From Victim to Survivor:

Healing and Recovery in a Drug Addiction Treatment Program in San Francisco

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Front page illustration: Unknown artist, Clarion Alley, Mission District, San Francisco.

Preface

This thesis is the result of two years of hard, but rewarding and enjoyable, work. Based on my fieldwork at the Healing Center, an addiction treatment program in San Francisco, from January to June 2007, I attempt to make sense of what goes on in treatment groups, and how it can be that treatment need not necessarily lead to sobriety.

I have been fortunate enough to plan and conduct my own fieldwork, which brought me in contact with a lot of people who have truly inspired me, and who have offered new perspectives on the world. Not everyone is represented in this thesis, but you are not forgotten. I owe everyone at the Healing Center my gratitude; without them this thesis would not be possible. The staff members welcomed me and granted me access to arenas which previously had been unknown to me, and would have remained so without their support. I also wish to thank the other interns who shared their time with me, also outside the centre, and who showed me other aspects of life in the city. Most of all I am in great debt to the clients, who on a daily basis shared their personal experiences and thoughts with me. Despite their own hardships and concerns they generously took the time to tell me about their lives, and whose support, kind words, and warm hugs got me through even the worst of days. I wish you all the best.

My supervisor Dr. Olaf H. Smedal has provided me with good advice and guidance throughout the process. His insightful and motivating feedback has been greatly appreciated.

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Contents

Chapter 1 Making sense of addiction

A hot July morning, 2007. A cluster of people are waiting outside the community centre, and as I get closer I recognize the familiar faces of Penny, Manuela, Erica, Jennifer, Ava, Barbara, and Lydia, women I have got to know during my six months at the Healing Center. Today is Graduation Day. Glad to see all the graduating women, I also note with some sadness the absence of a few I had hoped to see here. I cannot seem to let go that I am seeing the women for the last time, and yet it is as if I am meeting them for the first time, dressed up, wearing make-up, many surrounded by family and friends.

Inside, the room is decorated with small tables, flowers, and balloons. A large table buckles under the weight of salads, sandwiches, mineral water and desserts. As people settle down, music starts to play. The clients have chosen their own graduation song, "I Will Survive". The graduating women, their faces beaming, present a powerful and touching image as they walk down the aisle towards the stage. Despite the hot day I feel goose bumps up my arms and the sting of tears in my eyes. Sniffles tell me I am not the only one. One by the one the women enter the stage, where they receive flowers and a diploma as evidence of having completed the drug treatment program. Several of the clients take the occasion to say some words, they thank the facilitators and their peers, and encourage the present non-graduates to "stay focused" and keep attending groups. One of the facilitators addresses the graduating women and tells them that they are now ready to start their new lives as healthy, functional women, and that they should be proud of what they have achieved over the last few months. The crowd cheers. She tells them they are no longer victims, but survivors, and it is time that they get to live the lives they have been deprived of for so long. Once again cheers of agreement can be heard.

After the ceremony we hang out one last time. The atmosphere is a mixture of happiness, excitement, and anxiousness. Several of the women have specific plans for the future, and are looking forward to getting started. The women express being optimistic, yet nervous, about the coming days, weeks, and months,

wondering how they will manage on their own. Manuela tells us how proud she is to have graduated, and adds that this time she is not planning on coming back. She has made an arrangement with Jennifer and Penny to attend support groups together. Ava tells us she is moving back in with her husband, while Lydia has been accepted for evening courses at the city college and hopes to get a degree where she can help others who are struggling with drug addiction. Erica, holding her partner's hand, tells us they have found an apartment together outside town, while Jennifer proudly shows off her one-year old daughter. As people start to leave, phone numbers and hugs are exchanged along with promises to stay in touch and stay focused. Barbara turns to me, sighs, and smilingly tells me that it is only now, after having graduated, that she realises she is no longer a junkie. I look at her, and wish her good luck.

In order to fully appreciate the above episode, we have to begin six months earlier, in a day-centre for drug addiction treatment. The following chapters attempt to make sense of the "healing process"; the collective sense making activities which clients engaged in through participation in treatment groups at the Healing Center. Recovery, as will become evident, is not simply about treating drug addiction, but also about equipping clients with tools for making sense of the past and, according to the dominant treatment ideology, "empowering" clients to take control of the future. As such, it is a process of identifying and replacing what was referred to as "unhealthy" cognitive and behavioural patterns with new, "healthy" ones. The transition from being a "using addict" to becoming a "recovering addict" may be considered a kind of resocialization process.

The Healing Center presented an environment where clients engaged in forms of recovery work through participation in group sessions. An important aspect of the treatment involved clients learning to reinterpret their actions and selves in new ways, making recovery a process of self-reconstruction. Group sessions provided clients with an arena for this identity construction, in which clients' personal experiences were the ground for "healing". In the following chapters I attempt to find out what is going on when clients participate in group sessions.

It soon became evident to me, however, that a large proportion of those who became clients at the centre dropped out and did not complete their treatment. Similarly, a number of the clients

had graduated from drug programs several times, and were still struggling to stay sober. While clients were "empowered" in groups, many seemed to have difficulties actually applying these resources in practice outside the program in their actual everyday lives. This may indicate that while clients could be successful in "talking the talk", it was harder to change deeply embodied practices and actually "walk the walk".

This chapter will account for some of the central theoretical premises and tools for making sense of the material I present in the following chapters, starting with a contextualization of drug addiction within the debate of structural restraint and agency. This will be followed by a brief presentation of the Healing Center and the dominant ideological approach to addiction treatment. Language, it will be argued, provided an important resource for clients when attempting to make sense of addiction and self, and is a powerful ideological tool that cannot be understood separately from the specific discourses and practices at the Healing Center. I have used literature in two fashions in the following chapters. The works of Gregory Bateson, Pierre Bourdieu, and Deborah Tannen have provided useful tools when approaching my empirical material, while addiction and treatment literature has been used primarily to contextualize, support, or contrast my findings.

Addiction: structure and agency

The following chapters' attention to addiction, treatment, and recovery can be framed within a larger debate which has been a central concern of social scientists for a long time: to what extent do our everyday actions reflect conscious and intentional choices, and in what degree are they the outcome of structural forces which set the conditions for our decisions?

Addiction treatment agencies today often operate with a rhetoric which emphasizes clients' wilful participation as a necessary part of recovery, as agents who can make conscious and controlled evaluations about their behaviour and actions (Fox 2001; Paik 2006). Clients are expected to "work the program" both in and outside the program, making it part of their everyday life. When a client relapses on drugs or continues to engage in "unhealthy" activities, this is attributed to a lack of dedication towards the program, of not "working the program". In one sense addiction agencies like Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and the Healing Center *have* to establish the individual's potential to take control and change, as there would be little point in investing resources in a project where

clients were destined to remain the same. In this manner, clients are made responsible for their own recovery, and thereby also for their own failures.[1] If failure is cast as one's lacking dedication to the program, one would assume that clients who do "take the program to heart" and engage in recovery work will succeed in staying sober. This, however, is not necessarily the case, and indicates that there is a distance between *displays* of dedication, and actual practical use in everyday life.

I will not focus on the effects of drug use in this thesis, but I find it necessary to briefly account for certain aspects of drug use. While some drugs are primarily psychologically addictive, other drugs also induce a physical dependency, leading to withdrawal symptoms when the use is discontinued. Heroin and crack, the two most common "drugs of choice" among clients at the Healing Center, both manifest strong physical as well as psychological withdrawal symptoms. These cravings can be relieved through continued use. Most of the clients at the centre had completed or were going through drug detoxification while they were attending the centre. The physical as well as psychological aspects of drug addiction clearly complicate the question of agency, diffusing the line between wilful actions and triggered responses. Today, addiction is largely categorized as a disease (Denzin 1993), infusing the addict's activities as not self-governed and rational, and legitimizing the need for intervention. It is worth noting that while the distinction between "mind" and "body" is problematic in the social sciences, this was a fully valid one among both clients and staff at the Healing Center, who would often operate with this dualism when "sharing"[2] and interpreting experiences. In fact, the distinction was an important assumption of the treatment approach, which sought a form of "holistic healing" through presenting both "mental tools" and more physical "grounding techniques" in order for the clients to cope in a "healthier" manner.

Harvey Feldman and Michael Aldrich (2005:20) claim that a change occurred in the social sciences between the 1940s and 1960s, from an approach which emphasized *why* people use drugs, to a focus on *how* people get involved in drugs and remain involved. Alfred Lindesmith was, according to Darin Weinberg (1997:150), the first to present a distinctly sociological approach to drug use and addiction, which dominated drug research until the 1960s and still remains central today. Lindesmith's research was an attempt to formulate an

[1] According to a survey conducted among AA members, seven out of ten people treated for alcoholism relapse during the first six months of recovery (Denzin 1987:88).
[2] The terms "share" and "sharing" will be used when referring the specific ways in which clients communicated about their past experiences in group sessions.

alternative to biological or psychological reductionism, approaching drug use and addiction through a role theory perspective combined with a symbolic interactionist approach. According to Lindesmith, drug use has to be understood in terms of the symbolically mediated meaning ascribed the activity, through a focus on human learning through language and interaction (Weinberg 1997:150). Drug addiction is generated in the process of using drugs *consciously* in order to alleviate "withdrawal stress", and what the addict is missing is not so much the "hypothetical euphoria" of the drug itself, as the feeling of control (Lindesmith 1938:593; 606). In this perspective drug addiction requires both physical withdrawal symptoms as well as the reflective and conscious interpretation of the symptoms as related to the drug. If the person does not see a connection between these factors, he or she "escapes addiction" (Lindesmith 1938:593). Weinberg (1997) criticizes Lindesmith's addiction theory, claiming that he reduces drug activities to a matter of conscious and reflective actions. Weinberg (1998:208) notes that "linguistic competence is not a necessary prerequisite to the occurrence of learning process through which prolonged, self-destructive attachments to the use of drugs take place". Weinberg (1997:150; 1998:208) claims that because Lindesmith casts drug use "exclusively in terms of symbolically mediated mental representations of brute physiological sensations" he is never able to adequately account for "the possibility of a social learning process through which selves might progressively lose control over their personal actions and interpretations".

The 1960s and 1970s saw an increase in ethnographic studies on drug use as well as an increase of funding towards this kind of research (Feldman and Aldrich 2005). Drug research was characterized by ethnographies among drug using subcultures and their members, emphasizing drug use as rational, meaningful and status enhancing activities rather than as pathological (Feldman and Aldrich 2005; Rhodes 2005). While Howard Becker's (1966) study of marihuana smokers emphasizes how people are socialized into learning to appreciate the effects of their use, James Spradley's (1970) study of "urban nomads" focuses on structural factors and institutions as central for producing, in Jaber Gubrium and James Holstein's (2001) term, "troubled identities". Richard Stephens (1991), drawing on symbolic interactionism and role theory, claims that drug addiction should be understood in terms of socialization to the addict role. People become addicts when they see themselves as addicts and are treated as such by others. Over time, Stephen claims, the addict role becomes what one's daily life revolves around, and one becomes committed to it. "Being and becoming a heroin addict" is thus, according to Stephens (1991:103), "as much one's commitment to a

lifestyle as a dependency on drugs". As such, addiction cannot be understood in terms of a pleasure theory, but can rather be perceived as achieving normality. Drug relapsing, in this perspective, is a result of the individual's strong dedication to the addict role (Stephens 1991:57). Similarly, Dan Waldorf (1973, in Stephens 1991:58) found that "persons who were treated as addicts during abstention were more likely to relapse than were those who were not so treated". Stephens therefore claims that labelling has a great effect on people, and that there seems to be a close link between the labelling of people as addicts, and relapsing. I agree that drug addiction is not experienced as "addiction" if the person is unaware of him or herself as an addict. However, while not having the words for a phenomenon makes it harder to categorize and communicate it, this does not diminish the experience of something not being right.

According to Weinberg (2005:6-7, orig. emphasis), most research on drug addiction and mental illness is based on an "*a priori* analytic distinction between the *objective* causes and characteristics of the human condition" and "the *subjective* interpretations and enactment of the human condition". This, he claims, is empirically limiting. Weinberg claims that while an objectivist approach to addiction cannot account for how drug use or mental disorders become significant experiences to the agent, a subjectivist approach, which emphasizes the socialization perspective of becoming a user or addict through learning to appreciate the effects and meanings of drug use, neglects that our navigation in the world is always socially and historically positioned. I find that both approaches bring something to the table, whether they prove useful or trigger new thoughts. An interactionist approach to addiction, as seen in Stephens (1991), may be useful when accounting for how drug use is given meaning. However, while an interactionist perspective may to a certain degree be able to account for why people come to use drugs, it is somewhat less able to account for why people remain addicts; if relapsing is the result of one's dedication to the drug addict role, then why does not dedication to the client role lead to recovery? It seems that while this approach can account for the symbolic and conscious aspects of drug use, it reduces both the embodied and the material aspects of addiction to a secondary matter.

Rather, drug addiction has to be approached in terms of embodied, situated individuals. Weinberg presents, in my opinion, some insightful and useful observations in this respect. Not wishing to reduce drug use to intentional and wilful actions, Weinberg claims that drug use is "a visceral compulsion informed by the perceived practical demands of the moment"

(Weinberg 1997:158). Weinberg (1998:207; 208, orig. emphasis) advocates a "praxiological approach of human learning" that takes into account "the ways people learn to use drugs as resources in culturally and historically specific fields of practical action". Bourdieu presents important tools for Weinberg's practice-oriented approach, enabling an account of how drug use, despite clearly being socially learnt and suffused with meaning, also involves nonsymbolic and pre-reflective aspects (Weinberg 1997). According to Weinberg (1997:159), "drug use is often a more or less setting-specific coping technique that does not, as Lindesmith argued, automatically generalize to the whole of an individual's life activities". He claims that rather than being triggered by stress and discomfort, the compulsion to use drugs arises when the person is "confronted with situations reminiscent of their old drug-using settings and associates" (Weinberg 1997:159). Thus, he claims, drug cravings should be approached in terms of "the prereflective, though eminently meaningful, lived experience of former drug using settings and the practical demands they are tacitly perceived to entail" (Weinberg 1997:159). Weinberg (1997:158) claims that if a person experiences drug use, under specific conditions, to be a resource for "competent performance", it will likely be included in the person's "repertoire of techniques for coping with similar practical conditions". If, for example, alcohol has proven to be an effective stimulant for relaxation in a particular context, it is likely one will continue to use alcohol for this purpose. Similarly, clients at the Healing Center reported that specific drugs either helped keep them stay alert while "working the streets" or served to mentally disassociate when engaging in sex trade practices,[3] or for coping with negative thoughts and emotions in daily life. Others would speak about how their drug use had changed from recreational to a daily addiction, affecting their entire lives.

A central concern in Bourdieu's works is the attempt to formulate an approach which overcomes subjectivist and objectivist reductionism, accounting for on the one hand individual agency and change, while on the other hand also the structural forces which set the conditions and possible outcomes, leading to continuity rather than transformation. While an emphasis on the former risks neglecting the impact of social order on the agent, structuralist approaches tend to reduce human agency to the passive product of set systems. By casting

[3] The term "sex trade practices" has been chosen instead of the more commonly used "prostitution" or "sex work" as it focuses on the activity rather than the institution. Engagement in sex trades is illegal in all but a few states in the U.S., the prohibition applying both to selling and buying sexual services. While staff at the Healing Center approached sex trade practices as forms of violence and victimization, several of the clients were more ambiguous, at least outside group sessions.

human agency as informed by, yet not determined by, and at the same time also shaping, social structures, Bourdieu's stance emphasizes the *durability* and stability of the standing order. Emphasizing the practical aspect of human behaviour as seemingly rational outcomes to specific contexts, Bourdieu locates the social in the embodied agent, and the embodied agent in the social. Bourdieu's theory of practice locates social agents' "practical knowledge" within the complex interplay between historically and socially situated embodied individuals and social structures (Farnell 2000). Human agency, in other words, is the interplay between subjective dispositions and habitus, and the objective structures of fields, and is neither determined by, nor reducible, to either. His analytical tools prove useful when approaching human agency, in addition providing the potential for the objectivation of the researcher's own, often unquestioned, practices, which will be addressed in Chapter 2.

Bourdieu (1990:53) defines habitus as "systems of durable, transposable dispositions" that "generate and organize practices and representations". The habitus is comprised of culturally and historically informed values, dispositions, desires, motivations, and attitudes that are acquired through practical experience and are embodied in the individual, unconsciously informing what can and cannot be thought, said, and done. Bourdieu emphasizes the embodied and pre-reflective manner of the habitus, which operates predominantly on an unconscious level as durable schemas of interpreting, inclining people to think, act, and feel in particular ways (Farnell 2000:399). This largely unconscious aspect is central because it makes practices and values seem natural and self-evident. This, according to Bourdieu, is when habitus works at its best, generating seemingly common sense patterns of behaviours which appear to be the only possible logic responses. In this manner, what presents itself as options to the agent has already been filtered, and some decisions are already made in each situation (Bourdieu 1990:54). The options which appear available are also always *almost* made in advance, as they are regulated improvisations (Bourdieu 1990:54). However, these regularities in behaviour, practices, and thoughts are not governed by any form of rule, nor by norm, but gain legitimacy on the basis of their seemingly "common sense", which also leads to the apparent continuity of the same structures of expectations. Bourdieu therefore notes that the habitus is "more reliabl[e] than all formal rules and explicit norms" (Bourdieu 1990:54). Loïc Wacquant (1989:45) emphasizes that one may say that "individuals make choices, as long as we do not forget that they do not choose the principle of these choices". Habitus is thus a "*mediating* category" which resolves the distinction between social structures and agency by locating human activities in the interplay between social and mental structures, and

habitus is therefore practical in its nature (Wacquant 2004:391, orig. emphasis). This interplay becomes even more diffused in relation to drug addiction, complicating matters because addicts, per definition, are not in control of their lives.

The social world, according to Bourdieu, is comprised of several distinctive yet overlapping fields of action which all operate with their own logic, simultaneously enabling and setting the limits of practice (Adkins 2003:23). Human agency, therefore, cannot be understood solely in terms of habitus, but through the relation between habitus and the particular social field from which it is informed, and within which it works, in the relation between "incorporated history" and "objectified history" (Bourdieu 1990:66). A field, according to Bourdieu "is a social arena within which struggles or manoeuvres take place over specific resources or stakes and access to them" (Jenkins 1992:84), and if habitus is one's "feel for the game", then field is the game itself (Bourdieu 1990:66). Fields may therefore be understood as objective structures, or networks, which constitute a hierarchy of positions based on the unequal distribution of capital (Bourdieu 1990), and which both set the conditions and possibilities for what is possible not only to do, but also to say and perceive of. Capital, in Bourdieu's (1985:724) extended use of the term, refers to those resources which are perceived of as rare and valuable and are "powers that define the chances of profit in a given field". Practice is therefore the (largely fluent) encounter between the dispositions of the habitus and the particular social field with its expectations, opportunities, and restrictions (Jenkins 1992:78). For example, a facilitator at the Healing Center told me that many clients did not perceive that they had other options than "shooting dope" and "doing tricks".[4] Staff members would often emphasize that while they did not wish to force clients into changing, an important part of treatment involved presenting them with alternatives. Bourdieu's theory of practice brings an understanding to how the standing order is usually reproduced rather than challenged, and how change, when it occurs, is gradual and often hard to notice.

While Bourdieu claims that his concepts enable the researcher to approach social life without reducing agency to a matter of mental or social structures, many theorists claim that he is less successful at doing so, in fact falling back on the same dualism himself (see for example Adkins 2003; Crossley 2006; Farnell 2000; Jenkins 1992; King 2000). It is in particular Bourdieu's term habitus which is under scrutiny, as it is claimed to be incongruent with the

[4] Having sex with customers of sex trade practices.

rest of his theory of practice, several scholars finding the concept inadequate in order to account for individual agency, as the habitus is itself a product of the social structures (Farnell 2000; King 2000). Critics claim that Bourdieu seems to ascribe a deterministic force to that of social fields (and thereby also habitus), reducing human agency to the outcome of determining relationship between habitus and field. Anthony King (2000:428), for example, argues that if all human action is constrained by the habitus, then the field will simply be reproduced, and social transformation will not take place. This, King (2000:429) notes, makes the habitus unable to account for social change, but does quite well account for social reproduction. Wacquant (1989:45), however, claims that while the fit between habitus and field is the most prevalent aspect, there are also other possible outcomes, and he emphasizes how this relationship is both conditioning *and* practical, enabling improvisations. As such, the potential for change arises when there is a mismatch between habitus and the field, as when values, explanations or actions no longer make sense (Adkins 2003). In this manner, the habitus, always in relation to a particular field, does not determine people's actions, but rather inclines individuals to act in specific ways.

Richard Jenkins (1992:79-80) claims that Bourdieu operates with a deterministic relation between objective structures, habitus, and agency, and that he seems to operate with diffuse and shifting definitions of the relation between subjective habits and objective structures. Jenkins (1992:79) claims that habitus at times seems to be entirely subjected to the objective structures, other times adjusted to them, and yet other uses stress the dialectic relationship between the two. This latter reading coincides with my understanding of Bourdieu, as it seems to me that it is precisely the dialectic interplay which is his point. I find that Bourdieu presents useful tools for approaching social life which illustrate the complex interplay between agent and structure, emphasizing the practical and embodied aspects of agency as positioned both socially and historically. As such, Bourdieu's concepts are useful in order to make sense of how "working the program" proved to be hard to do within shifting environments and expectations, for explaining continuity over change.

Addiction and treatment

Getting off the train, I am on one of San Francisco's main streets. What meets me is a typical scene from any large American city an early morning, people everywhere on their way to work. This, however, is not my destination, and as I take a left, I am met by a completely

different world, or so it seems. The first thing that strikes me is the strong scent of urine mixed with that of rotting garbage. Garbage is strewn over the pavement, where an old man is sleeping, huddled up under a worn blanket, his head on a pile of newspapers. Next to him is a shopping cart, piled high with cardboard scraps and an assortment of "junk". As I pass him, I inhale the strong odours of an unwashed body. A woman by the bus stop asks for small change, before she turns to no one and starts cursing. A young man is rummaging the content of a rubbish bin. Standing in front of the Healing Center, I can feel my heart pounding as I press the buzzer.

The Healing Center is one of many addiction treatment programs in San Francisco. This multitude of services, I was told by several informants, combined with the liberal climate of the city, were important factors for coming to San Francisco. San Francisco is based on a peninsula, and has limited possibilities for geographical expansion. The population is therefore dense, with 700 000 inhabitants. The later years have seen a large increase in housing prices, forcing many out of the city to neighbouring districts. Poverty is particularly visible in the many homeless people. The neighbourhood where the centre is located is one of the poorer districts of the city. The area around the Healing Center is dominated by empty warehouses and few residential buildings, giving the place an empty and eerie feel after sundown. The neighbourhood is predominantly inhabited by immigrants from Central and South America, but the later years have also seen an increase of young families and students moving to the area.

The dull grey exterior of the Healing Center reveals little of what goes on inside the old two-storey warehouse. The windows on the ground floor are matted, limiting visibility from the outside. A metal gate with a buzzer informs the receptionist of visitors, admitting only those who have business inside. Inside, the white walls are peeling and the floor is covered by a dirty, grey carpet. The walls are mostly bare, except for a few paintings made by clients, and some sombre posters about the destructive effects of drugs and sex trade practices. One which always caught my attention was "Sex for sale is not a choice if it is your only option". Another one, referring to abusive relationships, reads "He only gave her flowers once", with a picture of a coffin with flowers on. The back half of the large room is divided into small office areas where case managers have individual sessions with their clients, creating an illusion of privacy. The front area is intended for clients, with the reception desk, available computers, and a sofa section grouped round an old television. Downstairs is where men's

groups are held, as well as the therapist's office. Upstairs is the staff meeting office, a room for acupuncture treatment,[5] and the room where the women's groups take place.

The Healing Center is a trauma and recovery centre which provides addiction treatment services for primarily low-income persons. The main criterion for becoming a client is substance abuse. Treatment groups are divided by gender, and while I worked with both women and men, I only participated in women's groups. Many of the clients, such as Barbara, Jennifer, and Lydia, had voluntarily sought out treatment, either being referred by other agencies, some entering directly from the streets. However, an equally large proportion of clients, such as Erica, Jamila, Manuela, and Penny, were mandated through the court system, having been arrested for smaller, non-violent cases of drug possession, and given a choice between prison time and enrolling in a treatment program.

On an average day somewhere between twenty to thirty clients would come by for services at the Healing Center, some staying most of the day, others only briefly in order to make an appointment. The majority of the clients were women,[6] some of whom I met only a few times, while others participated on a close to daily basis. Clients ranged from under twenty years of age to almost seventy, and were therefore often in entirely different stages of their lives. What they had in common, however, were issues related to substance use. The majority of clients came from so-called disadvantaged backgrounds, many growing up in broken or dysfunctional families with scarce resources, several having experienced substance abusing parents, violence, and neglect. Most of the them had little formal education, were unemployed, and survived on a combination of monthly welfare cheques and handouts. Some also received help from family members or partners. The majority of clients were without stable housing, either living in residential treatment housings or in transitional housing, with extended family, partners, friends, or in shelters. The bulk of the women also had experiences with engagement in sex trade practices, whether an occasional strategy or on a nearly daily basis. Several had experienced losing custody of their children.

[5] Acupuncture was an important part of the treatment at the center, and was said to help clients both through the detoxification process and for treating other pains. The acupuncturist also provided clients with herbs.
[6] I was told the small number of male clients did not reflect actual needs, but was a result of limited resources and a lack of funding. A facilitator claimed this could be the result of men's involvement in sex trade practices and sexual abuse being more taboo than in the case of women. The limited funding, I was told, meant that the center had to turn away a large number of men whom it was feared would have few other places to go to.

AA's approach to addiction is the dominant treatment ideology today (Weinberg 2000), and was clearly influential at the Healing Center through how treatment was approached and in the curriculum used. In fact, the large consensus on the methods and the efficiency of the AA approach has led to these premises becoming close to established truths about treatment (Weinberg 2000). According to the dominant AA ideology, addiction is a *dis-ease* of time and emotion, a kind of uneasiness which the addict copes with through intoxication (Denzin 1993). Addiction, in this perspective, is a chronic disease, marked by the individual's lack of control in relation to one's substance use. The addict is accordingly said to suffer from a kind of "spiritual and moral failure" through refusing to recognize that his or her actions are not self-governed (Gubrium and Holstein 2001:10). A person may learn to control his or her use through treatment, but will always remain an addict, and as such there are no *recovered* addicts, only *recovering* addicts (McIntosh and McKeganey 2000). Treatment is thus not about curing, but about "empowering" clients to take control over their lives and futures.

