

Unequal Treatment: Class, Race & Addiction Recovery in American Life

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Dedication

For Katie and other brave hearts

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Chapter 1: American Addict

Proliferating Addictions

We live in the era of the addict. Eve Sedgwick noted decades ago that addictions were “everywhere proliferating” (Sedgwick 1994). It turned out to be a sage insight. Over the last century, rates of addiction have continued to increase in nations across the globe (Alexander 2008). The latest chapter in the American drug saga centers on heroin use, which has increased over 63% in the past decade-- much of it linked to the abuse of prescription pain medication (Jones et al. 2015). Policymakers and treatment providers note with alarm that the United States is 5% of the world’s population but consumes 80% of its opioids, and that more people now die from prescription drug overdose than car accidents (Lavitt 2014). The latest figures claim that addiction is now a leading cause of rising death rates among middle-aged, white Americans—a first-time reversal in decades of health longevity for a group that is otherwise privileged on most social and economic indicators of wellbeing (Case and Deaton 2015). The “cost” of addiction is estimated to exceed \$468 billion annually—not including the untold costs to individuals, families, and communities who bear the weight of addictive suffering (CASA 2012).¹ The white, suburban, middle-class contours of the nation’s latest drug scare have generated new concerns and cultural anxieties, and a reinvigorated political commitment to go to war with the nation’s centuries-old scourge.

In many ways, none of this is a new story. Historical evidence of Americans’ long love-hate relationship with intoxicants abound. Even a cursory glance at American social history reveals that drugs, alcohol, and the many varieties of “getting high” were inscribed into the very foundations of the country’s social, economic and political order (Acker and Tracy 2004, Burns 2009, Courtwright 2001, Grim 2010, Musto 1973). From the consumption of morphine-laced “patent medicines” by 19th century housewives

¹ This is a conservative estimate that doesn’t include family, out of pocket or private insurance costs (CASA 2012).

(Acker 2002), to the drinking of “demon rum” in Prohibition-era speakeasies (Inciardi 2008), to the relentless mass marketing of pharmaceutical opiates and sedatives in the 1980s and beyond (Quinones 2015), the national consciousness has always been, in some senses, an intoxicated one. But the fact that so many more Americans seem to be turning to drugs and developing addictions in modernity requires new understandings and better theories. Sociologists have been offering some compelling ones. Their explanations highlight the cultural tensions between repressive Protestantism and indulgent consumerism (Reinarman 2008b); the mass dislocation caused by the spread of free-market capitalism (Alexander 2008); and the enduring social injuries of race, class, and gender (Friedman 2002).

I will revisit these theories in the pages that follow, but I first want to return to Sedgwick’s assertion that addictions are “everywhere proliferating” because it offers us another way to think about the addiction explosion—that is, as an expanding trope for reinterpreting social problems. As addiction has become a more common experience, so too have the logics of addiction gained deep cultural resonance. From mainstream talk therapies to more controversial, fringe approaches like “ayahuasca retreats,” more Americans than ever are finding themselves in treatment searching for answers to the problem of addiction. Since the introduction of its Twelve Step philosophy for treating alcoholism in 1935, the wildly popular Alcoholics Anonymous program has grown to become the largest self-help movement in the world (White 2004). Treatment goers are finding refuge in rehab’s logics—which provide explanations for the painful failures of their past and guides toward a better (sober) future. For many Americans, claiming an addiction is no longer an act shrouded in shame and secrecy. From A&E’s long-running series *Intervention* to VH1’s *Celebrity Rehab*, the amazing growth of reality television shows portraying compulsive behavior have heightened the visibility of addiction, suggesting a cultural fascination with the addiction trope.

One way of seeing the incredible rise of addiction as a kind of “commonsense” is to chart the explosion of addictions in academe. A key turning point came in 1990, when the notion of the “non-chemical” addiction gained wide acceptance among scholars and practitioners alike (Marks 1990). Addiction had long been recognized as a formal

medical disorder, but this shift was significant because it legitimized the severing of addiction from substance, meaning that many more people could be—and probably were—addicts. “Addiction” had become a vacuous, free-floating concept that could be used to understand virtually *any* human problem. Sex and gambling were the first “problem behaviors” to be recognized. Since then, internet addiction (Griffiths 2000), video game addiction (Fisher 1994), “workaholism” (Spence and Robbins 1992), shopping addiction (Hartston 2012), phone addiction (Billieux et al. 2014), television addiction (Sussman and Moran 2013), and even “love addiction” (Schaeffer 2009) have all been cited as legitimate conditions. In 2013, the DSM-V included behavioral addiction in their diagnostic schema, and by then, the burgeoning field of “behavioral addiction studies” needed its own journal (APA 2013). In *The Journal of Behavioral Addictions*, scholars have spared no human activity, writing about the emergence of exercise addiction (Egorov and Szabo 2013), cybersex addiction (Schiebener, Laier and Brand 2015), “clairvoyance addiction” (Ágoston 2015), Facebook addiction (Ryan et al. 2014), and even (seriously) addiction to the Argentine tango (Targhetta, Nalpas and Perney 2013). The journal recently began questioning the legitimacy of its own endeavor when it published an article critiquing the more than ten-fold increase in academic papers published on behavioral addictions since 1990. It was a sign, they feared, of the “possible unlimited identification of new addictions” (Billieux et al. 2015).

The Crisis of Legitimacy in Addiction Science

Each new proliferation of addiction seems to bring with it a new understanding of what causes the affliction. The overwhelming majority of those who engage in drug use, drinking, or gambling—an estimated 85%-- never become addicted (Grim 2010, Hart 2013, Inciardi 2008). But for those who do, what explains their trajectory? The *New York Times* posed that question to six experts in 2014, and perhaps not surprisingly got six different answers spanning poverty, personal choice, spirituality, and genetics (David Sack 2014, Raikhel 2015). One might say that addiction science is experiencing a growing “crisis of legitimacy.” The slew of recent academic studies, op-eds, essays and think pieces published on the topic point to an emerging heterodoxy in the field, and the

debate begins with basic terminology. Lack of consensus on what constitutes criteria for addictive disorder plagues the studies that attempt to measure its prevalence.² At what point does “use” turn into “harmful abuse,” versus dependence or full-blown “addiction?”³ Indeed, addictions have been “proliferating” in part because the concept keeps expanding to include an ever wider range of human habits, behaviors, and relationships (Alexander 2008).

There remains little to no agreement among specialists across the field as to what, exactly, addiction *is*. No studies have yet found universal differences between addicts and non-addicts, and none have predicted relapse or recovery accurately based on brain factors. The serious lack of consensus over what causes and constitutes addiction means that “recovery” takes shape in many varied forms. Still, American rehab is overwhelmingly based on three primary assumptions: that addiction is a disease of the brain, that recovery requires life-long abstinence from drugs and alcohol, and that addicts need professional guidance to recover. The American Psychological Association and the American Medical Association have institutionalized these standards, and the National Institute on Drug Abuse has legitimized and professionalized the notion that addiction is a brain disease (Courtwright 2010). Yet the rising swell of other voices in the debate—and the lingering presence of crucial questions—suggest that our understanding of addiction is far from settled. The various actors vying for ideological “ownership” over addiction have homes in medicine, public health, criminal justice, religion, economics, sociology, philosophy, history, anthropology, psychology, psychiatry and social work (Lilienfeld and Oxford 1999, Zieger 2001).

Recently, a number of competing logics have worked their way into mainstream public dialogue, and they seriously undermine both the biomedical “disease theory” and the much older truism that recovery requires sobriety. The “maintenance” movement, for example, directly attacks a central tenet of AA doctrine—that lifelong abstinence from

² For accounts of how the *Diagnostic and Statistical Manual*, the health practitioner’s “bible” for diagnosing addiction, has dramatically changed the classifying criteria with each new publication of the volume, see: O’Brien, Charles. 2011. “Addiction and Dependence in Dsm-V.” *Addiction* 106(5):866-67.

³ For a helpful clarification that I think is successful in sorting out this mess, see Bruce Alexander’s typology of drug harms in *The Globalization of Addiction*.

drugs and alcohol is the only cure for the perpetually powerless addict. The notion that addicts can learn to manage their drug use in incremental steps is a guiding principle of the much larger harm reduction paradigm—a broad spectrum of policies and practices that challenge the conventional wisdom of abstinence, and in some forms abandon it altogether for a “radical politics of junkiehood” (Roe 2005). Recent work goes even further, questioning the underlying rationale of the disease theory and arguing that conceiving of addiction as a brain disease is inaccurate, ineffective, and even actively harmful for an addict’s self-concept (Lewis 2015).

Many of the current critiques of addiction science rally around destabilizing the hegemonic power of Alcoholic Anonymous as the go-to treatment approach (Dodes and Dodes 2014, Fletcher 2013). By one study’s estimation, 95% of American addiction treatment professionals refer patients to Twelve Step meetings or otherwise incorporate AA philosophies into their program design, despite a considerable lack of evidence that these programs produce meaningful results. A meta-review of “evidence-based” studies of AA and Twelve Step programs conducted from 1966 to 2005 concluded that “no experimental studies unequivocally demonstrated the effectiveness of AA” in treating alcoholism (Ferri, Amato and Davoli 2006). The April 2015 issue of *The Atlantic* featured a story by Gabrielle Glaser titled “The Irrationality of Alcoholics Anonymous” in which Glaser cited an estimate from psychiatry professor Lance Dodes that AA works for “five to eight percent” of those who use it (Dodes and Dodes 2014, Glaser 2015). Yet Twelve Step models are typically the sole or most substantial components of the commonly recommended treatment programs in the country. Despite the shadow of doubt cast over the effectiveness of AA, my own fieldwork in Minnesota’s treatment scene confirmed that Twelve Steppers are not particularly tolerant of “non-believers.” People who claim to have recovered on their own (or without a structured program) are viewed with skepticism, inspiring the pejorative term “dry drunk.” Any insistence that one can stay sober without attending a Twelve Step meeting is often regarded as a form of “denial” by longtime devotees (Laudet 2003). Backed by science or not, AA continues to attract and retain members—an estimated 1.2 million people belong to one of the 55,000 meeting groups in the US (Koerner 2010).

The overwhelming focus on talk within American rehab is peculiar to say the least, given that NIDA's brain disease theory is widely regarded as the best addiction science we have. The treatment industry's failure to offer solutions that deal with the bodily, biochemical aspects of addiction has been questioned in several popular think-pieces on the topic (Glaser 2015, Hill 2015, Koerner 2010, Miller 2015). As the logic goes, if addiction really "hijacks" biochemistry and incapacitates the brain, then why aren't more treatment providers using the best available medical therapies? Today, those would include buprenorphine, naloxone, and naltrexone-- medications that either reverse overdose, block the effect of drugs on key neurotransmitters, or substantially reduce cravings. But mainstream rehab has mostly ignored, and in some cases actively resisted, reliance on "pharmacotherapies" in their programs.⁴ Instead, they cling to Alcoholics Anonymous' injunction to live life "one day at a time," and instruct their clients to "submit to their higher power." They warn against the dangers of "stinking thinking" and extol the virtues of "right living."

It is not just the Twelve Step tradition, but the whole endeavor of rehab that is being questioned. As the public health crisis of addiction escalates—and as more criminal justice reform advocates embrace medical understandings of drug abuse-- policy makers are taking a closer look at the treatment world, finding there is often little connection between how programs advertise their models and how they actually put those philosophies into everyday practice. The massive disconnect between the science of addiction and the practice of recovery can be seen as an outgrowth of how the larger treatment field is organized. Compared to other recognized medical conditions, treatments and therapies for addictions are highly unregulated and private facilities are virtually unmonitored. The fact that rehab is now a booming industry only exacerbates these trends as private practitioners look to capitalize on increasing demands for treatment. Growing profits in the treatment industry inspired a recent documentary entitled *The Business of Recovery* that indicts American rehab as "modern

⁴ I explore in later chapters how this began changing during the course of my research. Although still a contentious decision, more recovery programs are now incorporating therapies like suboxone in response to the recent national heroin epidemic.

pseudoscience” for its lack of regulation, high costs, unproven standards and dismal outcomes. Resort-like facilities promising life-changing experiences in extravagant settings charge fees that exceed tens of thousands of dollars per month, but fail to deliver the as-advertised results. The film portrays families desperate to find help for members struggling with addiction depleting their life savings or in some cases acquiring high-interest loans to finance the cost of treatment, only to see their loved ones relapse or worsen soon after discharge (Finberg 2015).

State funded programs in the non-profit sector are not immune to these trends. While residential treatment programs (or any programs that receive public funding) are required to achieve licensure and certification, in-practice standards vary widely and many programs offer a patchwork approach designed to attract the most clientele. In an atmosphere of scarce funding, programs compete for the biggest piece of recovery’s “target population.” Backed by state dollars, their funding ties them to the adoption of particular “evidence-based” practices. But while they might pay lip service to NIDA’s brain disease paradigm, in practice and on the ground, treatment is often a highly localized, eclectic, unmonitored and moralistic endeavor (Tiger 2012, Whetstone and Gowan 2011).⁵ This is due, in part, to the fact that rehab might be the only realm of medical practice where treatment is commonly administered by untrained, non-professional staff. A holdover of AA’s “self-help” culture, former addicts just out of treatment themselves often move into staff or leadership positions with little to no oversight. This lack of regulation extends beyond the spaces of formal rehab out to the much larger networks of sober houses, “¾ houses,” and other forms of post-treatment transitional living. The “sober living” industry is perhaps the most egregious example of “anything goes” addiction treatment. In some areas, sober housing is run largely by non-credentialed former addicts—and with poor living conditions and close proximity to

⁵ Kentucky drug courts, for example, have recently come under fire for refusing to allow patients to use medication-assisted-therapies (MATs) in their treatment programs. A number of exposés target drug court’s lack of professionalism, scientific rigor, and medical standards—questioning the role of judges as pseudo-doctors. A recent ruling requires drug courts that accept federal funding to allow the use of MATs in their programs. See, for example: Cherkis, Jason. 2015. "Dying to Be Free: There’s a Treatment for Heroin Addiction That Actually Works. Why Aren’t We Using It?" in *Huffington Post*.

active drug markets, they can be downright dangerous for recovering people (Fairbanks 2009).

Perhaps the greatest threat to rehab's legitimacy is that it so often fails to deliver its promised cure. While more Americans are investing in rehab, a surprisingly small number of addicts who receive formal treatment will actually recover from their addictions. The National Institute of Drug Abuse estimates average failure rates at upwards of 60% (NIDA 2012). Those might be conservative estimates. As I discovered in my work on this project, comprehensive data sources on recovery programs are hard to come by, and independent evaluation studies are rare because most programs don't track their own participants after treatment. Meanwhile, an emerging body of literature is claiming that many addicts recover just fine without ever attending rehab (Granfield and Cloud 2001). Recent recovery data, including the National Epidemiologic Survey on Alcohol, claim that up to three-quarters of addicts and alcoholics will get well on their own without any professional help at all (Lewis 2015). But the numbers ultimately carry little meaning because experts mostly disagree on how to measure recovery—or even what it is. Is recovery merely the cessation of drug or alcohol use? Is it the added presence of other psychological, social, or economic factors? Is recovery a period of abstinence, or does it require lifelong sobriety? Does one drink signal a slip back into darkness, or is “relapse a part of recovery?”

The “Two-Track Treatment System”

Rehab's Rise

Despite rehab's failures and crises, Americans keep renewing their faith in its power as panacea. The numbers entering rehab have remained relatively stable for the last decade or so, after steady increases since mid-century (SAMHSA 2014). Recent trends indicate that treatment admissions will continue to escalate. Rising rates of addiction, changes in healthcare funding, the expansion of treatment services, and the vast medicalization of social problems under the conceptual framework “addiction” are making treatment more vital and more accessible than ever. Spending on drug treatment has more than doubled since the mid-1980s, and by 2003, over three-quarters of all rehab

admissions were financed by the state (Levit et al. 2008, Mark et al. 2007). Healthcare reform under the Affordable Care Act, which requires many government-subsidized health plans to cover treatment, promises to dramatically expand the numbers of Americans who can afford to go to rehab. Some estimates put it at roughly 5 million, the largest expansion of treatment services in US history. Even with these projected increases, researchers claim that demand will far outstrip supply. The National Center on Addiction and Substance Abuse estimates that 40 million Americans meet the clinical criteria for addiction, but only 1 in 10 have ever received any form of treatment (CASA 2012).⁶

The Two-Track Split

If rehab is expanding, it is not taking shape in the same ways across the American population. This dissertation was inspired by the insight that there are enormous differences in how addiction recovery is experienced and understood across the structures of class, race, and involvement in the criminal justice system. Since the dramatic growth of alternatives to incarceration for drug crime in the 1980s, the treatment field has been shaped by a “split” between private-pay and health-insured programs frequented by the nation’s working and middle-class addicts-- and publicly-funded treatment heavily backed by the criminal justice system which is more commonly administered to the poor and people of color.⁷ The resulting divide—termed the “two-track treatment system”—entails shifts not only in form, but also in content. The highly medicalized “Minnesota Model” approach based on psychotherapy, Twelve-Step philosophy and medication to heal past trauma is usually what conjures up “rehab” in the popular imagination. Yet the Minnesota Model is a form of recovery that has been more widely associated with middle-class, and increasingly working-class, addicts. On the other hand, rehab for poor Americans and people of color is increasingly coercive rehab—mandated by the courts,

⁶ By current clinical criteria, that’s a conservative estimate—an additional 80 million people in the country are classified as “risky substance users,” meaning that while not officially “addicted,” they nonetheless “use tobacco, alcohol and other drugs in ways that threaten public health and safety” (CASA 2012).

⁷ After healthcare reform under the Affordable Care Act, poor and working-class Americans are expected to have expanded access to rehab outside publicly funded and court-mandated forms.

heavily monitored, and backed by the threat of incarceration. Drawing heavily on the “therapeutic community” model, court-mandated rehab has quite different objectives, with its primary focus on mutual surveillance and strict bodily discipline to accomplish moral reform.

Together, the Minnesota Model and court-mandated rehab represent two dominant “recovery paradigms” in the US, and they cater to two very different “target populations.” In this dissertation, I examine the two-track treatment system through a comparative ethnography of two typical programs in the state of Minnesota, humorously referred to as “the land of 10,000 treatment centers.”⁸ The birthplace of the apt named “Minnesota Model” is also home to a network of county drug courts that have become national exemplars, affording its reputation as the country’s “recovery capital.” For this and other reasons that I will address in the pages that follow, Minnesota is an ideal place to study addiction treatment. In this project, I ask questions about how Americans with different class and racial backgrounds, and with different levels of involvement with the criminal justice system, experience rehab. How do participants in these very different models come to understand their addictions, and how do they experience the recovery process?

The Middle-Classing of the Medical Model

Changes in managed care, the rise of corporatized medicine, and the burgeoning pharmaceutical industry have widened disparities in the availability and quality of treatment programs nationally (Rose 2003). The privatization of rehab had long been shifting treatment resources to those Americans with the best health insurance and those who could afford to pay out of pocket for lengthy residential stays. Long-term residential programs designed to stretch across several months were once the gold standard for both Twelve-Step and therapeutic community models-- two of the most widely disseminated forms of addiction treatment in the U.S. But transformations in the provision of

⁸ I discuss my case selection, the research design, and other methodological concerns in much more detail in Chapter 2 and in the Methods Appendix.

healthcare standardized the brief “28-day” inpatient program and the much more commonly used outpatient therapy as the models that Americans are most likely to encounter today.⁹ Of the 15,000 rehabilitation facilities in the country, the vast majority—81%-- are outpatient (CASA 2012).¹⁰ During the 1990s, more than half of all residential treatment centers in the nation closed their doors and many of the leading private facilities stopped accepting insurance, opting instead to target the upper-class with “destination rehab” modeled on a vacation resort experience (Worley 2006). What technically resulted was a “trifurcation” of the treatment industry-- into coerced and highly monitored inpatient rehab for the poor, flexible outpatient with limited inpatient rehab for the middle-class, and luxury resorts for the very rich. For working-class and middle-class addicts, extended residential immersion became an increasingly rare experience, as insurance providers opted to cover only brief outpatient programs or office visits (Hanson 2003).

Alcoholics Anonymous helped to destigmatize addiction for the more affluent with its “allergen theory”-- a sympathetic view that alcoholics should be treated as people who were suffering from chronic, relapsing illnesses. Those earlier understandings evolved into today’s fully developed “brain disease theory”—which, along with Twelve Step culture, cognitive-behavioral therapy, psychotherapy, and the 28-day program are among the hallmarks of contemporary addiction treatment. Taken together, they are common elements of the nationally diffused “Minnesota Model” (MM). Integrating recovery with everyday work and family life, Minnesota Model programs fuse biomedical knowledge of addiction-as-brain-disease with Twelve-Step philosophies and popular psychology to address past trauma.

Rehab in the popular imagination looks like the Minnesota Model. It provided the blueprint for nationally recognized names like Hazelden and Betty Ford, it is depicted on popular television shows like A&E’s *Intervention*, and it is referenced in bestselling

⁹ In Minnesota at the time of my study, many adults who lacked insurance also had incomes too high to qualify for public treatment funds. The American working-class and working poor were often the most unable to access services, but are estimated to have the greatest need for treatment (NIH 2013).

¹⁰ The remaining 26% are residential (inpatient) facilities and inpatient hospital treatments comprise 6% (SAMHSA 2014).

books like *A Million Little Pieces* and *Dry* (Burroughs 2013, Frey 2003). Although its cultural references are quite diverse and eclectic, it is a model that primarily constructs addicts as sick people who are deserving of help and sympathy, rather than morally weak or “bad” people. In this sense, MM treatment can be read as a product of “medicalization” in the classic sense—the process by which previously stigmatized or moralized identities or behaviors come to be seen as treatable medical disorders (Conrad 1992).

Strong-Arm Rehab as Poverty Management

The American poor, and especially people of color, were encountering a very different kind of rehab. Extended residential treatment became widely available for the poor as a publicly funded, court-mandated form of rehab backed up by the threat of reincarceration. Coercive treatment is a rapidly expanding “commonsense” method for treating addiction. Today, more than seven million people are currently under correctional supervision (Tiger 2011). At least one-third of all treatment slots — and in many programs up to 80 percent — are occupied by people whose only other alternative is prison (TEDS 2014).

America has always oscillated between criminalizing, prohibiting or punishing drug use and conceptualizing it as treatable condition that should be met with sympathy and rehabilitation (Musto 1973). Since drugs were established as “public enemy number one” by Nixon, the state has increasingly amped up its punishment of suppliers and users in its trillion-dollar drug war. But in the wake of the damage caused by America’s failed war on drugs, politicians and public health professionals began calling for treatment instead of prison, scaling back the country’s decades-long “tough on crime” approach for what is seen as a more humane, rehabilitative alternative. Pushing a “21st century approach to drugs,” the Office of National Drug Control has earmarked funding for drug education and prevention, dramatically expanded alternatives to incarceration for drug crime, and increased funding for rehab programs. With the expansion of probation, the “drug court” movement, and other alternatives to incarceration, the criminal justice system became the largest single referral source to publicly-funded treatment, coercing

more Americans into a form of rehab characterized by rigorous cognitive and behavioral modification, and careful criminal justice monitoring both during and after treatment (Gowan and Whetstone 2011, Marlowe, DeMatteo and Festinger 2003, SAMHSA 2008, Tiger 2011).¹¹ Nearly half of all the patients in the country’s outpatient programs and 36% of residential patients are now referred by the criminal justice system (SAMHSA 2014).¹²

As “problem-solving courts” have expanded across the nation to address drug addiction and other social issues, legal scholars have warned of their potential “net-widening” effects (Hoffman 2001, Nolan 2001). With a zealous mission to “treat the whole person,” both court professionals and law enforcement officials see these interventions as magic-bullet solutions for a whole host of social problems, eagerly casting a wide net of correctional control and surveillance over minor offenders who may have previously escaped processing through the system. In addition to widening the net of correctional control, drug courts have also been criticized for significantly extending sentence lengths and requiring a high level of intrusion into clients’ lives for relatively minor crimes (Belenko 2001, Burns and Peyrot 2003, Fischer 2003, King and Pasquarella 2009, Marlowe, DeMatteo and Festinger 2003).

Court-mandated rehab can be read as an inflection of the neoliberal era’s simultaneous rollback of social services and strengthening of the state’s “right arm.” Recent work on the relationships between punishment, disadvantage, and neoliberal social policy reveal that correctional institutions are “punishing the poor” as they replace the welfare functions of the state (Wacquant 2008). At the same time, existing welfare policy has taken on a paternalistic character that is not only punitive but also highly disciplinary (Soss, Fording and Schram 2011). Rehab backed by the carceral state—what Teresa Gowan and I have termed “strong-arm rehab” in previous work— has thus taken on new importance in the management of social marginality. It is also a form of rehab that departs considerably from the Minnesota Model (Gowan and Whetstone 2012, Whetstone and Gowan 2011). The drug diversion movement in criminal justice is based

¹¹ There are now more than 2,700 drug courts in counties across the nation.

¹² About 29% of addicts report *voluntarily* checking into long-term residential facilities (SAMHSA 2014).

on the belief that many non-violent crimes are the product of offenders' underlying and unaddressed addictions (Hora 2002). Yet these “hybrid” therapeutic-punitive programs never completely erase the stigma of criminality. Far from offering reprieve for those marked with the criminal label—I argue here that through its association with criminality, strong-arm rehab instead amplifies and intensifies the stigma of addiction. Strong-arm rehab constructs the addict as a decidedly *criminal*-addict. It is a form that draws heavily on the “therapeutic community” model, which began as an offshoot of AA, but was later developed specifically for use in criminal corrections. Its characteristic elements are mutual surveillance, an intensely confrontational therapeutic style, and strict behavioral and moral reform. As I show in the pages that follow, strong-arm rehab focuses less on treating the patient than it does on taming the criminal-addict.

Study Design, Case Selection & Methodology

How did a “two-track” treatment system evolve, how does it shape our understanding of addiction, and how does it shape the experience of rehab for the millions of Americans in recovery? What are the implications of the fact that poor Americans and people of color are more likely—by virtue of their higher representation in the criminal justice system-- to be *coerced* into rehab by the state? If rehab so often doesn't work to cure addiction, how else might it be “working” in the lives of addicts from different social backgrounds?

In this dissertation, I explore these questions through a comparative ethnographic and interview study of two programs in Minnesota that reflect rehab's national divides. To examine the two-track treatment system, I conducted nearly three years of comparative ethnography and interviews at Healing Bridges and Arcadia House. At Healing Bridges-- a 28-day, Minnesota Model residential and outpatient program with a highly developed Twelve Step culture-- I encountered mostly white working-class and middle-class addicts who had considerable social and economic supports.¹³ At Arcadia

¹³ Names of rehab facilities and some of their descriptors have been disguised to protect the confidentiality of my research participants.

House, a residential therapeutic community and “strong-arm” rehab, I met mostly unemployed men living beneath the federal poverty line who were court-mandated to attend nearly four months of inpatient treatment followed by 6 months of mandatory “aftercare.” Nearly half were African American, and many were “serving time” in the program for low-level drug offences.

This dissertation is about the treatment experiences and perspectives of the roughly 100 men that appear regularly in my interviews and field notes.¹⁴ Using a combination of ethnography, life history interviews, and discourse analysis, I examine the very different pathways that routed them into treatment-- and how they came to understand their lives in rehab.¹⁵ Discovering precisely *what* you are studying is often one of the exciting conclusions of research itself (Ragin and Becker 1992). I selected the cases for my comparative ethnography with the aim of better understanding my original theoretical interest-- the uneven terrain, both in form and content, of addiction treatment across social space. In this sense, I pursue a “narrative analysis,” which is usefully described by Howard Becker as “the story of how something inevitably got to be the way it is” (Ragin and Becker 1992).

The data collection and theoretical aims of the project can be roughly divided into two main parts. In various stages from 2009 to 2014, I conducted in-depth ethnographies of the men’s inpatient treatment programs at Arcadia House and Healing Bridges to examine the very different approaches of Minnesota Model and strong-arm style rehab.¹⁶ In this part of the project, I aim to sketch out the “treatment logic” of each model—that is, the operating discourse which establishes the causes and consequences of addiction, specifies who the addict *is*, and charts the appropriate course of treatment. I knew that these programs were differently organized, but to what extent were they based on

¹⁴ I encountered many more men over the course of the study—hundreds—but my analyses focus mostly on the one-hundred I was able to develop more sustained contact with in the field, or conduct a formal interview with. Of course, far fewer voices actually appear in the dissertation due to space limitations.

¹⁵ While my project is fundamentally a “cross-class” comparison, as you will see in the methods section, the participants in my field sites are also polarized in terms of race and institutional background. I examine how *multiple layers of social difference* shape addiction and recovery, so I use the term “social location” throughout as shorthand.

¹⁶ For an in-depth discussion of why I chose to focus on men and why I chose to examine inpatient rehab in both cases, see Methods Appendix.

different assumptions about the populations they served? To what extent, or how, did they offer distinct “logics” of addiction and recovery? And how were these logics put into therapeutic practice by staff and participants? How did participants make sense of their own therapeutic encounter? How did the programs encourage participants to interpret their life or narrate their experience? If rehab wasn’t working to cure addiction, how was it accomplishing other kinds of work?

To explore these questions, I observed every aspect of programming I could get access to—main group therapy sessions, lectures and presentations, AA or NA meetings, post-treatment “aftercare,” recreational outings, staff meetings, one-on-one counseling sessions, family visits, graduation ceremonies and unstructured “hanging out” time. During therapy sessions, I was more on the observer side of the participant-observation spectrum—I generally didn’t participate in therapy unless I was called upon, although I did participate in certain ceremonial aspects like sitting in the group circle and joining in the Serenity Prayer.

Outside of the formal spaces of therapy, I was much more involved with participants. I talked with them during lunch and on smoke breaks, and I engaged in countless informal conversations with them in between therapy sessions. For those in the study who weren’t court ordered to stay at the facility, I sometimes offered to give them rides to and from AA or NA meetings. After the residential portion of treatment, I tried to keep in contact with some of the men by meeting them for coffee or joining them in the aftercare program. In a few cases, I did form more lasting bonds with participants and I was graciously invited to their family events, birthday celebrations, or graduations from other treatment programs. In addition to observing these aspects of programming and some limited observation of life after treatment, I also collected and analyzed worksheets, key texts, therapeutic manuals, videos, and other treatment literature that clients were exposed to.

I documented my observations whenever I could immediately after leaving the field, either by recording my field notes or typing them up directly. Fearing it would be too intrusive in the therapy process, I opted not to ask for permission to audio record group or individual therapy sessions. I did, however, carry a small notebook at all times during

my fieldwork so I could fit in the classic “jottings” whenever possible. As I explore in detail in later sections, I soon became aware that much more was at stake in rehab than kicking addiction. Rehab was a site where participants actively produced new “selves” in line with the program’s treatment logic, and where they learned to individualize and pathologize their social suffering in different ways.

In the second part of the project, I draw on approximately 70 in-depth, “life history” interviews with men participating in the residential programs at Arcadia House and Healing Bridges.¹⁷ I conducted an additional ten formal interviews with program directors and with each counselor whose therapy sessions I observed. I also conducted supplementary interviews with treatment professionals from across the field to better understand how each program fit within the larger constellation of local service providers. The life history interviews with rehab participants were 1.5--3 hours in length, and they were designed to gain a broad sense of how drugs fit into the rhythm of their daily lives, how their addictions progressed, the different pathways that routed them into treatment, and how they made sense of their own recovery process. My aim here was to use my access to addicts from different class, racial, and institutional backgrounds as a window into how various social factors shape the patterns of drug consumption. Rather than seeing the treatment process—and the participants—as disconnected from social context or disembodied, the interviews allowed me to both contextualize and deepen my analysis by considering who my research subjects were before entering treatment, and how that might be impacting their experience of the recovery process. How did access to social, economic, and cultural capitals shape participants’ addictions—and their responses to treatment?

The interviews were also crucial supplements to my ethnographic analysis because they allowed me to question participants about events that had occurred during the program, or probe deeper into their thoughts or reactions to particular elements of therapeutic process. Perhaps most important, they provided some necessary distance from the watchful eyes of counselors and staff, and from the pressure the program

¹⁷ For a detailed discussion of this process, again, refer to the Methods Appendix. You can also view a copy of my interview guide in the attached Appendix.

imposed on participants to “talk the talk.” For these reasons, I waited to conduct an interview until I’d had the opportunity to observe someone for several weeks and work on building trust and rapport.

While I was not able to follow these men very far outside the spaces of rehab, I talked to them at length about their lives, their addictions, and their past attempts to stay sober in the interview portion. I saw them when they returned for outpatient therapy after the residential phase-- as they struggled to return to work or find any work at all, meet legal requirements, or reestablish bonds with family—and avoid drugs. So while I spent far less time than I would have liked with participants outside official institutional spaces, I do have some sense of how they fared, or how they might have fared, in life “on the other side.”

Governing the Addict: Theoretical Anchors

Making the Self in Modernity

If rehab doesn’t often “work” to cure addictions, perhaps we continue to believe in it because it accomplishes other kinds of work. It was immediately clear in my fieldwork for this project that rehab was about so much more than kicking drugs or alcohol. As they struggled to transform their lives, the men in my study embarked on a project of self-reconstruction-- one which called on them to make sense of their pasts through new frameworks. While their struggles to transform themselves were sometimes successful and other times met with heart wrenching failure, there is no question that their efforts to change in the face of often insurmountable odds were truly valiant.

Scholars point to the “therapeutic turn” as a crucial shift in cultural conceptions of selfhood. Traditional sources of the self—work, family, and religion—have given way to a “therapeutic culture” emphasizing the reflexive turn inward, personal psychic development, and mastery of individual cognitive and emotional obstacles (Bellah et al. 1985, Foucault 1975, Giddens 1991, Illouz 2008, Martin 2007, Nolan 1998, Rieff 1987, Silva 2013). Talking and “telling one’s own story” are crucial acts in the therapeutic turn, and because storytelling requires a witness who recognizes and validates self-expression,

self-making is ultimately a deeply social and interactional accomplishment (Taylor 1989). In one reading of the therapeutic exchange then, telling one's story to a witness is central to human recognition, dignity, validation, and respect (Davis 2005, Silva 2013). More critical interpretations locate therapy in a field of unequal power exchange. For example, sociologists have argued that the individualism of therapy undermines social and cultural membership (Bellah et al. 1985, Rieff 1987), legal scholars have analyzed how therapeutic logics are transforming the values of traditional justice (Nolan 2001), and cultural theorists have studied how professional and popular notions of "self-help" construct the practical categories of cultural meaning that we use to make sense of our world (Illouz 2008).

Probably the most influential body of work in the critical tradition has been that of Michel Foucault, who analyzed the constitution of power through the management of "docile bodies" and the making of delinquent subjects in the earliest prisons (Foucault 1975). One of Foucault's most essential contributions was to demonstrate how the prohibition and policing of behavior is *productive*, calling forth a confession-- an "infinite act of telling"-- which works to modify desire through the construction of subjectivity and the practice of self-regulation (Foucault 1978). Scholars of "governmentality" have observed that the dominant discourses of psychology and psychiatry enact governmental power by producing citizens who self-reflect and self-regulate in particular ways. Nikolas Rose, for example, argues that the expanding "psy disciplines" increasingly do the work of governing subjects through the power afforded to professionals in the therapeutic encounter (Rose 1990, Rose 1998, Rose 2006).

In the pages that follow, I build on these interpretations by drawing attention to rehab as a space where addicts engage in the work of reframing narrative, identity, and experience in line with the logics of addiction and rehabilitation. As E. Summerson Carr argued in her ethnography of an addiction treatment program for homeless women, rehab might have more power to reorient the way one talks and thinks about addiction than to cure addiction itself (Carr 2010). I argue that rehab is not just an opportunity to heal suffering, a clinical approach, or a kind of "medicine"-- but that it constitutes an important, yet understudied, project in contemporary governance.

I analyze the “treatment logics” of Minnesota Model and “strong arm” as complementary and contradictory strands of addiction *discourse* that are circulating within American rehab. Borrowing from Julie Bettie, I define discourse as “ways of giving meaning to the world which imply differences in the organization of social power” (Bettie 2003). Discourse carries cultural force because it is always *materialized* in practice-- working to organize, and thus on some level constitute, action (Mouffe 1979). I see rehab then as a collective endeavor that works both to produce categories of social difference and to reaffirm shared moral sensibilities (Erikson 2005, Foucault 1975).

