010, 37 percent of admissions to treatment programs came through the criminal justice system (Fletcher 2013:204).

The welfare state is increasingly incorporating punitive judicial-legal regimes. For as Goode (2002) points out:

"*Welfare-state restructuring can also be conceived as one of a number of sites where the boundary between coercion and consent is being redrawn in the remaking of the neoliberal state. This is evidenced in work that shows how more punitive state policies have been implemented and time limits, diversion programs, and more-punishing sanctions have been enforced*" (in Morgen and Makovsky 2003:330-331).

Market-based Principles: The Insurance System and Pharmaceutical Companies

Market-based principles dominate U.S. medical practices today with the incorporation of insurance companies into the health care system. The absence of national health insurance means that access to health care services are limited for poor families and this has deepened the structure of inequality in the United States. Insurance companies have varying practices when it comes to coverage, some plans only cover detox ("medically supervised withdrawals"), and others cover inpatient programs, OTP (Opiate Treatment Program) or IOP (Intensive Out-Patient Programs). Coverage for addiction treatment changed in the national health system in 2014 under the Affordable Care Act (also referred to as "Obamacare"). The new system is expected to insure about half of U.S. citizens who are currently uninsured, and many of those will be persons with some sort of addiction disorders. Money for drug and alcohol treatment will flow in a different way, and the current treatment system will again change.

Insurance Policies at Cliff House

During my time at Cliff House I met Christina, who held a position called Utilization Review Coordinator. She was kind enough to patiently describe how the insurance system worked in mental health care. Her job is to prove to insurance companies why a client needs coverage, under an umbrella that is called "*medical necessity*". If the client meets the requirements on the checklist, they get coverage for a certain amount of days. When that coverage is up, Christina needs to call them and give them another update and prove whether clients are in need of more treatment. Even though it's a 30-day program, the insurance company is likely to cover at most 15 days for a client, and then they want them to step down until they're free of care. She explained that this practice comes from their belief and research that shows that short-term therapy can be successful. Christina has been working at Cliff House for about two years, and has already noticed a change in how insurance companies are handing out days for therapy. While there has been no declaration of a shift, she tells me it's clear: "*You know, at one point you would get ten days up front and now you get four, and you have to do a review again*". Her job is to look at the list of clients and see who has a review that day. She then meets with the client, review the progress notes and speaks with her co-workers. She looks at the psychiatric evaluation done by the rehab's doctor, and identifies what they have done in treatment and whether it's important to continue with their treatment. It's very important to focus on what's not working, according to Christina, because if you give them too much good information, insurance

companies think that clients should end their treatment. In her job, Christina tries to balance this contradiction by showing progress but acknowledging work that is left to do. She then gives a specific treatment plan for the four days that she will request. If the care manager doesn't agree with Christina's opinion that the client should continue with treatment, she can ask for what is called a "*doc-to-doc review*", meaning she wants to talk to a doctor to prove why she thinks the care-manager was wrong and that the client needs the extra days. If the client isn't covered completely or coverage is being dropped, she contacts the Program Director at the rehab and he or she can offer a deal to the client. This means that if a client's insurance only cover the level called PHP (partial hospitalization), the company only pays for day-treatment, and the rehab can sometimes wave the boarding fee and the client doesn't have to pay for the night. This is an informal aspect of institutional care, where employees work together to keep the client in treatment even though the formal structures doesn't provide the opportunity.

What Christina's work indicates is the emergence of a new structure of privatized surveillance and auditing, where it is not only addicts that are being evaluated but also institutions, therapists, and their programs. Everyone and everything must be made to work efficiently and yet this system has its own inefficiencies requiring an enormous amount of work from staff to justify necessary health care. Because treatment programs are subject to an "*audit culture*" (Strathern 2000 in Bourgois and Schonberg 2000:179), they have to justify their limited funding and as a result, they will sometimes exclude "risky" patients. This was also the case at Cliff House, where clients with severe psychiatric problems or clients without insurance, were not accepted into the program. I came to a group session one day, where a poor, black female client was only there for one day before staff members decided she was not "fit" for the program. Cliff House had previously offered a program for homeless, addicted women a few years ago, but because of lack of funding, the program was closed. Counselors were aware of the contradiction of needing to give humane standards of treatment but at the same time achieve the efficiency and rational goals promoted by external funding institutions. Many counselors were critical of the limits of funding and the new business-orientation of many treatment programs in the U.S. Here is how one counselor explained their program:

"*A lot of people can't afford that, because it's 14K a month for 30 days, and if you relapse, say three times in a year, that's 42K right there, just for rehab. So if you look at our rehab, most people here have jobs, they are somewhat functional, or they have family who can cover their bills. You don't see people who are lower-income, poor, living on the streets, who are actually the ones who need help. And there are a lot of them. So it's not a functional system. And some rehabs turn out to be business-oriented, they don't really care whether you do it or not, because in some cases insurance companies will pay for it, so whether you use it ten times in a year, they don't really care. It's a revolving door you see. I will say that our program is very much client-oriented for their well-being, but I can't say*

the same of other rehab programs in this country, and that's a problem too. Every time you run something for-profit, the first thing you seek is the profit, not the well-being of the person".

Pharmaceutical Companies

Under the managed care model of health care, the definition of addiction done by the "Diagnostic and Statistical Manual of Mental Disorders" (DSM) connects the mental health system with insurance systems such as Medicaid, Social Security Disability Income and Medicare. Pharmaceutical companies have also had an interest in the classification of mental disorders that can be treated with psychiatric medications: "*For drug companies… unlabeled masses are a vast untapped market, the virgin Alaskan oil fields of mental disorder"* (Kutchin and Kirk in Illouz 2008:166). There has been an explosion of prescription drugs produced and prescribed by pharmaceutical companies whose size, wealth, influence and power have increased radically under neoliberalism that promote individual self-control, and maximized awareness and productivity.

Prescription drugs, as well as the distinction between methadone and heroin, present us with an interesting example when it comes to the distinction between legal and illegal substances. I had a discussion once with a counselor about the distinction between "medicine" and "drugs", and he said he was overwhelmed by the number of prescription drugs every client brought in when they are checking in for substance abuse:

"*They're checking in with prescriptions for anti-depressants, benzodiazepines for anxiety… I can go on and on, they're on four to five medications. We in America appear to be very focused on medicating ourselves so early when people aren't behaving correctly and I think this creates a predisposition. When things don't go well, take a pill*".

254 million prescriptions for opioids were filled in the United States in 2010. Abuse of prescription drugs like OxyContin has become a national epidemic, where 15,000 Americans died from opioid overdoses in 2008, more than from heroin and cocaine combined. Purdue Pharma, the pharmaceutical company behind OxyContin generated $3.1 billion in revenue in 2010 from this prescription drug alone (CNN, *November 9, 2011*). It came on the market in late 1995, and it is used for a broad range of treatments for chronic pain. While their target group was for people with real physical pain, it was soon misused by addicts who discovered that they could get high by crushing the pills and then snorting, chewing, or injecting them.[16] Users of OxyContin have claimed that the withdrawal symptoms can easily be compared to those from heroin, and many switch to heroin because it's a lot cheaper. A young female client at Cliff House said she sold illegal drugs to support her expensive Oxy-

[16] In 2007, Purdue Pharma pleaded guilty for misleading the public about the potential for abuse concerning OxyContin, and was ordered to pay a $634.5 million fine.

habit. She described how she and her boyfriend felt like "*real-time dealers*" when they had connections with access to OxyContin, also called "*blues*" in street-slang. She was also involved in stealing prescription drugs from pharmaceutical companies along with cough syrup:

"*Years go by, the pharmacies in town have no more pharmaceuticals and they're wondering what's happening, and I had kids who were jacking it off the back of the trucks in the morning when they were trying to like load it into the store, so we would have the whole thing of sixteen ounces of bottles of cough syrup*[17]".

Although OxyContin is prescribed by doctors and supplied by pharmaceutical companies, addicts can use it for different purposes, and it can therefore circulate on the streets in the same way like every other illegal drugs. Legal drugs can become symbolically re-coded in subcultures, where for instance this female client speaks of OxyContin as part of a symbolic hierarchy of users, where wealth and access to different drugs is transformed into cultural capital. OxyContin dealers were "*a part of the game*" on the streets, at the top of the hierarchy of dealers because their customers were seen as more "respectable".

Counselors at Cliff House were worried about the increase in prescription drugs, and talked about how doctors as well as consumers were not educated about the potential danger of these substances:

"*The problem is that there is so much drug trafficking going on in this country, and the drugs are so available, and we are, as a society in general, taught to take a pill if we're not feeling well. If you watch TV, every advertisement is about abilify*[18] *or depression medications… If you're not feeling well or your girlfriend left you, or if you're having a bad day, pop one of these and you will feel like sunshine - like a person running free among the flowers."*

There are different kinds of suffering that are being medicalized in the legal and illegal use of prescription drugs. There has been a growth of unhappiness and not just in the impoverished and marginalized poor but also in the middle classes, with Prozac for example being used to treat more and more forms of depression that often do not have an identifiable source (Wurtzel 1995). The above quote which emphasized the recreational and subcultural status use of prescription drugs whilst partly true, also obscures the everyday forms of suffering that pervade not just the impoverished but also the affluent. There is more and more stress in everyday life, such as more individualized forms of performance appraisal as work, that are being managed to create people who are better than well.

[17] High doses of cough syrup can produce intense euphoria and can also be used to enhance the effects of other substances such as alcohol.

[18] Abilify is an antipsychotic medication used for treatment of schizophrenia, depression and bipolar disorder.

Concluding Remarks

The welfare state is today being increasingly questioned and critiqued and more particularly so in the United States where huge corporate think tanks and the mass media are devoted to a critique of the state in ways that promotes the growth of non-state private institutions and an individualist philosophy of personal responsibility. The activities of the welfare state have increasingly undergone processes of devolution and privatization which make religious, philanthropic and community organizations central in treating addicts and alcoholics. These private institutions are seen as more akin to the intimacy and authenticity of communities and families, which are seen as more "natural" socializing institutions, that stand in contrast to the supposedly inauthentic "artificial" public sphere of the state. Such a philosophy and its policies has encouraged other kinds of knowledge and practices to exist outside the state and its regulatory apparatus.

Under the neoliberal era, policies and practices use market-oriented assumptions about individuals and productivity, and this coincides with the growing role of corporations like insurance companies in the management of health care options and practices. This privatization and corporatization of therapy involves ideological work. It also involves a certain celebration of the individual as the source of social order and of American exceptionalism. This ideological celebration of the individual is not unique to the United States and to this historical period, but it has been continuously revisited and given new urgency as part of the need to shift responsibility away from the state and back to the individual, families and communities. This cultural construction of social order and personhood celebrates "personal responsibility" and the authenticity of the private sphere. It is the private domain which is increasingly gaining more responsibility in the therapeutic reconfiguration of addicts into self-empowered and self-governing individuals - that is into the ideal free subjects of a modern world.

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Chapter 3: Junk as a way of life

This chapter will present therapy sessions and the dialogue between the psychologist Karen and the meth-addict Laura, a female client starting her 30-day recovery at Cliff House. I will present Laura's life history and her involvement with different forms of institutions as well as her involvement with a subculture. I will argue that addiction can be seen as a reflection of our broader socio-cultural western world, where addicts' narratives of their substance abuse is often connected to a lost sense of place in relationships, society and values.

Emotional Awareness and Stress Management

"*How does your addiction support your identity*"? Karen, the addiction counselor has started a cognitive behavioral exercise in today's group session. She asks the clients: "*How can I change my story about who I am*"? She then proceeds with giving them a task where the clients are doing role-play with each other to discover their defense mechanisms. She tells them that defense mechanisms are triggers that are not necessarily obvious to us. Karen, a licensed psychologist, has a strong belief in cognitive behavioral therapy, and is usually working from that model. She once told me that "*we are the stories that we tell ourselves about who we are*", and emphasizes the importance on what she calls the capacity to step back and notice that none of us *is* an addiction but we *live in it.* Karen tells the clients that they need to "*step outside*" to be able to see what they are doing in their addiction, because the identity that each person has constructed as an addicted person has to go in order to recover. "*If you can't step back, if you can't come inside yourself and witness, you won't be able to tell what your triggers are*". While Karen talks I notice the attentive looks on some clients, while a few are almost about to fall asleep. The group consists of mostly white, adult, male clients, but there are a few women there as well as clients in their early 20s. Karen is having an "education group" today focused on addiction, and she asks the clients to share their story so they can learn from each other. The clients go through an exercise where they explore a provocative situation and are asked to present their thoughts, emotions, physical symptoms and behavior so as to show what they had done in similar situations. This is part of what's called emotional awareness and stress management, where clients are invited to revisit past events that caused resentment and a relapse back to alcohol or drugs. The group members are asked to elaborate what has been shared and all members of the group are encouraged to participate in discussing past events and how they might have reacted differently.

Cognitive Behavioral Modification is an approach that deals with dysfunctional emotions and maladaptive behaviors. Cognitive Behavioral Therapy has six foundations: Motivation, coping with craving, managing emotions, nurturing relationships, life-style balance, and finding purpose in life (Fletcher 2013:132). All of these foundations were regarded as crucial in the recovery process, and especially the verbalization of emotions was of critical importance at Cliff House. Clients were

educated in emotional awareness and “*the Disease of Emotion*”. They were given educational lectures during our group sessions, and learned to identify and label triggers and emotions. In one of these lectures, Karen used an essay called “Chemical Abuse & the Disease of Emotion”, that stated the following: “*They [emotions] are essential to the evolution of human relationships and social order. Emotion is the instrument of self-correction. To renew or cultivate emotion is essential to the process of recovery. It integrates us within ourselves. Honestly experienced and expressed emotion is both unitative and expansive, unlike any artificial stimulant or depressant. It takes what is most intimate within me and shares it with you in the trust that you will not abuse this gift of self. The art of clearly experiencing, identifying and expressing emotion is the art and skill of personal identity and intimacy with another* ”.