Many programs approach addiction recovery as a kind of identity transformation, which occurs through treatment in groups through utilizing the available institutional resources for self-construction (Burns and Peyrot 2003; Cain 1991; Gubrium and Holstein 2001; Paik 2006). Leslie Paik (2006:213) claims that addiction agencies expect participants to "construct a new sense of self according to institutional parameters". Institutional identities such as "alcoholic" or "addict" constitute, according to Gubrium and Holstein (2001:10), important resources for recovery work as they provide members with tools for reflecting on their experiences, and enable them to frame their lives in terms of "troubled identities". An equally important aspect of recovery is, according to James McIntosh and Neil McKeganey (2000:1502), the construction of a non-addict identity, installing clients with a new, meaningful, and positive sense of self.

Clients at the Healing Center engaged in forms of recovery work, and were encouraged to interpret and make a connection between the "unhealthy" behaviours of the drug using addict and their own actions and thought patterns. More specifically, clients were presented with new interpretations of their pasts and actions, cast as forms of "victimizations". As such, clients were enabled to interpret their past, present, and future through the roles of the "victim" and the "survivor" in which drug use and sex trade practices presented their lack of alternatives, and recovery that they could be "empowered" to take control. I will refer to this "transformation" as a reinterpretation process, which I consider to first involve an

identification, or perhaps increased familiarity, with the "active addict", which clients could distance themselves from through "working the program" and identifying with the "recovering addict". In Chapter 4 I will address how the distinction between the active and recovering addict was a central part of treatment at the Healing Center. Following Peter Stromberg (1990), I consider the ideological language used in groups to be of the utmost importance, providing a tool for clients to create coherence and meaning of their past, present, and future.

The use of former addicts as facilitators is considered particularly favourable in addiction treatment (Denzin 1987), as it is said to create a nonjudgmental environment in which clients can feel understood and safe. Both clients and facilitators at the Healing Center emphasized the importance of this, the majority of the facilitators having themselves had close experience with substance abuse, homelessness, engagement in sex trade practices, and not least with recovery. As such, their personal experiences were considered resources which invested them with a particular form of competence and authority, while simultaneously creating a bond with the clients. Staff members at the Healing Center claimed that, unlike many other programs where counsellors have "book knowledge" on the issues they are treating, *they* really knew what they were up against. As one facilitator told me, "they can't say we don't understand what they are going through, since we have all been there". Staff members referred to themselves as "survivors", meaning they had gone from being "victims" to "survivors" who were in control of their own lives. In addition, the staff represented a possible future as they themselves had been able to rebuild a functioning life after treatment, and several of the clients said they hoped someday to become treatment counsellors so they could help others.

Before clients are granted full access to the services provided at the Healing Center, they have to go through a process in which their needs and suitability for treatment is assessed. During this period, clients are expected to show their dedication for treatment and recovery through engaging within a limited range of activities. After this period they are assigned a case manager who will assist them with obtaining housing, securing welfare rights, and arrange appointments, and who has extensive knowledge of the client's specific case. They plan the treatment process together, and the client is encouraged to take responsibility for her own recovery. The bulk of the treatment occurs in group sessions. Clients are obliged to participate in a minimum of twelve hours a week and have regular meetings with their case manager in

order to remain clients. In general, clients complete their program at the centre in six months, some dropping out before this, others extending their stay. In this time they have to complete a certain number of topic groups, each including twelve group sessions. Treatment at the centre is often closely accompanied by participation in other addiction treatment facilities. The Healing Center is a nonresidential day-care centre that only provides services during weekdays. This means that clients live outside the centre, often without the support of peers around them. Clients would frequently share about how hard they found it to "work the program" when they left the centre for the day.

Both AA and the Healing Center emphasize the importance of ongoing participation in treatment groups. Clients at the Healing Center were encouraged to seek out AA or NA groups after completing their treatment. Treatment is not so much about *getting* off drugs, as it is about *staying* off drugs. Weinberg (2001:91) notes that beyond abstinence, recovery work entails "changing one's life sufficiently so that drug use no longer seem[s] necessary". Treatment therefore needs to attend to a wide range of issues, focusing on replacing self medication and unhealthy patterns with "healthier" coping strategies in order to stay "clean and sober". An important part of treatment at the Healing Center involved clients sharing personal experiences, which would be collectively discussed in order to reflect on alternative interpretations and ways of handling similar situations in the future. Group sessions therefore often involved the introduction of specific "tools", usually about ways of thinking, which were resources for coping in a "healthier" manner. Clients were expected to demonstrate their dedication to the program through participating and putting to practical use the tools they were presented with. Attending groups on a close to daily basis meant that clients grew familiar with alternative ways of thinking and behaving, which was considered important in order to establish a degree of consistency in thought and behaviour, even if this was only during groups.

Sharing and identity work

> "Communication cannot be studied in isolation; it must be analyzed in terms of its effect on people's lives". (Gumperz and Cook-Gumperz 1982:1)

Group sessions provided perhaps the most important arena for "healing", a process where clients shared and discussed their past and present experiences, learning to identify

"unhealthy" patterns in order to discuss alternatives. Each session lasted for ninety minutes and was led by a facilitator, the size of the group varying from three or four clients to more than twenty. As the time for group came closer, clients would make their way towards the group room and settle down in one of the chairs which formed an inward circle. The room where groups were held was also used for art therapy, and was a colourful and chaotic mix of equipment, artworks, and projects made by clients. A small section was reserved for group sessions, where chairs were arranged in a circle. This formation enabled direct contact between all participants, and integrated the facilitator with the clients. The facilitator would introduce today's topic while passing out the sign-in sheet where clients signed in.[7]

Group sessions were to a large degree a matter of standard procedure, and clients were given few directions for participating in groups, rather learning through observing peers. One by one everyone would "check-in", stating her name, and perhaps how she was doing. Clients took turns sharing, usually following the order of the circle. Groups were often based on a particular topic treated in the group, such as "drug cravings", "personal boundaries", or "domestic violence", where clients would be asked to relate their experiences in light of the specific topic. Clients could for example be asked to identify, from a list of "negative patterns of behaviour", one or two statements which applied to them. In her study of study of anger management groups in a prison, Kathryn Fox (2001) found that inmates who failed to make an appropriate link between their emotions and "patterns of criminal thought" were sanctioned against. Similarly, clients at the Healing Center who failed to make the link between "unhealthy" behaviour and themselves were often accused of "not working the program". Sometimes the facilitator would share her own experiences, and how *she* had learnt to cope differently. Other groups were less structured, allowing the clients to bring up concerns. Clients were expected to downplay the retelling of concrete episodes or events, and encouraged to focus on how they handled the situation, as well their emotional experiences of it. When clients shared in group, peers were encouraged to give feedback.

Clients would be encouraged to share about past and current experiences in order to identify negative patterns of thought and behaviour. The group would then discuss what had been shared, focusing on how the person had acted and how she interpreted her own role, and how she alternatively could have reacted. These collective reflections were supposed to make

[7] The sheet was later used to update each client's record, noting attendance, specific comments, and a general review of the person's participation.

clients reflect on their own "unhealthy" addict ways of acting, relating negative thought patterns to the "using addict", while associating healthy ones with the "recovering addict". As such, most shared episodes were categorized as either "healthy" or "unhealthy", marking up distinct correct and incorrect ways of thinking and acting. At the end of group, the facilitator would often do a quick summary of the central points of the discussion. Sometimes this would be followed by "check-out" where clients would be asked to respond to a specific question, such as "say something positive about yourself", or "share a good thing you will be doing for yourself this week".

Following Jenkins (2004), identity is best approached as a constant process, and, identity is thus about *becoming* and *doing* rather than *being*. Social interaction provides one of the most important sources for constructing and displaying identity, and as such our understanding of self is at the same time both internal and social. The self, according to Erving Goffman (1990), is performed in everyday life. Goffman's dramaturgical account emphasizes how "self" is *given* meaning through interaction, and how individuals work to present themselves in a particular way. Goffman (1987:154) locates the self not as a property of the person, but within institutional and social relationships, which do "not so much support the self as constitute it". According to George Herbert Mead (1962), the self arises from the interplay between on the one hand the experiencing and acting subject, the "I", and on the other the embodied, objectified conscious notion of "me" which is acquired through "taking the role of the other". Mead terms this relationship "the two bodies". The distinction between the thinking "I" and the objectified "me" is a necessary aspect of self-reflection (Crossley 2006). A more stable "self" can be obtained through taking on consistent attitudes through adopting "the internalized voice of a generalised other" (Jenkins 2004:41). This, however, does not determine one's sense of self, as it is informed through a range of social relations, rather producing a "series of 'me's" (Jenkins 2004:41). As such, Mead emphasizes ongoing social interactions within multiple networks, and Jenkins (2004:40) notes that Mead seems to operate with a notion of *selves* rather than of one self. Nick Crossley (2006) claims unlike Bourdieu, who locates agency within the pre-reflexive domain of the habitus, Mead is able to account for how individuals are active agents in constructing themselves through reflexivity, locating the mind as both embodied and social.

According to Goffman (1990), a sense of self is shaped and given meaning through everyday practices and interaction, and identity is therefore a construction process which is part of

everyday life. Gubrium and Holstein (2001:9, orig. emphasis) stress that identity "emanates from the *interplay* between circumstantial demands, restraints, and resources, on the one hand, and self-constituting social actions on the other". This, however, requires engagement in forms of "identity work", which may be understood as "the range of activities individuals engage in to create, present, and sustain personal identities" (Snow and Anderson 1987:1348). This concept has been a useful tool both during my fieldwork and later in the writing process as it has enabled a practical approach to identity construction, while at the same time including a wide assortment of activities. Identity work encompasses both symbolic and material strategies for negotiating and construction a sense of self. Individuals are active agents who create and maintain a sense of self through engaging in identity work. Robert Desjarlais (1999:466) claims that identities are both pragmatic and political in their making because individuals are strategic in their interactions with others, but political in the way that our interactions are shaped within certain discourses of authority and power.

Talk and interaction provide one the most important sources for constructing, maintaining, and presenting "self" and identity (Gubrium and Holstein 2001; Gumperz and Cook-Gumperz 1982). Individuals who lack social or financial resources are, according to Snow and Anderson (1987:1348) more likely to rely on verbal strategies, "identity talk", in order to negotiate and communicate identity. One may therefore assume that one of the most important resources clients had for engagement in identity work was provided through identity talk. Further, one may also assume that the talk in which clients participated in group sessions was of especial importance, providing clients with linguistic tools for constructing and negotiating personal identity, which, according to McIntosh and McKeganey (2000:1504), involves a reinterpretation of one's drug use as well as of oneself.

Addiction treatment aims to "empower" clients to stay "clean and sober", a process which involves coming to reinterpret oneself from a using non-addict to a nonusing addict (Cain 1991:210). Gubrium and Holstein (2001:13) note that there are many different discursive environments for identity work in everyday life, which both set the conditions for and restrict the possible outcomes of identity work. Different discursive environments will therefore make possible the construction of different identities and personhoods (Weinberg 2001). The use of recognizable identities, such as "alcoholic" or "addict", is an important aspect of treatment and self-construction in institutions, as they provide members with models and resources for identity work (Gubrium and Holstein 2001:11). Participants are expected to make a link

between these models and their own patterns of behaviour, making a connection between their actions and the "unhealthy" identity. When clients at the Healing Center engaged in forms of identity work, they did so making use of the available identity models such as "active addict", "victim", "survivor", and "recovering addict". These presented clients with alternative interpretations of their past through emphasizing the lack of agency and control they had had, as victims of their environment, while locating empowerment and control in the recovering survivor. Clients did not only appropriate the *language* presented them at the Healing Center, but also the particular *rationalities* which were inherent to it, affecting their very sense of self through enabling, and restricting, particular perspectives. It is thus not simply talking about one's problems that helps, but the specific ways of speaking (Miller 2001).

Self stories, or narratives, provide an important sense making device for individuals, and are, according to Jens Brockmeier and Donal Carbaugh (2001:15), particularly suitable for "the exploration of the self or (…) the construction of selves". Narratives are "how people give account of themselves" (Bruner 2001:25), and are important sense-making tools for creating cohesion and agency (Ochs and Capps 2001). Narratives constitute a central part of identity construction processes (McIntosh and McKeganey 2000:1503), and self stories are thus intrinsically related to identity and one's sense of self (Ochs and Capps 1996:19). Stromberg (1990) claims that narratives enable the person to come to terms with underlying concerns and issues, giving a sense of having undergone a change, while Elinor Ochs and Lisa Capps (1996:30) note that narrative activity is an important part of treating posttraumatic stress disorder (PTSD), which arises when episodes are too overwhelming to talk about. Self stories, however, do not always function to create consistency, but may also evoke strong feelings and challenge the narrator (Ochs and Capps 1996). This seems to have been an important aspect of treatment in group sessions, where clients were expected to mark discontinuity through reinterpreting their past experiences and selves from their present selves. McIntosh and McKeganey (2000:1501) emphasize the importance of narrative activity in addiction treatment, as it provides clients with a tool for explaining and reinterpreting drug use and addiction. Self stories do not necessarily follow a chronological rationality, often focusing on particular topics (Ochs and Capps 2001). This was evident at the Healing Center, where group sessions approached treatment via several different topics, enabling new perspectives and interpretations. Therefore, rather than viewing contradictions in clients' stories as problems, they may better be understood as necessary elements which made possible a larger process of sense-making. Carole Cain (1991), for example, notes that members in an AA group would

reinterpret others' narratives if they failed to be consistent with the AA model. Different aspects are emphasized or left out depending on one's audience, the specific expectations of what and how to share, and on one's perceived idea of the function of one's self story.

Self-construction, through forms of identity work involving self stories, is a social and collective process which has to be understood in terms of social and historical embeddedness, not only of the individual, but also of the institution and its language (Gubrium and Holstein 2001). Self stories do therefore not present objective interpretations, and have to be understood as contextual products (Bruner 2001; Loseke 2001; McIntosh and McKeganey 2000; Ochs and Capps 2001). They provide tools for the collaborative reflection on experiences and self (Ochs and Capps 2001:2), and as such, clients' interpretations cannot be understood separately from the linguistic repertoire of the Healing Center. Clients' sharings affected what and how others said in groups, both enabling the process of putting into language, while at the same time restricting what was spoken about. In group sessions, clients would often refer to what clients had shared in their own interpretations. References to and supports of previous sharings constitutes an important aspect of group treatment, according to Illka Arminen (1998), as they are resources which help clients verbalize their experiences in an understandable and recognizable manner. However, as will become evident, clients did not always agree on each others' interpretations, and would sometimes challenge or reinterpret what had been shared.

Language is not a neutral tool for communicating, but is the practical outcome of interactions between agents positioned within specific fields, who possess different amounts of capital (Bourdieu 1994). Language is therefore always a socially and historically conditioned phenomenon, and as such is a powerful tool. As will become evident in the following chapters, certain discourses were more legitimate than others, bestowing some clients' contributions with more authority and legitimacy than others. Knowing *how*, but also *when*, to talk was an important resource which enabled some clients to talk with more authority than others. This may be understood in terms of their acquired "linguistic capital", that is, an agent's knowledge and competence about the linguistic demands and discourses of the specific linguistic market (Bourdieu 1994:57). Chapter 5 will attend to how two forms of capital provided important resources for many of the clients' participation within two different environments.

According to Goffman (1974:8), individuals are constantly engaging in framing activities in order to make sense of ”[w]hat is it that's going on here?”, and are through this “forming conjectures as to what occurred before and expectations of what is likely to happen now" (Goffman 1974:38). “Framing” may be understood in terms of the practical employment of interpretive tools, or structures, in a particular situation, which informs the agent on what is going on (Goffman 1974). The term “frame” was developed by Bateson in the 1950s in order to explain how “individuals exchange signals that allow them to agree upon the level of abstraction at which any message is intended” (Tannen 1993:18). As such, frames provide important resources for navigating and communicating in social life, and “emerge in and are constituted by verbal and nonverbal interaction” (Tannen and Wallat 1993:60). Both Bateson and Goffman emphasize the practical aspect of framing, focusing on what people think they are *doing* while communicating. Deborah Tannen and Cynthia Wallat (1993:67) note that the frame concept is useful as it helps us explain why “activities which appear the same on the surface can have very different meanings and consequences for the participants if they are understood as associated with different frames”. Frames are not only shaped by the particular situation, however, but are also based on past experiences and expectations (Tannen 1993). Tannen, drawing on Bateson (2000), Goffman (1974), and Gumperz (1982), introduces a useful term, “schema,” which complements the frame term, providing useful tools for approaching communication and meaning. Schema, also referred to as “knowledge schema”, refers to the individual’s “patterns of expectations and assumptions about the world” (Tannen and Wallat 1993:73). These are central for making sense of and navigating in the world, and form more general “structures of expectations” (Tannen 1993:16).

Schemas are “framing devices” which both inform and shape frames, as expectations are verified or challenged (Tannen 1993). The frames we navigate with in everyday life are, according to Tannen and Wallat (1993:69), based on several different schemas, which we in general manage to balance unconsciously. Framing is therefore understood in practical terms as the application of schemas to a particular situation. While structures of expectations are not readily available, being deeply embedded, Tannen claims that these may be revealed in communication through “surface evidence”. Surface evidence may be understood as both verbal and nonverbal cues which may be revealed in interaction, and represents “the impositions of the speakers’ expectations” about the situation (Tannen 1993:21). Underlying schemas may be revealed when there arises a mismatch between the agent’s expectations and the situation, which, according to Tannen and Wallat (1993:61) has the potential to trigger a

shift of frames. The authors emphasize, however, that while we constantly modify, or reframe, our frames based on new experiences, schemas are not easily altered (Tannen and Wallat 1993:72).

I find that Tannen's elaboration of the term framing provides useful tools for attempting to make sense of the underlying structures which direct human agency. Approaching communication from a more cognitive and linguistic approach, these tools enable an understanding of how underlying expectations and interpretations form human agency. This may be useful in order to understand how clients at the Healing Center in fact had very different premises and assumptions for participating in group sessions, depending not primarily on whether or not they were court mandated or participating on a voluntary basis, but based on prior experiences with treatment programs and similar agencies. In fact, one cannot approach the question "what is going on" expecting an objective answer. Rather, one has to focus on what individuals *think* is going on. Talk in groups, it seems, proves useful resources for approaching this.

So far it has been argued that language provides an important resource for engagement in identity work, and for constructing and presenting a sense of self. The tools and resources clients acquired in groups were intended to help them engage in self-inspection and to become aware of their "unhealthy" behaviour patterns, while equipping them with new "healthy" ones. Clients' sharings in groups were evaluated based on a distinction between the "unhealthy" actions and mentality of the "using addict" opposed to the "healthy" ones of the "recovering addict". This distinction served to structure and make sense of recovery. I believe that treatment in group sessions is important because the collective process of sharing and reflecting on each others' interpretations has the potential for enabling participants to objectify and reflect on their own practices. While clients sometimes seemed to have problems applying the material to their own actions, it seemed that pointing out others' "unhealthy" practices was easier. I believe that ongoing, for some clients daily, participation in the treatment setting was important because it enabled, or required, clients to assume a more consistent perspective. This daily reflection on one's own practices had the potential for a gradual reinterpretation of one's actions as those of the active addict, while simultaneously learning new "healthy" ways.

The structure of the thesis

I have in this chapter attempted to outline central concepts, tools, and questions which are addressed in this thesis. In Chapter 2 I will attend to some methodical concerns, ranging from my participation during the fieldwork to issues involving my academic positioning. As such, the framework outlined in Chapter 1 is an attempt to locate the influences and ideas which have been the basis for my positioning. In Chapter 3 I will focus on some aspects of addiction treatment, such as court mandated participation and harm reduction, and go more in-depth on the specific treatment practices at the Healing Center, drawing on its resemblance, but also differences, to those found in AA. I will in particular focus on the institutional language promoted in groups, and how these dominant discourses presented resources for clients while simultaneously excluded other interpretations. The identity positions "victim" and "survivor" presented perhaps the most important explanatory resources for clients, helping clients to structure and make sense of their experiences through emphasizing "victimization" interpretations. In Chapter 4 I will present a set of dichotomies that structured the manner in which both clients and staff members at the centre spoke about drug use, relapsing, and recovery. The distinction between "unhealthy" "active addicts" and "healthy" "recovering addicts" was an important one which structured treatment through creating clear opposites, establishing appropriate and inappropriate activities, thoughts and mentalities. This dichotomy was central in most aspects of communication in group sessions, and provided a way of structuring recovery. In Chapter 5 the focus will be on how clients relied on different kinds of capital when engaging in negotiations within different contexts. The body provided perhaps the most important resource for many of the clients in order to obtain money, drugs, shelter or other needs. This part also draws on my contact with a sex worker organization in San Francisco in order to highlight various experiences and aspects of engagement in sex trade practices. In groups linguistic resources provided an important means for negotiating meaning and for displaying one's attempts at "working the program." In Chapter 6 I will attempt to draw some concluding remarks as well as look at possible implications of my findings.

Chapter 2 Methodological concerns

In this chapter I will account for some of the methodological considerations that have arisen over the past two years. I will address practical and theoretical concerns, in particular focusing on issues related to my positioning in the field and theoretically.

Practical positioning

The months leading up to the fieldwork were spent reading up on relevant literature, developing a project proposal, and establishing contact with the Healing Center, which was one of several institutions I contacted in San Francisco. Correspondence was done via e-mails, where it was agreed that I would participate at the centre as a volunteer on a close to daily basis while conducting research for my thesis.

Clients were informed verbally, either during group sessions or individually, about my project and my intention to join them in group sessions. They were informed that participation was voluntary, and that they were free to withdraw at any time. Some of the women, who so generously have shared of themselves, are currently working on changing their lives, building new networks and getting jobs, and my intention is not to make this process harder than necessary. All names, including that of the centre, have therefore been altered in order to secure anonymity. These measures were established in line with NSD's rules on how to handle personal information. These regulations, however, proved somewhat difficult to practice once in the field, where the Healing Center's requirements to volunteers held other, sometimes conflicting, considerations for "the good of the client". This would at times put me in a predicament of sorts, as information at the centre was sometimes shared with me as a volunteer, and therefore in a client-facilitator relation, at other times in that of informant-researcher, or even shared between friends. However, the different kinds of documentation, that is, my notes versus the centre's notes, enabled me to establish fairly clear boundaries for what was considered relevant and important information to pass on. Throughout the thesis I will mark off both clients' as well as theoretical concepts with quotation marks.

Clients, I soon found out, travelled from all over the city, as well as from nearby towns, in order to attend treatment. This made it hard to follow clients in their lives outside the centre, and as such, the physical and social boundaries of the Healing Center also marked off my

field. Rather than treating the Healing Center, the field, as a *place,* it may be more useful to approach it in terms of a habitus, enabling a perspective on what was going on as "a cluster of embodied dispositions and practices" (Clifford 1997:199). Focusing only on what was going on within the centre both restricted and enabled my possibilities, as it on the one hand gave me access to a fairly stable group of women, while on the other hand left it me clueless to what was going on in their lives *outside* the centre, rather having to rely on the clients' own accounts. I did, however, spend time with some of the women outside the Healing Center, accompanying them to public offices and services in the city, as well as visiting them at home. This allowed me at least some insight to their everyday lives outside the institution, as well as their experiences of social space. Had I, however, known the direction my work was to take, I would clearly have pushed harder for participating in arenas also outside the centre.

During the day, I would take notes in a little notebook which I kept with me at all times. I soon found out, however, that taking notes during groups did not work out. Scribbling notes while someone was sharing painful and very personal experiences, was, to say it the least, not only a bad strategy for actually *participating* in the event, as my writing marked my actions from that of the others, but it also risked me missing nonverbal forms of communication as well. Some of the women objected to my active note taking in groups, finding it disturbing. Ava, a client in her early fifties, who in every other way showed enthusiasm about my project, said that she felt she could not share properly when she knew it was being recorded verbatim. It turned out to be a better strategy to jot notes between groups. This, however, meant that it was harder to get exact quotes. Clients were more open to me taking notes during private conversations, enabling an elaboration or even an unofficial version of what had been said in group. However, the ambivalence about my note-taking, or perhaps more in relation to *what* I was taking notes of, continued. A few clients asked me about what I was writing; however, my vague answers about wanting to learn about their experiences most likely served to confuse them even more.

Clients were often surprised by my ability to remember things to a greater extent than both themselves and staff could, having, perhaps, forgotten that I took notes regularly. Not only did I work with my notes at the centre and at home during the evenings, but as a volunteer I was also responsible for charting groups' and clients' activities. These latter notes were, however, of a different kind than those I took as a fieldworker as they were used for a different purpose, and I had to learn what was considered to be relevant information. Also, while clients and

facilitators changed from group to group, I remained, often hearing the same event shared from three different perspectives, all in a day. These repetitions proved useful in several ways, most notably through noticing how clients' versions changed depending on the group, and by finding reoccurring formulations. While I was provided with a "good memory", that is, with my notes, for navigating with, clients had no such thing, and many of the clients seemed to have problems remembering things in their everyday lives. This presented at times a methodical problem, as it turned out that simply having presented myself and my project for a client did not necessarily mean that she would associate it with me later. I was more often addressed as a "volunteer" than as a "researcher". This was not surprising, taking into consideration that I was acting and functioning like the other volunteers. However, it did become problematic when clients who had been informed about my project later reacted as if it were the first time they heard about it. Luckily, most clients' responded with enthusiasm and interest, even the third time they were reminded. In fact, an extreme variant occurred when Rebecca, whom I had spoken with on several occasions, returned after having been away for some weeks. Asking for my name, I told her, thinking she needed a reminder. I therefore struggled to hide my surprise when she enthusiastically responded that there was *another* volunteer at the centre who was also called "Fiona" and came from Norway.

One can never be sure how one's presence is experienced or interpreted, and attempts to control how one is perceived may in fact lead to more confusion. Throughout my fieldwork, I was associated with different roles, and people were continuously trying to make sense of who I was and my position. I did for example not fit into their definition of what a volunteer or staff member was, and presenting myself as an anthropology student did not have the intended clarifying effect. I realised just how confusing my role must have been through a seemingly innocent little joke. I was sitting at a table in the reception area, jotting notes, when Manuela, a woman in her mid-forties, sat down. After some moments she said "You're not really a student from Norway, are you? You're a FBI-agent, working undercover". Innocent as it may seem, this comment made me realise the anxiety and ambivalence I may have evoked in some people, as I had the authority of the staff, but on the same time was using the information gained for purposes outside the institution.