Governing the Addict & Shifting Governmentalities

Sociology’s classic statements on self-making have overwhelmingly focused on middle-class depictions of “the self” (Taylor 1989).¹⁸ Similarly, much of the governmentality literature lacks any class analysis at all, implying that broad models of self-management are widely diffused throughout the population and working to produce homogenous effects. For example, I made this critique in previous work with Teresa Gowan and Tanja Andic when we analyzed the messages of self-management circulating in a harm reduction needle exchange program that provided clean syringes, medical help, and non-judgmental support to a group of active drug users (Gowan, Whetstone and Andic 2012). Governmentality scholars have critiqued harm reduction interventions as collapsing neatly into the broader neoliberal projects of individual “responsibilization” and risk management (Moore and Fraser 2006). But at Connection Points, the Midwestern needle exchange we studied, discourses of “self-management” were used to construct radical autonomy-- and an emergent political solidarity-- among poor, marginalized participants who routinely discussed ways to counter the structural violence inflicted upon “junkies.”

Theorists often apply Foucauldian conceptions of power in broad strokes, seeing them as eras that phase in and out rather than simultaneous inflections of modern life.

¹⁸ A recent corrective to this is Jennifer Silva’s phenomenal work *Coming Up Short*, which examines therapeutic self-making as a central preoccupation for working class young adults (Silva 2013).

The “disciplinary era” with its focus on “docile bodies” and centralized institutions of control gradually moved into the “biopolitical era” with its more decentralized elicitation of desire. While disciplinary power sought to manage individuals through monitoring and shaping their behavior more directly, biopower accomplished a deeper internalization of power through the harnessing of desire and purpose within self-managing individuals (Foucault 1975, Foucault 1978, Foucault 1980, Foucault 1985, Foucault 1988, Foucault 2008). To better understand rehab as a form of social control, I apply these notions of power as various iterations that are always present, yet differentially mobilized across the categories of class, race, or gender. The question is not so much “Which kind of power prevails?” as “When, where, and how does power produce (classed and raced) subjects in particular ways?” In examining rehab across social space, I analyze the “shifting governmentalities” of the neoliberal state-- particularly in terms of how ground-level criminalization and medicalization processes are enrolled in broader projects of social control. I hope to show how the pathologization of both poor, working *and* middle-class addicts in rehab is connected to shifts and divides in contemporary forms of governance.

To accomplish this, I build on several key critiques of addiction treatment. Observing the stronger association of Alcoholics Anonymous with more advantaged Americans, Kathryn Fox argues that treatment models contain crucial assumptions about the target populations they aim to treat. With its more voluntary and autonomous character, drug counselors and medical professionals assume that Alcoholics Anonymous is a good “fit” for middle-class addicts mainly because they assume that self-control is a “middle-class virtue” (Fox 1999). On the flip side—and like ethnographer Phillippe Bourgois-- Fox sees the micromanaging and often degrading character of the methadone clinic as an enactment of disciplinary power on the bodies of mainly poor addicts (Bourgois 1998, Bourgois 2000, Fox 1999).

While several theorists have applied Foucault fruitfully in studies of drug rehab, very few use a governmentalities framework in a cross-class comparison. A recent New York study compared the use of methadone maintenance therapy in urban, poor, Black and Latino communities with the use of the synthetic opioid replacement drug buprenorphine in white, middle-class suburban communities. The authors found that

buprenorphine and methadone treatment rates were significantly correlated with the ethnicity and income characteristics of ZIP codes—buprenorphine treatment rates were highest in the areas with the lowest percentage of Black and Latino residents, while methadone rates were highest in the areas with the most Latino residents and the lowest income levels. Calling this an instance of “two-tiered biomedicalization,” the authors argue that these different addiction therapies reach different “target populations” precisely because they seek to manage and control addicted bodies in different ways (Hansen and Roberts 2012, Hansen, Bourgois and Drucker 2014, Hansen et al. 2013).

Methadone is a highly monitored and controlled heroin replacement therapy that is dispensed only out of a dedicated clinic. It also exacts a tougher toll on the body, and is regarded as more difficult to kick than heroin. While some addicts can “earn” the right to take multiple doses home, their movements are highly restricted because they generally have to report to the clinic each day. When they do so, they can be interrogated by clinic staff or denied the drug for a variety of reasons, and withdrawal is an extremely painful and physically debilitating experience (Bourgois 2000). Buprenorphine offers more “freedom”—both biochemically because it is easier to quit, and because addicts can obtain prescriptions for monthly supplies dispensed by doctors instead of methadone clinics.

Like these studies, I analyze my cases as forms of governance that shift when their target populations shift. While the Minnesota Model has its roots in the Alcoholics Anonymous movement that was first created by alcoholics as a “bottom-up” means of self-help, the therapeutic community evolved in its later stages as a “top-down” means for the state to control criminal impulses. The disease concept of addiction can be traced back to the mid-late 19th century when the term “alcoholic” emerged to replace notions of drug use as moral vice. But from the beginning, the concept was differentially applied, with white middle-class opiate users (many of them women) viewed as sick and suffering, and Chinese immigrants smoking opium cast as morally corrupt (Syvertsen 2008). This was the beginning of an early divergence that I intend to more fully trace out in the pages that follow.

The “medicalization thesis” contends that neurobiological conceptions of addiction as a disease have supplanted previous etiologies emphasizing flawed morals and weak will, decreasing stigma while offering the addict reprieve from responsibility for their condition (Conrad 1992). There is certainly evidence that the growth of self-help groups like Alcoholics Anonymous and the “biomedicalization” of addiction did lead to a considerable destigmatizing effect (Conrad and Schneider 1992). Yet, unlike other medicalized phenomena, addiction remains tainted through its intense drug war policing, criminalization, and moral condemnation. Medical models of addiction sometimes work to reinforce and intensify the stigma, especially when layered over other forms of marginality (Buchman and Reiner 2009, Gowan and Whetstone 2011, Reinerman 2005, Whetstone and Gowan Forthcoming, 2011). For example, Teresa Gowan and I argued that the disease concept of addiction was only superficially applied in the process of treatment for poor African Americans at Arcadia House-- but because it provided a scientifically neutral front, it masked underlying projects of moral and racial-cultural reform. In Chapter 3, I explore this idea in much more depth when I examine the rehabbing of *criminal*-addicts.

Importantly, I avoid the reductionist notion that the Minnesota Model is *only* being applied to white, middle-class clientele—or that court-mandated rehab is only experienced by the nation’s poor addicts. Rather, my argument is that the Minnesota Model is influential to the point of being hegemonic. Indeed, few forms of rehab exist that don’t reference the notion of addiction-as-brain-disease or incorporate some aspect of Twelve Step philosophy. Yet, biomedical models are referenced differently in each of the programs I study, sometimes working to intensify blame and stigma when tied to racial identity, poverty, or criminality—and offering limited forms of reprieve when tied to white, working and middle-class men who have been largely insulated from the criminal justice system. Other ethnographers have fruitfully examined how mainstream MM ideologies are applied in the treatment of poor, homeless women (Carr 2006, Carr 2010) and the homeless “dually-diagnosed” population (Weinberg 2005). These studies are important complements to the analysis I present here, as they establish how MM treatment—although associated with the middle-class rehab experience-- is also being harnessed and expressed in various forms of poverty management.

Theorizing Strong-Arm Rehab

While the Minnesota Model is widely diffused in rehab culture, the “strong-arm” model is more firmly tied to the poor and people of color, who are disproportionately represented in the criminal justice system. The affinity between the therapeutic community and criminal corrections is a relatively singular phenomenon. Loic Wacquant has argued that the carceral arm of the state increasingly takes over from the welfare arm of the state in managing the growth of inequality spawned by neoliberal social and economic policy since the 1970s (Wacquant 2008). Court-mandated rehab is one inflection of this phenomenon that has been less explored by theorists of hyper-incarceration. The “strong-arm” of the state does not so much disappear, as it gets shifted into the spaces of rehab—the softer, “fuzzy edges” of the criminal justice system. Stanley Cohen early articulated this idea when he argued that the “community corrections” efforts of 1960s were not a retreat from state control, but a powerfully invisible *extension* of it (Cohen 1985).

An emerging body of scholarship examines the nature and function of these punitive-therapeutic “hybrids,” analyzing the ways in which legal-correctional, therapeutic, and medical discourses intersect both in the correctional system, and in the programs working closely with the courts to deliver the “sentence” of treatment (Gowan and Whetstone 2012, Kaye 2010, Kaye 2012, McKim 2014, Murphy 2011, Murphy 2012, Tiger 2012, Whetstone and Gowan 2011). Drawing from traditions in the governmentality literature, these approaches theorize therapy as a form of social control where subjectivities are produced, harnessed, and worked upon. In one of the first ethnographies of a “strong-arm” rehabilitation program with strong ties to the criminal justice system, Teresa Gowan and I began theorizing Arcadia House—one of the two programs I examine in this dissertation—and the ideal-typical institution at the center of the drug diversion movement (Gowan and Whetstone 2012). Acting as “satellite prison,” the strong-arm’s character is well captured by both Goffman’s classic “total institution” and Foucault’s seminal concept of “disciplinary control” (Foucault 1975, Goffman 1961). Living in bare-bones, dorm-style housing, the men at Arcadia participated in a strict daily

regimen of group therapy, lectures, and chores for six months to one year, in exchange for staying out of prison. The facility's cramped spaces, extreme temperatures, and what some clients called "recycled prison food," made it an uncomfortable place to live for an extended period of time-- a constant reminder that rehab, was in fact, punishment.

While some of Arcadia's features certainly echo the prison experience, its program departed significantly from the "warehousing," anti-rehabilitative qualities attributed to punishment in the tough-on-crime, "New Penology" era (Feeley and Simon 1992, Simon and Feeley 2003). Rather, strong-arm rehab resembled the classic disciplinary institution that Foucault had in mind, producing the recovered subject through transformation of body and mind. The few studies that exist of therapeutic communities illustrate how effective they are as forms of micro-social control and surveillance (Kaye 2012, Skoll 1992). For example, Skoll examined how a strong group identity was constructed and reinforced in rehab by policing residents' "talk," in order to suppress the recognition of social difference (Skoll 1992). In his ethnography of a similar court-mandated therapeutic community in New York, Kerwin Kaye argues that such programs function as "prevocational training," their menial chores and trivial rules designed less to recover drug offenders from addiction than to "reshape participants' habitus for the low-wage labor market, though it is explained in terms of the need for 'right living'" (Kaye 2012).

Others similarly analyze court-mandated rehab as a kind of governmentality, focusing on how such programs police appropriate gender and class performance (McKim 2014), reinforce the values placed on "personal responsibility" (Burns and Peyrot 2003), and construct the moral identities of drug offenders (Mackinem and Higgins 2007). These analyses are complementary in many ways with earlier generations of scholars who focused on the symbolic or constructivist dimensions of drug law and policy. In his analysis of the public anti-drunk driving campaigns in the 1970s, for example, Joseph Gusfield argued that punishing alcoholics enacted "ritual dramas" integral to the maintenance of public moral boundaries (Gusfield 1984).

At Arcadia House, the disease concept of addiction was quickly set aside for a confrontational program of moral and cultural reform. Clients were called upon to mold

themselves in the image of what was referred to by staff as “Joe Taxpayer”—the law-abiding (low) wage earner of mainstream American society (Gowan and Whetstone 2012). The “criminal-addicts” at the center of Arcadia’s reform process were thought to be fundamentally different, defective, and even “un-socialized” people-- justifying the state’s role in the management and correction of large numbers of poor, and especially Black, low-level drug offenders.

Spending time in a “total institution” is a deeply stigmatizing process that can have a number of adverse effects on psychological and social functioning (Goffman 1961, Irwin 1970, Irwin 1986, Sykes 1958, Travis 2002). These obstacles are made more injurious by the fact that institutions often fail to provide people with skills, opportunities, or cultural capitals that could facilitate successful social reintegration (Fader 2008). My study of court-mandated rehab revealed many of the same obstacles that plague prison rehabilitation-- facilities were often understaffed and ill-equipped to help addicts in any truly meaningful ways in their lives on the outside.

My early fieldwork and writing on Arcadia House provided much of the analytic inspiration—and a substantial amount of the data-- for the case comparison I pursue here. Exploring court-mandated rehab prompted me to ask questions about how Arcadia’s more advantaged—and less coerced-- counterparts were experiencing rehab. In another facility just several miles away, I would discover a completely different recovery world at Healing Bridges. There were some similarities—the characteristic group circle, the token Twelve Steps poster on the wall, and of course, many courageous men who had grown weary of their battles with addiction. But for the most part, the programs imparted vastly different “treatment logics,” encouraging participants to understand addiction-- and themselves—in distinct ways.

Bridging Divides: Back to the Body

Sociological research in the symbolic-interactionist tradition focuses on the role of identity, meaning and interpretation in the cessation of drug use (Becker 1963, Denzin 1993, Lindesmith 1938). While this research was an important early contribution to

knowledge on the socially constructed aspects of addiction, the physicality of addiction demands recognition of the body. While addiction is undoubtedly a “discursive accomplishment” (Reinarman 2005), it is also always a profoundly physical embodiment. This is especially evident in rehab, where some addicts suffer the tortuous aspects of withdrawal while they recite the Twelve Steps or learn to narrate their lives through the logic of recovery in their “goodbye letters” to drugs. For all its “talk,” the study of rehab—if not rehab itself-- can sometimes obscure the fact that recovering from addiction is a visceral experience.

The emphasis on language and self-presentation in talk therapy can also obscure how addictions are rooted in social relations-- effectively atomizing the drug user and severing addiction from the world outside the institution’s walls. At Arcadia, for example, the recognition of social structure was actively suppressed and written off as “addict talk”-- evidence that the patient was unwilling, or unable, to take full personal responsibility for change. Eclipsed by ontological individualism, the problems of addiction recovery are reduced to the simple migration from an “addict” to a “non-addict” identity (Hughes 2007). Studying treatment then, runs the risk of reducing participants to the process alone, rather than seeing each of them—and their addictions-- as complex intersections of history and biography. The sociological imagination is an excellent tool for combatting some of these problems (Mills 1959), but I also needed a framework that could grapple more directly with the embodied aspects of compulsion.

By centering the embodiment of structure in a Foucauldian-inspired discourse analysis, I hope to bridge two theoretical divides. I argue that we must understand both “the addict” and “the recovering addict” as discursive productions *and* as the physical inscription of social structure on the body. Pierre Bourdieu’s influential theory of “habitus” views the body as a materialization of social forces (Bourdieu 1977, Bourgois and Schonberg 2009, Weinberg 2002). Not reducing addiction to either a purely symbolic construction or a purely neurobiological phenomenon, this approach theorizes addictions as particular kinds of habitus-- crystallizations of social structure embodied deep within the person, and manifest as pre-conscious disposition or habit. Following an emerging emphasis in the sociology of addiction, I build a “praxiological account of

addiction” which considers not only how addicts have been produced through discourse, but also how they have been shaped by structure (Weinberg 2005).

One key aspect of this approach is considering how the capacity for reflexivity is itself socially distributed. In my own fieldwork, the profound “mismatch” between the discursive world of rehab and the social realities of some participants—highlighted the need to reconcile Foucauldian and Bourdieuvian perspectives on power and the body (Bourgois and Schonberg 2009). Thus, one of my goals in this project was to consider how the men’s former lives and experiences not only routed them into treatment, but also shaped their patterns of drug use, their encounter with the therapeutic process, and their “take up” of treatment logics. In the next sections, I outline some of the essential contributions in the sociology of addiction which guide and inform my work.

Addicts in the Sociological Imagination: Race, Class, Drugs & Addiction

Sociologists know that class matters tremendously for physical, mental, and behavioral health outcomes. That differential health outcomes are an expression of racial inequality, for example, was articulated as early as W.E.B. Du Bois' *The Philadelphia Negro* (Dubois 1899). Since then, medical sociologists have established that structural contexts generate racial and socioeconomic disparities in physical and psychological wellbeing. Race and poverty have been linked to increased vulnerability for illness and death, exposure to environmental toxins, elevated levels of psychological distress, blocked access to healthcare, and a higher likelihood of drug-related harm (Williams and Sternthal 2010). Exposure to stressful life events or negative relationships are some of the well-known mechanisms by which racial-ethnic and class inequality impact mental and physical health (House, Landis and Umberson 1988, Thoits 2010). But basic contextual factors like socioeconomic status and social support still comprise the “fundamental causes” that impact health even when intervening circumstances change (Link and Phelan 1995).

Studies on the social dimensions of health have evolved separately from the literature on substance abuse-- likely a product of the fact that in mainstream sociology, drug use tends to be the purview of criminologists. Research shows that rates of drug use

look roughly similar by race and class (Alexander 2012, Western 2007). Work zeroing in on addiction, however, reveal that the poor can be more vulnerable to a number of chronic drug-related problems (Friedman 2002). These studies argue that like other health issues, addiction is not an “equal opportunity” affliction—it disproportionately affects the disadvantaged, who have less access to reliable medical care or socioeconomic supports (Hart 2013). The poor are more likely to be exposed to violent drug markets (Waterston 1993), rely on drugs for everyday economic survival (Bourgois 1995), and experience social hardships that intensify the consequences of chronic drug use (Lovell 2002, Murphy and Rosenbaum 1997). “Rock bottom” is likely to hit much sooner for the poor, and when it does, it is more likely come in the form of homelessness, violence, contact with law enforcement, or sexual victimization (Murphy and Rosenbaum 1997).

All of these experiences can compound preexisting troubles with drugs, or generate new ones (Lovell 2002). A lack of economic resources might lead to patterns of more intense, sporadic highs as opposed to regular use, or engaging in crime to obtain more drugs (Room 2005). Homelessness and other vulnerabilities increase the likelihood of engaging in risky administration practices like the use of contaminated syringes (Boardman et al. 2001). Arguably, all of these hardships intensify the psychic pain which might drive a person to “escape” through repeated intoxication (Friedman 2002). On the flip side, privilege has a “multiplier effect,” as socioeconomic status, education, family support, and whiteness provide “buffer zones” from the worst effects of addiction. Once an addiction develops, its severity can be significantly mitigated with access to social and economic support (Granfield and Cloud 2001).

Race intersects with class to compound these inequalities. Mass incarceration via the drug war is probably the most salient example of how race structures drug involvement. African Americans’ far greater presence in the criminal justice system has now been extensively documented, exposing their status as targets of drug war policing, victimization, and “hyper-criminalization” (Alexander 2012, Rios 2011, Tonry 2011, Western 2007). The period from 1980 to 2000 saw a ten-fold increase in drug crime incarceration (Western 2007), and in the nation’s largest cities, drug arrests of African Americans rose at three times the rate of whites (King 2008, Mauer 2009, Tonry 2011).

Importantly, drug use patterns among Black men have not mirrored the amazing growth of their imprisonment for drug crimes (King 2008, Mauer and King 2007, Mauer 2009, Tonry 1995, Tonry 2011, Western 2007).

Disparities in policing and sentencing drive much of the racial disproportionality in mass incarceration. African-American drug users are more likely to purchase product in open-air markets in plain view of law enforcement, while middle-class whites tend to purchase and consume drugs in the safety of their homes (Hagedorn 1998, King 2008, Mohamed and Fritsvold 2010). Crack cocaine became much more concentrated in African American neighborhoods and among poor and working-class drug users due to its lower cost relative to powder cocaine, which helps explain why Black communities were particularly hard hit by the crack-powder cocaine sentencing disparities (Mauer 2009). Similarly, the rise of methamphetamine use among more whites and Latinos than African-Americans has contributed to recent increases in those groups' presence among drug offenders-- a pattern captured by changes in Minnesota's correctional population (Mauer 2009). The recent statewide opiate epidemic is in part a reflection of white, middle-class communities' greater access to pharmaceutical painkillers.

Kicking the Habit(us): Addiction as the Embodiment of Social Structure

Sociologists are increasing our understanding of the link between social inequality and addiction by examining how the roots of compulsion and control lie in the ways that everyday orientations to work, family, leisure, and community are inscribed on the body. Rising inequality and unemployment, exposure to chronic stress, and the increasing isolation that many Americans experience might be better predictors of addiction than strictly biological or biochemical markers.¹⁹ Scholars have analyzed addiction as a product of rising inequality, like Waterston, who argues that addicts are “human casualties of capitalist development,” alienated through violence, poverty, racism, sexism, and limited opportunities for mobility (Waterston 1993). Bruce Alexander argues that it is mass dislocation in a globalizing free market system which accounts for

¹⁹ Of course, socially induced stressors are also preconditions for a number of biochemical outcomes.

rising rates of addiction *across* social groups (Alexander 2008). Once occupying the margins with an interdisciplinary, social-structural take on addiction, Bruce Alexander's studies have gained much more attention as the social contexts of addiction are taken seriously (Alexander 2008).

The cultural Marxist tradition reminds us that “class” does not simply unfold from structure. Rather, it is a learned disposition that we make sense of with the cultural resources we have (Bettie 2003, Hall and Jefferson 1993, Steedman 1987). Drugs are central to the acquisition of status, the expression of class identity, and the production of social distinction. The white, working-class, teenage “smokers” Julie Bettie studied responded to their marginalization by rejecting academic achievement and going to class intoxicated—drugs had symbolic importance as an expression of their class status (Bettie 2003). In this tradition, drug consumption has been usefully analyzed as a “field-specific capital” that individuals acquire and accumulate while navigating their social worlds (Haines, Poland and Johnson 2009, Hughes 2007, Katainen 2010).

The organization of work and leisure time, orientation toward the future, and emergent patterns of self-efficacy may shape the *embodiment* of addiction in particular ways. For example, the urgency and immediacy of poverty makes planning for the future difficult or impossible-- a temporal organization that might shape the patterns of drug consumption (Venkatesh 2006, Young 2003). Robin Kelley observes that the development of “leisure time” coincided with the development of wage labor for the urban working classes. But as opportunities for wage labor disappeared for workers of color, the use of the body for “the pursuit of leisure, pleasure, and creative expression” became more important for dislocated African American men-- an insight which could illuminate drug use (Kelley 1997).

Conversely, immersion in the routines of stable work could enable some level of control over drug consumption through the negotiation of “work” and “party” identities. Unlike some of the other homeless men Teresa Gowan studied, the pro-recyclers’ work roles made it easier for them to relegate getting high to an after-hours, leisure activity (Gowan 2009). In their ethnography of homeless street addicts in San Francisco, Bourgois and Schonberg argue that their informants’ “addict habitus” arose from shared

social suffering-- the US neoliberal economic order had created a class of street addicts with a particular “lumpen subjectivity” (Bourgois and Schonberg 2009). In an approach I have found particularly useful, they theorize the addicted body as a site upon which the injuries of class and race are inscribed and felt, exposing the still-violent and brutally forceful side of biopower. Inverting Foucault’s bodily image in the opening of *Discipline and Punish*, they described how street addicts are “drawn and quartered” in San Francisco’s shooting encampments.

The sociology of emotion reminds us that one’s place within the social structure shapes the very capacity to feel and express emotions (Goffman 1959, Hochschild 1983, Hochschild 1995, Illouz 2008, Williams 1977). Emotions and emotional expression can thus have profound consequences for the reproduction of inequality—and capacities for the reflexive transformations sought in rehab are themselves socially distributed. Both class membership and gender expectations can shape how participants interact with treatment professionals or their willingness to become vulnerable in the presence of peers—making the work required in rehab a more familiar and less alienating process for middle-class addicts (Illouz 2008, Lareau 2003, Sweetman 2003).

If rehab is the process of refashioning habitus, then differences in communication styles and emotional repertoires make rehab a “better fit” for some addicts, and a more alienating space for others. Jennifer Silva argues that therapeutic frameworks serve different purposes for the middle and working classes. For the middle-class, they allow for “emotional self-realization and wellbeing,” while the working-class draws on them to “temporarily keep anxiety and risk at bay, anchoring their lives in self-management.” The resulting culture of neoliberalism accomplishes exploitation “at the most intimate level of the self” (Silva 2013).

My own work reveals that the racially and economically marginalized often find the therapeutic process alienating for a number of reasons-- masculinity norms linking emotional vulnerability with weakness, cultural codes against “snitching” and a deep distrust of “helping professionals,” and the knowledge that saying the wrong things in

therapy might trigger legal sanctions.²⁰ The emotional vulnerability required by rehab was a much more familiar and “comfortable” experience for the middle-class men getting treatment at Healing Bridges. In the chapters that follow, I develop these ideas further, showing how rehab participants’ habitus conditioned their responses to the therapeutic encounter.

Invisible Addicts

Sociologists have seldom focused the lens on drug involvement *across* the class structure. While health inequalities research links poverty to various risk factors for addiction, the notion that the poor are more likely to struggle with addiction is complicated by their hyper-visibility and labeling within systems of control. Seldom caught up in the criminal justice system or monitored by the welfare state, middle and upper-class Americans can more easily hide their addictions from view. Unlike the poor or homeless, they rarely if ever have to use rehab as a form of temporary housing or to access other vital material resources. These invisible, undocumented addicts should cast some doubt on popular claims about the social distribution of addiction. The class demographics of the current heroin epidemic—an overwhelmingly white, suburban problem—are revising earlier beliefs about the concentration of US addicts. Indeed, middle-class addiction is now becoming more visible, as advantaged Americans head to rehab in larger numbers. The Minnesota Model program I studied, Healing Bridges, is a reflection of these trends—the number of young, educated, white middle-class men and women entering the program for opiate addictions nearly quadrupled in the five years before I entered the field.

The stigma of going to rehab is arguably reversing as much of society accepts addiction as a legitimate medical condition, and as pop culture phenomena contribute to the normalization of addiction treatment. The celebrity surrounding Amy Winehouse and Lindsay Lohan—both of whom had very publicized stints in treatment—reflect a

²⁰ For these reasons (and others), establishing good rapport and distinguishing myself from treatment staff in my interviews was vital for learning about these men. See Methods Appendix.

growing commodification—even glamorization-- of rehab, even if their stories often reinforce punitive attitudes toward drug use (Tiger 2015). My own study confirmed that rehab still has a long way to go through the process of de-stigmatization. A good number of the men at Healing Bridges, for example, were hiding their participation in the program from family and friends. Some had even constructed elaborate stories about going on lengthy “vacations.”²¹ Far removed from the shadow of the criminal justice system, it was easy for these men to frame treatment as a voluntary respite. Put simply, the middle-upper classes are much less likely to be *labeled* as addicts by social institutions, even if the extent of their drug involvement is similar to that of poor and working-class Americans.

The preoccupation of drug studies with the behaviors and experiences of marginalized people only reinforces the invisibility of white, middle-class drug use. What we know about addiction is overwhelmingly what we know about the addictions of the poor. Studies that deal either directly or indirectly with drugs focus overwhelmingly on gangs, the informal economy, the homeless, or the urban poor-- confining drug use to zones of marginality. Some of the classic urban ethnographies have done more to obscure than illuminate the role of addiction in marginalization, either by conflating street poverty with drug use (Anderson 1999), or by reducing addicts down to their impulses (Duneier 1999). Sociologists have thus contributed to stereotypes of poor and working-class Americans as drug-addled and essentially “prone” to addiction-- reinforcing the misconception that addiction is mainly a problem that the poor experience.

Since the 1950s, criminology has also contributed to this problem by obscuring the relationship between class and “deviance” (Hagan and McCarthy 1998). The “control” theories of criminology, for example, imply that self-control is something that human beings simply possess, innately. Individuals who lack self-control, and thus engage in deviant behavior such as drug use, are thus fundamentally flawed—“impulsive, insensitive, physical (as opposed to mental), risk-taking, short-sighted, and non-verbal”

²¹ Indeed, one man in my study even refused to call his enrollment at Healing Bridges “treatment,” instead framing it as an actual, desperately needed “vacation” from his stressful job in real estate development.

(Gottfredson and Hirschi 1990). Notions of “low self-control” layer more stigma on those who are already disadvantaged-- while also obscuring how the roots of self-control are embedded in social structures. When class bias is not mentioned as such, it prohibits a critical analysis of class as a category of difference (Bettie 2003). Cross-class analyses are thus one way to uncover the social mechanisms of exclusion that remain invisible to studies focused only on the cultural worlds of the poor (Lamont and Small 2008).

“Poor” Science: Uses of the Powerless Addict

The notion that addiction renders the addict powerless is gospel in mainstream understandings. According to NIDA, arguably the most powerful institutional player in the dissemination of addiction science, drugs “hijack the brain,” and the first step of AA requires “admitting powerlessness.” But research on addicts who possess considerable social, economic, and cultural capital provide important correctives to this conventional wisdom. Perhaps most importantly, they challenge accounts of addicts as completely “out of control” and overpowered by desire. Rather, their research subjects use substances like heroin, cocaine, and meth casually for long periods of time (McCoy et al. 2005); they self-regulate their crack cocaine use through the daily obligations of work and school (Jackson-Jacobs 2001); and they “recover naturally” without any specialized treatment intervention (Granfield and Cloud 2001). There seems to be an important relationship then between class status (or capital) and the extent to which an addiction renders an individual “powerless.” For sociologists, this is not an essentially new insight. The correlates of higher class status afford a person more control over nearly every aspect of their lives—including their addictions.

More recent research is challenging the essential powerlessness of addiction for the poor as well—reminding us not to naturalize self-control as a “middle-class virtue.” For example, Carl Hart’s laboratory studies of men struggling with homelessness and crack addiction portrayed them as rational actors who responded to cash incentives over additional doses of the drug (Hart 2013). The trouble with extending rat studies to human beings aside, Bruce Alexander’s famous “rat park” studies drew similar conclusions, demonstrating that when given the choice between morphine-laced water in isolation or

active stimulation through desirable food, leisure, sex, and companionship—the rats always went for the non-drug options. Of course, harm reduction activists and researchers had long been documenting the ability of men and women across class to make informed, rational decisions about their health and their drug use, even in states of active addiction (Drumm et al. 2005, Gowan, Whetstone and Andic 2012, Lovell 2002, Roe 2005). But Alexander’s findings seriously destabilized decades of laboratory research in psychology that have been used to defend claims about the paralyzing effect of drugs on the brain. By exposing the importance of environmental context—even for lab rats—he offered a compelling new way to theorize addiction. A recent bestseller by journalist Johann Hari draws heavily on his models to support a scathing critique of the drug war (Hari 2015).

What is at stake here is a politics of representation with deep consequences. The characterization of addicts as people who have no capacity for self-control casts them firmly outside the bounds of citizenship, if not humanity. The bundling of addiction with poverty and with powerlessness reinforces a highly productive “tangle of pathologies”—and to untangle them would be to call into question many deeply held cultural beliefs and assumptions. Addictions have always been central to the construction of social Others. As early as 1873, the term tramp signified “a lazy, dangerous, and probably alcoholic man in search of a handout” (Katz 1989). The early twentieth-century moral crusades against alcohol were campaigns led by white, middle-class Protestants to re-socialize and discipline the working classes to the rhythms of industrial capitalism (Reinarman 2008a, Weinberg 2005).

The original “junkies” were poor, often homeless, heroin users-- symbolically distinct from the middle-upper class women who developed opiate addictions in medical settings (Radcliffe and Stevens 2008). In contemporary discourse, “drug addict” and “crackhead” are terms routinely positioned alongside “welfare recipient” in popular depictions of urban poverty (Copes, Hochstetler and Williams 2008, Fraser and Gordon 1997, Furst et al. 1999, Gubrium 2008). The hyper-incarceration of young African Americans in the War on Drugs has resulted in an intensified and deepened association of African-American identity with risk, danger, and drugs (Beckett, Nyrop and Pflingst

2006, Pager 2003, Reinerman 2008a, Ronell 2004, Simon 2007, Wacquant 2001, Western and Beckett 1999, Western 2007). As I will demonstrate in the pages that follow, social location is no less central to our understanding of addiction in contemporary America. While some of these representations endure, others have been revised, and still others are only emerging as addicts across the social structure participate in a “two-track” treatment system.

Dissertation Outline

In **Chapter 2**, “Kicking the Habit in the Two-Track Treatment System” I outline the historical development of both strong-arm rehab and the Minnesota Model, placing each of my field sites in the context of Minnesota’s larger recovery scene. The “strong-arm” rehab was born out of an affinity between the therapeutic community and the criminal justice system, designed to coerce so-called “criminal-addicts” into an extended process of behavioral modification, surveillance, and control. While the punitive-therapeutic hybrid of court-mandated treatment carries forth earlier notions of addiction as criminal and moral failure, the nationally prominent “Minnesota Model” has its roots in the “bottom up” Alcoholics Anonymous movement and the medicalization of addiction as a treatable, if not curable, disease.

These distinct treatment logics became tied to their “target populations,” exposing addicts into very different kinds of reform projects. Through the opening vignettes of two program participants across the social structure—KJ and Kevin-- I introduce the reader to some of the different pathways by which the men in my study were routed into treatment, and begin to show the ways in which social location profoundly impacted the experience of addiction. As readers follow KJ and Kevin into their programs, I provide context and ethnographic description that sets the scene before moving into the in-depth ethnographies of Arcadia House and Healing Bridges in Chapters 3 and 4.

Chapter 3, “Habilitating the Hustler: Rehab in the Shadow of the Carceral State,” and **Chapter 4**, “Recovering the Self-Manager in the Minnesota Model,” delineate the “treatment logics” that produced the addict as an object of reform in each of the models I

study. While Healing Bridges worked to elicit the active “self-managers” within recovering participants which had only been temporarily masked by disease, Arcadia’s *criminal-addict* was fully flawed and resistant—and had to be coerced to into meaningful change. These basic understandings of the addict underpinned and informed the recovery programs pursued in each of my sites. Healing Bridges focused on eliciting desire through positive psychology, mobilizing the language of empowerment, and destigmatizing addicts through the reprieve of the disease model. Arcadia House took a very different approach, working to “habilitate” and discipline their clients’ deviant “lifestyle addictions,” correct “criminal thinking,” and apply punitive sanctions to program failure. As staff and clients put treatment logics into practice through everyday acts of “working the program,” they generated profoundly different therapeutic encounters. The centrality of the state at Arcadia House, for example, could not be underestimated, as it influenced nearly every aspect of programming and produced a decidedly “anti-therapeutic” experience.

In these chapters, I also aim to address how participants in each site responded to the dominant treatment logics—internalizing, negotiating, or resisting them in different ways. I explore how treatment-goers were encouraged to think about themselves and their peers in the program, and how to make sense of social and cultural difference within the space itself, as well as the “world out there.” In doing so, I had to acknowledge the social worlds participants brought into treatment with them—that is, how their habitus interacted with the project of recovering “the new self.”

I explore this more fully in **Chapter 5**, “Recovery Narratives across the Social Structure,” which examines the tensions between addiction-as-lived-experience and the institutionally produced discourses of the addict I laid out in Chapters 3 and 4. Here, I draw mostly on the life history interviews and shift my comparative lens from field site to addicts across the social structure. I develop the link between social inequality and addiction by considering how poor, working, and middle-class participants’ addictions were patterned in particular ways. I argue that the men in my study had developed distinct addict habitus—classed and gendered versions of addiction that were both embodied *and* discursively produced within institutions. While the point of treatment was

to reshape habitus, its discursive logic often clashed with participants' lived experience. I use Bourdieu's concepts of "symbolic violence" and "misrecognition" to theorize the "mismatch" between participants' embodied experience and the "logics" of addiction that were circulating in treatment (Bourdieu and Wacquant 1992).

In **Chapter 6**, "Shifting Governmentalities" I offer concluding remarks and summarize the application of a governmentalities framework to my cross-class comparative analysis.

Chapter 2: Setting the Scene: Addiction Recovery in the “Treatment State”

In 2013, I sat across from Kevin and KJ at a picnic table on a balmy September afternoon in Minneapolis, Minnesota. We were in the “land of 10,000 lakes,” and the mosquitoes were biting like mad. Kevin swatted one off of KJ’s arm, wiping it away.

“See?” Kevin said, turning toward me, “That’s what brothers do for each other! You wouldn’t know it by looking at us, but that’s what we are. That’s what I found out when we both started talking about our addictions. We basically had the same life.” He grinned at KJ, who put his arm around Kevin in a display of admiration.

Along with its humorous claim on the mosquito as its “state bird,” Minnesota could also lay claim to a national reputation as the “land of 10,000 treatment centers.” On that day, at a “sober picnic” in the Twin Cities, arguably the state’s “recovery capital,” it was a reputation that seemed warranted. I was attending one of the many events taking place during Minnesota’s officially recognized “Recovery Month,” designed to raise awareness about existing chemical dependency treatment and to galvanize public support for the expansion of services. A series of “sober outings,” conferences, meetings and fundraisers sponsored by a burgeoning network of treatment providers, recovery organizations, and advocacy groups would bring people together from across Minnesota to proudly proclaim and celebrate the mantra “recovery works.”