There is a remarkable amount of textuality in drug rehabilitation programs, such as educational lectures and various forms of introspection (daily journals, moral inventory, diaries etc.) that are required to be written down and documented. Cultural codes do not only exist in social practices and interaction but also in texts: “*Making people write things down, prescribing what must be written down and how, is itself a kind of government of individual conduct, making it thinkable according to particular norms*” (Barry et.al 1996:55). The above text illustrates how emotions have become a central component in the treatment setting, which in a subtle way prescribes norms on how to manage emotions and social relationships. The use of literary texts tends to objectify emotions, resulting in ideas about emotions as fixed entities that can be measured and balanced: “*In this process, emotions are externalized in the sense that they become separate from the subjectivity of the speaker, with the aim of taking control of and transforming them*” (Illouz 2008:140). Far from being an antithesis to rationality, emotions are consonant with rationality, self-interest, moral autonomy and self-mastery: “*The control of emotions, the clarification of one’s values and goals, and the objectification of emotions all indicate a broader process of rationalization of intimate relations*” (Illouz 2008:142). Emotional control in addiction programs as well as other forms of institutions is a cultural value in that individuals aspire to manage their emotions to become rational subjects. The discussion and elaboration of emotions at Cliff House was thought of as a practice of objectifying emotions that could be observed and therefore controlled. The objectification of emotions allowed them to be shared and exchanged with other participants so as to create new relationships of intimacy and belonging that could offer a powerful fulfilling social world to the drug subculture. The emphasis on confessions and emotions confers a powerful religious-like atmosphere within this salvational community. It allows the individual to step outside him- or herself and see themselves anew from the point of view of the therapeutic community.

“*People have reactions to situations and start to have feelings about that and start to make choices*”, Karen says to today’s group. “*When a negative situation comes up, a feeling of craving, they can actually observe their thoughts and take ownership of it, to observe as if they’re watching*

someone else than themselves". Karen goes on talking about irrational beliefs and cognitive distortion. These include all-or-nothing thinking, black-and-white thinking, catastrophizing and overgeneralizing, which causes a behavior that is unhealthy. She tells the clients that when they are aware of what is going on, they can actually control the situation by making a choice that is more healthy and allow unpleasant realities to pass.

Most of the time Laura and her fellow clients are exposed to such group sessions. Like most traditional 12-step rehabs in the U.S., there is an emphasis on the community to combat the disease of addiction through the fellowship. The group is the cornerstone for growth in recovery at Cliff House. Shared forms of intimacy are created with other addicts, and these are often based on highlighting near death experiences that serve to authorize a voice of truth that can call for self-reflection and change. There are solidarities being created in this sharing of private experiences such as secrets, shame, and fears. Guilt and shame for addicts comes from recounting a personal history of begging, lying and prostituting oneself. Guilt and shame had partly created the need for drugs to create an alternative experience of the self. Addicts can idealize their drug experiences but they also see themselves as trapped and needing to break out, because they also participate within dominant therapeutic-penal discourses that calls upon them to sober up; to rediscover reality, to assume self-control, to escape from the prison of their desires and emotions. It is the practice of placing private suffering into a clinical language that shares that suffering and has the power to transform it through the resulting intimacies.

Counselors often claimed that without healing the shame and guilt, one could not heal the addiction. During therapy sessions, we watched different documentaries about shame and addiction, where clients learned that guilt is *doing* while shame is *being*. Educational lectures about shame and guilt had statements about "*toxic shame*" which led to the "*sadness of losing one's authentic self*": "*Perhaps the deepest and most devastating aspect of neurotic shame is the rejection of the self by the self*". Client's inner states are presumed to be hidden underneath layers of shame that produce forms of self-alienation, such that recovery is about discovering one's "authentic" self that supposedly is denied in active addiction. The confession of sins is about giving verbal accounts of past actions and desires so as to be cleansed and purified, so as to restore the self back to itself. The quest for an authentic self becomes a salvational project mediated by using a shared language of suffering.

"*We can look at addiction as a story*", Karen once told me. "*What I tell people is that we are the stories that we tell ourselves about who we are. So identity is reconstructed all the time, and to be able to change the story, you have to be able to step out at least a little bit*". The verbalization of emotions is crucial to overcome the addiction, and the goal of therapy is to attain an accurate knowledge of oneself. There is a distinct clinical theorization of addiction that implies that what is not spoken aloud of with others, is yet to be acknowledged by the client. Though the focus is on self-knowledge, it is not

just sufficient to say it out to oneself in a private context, it has to be shared aloud with others who also share their autobiographical stories. I often heard Karen and other counselors tell clients that they "*held back*", or didn't "*work the program*" when they refused to share in front of the group. It is the social nature of identity that comes to the fore here where self-identity and self-knowledge are still socially mediated and shared through others. Identity and self-knowledge come back through the eyes and narratives of others (Goffman 1971). It is others who validate one's story and self-reflections by making one's story a refraction of their own stories and struggles for self-awareness. When others learn one's secrets, they break that monopoly of self-truths that alienates the self from others in an alternative separate reality. The breaking down of secrets is the breaking down of borders. It is also a process of shaming that grinds the self down to the lowest level from where it can be rebuilt with the reflexive supervising eyes and narratives of others. A community of people who have experienced the same needs and shames bind themselves to each other in a collective struggle against the alienating powers of deception. Their salvational quest is for new domains of truth and self-awareness, where what is being policed is the capacity to be honest with oneself within a community. These are the new self-governing communities that are re-mobilized and re-invigorated in a neoliberal era where economic interests seek out private communities and congregations organized around confessional technologies. These pastoral communities have clearly a religious heritage but their governmental pastoral practices and strategies have assumed a renewed importance in a risk society that polices risk and that, moreover sees the growth of the state as increasing risk rather than minimizing it (Rose 1996). Paradoxically, a great deal of state resources has gone into producing a private sector that is supposed to be more efficient than the state in the management of subjects and their subjectivities.

Karen educates the group by saying that "*by not using you have removed your number one coping mechanism*". She then asks Laura, a female client in her early 30s, to explore a provocative situation and explain to the group how she felt and whether she acted on these feelings that occurred in that particular situation. By this time I have come to know Laura's story and that she is well familiar with treatment settings such as this one. Laura has since the age of 17 been in a variety of institutional settings such as jail, methadone clinics, behavior modification programs, the psych-ward, the emergency room, in-patient rehabilitation centers, in addition to various community social services such as needle-exchange programs and Project Homeless Connect[19]. This time around she is seeking treatment for her meth-addiction that she has been struggling with for about six years. Karen asks Laura to be honest and open about the person she is, which is commonly heard in the rehabilitation setting. While some clients appears to show some resentment about being open and honest in front of a group consisting of about 15 people, Laura has been through these sorts of process groups before and begins to tell her story.

[19] For more information about Project Homeless Connect, see: http://www.projecthomelessconnect.com

Laura always felt very alienated from other people, and was fascinated by the dark side of life. In high school she started hanging out with a crowd that was involved in the grunge scene, a subgenre of rock music that often has references to alienation, apathy and a desire for freedom. She became increasingly involved in this subculture with a lot of alcohol use and after a while she started experimenting with heavier drugs such as heroin and crack. "*Loved heroin the first time I did it, it made me feel like I was in love with the world, I just wanted to hug everybody, I was just so happy*". After a while her family discovered that she was using drugs, and they were mortified. They believed her when she said she wanted to get clean, and sent her to a therapist to talk about her problems. A week before she would have turned 18 and have received full medical confidentiality, her therapist called her parents in for a family-session and told them what she was doing and how much drugs she was using. They were again mortified and tried to send her to the psych-ward. However, the psych-ward did not want to take her in because they were afraid she was going to run away, and they decided instead to send her to an adolescent program at a drug rehabilitation center called Walden House.

At first Laura was enrolled in their adolescent program with a lot of troubled teenagers who she said "*didn't obey their parents rules*", and one teenager was as young as 12 years old. She told me about how she spent most of her days on the couch while they tried out different psychiatric medications on her to see what would work so as to help her to recover. After a while she moved to the "adult Walden House", and started hanging out with "*the big fish*", in other words, more hard-core drug addicts from both the streets and prisons. In effect, the rehab centers operate like prisons which are known to be sites for the diffusion of knowledge about crime and help to professionalize criminals. If one was to push the analogy further, it could be said that some rehabilitation centers work in a similar way for some drug addicts. Laura's account of Walden House reveals that many clients learn a great deal about the drug subculture from other older and more experienced clients when they're in a treatment setting, and that the drug economy of the streets is highly present in rehabilitation centers:

"*The thing in Walden House that I learned was how to get cheaper drugs quicker and sneakier. It was a lot of people that wanted to get off paper, you know the court system, people straight out of jail, and all they wanted to talk about was the good old days and how they can't wait to go out and get high again*."

According to Laura there were also a lot of clients there who just wanted housing for the winter (see also Goffman 1961). Such accounts show how addicts can use programs and sites such as Walden House as temporary forms of rest, so they can strengthen the body and keep on using when they're back in their old environment.

Laura managed to convince her parents that she was a changed person after she was released from the Walden House program. She moved to another city and convinced her parents that she was ready to go back to school. After only two days in her new environment, she managed to get a connection to

heroin again and quickly became hooked on it. She went through all her money to support her heroin-habit and turned to her parents for help. Although they provided her with some money, she went through all the money they put into her bank account; she stole her roommates laundry quarters and started doing her laundry in the sink; she started textbook-scamming, where she would send receipts from other people's textbooks that they bought and show it to her parents. "*I was always having to scam how to get money or had to rip someone off to get drugs, it was just an exhausting habit, it's all you can think about, to get heroin*". In his autobiographical book *Junkie: Confessions of an Unredeemed Drug Addict* from 1953, William Burroughs writes about the "junk equation". He writes that junk is not an increased enjoyment of life – Junk is rather *a way of life*. Addiction is more than just an expensive habit, it leads people to engage in all kinds of scams and self-deceptions with those who trust and love them. They make promises and swear that what they are saying is the absolute truth when it is not. This inability to be trusted by others and this abuse of their trust also eats away at individuals and fragments them, and it further isolates them. They live in worlds of secrecy and fake performances that are and have to be very convincing, even to themselves (Goffman 1971). It is this sense of performative fraud that can get imported into the therapy session which becomes yet another scam, another performance within a performance. Yet addicts also use therapy to try to escape this world of masks and staged dramas, they perform authenticity but they are also trapped within the need for authenticity.

Eventually things got out of hand and Laura called her parents to "*lay it all out*" and seek help. They decided to pay for a methadone detox for her. The methadone maintenance treatment became difficult for Laura because it would take her several hours on the bus to get to the clinic, and in those hours she was supposed to be in class, so she got further and further behind at school. This is a common problem for methadone patients, where the methadone's rigid institutional structure which requires daily attendance, prevents patients from going to work or school. Laura told her parents that she could not combine going to the methadone clinic every day while at the same time attending school. Her parents therefore sent her to another treatment facility which offered a 28-day program. After finishing this program, she once again managed to convince her parents that she wanted to get clean this time around, and went to an SLE (Sober Living Environment). Laura became more depressed during this period and started doing drugs to lose weight and she also started doing 'dates' for money and cocaine. One night, she overdosed in her room at the SLE and her roommates found her lying on the floor and called the program director. The program director told her to pee in a cup, and said she could come back to the SLE after going to a detox. Laura instead took her syringe with heroin and took off. She stayed a couple of nights with the parents of some of her high school friends and asked them to drive her to an A.A.-meeting on Thanksgiving. Instead of going to the A.A.-meeting, she started her life as an 18-year old homeless girl.

“*We spent the night on the street, we had blankets to keep us warm. I woke up the next morning and I was so sore from the concrete, everything was just awful, I was freezing and it was 6 am, because we had to move before the cops got there, and I just felt like crap. But she [her friend] gave me a shot of heroin in the morning and everything went away, everything was perfect again, I was warmed up and everything felt good*.”

There had been too much emphasis on getting into college for Laura, and she felt that she just needed a break. She told me she was burnt out after high school and was tired of trying to balance school and methadone to keep her from feeling dope-sick. She had always felt very alienated from the mainstream society and talked about how her life on the streets gave her a new sense of freedom.

“*I was like, you know, this is really delightful to me, I don’t have to lie to people about what I’m doing, people I’m hanging out with, and she introduced me to all the street-people in the area, and it felt like one big family, it was all people that had common interest, and I’ve never had that before. So it was a new sense of freedom and freedom from responsibility*”.

Laura’s sense of alienation within mainstream society was medicated by drugs and the subculture of addicts she encountered on the streets gave her a form of connectedness she had never felt before. Laura felt she was excluded from mainstream society and her engagement with an oppositional subculture provided her with a community of fellow “outcasts”, for as James Spradley argues: “*In that culture he may still be alienated from the rest of society – but not from himself or others like him*” (1970:29). Laura’s statement about “*freedom from responsibility*” can be read as an escape from the obligations of the modern self, that is, to achieve personal fulfillment by acts of personal decisions and personal responsibility. She was not able to “invest” in herself in line with the government of conduct (Rose 1996), and therefore sought membership in a subculture that could give her value and respect that she could not attain from mainstream society (Bourgois 1997, 2009). Laura also lacked social and cultural capital (Bourdieu 1985) in the mainstream society and searched for an alternative community with an alternative value structure and different forms of subcultural capital (Lalander 2003).

After two weeks of living on the streets, her friend was arrested and Laura did not know where her next fix was going to come from. After a while she met somebody in the area who sold speed and she started running with this guy to score both heroin and methamphetamine. Laura told me that meth at first gave her a sense of control and power, and she could function very well on it, and that she was more productive and motivated when she was high. But there are consequences that come for long periods of high peaks and low valleys. Laura would have these monumental crashes when she came down from meth, unable to evaluate what she was doing with her life, and how it might end. We walked through the beautiful Golden Gate Park once when she told me that she heard constant voices in her head for about six years. She would hear children talking, and they would repeat everything she was thinking and make comments about it. “*I thought everyone else could hear it, you know, I’m a*

very scientific-minded person so I thought if you can hear it, smell it, taste it and touch it, it's real". She would try to stay high all the time and not let herself come down, often with a mix of different substances that were used for different purposes. She was still regularly using heroin on the streets, and would sometimes use meth "*to cut a detox*" from heroin.