Being a peer-driven program, my lack of personal experience as a "survivor" meant that on occasions my credibility was questioned, both facilitators and clients challenging that I could possibly understand their concerns. Having been through the same trials served as a point of

both inclusion and exclusion, and as such I had to prove my solidarity in other ways. I could listen and spend time with clients, which seemed to be appreciated, as well as prove that I listened through remembering things I had been told earlier. I could spend more time with the clients than staff members could, and while the staff had to interact with clients as "staff to client", I could be more flexible in how we communicated. It was not, however, possible to be completely disassociated from the staff, as my position as a volunteer gave me most of the same responsibilities and privileges as them. Having the authority to sign a client's participation slip or facilitate groups obviously led me to be identified as one of the staff. Hanging out with clients between groups, however, I often learnt "unofficial" versions which clients did *not* share in groups, and which would not have been available had I communicated with clients through a purely "staff role" and only in the correct settings. When clients were alone, they would sometimes talk about topics which were considered "triggering" by the facilitators, such as discussions about one's "drug of choice". While these conversations were abruptly stopped when staff members were around, I noticed that my presence did not seem to have this effect. This gave me a sense of inclusion, knowing that while I was sometimes experienced as being part of the staff, I was at other times perceived more as an allied.

Many of the clients had at best a strained relation to authorities and "outsiders", and were highly aware that any information given may be used against them (and, based on experience, most likely would be). Unlike the US Embassy or the Healing Center, where my letter of recommendation from the university gave me admission to the field, these qualifications did not automatically gain me access among the clients themselves. Many of the clients were participating on an involuntary basis, and as such were not sharing their personal and traumatic experiences of free will. Trust and respect is not something one can demand, but something one builds up over time, through proving one's reliability and worthiness. Being an outsider, I was both associated with the staff, while also seen as "someone else". This seemed to give me an advantage, perhaps in particular with those clients who were not voluntarily enrolled, as I did not represent the institution to the same degree as the staff members did.

Theoretical positioning

My main method of collecting data was based on participant observation, in which group sessions, the reception, and the smoking area provided the most important arenas for

interaction. During an average day I would participate in a range of activities with both clients and staff at the centre, such as attending or facilitating group sessions, doing "paper work", answering phones, and doing "screenings" of new clients. A lot of time was also spent in the reception area, chatting with clients or jotting notes between groups. I did not conduct any formal interviews, rather relying on informal conversations. Having experienced the way things were shared in group sessions, I considered the interview setting less appropriate for communicating, more likely to create distance and, perhaps, potentially being perceived as an interrogation.

Participant observation, though increasingly a part of other disciplines, is perhaps what distinguishes anthropology from other forms of social science, requiring one to participate in everyday activities along with one's informants in order to get insight to what *informants* see as important and relevant. Extended participation provides a resource for approaching both the linguistic and non-linguistic aspects of informants' cultural knowledge, which cannot easily be accessed through shorter encounters or verbalized (Jenkins 1994). As students we are reminded not to rely on what informants *say* they do, but rather observe what they actually do. While I could not accompany clients in their lives outside the Healing Center, I did have access to what they said, and how their interpretations changed within different contexts. Clients would sometimes present one version in group, while sharing their less official versions with me when we were alone, for example smoking at the street corner or huddled in the sofa. The difference between official and unofficial versions should not, following Wolf Bleek (1994), be considered a problem. Rather, variations in clients' accounts represent resources for mapping out sensitive topics, the verbal strategies employed in order to negotiate meaning and agency in interaction, and the different expectations and relations of power involved in the particular context.

The importance of practical experience is, according to Michael Jackson (1983:339), important because a lot of meaning cannot be put into language, rather being embedded in praxis. Jackson (1983:340) therefore suggests a methodical approach which involves "joining in without ulterior motive", requiring the researcher to put him or herself "in the place of another person: inhabiting their world". Jackson (1983:340, orig. emphasis) claims that this method enables participation to become "an end in itself rather than a means of gathering closely-observed data which will be subjected to interpretation elsewhere after the event", and that this allows the researcher to "grasp the *sense* of an activity" through using one's body the

same way as those one is studying does. As such, Jackson claims that participation in everyday tasks is the means to grasp the underlying, embodied and practical experiences of informants' lives. Is this kind of immersion into the informants' world, however, what one should strive for as an anthropologist, and is it even possible? Timothy Jenkins (1994) suggests that the anthropologist's experiences can be seen as a series of apprenticeships, and that this process is the same as that people undergo in everyday life through acquiring skills and social competence. This leads to a perspective of fieldwork as an "apprenticeship of signs, a process of entry into a particular world, governed by a variety of factors, including the situation and previous experiences of the anthropologist" (Jenkins 1994:443). Through participation one gains insight to both one's own, largely unconscious, assumptions, as well as to those of the informant (Jenkins 1994). Jenkins (1994:445) emphasizes, however, that there is no ultimate indigenous insight to gain, no way to "learn to 'think like a native'".

According to Bourdieu (2003:281), there is an inherent problem in the anthropologist's method of participant observation as one cannot simultaneously both be the observer, while also being the observed, being both subject and object to oneself at the same time. Bourdieu claims that while social scientists constantly objectify the practices and actions of informants, they often fail to apply these same tools on their own practices. He claims that social scientists have to a large degree reduced this critical reflexivity to a matter of "observing oneself observing" (Bourdieu 2003:282), rather than addressing the role of the researcher as a cultural producer (Bourdieu and Wacquant 1992:36). Bourdieu notes that every methodological choice the researcher makes, no matter how seemingly small, also includes theoretical ones (Bourdieu and Wacquant 1992). Following this argument, the separation of methodology from theory is an artificial one, potentially obscuring the fact that choices are made during the whole research process, shaping one's findings.

Participation without "epistemic reflexivity" is, according to Bourdieu (1990:34), "simply another way of avoiding the question of the real relationship of the observer to the observed and its critical consequences for scientific practice". He claims that without objectivizing one's own practices, one remains oblivious to "*the universal logic of practice*", the dispositions and schemas which agents, whether informant or researcher, navigate with in daily life (Bourdieu 2003:286, orig. emphasis). He therefore emphasizes that as researchers one needs to turn on one's own practices, and in particular those from the academic field, with the following traditions, habits of thought and so on which set the conditions not only for

one's methods but set the limits for what can be thought, and how (Bourdieu and Wacquant 1992). Hence, Bourdieu (2003:281) calls for "participant objectivation", a useful tool which should be used throughout the whole research process in order to "grasp and master the pre-reflexive social and academic experiences of the social world that he tends to project unconsciously onto ordinary social agents". Bourdieu (1990:33) notes that the researcher has, in fact, no natural place among informants, and is always excluded from real participation. What distinguishes the researcher from his or her objects of study is that they are engaging in different activities, so to speak, and utilizing entirely different tools. For while the informants are busy doing whatever they think they are doing, such as engaging in "healing", the researcher is engaging in those activities with other aims in mind. Bourdieu (2003:288) emphasizes that the challenge lies in remembering that the researcher is employing specific tools for making sense of informants' activities which they themselves do not have. As such, both Chapter 1 and Chapter 2 should be read as an attempt to account for the ideas and tools which have influenced and shaped the entire research process.

Following the frame-perspective outlined in the previous chapter, it seems that researcher and informants are applying radically different frameworks for interpreting what is going on. While clients at the Healing Center were participating in forms of "treatment", I was – in the end – participating as a researcher, aiming to make sense of what was going on. Accordingly, what occurred in groups turned out to be experienced in very different manners. This became particularly evident to me after one group session when several clients were talking about how inspired and moved they had been by something that had been said. What occurred to me to be ambiguous and somewhat hazy phrases, seemed to make sense to many of the clients, who felt that they had been affected by what had been said. In fact, one of the women even asked me to make her a copy of a particular part of the curriculum, so she could keep it with her. As such, our different degrees of association with, or disassociation with, the "healing language" illustrates how polysemy works, enabling both identification with and distancing from what was going on. What I categorized as "identity talk" or "identity work" was by clients referred to as "healing", or in some cases "bullshit". Facilitators would mix levels, sometimes talking about "healing", other times referring to group sessions or the curriculum in terms of "recovery work". These may be understood as what Clifford Geertz's (1976) refers to as "experience-near" and "experience-distant" terms, representing respectively informants' emic and the researcher's etic terms. Learning the institutional use of these and other terms provided me with tools for translating between different levels of abstraction. This

illustrates how my academic positioning enabled me a different approach to what was going on, by using other tools than the clients. As such, while the “language of healing” may have been a tool in itself for clients, it provided me with material for applying other analytical tools. My whole positioning, both as a “nonaddict” who had not “surrendered” and sought out treatment, and my academic positioning as a student doing research, meant that my idea of what was going on could not, in any manner, be the same as that of my informants. While the former meant that some clients questioned my ability to really understand their concerns, the latter both enabled and restricted what I could and could not see, and how.

The issues I have addressed in this chapter are obviously only a few of many relevant ones. However, the relation between researcher and informant is a reoccurring one, addressed both in terms of the practical positioning in the field and in regards to concerns involving the production of knowledge. In light of Bourdieu’s criticism of the lack of reflection on one’s academic biases, it seems that a framing approach provides a useful tool for making sense of how each participant, including the researcher, operates and navigates with different schemas.

Chapter 3 Treating addiction, treating trauma

In this chapter I will contextualize and go into more detail on the specific treatment approach used at the Healing Center, emphasizing language as an important aspect of treatment. I will first address court mandated treatment. This is followed by an account of certain aspects in which the Healing Center's approach to addiction treatment differs from that found in AA, addressing the link between addiction and trauma, as well as the principle of "harm reduction". Then I will focus on the use of institutional identity models in treatment, as resources which helped clients make sense of and structure their experiences in terms of "victimizations". I will claim that the institution presented a particular discursive environment, which provided clients, through the identities models "victim" and "survivor", with conceptual models for making sense of and coping with experiences of addiction and trauma. These identities presented different tools and perspectives for self reflection, and enabled clients to undergo an identity change. I will claim that it was the inherent vagueness, or polysemy, of this language which enabled clients to identify on a personal and experiential level. The final part of this chapter will focus on how the "talk" in groups provided a potential for a change in the client's sense of self.

Punishment and rehabilitation

Drug addiction has been perceived in different ways through history and in different societies, leading to various forms of intervention. Drug use was long understood as an individual, pathological problem, and approached as a criminal concern. Today, however, substance abuse is largely approached through a theory of addiction as disease. How society reacts to and constructs drug use, and not least drug *users*, has to be conceptualized in terms of a legal and cultural process (Whiteacre 2005). Institutions such as the legal system and the medical field, including psychiatry and treatment programs, hold a central role in defining and controlling ideas of normality, deviance, and disease. The dominant discourses that are produced and reproduced within, and between, these authorized knowledge systems are legitimized and rationalized as scientific truths, gaining a close to unquestionable, or hegemonic, authority. It is important to note that these truth producing institutions and discourses do not work separately, but intersect, legitimize, and challenge each other, creating a seemingly coherent set of truths. According to Gubrium and Holstein (2001), there has been a large increase of agencies and institutions which aim to help so-called "troubled identities"

change, and they often co-operate in doing so. In relation to drug addiction, this may be seen in the close interplay between the court system, treatment agencies, medicine, and the welfare system. This also manifests itself in the drug treatment program itself, which combines scientific research with ideological beliefs, establishing truths which are hard to repudiate.

The common agreement on addiction being an uncontrollable disease, not only in larger society but also among many addicts themselves, may be understood in terms of what Bourdieu (1994) calls symbolic violence. Symbolic violence requires, in order for it to be successful, that also those subjected to it acknowledge its legitimacy. This means that people are themselves unknowingly actively complicit in their own subjection. Though individuals termed addicts often hold little power over their own treatment, or even their own status as addicts, many come to believe that intervention and rehabilitation is the most efficient, and often only successful, response to the addict diagnosis. In fact, many are told that the AA way is the *only* way. According to Bourdieu, institutions gain their authority and legitimacy through power relations which are concealed in everyday communication and interaction, making them seem self-evident and natural.

According to Spradley (1970), categories come into existence through labelling and categorization, and he notes that institutions have a central role in this. He claims that it is through the institutionalized stripping of personal identity in jail, which provides an identity change through being labelled and treated as a "hobo", that people come to see themselves as and identify as such. This is a process of *naming*, a performative action which brings into existence sometimes new categories, and is a powerful tool because classification is a way of constructing realities (Bourdieu 1994). In Bourdieu's words, by "structuring the perception which social agents have of the social world, the act of naming helps to establish the structure of this world, and does so all the more significantly the more widely it is recognized, i.e. authorized" (Bourdieu 1994:105). At the Healing Center, for example, there existed two forms of addicts: the "using" addict, and the "recovering" addict. These categories had consequences for the clients' recovery process as well as their perception of self. In fact, the very institutions which aim to *cure* addiction can be said to *produce* addiction, and therefore also addicts.

The passing of Proposition 36 in California, known as the "Substance Abuse and Drug Prevention Act of 2000", opened up for applying "tough love" to non-violent drug offenders

through emphasizing rehabilitation rather than incarceration (Burns and Peyrot 2003). The intention is to offer treatment as an alternative to imprisonment, and involves supervised drug program participation that aims to combine addiction treatment and training life skills (Burns and Peyrot 2003). Instead of punishment, addicts are enrolled in programs where they are treated and rehabilitated through closely monitored participation and progress, frequent drug testing, and the constant threat of a more severe restriction of freedom. The shift to addiction as a disease, rather than as an individual vice, has led to a change in how addicts are treated as one cannot punish people who are defined as sick through conventional methods. According to Laurence Kirmayer (1988), the labelling of addicts and other "deviant" behaviours as "sick" has had implications beyond simply diminishing the moral blame of the individual. He claims that the medicalization of addiction "implies a diminished capacity of the person to govern his action" and that this makes the person blameless in relation to his or her actions because the person is considered to have a diminished moral awareness (Kirmayer 1988:81). This, he argues, leads at the same time to the addict being reduced as a social being and legitimates particular forms of intervention, such as rehabilitation instead of punishment.

The change to seemingly more "humane" forms of treatment of criminal offenders is far from a new phenomenon. Michel Foucault's (1979) study of the development of the modern penal system, for example, shows how there was a shift from physical punishment to more refined techniques of control, from punishing the body to rehabilitating the person. He notes that these new forms of intervention are "intended not to punish the offence" but rather to "supervise the individual, to neutralize his dangerous state of mind, to alter his criminal tendencies" (Foucault 1979:18). He claims that this shift does not reflect a wish to treat the accused in a more humane manner, but rather the need for new techniques in which the punished is seen as undergoing correctional treatment. This coincides with the development of closely connected institutions which provide different forms of rehabilitation adhering to different forms of crime and deviance. Likewise, one can view the treatment of those defined as addicts as a seemingly more humane form of sanction, which passes not as punishment but as a necessary intervention on behalf of someone who is out of control.

While drug courts often treat recovery and drug treatment as personally motivated, Stacy Burns and Mark Peyrot (2003:423) note that the defendant's consent to participate in such programs need not be based on a desire for treatment, but rather as the better option compared to prison time. Erica, a court mandated client at the Healing Center, was honest about her

motivation for choosing treatment over imprisonment, arguing that at least she was not incarcerated. The fact that the addict has to undergo treatment *after* the initial detoxification period implies that the sickness of an addict not only sits in her body but is a form of dysfunctionality inherent in his or her very self, which is also ascribed certain moral deficiencies. This is a regime of discipline which the regular ill person never would be exposed to, and shows how the addict is, although recognized as being sick, also to a large degree seen as responsible for his or her actions. Paik (2006:214) notes that coerced voluntarism in treatment programs "undermines the institutional assumption of self-help programs", based on voluntary participation and surrendering. Following Norman Denzin (1987:78) it may seem like the very treatment system itself, through indirectly forcing people into treatment, produces clients which are deemed to relapse due to their lack of wilful participation.

Like addicts, people engaged in sex trade practices have been subject to a wide range of intervention practices. Allison Diduck and William Wilson (1997) claim that the legal system has had a central role in reinforcing "the prostitute" as female with deviant sexuality, and the client as male and driven by natural, sexual urges. Today, despite gender neutral laws in relation to sex trade practices, women are more often arrested for engagement in these activities than men (Diduck and Wilson 1997).[8] According to Mary Spongberg (1997), there was a shift within the medical discourse in the 19th century from locating the female body as the site for venereal diseases to locating it within the body of the "prostitute". This, she claims, led to a change in the position of women engaged in sex trade practices from being "fallen women" to becoming "less than women". Another important shift occurred during the 1950s, in which "the prostitute" changed from being viewed as primarily a social threat to becoming a threat to herself (Spongberg 1997). According to Joanna Phoenix (1999) this coincides with a shift in the 20th century from a pathologizing of her *body* to a pathologization of her *behaviour.* Localizing the problem as lying within the person implies that he or she needs help to be controlled and treated. Sex trading is still infused with both pathological and moral judgment, and Phoenix claims that women engaged in these activities are both seen as similar to and at the same time different from other women. This is reflected in the way sex trade practices are spoken about and in the metaphors used. It is, for example, usually seen as an institution in which healthy, free people would not voluntarily participate.

[8] This cannot simply be reduced to a matter of gender, but also has to be seen in relation to other factors such as their visibility.

This is often backed up by statistics which show that the large majority of those in the sex industry have suffered sexual abuse and neglect prior to their engagement. These data are used to explain and rationalize persons engaged in sex trade practices as damaged people scarred by unhealthy boundaries and trauma. However, engagement in sex trade practices has a moral character to it which addiction as a disease does not have. Addiction implies a loss of control, and for many of the clients I met engagement in sex trade practices was an important source for maintaining their addiction in lack of other options. Despite it often being a last resort, engagement in sex trade practices does not disqualify the moral responsibility of participants as he or she is not understood to be sick in the same way as addicts are. Rather, engagement in sex trade practices still implies an inherent moral quality of the person, and this embeds it with an extra level of meaning of shame and guilt which has to be worked through. Not surprisingly, many clients at the Healing Center spoke about their drug issues long before they spoke about their engagement in sex trade practices. Still, there was no singular experience among the clients, and as I will return to later, sex trade practices could also present independency and choice.

The Healing Center is a non-profit organization which is free of cost for clients, and is therefore dependent on economic support from both public and private sponsors. It seemed that an important strategy for receiving more funding consisted of offering clients a wide range of services, such as addiction treatment, mental health, men and women's groups, transgender services, an own branch working with under-aged females, and not least issues related to "prostitution". Documenting each client's treatment process was important as the centre had to prove that they had results and were efficient. According to Peyrot (1991:27), record-keeping and documenting the program's activities is an important strategy for many treatment agencies in order to receive funding through showing that one attends to a wide range of issues. A facilitator told me that there was a lot of competition between the treatment agencies in the city, as they were struggling for the same limited resources. It was important to be strategic in relation to how the centre presented itself outwards, sometimes emphasizing their work with addiction treatment, while at other times their work for people involved in sex trade practices. This became more evident through my contact with a sex worker organization, which did not receive public funding. Members of the Sex Worker Organization explained the lack of funding as a result of their promotion of the discourse "sex as work". The Healing Center's approach to "sex as violence", however, accorded more with the larger society's perception and condemnation of these kinds of activities. It is therefore evident that the

Healing Center's approach to treatment cannot be isolated from other institutions, as its economic funding is dependent on portraying a specific image while distancing itself from others.

Tenable living conditions were stressed as perhaps the single most important factor for continued sobriety by both clients and facilitators. As a nonresidential treatment program, the Healing Center is open during daytime on weekdays. In his comparative study of a residential and a nonresidential treatment program, Weinberg (2001) found that the programs differed in how they were organized and which concerns they attended to. This he relates primarily to the residential status of clients, rather than to different treatment philosophies. While residential programs get clients out of their former living arrangements, providing them with basic needs and structure, clients in nonresidential programs have to return to the same environment came from. Weinberg therefore claims that while residential programs can focus primarily on internal processes of recovery treatment, and on morally enforcing "correct" living, nonresidential ones have to tend to external, environmental factors as a part of treatment (Weinberg 2001:88). In this manner, treatment programs like the Healing Center cannot fully focus on the individual's past patterns of drug use, but needs also to address living conditions. This was done through for example helping clients obtain welfare benefits such as SSI and GA,[9] affordable housing, legal aid, and physical and mental health treatment. In addition, the centre would on occasions provide clients with handouts such as food, clothes, and hygiene articles.

While self-empowerment in residential programs can focus on the clients, treatment in nonresidential programs needs to focus more on "looking forward than backward, more in the work of realistic planning than in the work of therapeutic retrospection", such as addressing potential obstacles such as "slippery" places and "triggers" in order for clients to make it (Weinberg 2001:93). Treatment in nonresidential program thus needs to focus on what he calls the practical logic of empowering clients (Weinberg 2001:101). In this manner, it may seem that addiction programs such as the Healing Center are of necessity more present-oriented, as they focus on the needs of today, in order to provide for tomorrow. This is evident through the promotion of realistic planning and in the emphasis on "building a stable foundation". At the Healing Center, both internal factors and external ones were treated. The

[9] General Assistance and Supplemental Security Income are relief measures which help low-income individuals. Clients, however, reported the criteria for receiving such help to be strict.

curriculum used in groups addressed primarily the former, but clients often brought up the latter through discussions on the difficulties of "working the program" and staying sober. For instance, drug using partners or public shelters were factors which made sobriety hard for clients. Environmental factors were, however, a more prominent part of the client's contact with her case manager.

Triggers, trauma, and addiction

Most treatment programs today are based on two premises (Weinberg 2000). First, that addiction is a disease in which the person has no control over his or her use and secondly, that addiction can be controlled through ongoing participation in treatment groups. In fact, these are close to established truths within treatment agencies today, both among staff members and clients (Weinberg 2000). One may therefore say that they have become "doxic", that is, nonnegotiable facts, which have become taken for granted and close to unquestionable, while they in fact present a specific approach. In general, neither clients nor staff, most of whom themselves had been through similar treatment programs, questioned the way treatment was organized. If a client *did*, however, she risked being accused of "not working the program".

According to the dominant AA ideology, treatment will only be successful if it is voluntarily sought out by a person who has hit "rock bottom", accepted that he or she is an addict who is powerless without external help, and has "surrendered" to a treatment program. According to this ideology, clients need to apply and internalize, in Denzin's (1987:22) terms a form of "self-labelling", what it means to be an addict. This may present a resource for some as it may enable the person to make sense of and explain his or her actions as those of an addict. Being an addict involves identifying oneself as someone who is unable to control one's substance use, involving a change from seeing oneself as a using nonaddict to being a nonusing addict. According to Bateson (2000:313), the addict suffers from a division between "conscious will" and "the remainder of the personality". He calls this an "incorrect state of mind", to which intoxication provides a shortcut to a "more correct" state (Bateson 2000:309). This dualism may be broken down through a process in which the first step involves coming to see oneself as an addict. Bateson (200:313) calls these first steps not a surrender, as one does in AA and at the Healing Center, but a "change in epistemology, a change in how to know about the personality-in-the-world. And, notably, the change is from an incorrect to a more correct epistemology".

Hitting “rock bottom” may, according to Bateson (2000), be understood as moments of panic that leaves the person particularly receptive to intervention through the realization of the severity of the individual’s situation, making change seem both inevitable and favourable. Episodes of “rock bottom” have, according to the AA approach, the potential to bring about the realization of one being an “addict”, what Bateson (2000) terms an epistemological change. This, however, does not automatically lead to sobriety, but rather to a temporary state in which the person is *more* susceptible for treatment and change. Rock bottom is not one singular kind of experience, and Bateson claims that rock bottom may occur several times for a person, something which was expressed by clients at the Healing Center as well. Kathleen Boyle and Douglas Anglin (1993) claim that a person’s definition of hitting “rock bottom” changes over time. Jennifer, who had her own apartment and stable employment unlike most of the other women, felt she had reached “rock bottom” when her ex-partner threatened to tell her employer about her addiction to pills. Jamila, however, who had been a “crack-head” for the past ten years, was homeless, and had been arrested several times over a short time period, claimed to hit “rock bottom” several times without it having the same motivational effect as it had on Jennifer. As such, severe episodes may spur a want and a need to change, while discouraging others by making change seem impossible.

Relapsing is explained as not yet having hit “rock bottom”, thereby not being ready for recovery, and thus not being dedicated. At the Healing Center, where many of the clients did *not* participate on a voluntary basis, the link between voluntary participation and “successful recovery” was toned down. The emphasis was not so much on *how* one came to be a client, as to what one *did* as a client. Unlike AA groups, where the statement “I am an addict” is central, clients rarely referred to themselves in these terms. While in an AA approach “addict” refers to a person who voluntarily applies the category to him or herself, and as such is a category with potential, clients at the Healing Center would commonly use the term when referring to active drug users, primarily to label others rather than themselves. In groups, this distinction was often marked through the categories “using” or “active” addict as opposed to the “recovering" addict. While it is reasonable to assume that clients who participated on a voluntarily basis had an initial advantage compared to their mandated peers, “success” in recovery, which I define in terms of long-time sobriety, was not reserved for those who had a personal *a priori* motivation for treatment. In fact, it seemed to me that while most clients were somewhat sceptic in their early stages of treatment at the Healing Center, several of

them had a change in their perception over time. For example, when Erica, a woman in her late twenties, first enrolled as a client, she would rarely speak in groups, rather stating her dislike for the program. As the months went by, however, Erica opened up and started to share about herself. This was not only the case for mandated clients, but also for clients attending on a voluntarily basis. Jennifer, a client who was struggling with an addiction to pills and was one of few clients who had a stable job and apartment of her own, told me that she had initially found it hard to identify with the other women, many of whom were heroin or crack users, homeless, and had relied on sex trade practices in order to obtain drugs. Jennifer told me that as she had come to know the other women, she had realized that they were struggling with many of the same issues, and that, in the end, they were all addicts who needed help.