Nestled among the crowds I spotted Kevin and KJ, both of whom I met when I was conducting the ethnography of addiction recovery that I present in these pages. KJ, a 42-year-old African American male, had moved to Minneapolis to escape the Chicago projects in the mid-1980s. Instead, he found himself unemployed and homeless, and was quickly pulled into the city’s emerging crack trade. After a lengthy history cycling between prison, homelessness and the streets, he was court-mandated to attend nearly one year of programming at Arcadia House, a residential therapeutic community in the Twin Cities with strong ties to the Department of Corrections. Convinced that his alcoholism, his deteriorating health and his “lifestyle” had finally caught up with him,

KJ dedicated himself to “working the program” at Arcadia to become one of the institution’s celebrated graduates.

Kevin, a 38-year-old, white, lower-middle-class male, was originally from an affluent suburb in western Minnesota. After some post-college success in sales, the recession had plunged him into debt, and his once “functional” use of alcohol and cocaine had grown increasingly unmanageable. With his college drug dealing days far behind him, he had managed to avoid the criminal justice system, and at the urging of family and friends, eventually went into Healing Bridges’ 28-day Minnesota Model program where he was quickly recognized as a “hopeful case” by staff and patients.

Although KJ and Kevin had gone through treatment at different facilities and they had few social ties in common outside the recovery community, they kept in contact after meeting at local events like these. I was excited to catch up on how life had been for each of them after rehab. I learned that as graduates of their respective programs, each had been invited to address the recovering addicts, families, treatment providers and policymakers who had gathered for the day’s festivities.

Rising from his spot at the table, KJ turned to Kevin. “Yeah, you’re better than any family I ever had. That’s truth right there.” He straightened the collar of his pressed button-down shirt. “I’m all wound up,” he said, “I never really done this before, you know, talkin’ in front of so many people. I hope I don’t mess it up,” he laughed nervously. As he headed to the front of the crowd, he quickly mumbled the Serenity Prayer. “God, grant me the Serenity...”

“If you freeze up, just look for me out there,” Kevin said. “Your brother has your back!”

The Land of 10,000 Treatment Centers

KJ and Kevin were well suited to address the recovering addicts, families, and treatment providers who gathered for events during “Recovery Month.” Both had been exemplary participants in their rehabilitation programs—each had completed treatment, maintained some sobriety, and remained active in the local recovery community. More than that, they were both symbols of amazing human resilience. Each had managed to overcome lengthy battles with addiction. Their stories inform the statistics we like to talk about, and their success gives life to the mantra, “recovery works.” But while they might have shared a common bond as relatively successful recovering addicts, as I got to know each of them, I discovered that their lives could not have been more different.

In this chapter, I trace the trajectories of Kevin and KJ into their respective treatment programs, introducing the sites where I conducted over three years of ethnography—Healing Bridges and Arcadia House. While they might have been outliers in terms of their ability to stay sober, KJ and Kevin were very much typical of strong-arm rehab and Minnesota Model’s distinct “target populations.” Their pathways into treatment illustrate how the experience of addiction—and the project of recovery—is organized in vastly different ways across the structures of class, race, and the criminal justice system. Both men were “doing recovery” in Minnesota’s treatment world, but they had traversed different routes into programs that were distinct both in form and content. As I move from the men’s lives into the programs themselves, I present descriptive sketches of Arcadia House and Healing Bridges that anchor the in-depth ethnographies which follow in the third and fourth chapters.

After I introduce each program, I turn to each model’s philosophical and historical roots in order to further explore some of the factors that shaped the emergence of a “two-track” treatment system. Rather than any comprehensive historical, institutional, or clinical account of addiction treatment, my aim is to provide a “genealogy” that will contextualize the emergence of the sites where I conducted ethnographic fieldwork (Foucault 1977). This chapter will examine how each program’s distinct “treatment logic” evolved in the context of American efforts to either criminalize

or medicalize addicts—shaped by broader views of addiction as moral failure, medical illness, or medical-moral hybrid.

As I discussed in Chapter 1, I refer to “treatment logics” in this project to delineate the ways in which various models of rehabilitation both construct understandings of addiction *and* put those understandings into practice through the project of recovery. Treatment logics thus encompass both discursive constructions of “the addict,” and the particular practices linked to those constructions which are mobilized to remake the person. American addiction discourse contains multiple contradictory and complementary treatment logics which might overlap somewhat in terms of shared principles, themes, and language—but depart considerably in terms of how they conceptualize the causes and consequences of addiction, how they define the characteristic behaviors of the addict, and how they support various courses of action to guide the practice of recovery.

Arcadia’s treatment logic relied on a coercive form of rehabilitation that evolved from the therapeutic community’s close working relationship with the criminal justice system—a form Teresa Gowan and I have termed “strong-arm rehab” in previous work (Gowan and Whetstone 2012, Whetstone and Gowan 2011). Rooted in historical associations of drug use with criminal and moral vice, strong-arm rehab draws on a set of assumptions linking addiction to an underlying, flawed “criminal personality”—and provides a blueprint for behavioral modification that could function as an analog to prison. While both of the models I study reference Alcoholics Anonymous and the brain disease theory of addiction, in practice they differ substantially in how they interpret and mobilize key strands of treatment logic. Arcadia’s project of court-mandated treatment—overwhelmed by the lingering stigma of criminality—articulated the brain disease theory in limited forms on the surface, while emphasizing the importance of moral and cultural reform in daily practice.

In contrast, the voluntary, flexible, and medicalized orientation of Healing Bridges’ Minnesota Model (MM) was more heavily immersed in Alcoholics Anonymous—a form of self-help invented by addicts themselves as a means of mutual support and validation. Fusing together AA with the emerging brain disease paradigm,

the MM approach was first crystallized in the 1950s in Minnesota's research hospitals and recovery groups for "professionals," before its replication on the national recovery scene. Far from the shadow of the criminal justice system, the addicts at Healing Bridges were mostly shielded from the stigma of criminality, and many could escape responsibility for a disease thought to be out of their control. The project of "voluntary" recovery unfolding there viewed the addict as a person who had been temporarily "hijacked" by the "other inside" of brain disease.

The "treatment logics" of Arcadia's strong-arm rehab and Healing Bridges' Minnesota Model form central strands within mainstream addiction discourse. With the exception of a significant number of rehabbers who enter local faith-based facilities, the programs at Arcadia and Bridges represent two of the most popular and widespread approaches in the broader recovery scene, both statewide and nationally.²² Both models come out of a long tradition of rehabilitation based on peer support, both revolve around talk therapy, and both invest ex-addicts with considerable authority—although to varying degrees (Borkman, Kaskutas and Owen 2007). The two models I study also map onto continuing debates within addiction science about the relative merits of coerced or voluntary treatment for client retention and long-term treatment outcomes (Klag, O'Callaghan and Creed 2005, Miller and Flaherty 2000).

And yet, I proceed with caution when making claims about the extent to which my field sites reflect the dynamics of other similarly advertised programs. The character of rehab is the product of specific local contingencies—a program's positioning in the broader recovery field, the local addict demographic base, ties to existing sources of funding, and even the presence of particular charismatic staff members. Attempts at generalizability are thus inevitably compromised as more details are introduced. Furthermore, my study reveals a considerable gap between how programs advertise their models and what they actually do in practice. For example, Arcadia House claims to be a

²² See, for example, Teresa Gowan and Jack Atmore's analysis of one such faith-based program: Gowan, Teresa and Jack Atmore. 2012. "Into the Light: Evangelical Rehab and the Seduction of New Life." Pp. 155-78 in *Advances in Medical Sociology: Critical Perspectives on Addiction*, Vol. 14, edited by J. Netherland: Emerald Publishing

“Twelve Step” rehab, but while some of AA’s language and iconography seeps into the program, very little time is spent “working the steps.” While most of the court-mandated clients begrudgingly attended their required weekly meetings off site, the non-court mandated clients tended to skip them. In contrast, the Alcoholics Anonymous’ “Big Book” was regular reading at Healing Bridges, most patients attended the on-site AA meetings, and working the Twelve Steps was a core component of therapeutic practice.

Mapping the Field in the “Treatment State”

Arcadia House and Healing Bridges are situated within the much broader “field” of Minnesota’s many inpatient and residential treatment programs, outpatient groups, detox facilities, halfway houses, “three-quarter” houses, transitional programs, and Alcoholics Anonymous and Narcotics Anonymous meetings. By the early 1980s, this burgeoning network of recovery services had earned Minnesota a national reputation as the “land of 10,000 treatment centers.” The scenes unfolding across the state during Recovery Month certainly supported such an assessment. Thousands of people turned out for various “recovery walks” around the Twin Cities’ scenic lakes, advocates helped potential rehabbers navigate the state’s system of publicly funded treatment, recovering addicts and their families hosted block parties and barbecues, and out-of-towners were encouraged to visit one of the hundreds of AA and NA meetings scattered across the metro area.

Minnesota’s perceived status at the forefront of the national recovery scene make it an attractive destination for rehab-goers across the country—and patients often travel to attend one of the area’s many well-known programs (Laudergan 1982, White 2002, Wormer and Davis 2013). By the early 1980s, Minnesota had more addiction treatment centers than any other state, a “per capita capacity for inpatient treatment four times the national average, and a per capita expenditure on chemical dependency care nearly 50% higher than the national average” (Laudergan 1982).

The state’s highly active recovery culture is the historical and contemporary site of a number of key developments in rehabilitation theory and practice. A handful of programs first developed in Minnesota are now national standards for “best practice,”

chief among them the Minnesota Model (Anderson, McGovern and DuPont 1999, Cook 2006, White 2002). Headquartered at Hazelden’s Center City campus, the Minnesota Model brand had by the 1960s become the “gold standard” of American inpatient treatment. It is arguably the most widely diffused recovery model in the nation, elements of its form and content showing up in 28-day programs and outpatient therapy of all types. In addition, a network of Minnesota county drug courts has been at the forefront of the “evidence-based practices” movement in corrections, developing an assessment tool that has been used to divert offenders across the country into “strong-arm” rehab. In terms of understanding the major fault lines of both “voluntary” and coercive treatment within mainstream American rehab then, Minnesota is in many ways an ideal setting for my study.

Minnesota also supports a significant expansion of treatment services for the poor and uninsured through the state-supervised, county-dispensed funding known as the “Consolidated Chemical Dependency Treatment Fund” (CCDTF). Established in 1986, the program determines eligibility through “clinical need” in a county-based assessment and “financial need” aligned with federal poverty thresholds.²³ Two-thirds of the three hundred state-licensed addiction treatment providers in Minnesota accept funding through CCDTF, forming the backbone of government-funded services for poor and uninsured addicts. About one hundred of these facilities are clustered in the Twin Cities metro area, making it a hotbed for treatment resources—and a little over half of all the rehab attendees in the state seek treatment in the Twin Cities (McRae 2013).

The CCDTF funds about half of all admissions to rehab, making it Minnesota’s largest treatment funding source (MNDHS 2006). The majority of funding for addiction treatment in Minnesota’s drug courts also comes from the CCDTF, and more than half of CCDTF recipients are under court supervision—illustrating the high prevalence of coerced treatment among Minnesota’s poorest rehab-goers. According to the limited

²³ The Minnesota Department of Human Services set CCDTF household income limits for one single adult at \$15,281 in 2014. If someone did not meet these income limits, they could still qualify for assistance if they met the eligibility guidelines for Medical Assistance, Minnesota Supplemental Aid or Supplemental Security Income-- and if they had no other insurance or third party that would cover the total cost of treatment.

available state-level data, these trends are also racialized-- American Indians were nine times more likely and African Americans were five times more likely to access treatment through the public funding option (MNDHS 2006).

New Crises & Continued Disparities

Minnesota's status at the center of recovery culture and the strength of its public treatment funding helped lay the basis for its national reputation as "the treatment state." Yet as I began researching state trends in treatment admissions, I discovered a much more sobering reality. Since the late 1990s, state budget cuts, freezes on public funding for treatment, and regulatory changes have eroded crucial resources. Data from 2007, for example, put Minnesota at a dismal 48 out of 50 states in the nation for the rate of adults per capita in substance abuse treatment—only Texas and Arkansas ranked lower-- challenging the state's reputation as a "treatment mecca" (Russell 2008). Compared to Minnesota, states with the highest admissions to drug treatment have up to three times as many adults enrolled. The perception among practitioners is that treatment demand in Minnesota far outstrips existing supply. For example, the Minnesota Department of Human Services estimates that about 8% of adults in the state meet diagnostic criteria for addiction, but less than 1 in 10 actually receive any professional treatment (McRae 2010, Steiner 2014).

More recently, several state-run residential facilities treating addiction and mental illness have dramatically reduced their openings, and addicts are facing ever longer waiting periods (Mannix 2015b). Some of these programs also began restricting eligibility only to court-mandated clientele, following a national trend toward the mass reduction of long-term residential care outside the criminal justice system. As insurance providers have been less likely to support extended residential treatment, the vast majority of Americans who attend rehab—over 80%-- go to its outpatient form (Fletcher 2013), but only 50% of Minnesotans who get treatment do so in an outpatient facility (McRae 2013). Likely due to the CCDTF, Minnesotan rehabbers attend residential facilities at rates considerably higher than the national average—26.5% attend short-term

residential facilities, and 19.3% attend long-term residential programs, compared to about 10% of all Americans who go to rehab (McRae 2013).

For those Minnesotans who attend rehab of any form, completion rates have been falling statewide in recent years, steadily declining since 2000 to around 58% in 2011 (McRae 2013). One study estimated that Minnesotans completed treatment at rates ranging from 51% to 70%, and African American and American Indian participants consistently had the lowest completion rates (McRae 2010). Differences in completion rates were driven in part by the fact that participants of color faced far more social and economic vulnerabilities both at admission and discharge. Statewide, for example, 18% of African American clientele were homeless and 77% were out of the labor force, compared to only 5% and 53% of white clientele. Unemployed participants had the lowest likelihood of completing treatment overall, and that trend was particularly pronounced among those getting treatment in residential facilities (McRae 2013).

Despite these challenges, evidence exists that state-level support for treatment is on the rebound, following national calls to reprioritize rehabilitation in the country's failed war on drugs. Since 2007, Minnesota has restored some of its rehab funding and earmarked more dollars for treatment beds (Russell 2008). A renewed focus on rehab is partially due to the dramatic rise of opiate addiction in Minnesota communities. In 2012, treatment centers in the Twin Cities metro area admitted almost twice as many people compared with five years earlier—and much of this increase was driven by opiate addiction (Case and Godar 2014). Opiate-related admissions to Twin Cities treatment centers reached record highs in 2014 (Falkowski 2015), and the number of people entering treatment for heroin addiction statewide has increased tenfold since 1993 (Forliti 2014).

Minnesota's heroin crisis emerged in the context of what is being called a "national epidemic"—one in which existing treatment approaches are failing to stem the tide of rising deaths related to heroin and opioid prescription medication. Heroin overdose deaths more than tripled nationally between 2002 and 2013 (Allen 2015, CDC 2015), and following these trends, the number of fatal overdoses caused by prescription opioids skyrocketed in Minnesota-- more than 16,000 people died of prescription opioid

overdoses in 2013 (Collins 2015). Emergency room visits involving heroin in the Twin Cities nearly tripled from 2004 to 2011, and in the same period, heroin arrests in the state increased 90% (MNDHS 2012). During the time of my study, local and national law enforcement officials claimed that the Twin Cities' drug market was offering the cheapest and purest heroin in the nation (Case and Godar 2014).

Opiate use in America, and especially injection heroin use, has shifted from a problem once thought to be concentrated in urban areas and more prominent among the nation's poor and minority drug users to a problem that is associated with suburban and small town America (Quinones 2015). The demographic trends have been overwhelmingly white—nearly 90% of those who tried heroin for the first time in the last decade were white, and many of those first-time users were introduced to the drug through prescription opiates (Cicero et al. 2014). On a national scale, the largest surge in opiate use and addiction has been among whites in the 18-25 age range (CDC 2015), but in Minnesota, heroin-related treatment admissions have been growing among all racial groups (Falkowski 2013, Falkowski 2015).²⁴ Still, much attention has been paid to the perceived “whitening” of the nation's latest epidemic, prompting both national and state-level politicians and policymakers to place renewed attention on drug rehabilitation, prioritize funding for treatment expansion (Mannix 2015b), and support innovations in addiction science like medication-assisted-therapies (Grim 2015).²⁵ The title of a recent *New York Times* piece reveals the racial contours of the latest wave of American drug hysteria: “In Heroin Crisis, White Families Seek Gentler War on Drugs” (Seelye 2015).

Changing patterns of heroin use both nationally and in Minnesota have shaped a wider divergence of the “two-track” treatment system. While lawmakers increasingly

²⁴ For example, whites accounted for 63-65% of all heroin-related treatment admissions in the Twin Cities from 2010-2014, despite their numbers in the Twin Cities metro population (about 80%). African Americans were about 9% of the population, but constituted around 20% of heroin treatment admissions. For prescription opioid admissions, the numbers are more representative. See: Falkowski, Carol. 2015. "Drug Abuse Dialogues: Drug Abuse Trends in Minneapolis/St. Paul 2015." Vol. National Institute on Drug Abuse

²⁵ Recent examples include the statewide efforts to institute “911 Good Samaritan” laws which would provide legal amnesty for people who call 911 in order to save a life, and the state campaign to ensure widespread distribution of naloxone—a drug that reverses opiate overdose. See: Pugmire, Tim. 2014. "Lawmakers Ok Emergency Use of Heroin Overdose Shot; Good Samaritans Protected." in *Minnesota Public Radio News*. St Paul, MN.

take a medicalized, public health approach to the opiate addictions of white suburbia, a parallel response has seen the state's drug-related incarceration rate soar. As calls to expand treatment resources mounted, so did efforts to criminalize drugs and their users. From 2010 to 2014, for example, the number of beds dedicated to drug-related offenders in Minnesota's prisons increased almost 40%, according to reports released by the Minnesota Sentencing Guidelines Commission (Commission 2014, Tigue 2015). Minnesota's drug sentencing laws have been singled out as among the harshest and lengthiest in the nation—and have been cited as a cause of prison overcrowding statewide (Commission 2014). Despite the fact that Minnesota's Department of Corrections offers drug rehabilitation to only a small fraction of the estimated 90% of new inmates who meet addiction criteria-- the institution still sees itself as "the state's largest provider of chemical dependency treatment" (Mannix 2015a). Yet the effect of prison rehabilitation is dubious to say the least, especially since restrictions placed on hiring and housing ex-felons create extreme obstacles for people in recovery.

In between the two poles of (non-court-mandated) substance abuse treatment and incarceration lie another set of "hybrid" responses which seek to expand addiction treatment as a main priority within criminal justice policy. Rehab in Minnesota must be placed within the national growth of addiction treatment through probation, parole, drug courts, and other forms of drug diversion. Mirroring the expansion of court-backed treatment on the national stage, criminal justice referrals in Minnesota accounted for about 38% of all treatment admissions—and another 32% were referred by other county agencies (McRae 2013).

Coercive forms of rehabilitation have been disproportionately mapped onto addicts of color via their much higher representation in Minnesota's prison system. The deep racial disparities that have plagued American corrections are especially pronounced in Minnesota-- African Americans made up less than 6% of the state's population according to 2013 US Census estimates, but comprised 35% of the state's prison population. Native Americans comprised about 1% of Minnesotans, but accounted for about 10% of the state's prisoners—and whites were 86% of all Minnesotans, but only 53% of the inmate population (MNDOC 2015).

Recovery in the “treatment state” then is structured by the same racial and socioeconomic disparities that shape the lives of its residents. For communities of color, those include higher rates of poverty, worsened health outcomes, and larger high school dropout rates. In the year I entered the field, data from the American Community Survey showed that 33.5% of African Americans, 30.3% of American Indians, 22.1% of Hispanics, and 16.6% of Asians had incomes below the poverty line in Minnesota—compared to only about 7% of whites (McRae 2009). Indeed, the socioeconomic gap between the state’s black and white residents is among the worst measures in the nation (Rose 2013), and by 2011, the black state poverty rate was as high as five times the rate for whites (Minnesota Council 2011). Much of the wealth gap can be linked to the forces that sustain chronic unemployment. In 2011, African Americans in the Twin Cities had a 22% unemployment rate, and they were more than three times as likely as whites to be unemployed (Austin 2011).

These disparities shape how addicts are routed into treatment at the local and state levels—and thus how different treatment logics are mapped onto rehab participants by race and class.²⁶ The available data on treatment referral sources offers a limited picture of disparities in the two-track system—but it does show that white clientele statewide were more likely to be routed into treatment through the professional health care system, while Minnesotans of color were more likely to be referred by the criminal justice system or another county agency. Criminal justice and county agencies were cited as referral sources for 80.3% of all Black treatment participants, 86.4% of American Indian participants, and 89.2% Hispanic participants—compared to 70.9% of white clientele. White clientele also had the highest rates of referral from “personal” or professional healthcare sources (McRae 2009).²⁷

²⁶ The year I entered the field, whites were slightly underrepresented among all treatment participants in Minnesota, comprising about 74% of all admissions. African American and American Indians participants were overrepresented, at 11.5% and 8.1% of all admissions respectively. See: McRae, James. 2009. "Racial/Ethnic Differences in Treatment for Substance Abuse and Dependence in Minnesota." Vol..

²⁷ These numbers are difficult to interpret however, because participants could report more than one referral source. More importantly, these numbers do not distinguish at all between the form and content of the programs court-referred clients were exposed to.

In a subsequent study using Minnesota Department of Human Services data, researchers noted consistent racial patterning in treatment referral source-- the criminal justice system referred 36.6% of whites to treatment, 39.2% African Americans, 47.3% American Indians, and 48.3% Hispanic participants (McRae 2013). While this data provides some insight on the racialized structure of rehab participation, a clearer demographic map of treatment divides would be difficult to create due to the impossibility of neatly matching referral sources—or even program types—to specific “treatment logics” without sustained qualitative study. What I refer to as “strong-arm” logic denotes a residential therapeutic community with substantial criminal justice “backup,” but the strong-arm version of rehab is not the only kind of treatment that court-mandated clientele may encounter. That is, court-backed programs can and do take on other forms.

In short, understanding the form and content of rehab requires placing programs within the highly local character of the treatment field, and considering how broader racial and socioeconomic disparities shape treatment participation. As the forthcoming analysis illustrates, disparities in the state’s criminal justice, labor market, education, neighborhood and healthcare systems— shaped both addictions and the dynamics of rehab participation in the Twin Cities. The polarization of race, class and treatment coercion across my field sites then, is a reflection of the strong relationships between poverty, racial disadvantage and institutional confinement in particular contexts. My targeted, comparative case selection was designed to illuminate these patterns— an opportunity to see more clearly how race, class and coercion (or the absence of coercion) work to structure the rehab experience. We begin with KJ’s story.

From Criminalization to Coerced Treatment: KJ’s Story

Jesse “KJ” Watkins left his South Side Chicago neighborhood to board a Greyhound bus for Minneapolis in the summer of 1988. He was headed to his sister’s home, where he would reunite with family for the first time since childhood. It was a

reunion that KJ, a tall, African American man with an energetic smile and sparkling eyes, had looked forward to for most of his young life. Abandoned by their parents when KJ was five years old, the Watkins children had been split up and scattered across the state's foster care system. Of all his siblings, KJ had fared the worst, suffering through several abusive homes before dropping out of school, living on the streets, and joining a local gang. It was the beginning of a decades-long cycle of drug-related crime, homelessness, and incarceration for which KJ would spend a combined twelve years of his life in prison.

At age 21, recently discharged from the Joliet Correctional Center, KJ got a call from his sister offering him a new start in Minneapolis. He eagerly accepted and packed his bags for another shot at "going legit." But leaving Chicago was not the new chapter KJ had hoped for. A high-school dropout who spent much of his young life in juvenile institutions, the enduring stigma of a criminal record meant he had no real prospects for employment months after arriving in a new city. His continued joblessness created tensions with his sister, causing a rift that left KJ without family support and back on the streets, once again.

He tried to keep to himself, sleeping out alone for the first few nights. But KJ had arrived just as crack cocaine was exploding on the urban scene, and it wasn't long before he was lured by the potential profit of a quick hustle. Desperate to make enough cash to get off the streets, he recounts how he landed at The Madison, a one-time luxury hotel which had become the city's notorious "last destination" for homeless and transient populations.

"I met a couple of friends I considered homies, and they were from the same organization that I was from, the gang that I was from. Same branch, but not the same people. I seen how they were selling crack, so I wanted to get involved. I invested a hundred dollars, and dude showed me how to cut it up, how to bag it up, and everything. And then, I seen from a hundred dollars, I made three hundred dollars. So I was like, 'Okay, what can I make off two hundred dollars?' And so I kept going. And next thing I know, I found myself doing more, 'cause that kept me with my weed, it kept me with money-- not worried about nothing."

KJ forged ties with affiliates from his former gang, who showed him how to process, package, and sell the newly popular crack cocaine for profits that could

quintuple principal investments. He lived at The Madison until 1993, where he quickly advanced up the ranks in the crack trade. While KJ's early days selling crack yielded high profits, drug money was "fast money"—rapidly appearing, and gone just as quick. To make ends meet, he routinely combined public assistance with dealing, other crime, and an assortment of odd jobs for cash. For a brief period in 2000, he attempted to "go straight" by taking a job washing dishes at a TGI Fridays. But when he saw his check for a week of full-time work—just barely \$150—he quickly reconsidered his efforts.

"To me, that wasn't no money. I'm talking about putting out a thousand or better out of your pocket, then you're doin' good. But the kind of money that I was making at that job, and then having to depend on the SSI to come in, oh no, nuh uh. I needed to sell drugs, and I wasn't fit go no other way. So I quit my job, and started back selling again."

Dealing provided KJ with a stream of income, however unpredictable, which he could never hope to see in the low-wage labor market. Yet the constant drudgery of scraping by, punctuated by the unpredictable dangers of street life, took its toll on KJ, fueling the escalation of his own drug use. Marijuana and alcohol had been his "drugs of choice" back in Chicago where he had often enjoyed "a blunt and a forty-ounce" to pass the time on summer nights "out on the block." Shaped by the rhythms of the informal economy, drinking malt liquor and smoking weed had become an everyday practice for KJ, an embodied aspect of the street dealer's "habitus."

KJ's marijuana use also reinforced a symbolic divide between his own identity as a street dealer, and the addicts who purchased his product. For years, KJ avoided the "harder" drugs that he sold to "out of control junkies," fearing that crack or heroin would destroy his ability to work long hours and maintain vigilance in precarious situations. While his safety had many times been compromised working in the drug trade, drugs had also become a significant source of security, power, and control for KJ.

"In the past, it was my bread. It kept me with clothes, kept me with money, kept me with weed, kept me with the lifestyle I wanted to live, so I didn't feel that weed was a problem. I didn't feel that hustling on the street was a problem. I felt it was a part of me surviving."

Hustling for survival in the city's most economically depressed neighborhoods left KJ vulnerable to constant surveillance by local law enforcement, and much of his life was spent "on the run"-- cycling between prisons, institutions, and the street (Goffman 2009). His chronic homelessness and involvement in the drug trade made him highly visible in the city's most heavily policed areas, resulting in numerous incarcerations. Prison was an excruciating experience, exacting a heavy toll on KJ's mental, emotional, and physical health. During one of his sentences, he suffered a brutal rape, an experience which left him traumatized and HIV positive. Each time he was released from prison, his drinking escalated, as he required larger amounts of alcohol to achieve the "numbed out" feeling that had become his respite from constant suffering.

For the next several years, KJ's role in the crack trade declined substantially, and he hustled only to support his basic needs and fund what had become daily alcohol and marijuana use. He became less able to distinguish himself from the addicts who purchased his product, as he started to view drinking as essential for his psychic and emotional survival. Marijuana and alcohol eased his intense social anxiety, provided a drifting relaxation, and offered crucial health benefits as well. His HIV-related health complications were worsened by his lack of regular access to medical care, but smoking weed eased some of the more intolerable effects of the medication he took. By 2009, KJ's health had rapidly deteriorated and he was homeless once again. But this time, another stint in prison would send him not back to the streets, but into court-mandated rehabilitation at Arcadia House.

I met KJ at Arcadia House in the fall of 2011, where he was completing a second round of court-mandated drug treatment-- what he firmly insisted would be his last time in "the system." As we sat down to record his "life history" interview in one of the facility's small group rooms, he clutched the key to the Lino Lakes prison cell he'd just been released from several months before. "I take this key with me everywhere," he explained. "Because it's a reminder of everything I went through, and why I never want to go back to that lifestyle."

KJ's story illustrates many common themes in the lives of Arcadia's most marginalized addicts-- entrenched poverty, little formal education, chronic joblessness and enduring homelessness; hyper-criminalization, frequent incarceration and institutionalization; and exposure to routine violence, victimization, and disease. The details of KJ's life capture the status of many clients when they entered Arcadia's program—over half had no income, about one-quarter were receiving public assistance, about half were homeless, and only 10% were employed.

Chronic poverty and labor market inactivity made the informal economy attractive to many participants. Combined with intense criminalization-- faced especially by the Black participants-- many had experienced quite extensive histories of institutionalization by the time they were court-mandated to Arcadia—although KJ was more involved in crime than many Arcadia men had been. During the period of my fieldwork at Arcadia House—late 2009 to early 2012-- client demographics reflected the racial and class disparities that plagued the larger prison population. African Americans were overrepresented at about half of the facility's clientele, about 36% were white, 6% were Latino, and the remaining 8% were comprised of Native American, Asian and African clientele.²⁸ Like KJ, roughly half of the men I encountered had at least some involvement in the drug trade, and the vast majority framed this involvement as a pathway to economic survival.

KJ had been court-ordered to attend rehab as one condition of an intensive supervised release from prison after his last drug conviction.²⁹ Like the vast majority of Arcadia clientele, his treatment was mandated by the criminal justice system and publicly funded, he would remain under considerable surveillance both during and after rehab, and he faced re-incarceration should he fail to complete the program.³⁰ After Arcadia's four months of required residential treatment, he would complete six months of mandatory

²⁸ See facility demographic information at the end of this chapter.

²⁹ One local news report estimated that nearly 40% of those placed on intensive supervised release in Minnesota reoffend within the first year. See: Howatt, Glenn and Pam Louwagie. 2011. "40% of Offenders Fail on Supervised Release in Minnesota." in *Star Tribune*. Minneapolis, MN.

³⁰ At the time of my study, three-quarters of Arcadia's clientele were referred by the criminal justice system—25% were on drug court, and about 50% were probationers and parolees. Very few clients reported self-referral. See program demographics table at the end of this chapter.

“aftercare” in which he would return to the facility three times per week for additional outpatient sessions.

While these terms were common among drug court clients and probationers, KJ’s supervision was even more intense. After treatment, he faced a period of GPS monitoring and house arrest, random urinalysis, scheduled weekly “check-ins” with his PO, and unannounced “house visits.” The “community” portion of his sentence would last nearly five years, and would require the successful completion of rehab and demonstration of continued sobriety. KJ’s story illustrates how chronic poverty, racial inequality, and hyper-criminalization worked to shape the lives of “*criminal-addicts*,” and to route them into strong-arm rehab. In the next section, I examine some of the social and historical forces that set the stage for contemporary forms of coerced treatment.

Coercing Criminal-Addicts: The Evolution of “Strong-Arm” Logic and Practice

Classing, Racializing & Criminalizing the Addict

For most of the 17th and 18th centuries in colonial America, the excessive or habitual use of drugs or alcohol was regarded as a choice which signaled moral vice or flawed personhood. In the late 1700s, Dr. Benjamin Rush’s efforts to protect habitual drinkers from “diseases of the will” formed the earliest articulations of the disease concept, and laid the basis for the opening of the nation’s first “rehab centers”-- the 19th century inebriate homes and asylums for the “care and control” of alcoholics (Valverde 1998, Weinberg 2005, White 2002). By the early 20th century, these institutional forms had evolved into a system of inebriate farms, state insane asylums and sanitariums.

Early progressive social reformers’ efforts to institutionalize the management of addictions were already taking shape along different “tracks.” Temperance crusaders-- often white, Protestant elites-- expressed mounting concerns over the public intoxication

and visibility of indigent alcoholics—often Irish-Catholic and German-Lutheran immigrants who had joined the ranks of the urban poor (Gusfield 1967, Gusfield 1986). By the turn-of-the-century, poor addicts were being treated in public hospitals, local jails, and county farms-- while affluent addicts frequented the nation’s private sanitariums (White 2002). At the same time, American experiments in drug criminalization were contributing to the widening distinction between licit and illicit users—which evolved into the full institutional separation of treatment for alcoholics and drug addicts.

As Darin Weinberg argues in his excellent genealogy of the treatment of addictions and insanities in America, the notion that “addiction” could be manipulated through outside intervention evolved in connection with the social conflicts arising during the country’s periods of rapid urbanization and industrialization (Weinberg 2005). While the techniques of rehabilitation were sometimes used to restore the moral identities of certain “respected troublemakers,” punitive approaches were usually applied to more marginalized addicts. With the expansion of free market capitalism came a greater emphasis on personal responsibility and self-control, and “addictions came to be viewed as obstacles to the economic exploitation of the poor, catalysts to their becoming dangerous, scapegoats for their apparent suffering and intransigence, and... explanations and justifications for their continuing treatment as *others*” (Weinberg 2005). Indeed, the practice of confining “troubled paupers” to publicly funded institutions long predated the presence of medical authority in those spaces. Almshouses, workhouses, and jails were the preferred techniques of management for the lower classes of America’s emerging industrial cities (Irwin 1986, Simon 1993).

Coinciding with the various waves of American drug criminalization, the stigmatization of addicts as “undesirable” spiritual and moral failures was also a highly racialized process (Acker 2002, Inciardi 2008, Musto 1973, Reinarman and Levine 1997, Reinarman 2008a). The 19th century hysteria surrounding Chinese immigrants in opium dens—which soon became marked as “vice districts”-- identified the particular habits of some opiate users as criminal and immoral. Meanwhile, housewives addicted to the opiate nostrums and tinctures that were widely available in legal patent medicines and dispensed in physician’s offices were viewed with far more sympathy and tolerance

(Acker 2002, Conrad and Schneider 1992). From opium and Chinese railroad workers, to marijuana and Mexican migrant laborers, to alcohol and impoverished European immigrants, to crack cocaine and unemployed, urban Black youth-- the drug habits and addictions of the marginalized have long been the more explicit targets of reform in the political, economic, and social management of American racial and class Others.

Even as Progressive-era humanitarian reformers argued that all addicts were harmfully “enslaved” by drugs, the Protestant ethics of self-control and Victorian condemnations of pleasure were mapped differently onto addicts across race and class (Becker 1963). For some middle and working-class Americans, emerging alcoholic mutual aid societies in the 19th century were avenues to greater social status. Aid societies like the Washingtonians allowed both women and men of lower class positions to become active in the temperance movements, distinguishing them from those lower on the social hierarchy. Yet the boundaries of inclusion extended only so far, and the urban, impoverished, and immigrant classes were mostly left out (Valverde 1998, Weinberg 2005). By the early 20th century, support for the inebriate asylum was waning, and Americans were increasingly turning to more coercive methods of managing the addict.

The passage of the Harrison Narcotics Act in 1914, the first major US anti-drug legislation, further cemented addiction as a mark of criminality, making those in possession of patent medicines containing cocaine and morphine in violation of the new drug laws. Many of those affected by this sea change in drug legislation were addicts whose conditions had previously been “treated” by physicians with the outlawed drugs (White 2002). After the Harrison Act, existing morphine maintenance clinics were forced to close as physicians working toward a medical cure for addiction were aggressively targeted and criminalized by Harry Anslinger and the emerging Federal Narcotics Bureau (Hari 2015). It was not until the rise of the 1960s-era methadone clinic that opiate addiction would come back under the domain of the physician (Dole and Nyswander 1980, White 2002). Early 20th century drug criminalization had shifted the control of addicts away from 19th century physicians and into the correctional system, driving a wedge between public health and punitive responses to addiction which would only splinter further into the “tracks” of the contemporary system.

Early Forms of Coerced Treatment

The vigorous creation of many new “drug crimes” in the first half of the 20th century routed more addicts—and especially poor addicts—into the hands of the criminal justice system, setting the stage for the earliest forms of coerced treatment. The “civil commitment” of addicts to compulsory treatment in state psychiatric hospitals dates back to 1874 when it was first used in Connecticut (White 2002). From the morphine maintenance clinics in the early 1920s, to the opening of the first public hospitals in 1935 that treated incarcerated and self-referred substance users, to the contemporary drug court movement—the American legal system has been coercing addicts into treatment for the past century (Klag, O’Callaghan and Creed 2005).