Institutionalized

Laura went to see a social worker while she was homeless, who asked her about her hallucinations and how they made her feel. She said it made her feel like she wanted to kill everybody, so they "5150" her (the code for involuntary psychiatric evaluation) because she was a danger to herself and others. She was sent to the psych-ward, and thought she was only going to stay there for a few days. They decided to conserve her, meaning she was incapable of taking care of her basic needs. She ended up staying there for over a year and when compared to living on the streets, she still views it as the worst year of her life:

"*It was horrible, we didn't even clean our rooms, everything was done for us and I'm more functioning than that. I mean, I came in a state of confusion, but once I regained my sanity I wished I was insane again, just something to take off the boredom*".

Throughout her teenage years, Laura was completely resistant to treatment, and she was very angry at her parents' effort to try and help her. Laura and other clients who are exposed to treatment interventions at an early age, becomes familiar in dealing with institutions, and it becomes their normal way of life. This is also noted in Goffman's *Asylums* where mental-hospital patients who have lived their previous lives in orphanages and jails view the hospital as just another institution, and they can apply the adaptive techniques that they have learned in similar situations: "*For these persons, playing it cool does not represent a shift in their moral career but an alignment that is already second nature"* (1961:66). As Laura explained it to me:

"*you can call it institutionalized in a way, and they become used to that setting, and I think it can be scary too, I know for me at least, the prospect of living a normal independent life is kind of frightening, because the age when I was supposed to be breaking off in high school and finding my own set of values and principles, I had this moral authority hanging over my head that was constantly telling me how to live and what to do, so as much as I hated it, I kind of got used to it in a way*".

The moral authority of institutions can sometimes be preferred to the moral authority of one's parents which is felt to be too intense and overbearing. The home as a space of sanctuary and identity is not what many addicts experience, but instead they seek to escape its policing regimes and the forms of abuse that can sometimes be found there. Laura told me she would steal pain-pills from her mother when her mother suffered different injuries or underwent surgeries. Her mother had kicked Laura out

of the house because of her behavior problem, and one night she tried to climb in through the window of her mother's house. Her mother called the police and Laura was sent to jail:

"*I was in there for a couple of days and I felt pretty abandoned by her [her mother], even though I could understand the reasons why she did it, it still hurt me on an emotional level because I felt like in some sense she was rejecting me. She was drawing a line, she's not going to continue to let me take advantage of her, so I had to come to terms with like okay, now I have to deal with this on my own, I can't rely on her to bail me out and let me sleep there and give me money and stuff like that. So it was kind of a wake-up call, it was really sobering*".

Laura's father on the other hand had more difficulties with drawing lines, and was more involved in her life while her mother became more distant. "*I moved back in with my dad because he took pity of me and didn't have the guts to kick me back on the streets because it's worse to do that for him than my mom, so I took advantage of that".* John Schwartzman (1975) has analyzed family systems at a methadone clinic, where he argues that families dealing with addicted adolescents often produce a situation where one parent becomes overinvolved and constraining while the other parent becomes distant. Both parents can have difficulties setting limits, and the addicted adolescent like Laura, can become even more "out of control" as a result. Laura's parents' drug tested her when she was in high school, and she felt that her personal space was being attacked and it was an invasion of her privacy:

"It just made me angry really, it didn't serve as any kind of deterrent or warning to me, it made me extremely angry at the authorities, especially when my parents, once, like instigating the police to coming, and it just made me pissed off and I think when I was younger that made me want to fight even more, like when I would get negative consequences instead of like saying hey I should probably change my behavior to get things the way I want them, I thought well I'll show you, I'm just going to fuck shit up even more and that was really the attitude that got me into a lot of trouble with my family."

Some clients already had addiction problems in their family, and a few told me they used drugs to escape from their parents heavy drinking, and this can also be accompanied with violence, conflict between spouses and poverty. They were angry at their parents and as a result also angry at different forms of authority. Many younger clients at the rehab got an ultimatum from their parents of either going into treatment or not getting support from their family. One client told me he spent most of his time grounded in his teenage years as a consequence for using drugs. He had to sign a contract to his mother, promising her not to use drugs or she would kick him out of the house. This signing of a contract is itself an interesting phenomenon, because it shows how forms of commitment in relationships become remodeled along the lines of a judicial-legal pledge. It is part of the state beginning to inhabit everyday life, and affects the everyday relationships of citizens so as to reconstitute their relationships without the state itself doing anything.

Crack, Sex Work and Incarceration

The first day after Laura was released from the psych-ward, she started using heroin again. Things quickly got out of control and her smile was wearing thin as she described it. She was homeless again, and became a sex worker to support her habit. During our conversations about Laura's life on the streets, it was impossible for me to fathom how she managed to survive all those horrible things that happened to her. As a working girl, she was constantly harassed by the police, sometimes for recycling bottles, or she would get tickets for sleeping on the sidewalks, and at other times the police would claim she was loitering with the intent to prostitute because she had a condom in her jacket. The former mayor of San Francisco, Frank Jordan, implemented the "Matrix Program" in August 1993 (McGarry 2008), which led the city's police to start issuing tickets for loitering, panhandling, drinking and urinating in public (Bourgois and Schonberg 2009:210). This is a common problem for sex workers where the Police Department and District Attorney use the presence of condoms as evidence of prostitution and other criminal activity (*San Francisco Chronicle* September 7, 2008 in Knight 2012). These kinds of policing are part of the criminalization of drug addicts and sex workers. It produces a situation where the public health system faces a significant barrier to the use of condoms as an important practice for promoting health safety issues, and more especially controlling the spread of STD and AIDS/HIV. "*Criminalization of prostitution increases covert behavior and stigma, thus interfering with the self-regulation of health and hygiene*" (Knight 2012:69).

Sex workers like Laura also become public women as they literally don't have a home. They are forced to live and work in the public sphere. Nancy Campbell claims that "*women who use illicit drugs are widely figured as failures of democracy, femininity, and maternity*" (2000:16 in Knight 2012:70). Society also disapproves of mothers more than fathers for active drug use and for supposedly abandoning their children (Bourgois and Schonberg 2009). Sex workers and drug addicts are key actors in the "*risky city*" (Rose 1996) through their visibility as public figures. Laura described how she fell in love with a guy and moved in with him, but it eventually became a very abusive relationship. "*This guy was perfectly nice in the beginning, he was 60-something, and I was about 18. And he would get heroin for me, ripping me off completely, and he also liked to molest me at the park, so that was the downside*". The underground economy is dominated by males, which excludes women from being autonomous entrepreneurs when it comes to dealing drugs and burglarizing to support their habit. "*While this is changing, as women increasingly penetrate violent male preserves in the street economy, women are still forced disproportionately to rely on prostitution to finance their habits and to support what remains of their families*" (Bourgois 2003:280). The second day at Laura's boyfriend's apartment, he left her a piece of heroin so she could feel comfortable. Then all of a sudden the cops came looking for her boyfriend, and asked her to step out on the street. They found heroin in the apartment, and immediately arrested her for intoxication in public, even though it was the police that asked her to step outside. I recounted several stories about police officials making up stories in

court, although I cannot validate these claims. Such accounts however, reveal that addicts have first-hand knowledge about how deception is not just something that belongs to them, but also to state officials. This too is part of their alienation, as it is grounded in a certain cynicism concerning figures of authority.

During her life on the streets, Laura also did a fair amount of crack every day, which led to what she described as "*weird muscle movements*". When she didn't have crack she would get these muscle tremors, her jaw would go back and forth and she couldn't talk properly, and had uncontrollable kicking movements, hence the expression "*kicking the habit*" (Cox et.al 1983 in Stephens 1987). The police actually stopped her a few times when she was having these tremors, and thought she was high on crack, when the situation was the opposite. This drug cycle just perpetuated itself, and she got raped one night at an SRO (Single Room Occupancy). When she told me she was lucky she didn't get HIV, I could not hide my inability to understand how she could see herself as lucky. I guess she could read my reaction and said "*eventually you kind of get used to things like that, they don't really trouble you anymore, you kind of check out*".

Trauma narratives like the above show how biographies of addicts contain everyday forms of violence that become normalized. Laura's narrative also reveals the defense mechanisms that she used to handle and normalize the violence that was part of the everyday life for a woman on the street. She avoids trauma by checking out, by absconding from the scene in various ways, and more especially mentally which can be achieved through the use of drugs. Drugs are part of the hidden injuries of class, they allow the poor and the homeless to normalize and medicate their pain, hunger, cold, loneliness, violence and everyday forms of harassment and abuse. For instance, one client I encountered in San Francisco told me he grew up in South Africa, and claimed that he and his friends used drugs to numb themselves of the effects of apartheid. Another client had PTSD after the Vietnam War, and used drugs to numb the injuries of war. There is also a gender specific form to the violence and abuse that lower class women can experience with rape, prostitution and the threat of HIV/AIDS as part of their everyday world.

When Laura was living in the Tenderloin she was arrested for a misdemeanor and went to jail. Even though she was in jail for a short period of about two weeks for retail theft, it's on her criminal record for another seven years. Because of this, Laura faces difficulties when it comes to getting a good job, since many employers at places like gas-stations, grocery stores and restaurants do a background check. When I was hanging out with Laura, she was on probation for another year and six months, and has to pay off her 1200 dollar court fee. However, she won't be able to pay it off because she is not able to get a job. Laura was on informal probation, which basically means that she is not supposed to leave the county, but doesn't have to check in with a probation officer. If she did get arrested again though, she might not just go to jail, but to prison for a longer period of time. This illustrates the

problem of the mass incarceration of drug addicts in the United States. The so-called "War on Drugs" has disproportionally affected the already dispossessed. More than half of the United States federal inmates are today in prison on drug convictions. In 1980 there were 15 inmates per 100,000 adults, and it increased almost tenfold in 1996 with 148 inmates per 100,000 adults. The United States has spent more than $1 trillion fighting the "War on Drugs", and 4 out of 5 of those arrested were simply for possession of drugs[20] (*TIME,* April 2, 2012). This causes major problems for convicted drug addicts, who not only must spend time in prison, but are highly discriminated after their sentence has been served when it comes to housing, employment, loans and the right to vote. At the same time as the imprisonment rate has gone through the roof, there has also been the privatization of prisons, which increasingly are managed by private corporations (see Rhodes 2004).

Laura said she couldn't function as a human being without heroin in her body. She spoke of herself as constantly chasing her first initial high which made her feel like she was in love with the world. This chase for the authentic, initial high became a destructive cycle:

"*Things were just getting so ugly, there was no joy, no happiness, just me wondering how it was going to end. Am I going to get shot in some Tenderloin-hotel, am I going to OD*[21] *behind some fucking building. I just didn't want to go out like that, I was too proud and I wanted to get straight*."

Following the life history of Laura can illuminate a condition that is more than hers alone. Her movement between both judicial and medical institutions illustrates how addicts are subjected to both being an offender *and* a patient. She has been exposed to regimes who either want to punish her behavior, or cure her illness. Laura has also learned to move between these ways of identifying herself as an offender and patient, and she has learnt to play one off against the other. This performative sense of one's self, as playing different scripts for officials, parents, and relatives creates a sense of inauthenticity, of emptiness, and gives rise to a search for authenticity, for a more real truer self. Paradoxically, this search for the authentic can also tip off over into becoming another script to be performed for family, counselors, social workers and in doing so, further confers the sense of one's self as fraudulent, immoral, deceptive, empty, or lacking. As Anthony Giddens argues: "*Identities, subject to processes that, while offering opportunities for self-actualization, can also lead to fragmentation, insecurity and powerlessness*" (1991:187-201 in Barry et.al 1998:213). Individuals can experience themselves as simulated performances and seek out the intensity of drug experiences to reconfirm the authenticity of their being. Drug addicts are caught within complex discourses and experiences of authenticity and truth. The drugs create a sense of a unique authentic experience and

[20] For further information about the unjust War on Drugs, I recommend the critical documentary "The House I Live In" by Eugene Jarecki from 2012.

[21] "OD" refers to a drug overdose

their subculture can often sustain notions of authentic grounding in intense shared experiences where, for example, heroin can be idealized as a more truthful drug. Yet, there is a contradiction, for at the same time as this culture of authenticity is articulated by addicts themselves as a self-truth, they are also aware of each other as engaged in scams, and as peddling authenticity to create trust that can become the basis of scams. Here is the loneliness of addicts in this fragmentation and betrayal of trust between each other and with their friends and relatives, and it is this knowledge of shared practices of inauthenticity that is again flipped to become the basis of therapy and its shared authenticities. Here I see authenticity as a cultural value and ideal for grounding the self in self-truths and it is a socially managed and used cultural value.

Laura has since the age of 17 been subjected to two different discourses of human nature; chronicity (addiction as a lifelong disease) and choice (addiction as an act of will). Her addiction is viewed as an illness, and because of the illegality of drugs, she has been involved in criminal activity to support her habit. Given the poor state of the social welfare system in the United States, it is difficult to know how the homeless like Laura are meant to support themselves. There is a need to explore the structure of treatment failure for addicts like Laura, who hasn't complied with different forms of medical and penal interventions. Her movement between institutions can reveal the structural violence addicts experience when they fail forms of governmental interventions. As Garcia (2010) points out, even though "relapse" is considered neutral from a medical point of view, the addict will be assigned blame when he or she doesn't succeed in their recovery. In addition, by placing addiction within the self, addicts are always reminded that no matter how long they manage to stay clean, there is still a capacity in them to relapse. Many addicts have described it as "*their hidden personality*" or as Dr. Jekyll and Mr. Hyde, where one side of their personality takes over when they drink or use. It is this problematization of agency ("*the hidden personality*") that brings together legal and medical discourses and institutions, whilst also positing a problem for the wider society about how free people really are.

Methadone Maintenance and Voluntary Organizations

Fed up with existing life, Laura therefore decided to sign up for methadone maintenance with her boyfriend at the time. He got enrolled because he was diagnosed with hepatitis C, a common disease among drug addicts. The methadone clinic got Laura on SSI (Supplemental Security Income), but eventually her boyfriend took control over her SSI credit and basically spent it on whatever he felt like. He ended up going back to jail, and she was left alone with no apartment and was forced back on the streets. Laura started living in the Tenderloin District in Downtown San Francisco, a high-crime neighborhood with a highly visible drug culture. Her street life in the Tenderloin was characterized by unstable living conditions, financial insecurity and crime.