An important aspect of the language used at the Healing Center was its vagueness, or polysemy. Polysemy may be understood as the quality of a word to evoke several meanings, enabling different interpretations (Johnson 1987), and polysemic words are flexible and manipulative tools that can be used strategically in order to produce an apparent consensus about realities. The interpretations enabled by polysemy are not random, but are rather systematically related (Johnson 1987). The inherent ambiguity of the language used in group sessions at the Healing Center enabled not only words to have many meanings but could also be used strategically as if they had only one meaning. While polysemy is a potential source for miscommunication, Bateson (1968) also emphasizes that it is also an important part of what makes communication possible. The deliberately vagueness of this language was perhaps a necessity for treating clients who had had different experiences. Following Bourdieu (1994:39), it is the very vagueness of the legitimate language used in groups which made it so effective, enabling clients to identify on a personal level and creating a unifying effect as clients got a sense of talking about the same things. This does not, however, mean that clients and staff were aware of this ambiguity, but that is was an important part of communication. One of the most used books on treatment at the centre, for example, states that “using a less negative term improved patients’ morale” (Najavits 2002). The treatment process was often talked about in positive, but equally vague terms such as “healing”, “empowerment”, and “successful recovery”. These terms were not randomly selected, but rather used in quality of their seemingly positive value and used strategically in order to facilitate certain processes. They were embedded with specific meanings – and expectations – which clients were encouraged to identify with and internalize. The inherent vagueness of the

"healing language" was therefore more likely a necessity which *enabled*, rather than restricted communication, and created a sense of shared experience (Bateson 1968; Bourdieu 1994).

"Trauma" and "trigger" were both vague terms which were commonly used at the Healing Center. Addiction was often said to be an outcome of untreated trauma, which could imply that all clients had some form of trauma. Trauma was a common topic in group sessions, and was often treated by facilitators and clients as if it described a distinct form of experience. When the Healing Center, explicitly or implicitly, referred to for example prostitution as victimization, clients were able (and encouraged) to reinterpret their experiences in terms of trauma. Trauma, then, was not *one* kind of experience, and different experiences could be interpreted into the frame of trauma. The client, in order not only to be a "normal" client, but also in order to be rehabilitated, had to identify certain experiences as forms of trauma. The facilitator would therefore sometimes help clients during group sessions if they were unable or unwilling to interpret experiences as trauma. "Healing trauma" was a matter of equipping clients with better coping mechanisms. While trauma was a diffuse experience which was given meaning in retrospect, triggers could be identified and made real in everyday life. Trigger was used in a number of ways by both staff and clients, and could for example refer to a cologne, angry voices, or specific places and objects. This made triggers useful in the process of making sense, as they were concrete and manageable. Clients learnt that they would always experience triggers, but that they could learn to live with it in a healthier way. In this manner trauma and trigger were polysemic words which were ascribed meaning by each person, while simultaneously enabling clients to talk about them in a particular way.

While the Healing Center was heavily influenced by the "12 Steps" program established in AA, clients also claimed that the centre was different from other treatment institutions they had encountered. Both AA and the Healing Center treated substance addiction as an emotional illness. Unlike AA, however, the Healing Center emphasized the close link between addiction and untreated trauma, or PTSD, claiming these to be complexly related phenomena which could not be separated. This dual diagnosis is often ignored in treatment programs, which usually provide treatment for only one (Najavits 2002). Clients experienced episodes on a daily basis which triggered trauma and the need to get high. Lacking other "healthier" coping mechanisms, the addict, according to the approach used at the Healing Center, self-medicates in order to cope with negative emotions. These negative emotions consist of untreated trauma, and the addict is using drugs as a mechanism for handling

everyday life. Traumatizing events may lead to new trauma and increased drug use in order to cope, which again leaves the person prone to more victimization. The Healing Center emphasized the healing of trauma, as it was said to be an important cause for substance abuse, and addressing these issues together was said to be the best strategy for continued sobriety. Thus, if addiction is an emotional illness, then untreated trauma and unhealthy coping mechanisms are the primary concerns. The function of rehabilitation, therefore, is not simply to help the addict quit using and staying sober, but also to learn to cope with trauma and handle triggers in a healthier way. In this perspective, addiction is better understood as a symptom of emotional disturbances. The Healing Center was thus not so much a drug rehabilitation program, as a recovery centre for trauma and coping. This approach to treatment not only affected the treatment practices, but also the identities which were produced through the process of "healing".

According to Peyrot (1991) there are two main kinds of addiction treatment agencies. Programs such as AA and NA represent one branch, the only requirement to their members being that they work to stay sober (Denzin 1987). Abstinence is held to be the most important goal for treatment in these kinds of programs, and they usually use former addicts as counsellors. Other programs, however, address a wider spectre of concerns, focusing on material as well as drug related issues, but do not necessarily employ former addicts for this treatment (Peyrot 1991). The Healing Center may be located somewhere between these two. Unlike AA, for example, the centre promotes the principle of "harm reduction". The harm reduction approach emerged in treatment agencies 1980s, and presents a more pragmatic approach to recovery through motivational enhancement and gradual goals (van Wormer and Davis 2008). Harm reduction aims to create balance by enabling the person to identify and modify involvement in high-risk activities such as drug use and sex trade practices. Harm reduction treats drug use as neither right nor wrong, and rather as one among many harmful practices people engage in (Whiteacre 2005). Rather than expecting clients to quit using drugs altogether, which was said to be somewhat unrealistic considering the actual conditions of their lives, clients were encouraged to reduce the amount of drugs they were using and the methods used, such as smoking heroin instead of injecting it, and of changing the patterns of use. This also included methadone treatment or the use of medical marihuana. The aim of harm reduction is often total abstinence, but through setting realistic goals of reducing harmful practices and meeting the person where he or she is at. Accepting some use of drugs, while promoting abstinence, was a way of allowing clients to medicate as a coping

mechanism until they had better tools. Harm reduction was practiced by a few clients at the Healing Center, though it was not overly promoted by facilitators. From the AA perspective harm reduction is unacceptable, as it is not the clean break with drug use that is required, but rather a continuation of the same practices.

Harm reduction is not, however, simply a matter of drug use, but may also include safe sex practices such as condom use and regular testing for venereal diseases, as well as more "basic" ways of functioning such as brushing teeth or cleanliness, which may seem as obvious practices, but which people may have neglected for some time. These simple procedures can make a great change for the person's often neglected and deteriorating health. Harm reduction was thus explicitly and implicitly part of the tools and resources taught in groups, through mental techniques of coping with trauma and triggers in a healthier manner. These were presented as "self-care practices" and clients are encouraged to implement them in their daily lives. Clients at the Healing Center participated in a wide range of harm reduction practices, some promoted through the Healing Center, others through programs such as Needle Exchange, food-hand outs and shelters, and sex worker organizations. Treating trauma through teaching alternative practices, rather than focusing solely on addiction, was considered the best way to secure stability and long-time sobriety. If drug use is simply a coping mechanism, the excuse to get high will no longer exist. Harm reduction can therefore be understood as a specific discourse on drug addiction.

Drug related harm reduction was not an unproblematic issue at the Healing Center. Several of the staff members were ambivalent towards the practice of it, one facilitator telling me she did not believe this "soft" approach would be sufficient to get people off drugs. Rather, she preferred the "old fashioned" methods used in many other program, of "breaking you down" and "rebuilding you". The bulk of clients said they did not practice drug related harm reduction. Some clients said that they believed "controlled" continued drug use to be unrealistic, or even an excuse to continue getting high. These doubts were also evident among those clients who did practice it, one woman excusing herself in group for not having started her recovery yet, as she was practicing harm reduction. Others were enrolled in treatment facilities where harm reduction was not tolerated. The clients who based their recovery on harm reduction were therefore not always seen as doing it the "proper" way. Several clients found it to be a good way of handling their recovery, one woman allowing herself one evening a week where she could smoke a little marihuana. This, she claimed, helped her get

through the rest of the week. Others expressed jealousy of her ability to use in this controlled manner, stressing how they would never be able to do so themselves. In this perspective, harm reduction may be seen as presenting a somewhat contradictory message. On the one hand, clients learned that they suffer from an uncontrollable addiction, while drug use was somewhat tolerated through the practice of harm reduction. However, most clients distanced themselves from practicing drug harm reduction, saying *they* would never manage.

Harm reduction is widely discussed in relation to addiction treatment. It is for example said to be too "soft" an approach to addiction, that it implies that one gives up on addicts, or that it actually encourages drug use. It seems to me that harm reduction presents a more realistic and responsible approach to treatment, as it allows individuals to gradually change their habits. Harm reduction is also said to be beneficiary because it reduces the barrier for seeking help as clients know they are not required to quit entirely (van Wormer and Davis 2008). The clients who did practice harm reduction said that it reduced their anxiety, enabling them to focus on other needs they found more important at the moment.

A more problematic issue is presented by Bourgois *et al.* (1997:160), who claim that the messages promoted through harm reduction, such as reducing "risky needle practices" and other self care messages, may in fact work against their intention because they promote unrealistic practices, and in this manner alienate users. According to Bourgois *et al.* (1997:160-161), "hypersanitary outreach messages" such as "bleach it",[10] and "don't share needles" present unrealistic messages loaded with symbolic violence that "relegate street addicts to the category of self-destructive other". Hubert Dreyfus and Paul Rabinow (1982, in Bourgois *et al.* 1997:161) claim that harm reduction can be understood as imposing what Foucault (1979) calls a "normalizing judgment" on street addicts. Harm reduction messages can be unrealistic practices which in fact alienate the users from such advice because of the actual environments in which street addicts live (Bourgois *et al.* 1997). Clients at the Healing Center, for example, were taught a wide range of self-care practices, often promoted as "simple" and easy to incorporate into their daily lives. Many of these procedures, however, proved hard to implement in clients' lives outside the centre. A healthy diet was, for example, often emphasized as important, but was hard for clients to actually prioritize with without economic resources to do so. In fact, clients reported finding some safe care practices to be

[10] Referring to rinsing hypodermic needles.

contradictory, and further could not always understand the reason for practicing them. Harm reduction may in other words impose unrealistic main stream values, which do not resonate with the actual lives and conditions of addicts.

Harm reduction practices such as safe needle use or condoms may prove less effective to prevent HIV infection, for example, because "they are as much expressions of a repressive medical discipline as they are rationally implementable solutions" (Bourgois *et al.* 1997:168). Outreach programs therefore have to provide users with factual but also realistic practices in order for them to have any impact. In order for outreach to be meaningful to the street addict, intervention has to avoid reproducing "structures of inequality and discourses of subordination" (Bourgois *et al.* 1997:168). Lack of knowledge leads to misunderstandings in communicating messages of safe practices, and may lead to myths about how to treat overdoses or practice safe using routines. Educating and providing users with knowledge about safe using and handling overdoses enables people to make educated choices and offers users dignity.

Victims and survivors

When clients first came to the Healing Center many were traumatized and had problems making sense of, and even verbalizing, their experiences. Many had gone through several years of substance abuse, engagement in sex trade practices, and homelessness, living unstable lives while not perceiving to have any alternatives. The women were often struggling with a wide range of concerns, ranging from material and practical needs, like housing, obtaining welfare rights, food and other basic needs, as well as emotional issues including guilt, shame, anxiety and untreated trauma. Treatment at the centre aimed to "empower" clients to take control over their lives, and "healing" may thus be understood in terms of a process of identifying and replacing "unhealthy" practices with "healthy" ones. As such, the treatment at the Healing Center focused more on teaching life skills than what is commonly found in AA, where the focus primarily lies on substance use per se rather on the general conditions of one's life.

Group sessions are widely considered the most efficient form of treatment of addiction (Bateson 2000; Denzin 1987; Weinberg 2000). At the Healing Center, group sessions provided a forum in which clients could feel safe and understood, and talk about their

experiences in a non-judging environment. Several clients expressed that it had been a relief meeting other people with similar experiences as themselves, making them realise they were not alone. Group treatment did not only provide participants with a safe forum in which clients felt understood, but also with tools and resources which made possible an identity change. In groups, clients also learnt the format and language of the institution, how to share experiences and talk about trauma and addiction, give appropriate feedback, and how to interpret their experiences. For many, this involved learning to put the unspeakable into words. The tools and resources taught in group sessions were intended to empower the client to take control, and responsibility, by learning alternative ways of coping. Being both mental and social tools, they worked through enabling verbalization and reflection on self practices. Clients could for example be asked to do what was called a "moral inventory", or to reflect on their boundaries and relations to other people. The treatment process of the individual, then, was social, verbal and collective, as participation in groups not only helped the individual but the whole group.

More practically, participation in groups also helped to structure the client's daily life, which was an important part of getting people out of their environment. Since clients tended to participate in the same groups each week, a rigid schedule made sure that the client knew where she should be at different times of the day. In addition, it provided clients with a social environment among others recovering from trauma and addiction, which was important as many had limited non drug using networks outside the institution. While some clients also socialized outside the Healing Center, for example attending AA or NA groups together, my general experience was that the majority had little if any contact with peers outside groups, the exception being those clients who stayed in the same residential program.

Clients were said to enter treatment with an "active addict" mentality, meaning they were thinking and rationalizing as drug users. The centre presented a safe environment where clients were introduced to explanations and interpretations which helped them explore and make sense of their experiences. Clients were told that their past experiences with drug abuse, abusive relations, and other "unhealthy" activities were the outcome of victimizations and of "not knowing better", and therefore that they were not responsible for their past. The victim identity acknowledged and symbolized to clients that they had been deprived of a regular life through forms of violence and victimizations, and had engaged in harmful and degrading practices because they had few other options. Through participating in treatment at the centre,

however, clients were to learn to identify negative patterns, making them capable of change, and as such also making them responsible for their future. These particular discourses emphasized victimization rather than personal fault, encouraging clients to interpret their experiences as series of victimizations and trauma. This seemed to be important as it helped clients accept the past as something they were not in control of. The victim identity somewhat relieved clients of shame and responsibility, while the survivor identity emphasized that they were capable of rising above their past and act differently in the future.

An example of this was when Manuela, after repeatedly arriving bruised and battered told, us that her partner was violent. At this she was told that she was not responsible for what had occurred, but if she returned to her partner, she would be. Manuela returned to her partner, explaining that this was her only option, and did not share about her partner's abusive tendencies again. Similarly, Barbara, a quiet woman in her early forties, told the group about her partner who had recently relapsed on drugs. He had been evicted from the shelter which he had stayed in, and would seek her out on a daily basis in order to obtain money and food. He had promised her that he was going to get off drugs if only he could get some stability. Barbara shared that she was considering letting him stay at her place in order to help him "get back on track", and that she felt she owed him this because he had helped her out before. Her peers, both clients and the facilitator, responded with disapproving remarks. They told her that her partner was acting as a typical, cynical addict, using her in order to meet his own needs, and that she ought to recognize this kind of behaviour. Barbara was told that she had to put her own recovery first, and that if her partner really wanted to quit drugs he could look up one of the treatment agencies in the city. She was told that if she really cared about him she should cut him off, rather than keep supporting his drug use. If she did not distance herself from him, she was warned, she was likely to relapse herself. Barbara *did* break up with her partner, but under a lot of pressure, and she would sometimes share about feeling guilty and having let him down. Her peers gave her support in groups, telling her she had done the right thing by taking control and not allowing him to use her.

Discourses such as "addiction as disease", caused by loss of control and untreated trauma, and "prostitution as violence" as a source for drugs and trauma, enabled clients to make a connection between themselves and the victim identity. Furthermore, they provided clients with a *legitimate* victim role. These ways of speaking about the recovery process presented clients with concrete and legitimate frameworks which required and enabled special forms of

identity work. The language seemed to both make sense in its rationale and was recognizable to clients on a personal, experiential level. In this manner language is not enough in itself to implement meaning and reality, but also has to resonate on a nonverbal level of experience. The distinction between the passive "victim" and the recovering and empowered "survivor" was one which resonated with clients, making the discourse a particularly powerful one. This particular language of victimization was presented through staff members, whose language was invested with authority based on their position as facilitators, their credibility of being survivors, and of the clients' recognition of this authority. The authority of the facilitators was explained as particularly effective because they themselves had "been there" in relation to addiction and prostitution, creating mutual understanding and a nonjudgmental environment. The language of healing proved effective, then, because it made sense to and was recognizable to clients, and was presented by legitimate survivors. Learning to interpret one's experiences from the perspective of the "victim" or the "addict" could be a relief and a resource for clients, as it enabled one to create coherence in one' life. The same label could, however, present a burden for others.

Treatment programs often oppose victimization-explanations and approaches to addiction, as this is said to exempt individuals of their responsibility, while they actually need to take accountability for their action (Fox 2001). At the Healing Center, however, clients were told that they had been deprived of having healthy and good lives, and that treatment could make them overcome their pasts, making them "survivors" who were in control over their own lives. As such, the discourse of victimization could give clients a sense of agency over their past, present, and future, but also meant that other perspectives and explanations were excluded. By identifying, interpreting and narrating their experiences as forms of violence and traumatisation, many clients learnt to interpret their past experiences as forms of victimizations.

Institutional discourses create expectations which structure how self stories are shared and interpreted (Cain 1991; Loseke 2001). Cain (1991:215; 234) claims that AA members learn how to interpret their experiences into the AA story model, and that the cultural knowledge of AA is often reflected in personal stories. Self stories are therefore cognitive tools for interpreting the past and self through one's AA identity. According to Donileen Loseke (2001:107), group therapy settings often operate with and encourage specific interpretations or narratives which become acknowledged ways of making sense of experiences. These are

what Berger (1997, in Loseke 2001:107) calls "formula stories", narratives involving a particular kind of participants and sequence of actions, which come to "make sense". According to Ruth Dean (1998, in Loseke 2001:108) "formula stories shape the experiences of women who participate in support groups". As group participants at the Healing Center, clients were introduced to interpretations of their experiences as forms of victimizations and violence. These can be seen as formula stories. When a client was encouraged to interpret her experiences from the perspective of the "victim", she could emphasize her passive and coerced role in for example engagement in sex trade practices. The Healing Center's stance on "prostitution" was that is was a corrupting and degrading institution. Engagement in these practices was thus treated as the outcome of one's lack of options, and rather something which was *done to you.* Clients would often come to appropriate aspects of these legitimate discourses in their sharings. It was, for example, common that clients' self stories involved episodes of "rock bottom". The fact that so many clients could identify episodes of "rock bottom" in their stories implies that this was an important expectation of the *story* rather than necessarily of the event in itself, and that this was given meaning in retrospect. According to Jerome Bruner (2001:32), "rock bottom" episodes are important because they represent a turning point in the person's life and enable people to "free themselves" from their past by marking discontinuity. The fact that so many clients came to adopt similar versions of their experiences indicates that these stories were powerful tools which resonated with their experiences as they were interpreted within the group setting.

The use of distinct identities models such as "victim", "active addict", "survivor", and "recovering addict" was an important part of treatment at the Healing Center, and served to help clients structure their actions as respectively "unhealthy" or "unhealthy". Gubrium and Holstein (2001:11) claim that the construction of institutional identities can be understood as images or templates for self-construction which "serve as resources for structuring selves" and are recognizable identities which help clients make sense of their experiences. As such, these identities are better understood as narrative constructs which served as resources for engagement in "healing". Identity positions are only functional, however, when the person manages to make a connection between themselves, their experiences, and the label (Gubrium and Holstein 2001). According to Ochs and Capps (1996:28), narratives are a fundamental way of creating continuity between past, present and future, and can therefore be understood as "linguistic tools and resources for painting selves in the world" (Ochs and Capps 1996:28). When clients shared in groups, they engaged in constructing their own self stories, using the

available linguistic repertoire and resources available in that context. In particular, these resources helped clients construct non-addict identities, which, according to McIntosh and McKeganey (2000), is of the greatest importance for the recovering addict. Self stories are, however, not only about creating continuity and meaning through remembering, but also about excluding and forgetting (Knudsen 1990). For clients, this involved not only working through past experiences through talking about them and forging connections, but also involved allowing oneself to "let the past go". Clients were told they needed to forgive themselves for their past actions, rather than "beating yourself up" over things that could not be changed.

While coming to terms with and forgiving oneself was an important part of treatment, there were some issues which, it seemed, were harder to deal with. Drug addiction did not only affect the women themselves. Many of the women had children, and while some of them still held custody of their children, others had experienced having them placed in foster care. The women would frequently speak of their children, some reminiscing about better times before families were broken, others holding on to the contact they still had with them, either through phone calls or scarce meetings. Though the women would speak lovingly about their children, their sharings were equally marked by guilt and remorse. Rebecca cried as she told the group about the physical and emotional neglect her two daughters had gone through before they were taken away. She was afraid they would be scarred for life, a concern which was shared by many of the women. The women would comfort each other, rather emphasizing what they could do for their children now, such as working for continued sobriety. For many of the clients, the prosperity of someday getting back in touch with, and perhaps even regaining custody, was a motivational factor (see also Hardesty and Black 2005). Drug abuse had, however, also marked some of the women's children in other ways as well. Drug use during pregnancy was a painful and shameful topic among clients, several of the women sharing about how their children had been affected in one way or another. Ava, Rebecca, and several of the other women had experienced miscarriages, which was often attributed their heavy drug use. Penny, a tall woman in her mid-forties, had a prematurely born son who had been born with withdrawal symptoms, and who was both physically and mentally impaired. She said she would never forgive herself for what she had afflicted on him, and that she would have to live with her guilt forever. Similar stories were shared by other women as well.

Conversion through conversing

The treatment form used at the Healing Center was a kind of cognitive therapy, in which clients were expected to get in touch with their emotions and to reflect on and modify "maladaptive thinking" (Neenan and Dryden 2004:3). Cognitive therapy rests on an understanding of the individual as actively involved in his or her own identity construction, and that this can be done through changing the way we interpret the world. Bateson calls this a change in epistemology, which is "a change in how to know about the personality-in-the-world" from an incorrect to a more correct epistemology (Bateson 2000:313). Recovery may in this manner be understood in terms of a process involving a reinterpretation of the self. Learning to view the self in a new way may eventually lead to one *being* in the world in a new way, and as such may involve not only an epistemological change, but also an ontological one. Treatment aims to cause a change in the clients' conceptualization of his or her substance use, his or her sense of self, and one's relation to the world in general. Self construction is always pragmatic, according to Gubrium and Holstein (2001), and based on the available resources within a specific context. Clients' close to daily participation at the Healing Center presented an important arena for facilitating such a process.

In her study of women at a shelter for battered women, Deanna Chang (1989) found that while some of the women did return to their abusive partners after their stay, others did not. Chang ascribes this to the women's successfulness, or lack of, in undergoing an identity transformation through treatment offered at the shelter. According to Chang (1989:536), the women who did not return to their abusers had undergone a "transformation in their view of themselves and of social reality; they specifically come to redefine the self as being empowered to save them from further victimization (…)". Chang found that those women who came to see themselves no longer as victims, but as "self-savers," were more likely not to return to their abuser. She claims that the women's decisions to return or not "occurs in a reality-defining social context influenced by the organizational and ideological characteristics of shelter as experienced by their residents", but emphasizes that one also has to take into account the structural factors of the women's lives, such as their social network outside the institution, which enabled or restricted the women's possibilities (Chang 1989:536). Chang claims that a total "conversion" or change only occurs when several factors enable the women to leave her abuser, and that those who returned to their abusers failed "to undergo successfully a transformation process to a self-saver identity" (Chang 1989:548). Chang

seems to imply that self-transformations may be observed in the women's actions, based on whether or not they returned.

Identity transformations, or epistemological changes, are perhaps better approached as several processes involving different forms of identity work. Self-construction is, according to Paik (2006:213), often required from clients participating in treatment programs. However, evaluating whether or not someone is actually engaging in this process, or simply faking it is, according to Paik, hard to tell. In fact, Paik (2006:214-215) found that staff at a treatment centre encouraged clients to "'act as if' they are committed to the self-construction process, because they believe that clients may eventually embody the new self by going trough the motions. Paik claims that many treatment programs resolve this problem by incorporating the monitoring of others into the treatment of the self. According to Paik (2006:214-215), the monitoring of each others' progress has a reflexive effect on clients, and as such clients do not only engage in their own treatment, but also in his or her peers'. Paik (2006:231) claims that these evaluations serve a dual purpose because they make "both the assessor and the assessed accountable to the same ideal of an institutional self". In this way, evaluating other clients' efforts becomes a way of displaying one's dedication to the program (Paik 2006:216). Similarly, Fox (2001) found that inmates were encouraged to "fake it", which was explained to be beneficiary because it got them to think in other ways than "criminal thinking". Fox notes that *not* adapting to this requirement was regarded as resistance, and as evidence of "criminal thought". Though clients at the Healing Center were not explicitly encouraged to pretend in this manner, they were sometimes told off for not trying hard enough, and told that they should try to think in different ways. Similarly, clients who were "working the program", through displaying their verbal competence, were encouraged and promoted as good examples.

Stromberg's (1990) study of religious conversions, also referred to as personal transformations, provides an interesting approach to making sense of treatment at the Healing Center. Stromberg claims that conversions are best approached through the conversion *narrative* rather than the so-called conversion event in itself, as the narrative is an observable event. He emphasizes language, and claims that "a person can be changed in significant ways through contact with an organized system of symbols" (Stromberg 1990:42). Stromberg claims that ideological language and symbols presents important resources for individuals, as they enable communicating and creating coherence of their actions, thoughts and selves. Self-

transformation, according to Stromberg, arises from the person having learnt an "organized system of symbols," in other words become familiar with an ideology, which enables him or her to resolve and verbalize experiences and problems (Stromberg 1990:42). These issues are, however, not resolved once and for all, and change is therefore not a single event but is a process involving the "ongoing resolution" through the use of the ideological system of symbols and meaning structures which helps the person "express and come to terms with persisting emotional ambivalence" (Stromberg 1990:42; 43). Self-transformation is thus not so much an event, as a process which is interpreted as a change of self.

In light of Stromberg's conclusions it seems reasonable to claim that self-transformation involves an ongoing process which involves *reinterpreting* oneself and one's experiences within a specific set of symbols. The continuing process of verbalization, which enables the person to resolve these issues, gives a sense of resolution. Narratives, or self stories, provide an important tool, both for individual and researcher. Weinberg (2001:84) emphasizes, however, that self-construction is "grounded not in symbolic systems but in materially embodied practices". While there has been much interest in how selves are *shaped* by the social environment, less has been accorded the practical aspects of this: how "selves are put to *use* in our everyday lives" (Weinberg 2001:84). Weinberg claims that an important aspect of drug treatment involves a process of self-constructing and reinterpreting the past. He emphasizes that this is not simply a symbolic process, but also involves an embodied and practical level. Weinberg (2001:84) claims that an important aspect of treatment is the empowerment and incitement of clients to accomplish such a change, and that recovery is thus not simply about getting off and staying off drugs, but also about making clients morally accountable for their past and recovery. One should therefore not assume that all clients who underwent treatment in groups experienced a sense of having changed. Rather, the linguistic tools and resources presented a *potential* for coming to see oneself in a different way through the process of participating and communicating in groups.