Rebecca Tiger’s *Judging Addicts: Drug Courts and Coercion in the Justice System*, documents how the ideas and impulses that gave rise to coercive addiction treatment were first set into court practices during the Jacksonian and Progressive Era transformations in punishment. Ideas informing the involvement of criminal justice in the treatment of addicts were “neither radical, nor a triumph,” but instead resulted from competing medical and moral theories of deviance that were unfolding in the progressive-era reforms of the late 19th and early 20th centuries (Tiger 2011). Like later drug court advocates, these early reformers used medical models of deviance to justify the expansion of the correctional treatment of addicts, rather than relinquishing ownership of the problem to medical authority.

Beginning in the 1920s and 1930s, the federal “narcotic farms” functioned as early forms of “drug diversion,” routing addicts who were legally committed by the federal courts from the newly overcrowded prisons after enforcement of the Harrison Act. The narcotic farms served another purpose which had intensified after mass drug criminalization—the sequestering of the much more stigmatized illicit drug addict population from alcoholics and other “problem” users (Campbell, Olsen and Walden 2008). The narcotic farms are important developments in the history of court-backed treatment, and they eventually evolved to treat addicts who had been “sentenced” to residential therapeutic communities, before closing in the mid-1970s.

In the 1960s, criminal justice involvement in addiction treatment intensified. In the crucial *Robinson v. California* decision, the Supreme Court reinforced its position that addiction was a disease worthy of treatment, striking down laws that proposed making narcotics addiction a punishable crime (Tiger 2011, White 2002). By the 1960s, most states with large addict populations had instituted civil commitment programs. California's Civil Addict Program, for example, permitted the state to involuntarily commit addicts to inpatient programs, and in 1966, the federal government passed the Narcotic Addict Rehabilitation Act under which all states could implement coercive treatment (Musto 1973). While most of these early reforms were happening inside correctional institutions, the Treatment Alternatives to Street Crime (TASC) initiative was the first one to relocate participants to settings outside prisons (Nolan 2001). Despite these early transformations, at mid-century, few addiction treatment resources were available on the national scale. It was within the context of amplified drug criminalization and the increasing involvement of corrections in the domain of rehab that the therapeutic community model of treatment first emerged.

The Rise of Therapeutic Communities

The therapeutic community (TC) has its roots in the ex-addict-directed “anti-criminal” societies of Synanon that began in the late 1950s. Alcoholics Anonymous follower and ex-alcoholic Charles Dederich drew on basic Twelve Step philosophies and principles to inform the creation of the first TC based on non-professional leadership, conformity, intense confrontation, and family structure (Gowan and Whetstone 2012, Kaplan and Broekaert 2003, Sugarman 1974, Yablonsky 1962). A domineering personality, Dederich quickly severed ties with AA to focus on developing his own model-- a radically different approach centered on a firm commitment to abstinence and “right living.”

Just as AA and the Minnesota Model were medicalizing addictions (which I address in the sections that follow), the TC was popularizing a very different view. Dederich rejected AA's “allergen” theory, with its focus on exoneration from moral culpability and destigmatization of the addict. Instead, he drew on the much older

moralistic logics, arguing that addiction was the manifestation of an underlying character defect, and that addicts were fully responsible for any problems they experienced (Weinberg 2005). Addicts were portrayed as grandiose, hedonistic, and narcissistic. Never having properly developed, they were locked in perpetual immaturity, and recovery was envisioned as the process of emotional maturation through self-discipline.

Therapeutic communities attempted to instill self-discipline through “habilitation,” the process by which participants were aggressively re-socialized for “right living.” Programs were typically structured according to a hierarchy of positions through which patients had to rise toward successful completion-- and regular confrontational forums reinforced moral accountability in a “pressure cooker” environment. The engine of the resocialization process was thought to be the internal system of rewards and punishments, which would ensure behavioral compliance and submission (Janzen 2001, White 2002, Yablonsky 1962, Yablonsky 1965). Transformation for the defective addict was thus possible, but according to Synanon’s philosophy, it should encompass all aspects of the addict’s former life-- personality, interpersonal relationships, lifestyle and cultural milieu (White 2002).

Extremely confrontational and humiliating “attack therapies” were key devices for accomplishing this re-socialization. The use of these therapies was based on the core belief within the movement that treatment had to be forced upon addicts, who were otherwise incapable of meaningful change. Psychological insight was considered ineffective, and humiliation tactics were embraced as “learning experiences.” Hallmark techniques of Synanon, which were common in other early TCs, included confrontations between staff and clients known as “pull ups,” degrading punishments that required patients to wear humiliating signs or outfits, and shaming rituals like shaving the heads of non-compliant members. In one particularly illustrative example, the intake process at an early TC required the patient to admit “I am a baby,” “I am stupid,” and “I need help” before they entered the program (White 2002).

While the most extreme tactics of earlier TCs have faded away, therapeutic community principles and methods have been highly influential in shaping the history of American addiction treatment. Lay therapy had previously been common in early

mutual-aid societies for alcoholism, but Synanon's legacy included mainstreaming the recruitment of ex-addict counselors and staff in residential programs. Perhaps more importantly, the early therapeutic communities first popularized the notion that addiction treatment should entail a radical resocialization of the whole person, based on Synanon's mission to "habilitate" addicts and alcoholics through participation in a tightly organized community (De Leon 2000, Kaplan and Broekaert 2003, White 2002).

The Birth of Strong-Arm Rehab

Today, many long-term residential treatment facilities in the US employ some form of the "therapeutic community" model first crystallized in Synanon, despite the institution's tragic and bizarre endings.³¹ State-funded programs drawing on the TC model proliferated in the 1960s, and early iterations included the "anti-criminal societies" of Phoenix House, Daytop Village and Delancey Street. The programs that eventually merged with the state differed from Synanon's template in significant ways, however. These models sought to reintegrate addicts back into society, while Synanon's method had eventually become the permanent maintenance of a self-contained utopian community. Therapeutic communities accepting public funds also had to modify some aspects of their programs to state and federal guidelines, which included utilizing more professional staff and abandoning the most egregious degradation tactics (De Leon 1995, De Leon 2000, White 2002).

Therapeutic communities provided treatment for addicts in prison or on probation in limited forms in their early days (Janzen 2001). Yet because of the "natural" affinity between criminal corrections and the TC approach, this relationship would strengthen and expand as the TC became the preferred model of court-backed addiction treatment. Among other things, TCs provided 24-hour, monitored community environments; they

³¹ The institution first evolved into a "utopian community," and was later portrayed as a "paramilitary religious cult" when Dederich—a leader described as having a "messianic complex"—was charged with conspiracy to commit murder. See: White, William L. 2002. *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*. Chicago, IL: Chestnut Health Systems..

applied numerous restrictions, rules, and routines; and they employed confrontational styles designed to enforce personal responsibility among “pre-socialized” addicts (Yablonsky 2002). The TC approach was thus highly resonant with many forms of correctional psychology, its “total institution” feel mimicking the panoptical control which was established as an effective disciplinary technique in the nation’s first prisons. Commenting on the social control imperatives of prison rehab, Darin Weinberg insightfully remarked, “The willingness to let inmates exercise therapeutic authority was driven less by a respect for their insights into the nature and management of addiction, than by a concern to divide the ranks of what [was] regarded as a hostile and criminal culture” (Weinberg 2005). In many ways then, the operating structure of the TC was an attractive disciplinary mechanism that could function as an analog to the surveillance and control of the prison.

One early example of a “strong-arm” rehab was Daytop Village, established by the Probation Department of New York in the mid-1960s. Designed and operated by the state, Daytop focused on the rehabilitation and reintegration of former drug criminals (Kaplan & Broekaert 2003). Daytop graduates were meant to be sent out into the world to “act as role models for a drug-free lifestyle and therefore exert the social impact of the TC on the wider society” (Sugarman 1974; Kaplan & Broekaert 2003). These strong-arm rehabs, and others like them, built strong relationships with local probation and parole offices. Not only did they admit recently released offenders, but beginning in the mid-1970s, judges and probation officers started considering them as alternatives to prison sentencing (Gowan & Whetstone 2011).

As strong-arm rehab proliferated across the country, it advanced a particular fusion of two logics: TC notions of addiction as a sign of an underlying character flaw, and psychological notions of “the criminal personality” that were being popularized in criminology and correctional policy. The “psychogenic” theory of addiction popular in the TC has more than one hundred years of support in treatment communities, and links addiction with a constellation of other dysfunctional behaviors including irresponsibility, a lack of impulse control, lying and manipulation (Dole and Nyswander 1980). Movements in criminal psychology seeking to determine “the mental makeup of the

drug-using criminal” were similarly attempting to establish the roots of addiction in underlying “criminal personalities” (Yochelson and Samenow 1976). Crafting portrayals of criminals as “rational, calculating, and deliberate,” substance abuse was cast as one of the many manifestations of their fundamentally antisocial nature (Samenow 2004). These approaches draw clear distinctions between addicts and *criminal-addicts*: “Unlike a disease that a person contracts through no fault of his own, the criminal chooses to ingest, inject, or smoke certain substances. Nothing compels him to do so” (Samenow 2004). Habitual drug use among criminal-addicts is reframed as the result of choice, thrill-seeking and acquisition of control—and a key determinant of future criminal activity.

The TC was in many ways perfect then—both in form and in content—to unify with emerging correctional theories and form a new set of techniques for correcting cognitive deficits, reforming deviant subcultures, and treating criminal-addicts. But while converging philosophies might have sparked an initial affinity, the state’s increasing involvement in the TC’s model and method required several transformations. For one, the highly degrading techniques which characterized the infamous early approaches had to be tempered. Since the 1980s, widespread consensus among addiction treatment professionals has been that approaches based on confrontation and shaming are not helpful—and even actively harmful—for an addict’s recovery (White and Miller 2007). So while they defend the necessity of coerced treatment, programs today have moved away from the most extreme tactics of earlier therapeutic communities. Yet as my ethnography of Arcadia shows in the next chapter, they have not completely evaporated. Second, state involvement has forced TCs to reckon with more medically legitimized versions of addiction-as-disease. While they might pay lip service to NIDA’s brain disease model on the surface though, as both previous work with Gowan and my current work shows, strong-arm rehabs rarely mobilize those models in practice (Whetstone and Gowan 2011).

The Expansion of the Drug Court Movement

In the 1970s and 1980s, the “pendulum” of criminal justice reform had once again swung back to an anti-rehabilitative approach. In Nixon’s declaration of the “war on drugs,” in Reagan’s era of “law and order,” and in policies that were escalated by nearly every administration since, a reinvigoration of moral discourse led to various cultural and ideological assaults on the state of American addiction treatment-- and on addicts themselves (White 2002). Indeed, since the 1960s-era, Republican-led “Southern Strategy,” American punishment has taken on a “purple” hue. As policymakers of all political persuasions have embraced harsher methods of “governing through crime,” support for punitive drug crime policy has consistently defied the “red” and “blue” of traditional party lines (Page 2012). By the late 1980s, classic critiques like Stanton Peele’s *The Diseasing of America* drew on the “nothing works” zeitgeist of the times to critique what had by that point become the accepted wisdom of the “disease model” and the hegemony of AA discourse (Peele 1995). During this period, treatment resources dwindled nationally, and addicts were once again incarcerated en masse. Rehabilitation became inaccessible for most of the nation’s poor and working-class addicts, and the treatment field moved almost exclusively toward outpatient services for addicts outside the criminal justice system.

Ironically, the one area where treatment dollars were still being spent was in the war on drugs, fueled by an intensifying collaboration between the treatment industry and criminal corrections. The 1990s, for example, saw the expansion of criminal justice case management in rehab, the growth of drug court initiatives, more treatment inside jails and prisons, and drug rehab as an increasingly common feature of probation and parole. The drug diversion movement represents an important element within the latest “rehabilitative turn” in American punishment (Hora 2002, Nolan 2001, Tiger 2011). Along with the newer phenomenon of drug courts, the classic correctional models of probation and parole are increasingly sentencing low-level drug offenders to programs like Arcadia House. Indeed, drug courts represent only a fraction of this much larger expansion of the “fuzzy edge” of the criminal justice system—an expansion that occurred even as the core of national treatment services dwindled.

Of the various forms court-backed treatment has taken on, drug court programs have been lauded as the most “promising.” The drug court movement diverts low-level drug offenders out of prison and into community-based addiction treatment facilities—many of them “strong-arm” programs like Arcadia House. Since the birth of the movement in 1989, drug courts have been backed by widespread political support-- in part, because they provide solutions to address prison overcrowding and other crises which do not seriously threaten the role of criminal justice in managing addictions. These courts rely on the notion—now accepted belief-- that addictions underlie and exacerbate criminal behavior, and that criminal-addicts can be helped through court intervention (Tiger 2011).

Once heralded as revolutionary, the notion that drug courts “work” seems to have been settled among court advocates, evidenced by one prominent advocate’s claim that, “Working therapeutically is an appropriate, effective, and productive way for the justice system to function” (Hora 2002). Advancing the view that “force is the best medicine,” advocates contend that punishment constitutes an essential part of the healing process, rather than a serious conflict with the goals of therapeutic intervention (Tiger 2011). To support the use of coercion, they point to studies showing that coerced patients tend to stay in treatment longer than voluntary patients, and that coercion is a more effective motivator for addicts recovering from the most severe forms of the disease (Kelly, Finney and Moos 2005). They also cite a large body of work claiming that drug courts are cost-effective methods for reducing recidivism (Hora 2002, Huddleston III, Marlowe and Casebolt 2011, King and Pasquarella 2009, Rossman et al. 2011b).³²

While short term reductions in recidivism might make for correctional policy that is more cost effective than prison, drug court’s impact on long-term sobriety for recovering addicts is far more dubious. Some studies have argued that coercion has negative long-term effects on sobriety (Urbanoski 2010, Wild 2006), and others raise

³² Despite the popularity of these studies, they continue to be debated and disputed. One meta-analysis, for example, found that drug courts only effected an 8% reduction in recidivism, much lower than what is typically claimed. See: Gutierrez, Leticia and Guy Bourgon. 2012. "Drug Treatment Courts: A Quantitative Review of Study and Treatment Quality." *Justice Research and Policy* 14(2):47-77..

doubts that court-mandated treatment can respond to the complex needs of addicts (King and Pasquarella 2009, Lutze and Van Wormer 2007). One of the most comprehensive evaluation studies to date determines that drug court's outcomes are no better than those of voluntary treatment—which continue to be dismal (Rossman et al. 2011a).³³ Indeed, while drug courts might “work” to keep people sober long enough to fulfill their court requirements, my observations at Arcadia House suggest that they expose participants to decidedly anti-therapeutic settings which might actually be counterproductive for longer-term sobriety.

Beyond questions about their effectiveness, serious criticisms of drug courts include their potential “net-widening” effects, their potential disproportionate racial and class effects, and their potentially extreme levels of intrusion into clients’ lives (Gebelein 2000, Tiger 2011). The vast majority of non-violent offenders entering drug court might not have been processed through the system at all, or might have received comparatively shorter sentences. There is a growing concern that instead of providing an alternative sentencing route for arrestees, drug courts actually “widen the net” to increase the number of people being processed through the system, while also potentially increasing their sentence lengths (Hoffman 2001, King and Pasquarella 2009, Mauer and King 2007, Mauer 2009, Pollack, Reuter and Sevigny 2010, Sevigny, Fuleihan and Ferdik 2013).

Drug court's effect on racial disproportionality in the criminal justice system is not well understood. Racial representation in drug courts has been reported with extreme variability across jurisdictions, but the common perception is that African-American participants are underrepresented in drug court, still far more likely than their white counterparts to be sent to prison for drug crimes. According to one study, the representation of African-Americans in jails and prisons was nearly twice that of their representation among drug court defendants and probationers (Huddleston III, Marlowe

³³ These critiques also acknowledge that drug court evaluations rarely examine the inner workings of the rehab facilities where participants spend most of their “sentence,” leading to little understanding of the mechanisms that drive any purported reductions in recidivism. See: Goldkamp, John S, Michael D White and Jennifer B Robinson. 2001. "Do Drug Courts Work? Getting inside the Drug Court Black Box." *Journal of Drug Issues* 31(1):27-72..

and Casebolt 2011). Systemic differences in plea-bargaining, charging or sentencing practices might be screening otherwise eligible minority citizens out of drug court. When they do make it in to a program, studies show that clientele of color are less likely to successfully graduate than their white counterparts, and more likely to receive punitive sanctions for program violations (Gross 2010, Howard 2016, Marlowe 2013).

For these reasons, drug courts have failed to ameliorate any of the racial disparities that plague the larger prison system (O'Hear 2009). While drug courts were early on credited with helping to reduce the disproportionate prison confinement of racial minorities (Mauer 2009), jurisdictions are now claiming they are “failing Black defendants” and calling for transparency and equity in the extension of drug court options (Ulloa 2015). Yet even as participation expands among drug offenders of color, my research suggests that drug diversion poses potentially more serious threats: In diagnosing criminal-*addicts* through a medical-moral lens, they contribute to the naturalization of systemic racial bias in mass incarceration.

Drug courts—and other forms of drug diversion within criminal corrections-- are not only expanding access to longer-term, residential “strong-arm” programs. National reductions in residential treatment services increase the likelihood that the non-poor will take part in outpatient addiction treatment—both its “voluntary” and its more coercive forms. A larger number of addicts are encountering court-mandated outpatient treatment—a form that is considerably more diffuse and less intrusive than its residential counterpart. Yet while these programs may not be able to accomplish the “full immersion” social control of residential rehab, the presence of court backup no doubt creates a significantly more criminalized therapeutic encounter with a greater focus on tracking and surveilling those participants whose daily behaviors are not being policed within institutions.³⁴

³⁴ While I wasn't able to conduct observations of court-mandated outpatient treatment for this dissertation, in previous work I conducted as an undergraduate intern at an outpatient county drug court program in Illinois, breathalyzing, drug testing, and documenting attendance for the court system comprised much of the process of “therapy.”

Yet while court-backed treatment can take on a variety of forms, I argue that “strong arm” residential rehab constitutes a unique institutional development within the American treatment scene, and one which is unparalleled in its expansion on the national scale. The criminal justice system now makes nearly 40% of all referrals to addiction treatment, and many of these rehabbers will end up in strong-arm facilities (SAMHSA 2014). Despite the growth of this phenomenon, there has been little recognition of its impact on therapeutic practice in clinical literature or among treatment practitioners. A good example of this glaring oversight can be seen in Anne Fletcher’s book, *Inside Rehab: The Surprising Truth about Addiction Treatment—and How to Get Help that Works*. Reviewing American rehab for families and consumers, Fletcher documents the form and content of many key Minnesota programs, but barely mentions the existence of coerced treatment. Perhaps that is why after her “exhaustive” review of the treatment world, she claims not to have seen any of the “old-school, confrontational strategies from the past” (Fletcher 2013).

Inside Arcadia House

The historical trends and social developments I have discussed so far set the stage for the routing of low-level drug offenders into Arcadia’s dorm-style housing, where they would encounter the particular treatment logics of “strong-arm” rehab. While it was possible for privileged clients to leave on a ‘pass’, and indeed for anybody to decide to ‘walk’, Arcadia House felt like a custodial facility. The three floors open to the clients had a bare-bones, firmly institutional character. ‘The Board’ was one of the few images on prominent display in the hallways, listing clients’ room assignments, house tasks, and currently sanctioned individuals. Close by was “the bench,” where resistant clients were sometimes ordered to sit in silence for hours at a time—one of the program’s many infantilizing punishments which conjured up the legacies of Synanon’s therapeutic community.

Arcadia housed up to 30 men at a time, and the men slept four to a room. They spent their daylight hours in even closer quarters, shuttling on a strict schedule between the group therapy rooms and the dimly lit dining room in the basement. For relief, they

looked forward to the privilege of using the single television to watch an approved video, making a call on the lone payphone in the lobby, and using the soda machine--moments of normality which for many symbolized the sole vestiges of their lives outside.

The 120 day program combined elements of intensive behavioral modification, Alcoholics Anonymous meetings, family therapy, and 'life skills' development.³⁵ Once diagnosed as a criminal-addict and "sentenced" to treatment, Arcadia men would participate in an intense daily regimen of group therapy, lectures, and chores for six months to one year in exchange for staying out of prison. Each man attended several group therapy sessions per day, alternated with lessons organized around themes like "accountability," "emotional maturity," or "relapse prevention." The "criminal thinking curriculum" and the confrontational "report group"—which I discuss in detail in the next chapter—positioned correctional objectives front and center in the therapeutic process.

Like in other TCs, staff and counselors theorized addiction as a symptom of an underlying "criminal personality" which causes "criminal-addicts" to engage in a range of dysfunctional behaviors requiring full "habilitation."³⁶ Staff were typically former addicts themselves, and some lacked professional credentials. While the program officially acknowledged the brain disease theory of addiction, neuroscience was quickly set aside for a program based on strict discipline and mutual surveillance, aiming to reform bad behaviors. The program's punishment-reward system was designed to rehabilitate the addict by making him more productive and accountable through strict rules, mundane tasks, and deference to the hierarchical "coordinator" structure.

Coercion and criminal justice backup had far reaching effects on the process of treatment at Arcadia. As I'll discuss later, the strong evocation of "family" and the peer-supported model of recovery that was instrumental in making AA the largest self-help movement in the world was invoked in Arcadia's program, but ultimately undermined by the strong sense of distrust created through close contact with the criminal courts.

³⁵ Arcadia House also had a shorter 60-day "day program" for clients who lived offsite, but my focus is mostly on those men who were in the residential portion of the program.

³⁶ Arcadia staff refused to call their work "rehabilitation," believing their clients were learning "pro-social values" for the first time.

Arcadia's widespread reputation among both participants and practitioners as an "end of the line" institution which served only the most "treatment resistant" client only reinforced high levels of distrust and suspicion. Neil, an Arcadia graduate, put it this way:

"When you come to Arcadia, this is the end of the road, pal. We've tried. You've been to this treatment, and this treatment, and this treatment. People don't just go to Arcadia as their first treatment center... There are a couple people in there that will say, 'Yeah, this is my first treatment.' No. That's one of the criteria. They don't belong there, and they wouldn't understand the program. They'll send those people to Fawndale, New Connections, Healing Bridges, or someplace else."

Yet while Arcadia had a local reputation for dealing with the "hardest cases," I found this wasn't the case in terms of the severity of participants' substance abuse problems. Arcadia clients experienced far more social disadvantage and legal troubles than the men at Healing Bridges, but I was repeatedly struck by how many of them had relatively tame histories of drug use, mostly confined to alcohol and marijuana. Those who had taken on the label of "addict" to avoid incarceration for small-scale dealing or minor possession often didn't truly believe they were addicts, and they struggled to engage in the radical reframing of their pasts required by the program to demonstrate compliance.

While Arcadia is similar to "strong-arm" rehabs described in other ethnographies (Kaye 2012, McKim 2014), racial divides between the all-white staff and the majority clients of color-- combined with local disparities to shape a facility that was more racially charged than the sites in other accounts. This can be traced in part to the "net widening" effects of the local drug court I studied which routed clients into Arcadia. In the first phase of its history, the court had wide eligibility standards, and was among a handful in the nation allowing offenders to enter the program for both drug-related and property crimes.³⁷ Since the inception of the court in 1997, arrest rates in Minneapolis increased 17% the first year, the number of defendants prosecuted for drug crimes had risen by

³⁷ Violent offenders are generally excluded from drug court programs.

50% one decade later, and the number of people sent to state prison for drug offences had increased considerably-- most of them racial minorities from a handful of the city's poorest neighborhoods (Briefing 2007, Hawkins 2003). About 60% of the early cases were low-level possession cases that police and prosecutors might have let go before the inception of drug court (Hawkins 2003).

As a result, in the court's first decade, a significant number of men were routed into treatment whose status as chemically dependent was questionable.³⁸ Even with increased attempts by the court to weed out the "non-addict" population, while I was in the field, about half the men in my interview sample reported drug histories that challenged a firm diagnosis of addiction, identifying far more as drug dealers than drug users.³⁹ I learned that Arcadia's relatively high rate of admission for "marijuana addiction"-- 32% of admitted clients identified the substance as their "drug of choice" by the institution's own count— reflected participants' criminal charges more than their chemical dependencies.⁴⁰

To be sure, there were far too many men with severe, life threatening addictions at Arcadia House. A significant group of clientele were homeless street addicts, some of them fighting lifelong, debilitating addictions to crack cocaine, heroin and alcohol. Yet Arcadia's behaviorally-focused program was ill-equipped to deal with the "hardest cases" from a medical standpoint. They lacked an on-site, supervised detox unit, and several times during the course of my study, clients undergoing risky detoxes from alcohol or benzodiazepines were left without proper care and had to be rushed to the hospital by staff. As a result, Arcadia put the most severe addicts at risk, while drawing a larger number of "questionable" addicts into its net of behavioral reform.

³⁸ In response to these trends, admission requirements have been more closely monitored since 2009 using a standardized assessment tool designed to determine the "highest risk, highest need" offenders. These significant changes in eligibility requirements that took place while I was in the field eventually led to a reduction in the number of Black clientele.

³⁹ I suspect this number could have been even higher, as all clients had a vested interest in performing the identity of "addict" to make it through the program and avoid incarceration or other penalties.

⁴⁰ Other ethnographies of drug court's expansion and labeling process have similar findings, particularly that low-level drug dealers who didn't clearly fit DSM criteria for addiction were included in the program. See, for example: Murphy, Jennifer. 2011. "Drug Court as Both a Legal and Medical Authority." *Deviant Behavior* 32(3):257-91.

While the association of Arcadia House with only the “hardest cases” was exaggerated, the facility’s reputation as one of the most “hardcore” rehabs in the city was probably warranted, at least in terms of program length. While clients faced different court requirements depending on their individual sentences, each was mandated to participate in a minimum of four months of residential therapy followed by six months of “aftercare”—which made it one of the lengthiest rehabs in the state. Court-mandated clients faced additional requirements and surveillance, such as frequent urinalysis and regular court appearances. Freedoms gradually increased for compliant participants after the first two months, and more requests to leave the house were honored—especially to encourage clients to fulfill the education and employment requirements of the drug court program.⁴¹

If all went well, it was possible to finish the program in one year, but that often wasn’t the case. Minor infractions and negative reports from treatment staff often extended participants’ rehab time or led to re-incarceration. The stakes were high--clients who were determined by the judge to have failed out of treatment were required to serve their original sentence in full. Like KJ, many of the men in the study also faced additional correctional surveillance and regular drug testing after completing the rehab portion of their sentence. Not surprisingly, the program’s intrusion was resented among Arcadia clientele, many of whom stated that if given the choice again, they would rather just “serve their time.”⁴²

Following the waves of national excitement, there was intense local optimism about drug courts. A 2009 study, for example, claimed that local drug court programs had achieved an average 37% reduction in recidivism compared with non-participants, a 47% reduction in reconviction, and a 54% graduation rate (Williams 2014). The reality I

⁴¹ Drug court clients generally had the most extensive requirements outside of treatment, including the receipt of a GED and proof of an employment search, in order to graduate the program.

⁴² In an interview with the drug court coordinator after I left the field, he suggested that eligible Black clientele were opting out of drug court. While structural changes that restricted program eligibility no doubt played a role in the declining participation of Black men in this drug court, conversations I had with people in the field confirm that the word had gotten out among Black offenders that drug court simply wasn’t worth the hassle, and that it would be more efficient—and much less intrusive—to take straight prison time.

observed was much more sobering. The drug court working with Arcadia House in this study had a graduation rate under 50%-- significantly below the national average, and Arcadia's graduation rate was about half of that. Like most other programs, staff were overburdened and underpaid, and they struggled to provide clientele with the meaningful supports and services that would improve their chances at recovery. Precarious funding threatened both the family program and the mental health counseling services which were standard components of treatment in other programs, but impermanent features at Arcadia. The family program was particularly vulnerable, having been suspended and reintroduced three times during the course of my study.

That is why KJ's success both during and after the program—despite the fact that Arcadia could offer him few resources outside the facility-- made him a truly exceptional client. He embodied Arcadia's institutional mission of “habilitation,” dutifully completing house chores, tucking in his shirt each day, and making his bed—he had the neatest one in the facility. He policed his own, and other clients' infractions, showing up to house “report groups” armed with information about his peers. The fact that he was so willing to expose other clients certainly cost him camaraderie with other men in treatment, but afforded him a status as one of Arcadia's “celebrated graduates.”

KJ seemed to have been truly “transformed” by strong-arm rehab, eagerly reframing both his involvement in drug dealing, his drinking, and his addiction to “fast money” within Arcadia's broad framework of “lifestyle addiction.” Almost two years after treatment, he was managing to stay clean and fulfill his many court requirements, a truly exceptional feat indeed. In many ways then, although KJ was in the extreme minority of clientele, he was the perfect illustration—and justification-- of Arcadia's reform project, which—as I discuss in the next chapter-- cohered around the coerced habilitation of the Black street hustler.

Yet upon closer examination, KJ's “success story” started to unravel. Long after rehab had ended, KJ was unemployed, isolated, still living in transitional housing, and growing less hopeful about his future prospects. He attended meetings regularly and sometimes spoke as a “program ambassador” to other recovering addicts, but his involvement in the recovery world seemed largely surface and symbolic. He had few

primary relationships outside of his NA meetings, and privately, he admitted that he lived in daily fear of relapse. It had also become increasingly difficult for him to keep up with his many court requirements. As the next chapter illustrates, the struggles KJ faced before, during, and after rehab were widespread among Arcadia men.

Middle-Class Pathways to the Minnesota Model: Kevin's Story

On the day Kevin McIntosh left home for college the second time, he promised his parents that this attempt would be different. Waving goodbye, he made his way through his old neighborhood-- a maze of neatly manicured lawns in suburban Minnesota. His girlfriend at his side, he was headed for Bar Harbor, Maine, where he would begin a program in environmental science and embark on a fresh start.

It wasn't the first time Kevin was beginning studies as an out-of-state university student. He was twenty-eight years old now, but ten years earlier he had traveled to Missouri to enroll as an undergraduate after high school. Back then, as a fresh-faced eighteen year old, he was excited to transition into adulthood with his two best friends at what was widely regarded as one of the best "party schools" in the Midwest.

Kevin's parents had each finished one year of community college, but they never graduated, and they were working-class for most of Kevin's young life. His father eventually managed to scrape his way into the ranks of regional management at a popular hunting supply store, affording his family a lower-middle-class income by the time Kevin was a teenager. His mother did secretarial work in between raising the children, and often talked with regret about her own unrealized ambition to get a college degree.

By the time Kevin was in high school then, his parents were obsessed with sending him to college, convinced that a degree would give him a better life than they had. So when he selected a public university in Missouri, he emphasized the academic rigor and reputation of the school, instead of his more immediate motivations: the fact that his best friends were going, it was further away from his parents, and there was a killer party scene.

A self-described “mischievous kid,” Kevin’s curiosity about drugs and alcohol started around age twelve when he began stealing beer from his father’s garage and sneaking to the back of the family’s wooded lot to drink them with friends on summer evenings. For Kevin, early drug experimentation was always social in nature—an activity that made it easier for him to hang out and “be on the guys.” Active in baseball during high school, it was common for the team to plan “drinking parties” when somebody had the family house to themselves for the weekend. He started smoking weed regularly, and sniffed cocaine occasionally when he could afford it—but he continued to do fairly well in school and kept his drug use mostly confined to weekend parties.

In college, Kevin encountered a different drug scene, which included considerable pressures to take on the excessive drinking norms of his fraternity house. In addition to “all out” drinking marathons every weekend, there were drugs he had never tried before—and more of them. By his second semester, he had become a heavy poly drug user—consuming alcohol, cocaine, marijuana, psychedelic mushrooms, LSD, MDMA, and amphetamines regularly. His behavior grew increasingly erratic, culminating with his first drug-related arrest-- for public intoxication at a college sporting event.

“All I remember was, it was in the middle of winter, and we were tailgating. And I had taken all these mushrooms, so I didn’t know that I needed a coat because I didn’t even know what was going on. I was running around with nothing on, and then I started drinking the brandy, and that’s the last thing I remember before blacking out and waking up in the hospital with a ticket for being drunk in public.”

Kevin’s partying escalated, and soon he was failing all of his classes. He made the decision with two other friends to drop out and tour the country selling drugs to “jam band” festival attendees, starting with Grateful Dead shows. He spent most of his early twenties sleeping in a van, moving from show to show in a haze of daily LSD, marijuana, and cocaine use. Finally out of drugs and money, and exhausted, he met his girlfriend on the road, a graduate student who convinced him to clean up and recommit to his academic studies.

After a respite back home for a couple years, and two stays in 28-day rehab programs, his parents loaned him the money he needed to remake himself in Bar Harbor, Maine.

“I wanted to be an environmental scientist, so I was really into that... Wasn’t drinking, wasn’t using anything for awhile. But then eventually... you know how it is in a college environment. I started drinking with my classmates. And that place was full of hippies-- same kind of kids I was hanging with out on the road. So I got back into it. Started smoking weed again, too. And there was no weed to be found in Bar Harbor, so I started selling it myself. I would get one paint can full of marijuana every week in the mail, from my hookup in Arizona. In those days you could still send stuff in the mail if you packaged it right.”

Seeing an opening in his new college market, Kevin was soon back to dealing full-time, selling marijuana and cocaine with his friends to fellow classmates out of his living room. For the first year, sales were high with no interference from local law enforcement. But their brazen methods caught up with them when they were raided, and Kevin’s dealing partner went to jail to await trial. Kevin, however, was luckier.

“So here we were with these felony possession charges. Somehow, and I have no idea how, I got off on a technicality. Something about how they booked us, they didn’t follow procedures, so I only spent like a day in jail and then my lawyer came and got me out. So I just walked, got out of it.”

The Bar Harbor drug bust made front page news, but because Kevin’s parents had managed to provide for his legal defense, he escaped the criminal justice system. At age thirty, Kevin moved back home again. With no educational credentials and few job prospects, he struggled with depression and continued to drink daily. Eventually, he found work selling coupon books for a national pizza chain. While he hated the job at first, he soon realized he had a knack for the sales pitch, and he started to schedule his drinking more carefully around work. After a few years, he was successful enough to move to an advertising branch of the business in Minneapolis, where he picked up several major corporate clients. He met and married his wife, and they had three daughters together. He finally “felt like an adult.”

Things were going well for Kevin, but work was much more stressful than he had bargained for—and alcohol was a part of “doing business.” While he had been successfully managing his drinking for the first time in years, job-related exposure to alcohol and mounting stress made it more difficult than ever to stay away from his drug of choice. His condition quickly deteriorated.

“It started to creep up on me... There was always just something about alcohol. The way it tasted, the way it smelled. If it had anything to do with alcohol, I just loved it.... In advertising, probably like any business, social drinking is a big part of it. I was constantly drinking on the job, because we were going out with clients... I’m not exactly sure how many, because really, I didn’t want to know how many. I’d come home from work and fill a glass up with ice and vodka and top it off with some tonic, just to make a show like I’d mixed it with something... I was shaking so bad at work that I had to start taking benzos to deal with that. So I’d take a Xanax in the morning and that would get me through to lunch, then a Xanax at lunch and that would last until the end of the day when I’d race home so I could start drinking again.”

Juggling work and drinking became even more difficult when economic recession hit Kevin’s company, and layoffs ensued. Fearing that he would lose his job, he was soon consumed by a cycle of stress, fear, and drinking. When the worst happened, and his position was cut, Kevin was crushed under the ensuing debt that his growing family rapidly accumulated. This is when Kevin describes hitting “rock bottom”—despite doctors’ warnings that continued drinking would put him at risk for severe health complications, he continued to drink himself into what he called “a pit of despair.” When his wife confronted him about escalating liquor store bills and urged him to go to treatment, he was reluctant at first because he knew they couldn’t afford it, but as his condition worsened, he agreed.

“My wife was a lot more supportive than I thought... She’s been taking care of the kids, the house, everything... You know, I was an alcoholic. I mean, I am an alcoholic. But I was functioning for a long time. And I’d probably still be, to be honest, if my health hadn’t caught up with me.”

I met Kevin at Healing Bridges in the spring of 2014, on his third attempt at treatment. While he had been worried about affording the \$13,000 price tag on four weeks of residential programming without insurance, he managed to secure a loan from his parents that would cover the cost.⁴³ The vast majority of Bridges men were paying for treatment through insurance plans, personal savings, or family loans. In contrast with the men at Arcadia, most had stable work histories, and many had jobs to return to after treatment. Those who did struggle with economic misfortune, like Kevin, often had significant family support to fall back on.