"*When you're in that condition, those people down there, they are desperate, they're crack-heads, that's all they worry about, day and night, where they are going to get the next rock. And if you're a white women in the Tenderloin and it's 3 am, and you got a little cash in your pocket, they are going to work you until they either find dope so they can allegedly share it with you or they are going to smack you over the head and get your money, so it gets ugly*".

No matter how destitute her life at the streets was, she could not take another stay at a rehab or worse, the psych-ward. Laura thus started to make use of voluntary organizations such as needle-exchange programs and Project Homeless Connect, an organization that works to connect homeless people with the care they don't receive from other health care institutions. They helped Laura with a variety of her needs, such as dental care, HIV testing, food, SSI benefits, legal advice and medical care. The methadone clinic, the needle exchange and community organizations such as Project Homeless Connect provided important forms of care for Laura in the absence of more formal state institutions:

"*Through the methadone clinic I got hooked up to some of the services I needed, it is a lot easier to have a resemblance to a normal life when you're not on heroin. Some people take the methadone up to the point where they're nodding out, but for me it was freeing because it made life easier. I felt more alive, more of a person*".

The recent dismantling of many public institutions and services has shifted responsibility away from the state and to the more intimate private domains of family, community workers and activists. As mentioned in chapter 1, Rose (1996) claims that self-governing communities are part of an economy of power, of supposedly minimalizing the state and its interventions by passing the obligation to police onto individuals and groups. I attended several activist meetings during my stay in San Francisco, and was trained at the SF Drug Users' Union in how to manage naloxone (overdose prevention training) which is used to counter the effects of an opiate overdose. SFDUU and similar organizations provide a safe place for addicts where they can share their experiences free from shame and blame. Overdose prevention training and the rise of needle exchange programs exemplify this shift of responsibility from the state to more intimate private domains of family and community.

Chapter 4: Rites of Passage in Addiction Treatment

In this chapter I will discuss the problem of defining addiction as a disease, and look into how users of methamphetamine can be considered as some of the most difficult drug treatment patients. I will argue that it is everyday forms of suffering that are being medicated by the use of drugs, and that addiction is a shared corporeal world of self-abuse and pleasure.

Karen applauds Laura for being honest about her life on the streets and tells the group that "*this is stuff you don't talk about anywhere else*". Laura continues talking about the fear of entering a mundane life, and that she wanted to go back to the excitement that accompanied her life surrounded with drugs. Likewise, Howard Becker's (1963) and Richard Stephens' (1991) ethnographic work documents how addiction is a socialization process. Being a drug addict is thus "*as much one's commitment to a lifestyle as a dependency on drugs*" (Stephens 1991:103). Karen replied to Laura that she was looking for a quick fix, and that Karen "*sensed a certain amount of fear around her emotions*". Laura paused for a moment and asked Karen to "*help me understand myself, help me find a better way*". Karen replied to all of the clients that most of us have a fear of not living up to our expectations of life and "*when you drink you don't care anymore*".

While Laura expresses a pessimistic view on the prospect of becoming clean and sober, Karen on the other hand, tells her that "*history doesn't have to repeat itself*" and she has to "*get out of the mindset*" she was in, and to not let the past occupy her present and influence her future. Another client joins the discussion about Laura's progress at the rehab and tells her that "*we relapse because we can't handle the responsibility and we can't manage it by ourselves*". Karen nods while she proclaims that "*A part of recovery is listening to suggestions. You got yourself into the addiction and it's simplistic to think you can get yourself out of it by yourself*". The group works to morally enforce correct ways of thinking and speaking, and the evaluation done by clients of other peers' narratives, is a way of displaying one's own success in recovery and dedication to the program. Clients challenged each other's statements in terms of authenticity, where clients would question the other person's ability to be transparent and urge these clients not just to say what was expected and hide behind their masks. The group functions as a field of confession and judgment by all, but the therapist or counselor has the moral authority and can therefore determine whether such critical comments are valid or not, or have gone too far. Laura told the group that drugs were indeed her number one coping mechanism, "*because if anything goes wrong, your first thought is to use. Luckily I was only using for 10 years, some people have been using for 40 years or more, and they just forget how to exist without it…*".

Assessments of Addiction

In addition to group sessions like process groups, education groups, steps-presentation, emotional awareness and stress management, there was some individual counseling at Cliff House as well. When Laura first came to the rehab she went through what is called an individual assessment, where they use what is called an "*Addiction Severity Index*" (ASI). This assessment is crucial in turning people into clients, and identifying addiction, and this is commonly done through the DSM.

In Laura's first evaluation she met with a doctor and they went through information like her medical history, psychiatric illnesses and episodes, drug history and her current mental status exam. Her doctor at Cliff House tried to evaluate whether she had on-going depression or anxiety, and if this was separate from her drug intoxication and withdrawal symptoms. If Laura was evaluated as having psychiatric symptoms even when she had not actively been using or withdrawing, the doctor might have considered starting her on anti-depression medication: "*The reason for that is that when a person is not depressed or anxious, their quality of life is way better and their rates of relapse are much lower*". The doctor also assessed Laura for safety, making sure that she was not having thoughts of hurting herself or anyone else, and tried to assess if it seemed like she was going to be able to stay in the program and not leave in the middle of the night because her cravings are so strong.

Laura was also assessed by an addiction counselor upon her arrival, and had several individual counseling sessions during her 30-day stay at Cliff House. She underwent what is called Motivational Interviewing (MI), which is part of the "*stages-of-change model*" that has become very popular in the addiction field. MI is used to discover what might motivate a client and could be used to help the client see some of the contradictions in their behavior, in the way they have been living their lives versus what they want from life. Such assessments and interrogations are supported by techniques such as MI, which work to evaluate the individual's behavior, and are also crucial in turning people into clients. Goffman (1961) argues that turning individuals into patients is done by providing evidence that individuals all along had symptoms of insanity: "*the case-history construction that is placed on the patient's past life, this having the effect of demonstrating that all along he had becoming sick, that he finally became very sick, and that if he had not been hospitalized much worse things would have happened to him – all of which, of course, may be true*" (Goffman 1961:145). MI is slightly different for it involves clients and care-givers working together to identify and overcome addictive behaviors (Carr 2011:236). The role of the therapist is to stabilize and more firmly implant the desire for therapeutic change.

Rites of Passage

Recovery is posited as discovering one's inner self that is denied through one's active addiction and this recovery is done through the telling and listening to auto-biographical stories in group sessions.

This is a form of pastoral power, that seeks to manage and craft subjectivity by providing it with a shared language which is connected to confession and truth. The addiction is not just to the drug but also to practices that prevent full confession and the pastoral community from knowing their true secrets. Some treatment centers as well as A.A. claim that addicts must "hit bottom" to be able to confront their denial and become more willing to change their behavior. Hitting bottom refers to the total loss of the self in addiction, and addiction treatment systems work to break and remake the self. Such practices and understandings are very similar to the rites of passage ceremonies that anthropologists often study where individuals are moved from one social role into another, a boy into a man; a girl into a woman; a commoner into a chief; a sick person into a healed person (Turner 1969). In these rituals, initiates and the sick will be removed from society and ground down into a lower level: animality, dirt, childhood or biology - before being reconstituted with a new status, and given a new name. At the same time as they are hitting bottom, participants in these rituals learn new knowledge, roles, obligations and moral rules (Douglas 1979). Similar rites emerge in total institutions where inmates are humiliated before given a new institutional identity (Goffman 1961). Therapy sessions fit into a wide range of human practices for forming identity and they make the addict recount their fall into poverty, addiction, crime, immorality and danger. In doing so the therapy session operates like a liminal state, it leads individuals to re-experience themselves as having ground themselves to the bottom of human beings from where they can be rebuilt. What is partly different about the therapy session is that whereas rituals and institutions can often use corporeal practices to produce leveling, degradation and transformation, the therapy sessions use narratives. Stories posit and produce almost a pilgrimage form of travel where patients recount and re-experience their fall into an abyss of despair, immorality and poverty from where they can now journey upwards.

In his book "*Language and Transformation: A Study of the Christian Conversion Narrative*" (2002), anthropologist Peter Stromberg studies how people create and make use of conversion narratives that are likely to occur in experiences of emotional and personal conflict or mental illness. Addicts and others who engage in "undesired behaviors", can use a religious conversion which transforms their character and a transition from the meaningless to the meaningfulness occurs. They can seek relief by using language to re-describe and transcend their experiences. Many clients and addiction counselors who were former addicts frequently talked about hitting bottom. It was an important part of their recovery narrative, as hitting bottom can function as a promise of rebirth. Therapy has therefore a confessional aspect of cultivating practices of self-reflection that facilitate a reconstruction of personal identity but also of relationships. Moreover, therapy is the medicalization and professionalization of this confessional self-discovery project whose origins were systematized in religious practices (Foucault 1982).

Rituals of Speaking

The clinical theorization of addiction has to incorporate how language is both used for the client to overcome his or her addiction, as well as a measure of the counselor's expertise. Carr's clinical ethnography reveals that most clients were well aware of what counted as valuable inner stock (2011:110). While clients were encouraged to be open and honest about "*who they really are*", it seemed that many counselors already had rules for these rituals of speaking[22]. When Laura claimed that her life on the streets gave her a sense of freedom she had never experienced before, one could clearly see that she had to reformulate her words for it to fit the correct form of introspection, namely - that she was engaged in a false illusory pursuit of a better world. The counselors wanted Laura to see herself as they did, and to verbally reveal herself as a recovering addict. Since Laura had been in and out of institutions for over a decade, she was well aware of what counted as valuable inner stock. She told me she sometimes would just say what the counselors wanted her to say, what Carr calls "*flipping the script*". Script flippers learned metalinguistic practices that coincided with the expectations of an audience, and they "*learned to inhabit the identity of a recovering addict and strategically replicated clinically and culturally prescribed ways of speaking from that position*" (2011:182). The counselors were aware of this potential problem of what Goffman might call role distance, where "*Inmates use of the official staff language and staff philosophy in discussing or publishing gripes is a mixed blessing for staff. Inmates can manipulate the staff's own rationalization of the institution and through this threaten the social distance between the two groupings*" (1961: 97). However, the aim of the counselor was to use the intensity of the group encounter as a moment of authentic sharing and disclosure that would get the client to internalize their scripts. The problem here is that authenticity is also learned and performed but it must at the same time be seen to be spontaneous and immediate. Patients learn ways of performing "authenticity", that is scripts that come immediately from their heartfelt experiences but they also become entrapped in these heartfelt scripts. The relationship of patients to these scripts is ambiguous and ambivalent; it is a shifting relationship that involves embracing and re-distancing from these scripts of authenticity. What clients flip and play with can also entrap them and yet they also learn to perform entrapment, and the skill of the counselor resides in knowing where the patient stands in this web of self-disclosure. This is why the issue of honesty and self-deception is central, for they pertain not just to the everyday life of the patient but also to the therapy sessions. Therapy is a performance of transformation and within the intensity of those performances the patient can be incorporated and made to relive themselves and other possibilities of themselves.

[22] Robert Desjarlais in his ethnography "*Shelter Blues*" (1997), also noted that clients verbal tactics did not have the same force or authority as staff members use of language (in Carr 2011:221).

High Peaks and Low Valleys

Drugs change your perception of reality, and these changes may last long after a person has stopped actively using. Drug addicts are viewed as slaves to their instincts which damages their capacity for rational decisions and behavior. While therapy is directed at confronting this destructive behavior through the use of language and intense encounter moments, it becomes a complicated matter when long-term use can lead to changes in the addicts' brain chemistry. As with Laura who used meth for six years, she has experienced both the acute toxic effects as well as long-term physiological problems caused by this substance. Methamphetamine is a powerful stimulant that in the short-term produces the release of neurotransmitters such as dopamine and serotonin which is linked to the brain's system for reward and pleasure, appetite, sleep and mood. Long-term, chronic use may lead to impaired memory and coordination, mood alterations and psychiatric problems that may last long after a person has stopped using.

Nora Volkow, the leader of the National Institute on Drug Abuse (NIDA) stated that "*recent studies have shown that repeated drug use leads to long-lasting changes in the brain that undermines voluntary control*" (in Maté 2008:179). Because of the long-lasting symptoms of methamphetamine, its users are considered some of the most difficult drug treatment patients: "*Stimulant users in general and methamphetamine users in particular have unusually high rates of relapse, experience extended periods of depression and may experience continued episodes of confusion and paranoia, even after a long period of abstinence*" (Hunt et. al. 2006:47). Laura is very much aware of the complexity that surrounds drug addiction, and she provides an important alternative framework of knowledge to those who understand addiction as an act of self-will. This may explain why some people cannot just go whole-heartedly into treatment programs, and it can perhaps explain the high relapse rates among drug users.

The Spiritual Void

I wanted to know what interest drug addicts had in the medical model of addiction, and often asked addicts about their own conception of addiction. Like most addicts I interviewed, Laura saw it as a combination of mental and physical addiction, where many started their drug career as a way to mute out negative feelings. After a while they became physically addicted to these substances, and the fear of withdrawal becomes so great that the use just continued and escalated. As Laura puts it:

"*I think the reason I started using drugs was a kind of replacement for where a normal person would have, like direction and purpose in life, their fire passion whatever you want to call it. I never really felt like I knew what that was for me growing up. I kind of felt like this void in my future, what am I going to do for myself, and it led to a lot of worry and uncomfortable feelings. And I think I used drugs to fill that, to give me some sense of belonging in a group and later as a way to substitute for really*

having a life, having a meaningful existence. I didn't feel like I was really connected with anything that was fulfilling me, so I turned to drugs and alcohol as a way to kind of temporarily fill that empty space I felt within me. I was definitely lonely growing up, I had friends and everything but I felt this kind of gulf between me and other people. I guess like I lacked something that everyone else had, a feeling of connection and belonging with other people. I felt really out of place."