Conclusion

This chapter has presented a framework for addiction treatment at the Healing Center. The Healing Center has been presented as a specific social field which promoted discourses of victimization and healing. These dominant discourses not only made sense to clients, but also enabled them to reinterpret their very selves through forms of collective identity work. The

inherent ambiguity in the language of healing enabled clients to interpret and identify with it on a personal and experiential level. I have shown that language, and more specifically, what constituted legitimate and illegitimate uses of language, was central in shaping reality and therefore also identity. Power and authority was embedded in social relations rather than in language itself. Language is therefore interesting in relation to how it is *used* and its social effects.

Chapter 4 Dirty dope and clean clients

In this chapter I will address group participants' construction and use of dichotomies as sense making devices in recovery. This may be understood in terms of providing clients with frameworks which helped them make sense of the past and navigate in recovery. More specifically, I will attend to how the Healing Center and the activities going on there were spoken of as an opposite to what was going on outside, often spoken about as "the streets". Both clients and staff operated with these dichotomized spheres, interpreting actions, thoughts and behaviours as respectively "healthy" or "unhealthy". This distinction also corresponded with the "recovering" opposed to the "using" or "active" addict, and was a particularly important one as it functioned to label people as respectively "working the program", or as not being dedicated, and thus failing in their "recovery work".

Ascribing these and similar attributes to particular activities, people, and places, the distinctions between "moral" and "immoral" were important tools for clients as they enabled them to create spatial as well as mental maps for navigating with. These dichotomies were commonly used in clients' sharings and interpretations and helped clients to not only identify "unhealthy" addict mentalities, but also to recognize what was considered appropriate and safe for the "recovering addict". The particular discourses used at the Healing Center were important sources which enabled clients to make sense of their experiences, and also shaped what was spoken about and how.

The first part of this chapter will address how the construction of "unhealthy" and "healthy" places, activities, and behaviours served to make sense of the past and structure recovery. These two spheres were attributed radically different qualities, and functioned to structure appropriate and inappropriate activities for the recovering addict. The second part of the chapter will focus on differences in how clients spoke about and interpreted episodes of using drugs while in recovery, and how this distinction was used to signify two different mentalities. Finally, I will address the perceived close link between displays of "healthy" mentalities and activities, and how a client's appearance was said to correspond with her progress in recovery.

Out there: the addict mentality

The group is talking about how clients can learn to recognize and control triggers and "unhealthy" thought and behaviour patterns. By identifying triggers, the facilitator says, you can try to avoid them. However, she says, some triggers are harder to avoid in everyday life and one has to learn to interrupt them before they lead to a relapse. Penny tells us that the streets are a triggering environment to her, and that getting to and from the Healing Center is difficult because it is located in her old neighbourhood where she used to do drugs and "do tricks". The streets, she says, are full of dealers and users who try to lure her back out. She therefore tries to avoid specific areas when possible. Penny says that the smells on the streets, of urine, sweaty and unwashed bodies, garbage and the occasional whiff of pot, triggers her. These smells, she tells us, also trigger memories of cheap blowjobs in dirty alleys, sleeping on cold sidewalks and being hungry, dope sick, and alone. She says that the smells out there "stick to you" and that during her addiction, she was "filthy", "mean", and had "no limits". All that mattered was getting high, and she would do anything to get drugs. Several of the women nod in recognition, and Jamila says that there are "no rules out there" and that it is a "jungle". "Your have no friends out there", she says. She describes life on the streets as cynical and stressing, where people only look out for themselves, and people only hang around when she has drugs or money. Penny tells us how she used to literally live out on the streets in order to "not lose out on the action", and that all she owned were the clothes she wore and her drug paraphernalia. Her days revolved around hanging out, "turning tricks", and "getting high", and she adds that she never wants to have to compromise herself like that again. Jamila says she finds it hard to avoid the constant triggers at the shelter she is staying in where she frequently sees people getting high or experiences stressing and frightening episodes. She says that the shelter offers little, if any, privacy, and that she rarely gets a good night's sleep or feels she can relax. She adds that it is hard to stay focused in recovery when everything around her is "sick" and "unhealthy". Other clients nod in recognition, and Manuela tells Jamila that she would never manage to stay at a shelter while in recovery. The facilitator turns to the group and asks if anyone else wants to share about

their triggers. Carla says she has a hard time when she sees other people using drugs, making her feel like using too. She adds that she sometimes delays leaving the centre, because she knows what awaits her out there. Manuela responds to Carla's sharing, and tells us that just a few days ago, while following her son to school, she met an old friend sitting in a hallway smoking crack. Manuela says she hardly recognized her friend, who was very thin and run down. The thought of ending up like her, she says, "dirty" and "filthy", made her not want to use again. Manuela says that when she finds herself triggered, she tries to "play the tape all the way out", focusing on how bad her addiction was. The facilitator interjects, and says that the streets are a "destructive" place, which "breaks you down" and "corrupts you". Clients agree, and Penny says that on the streets "anything is tolerated" in order to get drugs. She adds that "You know how we act out there. We are all about the drugs".

The above episode illustrates how relapsing and drug use were spoken about in a particular way, and attributed to a space outside the Healing Center. This was part of a larger discourse on drug use and recovery at the centre, which was characterized by several dichotomized oppositions such as "healthy" and "unhealthy", "good" and "bad", "in program" and "outside". More precisely, activities such as relapsing and drug use were attributed to the immoral, dangerous and uncontrollable environment found outside the centre, and in particular ascribed to the streets. Conversely, recovery was associated with the centre, which represented security and safety in an often otherwise chaotic, stressing, and triggering every day life. These dichotomies were used by both clients and facilitators in group sessions.

The streets were described as a dirty and dangerous, while at the same time tempting, place, which triggered clients and made relapsing likely. For many of the women, the streets were where they had engaged in sex trade practices, done drugs, and periodically also lived. The street addict scene was commonly described as "wild", "a jungle", and crack smoking as bringing out "the monster" within, creating an image of an uncivilized place where normal rules were invalid. Penny described how people on the streets seemed incapable of leaving, saying that the streets "eat you alive". Locating drug using activities out on the streets also meant localizing the streets as the place which was frequented by active drug users, as opposed to the "recovering addict". The active drug addict was depicted as driven solely by drugs, creating an image of someone who was less than human. It is not surprising, then, that

this environment was considered no place for the recovering addict. The severity of the street life, such as its capacity to completely absorb its frequenters, was a reoccurring topic among clients. Drug use and sex trade practices were never actually "appropriate" anywhere, both being illegal activities. The commonness of these activities in particular areas of the city, however, established places where these activities were considered *more* appropriate and likely. The ever-present space out there presented a constant threat to the recovering women, and many had to navigate through these extremes, from the streets to the safety of the program, and back to the triggering and tempting environment out there. Drug activities and sex trading were often highly visible, and clients also risked encountering an old friend or perhaps a spouse. Sometimes the women would arrange to walk together to and from groups for support to cope with the triggering landscape out there.

The street addict scene was often spoken about as lonely and dangerous, and as a place where anything could happen. In fact, this unpredictability both repulsed and attracted the women, who said that they sometimes felt the tingle when thinking about being back in the midst of it again. However, most of them agreed that prolonged exposure to this environment broke you down, degraded you, and *made you less human.* By this, clients said that they stopped caring about themselves, sacrificing anything for the next hit. In Manuela's case, which I will return to in Chapter 5, this culminated in direct sex-for-crack-exchanges. She shared that had she not left the scene when she had, she would most likely have been dead by now. Manuela told me that after living on the streets and participating in the street addict scene over time, she was finding it hard to adjust to a "normal" structured life with schedules and taking care of herself (see also Desjarlais 1997; Golden 1992).

Interestingly, Jamila's characterization of the shelter where she was staying was rather similar to those of the streets. Depicted as a "slippery place", staying sober was considered to be almost impossible. The shelter was described as an unhealthy, sick, and triggering environment, which was particularly unfavourable for the addict in recovery, making relapse an almost unavoidable outcome. In this manner the shelter was described as simply an extension of the streets, housing those who had no other place to go. Several of the women at the centre stayed in similar, unstable living arrangements. Erica and her partner, for example, were continuously on the move, staying some nights at shelters, other nights with contacts or on the streets. Erica described these living conditions as tiring, offering little privacy and safety, and said that the constant tension at the shelter, being surrounded by strangers, many

with drug problems or mental illnesses, was a stressing environment where she felt she had to be on the alert. Erica said that staying in shelters made her think and act like she had on the streets, monitoring and strategically evaluating everything around her. In fact, stable housing was described by both clients and staff members as one of the most basic needs for addicts in recovery in order to establish a stable and healthy foundation.

While the program can be isolated to a particular place, the streets cannot as easily be. Still, both clients and staff spoke about the streets as if they were a single location, and there seemed to be a large degree of consensus in relation to the qualities of this environment. Similarly, Desjarlais (1997) found that users of a homeless shelter spoke of the streets as a single location, which was characterized by fear, isolation, and violence. He claims that this way of speaking of the streets involved creating a "sociogeographic domain that intimated a specific way of life and certain frames of mind" (Desjarlais 1997:120). In thus seems reasonable to assume that the women's similar ways of speaking of the streets, and the ascribed qualities of the people and the activities there, were generalizations which functioned to attune clients to a similar set of associations in regards to "healthy" and "unhealthy". This helped participants make sense of and communicate their experiences of recovery and drug addiction.

Penny's description of the smells on the streets such as that of urine, dirty bodies and drug use, as well as others' reports of the flow of garbage and the presence of rats, illustrates how multiple sensorial and social experiences moulded the construction of the space out there. However, descriptions of the streets as dirty and filthy were not so much used to refer to the streets in themselves, though the visible decay of these areas cannot be ignored, as to the activities going on there and the people who frequented these areas. These ascribed qualities may therefore be understood as social and contextual constructs rather than reflections of actual places themselves (Holloway and Hubbard 2001). Mental mappings, or in Tannen's (1993) terms, framing, are based on the individual's experiences and associations, are important sense-making tools in everyday life, and are constantly modified and adapted (Holloway and Hubbard 2001:49).

Just as the addict rationality was said to incompatible with the program, many of the women found the tools and resources they learnt in groups to be unsuitable outside the centre. Several spoke about how hard they found it to "work the program" and maintain a "healthy mentality"

in their regular environment. Rebecca, for example, shared that her partner, himself an addict, was not supportive of her recovery. He would make fun of her, tempt her with drugs, and even question her attendance at the centre, accusing her of spending the time with numerous lovers. Similarly, several other women expressed finding it hard to combine the program with the environment out there, whether a partner or friends sabotaged their participation or they struggled to "stay focused".

The streets were where one relapsed, did drugs, and engaged in sex trade practices. It was where one neglected one's responsibilities, and where drugs were one's sole meaning. Carla said that while she was on the streets she was not really herself, becoming a dirty and lying dope fiend. Both clients and staff recognized such statements to be true. Participating, and in particular living on the streets, did not only involve engaging in "dirty" and risky activities such as drug use or sex trade practices. Practically, it involved having to live one's private life in the very public. Penny, for example, shared how having her period was particularly challenging out on the streets, having no money for sanitary pads or access to bathrooms. She shared how it had been somewhat of a relief when her menstrual cycle had stopped due to her rough life on the streets. Similar problems were reported by other clients, who reported giving up self-care and over time simply "letting yourself go". Desjarlais (1999:479) found that while life on the streets erodes a sense of personhood, the shelter worked to reconstitute a sense of self. He calls this a process of "person-in-the-making," which seems to correspond with that of the Healing Center where clients spoke of recovery as a process of relearning how to function. Promoting and teaching self-care practices was an important part of group sessions, helping clients adapt to a structured and functional life. The aim of the Healing Center was therefore not simply to treat addiction problems, but also to rebuild healthy and functional individuals through teaching "healthy" tools and empower clients to take control and responsibility for their own well being.

According to Tim Cresswell (1996:149), morality and normality cannot be cast without an opposite immoral and deviant dimension. In this manner the "immoral" and "polluted" geographies of the streets were essential in order to create an opposite "healthy" environment. While drug use, dishonesty, sex trading, and other "unhealthy" activities were ascribed a space out there, "working the material" and attending groups were considered healthy and positive activities which took place in and were motivated by participation at the Healing Center. The stability and "healthy" environment of the Healing Center signified a safe

landmark in the desolate space outside, where continued participation helped clients to stay "clean" and to make it "out there". Penny, who had to venture through her old using neighbourhood on her way to the centre, expressed the relief of coming in from the streets. When clients spoke about healthy and positive practices they engaged in, attending groups was usually stressed as essential for continued sobriety. Jennifer, for example, described the Healing Center as a place where she felt respected and understood. Others said that they felt safe and could relax. The Healing Center and attending groups were described as creating stability and security. The distinction between the safety of the program and the triggering environment on the streets served to structure rather rigid categories of healthy and unhealthy, moral and immoral, appropriate and inappropriate behaviours and activities. As such, these categories both constrained and enabled what clients were expected and able to do.

According to Cresswell (1996:8), our perception of place is crucially connected with ideas of correct behaviour, and he claims that we construct normative landscapes for what is appropriate – and similarly also inappropriate – to do in particular places. In this perspective, the clients' construction of the two spaces involved a collective mental mapping which organized appropriate and inappropriate activities, and mentalities, based on their ascribed moral and "healthy" qualities. The streets, associated with "unhealthy" activities, were cast as deviant and undignified, while the program presented "healthy" actions and "complete human beings". The distinction between the streets and the program therefore effectively created good and bad places. The clients' use of this distinction was important as it established a moral mapping for navigating with in recovery. Cresswell (1996:25) claims that "place plays a significant role in the creation of norms of behavior and thus in the creation of deviance."

By locating healthy and unhealthy places mentalities, clients constructed a framework for navigating in daily life. Not simply symbolic and moral maps, however, the use of dichotomies functioned to locate actual environments which clients should stay away from. Locating drug use, dishonesty and sex trade practices out on the streets, the women were warned of the consequences of using drugs or contacting tricks from the centre. These activities were considered displays of unhealthy attitudes, and may be understood as examples of what Cresswell (1996:10) terms transgressions of "spatial ideologies". Cresswell (1996:55) notes that "order is inscribed through and in space and place", and that failing to follow the expectations of appropriate behaviour, of acting "out of place", is "to fail to recognise the truth that has been established". Clients were for example told it was better to "keep quiet"

rather than to be dishonest during groups, as lying was seen as incompatible with a successful recovery. The phrase “You are as sick as your secrets” was used by both clients and facilitators, and illustrates the perceived close link between dishonesty, immorality, and illness. The women were encouraged to be honest in groups, as dishonesty was associated with the addict mentality and incompatible with a successful recovery. A client who was considered to “work the program” was in this manner someone who sustained the established boundaries of correct and incorrect behaviour.

The distinction between the program and the streets represented two entirely different environments, which were associated with different activities, such as doing drugs or working the material. Most importantly, however, these spaces were seen as inhabited by different kinds of mentalities. The “dope addict”, also referred to as the “using” or “active” addict, was described by the women as uncontrolled, desperate, and without boundaries, reigned the streets, where they would do anything in order to get drugs. People, it therefore seems, gained their qualities and descriptions from their environment, just like the environment gained its characteristics based on the perceived behaviour of its inhabitants. The streets were described as a place where one was alone and unsafe, where drugs were used, and where people got caught up in the addict life. Clients described life out there as “filthy” and “degrading”, and Penny said that her life out there had revolved round the next high. Similarly, Manuela described her old friend in terms of someone less than human, and said that she did not want to end up like her. Conversely, participating at the Healing Center was said to make one “more human”.

Just as places are ascribed meaning and qualities, so are the people who inhabit them. Herbert (1993, cited in Holloway and Hubbard 2001:56) claims that “people’s perception of place is crucial in shaping the way they behave in that place”. Similarly, Cresswell (1996:154) argues that places have “associated characteristics that influence our characterizations of the people in them or from them”. In other words, the morally inscribed activities ascribed to particular places influence the perception of the persons who inhabited these environments, making those within the street addict scene unhealthy and immoral. Phil Hubbard (1998), for example, notes that the social status of commercial sex workers in Britain is closely associated with cultural assumptions about moral geographies of the city, inscribing streetwalkers’ bodies with notions of pollution and deviance. Our perception of place, people, and morals are intimately related, suggesting that cultural imaginations of appropriate and

inappropriate uses of space greatly affect our mental maps and, as Matless (1995, in Holloway and Hubbard 2001:200) claims, also individual spatial practices. This was evident in the way the clients avoided certain areas.

Weinberg (2000) found that clients in an addiction treatment program operated with a distinction between "in program" and "out there". Similar to my findings, these spheres operated as opposites, and were ascribed very different qualities. Weinberg (2000:618) emphasizes that the clients' descriptions of "out there" as "savage and unhealthful" is better understood as a result of "the distinctive conceptual drug treatment discourse" than of actual conditions and experiences. This, however, does not mean that clients at the Healing Center did not experience a great distance between the program and the conditions outside the centre, but that the way they spoke about these spaces was heavily influenced by the discourses used in the treatment environment.

Narratives, or self stories, are also important tools and mediums for moral education (Ochs and Capps 2001:51) and for creating moral frameworks for interpreting everyday life (Küntay 1997, in Ochs and Capps 2001:49). In this perspective, the clients' use of the "in program"/ "out on the streets" dichotomy may be a way of not only making sense of experiences, but of creating moral frames for navigating within recovery. When the clients referred to drug use, relapsing, or sex trading as occurring out on the streets one may therefore understand these spaces as moral templates. By sharing and interpreting, clients located experiences, persons and mentalities within two opposite spaces, creating oppositional and incompatible units. In this manner, the self stories of clients went beyond simply sharing and interpreting experiences, but also established and maintained collective frameworks for appropriate and inappropriate behaviour. Though clients did not always comply with these interpretive expectations, receiving feedback as well as listening to the stories of peers functioned to tune them towards a more "correct" and "healthy" perspective. Self-stories, presented in clients' sharings, were therefore important tools for making sense of experiences by creating spatial and moral landscapes.

As group performances, the individual's map-making projects of locating healthy and unhealthy activities were also collective as participants shared and constructed these moral spaces together. The clients' agreement on the "slippery" quality of the shelter, or of certain blocks of the city being dangerous, meant that individuals' conceptualizations of these areas

were mapped onto a larger framework for navigating, both in moral and physical environments. In this manner the Healing Center did not provide clients with the moral frameworks, or cognitive maps, but provided them with a set of dichotomies which enabled this framing to be done (Frake 1980:58). The streets and the program were used in a metonymic manner where they came to represent specific kinds of activities, people, and mentalities. Metonyms, according to George Lakoff and Mark Johnson (1980:37), are important sense making devices that not only structure our language, but also help us organize our thoughts, attitudes, and actions. In this manner, "place is much more than a thing in the world – it also frames our ways of seeing and understanding the world" (Malkki 1992, cited in Cresswell 2004:110).

According to Weinberg (2000), the distinction between the program and "out there" may be understood in terms of two opposing ecologies that are a response to a paradox which arises from the previously mentioned doxic truths of addiction treatment.[11] Weinberg claims that the very structures and premises for addiction treatment also facilitate the needs for these distinctions. These dichotomies were constructed and reproduced through the clients' self stories, and should therefore be understood as a result of their "investment in the distinctive conceptual logic of contemporary drug abuse treatment discourse" (Weinberg 2000:618). Rather than focusing on whether or not these ecologies are empirically real, he claims that one has to focus on the practical use of them within the addiction treatment context. The distinction between the program, and what Weinberg terms "the ecology of addiction", helped clients organize relapsing and recovery in opposite ecologies. This enabled them to make sense of the recovery process by casting "out there" as an unhealthy, dirty, degrading, and lonely place which "systematically wreaks havoc" on its dwellers and makes relapse likely (Weinberg 2000:607). This distinction represented important discursive sense making tools.

Drug compulsions should, according to Weinberg (1997), be understood as a context specific strategy for coping with the particular needs of the setting, a sober state perhaps being intolerable in the clients' meetings with the otherwise chaotic and unstable environment of the streets (Bateson 2000), while intoxication made "more sense". In this perspective, relapse becomes not a "deliberate act of self-control", but rather a surrender of self-control when

[11] Addiction as an uncontrollable disease that can be controlled through ongoing participation in group sessions. Weinberg (2000:606) claims these create an inherent paradox which clients need to make sense of through treatment.

meeting the "overwhelmingly adverse circumstances" out there (Weinberg 2000:614). Relapse and drug use, as well as recovery and staying sober, were therefore "routinely cast as movement from one ecological space to another" (Weinberg 2000:609). In this sense, when the clients at the Healing Center distinguished between "in program" and "out on the streets" it should be understood as a sense making project which enabled on the one hand relapse and drug use to be understood as uncontrolled activities, while also making clients in control of and responsible for their recovery in program. Weinberg (2000:612, orig. emphasis) notes that through participating in the treatment discourse, clients learnt that their irrational and self-destructive addict behaviour was not only the result of addiction as a disease, but also of the *"despised ecological space that was held to sustain and exacerbate that disease"*.

The ever-present threat out there was often discussed both in and outside of groups, and was a central aspect of recovery. Clients' discursive engagements in the healthy/unhealthy dichotomy may also be understood as displays of what Goffman (1961, in Snow and Anderson 1987) terms "role distancing," in which the clients' descriptions of the streets and its associates may be understood as forms of creating distance to the active addict, while embracing the recovering survivor. The use of distinct dichotomies in the self stories of clients should therefore be understood as important tools for the identity construction process they participated in.

Slipping and relapsing

> *It is early Monday morning, and the clients are doing check-in. Lydia, a tall and slender woman in her late twenties, tells us in a calm voice that she has smoked crack during the weekend, but is doing fine. The facilitator decides that Lydia's "relapse" has to be given some priority, and when the other clients are done Lydia is encouraged to talk us through what has happened. Lydia begins by referring to previous group sessions and how last week she had shared on several occasions that she felt anxious and "triggered", and was increasingly thinking of using drugs. She says she had dismissed the possibility of relapsing as she did not want to lose her "clean time" and everything she has accomplished so far. Over the weekend however, she had bought a little crack, and had smoked it. Lydia says she does not consider her crack smoking a "relapse" because she had only*

> *smoked a little, got rid of the rest, and has not felt an urge to use after that. Therefore, she concludes, she has had a "slip" which, rather than being a set-back in her recovery, has increasingly motivated her. At this, Manuela exclaims, somewhat frustrated, that if Lydia's crack smoking is not a relapse then she does not know what it means to relapse. She says she has learnt in recovery programs that using drugs is the same as relapsing and this leads to you losing your clean time and having to start all over. Lydia responds, saying that she feels like she has been using her tools all along, and that she therefore feels like she has learnt more than she has lost. Jennifer agrees with Lydia, saying that her using did not cause her to continue using. The facilitator nods, and supports Lydia's interpretation. She says it seems like Lydia has been aware of the process, and that she therefore has not lost everything she has learnt but rather worked the material. Manuela does not seem convinced, saying, "But she* used".

Lydia was considered by both peers and staff to be a successful client who took her recovery seriously and had showed progress in her recovery work. In group sessions her witty remarks and personal reflections made her a popular and respected participant. She was a patient listener, and often gave thoughtful and considerate feedback to other clients. Outside the Healing Center she participated in NA groups, was active in church, and had friends she spent time with. In addition she was considering taking up her studies. Lydia had managed, it seemed, to build herself a stable foundation, with a non-using social network and what was considered "healthy" interests. After being sober for several months, she had just recently moved out of the residential program where she had been staying. This was a big step for Lydia as she now was to take responsibility of her own daily life, outside the structures of the program. She had shared that it felt like a huge responsibility, making her feel independent but at the same time vulnerable. Having discussed her plans with her case managers, they had decided that she was ready. Her new place was a subsidized apartment in one of the city's poorer districts. In group, her peers had commented on the high crime rate and the flourishing of drugs in her new neighbourhood. Lydia had argued that this was not a problem, saying that simply because people around her were using drugs, she need not. The fact that Lydia had been found ready for a place of her own was considered proof in itself of her success so far in recovery. It was therefore somewhat a shock to us when Lydia shared about her drug use.

"Relapse" can be understood as using drugs while in recovery. It did not, however, as the episode above shows, necessarily have only one meaning to the women. Manuela's interpretation resembled the traditional perspectives usually taught in recovery programs such as AA and NA. To her, and many of the other women, using drugs was synonymous with relapsing, and therefore of "losing your clean time". This again meant having to start one's recovery work all over, a discouraging and frustrating set back for clients who were often eager to start their new, drug free lives. Lydia, however, seemed to have a more pragmatic interpretation of her drug use. New to recovery, she did not, like Manuela or many of the other women, have a long history of failed attempts to "kick it". Lydia said that although she had known for some time that she had an issue with drugs, she had not attempted to quit before, knowing that without being motivated she would not manage to stay sober. Lydia claimed her crack smoking had boosted her motivation. Rather than leading to a full-fledged relapse, she said the experience had made her stronger in her belief that she could stay sober. Lydia's interpretation was supported by the facilitator, who, like Lydia, said that in her case it was more constructive to think of it as a "slip". The fact that she had shared about her use in group in such a thoughtful and calm manner, in addition to her not continuing using, was seen as proof of her not having relapsed but simply "slipped". Lydia was credited as having learnt, rather than having lost. In opposition to Lydia, the next extract is about Jamila, and illustrates how "relapse" may be understood in terms of a more systematic pattern of "unhealthy" behaviour.

> *Jamila is back after more than a week of absence. During her check-in she talks about how she relapsed on crack the previous week, was arrested, and is now ready to dedicate herself fully to the recovery program. When asked what went wrong, Jamila replies that her unstable living conditions, in a public shelter, along with too much money, triggered her husband into using which then triggered herself. Their crack binge, she says, did not end until their whole SSI cheque was spent. In addition, the three days spent in prison, the second time this month, has left her determined that things have got to change. She says that she feels empty inside, her last relapse really having made her realise that things are not going good. "I have to get it together this time" she says, "or I'll be dead". Jennifer gives her support, saying that it is hard to stay sober, and in particular under the circumstances that Jamila describes. She asks Jamila if she has a plan. Jamila tells us that she will attend groups on a daily basis from now on, that she*

will make plans for each day, and that she will stay away from temptations. Manuela says she should apply for subsidized housing, but Jamila is scared of having her own place, claiming it will only provide her with a private place to "hide out and continue getting high" and that she will rather wait till she has been clean for some months. Carla suggests getting a roommate, but Jamila tells us that she can't live with a stranger. The facilitator offers to help Jamila apply for a residential treatment program. Jamila instantly declines, saying she cannot leave her husband, and claims that she can manage on her own, and that she does not want to lose control of her life like they require in residential programs. Jennifer and several others, including the facilitator, exclaim the absurdity of her claim, pointing to how she will obviously not make it on her own. Penny says that she used to think like that as well, "setting yourself up to fail". She says Jamila will have to realise that her own willpower is not enough. The facilitator agrees and says that she should hand herself over, better now than later. She tells the group that it took her 15 years to realise that she needed help. After some discussion, in which clients recommend Jamila to get into a residential program, we have to accept her dismissal of the advice. The group starts focusing on how Jamila best can manage on her own. Money being an identified trigger, Jennifer recommends Jamila to hand her cheque over to someone she trusts who can then give her allowances and portion out her money to her. The facilitator, who is also Jamila's case manager, offers to do this, saying she does the same for several other clients. Jamila, who has just said she is nervous about going home later, having to pass several dope dealers on her way, is at first positive to this idea. When asked to hand over her money, she hesitates and turns sceptical. The facilitator says she wants to talk to Jamila after group. Barbara starts checking in.