Kevin's story reveals common themes in the lives of the relatively privileged Healing Bridges' patients. The vast majority of the white, middle-class, and privately-insured clientele claimed to be "self-referred." More often than not, this meant they had been pressured into treatment by family, friends, colleagues, or "private interventionists" with varying levels of coercion—a fact reinforced by the core Minnesota Model philosophy that addicts should enter treatment before they "hit rock bottom" (Johnson 2013, Johnson 1980). While many of the men at Healing Bridges had committed crimes associated with their drug use, astonishingly few had ever been arrested, and almost none were court-ordered to participate in rehab. Like Kevin, their racial and economic privilege protected them from "the system" in ways that Arcadia's more marginalize men were not. The comparative "voluntary" character of Healing Bridges had profound effects on both the form and content of its program. While the shadow of the state weighed heavily on therapeutic process at Arcadia, Bridges' Minnesota Model had evolved with considerable distance from correctional control.

⁴³ The program director frequently reminded me that the cost of treatment at Healing Bridges was "a deal" compared to one of their main competitors, Hazelden, where the bill could run upwards of \$50,000 for one month of residential programming.

From Bad to Sick: The Birth of the Minnesota Model

The Role of Alcoholics Anonymous in Early Medicalization

In the late 18th century, the very first framings of alcoholism-as-disease emerged, which were crystallized in the American Temperance movement of the mid-1800s (Levine 1985). Temperance crusaders, doctors, and other professionals began to speak of a “compulsion” to drink alcohol-- and later-- to smoke opium, eat hashish, or sniff cocaine. Addicts were compelled against their will to consume, an important shift from the more agentic drunk or dope fiend who had a wayward desire to become intoxicated.

Early temperance societies like the Washingtonian movement of the 1840s and the Ribbon Reform Clubs of the 1870s were organizing around the growth of inebriate asylums to deal with “problem drunkards” (White 2004). While these early mutual-aid societies and other Progressive-era groups like the Women’s Christian Temperance Union could be quite punitive and moralistic, as they rallied around the drinking habits of the more advantaged classes, their portrayals of addiction began to shift from moralistic to medical registers (Weinberg 2005). Yet it was not until the Alcoholics Anonymous movement played an essential role in destigmatizing the addictions of the white, middle-classes that the association of addiction with moral vice was seriously weakened.

Formed in 1935, Alcoholics Anonymous is now recognized as the largest and most enduring mutual aid society for recovering addicts in human history. Bill Wilson and “Dr. Bob” (Dr. Robert Smith)-- the white, middle-class, professional, Christian founders of the fellowship-- originally met through the evangelical movement known as the Oxford Group. These early moorings shaped what would become AA’s foundational tenets— that alcoholism was a mental, physical, and spiritual problem. Convinced that the wisdom of personal experience and the power of moral community would be more effective for recovering addicts than institutionalized authority, AA’s founders created a mutual-aid society based on the anonymity of members, the flexible and non-professional autonomy of individual groups, and an “anarchic” decentralization of authority with minimal to no hierarchy (White 2002).

Formed in the midst of the Great Depression, AA's mutual, peer-based support system was indeed the antithesis of a self-help, "bootstraps" mentality. Its "allergen" theory of alcoholism offered men a new language for claiming powerlessness against alcohol—men who may have already been made to feel "powerless" in the face of rapid economic change. Importantly, it was a notion of powerlessness that was considerably destigmatized for the nation's less marginalized addicts.

The notion that alcohol itself was inherently addictive had lost sway as evidence mounted that many drinkers could imbibe without succumbing to compulsion in post-Prohibition America. Dr. William Silkworth's view that alcoholics were a small portion of the population who shared an "allergy" that caused excessive drinking was profoundly influential in the later articulation of the disease theory (Weinberg 2005). But early AA members preferred the allergen theory less for its potential medical science than for its sympathetic view of the alcoholic. Indeed, AA continued to focus mostly on a moral cure involving spirituality and "working the Twelve Steps."

The more medical view of the allergen theory, however, was essential for enabling the moral community of AA projects. It was only through their destigmatization and restoration to the human community that reviled, feared addicts and alcoholics could come together in mutual aid. Yet exactly who could move through this process to join the AA community was—and still is—highly restricted. By the end of WWII, the vast majority of AA members were still native born white men from middle and upper class backgrounds, African Americans in particular were actively (and at first officially) excluded from AA groups (White 2002).

The idea of a biological sensitivity to alcohol posed by the allergen theory opened the door to a more specific-- and broadly accepted-- definition of addiction as a disease. Scientists recast a moral behavior in value-neutral medical terms, cementing addiction as a disease that only a minority of Americans suffer from. The Research Council on Problems of Alcohol and the Yale Center of Alcohol Studies were early incubators for the dissemination of this research—the center of the "Alcoholism Movement" (Gusfield 1982, Weinberg 2005). Scientists eagerly accepted new funding being made available by the liquor industry, private endowments, and state sources to study alcoholism (Acker

2002, Weinberg 2005). Obtaining this research funding meant shifting addiction away from the moral vices associated with the poor and people of color—and instead, framing it as disease pervasive among the middle-classes and one that warranted sympathy, study, and sound intervention. According to Darin Weinberg, “the disease theory of addiction was, then, in the first instance revived to exculpate middle-class drinkers specifically in contrast to those lower class homeless others who dwelt on skid row” (Weinberg 2005).

Roughly thirty years after AA was formed, another major challenge to the criminal model of addiction appeared. Criminalization in the era of the Harrison Narcotics Act, and later Prohibition, had wrested addiction treatment away from the authority of medicine in the first decades of the 20th century. With the enforcement of each new wave of drug legislation, the gap between public health and criminology grew ever wider, and reformers began to question some of the central assumptions of the criminal model of addiction and rehabilitation. Two of those reformers were Vincent Dole and Marie Nyswander, who in 1963, pioneered methadone maintenance therapy for heroin addicts at Rockefeller University Hospital. Methadone was a controversial therapy when it was first introduced, but it became essential in refocusing the practice of drug rehabilitation around a truly medical model.

In contrast to the “psychogenic approach” informing most of the criminological models of rehabilitation, Dole and Nyswander posited that addiction—and its hallmark symptoms—were a reaction to the severe withdrawal state caused by removal of the drug once the user had become physiologically dependent. Once treated with methadone, heroin addicts exhibited none of the psychological impairments that their addictions were commonly attributed to, and were able to “win acceptance as normal citizens in the community,” returning to work, school, and family obligations (Dole and Nyswander 1980). Dole and Nyswander’s theory was a crucial development in the medicalization of addiction. Not since the morphine clinics of the 1920s had physicians held primary authority over the treatment of addicts. Although Nixon is rarely thought of as a champion for rehabilitation, he significantly expanded funding for methadone research and recovery support as part of his 1970s drug war platform — and the logics underlying methadone were widely adopted in clinics across the country.

By the late 1960s then, two views had come to dominate mainstream understandings of addiction: addiction as metabolic disease and addiction as anti-social personality disorder. The widespread cultural acceptance of AA, and later, the rise of the Minnesota Model, would succeed in relegating the personality theories of addiction largely to correctional control. The 1940s and 1950s saw an explosion of AA membership in the US—and by the 1970s and 1980s, Narcotics Anonymous and a number of other secular, religious, and cultural offshoots had developed. The AA “fellowship” is now an international network, with over 108,000 groups worldwide and a U.S. membership of more than 1.25 million (Fletcher 2013). By the early 1950s, as Narcotics Anonymous (NA) and Hazelden’s “Minnesota Model” were getting off the ground, the disease nomenclature began to flourish.

The Minnesota Model

The Minnesota Model, the most common form of residential treatment in the United States, had its origins in several key Minnesota facilities in the 1950s (Fletcher 2013). Minnesota Model treatment entailed the full fusion of AA with the disease concept of addiction, and marked a firm shift away from the “degradation rituals” that alcoholics and addicts had endured in psychiatric asylums, and later, in forms of strong-arm rehab. As Alcoholics Anonymous gained new members in Minnesota, the public grew disillusioned with traditional psychiatric approaches to the treatment of alcoholism, leading to the opening of Pioneer House, the first three-week program based entirely on AA principles. The program emphasized flexibility, minimal rules and regulations, and an environment of empathetic support. Shortly after the success of Pioneer House, a similar center opened on Hazelden farm in 1947, envisioned as “a sanatorium for the curable alcoholics of the professional class.”

The main features of the Minnesota Model, however, came together at Willmar State Hospital, which had been involved in the custodial care of alcoholics for thirty years. In this model, alcoholism was not a symptom of underlying emotional problems or personality disorders, but instead was recognized as a chronic, primary, and progressive disease (Fletcher 2013, Laudergeran 1982, White 2002). The disease of alcoholism would

be treated with a multidisciplinary team approach involving physicians, psychologists, social workers, and clergy. Retaining AA's focus on the "knowledge of wisdom and experience," the Minnesota Model carved out a place for lay therapists—ex-alcoholics routinely became counselors and worked alongside professional staff. At the time of the model's emergence in Minnesota, there was no state designation for such a position without credentials, but one was created in 1954—it required a high school diploma and two years of demonstrated sobriety (White 2002).

While some of the early forms of MM did use more confrontational tactics, these faded in favor of a more medicalized, therapeutic approach (Wormer and Davis 2013). Today, most clinicians working in the Minnesota Model tradition position themselves against the logic of coerced treatment, setting aside confrontation and coercion in exchange for positive psychology, "motivational interviewing," and "strengths-based" therapy. A foundational aspect of this model is an approach which emphasizes "building motivation, resisting substance use and finding new activities to replace it, enhancing problem-solving skills, and improving relationships" (Fletcher 2013). Court-mandated treatment increasingly contradicts much of the psychological research arguing that coercion is a poor motivator for change, and that empathy and rapport between clients and counselors is the best predictor of positive outcomes.⁴⁴ Many MM counselors also contend that when a majority of clients are coerced into treatment, it jeopardizes the quality of the program for all involved—and treatment tends to be less effective. For this reason, some MM practitioners even set caps on the number of court-mandated clients they will accept in their programs (Fletcher 2013). As the logic goes, the more an addict is personally invested in the process, the higher the likelihood of a successful recovery (Miller and Rose 2009, Miller and Rollnick 2012). Studies have shown that patients undergoing Minnesota Model treatment experience "marked reductions in feelings of

⁴⁴ Indeed, there are a lack of studies confirming the effectiveness of coerced treatment in reviews conducted outside the US, which tend to be far more critical and cautious in making claims about utility of coercive rehab. See, for example: Wild, T.C. 2006. "Social Control and Coercion in Addiction Treatment: Towards Evidence-Based Policy and Practice." *Addiction* 101(1):40-9. doi: 10.1111/j.1360-0443.2005.01268.x..

personal responsibility for addiction,” and an increased sense of personal control over recovery (Morojele and Stephenson 1992).

As addiction treatment rapidly professionalized in the 1970s and 1980s, it was through the heavy infusion of Minnesota Model principles and practices. Hazelden, which became the largest publisher of self-help books and pamphlets in the world, played a major role in advertising MM, disseminating its particular logic out to diverse areas and applications (White 2002). As MM became synonymous with American rehab, its toolkit became even more eclectic and multi-disciplinary— yet still retained its original fusion of abstinence-based recovery, popular psychology, spirituality, and the self-help structures of Alcoholics Anonymous.

A number of historical and social transformations then, had allowed middle-upper class whites to claim addiction status without the attendant shame of moral failure and with decreased social stigma. Once characteristic of “dangerous immigrants” or the “threatening underclass,” addiction had become a chronic disease, and one which was certainly not the fault of the white, middle-class alcoholic. It was also a disease which required professional treatment—either in hospitals designated for the task, or in one of the many “self-help” groups which have come to define American recovery culture.

The increasing power of medicine as an institution of social control induced addiction’s rapid process of medicalization, and later “biomedicalization,” culminating in the now widely accepted “brain disease paradigm” (Zola 2009). By the time the World Health Organization recognized alcoholism as a medical problem in 1951 and the American Medical Association declared it an illness in 1956—and a disease in 1966—addiction had become fully medicalized. The American Psychiatric Association, the National Institute of Drug Abuse, and a number of other “gatekeeping” organizations quickly followed suit. Today, the brain disease theory of addiction rests on a rapidly expanding body of neurobiological research (Courtwright 2010). In the 1990s, the “decade of the brain,” the disease “concept” made the leap from descriptive model to scientific theory, as neuroscientists linked repeated drug use to the neural rewiring of the brain-- claiming clear evidence of drug-induced brain change after chronic drug use.

In just a century then, the first attempts to criminalize American addicts through national drug legislation had evolved into the full institutionalization of a medical model of rehabilitation.

Inside Healing Bridges

Stretched across the fifth and sixth floors of a psychiatric wing in a public research hospital, Healing Bridges was one of the largest providers of chemical dependency treatment for adults in the metro area. In addition to the residential program which could house up to 60 men sleeping two per room, they also operated separate women's and "dual diagnosis" residential programs, as well as 9 outpatient clinics scattered across the Twin Cities metro area. The men's inpatient program where I conducted most of my observations was a four week residential stay, followed by twelve weeks of once-per-week outpatient treatment.⁴⁵

There were very few cues—if any—in the hospital's public-use hallways which indicated addiction treatment was taking place-- no AA posters on the wall, and no prominent "board" like the one displayed at Arcadia. The setting was nondescript, even for a hospital. It could have been any number of institutions-- a doctor's office, a school, or even an office complex. I was required to wear a name badge like staff, but I was permitted to roam freely around the grounds without restriction—as were the patients, and anyone else who entered the facility. As a result, it had a much more "porous" feel than the heavier surveillance of Arcadia's "total institution."⁴⁶ Men and women mingled freely in all the common spaces except for group therapy rooms and bedrooms, in contrast with the strict gender segregation enforced at Arcadia, where "fraternizing" was prohibited and could be grounds for discharge.

⁴⁵ I conducted limited ethnography in the outpatient versions of the program, but I did attend several sessions to confirm that the program content matched the "treatment logics" of inpatient rehab.

⁴⁶ Indeed, staff and clients often complained that there wasn't enough security on the unit—At several points during my fieldwork, patients left with former drug dealers or still-using friends, after they showed up for visits.

Staff tried to temper the cold, “clinical” feel of institutional life on the ward by encouraging patients to hang personal artwork and family photos on the walls and doors of their quite spacious shared bedrooms. These “personal touches” did help to impart a sense of home, adorning the space with fragments of patients’ lives and identities outside the facility. The women on the unit often decorated their beds with quilts, pillows, and stuffed animals they brought from home. Patients set up their own libraries in their rooms, with favorite books from home, and of course, treatment literature provided by Bridges. Several common areas included lounge seating, phones open to clientele, board games, exercise equipment, and a few computers with internet connectivity. Indeed, Bridges went to great lengths to make patients feel “at home”—or as homey as one could feel living in a hospital psych ward. The much loved “home cooked meals,” the relatively comfortable accommodations (luxurious even, compared to Arcadia), and the significant involvement of patients’ families in the programming were consistently cited as main selling points of the program.

Lest one forget they were in rehab though, the more isolated group therapy rooms were lined with posters listing the “Twelve Steps and Twelve Traditions,” signaling the program’s reliance on Alcoholics Anonymous. Healing Bridges 28-day program is a classic “Minnesota Model” rehab, which actually evolved from a historical contributor to the model’s formation. Working the steps was constantly referenced in group therapy, and Twelve Step literature was required reading. The majority of the men attended at least three AA or NA meetings per week, and the more devoted clientele went on to be incredibly active in the local AA community after the residential portion of therapy. Predictably, those patients who weren’t amenable to AA philosophy tended to struggle more than others in the program.

Still, the general eclecticism of the MM approach meant that staff catered to diverse tastes, and indeed, they constructed “individual treatment plans” for each patient which focused on restoring the patient’s self-esteem through the removal of shame, and addressing any co-occurring mental illnesses that had gone untreated. Yet like the overworked and under-resourced Arcadia staff, Healing Bridges counselors were seldom able to offer much in the way of individualized, one-on-one therapy. The group therapy

model became a hallmark of American rehab in part because it provides a cost-effective, efficient solution for staffing facilities that are frequently running at full capacity. Yet the way in which group therapy was done at Bridges was radically different from Arcadia's model. Following the tradition of AA, the groups felt much more autonomous and patient-directed, and because few of the men had been ordered by the court to be there, levels of active, energetic participation were typically much greater.

Along with AA's influence, Bridges drew on the latest addiction science, and its program was administered by a professional staff of psychiatrists, psychologists, general practitioners, and addiction medicine specialists. Addiction was viewed as a temporary sickness resulting from brain chemistry gone awry which addicts could learn to manage through the right combination of medication, group sessions, and individual psychotherapy. After patients underwent a supervised medical detox—if necessary—they attended a combination of group and individual therapy sessions, educational lectures, AA/NA meetings, and a three-day “family program.” Educational lectures covered a range of topics—emotional wellbeing, “healthy pleasures,” communication styles, how to write recovery plans, the latest addiction science, nutrition support, and “co-dependency.” Indeed, many patients remarked that the heavy educational component felt like they were “back in college.”

Unlike Arcadia, Bridges' setting in a research hospital equipped staff to offer a full, medically supervised detox, and to handle any co-occurring physical or mental health issues. The extensive medical infrastructure allowed them to accommodate patients' healthcare needs, and respond to the more serious health concerns with cutting-edge services. Each Healing Bridges patient received an extensive mental health screening when they entered the program. As a result, it was not uncommon for patients to enter for drug or alcohol problems, and leave with a few more diagnoses—and medications to treat them.⁴⁷

⁴⁷ Staff estimated that roughly 60% of their patients presented with a “dual diagnosis” of addiction and mental illness. These patients occupied a separate ward, and I was unfortunately unable to expand the project for observations there.

The majority of Bridges patients—about 50-60%-- were primary alcoholics, and another 25% were opiate addicts—including both heroin and prescription narcotic addicts. The remaining quarter reported using marijuana, cocaine, or crystal methamphetamine. As I explore in later chapters, the availability of potent, low cost heroin on Twin Cities streets had substantially transformed Bridges’ target demographic. In the five years before I entered the field, the facility had seen a five-fold increase in patients seeking treatment for opiate addiction.

Like Kevin, many were resourced enough to pay for treatment through insurance, self-pay, or family support. Healing Bridges is a state-licensed, private non-profit facility, and unlike Arcadia, they rarely accepted clients on public funding-- instead relying on their contracts with major insurance providers for a steady stream of more privileged clientele. The program did accept a small number of CCDTF patients each year, and the staff recognized that the ability to fund lengthy residential treatment services was increasingly a privilege available only to the poor, upper-middle, and upper-classes—squeezing out working-class and lower-middle-class families from accessing long-term care (Fletcher 2013).⁴⁸ Indeed, treatment was a lucrative business, and one which was particularly vulnerable to the rapidly changing structure of healthcare. Bridges’ “28-day program,” for example, wasn’t based on any scientific understanding of how many days a person needs to recover, but rather, was the standard length insurance companies had agreed to pay for.

Even among the insured middle-class however, inpatient treatment was somewhat of a “luxury,” available only for those whose diagnostic classifications established the highest levels of “treatment need” and “addiction severity.” At Bridges, patients diagnosed as “less severe” during their intake would be sent to one of the many other outpatient day clinics scattered across the metro area—which served many more lower-middle-class and working class clientele whose insurance plans refused to foot the bill for residential therapy. Staff often lamented how their patients had to first fail at outpatient

⁴⁸ These annual “fellowships” typically amounted to less than 1% of clientele.

treatment before they could be considered for the residential programs they thought they really needed.

Many private insurers also refused to pay for the transitional housing piece, claiming that the “treatment” was already over. As a result, many insured Bridges clientele couldn’t go to a halfway or “three-quarters way” house after rehab unless they were able to self-pay-- or unless they qualified for the public fund. Nor would most insurance cover the program’s second phase of support groups, which became an important source of post-rehab social capital for some attendees. Staff recognized that it was the precarious lower-middle-class, the working-class, and the working-poor who were the least likely to be able to access residential services in the state of Minnesota, and sometimes they admitted to mobilizing more severe diagnostic classifications in order to buy their patients more time in treatment.

As is the case with rehab everywhere, completion rates were low in both of the programs I studied, and “success rates” even lower. Bridges advertised an average program completion rate of 63%, and Arcadia’s was around 24%. KJ and Kevin—despite being representative of each program’s “target population,” were very much program outliers in terms of maintaining sobriety. It was far more common for addicts in both of my field sites to relapse and return for multiple rounds of treatment. For example, I encountered Justin, whose words appear in the next two chapters, four times during my study—on separate stays at both of my field sites.

In the chapters that follow, I revisit the experiences of KJ and Kevin, as I analyze the very different logics of recovery that each were exposed to in their residential programs. Like the other men in this project, their life histories betray the popular notion that “addiction doesn’t discriminate.” Indeed, across the structures of class, race, and the criminal justice system, their addictions had never been “created equal.” Rather, the same inequalities shaping their habitus had set each on distinct trajectories with addiction, routing them into vastly different projects in self-making and social control.

Table 1: Program Snapshot

Program Snapshot	Arcadia House	Healing Bridges
Inpatient beds	50	60
Length of average residential stay	120 days	28 days
Range of treatment length	90 days - 1 year	21 - 60 days
Separate outpatient programs	1	9
Medically supervised detox	No	Yes
Certified to treat mental illness	No	Yes
Treatment model	Therapeutic community	"Minnesota Model"

Table 2: Program Demographics

CLIENT DEMOGRAPHICS*	Arcadia House	Healing Bridges
Race**		
White	36%	84%
Black	50%	8%
Hispanic	6%	2%
Native American	6%	4%
Asian American	1%	1%
“Other”	1%	1%
Source of Income		
Possessed job at time of entrance	12%	55%
Retirement/savings	2%	16%
Family/friends	7%	15%
No income at time of entrance	47%	3%
Public sources	26%	10%
Other sources	6%	1%
Source of Referral ***		
Self, family, or friend	23%	94%
Employer	0%	1%
Criminal justice system	75%	4%
Professional source	6%	20%
County social service agency	49%	1%
Other community resource	27%	24%
Primary Substance		
Alcohol	27%	60%
Methamphetamine	12%	4%
Marijuana	32%	6%
Heroin	8%	16%
Cocaine	16%	4%
Other opiates	3%	9%
Other drugs	2%	1%
Discharge Status		
Completed full program	24%	63%
Left without staff approval	50%	24%
Referred to another program	26%	13%

*Average measures across my years in the field, obtained from Minnesota Department of Human Services data

**Racial categories refer to identifiers used in program’s own data collection.

***A client could be referred from multiple sources.

Chapter 3: “Habilitating” the Hustler: Rehab in the Shadow of the Carceral State

A Scene from Report Group

In the summer of 2011, I had just resumed fieldwork at Arcadia House after several weeks away. Grant, a tall, twenty-five year old African-American man, volunteered to show me around the facility and “get me up to speed” on house drama since I’d been gone. Grant was a particularly quiet client, respected by others for his steadfast sense of calm and good listening skills. With two children and another on the way, he was eager to finish his court-mandated residential treatment and get back home. He kept a low profile, completed his assignments on time, and managed to stay off staff’s radar—no easy feat.

As we climbed the stairs to the men’s living quarters on the third floor, he told me proudly, “I’m finishing out tomorrow, and then I get to move back home with my girl... There’s some bullshit about to go down at group today, but I’m not worried. All kinds of rumors are going around that I’m getting discharged today, but you’ll see. It’s all good.” Before I could learn more, he scurried away to complete his morning chores before the first round of checks.

That afternoon, the second-floor group room was packed full for the day’s report group, a dozen more chairs assembled haphazardly behind the standard therapy circle. The mood was tense as Sylvia, the men’s program senior counselor, took a place at the front. The current resident director passed the week’s behavioral reports to Sylvia, half-slips of paper overflowing from a torn shoebox. Sylvia flipped through the stack, casually glancing at every few, but selecting only certain reports to read aloud. Although African-American clients comprised about one-third of those in attendance that day, every report she addressed was directed toward an African-American.

James, a fifty-year-old African-American man, was reported for getting the vacuum cleaner out before it was time to clean. When he defended himself, explaining that he was trying to be proactive and use the vacuum cleaner before it would be in high

demand, Sylvia replied "You broke the rules. Don't fight me on this." Another African-American client was reported for being in the wrong group when he was supposed to be finishing his program orientation.

He protested, "Did you even read that report? I reported someone else for that-- I'm not the one being reported!"

"Don't get that way with me, I'm allowed to make mistakes!" Sylvia snapped.

She then turned to Grant. Stepping up to face him, Sylvia began after a long pause. "Grant, did you smoke K2?" The room fell silent, as Grant stared at the floor, shifting uncomfortably in his seat.

"No," he whispered.

"I'll ask you again," Sylvia said, "Grant, did you smoke K2 with two other clients on your pass to leave the building?"

"No, I didn't do that shit!" Grant protested.

Sylvia was visibly angered. "You should know by now that I never ask a question I don't already know the answer to. Adele, the letter please!" Adele presented a piece of notebook paper to Sylvia. It described in detail a series of incidents in which Grant and three other young African-American clients-- Darius, Jamal, and Lee—had allegedly smuggled K2-- a synthetic marijuana substitute that was recently criminalized-- into Arcadia House, smoking it in their rooms and on outings from the building. After each of the men had been ordered to submit to urinalysis, Darius had apparently written the letter to Sylvia in a last ditch attempt to save himself from getting discharged back to prison on a "dirty drop." Sylvia also questioned Jamal and Lee in front of the group, both of whom vehemently denied their involvement.

"Well, what you don't know," Sylvia said, "Is that you think K2 isn't detectable by UA, but now it is. We had special tests ordered for this substance." Grant looked visibly ill and leaned over in his chair, clutching his stomach in horror. "You had the chance to come clean multiple times, and you sat here and wasted my time and the group's time. Get your stuff and get out." Grant scurried out of the room without saying goodbye to

anyone, and the other clients sat in stunned silence. With less than one day to go before completing four months of residential treatment, he had just been discharged from the program in the final hour. I knew from the details of Grant's case and the severity of this violation that this was a "last chance" discharge-- he would now have to return to prison to execute his original sentence—three years for drug possession.

Sylvia turned to Jamal and Lee, who were now talking over each other as they made final attempts to plead their cases.

"I swear it wasn't my idea!" said Jamal, wringing his hands in frustration.

She interrupted them, pointing toward the door: "Get your stuff and get out." Each time Sylvia banished a client, she sent an escort along, adding "Make sure nobody's stuff walks with him."

Darius had written a confession letter only after being drug tested. "You continued to lie about what you did, even after we tested you!" Sylvia yelled. "You came forward, but only to save your own ass. You had so many opportunities to make it go another way. What does everyone else think about this?"

The group was eager to weigh in. Tommy, a twenty-five-year old white man, rose from his seat and pointed at Darius. "I see Darius sitting over there, looking all sad and sorry like a little bitch, and it makes me mad. What you did compromised my sobriety Darius, and uh-- I don't need to be around that. Frankly, I'm pissed! And you went and snitched just to save your own ass? You should have been a man and taken care of it right away. That's some punk baby shit right there. It's fucking bullshit!"

Other clients agreed with Tommy, stating that Darius's last minute confession was morally questionable, and that he deserved to be punished for not coming forward sooner. A smaller but vocal group of African American clients admonished Darius for "snitching" at all, asserting that outing his Arcadia "brothers" was ultimately a selfish act.

Sylvia reiterated the importance of "honesty and accountability" for a successful recovery. "You all want to come forward and tell staff about things only when it benefits

you. Well that's not how it works here. We absolutely have to keep everything out in the open. It's best for you and your sobriety, and for everyone involved. Secrets keep us sick!"

Sylvia launched into a story I was by now quite familiar with. She told the group about how she cooperated with police to turn in her brother-- an alcoholic, cocaine addict, and sometimes dealer who had accumulated "seventeen DUIs." Convinced he was so out of control that he posed a great threat to society, she informed local law enforcement where he was stashing a large amount of cocaine for distribution. The tip off resulted in his return to prison for nearly a decade.

"Some of you probably think I'm a bitch for that, right?" Sylvia asked. Several clients glanced at each other nervously. "Well come on, I know some of you think that was a bitch move! Let's be real. But what if I had let him go on as he was, and then he killed your wife and kid in a drunk driving accident? Then would I be a bitch for preventing someone from getting hurt or killed? I couldn't have that on my conscience!"

Andre, a thirty-three year old African-American client, raised his hand. "I respect what you're saying and all, but me personally, I have had a situation like that with my brother. I have a brother, and I could never, ever do that to him. You know, it's just wrong, and that's a thing with me."

A paunchy white participant chimed in from the back of the room in support of Sylvia's decision. "Well, I think you did the right thing. I've been that person that needed to be outed, and look what happened. My family got together and did what they needed to do to get me in here, so good things come out of it, thank god."

Sylvia turned back to Darius. "I'm sorry Darius, but I have to let you go. You confessed, but it was only to save yourself. It is not acceptable to use any substance in this house. If you brought it to the group right away, maybe we could work with you, but you have to leave now." Sylvia then announced that because of the recent "negative attitudes" and "all the cliques and secrets dividing everyone," the clients would be put on "full ban mode" for the rest of the week. "Bans" were house-wide punishments triggered by infractions deemed particularly serious—in this case, drug use on the

premises. During a ban, Arcadia House went on “lockdown.” The men would now be restricted to the facility, except for required court appearances and only the most urgent medical appointments. Any “privileges” they had previously enjoyed-- phone calls home, movie nights, snacks, or softball games in the nearby park—would be suspended indefinitely.

As report group came to a close and the men shuffled off to the basement to complete pre-lunch chores, I noticed Grant in the stairwell, struggling to close the zipper on the stuffed, tattered backpack which held his belongings. Andre swooped in to assist him, patting him on the back. “Sorry man,” he said. “See you on the flip.” Grant turned away and descended the stairs despondent to wait for his probation officer.

Later, in the staff meeting, Sylvia turned to Adele, “And that reminds me. Tell Derek when he writes up the discharge report to make sure it states ‘use of K2,’ because then they’ll get hit with that charge too, and maybe they’ll learn.” Not only had Sylvia discharged four clients that day, sending at least two of them back to prison, she was also keen to initiate new criminal charges for them. At Arcadia, the unquestioned logic of treatment was that “force was the best medicine.”

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The first half of this chapter delineates how the “treatment logic” of strong-arm rehab subjects the addict to a process Victor Rios refers to as “hyper-criminalization”—that is, his labeling as deviant, risky, threatening, and in need of external control (2011). Arcadia’s “criminal-addict” was defined by his putative “treatment resistance,” and mapped in the image of the Black “street hustler,” thought to possess a defiant “penitentiary mentality.” I examine how “treatment resistance” was racially coded, as Black clients were more consistently identified as defiant and punished both in the residential program and by the “strong-arm” of the criminal justice system.

The ever-present backdrop of criminal control within Arcadia House undercut the therapeutic ethos of shared intimacy and trust that is the basis of the healing process in many mainstream recovery models, instead fostering a decidedly “anti-therapeutic” culture based on mutual surveillance, distrust, and suspicion. Not only did this highly

moralistic approach further stigmatize vulnerable and shamed addicts, it undermined the program's professed "brotherhood," deeply eroding solidarity among participants.

The second half of the chapter analyzes how the Black street hustler, despite having the least visible drug dependency, became the program's primary object of reform. Roughly half of the men I encountered at Arcadia had been sentenced to treatment as punishment for drug hustling, and their histories challenged a firm diagnosis of addiction. These men worked in the informal economy in response to extreme poverty and dislocation, mainly using alcohol and marijuana in recreational doses, and possessing considerable control over their drug use. The notion of "lifestyle addiction"—a dependence on street life, hustling, "fast money," and ultimately, the crumbling welfare state-- emerged as a primary discourse through which these men framed their participation in treatment.

Arcadia House offered recovery from "lifestyle addictions" through "habilitation"—the re-socialization of the criminal-addict for the world of legal, low-wage labor. Yet, the program's inability to provide participants with any real employment training or material support meant that the promised "habilitation" was primarily achieved through the erasure of "street culture." Read by both Black and white clients as primarily meant for "ghetto" Black clients, the program of habilitation was received as insult and injury by many Black participants. Finally, I discuss the various ways in which clients themselves grappled with the program's determination that they were "addicted to a lifestyle"-- ranging from subtler "micro-resistances" against treatment, skilled versions of "talking the talk," and the full internalization of Arcadia's logic.

Part I: Coercing the Criminal-Addict: The Punitive Face of Strong-Arm Rehab

Strong-arm rehab depends on the construction of its participants as both criminals and addicts. As shown in Chapter 2, the theory of the "criminal-addict" emerged from a movement within correctional policy capitalizing on the structure of the therapeutic

community to rehabilitate “criminal personalities.” The classic iterations of this model posit addiction as one manifestation of a larger “criminality personality,” a constellation of dysfunctional traits including the denial of responsibility, deceitful and manipulative behavior, disrespect for authority figures, a tendency to “play the victim,” a lack of impulse control, and an “addiction to criminal excitement” (Hazelden 2002, Yablonsky 1962, Yablonsky 1965, Yochelson and Samenow 1976).

The conflation of criminality with addiction was reinforced through nearly every aspect of treatment at Arcadia House, but was most clearly articulated in the program’s correctional core—the “report groups” and the biweekly Criminal Thinking” curriculum.⁴⁹ In the latter, clients were asked to make exhaustive inventories of past “addictive behaviors” alongside and indistinguishable from past “criminal acts.” Zeshawn, a 21-year-old African American male, initially struggled with the court’s ruling that he was an addict after being sentenced to treatment for minor drug possession. Reflecting on what he learned in the Criminal Thinking course, Zeshawn explained and questioned the program’s taken-for-granted fusion of criminality with addiction:

“I didn’t really see myself as an addict until they’re like, ‘No, this is what an addict is.’ They link it to a disease, and they say an addict has a disease because you do drugs. But then they start saying, ‘You rob for the drugs, you steal for the drugs, and do whatever comes to mind to get the drugs.’ But I never really was out there doing nothing like that. I always had jobs, temp jobs, or I always tried to get a job. I always had money in my pocket, so I didn’t really have to steal, rob or do nothing like that. To get the drug, I would just buy the drug. Yeah, I’d just do it, and get back to my life.”

As someone who used socially, without any sense of strong drug dependence, Zeshawn saw himself as neither criminal nor addicted, but strong-arm rehab had labeled him as both.

The dominance of the criminal-addict label in a space significantly shaped by the criminal justice system had profound effects on the therapeutic process. Perhaps

⁴⁹ In previous work, I have analyzed in more detail the “front-end” of this process—the court-led diagnosis working to label low-level drug offenders “addicts” and “dosing” the sentence of treatment. See: Whetstone, Sarah and Teresa Gowan. 2011. “Diagnosing the Criminal Addict: Biochemistry in the Service of the State.” Pp. 309-30 in *Advances in Medical Sociology: The Sociology of Diagnosis* Vol. 12, edited by P. McGann and D. J. Hutson: Emerald Publishing

unsurprising in a program where three-quarters of the clientele were court-mandated, staff assumed the majority would arrive resistant to treatment. Gaining compliance thus became a central goal of therapy. The public display of struggle and resistance, followed by full acceptance, was the gold standard evidence that inner transformation had truly occurred. Adele, one of the counselors, explained how she structured her primary groups:

“When someone comes in, I generally have them start off with the autobiography assignment, then I have them do a piece called ‘Why am I in treatment?’ ..If they just say, ‘Oh, I’m here because I caught a case,’ well then you know they haven’t made much progress, and we’ve got to get them to stop denying they have a problem. But if they say, ‘Because drugs and alcohol caused my life to become unmanageable,’ well then you know they are on the right track.”