What does Laura's account tells us about addiction in general? Her individual story can be used as a reflection of our broader world, where addicts' narratives of their substance abuse is often connected to a lost sense of place in relationships, society and values. "*The drug scene*", the psychiatrist Victor Frankl wrote, "*is one aspect of a more general mass phenomenon, namely the feeling of meaninglessness resulting from the frustration of our existential need which in turn has become a universal phenomenon in our industrial societies*" (in Carr 2011:416). Laura's story articulates a sense of alienation from others, being alone and removed from others. There were recurring themes in my interviews with addicts; alienation, distress, anxiety and loneliness. Some also described addiction as a spiritual void. The sense of a lack of meaning is partly a call to be filled with other meanings from psychiatry, social workers and therapy, but perhaps it also has class, racial and gender dynamics where life does not offer a horizon of self-realization through work, family and other social relations. People's sense of lack of meaning is perhaps an internalized refraction of their social context and what life has to offer to them. It is partly poverty, the cold, hunger and the shame of selling oneself that is medicated. One needs drugs to make life bearable and pleasurable. It is everyday forms of suffering that are being medicated and it is the social and cultural nature of these suffering that is being reconstituted as they become medicalized and psychologized into an individual quest for self-awareness. It is the power of individualism in Western societies and in the United States which here comes to the fore.

Addiction is a very broad term and it's easy to fall into the trap of generalization. Chronic, long-term abusers experience both a psychological and physical addiction, and as one client commented: "*It's like asking someone to change their personality, because it's very fundamentally at the core of how you relate to life, that's where the addiction comes from, the relationship to yourself and the world around you*". This addict rightly sees addiction as a way of being a person, a way of experiencing and presenting the self to others and to oneself. Drugs in offering an alternative experience of reality are used to articulate an alternative identity that knows the world differently and this is the basis of alienation from others. Heroin can be considered as medicine, where heroin both relives the pain of everyday whilst also creating pain, chaos and fragmentation from others.

Even though addiction today is viewed as a medical illness, moralism is still highly present. There is a huge stigma problem when it comes to drug addicts, and the public's obsessive fear of crime and drugs leads to misconceptions about addiction that does not take into account the complexity of the disorder

and the contradictions within which addicts find themselves and which they also create. Some addicts I interviewed have talked about how devastating it has been to notice looks on the streets that they can tell are full of contempt. Likewise, Laura talked about how embarrassed she felt in having to admit that she was an addict: "*I was ashamed to say that I was an addict, I thought alcoholics and addicts were freaks, and degenerates and bums, and I wasn't one of them. But I am, but they're not that either, they are every strata of society that has that disease, that compulsion to drink or use.*"

Some addicts don't find the motivation to get clean, because it entails giving up a way of life, a community of fellow sufferers and fellow pleasure seekers. Laura talked about how scary it was to stop doing drugs because she didn't know what would happen when she sobered up. She explained it as not wanting to wake up to reality and face what she had destroyed. There is a subcultural sense of the world as too real to be taken in, the world itself has to be blocked or filtered out. According to Laura, all strata of society need to do this and need their drug be it alcohol and one could add other recreational drugs such as cocaine or marijuana, but also legal sedatives and antidepressant whose use has skyrocketed[23]. What Laura points to is that it is not the quest for pleasure that pervades all strata of society, but the everyday suffering that creates a need to numb pain, anxiety, loneliness and a loss of self-confidence. It has been a massive expansion in the use of legal drugs such as sedatives and antidepressants, previously valium for women and increasingly Prozac to make people feel better than well. There is an unhappiness not just amongst the poor but also among the middle class who despite their apparent affluence can often experience depression (Pusey 2003). Laura locates herself and her addiction within this growing experience of modern unhappiness and she is not wrong to do so. There is a critique of society here as a reality that cannot be lived with or faced, as too real. In drug use this social critique is not formulated using the theories of socialism or feminism, but it takes the form of folk categories that internalize and individualize social suffering within popular notions of not being at home in the world.

Many of the people Laura has been hanging out with, have used drugs their whole life and she often talked about how simplistic it was to think that they lacked a will or a desire to recover, because maybe they just cannot live without the drugs.

"These people [on the streets] who have lost everything, they don't have that. Not only that, your body gets so warned down from the elements, the using and not eating, that in order to feel normal, even though you're not doing heroin, when you feel dopesick, when you don't have it [heroin], your body is so fucked up you feel that physical need to use".

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[23] From 1988–1994 through 2005–2008, the rate of antidepressant use in the United States among all ages increased nearly 400% (Center for Disease Control and Prevention, October 2011).

Addicts are aware of creating a different body for themselves, another corporeality, and there is a shared recognition of this shared corporeality and its suffering needs. It is this shared suffering, this pain and denial in the pursuit of pleasure, and the hunger and illness created that has to be appeased, that binds addicts in a collective world of shared experiences. Addiction is a shared corporeal world of self-abuse and pleasure. It is also people living with the loss of fellow addicts and friends around them through imprisonment but also death. It is these forms of loss that are being self-medicated.

Chapter 5: Making Amends

In this chapter I will follow the life history of the counselor Justin, a former addict who has witnessed and personally experienced drug addiction treatment from the 1970s. He has good detailed knowledge of how therapeutic practices have changed over time. Like many other counselors who have not gone through the university system, he identifies with addicts and presents himself as an exemplary model of self-transformation to clients. In this chapter, I will discuss how other counselors have their own harm reduction practices that confront and deal with the concept of denial in addiction treatment.

"*The steps are about change and how you view yourself*", says the counselor Justin who has started today's steps-presentations. "*You want to forgive yourself for the things you're ashamed of, and doing the right thing is a form of forgiveness. There is an incredible amount of freedom to be transparent*". This statement is indicative of the religious language of conversion that often forms part of therapy even when it seems non-religious. For therapy is phrased as forgiving the self, as escaping from self-hatred and self-harm, from self-alienation, and affirming the freedom to begin anew: the freedom to be spiritually reborn.

Justin looks over his list of clients who are supposed to present their first step in front of the group. All clients are required to present the first three of the twelve steps of Alcoholics Anonymous during their 30-day stay. Counselors integrated both clinical theory and folk theory in their therapy sessions. Justin is somewhat more of an old-schooler than Karen, meaning he is more committed to the folk wisdom of A.A. than the cognitive behavioral therapy model. These different models mark different levels of professionalization and commitment to academic theories, and I will elaborate this distinction later. Justin is a recovering addict, and was very open about his personal story, both to me and clients. For openness is the goal of therapy, to open up and share secrets, biographies, experiences and pain.

Peace, Love and Hypodermic Needles

Justin started using drugs from the age of 12, and soon became involved with dealing and criminal activity. He was the poorest kid in his class and used his connections to drugs as a way to fit in and be popular. Justin befriended an older guy who took him under his wing and taught him how to sell drugs. He became involved in a hippie subculture which was all about "*peace, love and hypodermic needles*" as he describes it. Justin and his older friend were partners for about 14 years and made a ton of money selling drugs. Justin's friend became a sort of mentor for him, and as Lalander (2003) has noted, mentors in a subculture can function as role models who teach and reproduce forms of subcultural capital. In 1968 he was caught by the police selling marijuana, psychedelics and cocaine. He was charged with the use and sale of dangerous drugs and hard narcotics, their inter-state transportation, and contributing to the delinquency of a minor (who was actually older than him). He was mandated by the court and was sent to a juvenile institution that focused on drug abuse. He was

only 15 years old at the time. The use of kids to sell drugs is a strategy that some drug dealers take advantage of, because they are cheap to hire and if they get arrested they don't have to do the same time as adults. Justin got out of the juvenile program when he was 16 years old and got high the day he left: "*Because that was all I knew, that was the only thing I was comfortable with, that was the only thing that made me feel accepted because I had a role*". Because of his parents' low education and poverty, Justin was more comfortable in the alternative youth subculture where he earned respect and felt accepted. The hidden injuries of class can be medicated with drugs, and the money that comes from the sale of drugs can be opposed to the poverty and begging of other addicts. The money that comes with dealing drugs can also function as a symbol of masculinity, of toughness, cleaverness, independence and male prowess (Bourgois 2003). The subculture that is formed with drug use can offer an alternative value structure and an alternative self-image. The hippie subculture that Justin was a part of celebrated all kinds of social marginalizations, and a refusal to conform to mainstream society and its dominant values. This culture of resistance amongst addicts is also evident in Bourgois ethnography of poor Puerto Rican immigrants in East Harlem in New York City who engage in selling and using crack to earn respect and social value, which they are not able to attain in the mainstream society. "*The oppositional identities of street culture are both a triumphant rejection of social marginalization and a defensive – in some cases terrorized – denial of vulnerability* (2003:158).

When Justin was 19, he was set up by a former client and was arrested for selling heroin to a police informer. The heroin he was caught with was cut and contained so little heroin that the police could only charge him with marijuana sale. Although it was only an ounce of pot[24], he was sentenced to five years in prison. He went to prison when he was 19 years old, and was later transferred to a rehabilitation program for heroin addiction. While Justin was in prison, he was still involved with selling drugs that were smuggled in by visitors, for the drug economy of the streets is also highly present in prisons. In prison, he was attacked by some of his fellow convicts and ended up in hospital. He was put in protective custody, and later interviewed to be a candidate for a drug treatment program. Justin was accepted and started treatment for addiction in a state program and in those days the major identifiable addiction was heroin addiction. He went to this program in 1971, and according to him, their strategy was to get them off heroin, but addicts could still use other drugs.

"*But of course, everyone is going to go back to their drug of choice, so none of us could stay clean and if we used heroin and they took a urine sample, we were all convicts, we just wait till night and break into the med-room and squish them, with someone's pee that was clean, it was crazy times*".

His story about fellow convicts and urine samples illustrates the solidarity and conspiracy between patients who play along with the appearance of therapy. Many addicts try to manipulate the system,

[24] An ounce of pot is about 28 grams.

they can buy clean pee or cheat on their urine samples as a way to avoid the truth of their bodies.

Confrontational Models

Justin spent about three to four years in and out of different treatment programs, but was still using drugs. In 1983 he underwent a tough behavioral modification program, which used confrontational approaches as their therapy model. This was part of the idea that addicts must be broken down and then built back up, and it was used to break down defense mechanisms that were seen to be the basis of addiction disorders. The addict was seen as in denial and as protecting his addiction through lies and self-deceptions which needed to be confronted with home truths. Underpinning this model was also the same quest for authenticity, for self-truth and self-knowledge but through different therapeutic strategies and group dynamics. Therapy here was the creation of a social collective that used certain pastoral tactics to transform the addict and in particular to make addicts work to transform each other. They must break and remake each other for they are most familiar with others' lies and self-deceptions. Justin explains that this was done by both a counselor as well as the group. There was a demand for clients to be honest and it was based on principles of confronting and pulling up, and raising the awareness of the other person by a peer group that operated as a collective conscience. Justin notes how the counselors were "*really in your face*", and that they knew how to get people to dig deep and get honest and challenge the client. Things changed radically when crack-cocaine entered the picture, displacing heroin addiction and the therapeutic community changed as well as the therapeutic strategies. Crack addicts were viewed as being on a lower level than other addicts, and the confrontational approach did more harm than good because crack addicts were re-traumatized by this tough approach: "*They were re-experiencing all the self-loathing they had for themselves anyway. So treatment had to change, and it became more mental health-based, more focused on the trauma, more focusing on the depression and the other corresponding issues*". Crack was a new powerful drug that disrupted the existing therapeutic techniques.

People who are addicted to crack experience intense cravings that results in a binge behavior, which leads to more vulnerability and instability. Bourgois (2003) argues in his book that sex work practices changed when crack moved prostitution into the crack houses. Female sex workers who previously had worked on the streets with more autonomy in terms of choice over clients, payments and practices, now suffered a loss of autonomy and suffered greater abuse from men when prostitution moved into the crack houses. This often violent, physical abuse of sex workers was part of a wider demonization of female crack users who were figured as failures of femininity and maternity:

"*The distinctive feature of the crack epidemic of the late 1980s and early 1990s, however, was that instead of an ethnic group or a social class being demonized for their proclivity for substance abuse, women, the family, and motherhood itself was assaulted. Inner-city women who smoked crack were accused of having lost the "mother-nurture instinct*" (Bourgois 2003:278).

During the 1990s, there was also a widespread fear of so-called "*crack babies*" that constituted a "*lost generation*" and a "*biological underclass*". This increased the number of reports of child neglect and abuse, and between 1980 and 1992 "*a tripling of the number of women incarcerated*" (White 1998:299). However, after nearly 25 years of research, it was concluded that there was no statistically significant difference in health outcomes to babies whose mothers had used crack cocaine during their pregnancy - the key determining factor was rather poverty (The Inquirer, *July 22, 2013).*

"*Your secrets are way too deep*"

Justin left the behavioral modification program after six months and told me that "*they really couldn't break me, which was exactly what they said, they said your secrets are way too deep, doubt if you even know where they're at*". There is a certain pride in this protection of secrets as much as there is a critique of the self's failure to plunge into its own depths. Some clients told me it was exciting to hide their abuse of alcohol and drugs from their families and friends at first, but it became exhausting to keep up with this world of secrecy and masks. It is the self-exploration of unknown depths, of secrets that the self hides even from itself that is used to individuate addicts, that is to create an individual identity for them based on their responses to therapy. A new kind of individualization emerges out of therapy whereby the responses to the program become a measure of the individual, of his or hers history and psychological capacities for self-awareness. It is the quantitative and qualitative nature of the patient's secrets and more especially of their willingness to explore and disclose these that marks and differentiate them, that individualized them. Though therapy sees itself as uncovering the individual, its practices can also be seen as creating a new individuality through the diagnosis and measure of resistance and acceptance of therapy and its narratives. It is through inscribing one's life in new narratives of self-awareness that one gains a new biography and sense of the history that marks and differentiates one's life from others. But it is also therapy itself, its various programs, the history of one's involvement with its diverse strategies, theories and practices that differentiates and marks out the individual. They become therapeutized not in the sense of being cured by therapy but in the sense of their serial involvement with a history of therapy session that then becomes their biography, their life history.