Jamila, unlike Lydia, had a long history of failed recovery attempts. Now court mandated to attend treatment at the Healing Center, she seemed to struggle to stay motivated. Her attendance, often interrupted by days, even weeks, of absence, was marked by her close to monthly relapses. She would often talk about herself as a hopeless case, doubting her chances of staying sober. Her living conditions were considered less favourable for recovery, and she seemed to struggle to establish a stable foundation for staying clean. Despite her many relapses, Jamila returned, time after time. During the first days back after having been on a

"mission",[12] she would be active in groups, repeatedly talking about how she had to "get it together", and how bad things had turned during her previous relapse. After some days, however, she would become quieter, her eyes cast on the floor, and her attendance would become more sporadic. This supports Bateson's (2000:329-330) claim, that episodes of hitting "rock bottom" provides a *temporary* "favourable moment for change," and that individuals may experience several such episodes. Jamila's credibility as someone who was dedicated to the program seemed to be suffering from her inconsistent behaviour, which was ascribed the "active" rather than the "recovering" addict.

The two episodes above illustrate what may be understood as opposing mentalities in recovery, and correspond with the distinction between "slipping" and "relapsing". In order to understand the significance of this distinction, one needs to understand that "relapsing" goes beyond simply *using* drugs. Following Bateson (2000), addiction relapses may be understood as a result of inhabiting an unhealthy mentality in relation to one's substance use. According to Bateson, the addict is driven by a particular addict "pride". This pride, he claims, is based on the addict's belief that he or she is in control of the addiction, believing that "'*I* can resist drinking'" (Bateson 2000:322, orig. emphasis). Bateson claims that as staying sober ceases to be a challenge, the addict will begin to take risks. The addict will then challenge him or herself by taking *one* drink, thereby attempting to master his or her use. This pride has disastrous consequences for the individual, who will repeatedly fail in his or her attempts to stay sober. Bateson (2000:313) terms this a *symmetrical* relation to one's addiction, which places the alcoholism or drug use *outside* the self, which he claims is an "incorrect epistemology". Through internalizing the "addict" identity, however, the individual may come to realize that addiction cannot be controlled without external intervention, and "surrender" him or herself to a treatment program. Here, clients learn that there can be no such thing as controlled use for an addict, and the consequences this has. This change in perception, not only of one's substance use, but also of oneself as an "addict", presents what Bateson terms a *complementary* understanding, which is an epistemological change to a more "correct state of mind" (Bateson 2000:309; 326). This epistemological shift is necessary for successful recovery, and it is commonly agreed that the person who has not had this change happen to him or her will continue to unsuccessfully fight the bottle or, in the case of some of the clients at the centre, the crack pipe (Bateson 2000; Denzin 1987).

[12] Crack binge.

Both Jamila and Lydia explained their relapse as the result of legitimate causes. Lydia explained her "slip" as the result of having "moved too fast" in recovery. Moving out from the stable structures of her residential program, she claimed that she had not been ready for being on her own. She claimed that the slip had made her realise that "my way does not work" and was willing to go back to a more structured way of living for the moment, of handing her power back to the residential program. Lydia said she wanted to slow down in her recovery, taking a day at a time. Lydia, in other words, admitted her lack of control and her need for guidance, and came over as taking responsibility for her crack smoking, and even *gaining* from the experience. In fact, Lydia said she almost felt relieved about her crack smoking, as she now felt better prepared for handling similar episodes in the future. As such, Lydia was praised for "working the material" even though she had used drugs. Jamila, when confronted with her most recent relapse, interpreted it as a result of the unfavourable conditions she lived in, such as the shelter, having money, and her husband for having tempted her. These were all recognized as legitimate reasons for relapsing in groups. Shelters were described by clients as dangerous, triggering and highly stressing places, and were generally seen as "red zones" for clients in recovery. Money, obviously, was a trigger, and so were partners who got high or did not support clients' recovery. In fact, she said in a later group that day that she could not simply sit there watching her husband smoke up their money. Jamila had previously been advised to break it off, at least temporarily, with her husband, who also struggled with crack addiction. Jamila said she knew they pulled each other down, but said they could not be separated after all they had been through together and said that it was their "clean" times together that now motivated her in her recovery work.

While Jamila's unfavourable conditions were acknowledged, her peers seemed to have grown weary and impatient with her, claiming that she was not trying hard enough, and often responding to her sharings with impatience. Jamila was interpreted as using these elements as excuses, placing her relapse, her failure to remain sober, outside herself and thereby not taking personal responsibility for relapsing. As legitimate reasons, *they* rather than *her,* explained her relapses. Lydia's "slip" and Jamila's continued "relapse" may thus be understood as representing drastically different mentalities. In Bateson's terms, Jamila and Lydia represent the difference between a *symmetrical* and a *complementary* understanding of one's addiction, Jamila placing the cause of her relapsing outside herself, insisting she could take control, while Lydia had realised her powerlessness. For clients at the Healing Center,

the distinction between a symmetrical and a complementary perspective was presented as the difference between "unhealthy" and "healthy," and between "using addict" and "recovering addict". The message "once an addict, always an addict" was, both explicitly and implicitly, repeatedly used by both clients and staff. Several clients identified having believed they could "kick it" on their own, but said that attending groups made them realise and focus on the impossibility of this. Barbara, for example, said that she had relapsed again and again when she thought she would be able to take control. She described it as a relief when she had realised that she actually was an addict, understanding that there was no point in even trying to take control on her own. Jamila's dismissal to get help made her peers claim that she was still thinking like an addict, and that she would fail repeatedly until she realized this. Jamila was accused of not taking responsibility for her recovery, rather still believing *she* could control *it*.

Rebecca was another client who tended to relapse on a close to monthly basis. She told the group that her continuing relapses made her feel stupid, as if she was not capable of taking control like the others did. Even though Rebecca had been a client at the centre for a long time, she said coming back after a relapse always made her feel like "the new girl in class", who did not know the rules. Over time, she said, it broke her down, and she now doubted whether she would ever make it. Barbara shared how she had managed to be sober for almost five years, before she had relapsed "big time," losing her home and job. This time, she said, she would not make the same mistake by thinking she could ever be in control again. The distinction in these cases illustrates how clients who continuously relapsed may be understood as having an entirely different perspective on their drug addiction than clients such as Lydia.

Both Jamila and Rebecca cited their monthly SSI cheques as an important trigger. Often absent the first week of the month, they would both usually attend groups the next three, and stay sober. When a new cheque came in, however, the cycle repeated itself. Relapses and binge sessions like those experienced by Jamila, Rebecca, and other clients at the Healing Center cannot, according to Bourgois *et al.* (1997:162), simply be understood as "pathological rituals of deviant individuals". Rather, they claim, crack binges need to be understood within the specific power relations which produce these kinds of behaviour. They note that binge sessions are somewhat "'regulated' and promoted by state institutions" through monthly welfare cheques such as SSI and GA (Bourgois *et al.* 1997:162). These monthly payments "energize the street economy" and have a destructive effect on many of the recipients who,

suddenly, find themselves with large sums of money, often leading to binge sessions (Bourgois *et. al.* 1997:163). Money was described as a common trigger among clients at the Healing Center, several of the women stating that their monthly payouts presented one of their biggest challenges in recovery. The cheque was both materially and symbolically important, as it signified both the opportunity to take and to lose control.

> *We are in "Relapse Prevention Group", and the women are talking about how they are managing in recovery. Justine shares that she feels she is "slipping". The facilitator asks her to elaborate, and Justine tells us that she has been slacking off on her group attendance lately. In addition she has been meeting up with some friends from back in her using days, going to a night club where they used to hang. Justine is worried, because she recognizes these as bad signs. She says she went through the same behaviour before her previous relapse, reverting to old ways of behaving. Justine says that she sometimes catches herself thinking that she can control her drug use, as she has managed to stay clean for soon two years now. This stresses her, because she knows these are dangerous thoughts, and says that attending meetings has kept her clean. The facilitator tells the group that having thoughts like these are common, but dangerous for people in recovery. She says that these are signs of going back to an "addict mentality". In fact, she tells us, when one relapses it is common to "mentally relapse" before one actually picks up on drugs. Lydia agrees, and says that when she slipped a few weeks ago, she noticed herself thinking in particular ways, rationalizing to herself that she could smoke a little, "just to see what happens". Penny nods in recognition, and says that she used to act the same way in recovery. She says she knows now that when she experiences thoughts like these she has to strengthen her efforts and "work harder".*

Attending groups was widely considered to be one of the most important activities for continued sobriety, as it involved engaging in healthy activities, and thus avoiding unhealthy ones, kept clients' minds on track, and helped them structure their daily lives. Slacking off on one's group attendance was therefore considered a first sign of relapsing, as clients' would often rationalize that they no longer needed the support of groups, or found participation in them "boring" or "meaningless". Other danger signs included hanging out with old friends or going to "slippery" places such as night clubs or other high risk zones. These forms of risk

taking were seen as setting oneself up to fail. Being aware of these signals, through attending groups and working the material, was a way of avoiding and controlling these patterns. Several of the women claimed they could recognize "unhealthy" patterns from previous relapses. Lydia, for example, claimed she had learnt a lot from her slip as she now knew what to expect the next time she felt exceedingly triggered. Conversely, Jamila seemed to ignore such patterns, claiming that she could control them, while others stated they could not identify a process of mentally relapsing before they picked up, rather experiencing sudden and overwhelming cravings.

The above episode illustrates a central point in how recovery and relapse were commonly spoken about in group sessions, namely as a *mental relapse*. Clients were told that relapsing involved not only the act of actually *using* drugs, but also a mental process prior to actually picking up. A relapse was seen as a reversion back to an unhealthy, "addict mentality" or which involved starting to think and rationalize as a drug addict. Similarly, AA members describe relapsing as "slip in thinking. It is a return to thinking that includes drinking" (Denzin 1987:93). In Bateson's (2000) terms it may seem that Justine was experiencing a symmetrical relation to her addiction, in which her two years of "clean time" led her to start taking risks and testing her self control, and thus setting herself up to fail. Clients were told that if they became aware of their unhealthy thought patterns, they could take control of them before they were manifested in their behaviour and escalated. Clients were therefore encouraged to reflect on their own self-practices and to study the process of mentally relapsing in order to identify patterns in their behaviour.

Healthy body, healthy mind

> *With still some time to go before the next group session, clients are hanging out in the reception area. Some are flipping through magazines, others are chatting while they finish off lunch, which is provided daily. Those clients who have kitchen duty have started to clean up after the meal. The door buzzes, and Barbara enters. Noting she is too late for lunch, she heads over to the table where Penny, Manuela, Ava and I are sitting. As she comes closer she flashes us a big, white smile. Cheers and congratulations greet her, as Barbara flops down in an empty chair, her smile getting even bigger. Barbara has had all her teeth, save*

one, pulled out and replaced. Her recent dentist visits have been the big topic among the present women, Penny having been through it before, Ava waiting to get her teeth done. Anxious to hear about the procedure, Ava asks her if it hurts. Barbara nods dramatically, but is still smiling. Opening wide, she points a finger at the still visible stitches in the back of her mouth, and Ava shrieks. Barbara says that it has been hurting pretty bad, but adds that she is nervous about taking the painkillers she has been prescribed. One of the facilitators comes over to our table and asks Barbara to give her a smile, giving her a hug and complimenting her new teeth. She tells the clients to get ready for the next group session, and the women ascend the stairs. Turning to me, the facilitator says that she is glad to see that Barbara finally has had her teeth done. She tells me that in her experience it is a good sign because it indicates that she is serious about her recovery. She explains that when clients prioritize saving money and go through with the painful, lengthy and costly procedure of having severe dental work done, it often means that they will succeed in their recovery. She adds that taking care of one's appearance and health is important, both personally but also socially, because it helps one create discontinuity to the past. Bad teeth are a visible reminder, she tells me, both to self and others, of who one has been. She tells me that personally, getting a new set of teeth made her past as an addict less evident.

In the example above both clients and the facilitator compliment Barbara on her new teeth. Many of the clients had poor dental health, drug addiction or neglect leaving them with rotten stubs or teeth simply falling out. Crack smoking, in particular, I was told, eats away the enamel on your teeth, and they come falling out. This meant that many clients had severe tooth decay, leaving their bodies visibly scarred. Several of the women had their teeth fixed during my stay at the centre, replacing black stumps with complete rows of white, previously tight-lipped smiles with toothy grins. Clients could tell me that having a new, unblemished smile was like having a new chance, finally not having to be ashamed of and covering one's mouth.

Barbara's new teeth were important, not only in the practical sense of having a full set of teeth, but because it signalled having a correct and healthy mentality, and being dedicated in recovery. Prioritizing to get one's teeth done was therefore an important way of removing a very visible sign of one's past, which, according to the facilitator, was also an investment in a

non-using future. In this way facilitators and clients established a close link between physical appearances and a healthy mentality, as well as being dedicated for recovery. It was common to hear both clients and facilitators speaking of "healthy" and "unhealthy" mentalities, usually in relation to discussions about the curriculum or during sharings. This also included having respect for oneself through taking care of important personal needs. When clients allowed themselves a pair of jeans, a new hair cut, or even a new set of teeth, this was often commented on in a positive manner. Similarly, Weinberg (2000) found that counsellors at a drug treatment program linked appearances to successful recovery. It was here claimed that taking care of one's appearance and health was a sign of "taking the program to heart" (Weinberg 2000:613; see also Desjarlais 1997). In contrast, attending programs while continuing to look scruffy and unkempt was interpreted as a lack of working the program (Weinberg 2000:613). In this manner, a client's appearances were used as indicators by facilitators of his or her dedication and likelihood of a successful recovery. Dressing, smelling, talking, acting, and thinking like a "healthy" person were therefore signs, both to self and others, of one's dedication in recovery, and were also measures by which clients were evaluated. A "healthy" mentality was therefore not displayed simply in a person's participation in group sessions, but was also said to be visible on the very body of the individual. Just as unhealthy activities were located out on the streets, healthy activities were associated with the centre and working the program.

Money was a trigger for many clients, and was a recurring topic in groups where clients worried about relapsing, asked for support and worked out strategies for controlling their use. Several clients reported money to be a constant trigger, while others argued that drugs were available to them whether they had money or not. Jamila, for example, claimed that when she had money, she was unable to think of anything else than how much drugs she could purchase. Similarly, Penny said that when she had money, it was as if a little voice told her to "use, use, use". Few of the clients had bank accounts, and had to work out strategies in order to best administer the monthly cheque. Some clients had made arrangements with family, friends, or their case manager who gave them weekly allowances. For others, spending the money wisely was an important strategy, either buying necessities for one's apartment, spending it on one's children, reducing one's debt, or taking care of personal needs such as clothes and health issues. Jennifer, for example, said she would always try to buy herself something for the apartment, feeling it was a double investment as she both rewarded herself for continued sobriety *and* created something she could lose if she relapsed.

Yet another way of spending one's money was getting one's nails done. During groups, clients would often be asked to share a form of self care practice they had or would engage in during the week. A common reply was attending groups, but an almost equally response was "getting my nails done". A relatively cheap, yet visible luxury, getting one's nails done in one of the many nail saloons was a popular form of self care which was easily available to the clients. In group sessions, the women would sit, their long nails, painted in reds, blacks, pinks or even peacock patterns, delicately folded in their laps. Getting one's nails done was recognized as a sign of not using. Not only would it be a waste for the drug addict to spend one's money on such "luxuries", as even the cheapest manicure could get you a fair amount of the cheapest crack. In addition drug use also had the effect on one's nails that they became brittle and chipped. Prolonged sobriety, however, strengthened the nails and made a manicure possible. Getting one's nails fixed, then, signalled that one was not using drugs and that one took care of one's appearance and self.

Taking care of one's appearance, whether it being having one's hair cut or nails done, using makeup, or getting glasses or new teeth, was therefore considered a positive sign. Often neglected during the addiction days, physical and mental issues were of great importance for building up a new "non-using" identity. Spending money on oneself meant not only that one was not using it on drugs, but also that one was prioritizing and taking care of oneself. This, however, was not always a simple and straightforward thing to do, as many shared not seeing any point in taking care of themselves, being too "fucked up" by addiction, or not even knowing how to. Taking care of the self was considered to signal dedication in recovery, and a wish for change. In this manner, appearances and self-care were closely associated with a healthy mentality. Many clients, who were struggling economically in the first place, found themselves unable to prioritize otherwise health beneficial concerns. Economy also affected other aspects of self-care such as safe housing or a healthy diet. Rebecca, for example, who was diagnosed with hepatitis C, told me that she would love to prioritize a healthy diet, which was essential for her disease, but she could not afford it. Court mandated to attend the Healing Center, she found herself having to negotiate between spending the money on transportation in order to get to the centre, or a healthy diet which was important for her physical well-being. In fact, she told me that she could only afford one meal a day, usually a greasy burger meal for a few dollars. Her public housing room did not come with a fridge for her to store foods in, limiting her options for food storage. Without food and clothing handouts, she told me, she

doubted she would have made it. Similarly, clients staying in shelters had restricted opportunities to store food, and had to share shower facilities with many other people. Jamila, for example, told me she rarely showered at the shelter because she did not have any spare clothes, and, as she gloomily added, would probably be dirtier *after* showering. For Barbara and many of the clients, "basic" self care practices were not always accessible or easy to prioritize. Prolonged neglect of tooth decay, hepatitis, a healthy diet, or mental health meant that many were struggling with a wide range of serious issues, which, on top of the agonies of being in recovery, could seriously challenge one's motivation.

For many clients, humour seemed to be an important way of coping, both with past experiences and with being in recovery. Integrating a humoristic analysis or comments to their own sharing, clients would at times make fun of their experiences. According to Melvin Pollner and Jill Stein (2001), humour is an important aspect of treatment programs, and is a built-in element of the format of self-stories in AA. The authors found that humour in members' narratives was an important mechanism for distancing oneself from the past. By talking about one's past, one automatically differentiates the speaker from the self which is spoken about, and "encourages if not stipulates the distinction between what she was like before and after joining AA" (Pollner and Stein 2001:59). Penny was particularly good at this, and her self-critical comments would take the edge off even the most difficult and sensitive topics. She would often make fun of her "using self", the stereotypical "addict mentality" a favourite. Imitating herself during a crack binge, Penny made a hilarious impersonation of herself one day. Several of the clients laughed and nodded in recognition, Penny's dope fiend imitation clearly hitting the spot. Similarly, Barbara, the woman who had her teeth fixed, joked that at least she would not become an old granny selling "toothless blowjobs". Not only did the image bring out laughter, but it also reminded clients of a not too unrealistic future potentially awaiting the women. According to Goffman (1986:108), humorous comments, irony, and jokes are a mechanism for coping with stereotypes and stigmatized identities. The clients, joking with stereotypical images of the drug addict, and even of their current situation as clients in recovery, made fun of these easily recognizable yet overly caricatured roles. By focusing on the weaknesses and ascribed flaws of the drug addict, such as her inability to control her money use, these parodies served to distance the client from the active addict (Snow and Anderson 1987).

Humoristic accounts, however, indicate more than simply creating distance to the past and making it manageable. Pollner and Stein (2001:61) claim that humour in therapeutic settings also functions as a collective affirmation of good and bad values. Laughing at Penny's stereotypical use of the crack addict, for example, was not only a matter of her successful imitations, but also indicated a moral denouncement of unhealthy addict activities. Laughing and joking, in this manner, signified an agreement of correct and incorrect behaviours. Sometimes when clients stood outside smoking, the occasional whiff of marihuana would reach us, or a dope dealer would be recognized. Clients' responses were varied, ranging from those who were aggravated or triggered, to those who responded with a longing sigh or deep draws of the sweet air. The latter responses were often accompanied by a laugh, the culprit friendly teased for openly showing her temptation. Making fun of and humoristically sanctioning "wrong" and unhealthy behaviours was therefore a way of promoting and affirming positive and healthy activities, and in this manner "humor-laughter sequences are significant vehicles through which collective identity is constructed and reaffirmed" (Pollner and Stein 2001:61). Clients also reported it being a relief to be able to both laugh and cry in groups, this mix of emotions making the atmosphere at times joyous yet solemn.

Joking and using humour was an important part of coping with trauma, triggers and recovery, which required sensitivity and awareness of past individual stories. As clients grew more accustomed with the group setting and their peers, it was common that their check-ins became less rigid, allowing more personal reflections to occur. Rarely did the new client deviate from the correct form of participating. Familiarity with the frame thus seemed to open up for flexibility and humour. However, not all topics were appropriate to make jokes of, and jokes and ironic remarks were therefore usually self-oriented. Cruel remarks were negatively sanctioned, and clients rarely made fun of each other, with the exception of Penny and Manuela who were close friends and who on several occasions gave "inappropriate" yet funny feedback to each other. Following Bateson's (2000) notion of special playing and joking frameworks, Joan Emerson (1969:171), notes that the person using humour in a serious framework, of which the group session definitely qualified, disrupts this frame, risking at best a lack of response, at worst being sanctioned against as behaving inappropriately. In this manner, a lack of response to a joke may be an acknowledgement of the taboo nature of a topic (Emerson 1969:171).

Prioritizing self-care practices, such as getting one's teeth fixed or having one's nails done, or making jokes and parodies of the old addict self were thus signs which both clients and staff members interpreted as indicating a healthy mentality. Being able to afford and prioritize the luxury of a new hair cut or a pair of jeans was a sign that one was no longer using drugs. Being able to joke about the drug-chasing, money spending addict was not only a mechanism for coping with difficult experiences, but was also a way of agreeing upon correct and healthy behaviour. In this manner the role of the active street addict functioned as a tuner for appropriate and moral behaviours, in which the temporary disruption of the serious framework in groups allowed for a role distancing from the active addict out there.

Conclusion

In this chapter I have presented the clients' use of dichotomies as central forms for making sense of and organizing "healthy" from "unhealthy." Localizing appropriate and inappropriate behaviours, mentalities, and persons in particular places, the opposition between the program and the streets was a powerful tool for clients in recovery. These dichotomies are also bring insight to the clients' construction and use of mental maps, or frames. Group participation may be understood as a collective process of constructing moral as well as spatial maps for navigation in recovery. Though individually constructed, group participation had the effect of synchronizing clients' frameworks, creating senses of likeness and of shared experiences. Polysemy was an important aspect of this, enabling clients a sense of shared experiences, but also potentially creating disagreements. Taking care of one's appearance and engaging in self-care practices was considered displays of a "healthy" mentality, and clients who prioritized looking after themselves were said to have a better chance in recovery.

Chapter 5 Negotiations

In this chapter I will focus on how informants engaged in forms of negotiations when participating in sex trade practices or at the Healing Center. In the following pages I will address how informants negotiated within two different social institutions, within sex trade practices and as clients at the Healing Center, and how these contexts required different forms of capital. Negotiations, whether within sex trade practices or during group sessions at the Healing Center, will be approached as mobilizations of forms of capital within particular social fields (Bourdieu 1994).

The first part of this chapter will focus on informants' ability to negotiate terms within "sex trade practices". I have chosen to use this term, which, although not a term used by informants, serves as an alternative to the more commonly used "prostitution" or "sex work", representing what Geertz (1976) calls an "experience-distant" term. The two latter terms, I found, were problematic among informants in several matters as they do not simply denote a specific form of activity, but also evoke specific kinds of experiences and personhoods. The term sex trade practices, however, encompasses a wider range of practices, while at the same time emphasizing that this engagement was of a particular form. Negotiating within sex trade practices involved such aspects as condom use, the option to turn down customers, or the kind of payment. This part draws not only on my participation among clients at the Healing Center, but also on my contact with members of a sex worker organization in the same city. This, I find, adds useful aspects for making sense of negotiations within a wider spectre.

Informants' interpretations and rationalizations of drug use and engagement in sex trade practices were, however, always done in retrospect. In the second part of this chapter I will therefore focus on how sense making and interpretations were contextual negotiations within the Healing Center. This part draws on group sessions as a particular social field for constructing meaning, where some versions or interpretations were deemed to be more legitimate than others. While clients negotiated body capital within sex trade practices, participation in group sessions required linguistic capital. In the second part I will also apply Tannen's (1993) use of the terms "schema" and "frame", as these offer useful insight when trying understand to how individuals negotiated meaning within the group sessions.

The final part of this chapter attends to what Bateson (1968; 2000) terms metacommunication, which I find adds useful insight to how participation in groups not only involved learning the material, but also served to confirm clients' expectations about what was going on. This part will also attempt to address clients' difficulties in converting "talk" into "practice" in meetings with other environments.

The body as capital

It is Monday morning and we are in the group session room. Except for some chattering, the only sounds are those of ten chairs being drawn across the floor. No need for words, we all settle our chairs facing towards the centre, creating a circle formation. Penny and Manuela are discussing a movie they saw the night before. Others wait silently for the facilitator to signal for the check-in to begin. All regulars in this group, the clients know that they are expected to give an update on what they have done and how they have managed over the weekend. Penny starts, sharing that she attended an NA group, went to church, and saw a movie with Manuela. Manuela, who is next, huffs in a pretend-manner and says that Penny has spoiled her check-in as she has nothing more to report about the weekend. Next is Carla, a woman in her late twenties, who tells us she took her two children out for pizza, and that they had a good time. It makes her feel sad though, she says, because they stay with their dad, and she doesn't get to see them very often. Her attention seems to be directed towards her fingers playing with a loose thread on her jeans. Carla's expression changes, a furrow marking its way along her forehead, and she adds that he makes her have sex with him in order for her to spend time with the kids. Jennifer sighs, mumbling that it sounds familiar. Carla tells us that he used to be a regular trick of hers, fathering two of her children, both now in his custody. She says that he used to take care of her while she was out on the streets, providing her with food, money, clothes and shelter. Now he keeps demanding sex from her when she comes to pick up the kids, and it makes her anxious and nervous every time she should be looking forward to seeing her kids. She says she usually complies, even though she doesn't want to. Carla tells us that it really "pisses me of", but that she feels like she owes him. "After all, he takes care of the kids".