Admitting “powerlessness” – that life had become “unmanageable” under the weight of addiction—was the first of twelve steps in the Alcoholics Anonymous program—an approach that is now integrated at least in some form in more than 90% of the drug rehabilitation programs in the nation (Fletcher 2013). Yet it was not as simple as giving the staff exactly what they wanted. Those who were too enthusiastic too soon were watched intently for signs of “talking the talk”-- the act of delivering the correct discourse without accomplishing true inner reformation (Skoll 1992). Men claiming to have entered Arcadia willingly were particularly suspect. Justin, a 30-year-old, white methamphetamine addict and self-proclaimed “treatment pro,” explained:

“Their idea is that you didn’t come here because you’re so full of wonderful ideas and you want to live this wonderful life. It’s because of the consequences that you’re here today, because your life is going to shit and you’re trying to get yourself out of that. You’ve been in and out of treatment, you’ve been in jail, you’ve been in the hospital. It becomes shame-based, because you’re backed to the wall, and how do you defend yourself when you’re in the program like that? It’s like, all of a sudden, you’re the bad person. Now when they ask me why I came to treatment, I say it’s because I was in jail. I don’t say it’s because I want to get sober anymore, because there is a fear that people are gonna say, ‘Oh, bullshit!’ and laugh at me. If someone comes in saying they want to be sober, they don’t know what they’re supposed to do with the guy because that doesn’t fit with the program. They’re supposed to be breaking you down, and if you’re already ready for change, it won’t make any sense to them.”

Justin's eloquent commentary reveals how Arcadia's criminal-addict was constructed as inherently resistant-- never truly "ready for change" prior to forceful intervention.

Crushing the Penitentiary Mentality

Indeed, staff saw their primary task as the suppression and reform of the "penitentiary mentality," a core characteristic of the "criminal-addict." This "mentality" was associated with an inability to display vulnerability, a deep distrust and open defiance of authority, and the manipulation of treatment staff and other clients. Commonly identified by staff as the biggest obstacle to clients' therapeutic progress and an impediment to Arcadia's ideal of "brotherhood," the penitentiary mentality was set in sharp contrast to successful recovery which mandated the public confession of wrongs and the rejection of the "anti-snitch code."

The program's confrontational "report groups" were widely regarded as successful models for the reform of stubborn "criminal personalities" – and especially "penitentiary mentalities." Along with the "Criminal Thinking" curriculum, the highly dramatized report group signaled Arcadia's close ties with the criminal justice system. Designed to push participants to internalize the mandate to confess, report group revived and reconstructed the specter of the criminal court within therapeutic space. The central role of report group in the therapeutic community helps to explain why this particular form of rehab has become the correctional system's drug diversion program of choice. Scholars have examined how these features of therapeutic communities function to reinforce the "moral economies" of recovery, establishing the structures of mutual surveillance and accountability that are the hallmarks of the "TC" model—and its most effective means of social control (Haney 2010, Kaye 2010, Kaye 2012, Paik 2006, Skoll 1992).

In report group, Arcadia clients were required to police not just their own behavior but also the conduct of their peers, both rewarding them for "good attitudes"

and “calling them out” for violations.⁵⁰ While most of these groups functioned to expose and sanction clients for minor rule violations-- such as being five minutes late to group, eating food in non-approved zones, or “fraternizing” with female clients—the centrality of the state in these spaces cannot be underestimated. In-house report groups were miniature trials that established the “unified front” between treatment staff and legal authority in formal court proceedings taking place outside the facility—often determining clients’ fates in the system.

As each member of the treatment community confessed their own violations and exposed those of their peers, they became “arbiters for the state”—determining who was “straight” on the road to recovery, and who still exhibited those signs of “the street” which signaled the lingering criminal-addict (Gowan and Whetstone 2012). While sanctions were often minor-- the suspension of phone privileges, lengthy journal assignments, a few more days in residential treatment—they could be much more serious, such as a few weeks in jail, discharge from the program, or the full weight of the original prison sentence. Staff used the report group’s function of mutual surveillance to control and divide criminal-addicts, preventing manipulation or collusion. In the face of dwindling resources, increasing bureaucratic demands, and ever larger caseloads, these processes also functioned as essential strategies for maintaining order. Understaffed facilities like Arcadia couldn’t possibly control so many men without the successful enrollment of clients in their own treatment and supervision. In true “panoptic” fashion (Foucault 1975), report group multiplied the eyes of the staff, ensuring that clients would dutifully police each other, and themselves, in the name of “working the program.” Ironically, and as I explore in more depth later, the effective social control mechanism of report group ultimately strengthened the very “mentality” it sought to break down by dividing clients, who became suspicious, distrustful, and hostile toward one another.

⁵⁰ This was markedly different from the collective work of recovery at Healing Bridges, where injunctions against “cross-talk” in the Alcoholics Anonymous community prohibited judgments of other patients’ progress. Rather, “speaking from one’s own experience” defined the culture of group exchange, and treatment staff were deferred to as the sole authority on individual progress.

When and how clients were punished in strong-arm rehab was an ambiguously complex process—a product of the client’s history in the program, the nature of the offense committed, and the combined discretionary “wisdom” of treatment staff and legal actors.⁵¹ While Grant, Darius, Jamal, and Lee were discharged from Arcadia House for on-site drug use—one of the more serious offences-- sanctions for “attitude problems” were far more common. In fact, as Sylvia stresses in the scene above, it was not their relapse, but their failure to confess it in the correct register which ultimately sent these men back to prison. While a drug relapse could trigger discharge from the program, often it did not, and clients were far more likely to be sent back to prison for “bad attitudes,” testament to Arcadia’s focus on effecting specific moral and cultural reform beyond the purview of drug use.

Other studies of court-mandated rehabilitation have emphasized their dual aims of curbing illicit drug use and constructing “good citizens,” noting how negative drug tests often matter much less than participants’ ability to “perform” recovery through the language, behavior, and affect which signal particular moral identities (Burns and Peyrot 2003, Mackinem and Higgins 2007, Mackinem and Higgins 2008). Foucault’s classic theory of subject production through surveillance, confession, and normalization can be fruitfully applied here (Foucault 1975, Foucault 1978). As Arcadia clients “called each other out,” policing each other’s behavior under the guidance of staff, they collectively produced and reinforced the program’s treatment logic and its notion of ideal recovery. The subjects of strong-arm rehab—the “truly recovered,” and its antithesis, the “criminal-addict”—were constructed and normalized through extended performances of surveillance, confession, and the application of sanctions.

The Racialization of Treatment Resistance

While report groups were house-wide affairs that enrolled every client in the therapeutic community process, it soon became clear that the more insidious

⁵¹ Numerous studies have criticized the lack of standardized sanctions and “evidence-based practice” across drug diversion programs. See, for example: Marlowe, Douglas B., David S. DeMatteo and David S. Festinger. 2003. “A Sober Assessment of Drug Courts.” *Federal Sentencing Reporter* 16(2):153-57.

manifestations of the criminal-addict-- treatment resistance and the “penitentiary mentality”-- were more firmly tied to the motives and identities of Black clients.

Recall Justin, the white methamphetamine addict and “treatment pro” I mentioned earlier. While “catching a case” had initially routed Justin into Arcadia, he stressed he had entered the program voluntarily and resented the implication that he needed to display himself as resistant to his own treatment. “I’d had my sights set on treatment for awhile. Just so happens I caught this case first, and ended up here. But this isn’t my first time... I know how to give them what they want to get through it,” he said. Indeed, Justin was a staff favorite, repeatedly promoted in the hierarchical “coordinator” structure, assigned to leadership roles, and awarded considerable power over other clients.⁵² Although he claimed his motivations to get clean were sincere, Justin openly admitted that his success in the program was mostly due to knowing how to “talk the talk.”

Justin’s emphasis on the voluntariness of his own treatment reflects the ways in which treatment resistance was often racially coded at Arcadia. White clients who possessed considerably more cultural and economic capital-- comprising about one-quarter of Arcadia participants—were much more likely to reject the notion that they required forced treatment. Some were court-mandated on a DUI charge, some had been referred through other service agencies when previous treatments had failed, and a very small number had been sent by family or self-referred in the hopes that Arcadia’s “tough love” approach would trigger long-term sobriety. The more advantaged, white clientele tended to construct recovery as a personal choice, albeit one that the courts might have “helped” them see was the right one.

Despite the fact that the majority of Arcadia clients were court-mandated, white participants were more consistently able to insulate themselves from being defined as

⁵² The “coord” (coordinator) structure was Arcadia’s client leadership system, designed to recognize those participants who were progressing quickly through the program by giving them more responsibility over other clients’ fates and in the day to day operations of the treatment facility. For example, the “dining coord” was responsible for doling out cafeteria chores and setting menus, while the “business coord” had the power to sign off on certain client requests to leave the facility. Resident director was the highest position, acting as a liaison between clients and counselors.

“treatment resistant,” or held suspect for “talking the talk.” After lamenting how much he “hates all those drug court guys,” Shane, a self-proclaimed “proud, working-class Irish-American guy” and a successful Arcadia graduate, told me how he could tell when someone was “just bullshitting”:

“They're talking the talk, but they're not walking the walk. They're not doing the right things... For example, they still have the same slang. You know, they can say it all in group, but then when it's free time, and they're like rapping in the corner and throwing gang signs up. C'mon, that's not the right thing.”

Shane’s remark, clearly directed at the African American drug court clients, illustrates the widespread equation of Black cultural styles with treatment resistance at Arcadia. Although Shane was also court-ordered, he often reminded me that it was merely “by coincidence,” emphasizing that his treatment was the result of his conscious, willed decision to change. Similar to the vast majority of Arcadia’s white clientele, he embraced his treatment as a “journey” for which he was truly grateful—so much so that he wrote the drug court judge a thank you letter for “bringing him back to life.”

In contrast, resentment over forced rehab participation was expressed almost exclusively by the more marginalized Black participants. For these clients, a lack of access to drug rehabilitation beyond the publicly-funded strong-arm system, a history of institutional confinement, and a widespread distrust of both “helping professionals” and legal authority combined to shape their perception that rehab was an unwanted intrusion—or just another instance of “doing time.” These important social distinctions were naturalized through Arcadia’s essentialist logic of the criminal personality, which both drew on and reinforced larger cultural stereotypes of the defiant, angry Black criminal.

Sure that the child-like, explosive rage of the “penitentiary mentality” lurked within, staff often attempted to provoke and agitate Black clients, testing whether they would act out or defer. “Image breakers” were classic holdover techniques from the therapeutic community tradition-- infantilizing and demeaning punishments designed to break down the addict’s defenses through confrontation and humiliation (White 2002, Yablonsky 2002). For example, participants sent on “ghost trips” were marked as

invisible, and weren't permitted to be acknowledged by other clients. The "bench" was an area in the center of the facility where rule violators were forced to sit, sometimes for days at a time, in full public display. Clients assigned to "luggage duty" had to carry their belongings with them everywhere to symbolize being "on the way out." These humiliations were overwhelmingly directed at Black clients. Steven, a forty-five year old African-American man, shared his opinion about staff's provocations and tactics such as "riding the splinter express," the men's euphemism for the bench punishment:

"I said during my stay here, I will not be riding the splinter express, and I never did. The director made me mad a couple times. There was one instance when we were on ban, and we had to write about the things we did. I couldn't think of anything off the top of my head. She said, 'You think you're better than everybody?' I said, 'What do you mean? If I can't think of anything, then I can't think of anything.' I was like, why are you irritating me... I'm here doing what you're all asking me to do. Get off my back... I guess it's something with your attitude, how you react. She was trying to see if I was going to blow up or start swinging. I said, 'No, I'm not giving into people's ignorance.'... Let them be ignorant."

Steven was clearly outraged over staff's assumptions that Black clients were excessively defiant and dangerous. Black clients often said that Arcadia's "punishments" were unnecessarily degrading and infantilizing, expressing unease and sometimes outright objection.

In contrast, white clients often said they felt image breakers were "harsh, but necessary" components of treatment, designed to "help those who need it most." Again, they did not usually count themselves in that category, emphasizing to us the supposed voluntary character of their treatment. Their ability to do this is all the more remarkable in the context of Arcadia's public status as an "end of the road" institution, a "hardcore experience" where only the most "difficult to serve" end up.⁵³ Their whiteness afforded them a kind of "exceptional status" in the strong-arm rehab—the flipside to the fusion of "treatment resistant" with urban, Black, and poor. Perhaps white clients exaggerated the

⁵³ Despite Arcadia's reputation as an "end of line" facility, a significant number of clients were first-time treatment participants (nearly 40%) or first-time drug offenders, due to local drug diversion's dual focus on chronic offenders and at-risk youth who could be targeted for early escape from the cycle of recidivism.

extent to which they were able to differentiate themselves as “voluntary” to staff, who saw the resistant criminal-addict in nearly every case. However, their insistence on doing so in interviews reflects the discursive mapping of race onto rehab resistance, and their desire to distinguish themselves. This mapping was reinforced through staff’s preferential assignment of white clients to leadership roles, and finally through Arcadia’s graduation rate, where white clients were represented at much higher rates.

The Anti-Therapy of Strong-arm Rehab

Treatment resistance at Arcadia, both real and perceived, was managed through the threat of re-incarceration, lauded as strong-arm rehab’s most effective “accountability structure.” That “force is the best medicine” has become the unquestioned philosophical underpinning of the strong-arm model, thought to produce the positive effects on recidivism rates seen in some drug courts across the country (Burns and Peyrot 2003, Nolan 1998, Tiger 2011).⁵⁴ But the hyper-criminalization of addiction within Arcadia clashed with the program’s more therapeutic aims, producing a number of unintended consequences and paradoxical effects.

The “penitentiary mentality” Arcadia worked so hard to break down was itself the accumulation of long-term effects of similar carceral institutions on the habitus of marginal men. Urban ethnographers have analyzed the masculine “street” subcultures which emerge among men cycling frequently between poverty, homelessness, prison, and other forms of structural violence, as they attempt to survive numerous hardships (Bourgois 1995, Gowan 2002, Gowan 2010). Arcadia’s therapeutic mandate of emotional vulnerability and “total honesty” was at odds with the cultural code against “snitching” that many participants identified strongly with (Anderson 1999, Majors and Billson 1992, Morris 2010, Topalli 2005). Emphasizing that “respect, security, and status come only to those with the proven ability to take care of their own business,” the “don’t

⁵⁴ Yet the success rates reported by drug courts across the country have been much more mixed than advocates have recognized—and existing studies have suffered from lack of standard measures or methodological rigor. See, for example: Belenko, Steven. 2002. "The Challenges of Conducting Research in Drug Treatment Court Settings." *Substance use & misuse* 37(12-13):1635-64.

snitch” code implores those involved in street crime not to cooperate with external authorities. Scholars have argued that this code now transcends narrow “criminal subcultures” to encompass the value structures of other disaffected groups and communities who have histories of strained relationships with law enforcement (Rosenfeld, Jacobs and Wright 2003).

Self-disclosure was seen as the main evidence that clients were engaged in the therapeutic process, signifying that successful recovery was in progress. Yet, self-disclosure was regarded by many clients, and especially those who had worked as dealers, as a grave violation of the “no snitching” code. They had indeed developed a deep distrust of institutions and authority figures, as well as their peers “out on the street.” The embodiment of a tough, aggressive “street masculinity” was a matter of daily survival, and they had learned that emotional vulnerability would threaten any personal safety or respect they had managed to amass. For many, “talking about your problems” was an extremely alienating concept. Hunter, a white ex-con from Iowa whose addictions had led him into years of burglary and street crime, stated this plainly:

“If somebody did that, came up to me [on the streets], and started talking to me about a problem they were having, to me, that is unusual... People do that, they talk to each other about their problems, but people who are in bars, and shooting up dope and smoking crack, or sitting in the penitentiary, they don’t talk like that about their problems.”

Many Arcadia men had learned that trusting others would only lead to unspeakable personal violations. For these men, vulnerability was a weakness that signaled “an open invitation to be fucked with,” as one participant put it. Nick, a fifty-three-year-old Native American man and Arcadia graduate describes how the therapeutic mandate was potentially dangerous, as it undermined the survival skills the men had acquired to cope with everyday violence and victimization:

“On the street, they’ll just shoot you or stab you... I was incapable of receiving any kind of compassion or love from anybody because the street had been so brutal to me, and unfair. So, what would make me think these guys are sincere?... When you go in there, I think you are just incapable of receiving any of that. You know, the system is pretty cold. The streets are pretty cold... This is what we

know, and not much has changed. So when you go in there, it's really hard to think, 'This guy is going to love me and care about me.'"

In part, these sentiments reflected how the violent cultures of street masculinity had shaped many poor and working-class men—the hard, non-emotional, tough display of the “cool pose” (Katz 2003, Katz 2006). Yet these attitudes were not only derived from masculinity norms and interactions on “the street”--- they were reinforced by the fact that life had often been a long series of disappointments and betrayals by institutions—family, the labor market, the education system, and law enforcement. Bureaucracies and authorities had only ever delivered false promises.

Other scholars have noted that therapeutic frameworks resonate more with middle-class cultural repertoires (Illouz 2008), while recent work argues that working-class Americans are increasingly expressing therapeutic versions of selfhood (Silva 2013). Yet the structure of strong-arm rehab at Arcadia ultimately forestalled the serious self-disclosure and deep emotional expression which characterizes therapy in the popular imagination—and which was far more active at Healing Bridges, which I examine in the next chapter. The strong-arm process only reinforced clients' hesitation to become vulnerable by constructing criminal-addicts as perpetrators, even predators, who were fully responsible for their addictions.

The strong evocations of family and community which were instrumental in making Alcoholics Anonymous the largest self-help movement in the world were symbolically invoked at Arcadia through appeals to “brotherhood,” but undermined by the program's close contact with the system, which created a culture of distrust and suspicion. Clients routinely expressed in interviews that Arcadia's atmosphere was decidedly “anti-therapeutic,” contrasting it with other models more firmly rooted in Twelve Step and psychotherapeutic traditions. For example, Justin noted the very different effects of the “Minnesota Model” and “strong-arm rehab” on therapeutic culture and emotional expression:

“When I was at Hazelden, we would talk about some pretty deep stuff. Being a guy, talking about deep stuff in Arcadia House is kinda like... no way. You know? ... At Hazelden, we could talk about feelings and emotions and talk about the past

and how it made you feel and you know the classic, ‘Well how does that make you feel?’ whereas at Arcadia House, you did get into some of that, but it was just not as open... or more rough around the edges I guess.”

While Arcadia staff urged clients to “become vulnerable” and “open up,” they simultaneously policed and repressed authentic expressions of anger, linking them to the toxic penitentiary mentality-- interpreted as defiance, dissent, or lack of respect for authority. As the theory underlying the therapeutic community goes, when clients learn to withstand repeated provocations and frustrations, their internal capacity to avoid the lure of drugs or the street is also strengthened. Yet for many clients, Arcadia House only mirrored the danger and distrust they encountered “out on the streets.”

Perhaps the biggest threat to therapeutic reflection and disclosure was strong-arm rehab’s close proximity to the criminal courts. When saying the wrong thing can get you sent back to prison, better to say nothing at all. Clarence, a forty-eight-year-old African American man and recovering cocaine addict, underscored this point when he shared the story of why he was transferred from Arcadia to another program:

“Man, they're so restrictive at Arcadia House I thought I was in prison... We had a meeting, and I said, ‘Shit, why don't we take ourselves off ban if we are all tired of being on ban?’ Well, they went and told [the director], and she sent a report over to drug court. And my probation officer said I have that penitentiary mentality, and I’m trying to cause some shit, trying to instigate the young guys. I said, ‘Hold up, man. I just made a simple statement. I didn't mean anything by it.’ My probation officer said, ‘You did too much time in the penitentiary.’ Because I do have a penitentiary mentality, because I did so many years, I'm used to causing some shit. And I'll speak up about things that maybe I should just keep my mouth shut about. But I've learned how to temper that now... The judge said, ‘You’re over there trying to cause some shit.’ I said, ‘Judge, I'm not trying to cause anything. I'm just trying to stay sober.’”

The judge handling Clarence’s case extended his time in the system and transferred him to another long-term residential program, showing Clarence—a generally cooperative and invested participant—that speaking openly and honestly was exactly what he should *not* do. Similarly, Merrick’s belief that showing vulnerability was

dangerous resurfaced for him at Arcadia, as clients demonized each other in the extended trials of report group:

“Somebody could be walking down the street coming towards me, and I would cross the street, because I was afraid they might think I’ve done something, and they don’t even know me... That’s the feeling that you get here... Even the paranoia of being around a lot of men. I don’t trust them. If I say something [in group] pertaining to what happened in my life, there’s only more judgment... People would say, ‘Well, did you do it? Were you drunk? Were you high?’”

These fears and anxieties could be even more heightened because Arcadia focused its reform project so strongly on dealers, some of whom had victimized their addict-customers outside of treatment. Men who were less drug dependent and more firmly tied to the dealer identity sometimes shared groups with addicts who had been terrorized in the local drug economy. Shane was one of the few white, middle-class dealers I encountered in the study—and one of the few white, middle-class men at Arcadia. He had quickly moved up in the crack trade before developing his own heroin addiction. His disparaging portrayals of “junkie whores” and cavalier descriptions of “working the crack houses” caused me to question his proximity to other addicts in the program. In one of our interviews, he described his routine interactions with addict-customers at two of the crack houses where he supplied product.

Shane: “Most people wanna use there because then they can wait for somebody else to get some and they might get a hit and then they get what’s called ‘stuck.’ And then they’re afraid to leave ‘cause they’re afraid they’re not gonna get another hit...”

Sarah: So the people that stuck around, did they sleep there?

Shane: Sometimes, if I didn’t kick them out.

Sarah: Okay. So you would usually have to tell them to get out?

Shane: Yeah. On a daily basis. Sometimes two or three times a day. I would get so sick of these junkies in my fucking house, I’d wave a gun around and tell people you need to get out now. And believe me, that scares a crackhead! [laughs]”

Strong-arm rehab portrays addicts as fully responsible, criminal perpetrators, and addiction becomes just one of their many crimes—a violation against the therapeutic community and society as a whole. The clients’ angry reaction toward the K2 users in the field note opening this chapter reflects a common sentiment at Arcadia. Participants who broke rules were dangerous and threatening, and in the eyes of staff, they deserved to be punished. The most devastating effects of this hyper-criminalization were wrought on those Arcadia clients who suffered from chronic homelessness and debilitating addictions to heroin, crack cocaine and alcohol. A core aspect of “treatment” for these men came with a heavy dose of moral castigation, blame, and stigma.

The criminalization of relapse is one of the key discursive fault lines between strong-arm rehab and the more mainstream medical orientation of the “Minnesota Model” where “relapse is a part of recovery,” shoring up enduring differences in the treatment logics of “bad addicts” and “sick addicts.” Portrayals of addicts as “victims” or “survivors” of a chronic and progressive disease, actively mobilized at Healing Bridges, did not have a space within the narrow, stigmatizing discourse of the criminal-addict. Rebecca Tiger argues that court-mandated rehab is a hybrid punitive-therapeutic form producing a “partially medicalized” notion of addiction, bridging the weak agency of a medical model articulated in terms of brain disease with older moralistic associations with deviant drug use (Tiger 2012, Tiger 2011). Yet in many respects at Arcadia, the therapeutic and the punitive worked *against* each other. Far from “force being the best medicine,” ties to the criminal justice system significantly undermined therapeutic ethos. While the disease model of addiction offered the addict “reprieve” from responsibility for their condition, strong-arm rehab effectively re-criminalized him, extending and intensifying the shame and stigma contained within moralistic frameworks. Indeed, the disease model threatened two essential functions of criminal rehabilitation which Arcadia’s program had to deliver-- the cultivation of personal responsibility and the casting of moral blame.

Rehab as Satellite Prison

Arcadia’s program ultimately “worked” as a form of social control. While clients were frequently sanctioned and sometimes discharged, most did not leave the facility on their own accord. In nearly two years of research, I only witnessed a handful of walk-outs. The threat of re-incarceration constantly looming, all but the most “prisonized” men seemed willing to “talk the talk” to avoid further sanctions—at least on the surface level. Arcadia House proudly promoted its “graduation rate” as one of the highest in the city.⁵⁵ Advocates of drug diversion are especially eager to tout these numbers as evidence of the success of coerced rehab.

Arcadia may have worked as a form of short-term prison diversion, but its success as a disciplinary project of reform and re-socialization was far more dubious. While clients couldn’t effectively resist by walking out, they did so in a range of other, more subtle ways, which I examine in the next section. Rehab in the shadow of the carceral state also produced a number of contradictory outcomes. As clients were urged to break the “no snitch” code and report each other, they became intimately tied to one another’s fates. A deep sense of distrust and suspicion resulted, antithetical to a truly transformative therapeutic experience. Community, supposedly the foundation of recovery, was undermined by design at Arcadia House. In sharp contrast to the peer-led Twelve Step process at Healing Bridges I explore in Chapter 4, Arcadia’s reform project relied on state-backed external controls to contain, discipline, and ultimately divide, recovering addicts. While a significant number of Healing Bridge’s participants went on to maintain a thriving post-rehab support network, Arcadia’s addicts were deeply isolated—and even fearful of one another. Their already strained support networks were further compromised by the program’s message that criminal-addicts were dangerous people—not to be trusted, and potential “triggers” on the road to recovery.

⁵⁵ While retention rates were relatively high for a court-mandated program, evidence of Arcadia’s effect on future recidivism was not available during the time of my study, and no long-term evaluation studies had been conducted to measure these trends.

Valerie's Primary Group

In August 2011, I sat in a cramped circle with eleven group therapy participants in the men's ward at Arcadia House. The air conditioner had been broken for weeks, and a general malaise had taken hold as the clients struggled to stay alert through a long day of programming in the stifling heat of the stuffy, three-story brownstone. Andre, a thirty-three year old African American male, rolled up his sleeves and repositioned his cap to wipe the sweat from his brow. "Dang, I just can't think in this heat today!" he exclaimed.

Malik, a twenty-two year old African American male, offered a quick retort. "Yeah, I'm sure it's the heat, that's what's been makin' you crazy!" Several of the other guys snickered at the remark, and Andre repositioned the window fan so it would blow directly on his back.

"Hey!" yelled Malik, "You're taking all the air up in here, I thought we were cool!" He swung his arms at Andre and hovered over him. Quickly patting him on the back, he thrust his face into the fan for more air. "Nah, I'm just playin' with you, man."

Malik and Andre had become fast friends, forming a rare bond that rivaled connections among some of the men who had shared a room at Arcadia for several months. I later found out they had grown up a few blocks from each other, but had not met until they'd entered the program. I'd been following this group of participants for several weeks now, and a marked difference had occurred as they grew comfortable with my presence, and trusted that I would not report behavioral violations to staff. Playful interactions like the one between Malik and Andre were often labeled by staff as "acting out," negative appraisals which could surface later in report group.

We were waiting for Valerie, the newest men's counselor, to arrive for the day's second "primary group." Aside from house-wide report groups and one-on-one sessions, clients traveled through most of the program in their smaller, more intimate primary groups. It was here that the men learned most of the details of each other's lives. Not nearly as tense and contrived as the report groups, here the clients spoke more openly, although always with the knowledge that the wrong words or a display of "bad attitude" could catch them a violation.

Valerie, a white woman in her late thirties, entered and scanned the room, taking a quick head count. "Andre! Baseball cap!" Andre nodded sheepishly, and quickly removed the cap, stuffing it into his back pocket. Valerie spotted a can of soda peeking out of the large side pocket of Malik's jeans. "Okay Malik, you're new so I'll let it slide this time, but you should know the rule. No drinks in group. Throw it away." Malik began to protest that he'd just spent his last several quarters in the basement machines, but Valerie cut him off. "Shush, we don't have time. Throw it away, please!" Malik looked dejected, and Andre piped up, "Don't worry man, I'll spot you for the rest of the week."

I had been waiting to see Valerie in action. She was a licensed drug and alcohol counselor and a recent community college graduate who had transferred from an internship at the Lino Lakes Prison chemical dependency program.

"I know how it looks, but don't let her fool you," Sylvia had said. "She's got the experience we need. She looks like a pushover, like she won't last in here for a second, but she knows how to lay down the law, trust me on that. And did I mention she has three kids? And one of them is in high school. Can you believe that? She has three kids. And they're all law-abiding!"

"We have a new brother in the house today," Valerie said. Malik stood up to address the group. "Well, I prefer to be called 'LA'..." he hesitated. "But I don't know if that's appropriate or not." Valerie rolled her eyes disapprovingly. "I can tell you right now that's not going to fly with Sylvia," she said.

Andre doubled over in laughter, "Yeah man, you can't be using your gang name in here!"

Malik shrugged, retreating to his seat. "It really ain't no gang name. I just use that because I was born in California."

"Why don't you stick with Malik, and tell us what brought you here?" asked Valerie.

“Well, I would say I was manipulated into being here, but... I guess I need to be here, too. I caught a 4th degree possession case, and I ran from my PO. Got caught, went to county, had some time to think, then came here. I wanted to run, but I stayed. I believe it was God's work. And because I'm not a quitter. I don't quit at anything, never have. I came to realize this place is less about chemical dependency for me and more about the... What do you call it? Behaviors?” Valerie nodded, and encouraged Malik to keep going.

“See, my behaviors are street, and I have all this pent-up aggression, so I guess I do need this program. I'm here first for my daughter, then for myself. I want to stick it out, because I love my daughter and I would die for her, and I want to die for her rather than die for drugs, or alcohol, or the street.” Malik leaned forward in his chair, clutching Arcadia's standard red workbook to his chest, his voice growing urgent and impassioned. “My soul was so beat down, let alone my flesh bein' beat down. I just couldn't take it no more. I have to do something now, or it's the grave. When you're ready, you're just ready, and nothin' can hold you back, not even a two-ton truck. I'm tryin' to get me some housing, some education, and a sober life out of this.”

Valerie thanked Malik, and addressed the group. “I met Malik today, and I was impressed by his positive attitude. Malik, you said that in other programs you left when you felt you'd done enough work and you were ready to leave. My question to you is, after one month in here, and you start feeling that way, what are you going to do to stick with it?”

Malik leaned forward in his chair. “I'm going to ask God to help me give up the fast life, and to help me have a strong mind, just one day at a time. When I get angry, I don't really stop and take time to think. I need to learn how to sit down and talk to someone more rational, or something... I don't know, just do something different. I get angry when I feel like I'm not being listened to, and I'm not getting respected.”

Malik paused for a moment, then continued. “The other day in report group, I felt like Sylvia made my anger about a gang thing or something, you know, some type of street shit or something. But I was just trying to explain that I was angry because people weren't listening to me. Some people always judge you by how you look, and that's it.

But if you cut me off, and don't hear me out, I feel disrespected, and then I'm gonna isolate. Like okay, I guess I don't need to be heard, you know? If I feel that I can't voice my opinion, I'll just shut down."

"Well, what can you do when you feel you're not being listened to?" Valerie asked.

Malik looked puzzled. "What I would normally do is say, 'Shut the fuck up!' You know what I'm saying?" The group burst into raucous laughter. "But I guess instead of that, I could just raise my hand nicely or something, and say [in a slow, deep voice] 'Excuse me, but you're not listening.' Coming from the street, I have the problem... See, I never had any support growing up. No mom, dad was off doing drugs and livin' fast. If something doesn't make sense to me, then I react."

Valerie interjected, "Listen, I realize there's this different way that you all act out on the street, but we just can't do that if we want to be part of society."

Andre, who had appeared to be nodding off, suddenly perked up in his seat. "But it's the same with me. It's a reaction to this anger we have," he objected. "And you can't be soft on the block!"

"Alright then, Andre," Valerie challenged, "Tell us again why you are in treatment. Why don't you take out your assignment, and read it for us?"

Andre crossed his arms and leaned back, balancing his chair on its back legs, a slight smile creeping up on his face. After weeks of getting to know Andre, I'd come to understand this gesture as a sign that he was getting ready to "talk some talk." It had been two months since Andre was sentenced to Arcadia's program for marijuana possession, and he had been slow to accept the court's determination that he had an addiction. Andre was quickly embraced by the other men for his light-hearted demeanor and quick humor. Among staff however, he'd earned a reputation as a "trouble maker," and interns were often warned to "watch out for his manipulations." I'd seen two other counselors quickly grow frustrated with Andre, as he directly challenged their authority. Sylvia assigned him to Valerie's group, where he was given another chance to complete

his “What Brought Me Here” assignment. Andre’s attempts so far had been deemed unsatisfactory by staff.

“Why am I in treatment?” Andre cleared his throat. “Let’s see... Well initially, it was because I caught a case, but--” Pausing, he produced a piece of paper from his back pocket, which had been elaborately folded into the shape of a bird. He unfolded it slowly, and read his handwritten notes in a monotone voice. “As I dug deeper here at Arcadia, I had this huge realization that my alcohol and marijuana use was a detriment to myself and to my family. Weed prohibited me from using all my potential...” Andre trailed off as several clients in the back row snickered, clearly amused by his performance. Valerie shot them a disapproving look, and Andre refocused.

“I thought because I wasn’t smoking crack anymore, I had escaped my addiction. But I see now, it’s all the same. And I’ll probably end up smoking crack again if I keep using weed. I quit the crack, but I couldn’t stop smoking weed on my own. And I abandoned a pregnant woman, my lady, because I couldn’t stop smoking weed, and that’s sad to me. I gotta get out of this crazy mode and get into the civilized mode. What I was doing, minimizing the weed, thinking that I had it under control, but it really had me in a chokehold. Now, I been in here sixty some days, and I’m clean, you better believe it! I can’t wait for my UA to be clean as the fresh, white snow! Now I’m at the point where I’m not thinking about weed at all, and I don’t want to go back to it.”

He glanced down at his notes before adding a final remark, “Oh, and I also realized I’m an alcoholic, too.” Finished, he flicked his notes across the room.

In the standard round of group feedback after an assignment, each participant took a turn offering a reflection on Andre’s speech. Ruben, a 28 year old Latino man who was battling an eight-year addiction to crack cocaine, said, “I’ll have to take your word for it man, that weed causes all these other problems. I never wanted to do more drugs or commit crimes because I was smoking weed. But coke and alcohol, now those go hand-in-hand. When I start drinking, then I get to wanting to smoke crack, and then I want to drink to come down from the crack high, and it’s like a fucked up roller coaster.”

Brody, a forty-year-old white man who had often complained about Andre's propensity to "talk the talk," quickly interjected. "Seems like you're making a lot of progress here, Andre. You were way in denial about your life when you first came in here, but now, it seems like you're finally working toward something good." Other clients nodded in support of this assessment.

Malik turned to Andre, addressing him softly. "I can relate to what you're sayin' man, because it's the same for me. You think you got one drug under control, but really, it's controlling you. Never think to yourself, 'I can do this,' because then it's gonna start handling you. Old heads on the block used to tell me, 'Weed is the gateway.' But you know when you're young, you not trying to hear all that, and the way I always thought was that weed was way different from crack. And the weed was always about security for me. I had a dream to have money stacked to the fucking ceiling, but in reality, everyone was coming to me and was using me, and then I ended up with nothing in my pockets at the end of the day, and here I am out on the block, all freaking about my weed and not wanting to smoke with someone else, because what if he steal from me and all that negative type shit?"

Andre nodded. "I look at my daughter as inspiration," he said. "I never wanted to stop weed because I looked at crack like that was the real shit that fucked me up. When I came here, I wasn't fucked up at all, and damn right I was still hustling! I had clean clothes, a roof, and some money in my pocket, so what did weed ever do to me? I could smoke a little, put it down, and then go take care of business and my head wasn't all fucked up the way crack do you. But I still couldn't quit that game... and I guess that's why I'm an addict."

Valerie spoke up. "Yeah, okay, you were thinking things were great, but in reality, they weren't. Think about it like this. You could have been picked up and arrested at any time! What if someone you were with had a gun in the car, and then you were caught up in that? You know, we've talked about this. It's not about the drug, it's about the lifestyle."

Andre continued, "I always thought because I'm not smoking crack, I'm not an addict. I always had money, had clean clothes, and wasn't running around all tore up

like some of these people. You know, because you see them. You can tell when somebody out on the street has just lost it. But bottom line, I wasn't all that. I should have been protecting my lady, should have been supporting her. She should be at home on bed rest right now, but instead she's pregnant and has three other kids, all bad as hell, running around, with no help from me. I ain't there to help, and that's why I'm an addict."

The group came to a close and we stood gathered in a circle, arms extended, for the ritual recitation of the Serenity Prayer: "God, grant me the serenity to accept the things I cannot change, the power to change the things I can, and the wisdom to know the difference. Peace."

Part II: Habilitating the Hustler

"Addicted to the Lifestyle"

Typical of the many "primary groups" I observed during my research, the field note above captures the relaxed yet highly scripted character of therapeutic exchange at Arcadia. The passage also reveals the net-widening effects of strong-arm rehab as it proliferates on a national scale—the routing of low-level drug offenders into addiction treatment whose substance use is minimal, and for whom drugs are a matter of daily survival and limited economic security. Andre and Malik are two such men. They had mostly been recreational marijuana users—although Andre had successfully kicked a crack addiction years before. As independent, small-time street hustlers who combined odd jobs and weed sales to support their families, both had acquired the "addict" label when they were court-mandated to Arcadia's program on minor drug charges.