The history of one's participation and of one's reaction to therapy (acceptance, rejection, resistance, half-heartedness, cynicism etc.) formulates an individuating biography that claims to measure self-awareness and well-being. One client who had serial involvements with the drug therapy context used a narrative of self-awareness to describe his drug abuse:

"*I think somewhere in the back of my mind I was conscious that this is not healthy behavior, but I did not chose to listen to that side, the rational side, I chose to ignore it. And I never admitted to myself that I had a problem even though I think deep down I was aware*".

The serial involvement with therapy that then becomes their life history, was evident to me when clients presented their conversion story during my ethnographic interview, which often took the formula of the A.A. story model. One client told me he had followed an "*alcoholic guideline*" to present his personal narrative. The cultural knowledge of A.A. was highly present in personal accounts of drug abuse, with serial involvement with A.A. and drug therapy forming client's auto-biographical sense of time, as a history of involvement in different institutions and therapies. Clients would also quote counselors in my ethnographic interview as part of their sense of history and themselves. Some spoke of how therapy helped them to realize that they didn't use drugs to party but instead to escape distress and loneliness. Clients often used quotes and concepts from the Big Book, like "*secrets keep us sick*", "*once an addict, always an addict*", "*slip in thinking*" and so on. They communicated and negotiated their addict identity through authoritative institutional narratives; they reformulated their subject position through recognition of what was required for them to become well (Carr 2011).

Making Amends

Justin had a pretty unstable life during his years of using heroin, cocaine and alcohol. He moved around a lot, what addicts sometimes refers to as being "geographic"; a strategy of moving to another place as a way to enhance your chances of becoming clean. Justin lost many jobs because of his inability to be accountable and responsible, and was getting more demoralized and depressed after his failed attempts to get clean. He overdosed after he injected cocaine, and while he stopped doing harder drugs he started drinking excessively. Justin was in and out of different institutions for a long while and said he "*learned a little bit more about myself, but not enough*". He would also go into programs just to rest and get his health back. Justin went to another program after his drug use escalated, and this time around he did it for his eight year old daughter: "*because she was always daddy's girl and I knew that she loved me unconditionally*". As with Justin, many addicts and especially women use their children to pull themselves out of the drug culture. This is also evident in Bourgois (2003) work, where mothers love for their children restored meaning to their life and was therefore a motivation to get clean from the crack subculture.

Justin has managed to stay clean and has obtained a certificate in addiction counseling. He has been working in the addiction field for over fourteen years now, and he viewed his service to other addicts and alcoholics as a way of making amends:

"*I was a real bad guy, I didn't go in to be a smuggler, I didn't go into being shot, being stabbed, having my girlfriend kidnapped, all kinds of repercussions. That's what happened to me, that's not what I did to others, and for many years I couldn't figure how to make up for it. And that's the other part of this job, I'm living amends to people that are not living because of my choices. That's another reason why I love this job, because I know it is making a difference in people's lives in a positive way, where [before] I had a difference in people's lives in a negative way for the first half of my life. I don't think a*

doctor can be any more proud of what he's doing than I am of what I'm doing, saving people, helping people to help themselves".

Many counselors create their work with addicts as a moral project of paying back for their own sins by helping others. Here they often use and celebrate knowledge gained not through academic institutions but from the streets and from the hard painful world of experience. The welfare state has not completely colonized and taken over the private therapeutic philanthropic projects such as Alcoholics Anonymous. This has allowed other kinds of knowledge and practices to exist outside the state and its regulatory apparatus. "*Perhaps more than any other discipline, the treatment of addicted people relies more on faith than science, more on personal experiences than empirical findings*" (Chiauzzi and Liljegren 1993:303 in Carr 2011:96). The state nevertheless seeks to control these therapeutic groups, to regulate them, and to license them. In the 1970s there was a movement within the addiction field where addiction counselors were required to get certificates and licenses to hold their therapeutic positions. As mentioned in chapter 2, the Minnesota Model had an enormous influence on the structure and techniques for the current addiction system. Many individuals who had been exposed to A.A. and the twelve steps program, started working in rehabilitation centers. There they disseminated the informal knowledge of tactics, group dynamics, motivational lessons and pedagogic strategies which can perhaps be described as the folk wisdom, or tacit forms of knowledge belonging to those dealing with recovering alcoholics and addicts. This form of therapy emphasized practical knowledge and personal experience. However, the increasing professionalization of medicine, psychology, psychotherapy and other forms of therapy has changed the forms of knowledge in addiction treatment:

"*Credentialing, by focusing on that knowledge which could be codified and transferred to others, implicitly pushed the recovered counselor to emphasize physical and psychological, rather than spiritual, dimensions of the recovery process*" (White 1998:337).

The academization of therapy is also a process of secularization, where the religious techniques of self-transformation are not so much eliminated as recoded into new professional theoretically grounded techniques. As with Justin, he is someone who is differentiating himself from professionals like psychiatrists and doctors, who in turn also differentiate themselves from him. For Justin, many professionals misdiagnose because they learned about addiction from a book. Such claims are a critique of this new higher status group whose knowledge is grounded in intellectual traditions rather than the experience of being an addict. There is a class distinction here in education and in the cultural capital being claimed by professionals who come from more middle class families and more respectable sections of the working class. Former addicts who have become counselors try to overcome this competition, this challenge to their expertise, claiming superior knowledge for handling drug addicts that comes not from academic books but rather from practical knowledge and experience. Justin had a discussion once about the diagnosis of addiction and how people can fit the criteria of

being a drug addict at a certain moment without, according to him, really being an addict. For Justin, there is a distinction between drug abuse and drug addiction. Justin went on to critique the kind of knowledge that comes from books and that equates symptoms too quickly with medical categories. It is the formalization of knowledge that is being critiqued as creating unexperienced counselors who are imprisoned in empty categories that cannot observe and rightly classify the reality in front of them.

The definition of addiction by the DSM, published by the American Psychiatric Association, changed in May 2013, which sought to eliminate the difference between abuse and addiction (Fletcher 2013:11). The definition of a diagnosis or illness has a major impact on how it is evaluated and treated, and whether insurance companies will cover its treatment. The move from viewing addiction as a moral failure to viewing it as an illness is a relief for addicts who earlier may have seen their problems as something caused by their own failure to become proper citizens. This moral problematization is something they experience from friends and relatives who now have an alternative way of relating to the addict as suffering from an illness. These newly asserted definitions may, however, have harmful consequences due to the fact that not all who (ab)use drugs at certain times in their life, are powerless or show evidence of an incurable disease. One who raises a critical view on this redefinition of addiction is Maia Szalavits who claims that it "*poses a huge problem, particularly for adolescents and young adults with mild problems who may be pushed to adopt an addict identity and to see themselves as having no way to control their drinking or drug use if they ever 'relapse'*" (in Sheff 2013:80). In order to "*work the program*" at Cliff House, one must admit to being a drug addict and that one has no control over the use of substances (i.e. "*powerless*"). Yet the clinic has to fight or subvert such a definition of the self and move the patient into taking responsibility for their behavior. The clinic will see it as harmful or a danger for individuals to adopt an exclusive view of their own illness as having its own inevitable trajectory. I constantly heard counselors and addiction specialists repeat the dictum that "*this is your disease talking*" and "*you are powerless over your disease and will die if you relapse*". Rather than being a self-fulfilling prophecy, this is a warning and a call to arms for the addict to stand up and do something, to not be controlled by their bodies, addiction, habits, drug friends, and irrational emotions. It is an attempt to *identify* the sources of addiction, and to produce transformation by pointing out the dangerous consequences of passive entrapment.

Instead of seeking knowledge from academic books or the definition from DSM, Justin tries instead to transform clients by using himself as a model, where his self-discovery must become theirs. Several times during my fieldwork he proclaimed that "*statistics doesn't matter to the individual*", and instead he often used his personal experiences to understand addiction. He places his faith in the community and the group sessions for transforming clients: "*The group has to help bring you in, because the group is going to ask for respect and the person want to respond to that*". The group acts like a collective community which watches and polices over its members (Foucault 1979). The group consisting of addicts, know each other's faults and truths, and are therefore considered more fit to

transform clients because they have personal knowledge and experience of addiction and addictive behavior. The group must work to break down defense mechanisms according to Justin: "*You know when they're sitting there hearing other people's stories, and thinking of how that applies to them, that's breaking through denial that might be building up as they have more time away from their last usage and all the damage that caused".*

Justin was also critical of bureaucracy and official rules in addiction treatment. He had witnessed how different rehabilitation centers changed after the criminal justice system became the only source for money. According to Justin, the bureaucrats started taking programs apart, and took away all the tools that worked. As the different money sources dried up at rehabilitation centers, it affected the autonomy of the staff working in the institution. The critique of bureaucracy can be read as a critique of the official rules that compromise the therapist's knowledge and autonomy, which dismiss the local knowledge built on familiarity with addicts and with one's own experiences of addiction. Changed forms of funding introduce forms of rationalization that are often not rational in the sense of increasing the efficiency of therapy programs and these changes run into the resistance of staff who are trying to create intense social relations and a community that can capture and transform addicts. It is hard to quantify the latter, and it is often built on strategic interventions in group sessions that are difficult to formalize and yet they are built on tacit forms of experiential knowledge which many counselors privilege and juxtapose to the medical, professional knowledge of the bureaucracy and academic institutions.

Some of the clients I talked to were more open to ideas coming from the folk wisdom of recovering addicts, probably because they had been in their shoes and represented a possible future as they themselves had succeeded in their recovery. They too would criticize the knowledge coming from counselors who only had experience with addiction from academic books. One client who was confronted one day at a group session became very angry with the counselor who was not a former addict: "*She has never been an addict in her life and she tries to act like she knows everything about it and just gives these ridiculous advices and tries to make assumptions about people that are not true at all and forces them to believe it*". There is a critique grounded in authenticity here, of trying *to act like she knows* without really having the authentic knowledge that comes from personal experience.

Staff members had different opinions regarding the use of former addicts in treatment settings when I interviewed them. Some said that if their personal experience was clinically and therapeutically relevant and useful for a particular client, they would use their personal experience. Others like Justin always used themselves and their personal experience with drugs in the therapeutic setting. One of the counselors who would at times disclose her personal experience, said it was a huge debate going on in the field whether it was appropriate or not:

"*I had a substance abuse teacher in grad school who said it's not necessary to be in recovery to work with addicts and alcoholics, a lot of people think that you shouldn't even, but I just think it provides an alignment with the client and an understanding that somebody who doesn't have that experience can't have, and I think if you're a skilled enough clinician of course you can do really good work but it makes a world difference to the clients if they know you have been in their shoes, so I've found that to be nothing but helpful*".

The disagreements between A.A.-members and psychiatric asylums in the 1950s, continue in many American rehab programs. To use Schwartzman's (1975) distinction between *paraprofessional* and *professionals*, many *professionals* were less open to the folk wisdom of A.A., and expressed ambivalence towards other counselors who emphasized using the social strategies of the 12-step program. There were different opinions among counselors who I interviewed regarding the use of the 12 steps in addiction treatment. In chapter 3, I introduced Karen, a psychologist (*professional),* who liked some aspects of the 12 steps but who did not see it as the only viable alternative:

"*I don't think A.A. has to be a life-long endeavor, and I don't think step 4-12 are that important. I think coming to groups with the truth about who I am as a human being, and what changes I want, what is meaning and purpose for me, and how do I want to live my life, I think that's of critical importance, but it doesn't have to be done through A.A. and it doesn't have to be done with 7 meetings a week.*"

Karen's statement about "*coming to groups with the truth about who I am as a human being*", relates to Foucault and Rose's point that human beings are urged to become ethical beings who define themselves according to a moral code through constant monitoring, testing and pastoral practices for improving the self, so as to realize the perfect, autonomous and authentic self.

Confronting Denial

Addiction is a problematic concept. The problem of defining drug addiction as a disease lies in the difficulty of identifying symptoms that can explain the complexity of the disorder, which many agree cannot be eliminated biologically. Unlike other diseases, the diagnosis of addiction is a subjective matter because it revolves around the interpretation of the patient's behavior and cognitive functions. Addiction specialists have theorized addiction as a disease of denial. The patient is therefore considered to be unaware or does not acknowledge that he or she has a problem[25]. The Freudian ideas about human nature played an important role in the concept of denial and resistance which are central concepts in therapeutic interventions. Traumatic events from early childhood were stored in the unconscious mind, and had to be articulated and brought up to the conscious realm of the psyche. This

[25] Bond defines denial as "*the automatic refusal to acknowledge painful or disturbing aspects of inner or outer reality*" (1986:138 in Carr 2011:88).

meant that any behavior or emotion that was not expressed and scrutinized could lead to neurosis, and thus in need of interpretation (Illouz 2008). Clients' inner states are presumed to be hidden underneath a layer of denial. Given that clients are assumed to be in denial, counselors work to recognize denial and identify the truth on behalf of their clients: "*The concept of denial is a central strategy in the broader project of bringing the addict back in line with authority, reality and Truth*" (Carr 2011:89). The concept of denial can also mean that resistance towards therapeutic interventions can be interpreted as symptomatic of his or her illness, and it further legitimizes the forms of power around him or her. This is also a point in Goffman's *Asylums* in regard to resisting treatment: "*The key view of the patient is: were he "himself" he would voluntarily seek psychiatric treatment and voluntarily submit to it, and, when ready for discharge, he will avow that his real self was all along being treated as it really wanted to be treated*" (1961:374). In addiction treatment, resistance means denial, and denial leads to relapse. This means that the client who relapses is considered a keeper of secrets. One counselor at Cliff House said that "*addiction is a lot about having a private secret between you and yourself, and sometimes denial is a way to keep that going*". It is the self-possession that secrets give that has to be broken down. Rejection of the call for self-disclosure, is a rejection of therapy and becomes proof of how truly sick the patient is and thus in need of even more therapy.

The concept of denial leads addiction counselors and specialists to try to confront denial through therapeutic tools; to build self-awareness of their illness and themselves so they can reverse these impaired insights. There were different opinions regarding the concept of denial among clients and staff. One counselor claimed that every single client he treated for the last 12 months at Cliff House had relapsed. He was working on his MFT (Marriage and Family Therapy) license which requires 3000 hours. He was an intern and was on a run to collect hours, and appeared to be exhausted by long days and hard work. He told me that when he was working with clients he was now much less optimistic regarding client's statements:

"*So I have a lot of compassion but at the same time I have to have a lot of awareness. My own sober thinking of what's going on here, I can't trust everything you say because either you're not saying it or you are fooling yourself with all these different things you're saying*".