The episode Carla shared in group helps to throw light on how the body was an important, at times the only available, form of capital for informants. This was only one of many episodes I witnessed in which clients at the Healing Center spoke about using their bodies for negotiating needs in everyday life. While Carla's case was not typical, a majority of the women attending group sessions had at one point or another found themselves resorting to bartering with their bodies. Jennifer identified with Carla's account, and shared later in the same group session that she had also been pressured into having sex with her ex-partner. He had threatened to reveal her drug addiction to her employer, which she believed would have gotten her fired. Instead, he continued to pressure her, leaving her few other options than to comply. Both women spoke about how these episodes made them feel angry, used and shameful, as if they did not have control over their own lives. Carla said it was like she was still "selling" herself, although without getting high anymore, and Jennifer said that it made her feel cheap. Most clients could identify with Carla and Jennifer on some level, having engaged in sex trades themselves for different reasons. While some identified these practices as "prostitution", even more identified them as forms of "survival sex". One of them was Ava who, according to herself, never had engaged in any direct form of "prostitution". Rather, she said, there had been times when she had been on the verge of homelessness, having nowhere to go. She shared that she had sex with men she didn't even know or like in order to have a place to stay, and she identified these activities as strategies for survival. She described these experiences as demeaning, knowing she was using them and being used. What these women had in common was an awareness of their bodies as capital.

Lacking other relevant resources such as an education, a job or stable family ties, bodies become a means for trading. According to Maria Epele (2002:170), many people find themselves entering the sex industry when they realise that their bodies are their only form of capital. The body therefore has to be understood as an important site for power negotiations (Ettorre 2007). It is useful to consider the body as a form of capital because it enables us to understand engagement in sex trade practices as a response to particular contexts, and to unequally distributed resources for participation. Following Bourdieu (1994), capital can be understood as the forms of resources which are required in order for an agent to participate in a particular social field. Though clients at the Healing Center participated within a wide range of social relations and contexts, making it hard to delimit a distinct social field in this case, many had experienced that their bodies could be used as resources. Whether this resource was

utilized in order to obtain daily needs such as shelter, food, or, as I will soon address, drugs, clients found this form of capital to be relevant within a range of situations.

Individuals navigate and participate in various social fields in everyday life. Participation in a field requires, but also enables, various forms of resources, or capital. Capital may be understood in terms of field-specific resources which are perceived to be rare and of value (Harker *et al.* 1990, in Webb *et al.* 2002:22), and is unevenly distributed among the participants of the specific field. Social fields are therefore also symbolic "fields of struggles" for capital, and individuals' practices may be understood as the constant struggle for maximization of capital (Bourdieu 1985:723; Wacquant 1989:40). Bourdieu's extended use of the term capital includes both material and symbolic resources, enabling an understanding of how different rationalities than purely economic may dominate. Distinguishing between, for example, economic, cultural, and social capital, Bourdieu accounts for how what is seen as a resource varies from field to field, and requires and enables different kinds of participation. What amounts as a resource in one field may, however, not be valid in another. Capital can be converted into other forms, such as when Carla converted her body capital in order to spend time with her children. Participation in a field thus involves familiarity with the expectations of the context, and correctly practicing this knowledge. In fact, Bourdieu notes that awareness of the relevant resource is in itself a form of capital (Bourdieu 1999). Following this, clients' use of or reliance on their bodies as capital is a kind of symbolic capital in as much as they were aware of the potential resource it constituted within certain contexts.

Penny once shared that she was no older than seven when she realised that she "had something men wanted". She said she used to get 25 cents, which was a lot of money for a kid back then, for showing herself off to men, making her "the girl who always had money". Manuela said she identified with Penny's story, as she too found herself "entertaining" elderly men in the neighbourhood by an early age. Neither of the women ascribed their later engagement in sex trade practices directly to these early experiences. Rather, Penny claimed these experiences had given her an awareness of a quality of something she had. Barbara presented us with a somewhat different introduction to bodies as capital. Her father, she told us, was a local pimp. He still was, actually. Barbara soon learnt the power her father had, and, when in need of money, she would approach "his girls" for cash. This also made her conscious of how her body could be a source of money.

While Carla and Jennifer constantly had to negotiate with the same person, their ex-partner, Jamila had to renegotiate in each case with unknown people. Carla, Jennifer and Jamila found themselves in a poor position to negotiate terms, finding themselves stuck within unequal relations of power. When talking about these activities it was commonly recognized that one did what one "had to do". Having a record of violence, prostitution, and several drug relapses, Carla believed her credentials were bad had she been able to take the case to court. Her ex-partner was, unlike herself, a "functioning addict", meaning he managed to maintain a façade while still using drugs. Carla seemed to not see any real alternatives for negotiating this situation as her ex-partner was still an important factor for her economic survival since he took care of the children. She said this was difficult for her, as she felt dependent and in debt to him. Ava rationalized her particular strategy as better than staying at the shelter or actually exchanging sex directly for money. Other rationalized engaging in sex trade practices as a safer and more moral way of making money compared to for example robbing people, claiming it did not harm anyone.

In all these versions, money and lacking resources were part of the explanations. The sanctions – not seeing one's children, losing one's job, or becoming homeless - were in all cases described as too high a price to pay. According to Sheila Jeffreys (1997), *decision* is a better term than *choice* when talking about engagement in sex trade practices, as it emphasizes the often limited alternatives women find themselves in. Engagement in sex trade practices should therefore not be understood as an either-or strategy, but one which many found themselves gradually entering through processes of negotiating and renegotiating. Negotiations were also internal as clients found themselves having to reconsider personal boundaries. The examples above also show how engagement in sex trade practices need not be based on an economic rationality, but that clients' socioeconomic situations affected their alternatives.

For many clients, engagement in sex trade practices was inseparable from their drug use. Elizabeth Ettorre (2007:6; 21) emphasizes "the centrality of gender in the lives of women drug users" and claims that drug use has to be understood as highly gendered because it structures the ways in which "users coordinate their space, their place, their time, their drugs management, their community resources and their relationships with significant others". Clients had a diversity of strategies they relied on in order to maintain their addiction. Some reported being "functional addicts", sustaining a job *and* continuing their drug use. Others

reported stealing, conning, or panhandling. For many of the clients, however, engagement in sex trade practices was the most effective strategy, the majority having been involved as "street walkers". According to Bruce Jacobs and Jody Miller (2005), the street economy is highly gender stratified, and women's strategies are controlled and restricted by men. This means that women often find themselves having limited alternatives within the social structures of the street economy, making their bodies the most viable form of capital. When taking into consideration that women's wages are in general lower than men's, and that engagement in sex trade exchanges usually pays better than available legitimate jobs, this may become a viable and attractive alternative (Carpenter 2000).

Between them, Penny and Manuela had more than thirty-five years of experience, on and off, from the street economy of drugs and sex trade practices. Now in recovery for crack-addiction they, like many of the clients, described their addiction as an all-consuming activity, their only priority, which structured their days. Manuela said her crack smoking had, at first gradually, then more rapidly, turned her life around. She had found herself renegotiating what she was willing to do for drugs, neglecting and then losing her children, then her house and partner. Homeless, she had found herself having to trade sex on the streets, something she had never considered even an alternative before. Drugs, she said, "pull you down" and "degrade" you, and make it hard to change things round. One therefore needs to approach engagement in sex trade practices in terms of forms of capital, power and social fields, encompassing the complexity of how these factors work on each other.

Penny, Manuela and many of the other women identified drugs as one of the most important factors for their engagement in sex trade practices. Justine shared that her engagement in sex trade practices had been drug motivated, and that she had been "selling" herself in order to get money for heroin. She explained that she had had no other options, living on the streets by the age of fifteen. An older friend, also "in the game", had initiated Justine's participation and had taught her how to act, mentally disassociate, hide visible signs of drug use, and avoid attention from the police. Justine said that she had hated it from the start, and could still remember her first trick, more than thirty years later. She described this period of her life as a constant series of having to engage in degrading activities in dirty alleys. She had finally left when her friend was killed by a customer. Most clients could identify with Justine, having at various points found themselves negotiating their bodies in order to get money for drugs. Ava, for example, said she would occasionally "turn some tricks" when she needed money for

drugs. Whereas most clients had engaged in direct sex-for-money exchanges, Jennifer shared how she used to go out to clubs to dance, flirt and "fool around" with men, who would get her drinks and drugs. She said she used to think of this as "fun", but now saw how she had been using her body to get high. Jennifer exclaimed, "I can't believe how *cheap* I was" when Manuela and Angelita discussed how much they used to earn "turning tricks". Jennifer, though not directly identifying her activities as prostitution like the other two, compared the drinks she would get with the money or drugs the others received.

Anna had a somewhat different version of how she became involved in sex trade practices. Her initial involvement was not based on money-for-drugs, but a commonly held belief of money involved in sex trade practices being "quick" and "easy". In the beginning she had done well, earning a lot and having fun. She described how the money came to mean nothing to her, spending and wasting it as soon as she had it. After some time, however, "fun" turned into daily drug use and she found herself having to get high in order to be able to work. She said she found herself living in shabby hotel rooms, either earning a few dollars per trick or getting paid in drugs. Her days revolved around getting high, and getting money for the next high. Anna said that by the end, she couldn't distinguish between whether she was selling sex to get money for drugs, or if she was using drugs in order to manage to sell sex. Drugs, she said, had become a necessity for her to be able to "disassociate" and "cope". Lacking alternatives, many find themselves having to continue engagement in sex trade practices "in order to obtain the minimum amount of drugs they need to get by and continue their sex work" (Epele 2002:167).

Penny claimed that she had never, even during the worst parts of her addiction, living on the streets, engaged in direct sex-for-drug exchanges. Directly exchanging sex for drugs was seen as the very bottom of activities, and Penny explained that getting paid with drugs makes you unable to negotiate price or what to spend the money on. She further claimed that being paid in drugs was a way tricks could control women, as in particular crack addicts, according to Penny, will be willing to do anything for drugs. Engaging in direct sex-for-drugs exchanges signified a total lack of control over one's drug use, one's body and one's ability to negotiate, and clients characterized getting paid in drugs as "degrading" and "low". According to Philippe Bourgois and Eloise Dunlap (1993:102), the intense cravings and binging behaviour following crack use has led to more prostitution and vulnerability. Unlike heroin highs which last longer and have a different effect, crack highs are short and intense, and lead to high

levels of energy. People report smoking as much as possible, priorities such as safety and condom use renegotiated for the benefit of more crack. Mitchell Ratner (1993:14) claims that the entry of crack has changed the dynamics between sex trade practices and drugs. While heroin has often been viewed as a strategy for coping with engagement in the business, trading sex for money represents a means to continue to stay high for the crack addict. In order to simply "stay well", drug addiction demands daily maintenance and clients reported rarely being able to "take a day off" because a day not "doing the track", i.e., working the streets, meant having no money.

Most of the women at the Healing Center denied having engaged in these forms of exchanges. Manuela, however, openly shared how she had come to engage in direct sex-for-crack exchanges, accepting degrading deals which left her particularly vulnerable for violence and trauma, and thus leading to an escalation of her drug use. Penny and other clients' distancing from engagement in these exchanges is interesting because it brings to attention how hierarchies existed also among people engaged in sex trade practices. Most clients, even those who had participated in such exchanges, agreed to the existence of this hierarchy in which those engaging in direct sex-for-drug exchanges were not only ranked as the lowest within sex trading, but also as being at the bottom of the street economy. Manuela's sex-for-crack trades were for most of the women evidence of the power drugs had to control every aspect of one's life. Penny said that although the money she earned was spent on drugs, she wanted to be in control of it.

Matters of safety

> *I am at an expensive nightclub in a fashionable neighbourhood in the city, attending a party arranged by the Sex Worker Organization. There are about twenty-five people in the room, which has been especially reserved for us, sipping their drinks, talking and dancing. I have secured myself a seat by the bar, and I am talking to a Hispanic woman in her late forties, dressed in a short, bright red dress. Nadia tells me she works in a club where she is a "stripper". She describes how the night club owners try to make the women work as much as possible for little money. Comparing the club to other places she has worked, she describes it as sleazy and dirty. She tells me she hates it, and that the strippers are pressured*

> *by the owners to have sex with customers. She tells me that several mattresses are lined up in a backroom, only separated by thin curtains. Another woman, in her early twenties, overhears this and sits down by us. Tammy says she has heard of places like that described by Nadia, and that it sounds horrible. She tells us she is an "exotic dancer" in a night club in town, and emphasizes style, bodily control and creativity as part of her work. The women are rewarded for being "social" with customers, but this does not include sex, she claims. Tammy has been working there for five months now, and tells us she really enjoys her work.*

This episode illustrates how there was no singular, shared experience of what engagement in sex trade practices was. Rather, informants both at the Healing Center and the Sex Worker Organization could have radically different experiences of their engagement. The women explained their engagement with the Sex Worker Organization in terms of fighting for the legal rights of "sex workers" and for legalizing "sex work". Both Nadia and Tammy identified as "sex workers". For Tammy it was a part time job besides studies, and she described it as artistic and enjoyable work in a professional environment. Nadia, however, presented an entirely different experience of working in a club, linking it closely to her limited abilities to negotiate wages, customers or even her own engagement in sex trade practices. Taking her clothes off for strangers, being pressured into having sex with them, and doing so for close to nothing made her feel used. Despite this she expressed not being in the position to quit, as she found herself not getting any younger and was afraid of having to work off the streets again. Therefore she found herself having to accept work in "bad" places where she was also expected to have sex with customers.

Working in clubs had, however, identifiable benefits according to both women. Not only did working via hotel rooms or clubs in most cases pay more than for example working on the streets. It also put them in a better position to negotiate potential dangers and unwanted attention, and this was expressed to be an important motivation for working indoors. Working on the streets was seen as restricting one's position to negotiate. Violence, threats, and abuse by tricks and random people were a much more common aspect of engagement in sex trade practices on the streets. In addition, working from the streets increased the chances of being arrested. Threats on the streets were, according to informants, a substantial stress factor which had to be negotiated. Barbara, a "sex worker" at the Healing Center, claimed to actually prefer working off the streets. She said she had worked in a club once, but found working on the

streets to be more effective as she could decide her own schedule, “tricks”, and price. Though working in clubs or from hotel rooms paid better, they were more time consuming. Barbara said that despite the dangers on the streets, she found the money worth the risk. In fact, clients often spoke of violent episodes as a matter of fact, a part of “the game”, as something to be expected. Manuela showed me a large scar on her stomach, telling me a trick had “gone crazy with a knife”. Her broken nose was evidence of another trick’s anger, and she told me that at times she wished she had had a weapon to protect herself with. Having feared for her life on several occasions, she said that the threat and fear of rape, beatings, being robbed, or being arrested was a constant part of the street life. It was a cynical place where one in the end had to look after oneself and where being “street smart” was considered essential for survival.

The above examples illustrate Phoenix’s (1999:100) claim that engagement in sex trade practices needs to be understood as constant “risk and cost” calculations. Barbara rationalized her preferred engagement in sex trades from the streets, balancing pros and cons such as money, independency and safety. While acknowledging the dangers of the streets, she also found that it was overall preferable to working indoors. Nadia and Tammy, however, held safety to be an important factor for working indoors. While Tammy claimed she was enjoying her work, Nadia was being pressured into having sex with customers. Were she to be fired from the club she would likely be working off the streets again. The negotiations informants participated in were therefore not necessarily based on a wide variety of options, but rather on reducing risk. Drug use was a factor which greatly affected one’s ability to negotiate risks, as well as limited one’s alternatives.

Boyle and Anglin (1993:176) found that women who were engaged in prostitution prior to their involvement with crack were much less likely to participate in direct sex-for-crack exchanges, and were also in a better position to negotiate condom use. The authors experienced that women getting into prostitution *after* trying crack were less experienced, and were therefore in a worse position to negotiate. This led to a distinction between “professional prostitutes”, who emphasized condom use and price negotiation as important aspects of working, and the “crack whores” who were accused of being unprofessional by compromising their very selves for drugs, who did not negotiate, and who drew down prices. Trading for money rather than drugs was seen as a sign of having control and of moral integrity, and was a way of avoiding a reputation of being a “crack whore” (Feldman *et al.* 2005). Drug use and

addiction was therefore an important factor which limited informants' position to negotiate while at the same time making them more dependent on their body as capital.

Several of the women at the Healing Center admitted having compromised condom use in sex trade practices, as doing so could be rewarded with more money or drugs. Clients recognized these as risky practices, and condom use was much repeated as a form of "self care practices", or harm reduction, in groups. Still, clients recognized condom use as problematic and at times hard to negotiate. One woman rationalized engaging in unprotected sex as only one of many harmful practices she engaged in. She argued that she was more likely to die of an overdose, and she had not seen any reason to take care of herself because she was a "worthless" person. Another woman said she had learnt to live with the risk. In fact, she said she almost believed she couldn't get infected by HIV after many years engaging in unprotected sex trade practices.

While condom use for some was not even up for negotiation, others reported it to be a practice which was so established that it did not even *need* to be discussed. Operating from fancy hotel rooms, Sharla, a member of the sex worker organization, told me that she viewed herself as a professional "sex worker". This included being organized, having advertisements on the internet, and engaging discretely with her johns.[13] Often including some social time, these sex trade practices were described as safe, prenegotiated exchanges which were enjoyed by both parties. Condom use, a sanitary and private environment, and a fair price were all basic premises for Sharla's engagement in sex work, and were, according to herself, rarely necessary to negotiate. Bourgois and Dunlap (1993:126) note that negotiating has to be seen as closely connected to power, and that "condom use is not a technical operation; it is a social assertion of power, control, and self-respect". Informants' abilities to negotiate terms such as price, place or condom use was therefore not simply a matter of stating one's terms and boundaries, but was closely connected to drugs, capital and unequally distributed power. The ability to negotiate terms was one of the biggest differences among informants.

In this part I have shown how informants engaged in various forms of negotiations involving bodies as capital. The position to negotiate terms was important and shaped the experiences. These negotiations, as has been shown, were not necessarily based on a purely economic

[13] While the Healing Center referred to customers of sex trade practices as "tricks", the terms "johns" or "clients" were preferred among members of the sex worker organization.

rationality, while simultaneously being intrinsically related to such needs. However, drugs were a central motivation for many of the women, which made many more dependent on the body as capital and also left them in a poor position to negotiate. Informants' experiences were, however, always given meaning in retrospect. This means that in order to understand how these activities were inscribed with meaning one needs to focus on the social context in which these interpretations were made. In the next part I will attend to how clients negotiated meaning in group sessions at the Healing Center.

Talk the talk

The group is discussing triggers and how to cope with situations which set off drug cravings. Clients are encouraged to reflect on what triggers them, ranging from internal impulses, such as anger, loneliness, boredom, to external ones, including for example specific places, money, people, or perfumes. The women are asked to try to find patterns in their thoughts and previous relapses in order to cope better in the future. Jamila sighs, and says that boredom is a big trigger for her and that she finds being in groups boring because she knows the routine. Both Justine and Carla agree, and Jamila adds that groups either bore her into wanting to get high, or she gets triggered by all the talk about drug use. She says she knows the material, and rather than just sitting here she wants to go out and have fun. Justine nods, and shares that her last relapse was after a NA group where she found herself leaving the meeting more triggered than when she came. The facilitator says that this is common for people in recovery and that it is important to "be aware" and talk about triggers. Carla says that for her it does not help to talk about how her drug cravings make her feel, *and she wishes groups would focus more on how to fight cravings. Jamila agrees and describes being in recovery as "slow" and "lonely", and that she misses the tempo of the streets. Justine nods, and remembers how there was always something going on back in her using days. Penny breaks in and accuses the women of "glorifying" their addiction, forgetting the bad times and only remembering the good ones. She tells the women they are not "working the material", and claims that it seems like they are not really dedicated. Justine protests at this, saying that she has been working hard in recovery. Ignoring her, Penny continues, saying that they must*

never forget how "far down" their addiction took them, and that they really have to work with themselves and their attitudes if they are to stay sober. Penny tells them that if they want to stay clean, they have to realise that they themselves are responsible for acting on triggers. "After all", she says, "only I trigger me". Others nod in recognition at this, and the facilitator turns her attention to Anna.

The above episode illustrates how clients evinced different degrees of familiarity with the appropriate and dominant ways of speaking about drug use and recovery. Jamila and Justine's discussion about recovery being "slow" and "boring" were to Penny signs of them not "working the material," which she identified as displays of "unhealthy" mentalities. Justine and Jamila objected to this, claiming that they were motivated for recovery and dismissed Penny's accusations. The facilitator, who seemed to agree with Penny's observation, told the women that their emotions were common ones and that these were signs that they should indeed focus more on their recovery. The women, however, continued to complain about finding group sessions predictable and triggering, at which Penny commented that one has to take responsibility for acting out on triggers. This observation appeared to me to mark a pronounced difference in the three women's approach to recovery. Penny, it seemed, spoke about recovery in a manner which closely resembled that promoted in the curriculum. She located responsibility within herself, and emphasized the importance of the continuous support of the group in order to cope with her triggers. Penny had gained a reputation after short time at the centre for being a dedicated client, and her feedback and comments in groups were usually considered insightful and helpful. Her advice was thus appreciated by both peers and facilitators, and when Penny spoke, people listened. Jamila and Justine, on the other hand, tended to display what was considered "unhealthy" attitudes. On the one hand they were capable of identifying triggers, but on the other they did not seem motivated to actually do what was considered necessary in order to handle such triggers. When considering group sessions boring, for example, they both wished they could go out and have fun, rather than following the widely recognizable advice to "stay focused" and continue to attend groups. In Penny's terms, the women were "glorifying" their addiction. So while Penny was considered a stable and dedicated client, Jamila and Justine seemed to struggle to keep up their minimum attendance in groups, not recognizing group sessions as tools for support.

Once again Bourdieu's concepts prove useful tools for making sense of clients' participation in group sessions, and how some clients' interpretations gained more legitimacy than others.

The authority of Penny's statements may be understood in terms of her overall acknowledged position as a "dedicated client" within the group session. By approaching the Healing Center as a sub-field within a larger field of addiction treatment, one can locate the particular discourses, resources, and identity positions which are enabled and conditioned within the institution. As was established in Chapter 1, social fields may be understood in terms of structures, or relations, which both restricts and enables actions, and form specific logic systems which are irreducible to other fields (Wacquant 1989:39). Along with other free addiction treatment projects, such as AA or NA, the Healing Center base their approach to addiction and recovery on the belief that addiction is a chronic disease which can be controlled through participation in therapeutic communities. This rationality has implications for the whole treatment process, and affects everything from the methods and the language used, to the personhoods constructed.

According to Bourdieu (1994:111), social fields need to be analyzed in terms of 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". The emphasis is here on social relations between participants of the discursive environment, and how daily interactions are based on unequal power relations, reproducing and give authority to the field. A participant's position within a social field is based on the unequal distribution of capital, creating a hierarchy which ascribes members with different degrees of power and authority (Bourdieu 1990). Both clients and staff members participated in group sessions, using their past experiences as resources for collectively making sense of their lives. For staff members their authority was based on "having been there" and having established themselves as "survivors". This infused facilitators' interpretations and statements with a legitimacy which clients rarely could repudiate. In this manner, the past represented an important capital for staff members. Clients, however, could not utilize their past experiences in the same manner, as their attendance in groups meant they had yet to take control over their drug use. While many clients had had to rely on their bodies as capital while engaging in the street addict economy, participation in the treatment setting required other resources. Clients' competent engagement in group sessions, understood as their knowledge about the correct ways to share, interpret, and give feedback, may be understood as displays of what Bourdieu (1994) terms "linguistic capital". This can be understood as one's knowledge about the legitimate ways of speaking, of how to not only speak understandably but also from an authorized position within a particular social field (Bourdieu 1994:54). Language, and in particular knowledge

about legitimate ways of speaking, became a resource for clients, who could now create not only coherence but also agency and authority.

Penny's participation in the group session, as compared to that of Jamila and Justine, may thus be understood in terms of her acquired linguistic capital, which functioned as a resource for competent communicating in the group setting. This authority, however, was not a quality Penny *had*, nor was it an inherent aspect of the particular language. Rather, Penny's authority was established and dependent on her peers' continued recognition. As such, authority has to be established and constantly negotiated, and Bourdieu (1994:109, orig. emphasis) notes that "language at most *represents* this authority, manifests and symbolizes it". Linguistic capital therefore has the potential both to establish and discredit authority, and Bourdieu (1973, in Gumperz and Cook-Gumperz 1982:5) claims that "communicative resources thus form an integral part of an individual's symbolic and social capital."

Authorizing one discourse disqualifies or weakens others. Not all ways of talking about addiction and trauma were equally legitimate at the Healing Center, and facilitators would at times help clients interpret their experiences by suggesting or encouraging specific explanations and perspectives. Peers would also offer their opinion, either supporting the facilitator's interpretation or through giving "negative feedback" to that of the narrator. In this manner, certain interpretations of experience could be sanctioned against collectively. The following episode occurred during an open group session in which the topic prostitution had been brought up. Several clients had shared their experiences of sex trade practices as being traumatizing and degrading, when a different interpretation was shared. Angelita, a woman in her early twenties, claimed that she enjoyed working in clubs because it was "easy money" and she could hang out with friends. The facilitator, who usually let clients speak uninterrupted, reinterpreted Angelita's account by correcting her observation of "doing tricks" as being "easy money" by claiming that there was no such thing as easy money. Angelina, unlike many others who usually would not openly disagree with facilitators, responded by saying that she had never experienced any negative incidents while working. The answer to this was that she may not have experienced harm yet, but that it was inevitable over time. The authority of this claim, based on the facilitator's personal experiences, seniority, her successful recovery from addiction, and the silence of the rest of the group left Angelita with no response. I did not hear the characterization of "prostitution" as "easy money" used in

group sessions after this, but it should also be added that clients were rarely corrected as strictly as in this case.