According to Arcadia's statistics, about 40% of men entering residential treatment report that marijuana is their "primary drug of abuse," whereas admission trends across the Twin Cities indicate that marijuana addiction accounts for only about 16% of all treatment cases (Wilson 2013). A product of the drug court's "net-widening" effect discussed in Chapter 2, I learned that a significant number of men were "serving time" at

Arcadia for drug charges linked to their involvement in the informal economy.⁵⁶ Without discounting the fact that many Arcadia clients were fighting chronic, life threatening addictions to drugs or alcohol, a significant number of participants rightfully struggled to think of themselves as “addicts.” While recreational drug use was no doubt common among all Arcadia men, few of their problems could be firmly linked to their drug consumption.

A central task of strong-arm rehab thus became convincing many men of their court-led addiction diagnosis. Andre and Malik rejected the addict label at first, but the program required them to “talk the talk”—to demonstrate acceptance of the addict label by performing the role of the client in therapy (Skoll 1992). Andre’s was quite the overt performance, a fact which did not go unnoticed by Valerie, who later remarked to me that she would have to push Andre to “get real” and “show more authenticity.” Dashonte, a 22-year-old Black male who started dealing to provide clothes and shoes for his younger siblings, was a typical Arcadia client. Sent to Arcadia after getting caught selling marijuana on camera in a downtown business district, his first and only adult offense, he struggled to accept that his marijuana use constituted an addiction:

“My mom and step dad don’t consider me to be an addict. My step dad brought it up that even though I was using on an everyday basis, there were periods where I could just quit... I never really spent my last little bit of money on alcohol. I never stole weed or robbed anybody to get weed. I never really did anything. I sold weed. I wouldn’t consider myself an addict. I would just consider myself misguided.”

As men like Andre, Malik, and Dashonte struggled to frame their pasts in terms of addictive pathology, the notion of “lifestyle addiction” accomplished powerful discursive work. Drug use was just one of many “deviant” values, behaviors, and cultural styles that

⁵⁶ After I left the field, the local drug court I studied altered some its eligibility requirements to further restrict its “net,” somewhat changing the profile of the offenders routed into the program. Focusing more on “high risk-high need” offenders with clear-cut diagnostic criteria for addiction, they allowed entry to fewer of the “hustlers” I observed, and drug court’s demographic was considerably whitened. An alternative explanation for this whitening was offered by the program’s director in an interview. He claimed that word on the street among Black, low-level hustlers was that drug court was a bad deal—and many of them were now rejecting it in favor of serving prison time.

participants spoke of being “addicted to,” including clubbing, partying, criminal activity, and making “fast money” in the drug trade. While easily expanded at Arcadia to include anything defined as problematic, “the lifestyle” was most clearly tied to working in the informal economy, crystallized in the concept of a shared “hustling lifestyle.” Arcadia staff and clients understood “the lifestyle” as a deviant subculture in which clients freely chose to participate, lured by the appeal of “making a hustle, fast money, cars, women, and drugs.”

Examining the discourse of a “drugs lifestyle” in a similar court-mandated therapeutic community, Kerwin Kaye notes that it bears a striking resemblance to the “tangle of pathologies” at the center of widely discredited “culture of poverty” arguments (Kaye 2012, Lewis 1968). Indeed, at Arcadia, the notion of behavioral addiction was reworked to encompass a whole range of disparaging values, characteristics, and identities commonly associated with the urban American “underclass”—crime, violence, gang involvement, lack of impulse control, diminished work ethic, absentee fatherhood, welfare dependence, and a general flight from responsibility.

Yet, “addicted to the lifestyle” was not merely a “top-down” institutional discourse. It also had currency as a reflection of many participants’ lived experience hustling on the street for survival. For many men, lifestyle addiction made intuitive sense, as it captured both the “lure” of fast money in the drug economy, as well as the hopelessness and despair that accompanied “getting stuck” there. For example, clients such as Merrick came into the facility with a highly developed idea about his own, and other dealers’, addictions to the power associated with hustling: “Selling drugs, you get stuck in the lifestyle. Part of that is about control... That's part of the seller's thing, you know... But they don't know they're addicted, too. They're addicted to that lifestyle.”

Ironically, clients who expressed the strongest independent “street” versions of lifestyle addiction were likely to be the farthest removed from Arcadia’s reform project, regarding treatment as just another kind of “doing time.” The most immersed in the drug economy, these men lived and felt “the lifestyle,” and it was an easy step from the power and pleasure of the hustling life into the addiction trope. Their versions of “lifestyle addiction” slipped readily into Arcadia’s discourse of the criminal-addict, although as I

argue in later sections, not without obscuring the social contexts of the hustler's lived experience.

Other dealers, such as Andre and Malik, resisted the program's pathologization of their hustling past, but realized that they couldn't graduate Arcadia's program without adopting its language. As a result, a significant "symbolic violence" occurred, as the men silenced the structural causes of their problems, reframing them as addictions and personal failings. Having kicked his crack addiction years before, by the time Andre was sent to Arcadia, he was struggling to provide for his new family, but failing to do so in the legal labor market. When he told the group, "I ain't there to help, and that's why I'm an addict," he reinterpreted his lack of economic independence as a particular kind of pathological dependence—a "lifestyle addiction."

In the absence of any serious drug problem, Andre's inability to fulfill his gendered provider role became the primary evidence of his addict status. Similarly, Malik claimed that his involvement in the informal economy was its own kind of addiction: "I couldn't quit that game... and I guess that's why I'm an addict." Malik and Andre quickly came to understand that mobilizing a discourse of "lifestyle addiction" was the easiest way to pass through treatment "talking the talk," and they readily did so, despite the continued suspicions of staff that they were merely "gaming the system."

Other clients, like KJ, had been truly converted. Fully convinced he was a lifestyle addict, he took up the discourse with sincere conviction. Consider his reflection on why he resisted strong-arm rehab the first time around, not sure he was really an addict, and how he later changed his mind:

"I quit treatment [the first time]. I didn't want to sit there and hear nobody telling me I can't skip on the stairs, I can't walk around with a cup in my hand, I can't use the microwave. I was like, 'How's this got to do with treatment?!' It's got nothing to do with treatment. But it has everything to do with behavior modification. But I didn't wanna hear that then. See, my thing was... I can stop smoking weed, but I got a lifestyle I got an addiction to. See, weed is easy to stop, I've been sober for two years and five months now. I'm sober because I don't want to go out there and use. I have been propositioned since I've been out here, to smoke weed, to sell drugs. And each time, I turn them down... In the past, I wouldn't have said weed was a problem. But now, I see that weed is just one part of my problem, my lifestyle. I liked how that money was coming in. When you see money coming

like that, continuously, like when I started selling crack, and I seen how quick the twenties started coming, I didn't wanna stop.”

In treatment, KJ came to see his lifestyle addiction—not his marijuana or alcohol consumption-- as the true object of his reform. In fact, in emphasizing he'd been sober for two years, he acknowledged that the “treatment” to which he eventually submitted was not even drug-related. In his life history interview, KJ described how marijuana gave him “a sense of courage... a sense of not having to worry about anything or anyone,” as he faced daily hardship on the streets. But Arcadia House had truly “produced” him as a criminal-addict with a lifestyle addiction. Discussing his transformation, KJ told me how he came to see his hustling not as a survival strategy, but as just another one of his addictions, alongside drugs and alcohol:

“Now, I look at the whole picture. If I smoke weed, I'm gonna get locked back up, and I'll lose everything... I didn't use to feel that weed was a problem. I didn't feel that hustling on the street was a problem. I felt it was a part of me surviving... But now I have no problem saying I'm an addict. I use weed. I use alcohol. And I *use* hustling out on the street selling drugs.”

While similar framings might have been taken up by those clients adept at “talking the talk,” a series of interviews with KJ confirmed that he had truly come to see many aspects of his former life as addictive. Other clients mobilized the discourse narrowly, only to reframe drug use which they previously saw as unproblematic. Zeshawn, who I described earlier as being unconvinced that he was a criminal or an addict, eventually did take on the language of addiction to link his “wrong decisions” to his marijuana use:

“Before, I didn't [see it as an addiction]. But then...I started to think, and they told me I had to accept it. So once I actually started accepting it, I started moving forward with it... I found out I was an addict in recovery... I probably smoked weed every day. But I was focusing on doing what I had to do. I wasn't letting the drug overtake me and... stealing and robbing for the drug. I could always buy it myself, and stuff like that. It wasn't like it was tearing me apart, nothing like that. But I think... it just made me make wrong decisions.”

While Zeshawn admits he started “moving forward” with the addict identity, he did so reluctantly, and continued to reject the attached label of criminality. And yet, while part of Zeshawn's acceptance was clearly the result of coercion-- a performance for

the courts-- in the absence of any other viable explanations for his predicament, he had truly begun to consider Arcadia's injunction that marijuana was the culprit.

Importantly, those Arcadia clients who had not committed crimes or had achieved periods of economic independence and legal employment could still not claim to be engaged in "right living." In these moments, drug use resurfaced as the primary evidence of addiction, such as when Clarence attempted to claim a responsible identity in Adele's group: "I told her that I was a responsible person because I had my own place, and I paid my bills. She said, 'You aren't a responsible man. If you were a responsible person, you never would have been getting high.'"

At Arcadia, drug use, criminality, poverty, and many other elements of a perceived "deviant lifestyle" were all invoked at various moments and in different ways to define clients as criminal-addicts in full need of "habilitation" from lifestyle addictions.

Erasing the Street

Conquering "lifestyle addiction" ultimately meant submitting to Arcadia's "habilitation" program, which relied upon a highly dualistic "ecology of addiction" setting the chaos and danger of "the street" in opposition to the "straight world" of the successfully recovered (Weinberg 2000). The program attempted to produce the transition from "street" to "straight" through a re-socialization process which focused overwhelmingly on moralistic valuations of clients' former lifestyles. As I have argued in previous work, once drug offenders were routed into Arcadia through the court-led diagnosis, notions of addiction-as-brain-disease were quickly set aside for a program of behavioral change focused on assuming personal responsibility (Whetstone and Gowan 2011). Refusing to call its program "rehabilitation" because they believed that criminal-addicts had not yet been properly socialized, Arcadia's brand of "habilitation" hinged firmly on clients' choices to reject their former lifestyles.

For the Arcadia client, this meant submission to an intense daily regimen of meetings, chores, and rules designed to transform the deviant poor into productive

citizens. According to Kaye's analysis of a similar program, the therapeutic community's focus on bodily discipline, work ethic, and normative values constitutes an effort to reshape the habitus, preparing people for low-wage labor (Kaye 2012). Both staff and clients at Arcadia offered similar rationales for habilitation, citing its focus on formal speech and dress, punctuality, and routinized labor as helpful preparation for participants' transition out of the drug economy. Avis, a 26-year-old Black participant, recognized that behavioral changes like tucking in shirts and removing "doo-rags," might actually be of some value for finding employment. When asked about the challenges he felt he faced in getting a job after treatment, he said:

"It's hard for a Black person, period... A lot of us drop out of school early and we don't have no skills, and nowadays you need degrees to do everything... I wouldn't even say just people who have been incarcerated. My kid's mom, she graduated high school, and got a couple years of college, and she can't even get a job. She's got a lot of practice in the nursing field, but it's hard for her. And I know for African American males, a lot of us get tattoos... I got one on my hand. I went in for an interview, and the interviewer looked at me like, 'He's a straight thug.' A lot of us wear braids, got gold in our mouth. Just our image scares people... I don't know, image is everything. They say first impression is everything. If I go in there, me being who I am, and I got these tattoos... and then they see a blonde-haired, blue-eyed white guy, he'd get the job before I would. We're both qualified for this job, you know. So, I think Black people got it bad."

In a rarely expressed critique of the structural constraints many Arcadia clients face, Avis acknowledged the paradox that while it is unlikely he would find secure work with few marketable skills and active job market discrimination, in a society where "first impressions are everything," Arcadia might be doing something helpful when they urge participants to erase their "street" styles and replace them with more "palatable" images of middle-class normality. Having never "worked a legal job a day in his life," Avis hoped to make the leap from the drug trade into legal work, and he welcomed Arcadia's mission to modify his "image" for the licit economy.

Indeed, "habilitation" at Arcadia became centered on the modification and erasure of "street culture" precisely because there was so little else they could offer participants. The program's employment and education components were the least funded. Although Arcadia was one of the best-funded "strong-arm rehabs" in the city, they constantly struggled to provide the kind of programming that would improve clients' education and

employment prospects. In the absence of any real work training opportunities, “habilitation” became a process of erasing the “lifestyle addictions” of the street hustler—which slipped easily into a condemnation of Black clients’ cultural styles. Clients frequently policed their own and each other’s strut-like gaits, their “baggy pants,” their penchant for writing rap lyrics during free time, and their speech patterns such as frequent utterances of “You know what I’m sayin’?” When asked why he thought staff cared so much about “baggy pants” and “untucked shirts,” Zeshawn responded:

“I really don’t know. I didn’t understand it either... But they say it makes you look neater... I didn’t see no difference, it was just, ‘Okay, I tuck the shirt in because I have to.’ But they would say, after all the groups is done, at eight o’clock, you can untuck your shirt. So then everybody would be untucking their shirts at eight o’clock... That felt a lot better. It didn’t really make me a different person... It made me feel like I was being controlled. It’s like, let them be in control. Like okay, they’re just trying to control me, I gotta tuck my shirt in. Like, how is that going to help me through my treatment? I didn’t understand it at all.”

If clients picked up any useful employment training at Arcadia, it was usually never applied. Six months after leaving the residential portion of rehab, few of the men we studied had found formal employment that presented a viable alternative to selling drugs. In those later follow-up interviews we were able to conduct with the men we could locate, the inability to find or maintain work was a consistent struggle, for both those who remained sober and those who did not. Arcadia House did offer a few highly coveted resources-- a network of sober housing for program graduates, a handful of jobs in a client-run café, and some post-treatment community support through the “aftercare group”-- although it was unclear how intact the community really was.

The rare connection that resulted in stable work usually came from former participants who had agreed to hire Arcadia graduates as part of their own “recovery stewardship.” Nick was one such former graduate-- He hired a handful of men every year to train and work in his painting business after treatment. Despite having been “transformed” at Arcadia himself, Nick harbored an especially disparaging view of the clients, reinforcing what he perceived as the social and cultural divides between “street” and “straight”:

“I’m just not where they’re at. They have never owned a house, never owned a new vehicle. They don’t know what it’s like to shop for groceries, or go clothes

shopping. We live in different worlds... They're okay with this general assistance welfare thing where you get your money on the first, and you're broke by the third... That's not me. There's nobody in my social group like that. We're gainfully employed. We're about something... I try to live legally, morally and responsibly... I identify with the good. Why would you want to identify with the junk?"

The Racialization of Habilitation

Everyone was expected to participate in the process of "habilitating the hustler," determining who was "going straight," and who was stubbornly "street." Yet the cultural erasure enacted through habilitation centered firmly on the Black street hustler. Both staff and clients routinely admonished the behavior of Black clients, but the harshest critiques often came from white clients, who repeatedly referred to Black clients as uncooperative, insincere, and aggressive. Sean was a fifty-year-old white alcoholic and outlier in the program due to his relatively high economic and cultural capital. Exposing his not-so-subtle racism, he remarked in an interview, "And then you get these younger Black kids that can't keep their fucking mouths shut, you know?... I don't know where they're from or what they...lived...but you know what I mean?"

Understandably, some Black clients found the habilitation process insulting, and considered it a direct assault on their autonomy. Avis related his reaction to being repeatedly provoked by staff:

"[The director] wanted me to be quiet like I was a kid. And fuck that, I'm a grown man. I'll say what I want to. If you don't like it, oh well. That's your business. 'Cause you say a lot of stuff that I don't like, and if that's the case, I should be able to walk out of class and go to my room. But I can't do that."

In contrast, almost all the working-class white clients said they understood the logic of habilitation. Douglas, a thirty-year old white participant, summarized his understanding of habilitation, which basically "made sense" to him:

"What *some clients* [interviewee's emphasis] call the stupid bullshit they have here, it brings out behaviors in you, and that is actually what you have to change in order to be a contributing person in society. It wasn't the fact that you know, uh, I was selling drugs. It was like, 'Why do you want to sell drugs? What made you want to use drugs?' What was the behavior happening long before drug use,

that you had all this shit going on in your brain, that entitled you to think that's okay?... Where's your brain at? That's what I think this place does somehow. They get you to recognize that while you're here...like, 'Oh hold on, I'm thinking kind of dumb.'”

Douglas' reiteration of the program's rhetoric reveals the contradictions which lie at the heart of how we conceptualize addiction—something residing deep within the brain, but also able to be defeated at any moment with a choice to think differently (Valverde 1998). It also displays, again, the racialization of Arcadia's treatment logic. While never explicitly stated, it was implied by the white clientele that the infantilizing, demeaning aspects of habilitation were meant for the majority Black participants. Perhaps white clients were generally more comfortable with Arcadia's confrontational program because they sensed they were not its real targets of reform.

In interviews, several Black clients voiced what they perceived as active racism on behalf of both staff and other clients. One of the most commonly mentioned sources of racial division and disagreement was assignment to the hierarchical coordinator positions, which rewarded successful clients by promoting them to leadership roles within the facility. Black clients were repeatedly passed over in favor of white clients for these positions, who were consistently identified by staff as “doing treatment better,” even though they were far outnumbered by Black clientele. While some Black Arcadia clients talked about these instances as cases of overt racism, the majority, like Avis, felt it “wasn't a racial thing”:

“I think they got their favorites around here. I think it's more of a favoritism thing than a racial thing... 'Cause I was a coordinator for a long time. There have been several Black coords, there's a couple now. But there was a point in time where there was nothing but all white coords, and the Black people didn't understand why that was... But at that time, the person who appointed the coords, she just had her favorites, her picks. The ones who went and told her everything. And the Black people weren't going down there for shit. We weren't going down there to talk about nothing. That's snitching, and we weren't snitching. But the white guys were snitching, they'd go down there and tell them everything they wanted to know. So that's why they got stuck in the coord positions, and got special perks and you know, treated better... I don't think it was a racial thing. It was who was telling and who wasn't telling. That's all it was, the Black guys weren't telling.”

Like many of Arcadia's white staff and clientele, Avis reinterpreted this seemingly clear racial pattern within a colorblind framework, insisting that any preferential treatment of white clients by counselors was only a reflection of white clients' ability to "do treatment better." While Avis admitted that it seemed like "favoritism," he refused to label incidents like these as "racial things," reinforcing the astounding silence around race within the very racially-charged atmosphere of Arcadia.

Like Justin, who I introduced earlier, Derek was a middle-class white client and a favorite of Arcadia staff. He was promoted as a coordinator multiple times despite his quite disruptive presence in primary group, and he quickly advanced through the ranks, becoming service coordinator, business coordinator, family coordinator, and eventually the resident director. Reflecting on the meaning of these jobs, Derek said:

"That was really useful for me because I was put in a position where now I have to interact with people. You have to make everybody's appointments and put them with escorts and all that... They think you are [the director] and you can make the calls. People come at you sideways all the time. It's like, what the fuck? I am just doing what I was asked to do... I got stressed out about that a lot. I would go talk to the counselors and let them know. They would be like, 'This is your individual treatment.' I needed that I guess, so I went with it. You get little perks and shit. You get to get out of here a lot more, and I took advantage of that... You have to make sure everyone is doing what they have to do... But it is not a career. I can't throw that on a resume."

Derek's dismissal of the coordinator roles as insignificant because you "can't put it on a resume" is ironic because these positions offered some of the few instances of legitimate "job training" at Arcadia. Mimicking entry managerial skills, the coordinator roles were among the few aspects of programming which could have offered some preparation for transitioning into the legal labor market. That Black clients were routinely denied access to these positions underscores the fact that Arcadia tended to offer the least to the most marginalized participants. It also suggests that staff may have selected white clients to fill leadership positions precisely because they were seen as better prepared, having been far more likely to have had a history of stable employment.

Staff often possessed drastically different expectations of clients' likelihood of future success, and while never explicitly stated in racial terms, their evaluations

reproduced the cultural stereotypes that sustain racial and class inequality. In one staff meeting I observed, Adele spoke to fellow counselor Valerie about what she saw as Andre and Malik's "resistance to change," saying:

"Yeah, they don't want to go to sober housing because they say their shit will get stolen. Yeah right, how much shit do you even have? Like a bag full of stuff? Who cares?... If I was trying to change my life, I wouldn't care about that... Seems like excuses to me... These guys, they just want to go home and mooch off mom or girlfriend, and that can't be good for their sobriety. They'll just go back to doing the same things they were doing... It just seems like a lot of these guys want to mooch instead of getting a job and figuring out their lives for themselves. You know, it's hard, because these guys actually think their families want them, too. But in actuality, I'm the one sitting down with their mom or their wife or whoever, and hearing them say they don't want them back in their home. And these guys think these women really want to take them back. And then I have to say, 'Well, we don't think your home environment is a stable place for your recovery,' and then I look like the bad guy."

It was not uncommon for white clients to echo the predominantly white staff's racist evaluations of "deviant lifestyles." In fact, white clients often didn't seem to see themselves as clients at all, positioning themselves in interviews closer to staff members, and offering judgments on what they perceived as Black clients' lack of commitment to treatment. Jonathon, a forty-seven year old white male who checked himself into Arcadia after reading about a celebrity's endorsement of the model, talked about the problematic "criminal element" in the House:

"The staff would forbid clients from watching MTV or BET and watching movies that glamorize a criminal lifestyle... The majority of the crowd just plunked down in front of the TV and watched Scarface. It was like kids watching TV... I think it was just an emotional outlet for being cooped up and kept away from that lifestyle that they're so familiar with, you know, hustlin' and workin' the streets, and workin' their trade, playin' their goods, using... you know, just being devious buggers. So it was sort of like a sweet letter from home, you know? It was something that brought about a real nostalgia in a lot of clients in the house. You know, I'm not a hardened criminal, and I in fact, don't have any felony charges against me. One, years ago, but it didn't stick. Judge threw it out. I was booked for inciting a riot during a Dan Quayle protest. I was cuffed and thrown on a bus with 52 other people, and it was thrown out in court because we were seized and cuffed in the middle of the street. Judge ruled it was public property."

Jonathon's clear-cut case of white privilege allowed him to disassociate from the "criminal element" at Arcadia, despite having his own criminal history and receiving treatment in the same program for a costly cocaine habit. Arcadia staff tried to mask the workings of race, both outside and inside Arcadia through appeals to the "race-neutral," ostensibly "colorblind" discourse of the criminal-addict, and by frequent assertions that "addiction doesn't discriminate." Yet, race was everywhere in the program, inescapable within the intensely racialized context of mass incarceration. That the program was primarily run and facilitated by significantly more advantaged, white staff was several times mentioned by clients in interviews, such as Marcos:

"Arcadia is run by people in suits, who live way out there in the suburbs. They never grew up in the projects, never grew up in a trailer park. Never grew up around gangs or bikers. They and their lineage have always lived out there... Today's lesson, I could tell you just by the way it is written-- wait a minute-- what is this dude talking about? I can tell you where he lives. He lives way out there somewhere... and that's what they go by."

Misrecognizing the Hustler's Habitus

Like the "penitentiary mentality," the "street hustler" had both discursive moorings at Arcadia, as well as "real," embodied street versions. A cycle of prison, poverty, homelessness and hustling had shaped many Arcadia men's habitus, informing their belief that drugs were their only hope for survival against state-sanctioned violence. The "pull" of the streets was a real force in the lives of many participants. Drugs and drug dealing provided freedom from the mundane routines and degradations of low-wage labor, a source of intoxication and pleasure, access to cash, and perhaps most importantly—respect and community. In the face of extreme marginalization, hustling was the best thing going. David described it this way:

"With drug dealing, you're the man, and it's easy money. People would do what I wanted when I wanted. People would buy what I wanted when I wanted. I was making two to three thousand dollars a night. It was all cash. I felt like I had respect. I had a ton of people calling me."

As Arcadia clients took up the discourse of "lifestyle addiction," any self-capacities they had mobilized as street hustlers were reframed not as agentic or creative

responses to social constraints, but as pathological loss of control. Just as each American drug scare before it, “lifestyle addiction” had spectacular power as a “vocabulary of attribution”-- a tidy framework offering a singular, individualistic causal explanation for a complex social problem (Mills 1940, Reinerman 2008b). It was an incredibly productive discourse for Arcadia’s treatment staff, who were seeking ways to deal with the influx of court-mandated cases who didn’t necessarily fit the diagnostic criteria for addiction. “Lifestyle addiction” also accommodated the criminal justice system’s aim of harnessing rehab for the re-socialization of the poor far beyond their patterns of drug use.

As I explored in previous sections, Arcadia men themselves had numerous reasons to take on the identity of “lifestyle addict”—chief among them avoiding re-incarceration. Yet, it was a dangerous compromise. In life history interviews, men frequently framed drugs as adaptive solutions to the structural problems of material and psychic dislocation. Their work in the informal economy could have been read as resistance, a form of “organic capital”-- the social and cultural capital developed in response to rejection from mainstream institutions and opportunities (Rios 2011). Instead, Arcadia House committed a spectacular “symbolic violence” by silencing the lived realities of marginal urban men, homogenizing their life histories into narrow frameworks of addictive pathology (Bourdieu 1992).

Blocked from fulfilling the gendered “good provider” role, dealing had become a primary way in which Arcadia clients performed “hegemonic masculinity” through demonstrating their lack of dependence, and their ability to exercise control and demand respect (Connell and Messerschmidt 2005). Ironically, while Arcadia attributed their failure as fathers, romantic partners, and family providers to lifestyle addiction-- it was in fact their collective desire to be good providers which had driven many of them into the drug economy, and hustling which provided one way to fulfill those dreams.

A common trajectory among Black participants was that initiation into the drug trade came after an early-life realization that it rested on their shoulders to provide for themselves and their families. Avis is one example. His single mother struggled in poverty to provide for the family, so he dropped out of school in the ninth grade to hustle drugs for household income:

“I was selling dope for income, to provide, period. Provide for my mom, provide for myself, provide for my friends. I got a lot of friends who were just hard up. Their parents were crack heads, and they didn't have nothing... I just know growing up in my community, things were tight. It'd be real bad for people around there. A lot of people drop out, and there ain't no father figures at home.... Mom could only do so much, with no father figure around, you know. In the African American community, men tend to run to the streets, they get dope in their hand, that's their means of providing for their family.”

Like Avis, a significant number of Arcadia men had been raised in single-parent homes, many of their fathers having gone on their own search for dignity and respect in the drug trade. Drug hustling was a generational response to the "crisis of masculinity" emerging from the rapid deindustrialization of the urban economy (Bourgois 1995, Bourgois 1996, Collison 1996). While other recovery models have attempted to reconstruct masculinity in light of these crises (Hansen 2012), the punitive and stigmatizing register of Arcadia's "criminal-addict" made it impossible for clients to claim any dignity as fathers or family men. Rather than a helpful reworking of masculinity, Arcadia offered only a deep stigmatization of its "street version," and the unreachable goal of "becoming Joe Taxpayer."⁵⁷ Anthony's reflection on why he started selling drugs illustrates a deep ambiguity over the meaning of these "choices":

“I had no self-control. I had a lack of motivation to do anything. I was focused on selling drugs and smoking-- all the wrong things. I was depressed about growing up without a father. All of my brothers are in the same situation. I used to always put everybody before me. I never really cared if I went to jail as long as I am helping them out and got them straight... As the big brother, I felt like I had to play the father role to keep all of my brothers in line. Make sure we were all going to school and all of that. I just never really cared about myself...”

At the same time Anthony constructs his hustling as a pathway to the male provider role—and a sign of the care and concern he had for his family—he also criticizes himself for “lacking self-control and motivation.”

⁵⁷ The effect of Arcadia's treatment logic on conceptions of masculinity and masculine identity is another point of contrast with the work that "codependency" accomplished at Healing Bridges—examined in the next chapter.

Yet, as numerous studies have noted and as my research at Arcadia confirms, drug dealing is associated with higher levels of control over drug use. While men who have turned small-scale dealing into full-time jobs are certainly not immune to developing addictions, they are much less likely to “get high on their own supply.” As Phillippe Bourgois’ classic ethnography of crack dealing in East Harlem illustrates, the dealer role discouraged excessive drug use, as it threatened to compromise job performance, undermine profits, and destabilize the powerful “hustler” persona (Bourgois 1995). Becoming a successful dealer required a high level of accountability, lucidity, and organizational skill. Intoxication among front-line dealers was seen as a liability and would cost you a coveted position in the hierarchy.

Echoing other studies of the "dealer identity" (Copes, Hochstetler and Williams 2008), some of the men we interviewed claimed that dealing afforded them more control over their drug use and their lives as a whole, distinguishing themselves from the "true addicts" who were under the control of both drugs *and* dealers. Lenny’s story is an example. Most of his young life spent working as a parking attendant while selling drugs in Chicago's Robert Taylor Homes, Lenny eventually began using the heroin he sold. For many years however, he moderated his use by snorting small, strictly measured doses and never injecting the drug—fearing that the euphoric rush of IV use would compromise his ability to maintain his foothold in the drug trade. As a result, he was able to hustle, work a legal job, and use heroin functionally for two decades. It wasn’t until he arrived in Minnesota and found himself chronically unemployed that his heroin use escalated into what he termed “full blown addiction.”

For many dealers at Arcadia-- KJ, Andre, Malik, and Lenny-- interacting with addict-customers on a regular basis was a constant reminder of the wreckage drugs could facilitate. For example, KJ explained why he avoided using “hard drugs” during his long career as a dealer:

“I wouldn't shoot needles in my arm, I wouldn't mess with no meth, no nothing. If it wasn't weed or liquor, you couldn't get me to mess with it. Because I seen what people go through to get it, and I see what people go through when they don't get it.”

KJ repeatedly reaffirmed that drugs were vital to both his economic and emotional security, but ultimately he felt that, “Looking back, the only thing weed ever did was make me look stupid.” Along with program staff, KJ admonished himself for “self-medicating,” but reported no adverse health effects as a result of smoking marijuana. Despite his continued insistence that the drug had caused a number of negative consequences, it was hard to see exactly how, under so many layers of disadvantage.

Recasting Urban Marginality in Drug Rehab

The expansion of the criminal justice system through strong-arm rehab is drawing an ever larger group of poor men and men of color into its net of social control. The state-backed project of “habilitation” at Arcadia House sought to re-socialize marginal urban men through the erasure of their “criminal-addict” culture, and its most prominent manifestations-- the penitentiary mentality and the hustler identity. Dashonte theorized the aims of habilitation quite powerfully in one of our interviews:

“I feel like when you’ve accomplished everything you want to, you should be able to relax and do what you want. When you don’t have all that stuff, it is not best that you do what you want... I am in recovery for my lifestyle... As long as you’ve got the things you need-- the house, the family, you know-- like rich people-- then you should be fine to smoke whatever you want to smoke... The reason Arcadia doesn’t want us to do that is because we haven’t got those things yet. It’s like, if you earn your place, then it should be up to you if you want to do drugs.”

Dashonte’s words signal his full internalization of Arcadia’s logic, and also reveal its ultimate function as a form of poverty management. Dashonte’s reflection summarizes a widely held belief among Arcadia men-- the notion that recovery wasn’t possible without achieving material stability, legal employment, and a hetero-normative family structure.

As drug dependency shifted to encompass an addiction to a broadly defined “deviant lifestyle,” and finally the dependency of marginal urban men on the state, “culture of poverty” arguments were revived and refocused through the essentializing notion of addiction as “criminal personality” or as a vaguely understood biological

disorder. Rather than illicit drugs or addiction, the “threat” within strong-arm rehab was mapped onto clients themselves—a model of recovery firmly tied to flawed personhood and extending onto Black identity, culture, and community. The “road to recovery” was paved with socioeconomic status, racial privilege, and cultural capital that the majority of participants did not possess—nor could they ever hope to gain through the program’s emphasis on tucking in shirts.

Their lives labeled pathological, the men were faced with a “choice” backed by the threat of re-incarceration: Continue to be “street,” or struggle to “go straight” through a moral-cultural makeover which required severing ties with friends, family, and in many cases, entire communities. In a post-treatment interview, Avis revealed his fear that there was just one single block in his entire neighborhood that might be “safe” for his recovery:

“What Arcadia House taught me is stay away from certain people, places, and things, ‘cause they trigger relapses. I know for me, if I go to North and see my people in the ‘hood, I’m right back smoking. ‘Cause they kicking it, and I know that lifestyle. You know, I ain’t even been to North since I’ve been out. I won’t even travel through. I’ll pass it on the highway, but that’s about it.”

Arcadia’s criminal-addict transcends both criminality and addiction, finally becoming an identity defined by one’s existence in a particular social location, marked by a lack of “gainful employment” or home ownership, the receipt of public aid, or the wrong kinds of consumption.

Strong-arm rehab inflicted deep symbolic violence, as most participants readily blamed themselves for their addictions and “dysfunctional lifestyles.” Beyond the incentives to “work the program” produced by the threat of re-incarceration, the highly dramatized “change or die” mandate of “street or straight” resonated with the life-threatening urgency many clients faced on a daily basis. Arcadia offered a model of change to men desperate to improve the conditions of their lives, and many became believers, no matter how untenable or out of reach. While other scholars have analyzed the potential of strong-arm programs for producing “bounded agency” (Kaye 2012), I argue that rehab in the shadow of the carceral state was neither redemptive nor rehabilitative—as any expression of agency was firmly tied to the pathology of the criminal-addict.

As Lenny reveals, the mandate of personal responsibility was particularly attractive when the implications of biological theories of addiction led to frightening conclusions:

“Research has proven shit saying addiction is a disease. My grandfather was a drinker, my father was a drinker, and I was a drinker that turned to drugs. I hope that I don’t pass that down to my daughter. It’s in our genes... but maybe not. I look at it like this. You make the person who you want to be. You can’t tell me I’m pushing my genes to my daughter, so she’s gonna be an addict. You can’t see it like that.”

Arcadia’s superficial overlay of the brain disease model suggested a biologization of clients’ racial and economic marginality, leaving participants with the terrifying notion that their problems were not just a failure to claim personal responsibility, but in fact were encoded “in their genes.” While the “medicalization thesis” contends that neurobiological conceptions of have supplanted previous addiction etiologies emphasizing flawed morals and weak will (Conrad 1992), Arcadia’s brand of “partial medicalization” worked in conjunction with hyper-criminalization to intensify blame and stigma when tied to Blackness, poverty, and “deviant behavior”—classifying “criminal-addicts” as biologically different, but still fully responsible. But while most clients would claim individual responsibility, the limits of discursive power were exposed at Arcadia as “talking the talk” became a part of the therapeutic habitus. Reinforced by the program’s narrow discourse, clients had learned to deliberately suppress any authentic reflexivity about the role of drugs in their lives, in order to “do time” in rehab.

While KJ’s life story was representative of the structural violence and suffering that shaped many clients’ lives—as I explained in the last chapter-- his recovery transformation as one of Arcadia’s “celebrated graduates” was not. The majority of clients would not be able to achieve the recovery ideal—either in terms of sobriety or other forms of “lifestyle change.” Whether they made it to graduation or not, they remained deeply confused and conflicted about the actual role of drugs in their lives. While few of the men I met at Arcadia House found the program useful for restoring their lives on the outside, many did feel strongly that the program helped them avoid re-

incarceration while under court supervision by providing dramatic incentives to stay sober.

An exceptional case, KJ had managed avoid a return to “the lifestyle” during the course of my study. He completed Arcadia’s program and earned his GED. He still struggled to find employment, and eventually enrolled in a supportive housing program where he was able to scrape by with food stamps and a small monthly allotment under general assistance. The last time I saw KJ, he was still sober. Yet he had not been able to secure a stable job that would allow him to become economically self-sufficient, and spent most of his spare time in Alcoholics Anonymous meetings.

As an example of someone who had “succeeded” despite the structural violence shaping his life, KJ became Arcadia’s proof that their mission to correct pathological lifestyles through the installation of personal responsibility had “worked.” KJ was truly a “habilitated hustler,” and as such, Arcadia often asked him to represent the organization’s public face.

One year after he left the program, I saw him speak passionately to a packed room of treatment professionals and members of the recovery community, gathered for the organization’s annual fundraiser:

“Arcadia House teaches you to end the dependence, and rely on yourself. If you really want it, you gotta work for it, brother... If you really wanna stay sober, you gotta really work for that. You can’t depend on somebody else to do it for you. As addicts, we always depend on somebody else to take care of us. That’s normal as an addict. But if I get out there and do it on my own, it means I become a responsible adult who is not dependent on somebody.”