His statement reveals that awareness is not just something clients engage in, as counselors are also required to work on their own awareness of clients self-awareness when treating clients because these clients are known to manipulate the truth. This sense that the patient is not in charge of their self-truths, that the patient is involved in self-deception, authorizes the therapist and the therapy group to take charge of the client's identity so as to get the patient back to self-truth.

Other counselors complained that in the A.A. context, denial could be used judgmentally, and that although it was an appropriate term it was also misused at times. Denial can be used as an important defense mechanism that enables addicts to survive and avoid "*normalizing judgments*" and

stigmatization: "*Denial should not be understood as a reductionist psychological construct, but rather as the deployment of agency within a socially imposed survival strategy*" (Bourgois, Lettiere and Quesada 1997:167).

Chapter 6: The Melancholic Subject

After being at the clinic for about three months, I came observe one of the process groups. As I entered the therapy room I could feel the tension that was building up. Two male clients had been caught having sexual intercourse at Cliff House, and they were both discharged from the rehab for breaking the rules. In the process group, the counselor Justin wanted us to have a discussion about this event and asked the other clients how they felt about the two male clients being discharged. There were many opinions on the matter. Several commented that it was not fair for one client who was poor and in an unstable period of his life. He was forced back on the streets, while the other one who was more wealthy, ironically, went to a rehab in Los Angeles for his sex addiction[26]. Justin told the group that no one should compromise their sobriety and that we were all accountable for respecting the rules.

On another occasion, Justin organized a group session called "*Self-Awareness and Steps-presentation*" and introduced Michael, a client in his sixties who bears resemblance to what Garcia (2010) terms the "*melancholic subject*". Michael was involved in the following dialogue with Justin over the presentation of the steps.

"*If you break down the twelve steps, all they're asking you to do, it's a roadmap for forgiveness of yourself, self-acceptance, loving yourself, and doing the right thing every day*", Justin tells the group. He is usually teaching from the Big Book by Bill Wilson, and is fond of using quotes from it. He then proclaims that "*You are only as sick as your secrets*", before he looks at Michael whose turn it is to present his first step: "*We admitted that we are powerless over alcohol and/or drugs… that our lives had become unmanageable*". His first assignment is to describe the use of alcohol or drugs in his childhood family, and what were some of his feelings growing up regarding drugs, alcohol and his family relationships. The sense of camaraderie between group members comes from this sharing of intimate family secrets and auto-biographical details so that this community can know one better than anyone else and even oneself.

Michael comes from a Catholic background, and as he said, he was born a sinner even before he started doing drugs. "*I was raised on guilt and shame, and that's how they get you to play the program. The first time I went to confession I had to make something up because I felt like I had to do it just to get through, and it makes you into a hypocrite*". He was also a very shy kid growing up, and drugs and alcohol helped with his shyness and his inability to deal with life. Michael is in his early 60s, and told me that the generation he was born in was raised to say yes to drugs. Michael was 17 years old when the Vietnam War began, and he decided to enlist in the air-force.

[26] I observed that there was a close connection between drug addiction and sex addiction at Cliff House, especially for gay men who abused meth.

"*because I thought it would be a better way to go than the army, and being completely shot at every day, I figured with the air-force I would be working on planes, I could be above it all*".

Michael was sent to North-Carolina to work on airplanes. He then got orders to go to Vietnam, which, he didn't even know where it was. Michael described himself as a green, naïve kid before he went to fight in the Vietnam War. He was first sent to Bangkok where he stayed between two and three months, because their base in Northern Thailand was not finished yet. He and the other soldiers had a lot of spare time with a lot of partying in Bangkok. He mostly drank alcohol and smoked thai-sticks[27], while some of his friends started experimenting with heroin. When the war was finished he returned back to the United States, only to find disapproving comments and curses shouted at him. Unlike other wars such World War II and the Korea War, where returning soldiers were cast as heroes, returning soldiers from Vietnam were cast as war mongers and drug addicts. Michael was met at the airport by protesters carrying anti-war posters who shouted insults at them. There was little to return home to for Michael, so he instead traveled to a new city - San Francisco.

Michael remembers the shift in the drug culture and traces it to the Rolling Stones' performance at the Altamont Free Concert in 1969, when the Hells Angels were present as security and it resulted in violence and four deaths, an event known as "*rock and roll's all-time worst day, December 6th, a day when everything went perfectly wrong*" (*Rolling Stone,* February 7, 1970). Michael had been living in Haight Ashbury[28], a neighborhood known for its hippie subculture, and noted that after this event is was the beginning of the end of the innocence of the hippie days. Things got ugly after that, and he noted how people he knew started doing heroin and meth whereas they previously had used psychedelics like marihuana, magic mushrooms and LSD. Michael went to the Fillmore West, a historic music venue, for four months in a row, and saw great bands like Jimi Hendrix, the Doors and Jefferson Airplane. After several positive experiences with LSD, he turned to cocaine and quaaludes (a synthetic central nervous system depressant). He described it as a great combination, where cocaine would take you up and if you felt you were getting a little too anxious or edgy, you could use Quaalude to put you down, so he said he had total control of his high.

Addicts can have a "*medical mind*" (Lalander 2003), where they use different forms of substances for different purposes. They can for example use cocaine combined with heroin (also called "speedball") or use benzodiazepines to enhance the effect of methadone. It is this medicated control of their own bodies which some addicts celebrate and seek. Addicts seek calibrated forms of pleasure and celebrate the detailed knowledge they have over drugs and how the quantity and quality have to be

[27] Thai-sticks are a form of cannabis from Thailand that was popular during the 1960s and 1970s.

[28] Haight Ashbury has undergone processes of gentrification and is now one of the most expensive neighborhoods in San Francisco (see: Davis 1990)

calibrated for their moods. This chemically managed existence through the body is a strange symbolic mixture of the synthetic and the natural.

The Melancholic Subject

After a while the party was wearing thin, according to Michael, and at that time he received a call from his brother telling him he was diagnosed with HIV. Michael was always very close with his brother, and when he passed away he was blown away by grief. "*I held his hand and he slipped away, and we covered his body in roses. I just sat there with him, I didn't know what do to, I was just blown away and paralyzed by sadness*". He was not able to integrate himself back to society and would go through periods of being clean and then go out on a binge again. Garcia (2010) introduces the concept of the "*melancholic subject*" to describe drug addicts' experiences. This melancholy is a condition of a "*mourning without end*", and similar to how Michael and other addicts experience themselves as trapped in the endless suffering of their condition. Michael said he "*was in so much grief that it didn't make sense*" and because of this sadness he was "*lost without a direction*", and became caught in a cycle of relapses.

Two of Michael's friends committed suicide and everything collapsed. He was suffering from insomnia, and constantly had nightmares from his war experiences. Michael started taking every prescription drug he could get his hand on – everything from Vicodine, Percocet and Prozac[29]. "*The more I used the smaller the world got*". Through a friend Michael got hold of the prescription drug OxyContin, an opioid derived from natural or synthetic forms of opium and morphine. His friend had a prescription and he would buy ten to twenty pills at a time, and at the end he used anywhere between 60 to 200 dollars on it every day. As with other addicts I have interviewed during my fieldwork, Michael also reported that heroin in the West Coast is lower in quality compared to the East Coast in the U.S. There is also a safety issue, with the heroin you don't know what you're getting: you don't know who is making it, and it could be cut with other substances. OxyContin on the other hand, is made by reputable pharmaceutical companies, and is therefore viewed as being a safer drug to use.

"*When I would smoke opiates, everything would be okay in the world for like two or three hours. I felt good about myself, I felt confident which is important to me, I could talk to anybody, and I felt I had increased work performance. It made me feel supremely confident and relaxed… it's a very supreme state"*.

The euphoria produced by drugs is highly present in popular books, music and films. Aleister Crowley described the euphoric feeling of cocaine in his book "Diary of a Drug Fiend" (1922): "*The depression*

[29] Vicodine and Percocet are opiate medications to treat chronic pain, while Prozac is an anti-depression medication.

lifted from my mind like the sun coming out of the clouds" (26). As Michael's use progressed, he got to the point where his finances were in disarray, and he became very depressed and "*so caught up in my head*". He started having three compartmentalized lives: His life at work, his life at home with his wife, and his third life where he was buying, selling and smuggling drugs. None of those lives ever collided, no one ever knew about the other one for about eight years. And then all of a sudden that house of cards that he built up with using lies caved in, fell apart, and everything started colliding.

"*I couldn't remember one lie to cover the other lie, and I was going home one night in the elevator, and that was the place where I would construct my excuses, and I couldn't think of another excuse and I was very tired, so I just laid it all out to my wife*".

Michael then decided to seek help at Cliff House for the first time in 1999. He managed to stay clean while he was in the program, but started doings drugs again after a few months. Michael told me he was "good actor" at Cliff House and was probably in treatment for the wrong reasons; he was there for his wife whom he wanted to keep and please. After finishing the program he ran into an old friend who invited him to smoke crack with her. He stopped going to A.A.-meetings and said he could not relate to his A.A.-sponsor[30]. His wife was later diagnosed with cancer, and things started slipping away again:

"*I would go through periods of clean, like a month or two and then I would go out again. I'm a serial relapser, that's what they call it, so I would relapse. I was drinking and using coke again, doing dealing on a low scale so I could use for free. Emotionally what happened, I don't know, I think I held that idea inside of me that I could one day be a normal person again, that I could go out and have a drink, on New Year I could toast the new year with champagne, and I just felt like this freak as an alcoholic.*"

I believe that symbolic violence is an intrinsic part of the experience of being a "*melancholic subject*". Many addicts I encountered said their addiction was in their blood, and uttered statements such as "*I don't deserve to be in life*", "*I was born a bad person*", "*I'm unworthy of help*", "*My integrity and values are lost*", "*I'm a danger to myself and society*", "*The fact that I was an addict was written on the wall*", and "*I will always be an alcoholic*". Addicts conceived their addiction as something caused by their personal character and failure, and blamed themselves for their condition. Even though many addicts had been abused as children, had been traumatized by the Vietnam War or the War in Iraq, lost families and friends, and suffered emotional and physical abuse, many still claimed that they only had themselves to blame. This is a form of symbolic violence that subjectifies

[30] Members of Alcoholics Anonymous are encouraged to find an experienced fellow alcoholic or addict, called a sponsor, to help them guide and follow the A.A. program.

suffering, which treats the individual as the origin and solution to the problem, which they are perceived to own and solve.

The Harm-Reduction Approach

During our conversations, Michael sometimes expressed a bleak view on the possibility of a sober future. Today he's on different psychiatric medications, and has tried out the relatively new medication Suboxone which contains buprenorphine. It is used to treat opiate addiction, in addition to the drug naltrexone which is an opioid antagonist that prevents its user from getting high. Suboxone is considered as a better alternative than methadone, mostly because of its lower risk for overdose. Methadone, buprenorphine and suboxone are part of the harm-reduction approach that emerged in treatment agencies in the 1980s. Harm-reduction approaches are applied to reduce the risk that accompanies drug use and sex work. It provides services to addicts that does not depend on their abstinence, but rather minimizes the risk from infectious diseases and overdoses. There were different opinions regarding harm reduction practices among staff members as well as clients that I encountered during fieldwork. Justin for instance, claimed that harm reduction was for people who have abused drugs, not addicts and alcoholics. I interpret Justin's opinion as perhaps a form of commitment to the drug-free ideology of the A.A. program. Some counselors saw the approach as giving up on people, and thought that the idea that addicts can reduce their use was unrealistic. Some counselors claimed that harm reduction and methadone maintenance did not address the real problem of addiction, as one counselor told me:

"*I don't consider them to be really addressing the problem, because the problem is not just heroin addiction, the problem can't be replaced with methadone maintenance. The problem is a desire to alter their perception of life, because experiencing life for them without their coping skill is scary, it's anxiety-producing, it's overwhelming, and that's what I want to work on. Why is it you're so afraid of life, why is it that life terrifies you or why can you not engage in life without altering your brain chemically. I don't think those questions are addressed when the person is on continued methadone maintenance*".

Moral puritanism has a strong hold in American society which sees the pursuit of pleasure, the use of drugs as immoral, as taking individuals away from God, morality and self-reflection. This moral puritanism has led to opposition against needle-exchange and methadone, as it is viewed as giving up on the idea that people can be "saved". Moral puritanism in the United States also affected research on injection drug users, since just using the term "harm reduction" made it difficult for researchers to receive federal funding:

"*Under President Georg W. Bush's administration, project officers at the National Institute on Drug Abuse routinely advised researcher to remove the words condoms, needle exchange, sex worker, and*

homosexual from the titles and abstracts of their grant proposals (*New York Times 2003*, April 18, in Bourgois and Schonberg 2009:302).

The deputy director Daniel Wolfe, of the New York-based International Harm Reduction Development Program, claims that it is evangelism in the United States that underlies most of the opposition against needle exchange and methadone maintenance: "*To give someone a needle or methadone is seen as giving up on the idea that they can be 'saved', and as a moral failure for both drug user and provider*" (in Maté 2008:338). Though evangelism is not the same as therapy, much of the same philosophy of being born again, of being saved, of dying and being reborn is present in both practices.

Moral Inventory

Justin once told me that "*the steps are really about self-discovery, awareness, and believing in something. I think the twelve steps are about discovering a greater purpose in life, I think it's the lack of greater purpose that causes people to do all kinds of crazy stuff.*"

The moral inventory that is required by the steps is about self-reflection and confession, but this is an ambiguous and ambivalent process. Clients were required to write daily journals and a daily personal inventory, and this functioned as ongoing self-monitoring (Rose 1996). In clients daily journals they could choose recovery slogans that best fitted their needs, which were often quoted from the Big Book of A.A. The daily personal inventory is used to deal with how denial can carry over into sobriety, causing clients to "*lose control of their judgment and behavior even when sober*"[31]. This means that self-vigilance is an on-going process that never ends, and the addict is always in danger of relapsing and in need of self-scrutiny and self-discipline. One counselor frequently talked about her previous "*addicted personality*" which caused her to relapse after 12 years of sobriety: "*Little by little I was moving away from the sober lifestyle, so my addict personality was really still into seeking thrills, or adrenaline or euphoria*".