Similarly, I experienced clients who, in group, distanced themselves from the sex industry while at the same time being actively engaged in it. Several of the clients identified as "sex workers", but told me they felt that they did not feel this was accepted at the Healing Center, despite the proclaimed nonjudging environment. Just as some clients were discredited, other clients' versions were invested with more authority. This was particularly the case for the soon to be graduates who had not only "worked the material" longer, but who also had grown more familiar with the institution, the clients participating in groups, and not least the particular language of healing.

Linguistic competence is not an either-or quality of a person, and while some clients were more successful in displaying their familiarity, they were all also subject to being discredited. In fact, Paik (2006) claims that challenging and questioning peers' attempts at recovery work is an intrinsic part of addiction treatment, as questioning others is a way of showing one's own success in recovery. Learning the dominant discourses and interpretations, and being able to utilize it in an appropriate manner seemed to present many clients with a way of making sense of their experiences by being able to talk about them. However, the linguistic repertoire also enabled clients to use it strategically when interacting with clients and staff members. In Chapter 4, Jamila's continuous relapses were used to illustrate what was said to be an "unhealthy" or, in Bateson's terms, a symmetrical relation to one's addiction. Jamila was told that she would repeatedly fail in her attempts at long-term sobriety as long as she did not accept responsibility for her own actions, while simultaneously accepting her powerlessness to beat her drug use. When Jamila resisted both the advice on applying for housing and on getting help with her money, several clients visibly showed their annoyance at her dismissing what was accepted as good advice. She dismissed alternative forms of housing, saying she did not want to lose her freedom. Confronted with her repeated pattern of relapsing, Jamila still claimed that she could manage on her own. This was a cue which her peers recognized as not having "surrendered", and thus as "not working the program". However, while this was interpreted by both facilitators and clients as Jamila "not getting it", the episode in fact illustrates that "getting it" is a process of learning.

By attributing her relapse to "slippery places" such as the shelter, and "red flags" such as her unstable, using partner, Jamila showed her familiarity with what was considered legitimate reasons for relapsing. Still, Jamila did not pull it off. Penny's comment about being responsible for acting out on triggers seemed to illustrate an understanding of the material which Jamila did not have. While the Healing Center promoted victimization interpretations, these were only legitimate as far as the individual was willing to take responsibility for the future. Both the episode in the previous chapter and the one above illustrate how Jamila assumed a victim position within unfavourable conditions that were out of her control, while at the same time failing to take responsibility for her past actions and recovery. To her peers her lacking responsibility signified that Jamila had yet to "surrender", and as such was not fully committed to the program.

Whether or not Jamila was working the material, the collective agreement seemed to be that she was in fact *not.* Accusations of one's lacking dedication was hard to disprove as Jamila's words, cycle of relapsing, and even her thoughts, were used as evidence against her. Even so, she kept returning to the centre. According to Denzin (1987), this may however be understood not so much as evidence of one's dedication, as of a wish to return to a social setting in which one feels understood. Jamila proved on this and other occasions that she was familiar with the Healing Center language of healing and recovery.[14] However, her seemingly missing ability to apply these resources to herself indicates that she was a case of what Denzin (1987:78) calls a *situational* rather than a *recovering* addict. This means that Jamila and other clients had learnt to talk like recovering addicts, without really having surrendered and internalized the addict identity. Following Denzin (1987:30), this distinction can explain Jamila's participation in terms of compliance rather than as an actual surrender. She talked like the other clients, but did not act like an addict in recovery.

John Gumperz (1982:130) claims that "any utterance can be understood in numerous ways", and that how the utterance is interpreted depends on the person's definition on what is going on. Different interpretations may therefore be understood as arising from different expectations, or framings, of the situation (Tannen 1993). Clients' ability to participate in an understandable manner thus involved negotiating meaning and expectations within the group

[14] In fact, Jamila told me that she had previously graduated two other treatment programs, but had on both occasions relapsed shortly after. In addition she had participated in several treatment programs that she had dropped out of.

setting. This required that clients were familiar with the linguistic repertoires of the Healing Center. Tannen's (1993) terms frame and schema prove useful in order to approach negotiations as forms of sense makings. When individuals participate in social fields, such as group sessions, they do so by engaging in framing activities for making sense of what is going on. Framing can be understood as what people think they are doing when engaging within a particular context (Tannen 1993). Clients based their participation in group sessions on prior experiences with similar agencies and institutions, employing schemas in order to frame the current situation. Schemas, or "knowledge schemas", refer to "participants' expectations about people, objects, events and settings in the world" (Tannen and Wallat 1993:60). Tannen (1993) notes that our expectations and assumptions are continuously compared and revised against our actual experiences, and schemas are therefore tools for making sense of the frame. Because each individual bases his or her framing on prior experiences, participants do not necessarily operate with the same cognitive maps for what is going on in the situation. For example, Erica, a court mandated client, described her participation at the Healing Center as punishment, implying that for her, group sessions were not about "healing" but about "doing my hours". Jennifer, however, talked a lot about how the Healing Center had changed her life, describing it as her "temple". The two women clearly had very different ideas of what their participation meant, and this may be understood in terms of the women framing the situation in different ways. Thus, with different frames at work, "the view that one person has of what is going on is likely to be quite different from that of another" (Goffman 1974:8). Conversely, the more similar the frames in operation, the more similar, presumably, are also the interpretations, as the frames of reference are closer.

Knowledge schemas are not easily accessible, but can, according to Tannen (1993), be revealed through studying "surface evidence" which is revealed in interaction. Attending to clients' varying use of the linguistic repertoire may therefore present resources for learning about underlying expectations with which clients navigated when participating in groups. Clients' participation and negotiations of meaning in groups was thus based on varying degrees of overlapping frames. Tannen (1993:17) notes that conflicting schemas, when people's behaviour and expectations clash, are of particular interest because they enable an understanding of the relation between attitudes and behaviour. Communication can therefore be understood as negotiations of what Tannen (1993:15) calls "structures of expectations", i.e., both the social frames within which we negotiate, and schemas, our assumptions, and Tannen (1993:21) therefore claims that "expectations affect language production". Meaning is

thus not static, and is rather negotiated in interaction. Clients' interpretations, or self stories, may therefore be understood as contextual negotiations of schemas.

When Penny became a client in early March, it was evident that she was familiar with the frames for participating in group therapy. Penny's schemas of the frame, it seems, corresponded closely with those presented at the centre. Unlike most newcomers, who would often remain silent during their first group sessions, Penny was active, both sharing and giving feedback. Now, giving feedback could be tricky, and required the ability to listen, reflect and respond in an appropriate manner. Not only could the person who shared be sensitive to criticism, the client giving feedback taking the risk of offending the sharer or other participants though her response. The clients also risked coming over as lacking abilities to "work the material", of not engaging on a self reflective level. In the above example, Jamila and Justine found Penny's interpretation of their descriptions of recovery, who claimed they were not motivated to stay sober, offensive, and they protested that they were in fact working the material. The facilitator supported Penny's diagnosis of the women, giving legitimacy to Penny's interpretation, and thereby also discrediting Justine and Jamila's claims. What Jamila probably experienced as a legitimate answer to the question "what triggers you?" was rather interpreted in terms of her "not working the material". Their interpretations were thus used as evidence of a wrong kind of mentality, discrediting the women's recovery work.

Both Cain (1991) and Loseke (2001) found in their studies of support groups that with prolonged participation, personal stories tended to increasingly assume the form of the encouraged formula stories of that context. I found this tendency to be present also among clients at the Healing Center, where many of the women over time came to operate with a similar language for interpreting and communicating. Over time, through interacting with staff and other clients, many clients came to take ownership of and utilize particular discourses for describing their personal process of addiction and recovery. This included what it meant to be an addict, what it meant to be part of a recovery setting, how to share and give appropriate feedback, as well as learning to interpret one's experiences as forms of victimization. It often became *the* way of talking about triggers, trauma and recovery. Participation in these kinds of therapy settings thus attunes members to particular premises, and ongoing participation may be understood as a socialization of participants into a complementary understanding of their addiction. In Tannen's terms, it seems like group participation led to the construction of different, though also often similar, frameworks for

making sense of the past, the present, and the future. The collective attunement of frameworks clients were part of was therefore not a complete one, and clients continued to have different understandings of what this meant. Group participation therefore seemed to lead to a synchronization of frames, while clients continued to operate with different schemas for interaction (Tannen 1993).

Penny, who had been a client for a significantly shorter time than both Jamila and Justine, seemed to be more successful in her displays of familiarity with the linguistic repertoire, and participated and proved her extensive knowledge of the right ways of not only right speech, but also of right thinking. Participation in groups did therefore not automatically make clients capable of using these resources. Both Jamila and Justine had been clients at the centre since before my arrival in early January. Justine attended on a regular basis, while Jamila had more sporadic appearances in groups. They both claimed to be "working the material", finding Penny's accusation of them doing otherwise both provocative and hurtful. Jamila in particular continued commenting this during the rest of the group session. Accusing someone of not working the material indicated that one was not dedicated to recovery. Taken into consideration the often repeated statement that recovery will only successful if one "surrenders", Penny's criticism of Jamila and Justine went beyond simply criticizing their statements about recovery being boring. Penny, in other words, indirectly doomed their recovery by claiming they had a wrong mentality. The example shows that Penny, despite being a newcomer, operated with a script which was more coherent with that of the overall expectations to the frame of the group setting than the other two women. This illustrates John Gumperz's (1982:140) claim that "understanding of communicative strategies is (…) less a matter of length of residence than of communicative experience."

Penny's responses to the women drew not only on the knowledge she had acquired during her time at the Healing Center, but also on experiences from other contexts, such as programs she had previously participated in. Following Tannen and Wallat (1993:69), Penny's competent knowledge of the linguistic repertoire can be understood in terms of her familiarity with and handling of a wide variety of schemas. References to "working the material" or "doing your steps" were not terms primarily used at the Healing Center, and were rather imported from NA and AA. However, after they entered group language through Penny's use of them, these terms found foothold among clients, who, either recognizing them from previous encounters with recovery programs or simply accepting their usefulness, increasingly integrated these

descriptions into their recovery language. Doing one's "steps" refers to the Twelve Steps which are presented in NA and AA as the path to recovery. Several clients were participating in these groups outside the centre, but few had used them as direct references before. However, they were now accepted as legitimate, and were used not only when clients referred to their progress in NA and AA, but also to assess their successfulness of working the material as clients at the Healing Center. Clients, therefore, drew not only on their knowledge about the legitimate discourses at the Healing Center, but also relied on other linguistic repertoires. Crediting these "new" terms entirely to clients such as Penny, Jennifer and Manuela would, however, be misleading. Just like some clients had previous experiences from treatment programs, also the staffs' language was influenced by their personal experiences. Still, it shows how both clients and staff members' language and interpretations were not only shaped by the language used in groups, but also shaped what was spoken about and how. This, following Tannen (1993), also illustrates how participants' framings were constantly negotiated and revised.

Messages of healing

Bateson (1968) presents an interesting perspective on framing and communication. He claims that all communication involves a metacommunicative message about the relevant frames for interaction. He suggests that our assumptions about the world are "more true if we believe and act upon them, and more false if we disbelieve them. Their validity is a function of our belief" (Bateson 1968:217). This means that one's sense of reality, of what is going on, is based on the continued affirmation or challenging of "frames". In group sessions, clients were expected to engage in forms of "identity work", through applying new interpretations and tools to past experiences. These collective processes of reflection had the potential of leading to change. Taking a cue from Bateson (1968), however, there was something else going on in groups as well, which may in fact have had a more significant impact on the effectiveness of treatment. According to Bateson, metacommunicative messages signal to participants the correct interpretation of frame for what is going on. This is an inherent element of all communication, not only between humans but also in interaction between animals. According to Bateson (2000:289), both verbal and nonverbal signs, or "context markers", give information about the correct frame for participation, thus also informing about the shared values and premises for interaction (Bateson 1968:213). In this manner, clients who did appropriate the encouraged ways of speaking in group sessions came over as having adopted the same value system.

Conversely, silence, or not appropriating the language of healing, could be interpreted as a lack of agreement (Bateson 1968:213).

Approaching talk in groups on a metacommunicative level enables another thought. When participating in groups, clients were employing different frames for making sense of what was going on. Following Bateson, clients were not only communicating about treatment, but also about frames for interaction. I will here apply a distinction between court mandated clients and voluntary participants, not because I believe this to be the most relevant distinction between them, but because it enables a clearer understanding of the effect of metacommunication for schemas. Jennifer was a client who was attending therapy on a voluntary basis, having chosen to attend addiction treatment. She would often speak enthusiastically about what she had learnt in groups, and would sometimes ask for a copy of the curriculum to keep with her. This may be understood as "surface evidence" (Tannen 1993), and indicates that she was experiencing her involvement at the centre in terms of "healing". As such, attending and engaging in groups held a positive value, a perception which seemed to be confirmed through practical experience. Attending groups may thus be said to lead to a affirmation not only of what is appropriate and expected by clients, but also confirms that what the client is doing is correct, and probably boosts her motivation for continued participation. Several clients expressed that treatment at the Healing Center made them feel "alive", and that it was the best thing that had happened them.

In the case of Erica, however, who was a court mandated client, participation at the Healing Center seemed to be perceived in terms of punishment. Being forced to participate in groups only seemed to confirm Erica's perceptions, as did the often negative feedback and evaluations of her dedication to recovery. Once asked in "Emotion Management" group what made her angry, she answered that "having to attend groups" did, and that she was only motivated by "getting my hours done".[15] When Erica had completed the required number of hours in "Trauma and coping" she displayed her happiness by cheering. Erica attended only the minimum requirement, and would occasionally skip appointments and group sessions, which only led to more negative feedback on her return. When communicating with peers, she was often hostile, and seemed to have difficulties identifying with their perception of treatment. This may perhaps have led to her distancing herself further from the group. From

[15] Court mandated clients were expected to complete a certain number of groups in order to fulfil the requirements and graduate the program.

the perspective of the court mandated clients, continued participation does *not* confirm the experience as "healing", but rather as "punishment". Other clients, however, may experience a change in their perception through participating in groups, their experiences leading to modifications of the relevant frames.

When clients participated in group sessions, they were taught specific tools and resources for coping. While these resources were taught and practices in group sessions, clients were expected to generalize and apply them in their daily life outside the centre. This may be understood as what Bateson's (1968:216) refers to as "deutero-learning", which, he claims, involves the capacity to generalize and transfer knowledge from one specific context to others. "Working the program" seems to be a good example of deutero-learning because this is exactly what is expected from clients. Learning the material was thus not simply about being familiar with and utilizing it in group sessions, but about understanding that it had to be put to use in contexts outside the treatment environment. Doing so was said to be essential if one were to remain sober and, it itself, simply being able to "talk the talk" in groups was not sufficient in order to remain sober. Perhaps the assumption was that if clients really worked the program into their daily routines they would experience that these "healthy" ways worked better than their old behaviours, and as such made more sense than their past patterns of reactions. Linking this kind of meta-learning to complementary and symmetrical relations, Bateson (1968:226) claims that deutero-learning is a matter of belief as the validity of the knowledge is dependent on one's belief in the system. In this manner, a client who has not "surrendered" to the program is less likely to consider the use of the material valid in various contexts, while a client who is dedicated in her recovery work is more likely to follow the facilitator's advice and apply it to other aspects of her life. This, in turn, may motivate her to continue "working the program".

Although it was widely accepted that "working the program" and applying it to various aspects of one's life was difficult, facilitators tended to under-communicate this in groups. They would emphasize that clients were themselves responsible for their own recovery, and also indicate that the difficulties of "working the program" could be overcome through enough dedication. Clients were thus made responsible both for their own recovery and for relapsing, and "failing" in recovery was partly attributed the conditions of clients' lives, but predominantly a client's lack of dedication. In this manner clients were made accountable for putting these tools and resources, learnt in the "safe" and "healthy" environment of the group,

into practical use in entirely different situations. While a client could be successful in displaying her ability to "talk the talk", she could struggle to convert the same tools and resources to practical use outside the centre.

Clients would often speak about the difficulties of actually "working the program" into their daily lives, some emphasizing the triggers and temptations, others how they lacked the support of partners, and yet others claiming they could not understand how to do so. This seems to imply that there was a gap between on the one hand the "healthy" and safe setting in which clients were introduced to the material, and on the other the actual conditions in which they spent the remainder of their time. While in theory the material could seem understandable when discussing it in group sessions, putting it to use in practice seemed to demand more than simply knowing the material. This may once again be understood in terms of clients' familiarity, or lack thereof, with the expectations of different environments. While clients had been familiar with the terms and "customs" of life as "active addicts",[16] and later becoming knowledgeable with the terms for participating in the therapy setting as "clients," returning to and partaking in society as "functional" people seemed to demand other kinds of resources. These expectations were perhaps unclear to clients, making participation difficult. In addition, many were still frequenting with old using friends, who had other expectations for meaningful participation, and with whom "recovery talk" was neither valued nor recognized. Our actions are, according to Bourdieu (1999), the practical outcome of encounters between habitus and field. When clients were met with mixed expectations from various environments, they responded with patterns which seemed to make sense to these demands. Being able to *talk* like a recovering addict in group sessions did not automatically mean that they could *act* like recovering addicts in other contexts, where they not only would have to put into practical use this knowledge in new ways, but perhaps also experience that these ways did not make sense. Thus, capital valid in one field may not be convertible or recognizable in others as social fields operate with different logic systems.

It may seem that while talk in groups had the potential to make clients aware of "unhealthy" practices, it need not have actual effect in clients' lives. As primarily linguistic and mental tools, taught in a controlled environment, clients were the ones who in the end had to transfer this knowledge into practical use. Long-time sobriety is thus not a matter of simply *talking*

[16] Being "street smart" was not a valid form of capital at the Healing Center, where it was rather interpreted as displays of one's "addict mentality".

like a recovering addict, but requires that the material becomes self-knowledge, something one *does*. Following Gumperz and Cook-Gumperz (1982:14), this indicates that clients' linguistic demonstrations may not actually be displays of "working the program", but rather be displays of "communicative flexibility".

Conclusion

Using examples both from engagement in sex trade practices and participation in group sessions at the Healing Center I have shown how the ability to negotiate was of great importance in the lives of informants. Bourdieu's terms capital and social field have been put to use in order to show how participation in different contexts required different kinds of resources. Tannen's approach to the terms "framing" and "schema" proves useful when approaching how individuals navigated and made sense of their participation in group sessions.

In the first two parts of this chapter I addressed informants' reliance on body capital as contextual negotiations, which at times constituted their only available resource. While some informants experienced that they were in no position to negotiate terms such as condom use or payment with their customers, others seemed to be better positioned, rather finding they did not *need* to. These concerns were prevalent among informants both at the Sex Worker Organization and at the Healing Center, and indicates that there was no singular experience of what it meant to engage in sex trade practices. Rather, drugs seemed to be a significant factor which influenced one's ability to negotiate, and in particular direct sex-for-drug exchanges. Informants' positions to negotiate were thus not dependent on one's identification with one grouping or another.

The two latter parts tend to clients' participation in group sessions, and how they negotiated and made sense of their experiences through talk. Clients' familiarity with the dominant discourses and expectations of the centre seemed to greatly affect one's ability to participate in a recognizable and legitimate manner. Meaningful participation thus relied on linguistic capital. Following Tannen, clients' engagement in groups may be understood as based on different schemas for interacting, each client relying on past experiences with similar settings. While group participation equipped clients with tools and resources, all communication also involves metacommunicative messages (Bateson 1968). It seems that clients' framings,

whether ones of “healing” or “punishment”, were reproduced rather than challenged. This may influence their motivation for “working the program” outside the centre, which required that clients converted “talk” to “practice”. This, however, proved difficult for most, as other environments held other expectations and challenges than the “safe” and “healthy” one of the Healing Center.

Chapter 6 Concluding remarks

The opening episode in Chapter 1, the graduation ceremony, was an important day for the graduating clients. Not only did it signal the completion of six months of treatment, but also marked the beginning of a new, drug free life. I do not know how things have turned out for the twelve graduating women after that day, and it would perhaps be tempting to believe that they all lived happily ever after. Based on what has been outlined in the previous chapters, however, it is more than likely that several of the women some day will return to a life involving drug use. Why?

The succeeding chapters have followed the clients' engagement in recovery work at the Healing Center on their path towards recovery, focusing on the treatment environment and in particular their participation in group sessions. Treatment at the centre was cast by facilitators as a process of "healing", attending not only to issues directly related to substance abuse, but also addressing untreated trauma. This link was said to be of the upmost importance if long-time sobriety was to be achieved. Group sessions thus addressed a wide range of concerns and topics, ranging from drug cravings and triggers, to violent partners, sexual abuse, engagement in sex trade practices, and self-worth.

The emphasis has all along been on language, and how the dominant discourses promoted in groups at the Healing Center provided clients with potential resources for making sense of and coming to terms with their past, while simultaneously taking agency of their future. Polysemy served as an important part of this language, enabling, in its vagueness, clients to identify with what was being said. Through participating in group sessions, clients grew familiar with, and sometimes came to utilize, discourses such as "prostitution as violence" and other interpretations which emphasized their lack of options. Many clients came to view themselves in new ways, realizing that they were not "bad people", but rather victims of abuse, neglect, and circumstances that were outside their control. In this manner their past engagement in drug use, sex trade practices, and abusive relationships were cast as forms of victimizations. The victim position was, however, not a viable one for the future, and while clients were told that they were not responsible for their past, they also learnt that treatment at the centre could "empower" them to take control over their drug use and future as "survivors". This was to a large degree done through investigating one's past ways of thinking and acting, the "addict mentality", and teaching clients "healthier" ways of coping

for the future. In this manner, the linguistic repertoires at the centre had the potential to install a sense of agency in the client, and perhaps also a new sense of self through reinterpreting the past.

In group sessions, clients' sharings provided the basis for discussions. Both clients and the facilitator would engage in reinterpreting what had been shared in order to point out "unhealthy" patterns and provide alternative reactions. The distinction between "healthy" and "unhealthy" practices and mentalities was a pervasive one which was found in several other dichotomies, such as "active addict" and "recovering addict". These served to help clients make sense of addiction, recovery, and relapse by structuring distinct oppositions. A particularly important one was the distinction between "the streets" and the Healing Center. The streets represented the "unhealthy" addict mentality, which was cast as irrational and dope-driven, as opposed to the centre which was said to reinstate agency and humanity. The distinction between these spaces served not only as moral guides for appropriate and inappropriate behaviour, but also as practical maps for navigating in the city. While descriptions of the street addict scene were generalized exaggerations, there was a large degree of consensus among clients on the general qualities of life "out there", and their descriptions bring attention to some of the things clients considered important. In the description of the streets as "lonely", for example, clients expressed feeling a lack of stable, meaningful, and close relationships. Relationships out on the streets were said to be superficial, based rather on strategic alliances rather than on friendship. This was a reoccurring topic in groups, where clients would talk about their dysfunctional families, the dissolution of their own relationships, lacking contact with family members, or losing custody over their children.

In Chapter 5 I addressed how clients engaged in various forms of negotiations of capital. The body provided an important, at times the only relevant, resource for the women, whether bargaining for shelter, time with one's children, or in order to acquire money or drugs. While some clients identified as "sex workers", other referred to these activities as "what had to be done", and defined them rather in terms of "survival sex". Negotiating terms such as condom use, payment, or safety were important concerns, and the women expressed that drug use was a factor which greatly reduced one's ability to negotiate. In group sessions at the Healing Center, however, other forms of capital were dominant. Competent participation, approached in terms of "linguistic capital", required familiarity with the legitimate ways of interpreting

and communicating in the group setting. Understood in terms of framing, knowledge about the expectations of the context served as resources which imbued some clients' sharings and interpretations with authority, while disqualifying others. While some clients seemed to be familiar with the specific ways of speaking and participating, others struggled to display such knowledge. This could lead to accusations of one's lacking dedication and of "not working the program". However, a client's ability to "talk the talk" need not necessarily be displays of "working the program", but may rather be understood in terms of a partial and strategic utilization of these resources in order to come over as being dedicated. In this manner, "linguistic competencies" provided practical and powerful resources for participation. Feigning dedication over time was difficult, however, as clients' past sharings would often be brought up in order to analyze patterns in their interpretations.

While I have tried to downplay the distinction between court mandated and voluntarily participating clients, it may seem that this difference was one which, at times, indeed did make a difference. It may thus seem reasonable to assume that if a person has experienced what may be termed an episode of "rock bottom", and thus of coming to define him or herself as an "addict", the person will likely also to be more susceptible to intervention, having, as Penny said, realized that "my way does not work". Attending treatment would thus be framed in terms of "healing", as opposed to for example "getting my hours done", and in this manner greatly influence the person's approach to what is going on, and thus of what was required of him or her. Following Bateson's (1968) approach to metacommunication and framing, it would appear that a client's idea of what was going on at the centre was more likely to be confirmed, rather than challenged.

Clients were told that "working the program" only in groups was not sufficient in order to achieve long-time sobriety. Rather, they were encouraged to apply the tools and resources in their everyday lives. This, however, proved to be challenging even to clients who were considered dedicated in their recovery work. While the tools and resources were acquired and practiced in the safe and "healthy" environment of the Healing Center, "the streets" proposed other expectations and challenges. A client could thus be competent in her participation in group sessions, while finding it harder to apply these tools in everyday life. In light of Bourdieu's theory of practice, it may seem like the distance between the treatment centre and the actual environment of their lives was too big, making conversion of one, largely linguistic, form of capital into practical action hard. It may thus seem that many clients struggled to

navigate as “recovering addicts” between the shifting expectations of two radically different social fields. While the Healing Center could install a sense of agency and equip clients with linguistic tools for “healthier” coping, these proved less applicable in life outside the centre. Addiction treatment programs such as the Healing Center are therefore up against a big challenge. While cognitive therapy, such as used at the Healing Center, can affect how clients *talk* about their experiences and themselves, in this manner affecting the linguistic habitus, it seems like practical effect, seen as what people *do*, is harder to come by.

For future projects I believe it would be beneficiary to follow individuals in other arenas also outside the institution in order to take into account the practical conditions of clients’ lives. This is particularly so in the case of nonresidential treatment agencies, such as the Healing Center, which only encompasses services during day time. In this manner, one would be better able to grasp the complexities of clients’ lives, and their daily navigations between different social fields. Long-time participation seems to be of the upmost importance for projects like these, as sensitive topics such as drug use and engagement in sex trade practices may be sensitive topics that are not easily accessible for the short-term observer. Both Ratner (1993) and Rhodes (2005) emphasize the importance of qualitative studies in regards to drug use, claiming this is essential in order to gain trust and insight to the everyday lives of drug users. Most importantly, however, long-time participation enables one to observe patterns in informants’ actions and statements.

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