It is a hidden possibility of the self that addicts fight to subdue and contain, and this is not just an imaginary discursive threat but is experienced as a lived corporeal desire that might overwhelm them. It is learnt pleasures and transgressive experiences that the addict fights to contain and these are posited and experienced as a hidden personality that inhabits them and prevents them from being good and moral. It is forms of alienation that are being lived in this battle to be a self-possessed subject.

Many clients said they were stuck on step 4: "*Made a searching and fearless moral inventory of ourselves*". One client complained that there was so much introspection in addiction treatment that you can become sick of looking at yourself. I interpret this as a backlash and evidence of some resistance

[31] This quote is taken from one of the educational lectures that were used at Cliff House.

to this ongoing self-scrutiny. Another client who joined the discussion in this group noted how the twelve steps only focused on their character defects and everything they have done wrong. Justin replies to the client, telling him to use introspection as a strength, and focus on how he can grow as a human being. Michael says he wants more individual counseling, and another client agrees and says he doesn't want to share all of his secrets to the group because some secrets are not meant to be told to anybody:

"*I don't understand some of the steps, like having to take a personal and fearless moral inventory, remember every single thing you did wrong in your life and having to write it down and tell someone else all your secrets that you don't want to tell anybody*"

Justin replies to the group that they are blaming the program so that they can justify another relapse. He starts talking about responsibility and if clients can't be accountable to other people in the program, they cannot expect it will work for them when they're back in their old environment. "*In a perfect world you would discipline yourself and your sense of honor*", Justin tells the group, "*we know you don't come in like that. We don't want to be cops but we have to*". He tells them to practice the steps in all of their affairs, and to "*check in with your inner sense of morality and integrity*". Justin holds a firm belief in the group process, and says that "*participation is a form of service*" in group sessions. He believes that in order to forgive oneself, one has to share secrets and shame so as to be able to overcome them. "*How can we forgive ourselves if we continue doing the same things*?". Justin goes on telling them that they need to break their patterns of secrecy and shame, and the only way to do this is through the fellowship. The beauty of A.A. according to Justin is that you never have to be alone again. I believe that such conflicts are also grounded in some middle class clients preferring a more individualized pastoral approach, the talking cure of psychoanalysis as opposed to the collective healing of group therapy.

The Pursuit of Pleasure

Justin, who has been taking notes while Michael presented his first step, says that "*there is a motivation in you that drives your drug use*", and that he *knows* that Michael wants to be sober. Justin goes on telling the group that they are "*not bad persons, they're just addicts*." Michael describes himself in today's group as a hedonistic person who loves pleasure. When Michael said he loves pleasure, Justin told him that he is not seeking pleasure but is instead escaping from himself.

"*I've worked with a lot of clients that still think they're using because they like to party, even though they've been in and out of jail, in and out of prison, lost everything numerous times or never had anything because of their using, and trying to get them to understand that they're not using because it makes them feel good, they continue to use because it stops them from feeling bad, and that is sometimes very hard for them to grasp*".

Justin's own self-discovery must become theirs, where the patient must see himself mirrored in the therapist, and the group helps to achieve that re-alignment of perspective (Levi-Strauss 1963). Justin uses his own life history as a spiritual pilgrimage for self-awareness. Every client including Michael needs to re-read their personal history and create a new biography in this clinical setting. The struggle is to create a way of reading one's drug experiences, one's life as not the pursuit of pleasure but the avoidance of self-consciousness. There is a critique of a culture of hedonism, of the pursuit of pleasure, which removes the self from its truths and from itself. Drug therapy enacts a pastoral project, which requires a re-reading of the self and its desires. This is what has to be recovered or reinstalled for self-consciousness is part of self-empowerment mode and self-disciplining techniques. The addict is accused of fuelling and legitimizing his use of drugs by locating it within a hedonistic popular culture that resonates with the wider consumer culture and its maximization of the pursuit of pleasure. There is a cultural contradiction here that addicts are confronted with, namely another cultural tradition that is religious and that sees the pursuit of pleasure as taking individuals away from God, morality, self-reflection and authenticity. It is this pastoral tradition which is being secularized and located in the drug therapy context. Michael talked about the difficulty of not letting desires and the search for pleasure rule his life:

"*It requires definitely a shift of perspective, but I think it's not giving up your will, it's just giving up your caving in to your desire. Which is really the hardest thing, abandoning your desires as a person, and find a higher purpose, a higher calling. But there is something virtuous about that, to do that*."

Concluding remarks

I have attempted to write a story of people, institutions, events and ideas that constitute addiction treatment in the United States. I have focused on the cultural and social relationships of drug addicts and their responses to different treatment practices. In order to do this I have used Foucault's historical work on the emergence of new practices of governmentality in the West, which were new practices for forming subjects, dispositions and behavior with a view to how these could contribute to the social order and its productivity.

Deploying a historical perspective on addiction treatment shows that the opposition against drugs intensified after the 1870s, when the use of alcohol and drugs increasingly became a societal concern, as modern society emphasized rational, effective and productive individuals, so as to secure social order and wealth. As in most western countries, in the United States there has been a strong emphasis on action, rationality and predictability, where the use of drugs seemed to oppose and threaten these generally accepted set of values and aspirations (Morgan 1981).

A new form of governmentality emerged that became dependent upon knowledge about the population as a thematic category that has to be managed and produced in a qualitative manner. This has resulted in public authorities seeking to implement a diverse array of experts in the management of the modern soul (Rose 1996). Systems of power and knowledge have involved the development of a set of technologies to restructure the subjectivity of those marginalized and alienated in modern society, such as drug addicts in rehabilitation programs. There has emerged a form of "politics of life itself" (Rose 1996), which increasingly is concerned with the shaping of individual capacities and conduct. Psychotherapies and the "*expert society*" are connected to the obligations of the modern self in terms of social roles and obligations. This has led to an explosion of therapeutic modalities and theories of human nature that are implemented and institutionalized in rehabilitation setting which experiment in ways of reshaping subjectivity.

In recent years there has been presented many critical perspectives concerning the unfolding of the therapeutic ethos. Whereas Lears (1983) views the therapeutic ethos as a replacement for religion, I will on the other hand argue that practices and concepts derived from religion are still present in addiction rehabilitation programs. As we have seen, these involve religious-like forms of self-examination, confession and salvation narratives. Christianity and the therapeutic ethos have entered into a complex symbiotic relationship with one another. The ethical self has a long religious tradition whether in the form of the Catholic confessional or Protestant self-examination. Personhood as founded in the pursuit of a self-imposed spiritual goal was made available through Christian spiritual discipline and pastoral powers. "*The result was a profound dissemination and individualization of*

Christian spirituality, as ordinary members of the flock were inducted into a practice of ethical life that made them "personally" responsible for their own salvation" (Martin et. al 1998:159).

Religious techniques of self-transformation are not eliminated but rather recoded into new professional theoretically grounded techniques such as behavior modification models. This pastoral tradition is being secularized and re-located in the drug therapy context, where addicts' irrational behavior and desires are to be resolved through confessional projects that have individuals as their focus. The techniques of the self originating in the Christian religious traditions, have been secularized and organized around professional authorities like the doctor, psychologist, and social welfare worker. I have argued that drug therapists in rehab programs operate in the same terms using their experience and history with drug problems to propose themselves as exemplary models of self-scrutiny and self-discipline. The counselor Justin for instance, was highly influenced by the social strategies derived from Alcoholics Anonymous in his attempt to transform clients, and celebrated his personal experience with drugs which was crucial to his authority. The rise of Alcoholics Anonymous has had an enormous impact on how we treat addiction treatment today for it took religious pastoral practices of conversion and re-systematized them for a specific target population and purpose. The fellowship of A.A., and different therapeutic groups, functions as a moral policing society which watches over its members on their way to salvation and sobriety.

Although religious beliefs and traditions have been concerned with self-scrutiny and introspection, the therapeutic ethos has however provided a new language of the self. In the neoliberal era the management and discipline of individuals has taken the shape of central concepts such as "responsibility", "empowerment", "self-actualization" and "self-development", where individuals are advised to work upon the self to achieve personal fulfillment by acts of personal choices and responsibilities, which is constructed as the perfect realization of social responsibility and self-authenticity. This is especially evident when it comes to the foundations of authority over the self, where:

"*older moral orders always looked to a transcendent being, a covenantal community, natural law, or divine reason to provide the substantive basis for culture's moral boundaries, whereas the therapeutic ethos established the self as the fundamental touchstone of culture*" (Nolan 1998 in Madsen 2011:3).

In the therapy sessions in rehabilitation programs, the self must be made to have moral authority over itself, which creates a constant need for authenticity and self-development. The ideal of authenticity is highly present in rehabilitation programs which have shifted the question of "Who is God?" to the question of "Who am I?" (Madsen 2011:18), which contributes to the individualizing nature of therapeutic discourses and interventions. A moral discourse underpins these processes of individualization, where the moral responsibility is placed on the individuals as a cultural value

deployed in the management and production of subjects and subjectivities. And yet this individualized project is also often a collective group project to produce the self-possessed individual.

I have used the work of Foucault and Rose in relation to their understanding of wider structures of knowledge and power, so as to provide a cultural analysis of therapeutic practices and discourses. I have also combined the work on the everyday life in institutions and their effect on personhood (Goffman 1961; Illouz 2008; Carr 2011). It is of critical importance to capture actor's understanding and use of therapeutic practices, which enables us to study how drug addicts understand the necessity to work on and perform the selfhood in an institutional context and in therapy programs.

The recent restructuring of welfare and therapeutic practices in the United States have often involved promoting the privatization of the cure, as the means of creating more effective cures whilst maximizing the use of scarce medical and state resources. In our contemporary society, neoliberalism has promoted the idea of "self-help" knowledge and collective strategies. Therapeutic models under neoliberalism have an individualizing language that celebrates personal self-control. Clients are learned to help themselves, and are educated in becoming productive, autonomous citizens (Rose 1996). Bourgois and Schonberg (2009) have pointed out that the self-help knowledge of the neoliberal era is both power and symbolic violence, as people failing to govern themselves through "self-help", only have themselves to blame. The individual client has a moral responsibility to choose a lifestyle that avoids risk, however "*medical social services predicated on "empowering" individuals to make "informed choices" misrecognize power relations*" (Bourgois et. al. 1997; Farmer 2003; Farmer et. al. 1996 in Bourgois and Schonberg 2009:107). Defining failure at the individual level can conceal broader failures of social policies.

Large-scale structural issues of inequality and power are often obscured in policy and popular debates about drug addicts, leading to an explanation of social suffering that treats the individual as the origin and solution to the problem, which they are perceived to own and solve. This celebration of the individual as the source of social order in the United States contributes to symbolic violence, because individuals, despite the fact that race, ethnicity, class and gender are active forces[32], are made to blame themselves for their suffering. The twelve step model and the therapeutic ethos emphasize a "turn inwards", meaning that clients are required to work upon their own selves so they can become

[32] Social disapproval of drug use has often had economic and xenophobic underlying reasons, in which different drugs have been identified with particular ethnic groups, classes and gender. Deploying a historical perspective shows that opium was linked to the Chinese (who during the economic depression and high unemployment in California, were willing to work for lower wages in less desirable working conditions, which led to laws against opium that were aimed at the Chinese population), marijuana was identified with the Mexicans (who were perceived as a threat to the white working class and as a potential drain on the social service system), LSD was connected to "hippie mothers" (who were accused of giving birth to deformed children during the 1970s) (Stephens 1987), and crack in the 1990s was connected to poor, black women who used illicit drugs in inner-cities (Bourgois 2003).

productive citizens, which can obscure the social and cultural context that causes suffering. In Illouz's words: "*In the therapeutic ethos there is no such thing as senseless suffering and chaos, and this is why, in the final analysis, its cultural impact should worry us*" (2008:247).

The female addict Laura for instance, has been in a variety of institutional settings during her life, and has been exposed to both the judicial model and the medical model of governmentality. She has been criminalized for her involvement in sex trade-practices, for burglarizing and the use of illegal substances such as methamphetamine and heroin. She has also undergone several forms of treatment; 28-day rehabs, the psych-ward and methadone maintenance treatment without succeeding in becoming clean. There is a need to explore the implications of treatment failure for addicts like Laura, who has not complied with different forms of medical and penal interventions. Her movement between institutions can reveal the structural violence addicts experience when they fail forms of governmental interventions. Laura's life history can also be used as a reflection of our broader world, where addict's narratives of their substance abuse is often connected to a lost sense of place in relationships, society and values. Depression seems to be the dark side in the pursuit of authenticity and self-actualization for those where life does not offer a horizon of self-realization through work or social relations.

It is paradoxical that the therapeutic ethos on the one hand praises the autonomous and self-reliant individual, while on the other hand, the individual is becoming more and more dependent on different forms of therapeutic interventions. I believe that the therapeutic ethos with its concepts, narratives and systematic use of introspection, has concealed power in that is has produced more subtle and invisible ways of influencing and managing individuals. As Foucault has remarked, the care of self under medical metaphors of health, ironically leads to a view of a "sick" self in need of correction and transformation (in Illouz 2008:173). The premise of the therapeutic discourse promotes the idea that the problem resides in the individual – not in society (Madsen 2014). There is certainly a danger in the moral emphasis on the individual as agent for those who do not have the capacity or skill for the management of themselves as rational subjects. I often heard counselors tell clients to "*generate happiness within*", and while I am sure this is meant well, I believe it obscures how addiction is a symptom of poverty, alienation, suffering and social marginalization.

Attachment

These are the original twelve steps as published by Alcoholics Anonymous

1. We admitted we were powerless over alcohol—that our lives had become unmanageable.
2. Came to believe that a power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will and our lives over to the care of God *as we understood Him*.
4. Made a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly asked Him to remove our shortcomings.
8. Made a list of all persons we had harmed, and became willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory, and when we were wrong, promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God *as we understood Him*, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

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