Chapter Four: Recovering the Self-Manager in the Minnesota Model

Constructing Addiction & the Talking Cure

In January of 2013, I trekked across the icy Minnesota winter to continue my first week of observations with men receiving inpatient treatment at Healing Bridges Chemical Dependency Program. Arriving after the day's first morning lecture, I spotted Ken scurrying across the cafeteria toward me, a broad smile creeping across his face. He rushed through the crowd of men and women who had just finished eating breakfast during a presentation on "healthy pleasures," excitedly waving a large poster board.

"You've made it just in time for my drug history!" Ken exclaimed. "Chuck promised I could read mine in group today. Finally. He said it's the right time for me to share. And you can have a front row seat, if you like. I think I'm closer to figuring out what led up to the relapse... You know, this might be my breakthrough day."

Ken was a tall, white man in his mid-60s with a well-trimmed, greying beard, and he was one of the first patients I met at Healing Bridges. He was soft-spoken, but intense, with a nervous energy in his light blue eyes. As I would soon learn, Ken was in many ways "typical" of Healing Bridges' target demographic. A former computer analyst in the financial sector, he enjoyed an upper-middle class lifestyle which allowed him to retire comfortably on a pension with his common-law wife Sandra and their two Labrador retrievers. He described an idyllic retirement—volunteering at an animal shelter, renovating a suburban home, tending a large garden, and working out daily with a personal trainer in his basement gym. An avid sports fan, he often traveled across the country to sit VIP at basketball and hockey games.

Ken was surprisingly cheerful for someone who had just returned to Bridges for a fifth attempt to quit drinking after several years of sobriety—a relapse he described as "a tragic fall out of balance." Ken was much more eager than most men I encountered to share his "recovery journey" with me. He became one of my key informants, excitedly introducing me to other patients, guiding me on a tour of the hospital grounds, piling me

with research literature and examples of “recovery assignments,” and volunteering for multiple interviews. As he reminded me often, he was “on a mission” at Bridges-- singularly dedicated to charting his relationship with alcohol, in the hopes that he could find the right “cure.” That day was thus an important one for Ken, as it was his turn to share his autobiographical “drug history” during a two-hour group session with the other men in his treatment cohort.

The presentation of a patient’s “drug history” was at the center of Bridges’ therapeutic model. Occurring during the first week of a patient’s program, it was designed to acquaint both counselors and participants with the key turning points and “triggers” in each addict’s life. Patients were asked to sift through their pasts and produce detailed charts linking patterns of drug or alcohol use to major biographical events. Each patient’s primary group dedicated one full day to excavating his past, searching for the set of factors that had fueled the onset of disease. The process included both detailed feedback from group members and one of the few individual therapy sessions Bridges’ program offered. With guidance and input from staff, each patient drafted an “individualized recovery plan” based on lessons learned from sharing the drug history.

Eager to be on time for his session, Ken whisked me down the main corridor of the men’s treatment unit, its bright white linoleum floors sterile and sparkling from a recent scrubbing. We made it to the meeting seconds before the hour, thankfully for us, because Chuck, the group’s primary counselor, was not fond of tardiness. Chuck, who had worked for twenty years as a juvenile court administrator before coming to Bridges, was a domineering figure with a “tough love” orientation. A towering white male in his late 50s with a booming voice, he had developed a reputation among patients as “the mean one.” Other counselors often described their own therapeutic styles by first emphasizing that they “were not like Chuck”-- that is, they took a softer and more tolerant approach to recovery.

Indeed, Chuck’s confrontational style was an anomaly at Healing Bridges. I would later learn in our interview that his more “strong-arm” orientation was a product of his background in corrections, which he had to temper considerably for Bridges’ much

less disciplinary Minnesota Model. Chuck had taken a “hardline” approach with Ken, despite the fact that Ken was a veritable poster boy for Twelve Step dedication. Sensing that Ken was “too eager” to present his drug history, Chuck made him wait a few days after his scheduled session in an attempt to “push his buttons.” But the day had arrived, and Ken had passed the test. He taped his poster board to the wall as the other group members leaned into the circle, angling their chairs for a better view.

Most men began these sessions with brief sketches of their lives up until “age at first use,” before launching into detailed accounts of relapse. Determined to discover the “trigger” that had prompted his last turn to drinking, Ken had mapped out the months since 2007 in tiny, pristine handwriting. He told the group how during his previous three stays at Bridges, he had learned that “functional alcoholism had caught up with him.” Recapping the “lessons” he gleaned from past rounds of treatment, he offered insight into the family dynamics he believed were at the root of his disease.

“My dad and I had a lot of conflict when I was growing up. I don’t know whether he said it or not, but the message I always heard was ‘You’ll never amount to anything, you’re not good enough.’ And, uh, I couldn’t do things right. He was a perfectionist, and I’ve certainly developed that trait to a certain degree. He was hard and tough.”

In treatment, Ken had learned that his early yearning for validation from his father was the key to explaining his “workaholic” tendencies, and later, the expression and progression of his alcoholism. Ironically, Ken’s self-professed “workaholism” began long before he took his first drink, in a post-high school job managing a local liquor store. In our interview, I learned more about how Ken’s drinking escalated as he attempted to cope with the mounting stress of his job as an IT consultant in the fast-paced banking industry.

“As my disease progressed, I really used alcohol as a tool for relief from stress... before it became a problem with consequences. I went decades, and I probably drank a lot more than the average person. But there were no consequences in the way I viewed it... Like, especially in the IT world, your best day is nothing’s too fucked up. There’s always stuff wrong, always... I became a manager, and then I became a project leader, and I was head of a large software development team... Mostly what we worked on, was

with executive-level people who were buying regional banks in the Midwest... We would convert all their accounts... and shut everything down and save a lot of money. So, it was stressful. A lot of people got fired. I mean, we'd go into these places like we were the grim reaper because they're all going to lose their jobs except for maybe some top guys... So, we were under the gun. I'll be honest. In that span of time, I think there were weeks or months where I'd hardly drink because we were working all the time. But I'll tell you, I developed a habit of going out after work and we used to call it 'letting off some steam.' That was drinking."

In previous group sessions and interviews, Ken had spelled out in detail how he "functioned" as an alcoholic for most of his life, managing the demands of work with a carefully scheduled routine of "letting off steam" at the bar. He described how the system of self-management that had sustained his functional alcoholism gave way to physical withdrawal during his retirement years, a crucial turning point for Ken.

"For most of my life, I operated in the coherent zone with occasional slips into overdoing it. I was speaking, functioning, going home, and making dinner... In that same area where hangovers changed to withdrawal symptoms, I developed the inability to stop... We used to sometimes wonder if we were functional alcoholics... Since I did have some control, I wasn't having consequences. If I had to stop, I could and did many times for work over those years... But I was going to take a long break [retirement], and part of the long break and the freedom from responsibility in my job was that I was going to, you know, be active in my recreational sports and I was going to drink beer and stuff every day. I mean, it was going to be like an extended vacation. When I took a couple weeks off to go to Mexico, we drank every day...."

For many of the years that I was working, Monday and Tuesday were my abstinent days, and then Wednesday I'd go out, for maybe an hour. Thursday I might go out for two or three hours, and Friday and Saturday, I'd shoot it up... You might say the change didn't happen until three or four years after I left work. It started initially when I'd go meet them [co-workers] after work and do what I had done before. After a while, I couldn't wait until they got off work, so I was starting at home. Then I'd catch the bus and we'd go downtown to the pub, and that was an escalation. When the physical

dependence stuff started... I would still go downtown, be operational, see them, have some beers and drinks, and then I'd go home to finish the job to oblivion."

A key break in Ken's narrative occurs with his transition from "functionally alcoholic" to "physically dependent," which he viewed as synonymous with "the disease of addiction."

"Working really kept me governed as far as drinking went... The change from hangovers to withdrawal happened after I was done working.... My treatment in 2007, um you know, their observation was that many people who retire and have more time on their hands suffer from addiction."

Ken left Bridges after his first 28 days of treatment in 2007 with a new understanding of his alcoholism, and its relationship to both his "workaholism" and to early interactions with his father. He had also become a fervent devotee to the Twelve Steps--reading the Big Book religiously, attending Alcoholics Anonymous meetings daily, and sponsoring other men in recovery. From treatment, he went on to spend one year in a "three-quarters house," which he explained to the group "is like a halfway house, but with fewer rules." Ken had become fully immersed in the recovery community, replacing his former social networks of co-workers congregating at the bar with coffee-fueled AA meetings and "sober outings." He fused his recovery with his passion for dogs—which he referred to as his "higher power"-- by taking on a full-time volunteer position at a local animal shelter.

"I love dogs, even more than people. I just feel connected to them, always have... When I came to treatment the last time, I wasn't liking that message about a higher power. I wasn't accepting the religious aspect of the program. But one of the counselors gave me something to read, and it said that your higher power can be anything that makes you feel connected to the world or other people... That's what spirituality is, because that can become something bigger than you. It's not about god or religion."

Two years into his sobriety, life was still going well for Ken. He started picking up old hobbies-- meeting up with friends to see hockey games, working out, and gardening. Continuing his journey through the past few years, he told the group about a

trip to Chicago for a hockey game, the first time he had traveled alone since his drinking days.

“I went around the city and visited some of my old haunts, you know bars and things I used to visit often, but I didn't go in. I just went on a little tour, looked around. When I came back, I sort of started slacking on my meetings... By this time, I was going to meetings four times a week, and I stopped going on Saturday so I could work out with my trainer more.”

Reaching the end of his presentation, Ken laid out the events that led to his relapse in 2012, beginning with a health scare that ensued when he exhibited symptoms for a fatal blood disease. As he waited on results from ambiguous tests, his dog fell ill, and he grew increasingly isolated. Soon after, he returned to drinking.

“I stopped going to my meetings after I took those first few drinks... The guys called me. I got a few phone calls, but my phone wasn't even on... I had the support networks, but I didn't use them... I had these medical issues that really scared me, and the dog almost died, and somehow in the anxiety, rather than talking about it candidly in my groups and getting some help, I made the unhealthy choice for some immediate relief. And because I didn't go off the deep end right away, I perceived the illusion of some kind of control. Then, after six or eight weeks, I fell off the map.”

Ken offered some final reflections on his assignment.

“I think I learned, like I suspected you wanted me to Chuck, that my relapse probably started way before I actually had a drink... but I still don't know exactly when it started.... The other thing I learned was how many great things I was doing when I was sober... I have been so down on myself, I was forgetting how many awesome things I did when I wasn't drinking. A lot of accomplishments. I'd forgotten about that guy.”

The room broke into applause, and as is customary, other group members took turns offering feedback. Everyone agreed that Ken was indeed “a great person,” and many patients emphasized that the drinking Ken “was not the Ken they had come to know at Bridges.” Chuck leaned back in his chair, and prepared to offer his opinion as he scrutinized Ken's timeline.

“It seems like something was up back then... You're going out by yourself, without your recovery community. You're visiting the places you used to drink. It's like you planted the seed saying you were going to do this. And then that seed got watered when you had the health scare. When your dog got sick, it got watered again. And then you stopped talking to your sober network, and then you got that news that the tests weren't conclusive, and that was all you needed to say, 'Well, I'm gonna die, so I might as well drink.'”

Ken nodded slowly, agreeing with Chuck's theory that his relapse had probably started back when he started traveling alone. He affirmed that the exercise had helped him see the pattern clearly, and thanked Chuck for giving him the assignment. Other group members commented less directly on the causal flow of Ken's narrative, instead offering words of support and encouragement that emphasized Ken's redeeming qualities. Ahmik, a 28-year-old Native American man, and one of the few patients court-mandated to attend the program, urged Ken not to “beat himself up,” but instead to focus on the promise of another try at recovery:

“Hey man, I don't think you should beat yourself up too bad about picking up again. From the sound of it, anybody would have, with what you were going through and all. And it could have been a lot worse, you know? You're in here now, getting yourself back on track. Workin' the program, all that. You could have let it go way, way down. But what are they always telling us in here? 'Relapse is a part of recovery,' right man? And I feel like with you putting so much work into this, it might be the one for you. The time it sticks, you know?”

Alan, a white surgeon in his late 50s, had a less hopeful take, expressing dismay that Ken's story was evidence of endemic failure in the Twelve Step tradition. Ken was an outlier in terms of his heavy commitment to AA. It was far more common—and indeed recommended by staff—that patients attend 2-3 meetings per week early in recovery, and gradually fewer as they transitioned back into work and family routines.

“You're like the poster boy for AA and working the steps,” Alan said to Ken. “I mean, you go to meetings seven days a week, you've gone religiously for years, and yet

you still had those relapses and it was still really bad for you. So I started thinking, 'Wow, does this even work? Maybe it doesn't work.'"

Alan's concern illustrates the patient's power to debate the basic treatment process, which produced some level of active dissent in the therapeutic exchange. Today, several participants nodded enthusiastically in support of Alan's critique. Although in this instance, Chuck quickly intervened, reframing Ken's relapse not as a question of AA's efficacy, but as evidence that he simply wasn't "doing recovery" properly. The problem was not with AA itself, but rather, with the quantity or quality of Ken's AA participation.

"I think we all know that Ken was going to meetings physically, but he wasn't there emotionally, right?" Chuck addressed the group. "Ken's situation is a good one to get us to see that it's not enough just to show up. It's not enough just to go to the meeting and be there. That is necessary, but if you aren't invested emotionally as well, if you're not working the program and talking about stuff, letting that guard down, then it's not going to work for you. We have to do the emotional work."

With the session ending, we rose from our seats and joined hands to recite the Serenity Prayer.

Part I: Addiction, a Disease of Your Own That is Not Your Fault

Addiction as Brain Disease

In contrast to Arcadia's partial or hybrid model, the Bridges addict had undergone a "fuller" medicalization. Along with the American Medical Association, the American Psychiatric Association, the National Institute on Drug Abuse, and other institutional gatekeepers, Healing Bridges' "treatment logic" understood addiction as a chronic disease which was a product of brain chemistry, genetics, and environmental factors (Courtwright 2010). In weekly lectures on addiction science and NIDA-sponsored educational videos, patients learned, for example, that "studies show that 60% of

addiction can be accounted for through genetics. The other part is environmental, and our brains can be rewired when we overuse something for a long time.” The notion of “plasticity,” a key part of the scientific discourse, maintained that even without genetic predisposition, the risk of developing addiction was always present, as certain neuropathways could be strengthened with repeated substance use, resulting in a rewired brain (Hyman 2014, Kauer and Malenka 2007, Koob and Le Moal 2005). This framing of addiction meant that Bridges participants were “patients” getting treated for chronic disease, in contrast to Arcadia’s “clients.” The program’s location across one wing of a large hospital, and its proximity to a medical detox unit and a team of psychiatrists, nutritionists and other practitioners, fused addiction recovery with professional medicine and firmly established addiction’s status as a chronic illness akin to cancer—heritable, progressive, and potentially fatal if left untreated.

Bridges’ staff followed the DSM-V classification of addiction as a mental disorder, and much like depression, anxiety, or bipolar disorder, the sufferers had broken brain chemistry which could be balanced and corrected through the right combination of medication, talk therapy, and sometimes, social intervention (APA 2013). Indeed, about 60% of patients acquired a “dual diagnosis” of mental illness and addiction upon entering Bridges, for which they received medication and psychiatric care. Ken was an example, having picked up a diagnosis of “generalized anxiety disorder” the first time he went through the program—a label he found questionable. “I had never seen anyone for anxiety in my life. But I guess, in detox, they had me on Ativan, and they told me I was self-medicating for my anxiety by drinking a depressant, alcohol.”

Although Ken thought the diagnosis dubious, he saw a psychiatrist referred by Bridges right after treatment, and began a course of SSRIs upon his recommendation. By the time I interviewed him, he had discontinued the medication and fully rejected his GAD diagnosis, committed to the belief that drinking had caused his anxiety, not the other way around. While some patients, like Ken, questioned their newly acquired labels, many others did not, firmly believing that unresolved mental health issues were inextricable from their addictions. Bridges’ mission to “treat the whole person” meant that it was not uncommon for someone to enter the program for a cocaine addiction and

leave with plans for addressing depression, nutritional deficiencies, and co-dependent relationships. Like “lifestyle addiction” at Arcadia, the addiction trope had migrated to include a “package” of other life problems that took the project of recovery far beyond drugs or alcohol.

As a result of this discursive migration, the brain disease theory of addiction was often mobilized alongside other, sometimes contradictory, causal explanations such as mental illness, interpersonal or family dynamics, and environmental conditions. The notion of “disease” thus depended less on its validity as a *causal* theory, and much more on its utility as a concept that could capture the highly individualized, neurochemical nature of addiction as an experience. The expression of the illness could be triggered by factors as diverse as childhood neglect, untreated mental illness, or co-dependent romance—three of the most common narratives among Bridges men.

And just as a whole range of factors could “trigger” addiction, many things could be evidence of addiction’s existence. The popular notion of the “dry drunk” moved the disease far beyond the domain of compulsivity around drugs and alcohol to include a number of behaviors, personality disorders, reoccurring thought patterns, and dysfunctional traits. As Chuck reminded Ken in the scene above, “picking up” the drug or the drink symbolized not the beginning, but the *end* of a relapse which was present long before in the form of dysfunctional thoughts, emotions, and relationships. Thus, “addiction” referred to an undesirable way of relating to people and things, and one could be an addict far removed from her drug of choice. Addiction was a broadly medicalized and highly individualized orientation of the self—a matter of self-management gone awry, via “brain chemistry.”

In Ken’s case, there was no doubt among staff that he was “born” with the disease of addiction, and his life story became an illustration of its progression: from his early perfectionism and an unhealthy “need” for validation from his father, to his overworked years with “functional alcoholism,” to the final and most progressed stage of physical dependence on alcohol during his retirement. According to Bridges’ model, Ken was merely exchanging one crutch for another—he worked long hours to mitigate an unhealthy attachment to his father, he used alcohol to mitigate an unhealthy attachment to

work, he used more alcohol to deal with the void left in his retired life, and finally, he relapsed on the heels of what Chuck thought was an unhealthy detachment from his AA group.⁵⁸

In each instance, he had lost a crucial sense of balance—his life had become “unmanageable.” While Ken might not have considered himself a “real addict” until hangovers turned into withdrawal, as far as staff were concerned, it was all part of his disease—including, and perhaps most importantly, his denial. Ken’s story collapsed neatly into the profile of the “high-achieving alcoholic” upon which the Minnesota Model was based, the addict-prototype canonized in Bridges’ recovery bible (Johnson 1980). According to this formula, advanced alcoholism is the last stage in a long series of mental, emotional, and behavioral dysfunctions that mark the “addict personality.” Chief among them are elaborate rationalizations and defense mechanisms—and a primary feature of the disease is the prolonged denial of those who suffer from it.

The drug history then, was an important step in leading the addict out of denial by encouraging him to narrate his life through the lens of addiction-as-disease. Like Ken, Bridges’ men learned to reframe past events as precursors to relapse-- the dots that had to be connected to comprehend the origin and nature of each person’s unique affliction. In this way, a person’s entire existence was in a sense medicalized, as experiences with work, family, and relationships became stages or manifestations of disease. At Healing Bridges, the disease metaphor was a highly flexible discourse which sought to define the present through placing the past in a medical framework. In the process, it accomplished a vast medicalization of everyday life. The program could thus claim institutional legitimacy through its disease framework, yet still retain a highly individualized approach promising to “treat the whole person” by accommodating a range of competing etiologies.

⁵⁸ Some patients had other theories about Ken’s relapse, most notably that he was in fact, “addicted to AA.”

Removing Shame, Restoring the True Self & Empowering the Patient

Much like the “dual selves” model Darin Weinberg describes in his ethnography of a mental health and addiction treatment program, Healing Bridges insisted that addicts were not inherently flawed, but rather temporarily suffering people who could return to their former authentic selves if they applied their efforts to “working the program” (Weinberg 2005). The “dual selves” framework offers the addict considerable reprieve through the “sick role”—the notion that disease hijacks the “real self” in a momentary state of illness for which the addict is not responsible, and from which they can recover with appropriate, professional medical help (Parsons 1951). Marlene, self-proclaimed “sugar addict” and a regular on the Healing Bridges lecture circuit, described her addiction as an invasion, a movement of external forces inward:

“I felt like my addiction was some kind of parasite or virus that had completely invaded my body and taken me over on the inside. It turned me into a different person entirely, and it wasn't going away.”

Images drawing on the disease metaphor-- “parasite,” “virus,” “invasion”-- were often invoked by staff and clients to describe how addiction took hold, and to maintain the crucial distinction between the illness and the person experiencing it. The severing of the authentic self from the disease was an essential element of the discourse, because it salvaged an identity that was not tarnished by addiction, while also promising that self-transformation could begin from within. Patients thus began recovery with all the raw material they needed to “remake” themselves. In recovery, they learned that they were not, in fact, bad. Instead, their task was to rediscover the essentially good person trapped beneath the mask of illness, reconnecting with who they were before disease took hold. Patients frequently told each other that the addicted people they described in group therapy were “not the people they knew today,” reaffirming the distinction between addict and self.

Patients received constant verbal affirmation from staff and group members that they were not defined by disease. Just as often, they were also framed as *victims* of addiction, mental illness or abuse. This was strikingly different from the mandate of personal responsibility thrust upon Arcadia’s *criminal* addict, where shaming, blaming,

and stigma could fuel or intensify the dramatic binaries of sobriety and intoxication. Healing Bridges' reprieve offered an escape for the self-castigating addict who might have believed the disease was his fault.

Consider Marcus, a 43-year-old Black male who left school in 11th grade for what would become a decades-long involvement in the crack trade. One of the few patients at Bridges who fit the "hustler" profile so common at Arcadia House, Marcus had grown up poor in a North Minneapolis neighborhood where drugs were rampant and other opportunities were in short supply. His perspective on addiction was a dramatic departure from the constellation of "deviant lifestyles" thought to produce the addictions of Arcadia's criminal-addict. At Bridges, staff had encouraged him to process the verbal and sexual abuse he experienced at the hands of his father, as well as consider the effect of the violent crack trade on his psychological development. Marcus' therapeutic transformation mirrored the addict's move from "bad" to "sick" in the process of medicalization. By locating the roots of his addiction in childhood trauma, he was afforded reprieve from responsibility and the opportunity to identify as a victim of abuse.

"My drug addiction is not my problem, the roots of traumatic things that happened in my childhood—that's my problem. If I take care of that, it will take care of the drug problem... I'm learning the more I talk about what I've been through, the less power it has over me... Matter of fact, today is probably one of the only times I've talked to a real therapist, and really let somebody know what I was going through, because I don't know how to do right by my emotions. It affected me... the sexual abuse. Growing up without a dad and all that stuff has taken a toll on me... People getting shot and killed, people getting crippled... I've seen so much stuff with these eyes, I literally have visions at night... I mean, some of the stuff you can't shake mentally, for whatever reason it's sketched in your mind. Some of that stuff still bothers me to this day, on top of the visions I have from childhood... I don't remember anything good before age fifteen, and that's probably because of the trauma."

Marcus had spent some time in prison for drug trafficking, but had never been court-ordered to treatment. After attending a handful of other Minnesota Model facilities, he was on his second stay at Bridges. He didn't have much exposure to the "strong-arm" style of rehab, which showed in his markedly different take on the hustler's "lifestyle addiction," which he shifted from Arcadia's overtly moralistic tone into a more therapeutic register.

“You can ask a lot of people in recovery now, and they are going to say it's not even the drugs, it's the atmosphere you get accustomed to. That's your high... it's a lifestyle. Drug dealers get their high by making all this money... because that void-- whatever it was they were trying to fill-- it's still there, and they've done everything else to try and fill it. That psychological state is not a good place to be. You can't make me believe that any person out there in their worst state wants to be out there, spending every one of their dollars, not eating, smelling because they haven't taken a bath in days, body aching. Something started it, and I feel like the only choice you have in drugs is that first time, then it gets bigger than you.”

Marcus' past in street dealing meant he was familiar with the construct of “lifestyle addiction,” but his grounding in a medical model of recovery had clearly shaped his perception. For Marcus, the hustler's “cash addiction” was not driven by a refusal to “go legit” or by the irresponsible pursuit of illicit pleasures. Instead, the sense of psychic emptiness and the human desire to “fill the void” led the dealer to chase “fast money.” One has to wonder whether Marcus' reflection would have been elicited at Arcadia, an institution where deep reflection was undermined by proximity to criminal corrections and recognition of systemic violence was far too uncommon.

Yet, the reprieve extended at Bridges had its limits. Marcus articulates an important caveat to the disease model when he says, “the only choice you have in drugs is that first time.” Because the model retained the idea of responsibility for first use, patients could mobilize victimhood in the active disease stage, but they were not completely “off the hook.” In fact, the men at Healing Bridges were charged with a very big responsibility: to “(re)make their brains,” either through active rewiring with medication, or through ‘talking’ and ‘thinking’ their way to mental and emotional stability. And once on the road to recovery, the addict assumed full responsibility for “working the program” with sincerity, under the guide of medical professionals. Defining the limits of personal control in this way shielded the addict from responsibility for the disease, yet still allowed him to claim full ownership over the recovery process.

This rapid “switch” from powerless victim-addict to agentic patient was the first step in eliciting the active self-manager at the heart of Bridges' reform project. Staff believed if they put the removal of shame and the restoration of self-esteem center stage, they could build people back up, “empowering” patients who had just followed AA's first

step of admitting powerlessness. A crucial aspect of Bridges' program then, was an effort to erase historical associations of addiction with vice, moral flaw, and personal failure. Lectures and activities were full of "positive affirmations" designed to correct the notion that those suffering from addiction were just "bad people." In a lecture on self-esteem, senior counselor Peggy reiterated some of these affirmations.

"We can restore our sense of self-worth if we get our self-esteem back... There are two things you need to say to yourself every morning. 'I'm enough,' because we are all we've got, so we have to be enough. The other thing is, 'I love you,' because if we don't love ourselves, who is going to love us?"

Most of the counselors I spoke with had adopted the basic premises of labeling theory, recognizing that the internalization of shame could keep addicts from seeking out desperately needed medical care, or worse, lead them to the self-fulfilling prophecy of "secondary deviance" in which drug use is a response to acquiring the addict label (Becker 1963, Goffman 1963). Staff took care not to demonize relapse, so that addicts might remain open to the supportive structures of the recovery community and make a quicker return back to treatment. Brad, one of the men's counselors I often observed, explained it this way in a group session:

"What happens when we relapse and we immediately hate ourselves, is that it makes the problem worse and encourages us to get further off the road to recovery... All of us in this room have cognitive distortions, thinking that people are thinking negative thoughts about us, and often times, this simply isn't true."

Ken agreed, his comment a textbook illustration of "self-fulfilling prophecy":

"Yeah, I can relate to that. Because in the past, when I've had a slip up, I'll think, 'Well, I might as well just go all out because I messed up.' So, it starts with one drink, but then thinking like that turns it into-- It's like you're right back where you started. You start feeling bad about what you did, and then you drink more to cope with those bad feelings."

In contrast to the criminalization of relapse at Arcadia, Bridges' staff saw relapse as an inevitable, if not necessary, part of the recovery process. With each new relapse and return to treatment, the patient was closer to achieving a life of sobriety and successful self-management. When it was applied, this (re)framing was an especially powerful tool for chipping away at the many layers of stigma surrounding frequent relapse. For

example, it was not uncommon for someone with a lengthy treatment record to be talked about as “closer to figuring it out” or “steeped in recovery wisdom,” instead of just failing at sobriety.

Positive Reinforcements & “Active” Sobriety

Flipping the logic of court-mandated rehab on its head, Healing Bridges’ staff mostly rejected the utility of negative sanctioning in favor of positive reinforcements. While they did focus on the negative outcomes of staying “stuck” in addiction through activities like the “Five Years From Now” assignment, in general they believed that fear was a poor motivator. Instead, they borrowed heavily from the “positive psychology” movement, encouraging patients to identify and emphasize the *benefits* of a sober life. In assignments like “Twenty-five Things I Can Do When I’m Sober,” patients listed fun activities and “healthy pleasures,” imagining an attractive recovered life. In his presentation of this assignment, Max asserted:

“Recovery for me has to be fun. It has to be active. I like to get out and do things—mountain biking, canoeing, anything— just keep busy! If I’m only sitting around all day worrying about not using and maybe hitting a meeting or two... That hasn’t worked for me in the past. I just keep ending up back here.”

Of course, the relatively privileged clientele at Bridges meant that staff could count on working with many men who had the resources to support recreation or leisure activities and the time to pursue special interests. For the most part, Bridges men possessed the capital required to create and enact their idealized recovered lives. But finding “internal motivations to stay sober” also resonated precisely because many participants lacked externally imposed, state-sanctioned consequences for continued substance use. Almost none of them had prison time hanging over their heads. Most had jobs, families, and homes to return to after the residential portion of the program. In the absence of external threats or coercion, positive motivations for sobriety took center stage, in part, because they had to. For most patients, it just wasn’t likely that their next drink would leave them destitute, homeless, or out of work. With the exception of those

experiencing critical health failure or family dissolution, they spent far more time mourning squandered opportunities and lost potential than fearing for basic survival.

Staff however, valued positive reinforcement for its ability to frame recovery as something the patient *desired* and would strive for. Luke, one of the men's counselors most invested in positive psychology, laid out the model's rationale:

“When we're only staying sober because we're afraid of the consequences if we use—well, that's not going to last long. If we're doing it for somebody else, for the courts, for any reason other than because it makes sense so you can have the best possible life, well... You'll find yourself on the road to relapse, because we don't respond well to negative sanctions. We respond well to positive incentives. We need to have a plan for ourselves, we need to believe in a sober life, and we need to choose it simply because it makes us feel good and because we want it.”

Luke directly refuted the logic underlying Arcadia's strong-arm model—that “force was the best medicine.” He shared the judgment of many Arcadia staff as well when he claimed that coerced treatment was only evidence that the addict wasn't “ready and willing to change,” dooming the process from the start. Like other Bridges counselors, he firmly believed that the desire to change was a necessary *precursor* for successful recovery. It was Luke's job to elicit this desire in participants. For recovery to work, patients essentially had to become active in producing themselves as recovered subjects—as ready and willing for change. In an afternoon lecture, Luke summarized Healing Bridges' philosophy as he reiterated the core principles of an “active” recovery:

“Addiction is a chronic, progressive, and fatal disease that affects the whole person—mind, body, and spirit. What we have here is not a room full of bad people, but a room full of people with a bad disease... That's why at Bridges, we call you ‘patients,’ respectfully, because we recognize that you have an illness and that you're coming here to get well. You're not bad people who are coming here to be made good. Everyone here is good, and everyone has their own natural strengths and abilities. It's just that these good qualities get covered up by the wreckage and the chaos of our disease... If it doesn't stick the first or second or third time, it doesn't mean you're a bad person... Maybe your boss sent you here and you didn't want to think you had the disease. Maybe you were court-ordered, and you resisted the process... The point is, you have to be ready and willing to change, or treatment for this disease won't work... Is chemical dependency an issue of chemical imbalance? You bet it is, and that has been proven. We have a disease, and without professional treatment, there is no way we're going to conquer that... It is not your fault that you're chemically dependent... The sooner

we can separate the good person from the bad disease, the better. There's no use in thinking, 'My god, what is wrong with me? Why am I so messed up that I can't have a drink like everyone else?' Here, you've learned why. You're just in the 10% of people out there who have the chronic illness."

The "diseasing" of addiction through medicalization and its attendant de-stigmatization of the addict had a powerful effect on the therapeutic tone and character of recovery at Healing Bridges. The many contrasts with Arcadia's model should be evident. While the criminal-addict was thought to require full-on, coerced habilitation from deviant lifestyle choices, Bridges' victim-addict was "ready and willing" to recover himself from a disease which was no fault of his own.

Yet Luke's impassioned speech, much like the addiction science which informed it, was wrought with contradiction. If addiction had hijacked the brain, and as staff claimed, denial was part of the disease, how could any "true addict" ever be "ready and willing" to change? And yet, Bridges was continually painted as a program where one would find the "ready and willing" addict. This had the broad effect of characterizing Bridges' addicts as less mired in their addictions and more "willing" to recover, despite the fact that participants there generally reported greater levels of drug use than Arcadia men, and the program's success rate was only marginally better than the city's other rehabs.

In the sections that follow, I analyze how Bridges' discourse of addiction-as-disease was put into practice through a flexible, patient-centered and peer-led program designed to produce the "recovered self-manager"-- the analog to Arcadia's "habilitated hustler." Instead of a moral-cultural makeover, Healing Bridges sought to produce flexible self-managers-- people capable of regulating their moods, relationships, and desires in an increasingly uncertain, precarious world.

Part II: Eliciting the Recovered Self-Manager

“Welcome to Bridges”

The hour after lunch at Healing Bridges was designated free time. While some patients preferred to put finishing touches on assignments before the afternoon sessions, read recovery literature, or sit in quiet reflection-- the younger patients, the opiate addicts, and the more disaffected clientele usually stood huddled together outside the building in one of the two designated smoking areas. I soon realized that cigarette breaks were also good opportunities to observe “breaks” in the institutional discourse. The smoking area, if not the act of smoking itself, represented distance from Bridges’ program, and more connection to patients’ outside lives and identities. Hanging out with the smokers often increased my understanding of how people “worked the program,” “flipped the script,” or otherwise responded to the logic of treatment. Here, in a more relaxed setting outside the authoritative gaze of the counselors, patients were much more likely to reveal their underlying reactions or motives.

This is where I got to know Blake, on a freezing cold day in February. Blake was a 21-year-old white male who had arrived at Bridges several days ago to get help with his opiate addiction. In group, where he often sat hunched over in the corner peering out from under an oversized sports hoodie, I learned about his lower-middle class, Catholic upbringing in the city of Forest Lake. One of three siblings, he was raised by his parents who married shortly after high school-- his mother who worked as a public school lunch lady, and his father—a locomotive engineer.⁵⁹

Blake was what the other patients affectionately referred to as a “first timer”-- a newbie to the 28-day circuit. He often seemed guarded and chose to isolate in his room during the day.⁶⁰ Yet so far, he had participated well enough in Chuck’s group to avoid placement on the short list of patients deemed “treatment resistant.” While some of his

⁵⁹ I sometimes alter specific biographical details slightly to protect participants’ anonymity. I always attempt to do so in ways that do not compromise the general character and feel of research subjects’ experiences and identities.

⁶⁰ I later learned in our formal interview that Blake had been through inpatient treatment twice before-- once as a juvenile and once as an adult—both times also at Healing Bridges.

peers who behaved similarly might have been admonished for “lack of emotional openness,” Blake’s youth, his relatively short track record in treatment, and his status as an opiate addict in the detox phase all afforded him more tolerance from staff. The previous day, I had witnessed an unexpected fiery oration from Blake in group, where he emphasized his strong commitment to recovery, perhaps sensing that his “performance” had not been up to par. But today, Blake seemed particularly anxious and despondent as he ripped corners from treatment worksheets, lit them on fire, and watched as each cinder drifted down to the muddied snow. As we smoked and shivered in the winter air, I asked him how treatment was going, and he became surprisingly confessional.

“I don’t know what to do. I’ve been having cravings... like, bad ones. Haven’t really been talking about it, but I’m thinking of jetting out of here. I heard about a guy the other day who left after his dealer came to see him... You know, I’m still detoxing, and it sucks. At least I still got a little sub [suboxone] in my system from when I kicked, but I’m worried once it runs out... I checked myself in, but my mom was gonna cut me off if I didn’t come.”

To bypass the long waitlist for Bridges’ relatively new buprenorphine program, Blake opted to kick by himself at home, with some suboxone he scored on the street. In order to get admitted to the inpatient program, a person had to first demonstrate freedom from all substances other than prescribed medications by “pissing clean.” While many other heroin addicts I spoke with had been deterred by this procedure, Blake was desperate to get into treatment. He had managed a home detox, but was still dealing with the full effects of withdrawal. Overhearing the conversation, Wyatt, another young opiate addict, urged Blake to go talk to Chuck before “listening to the cravings.” He hesitated, but agreed. We accompanied Blake to Chuck’s office, where we found him talking in heated whispers on the phone, barely visible from behind the stacks of paper and file folders littering his desk.

“Wait it out until group tomorrow,” he said, whisking us away. “And Blake, we’ll see what we can do about making all this more comfortable for you.” Chuck’s promise meant that Blake would probably receive medication to ease withdrawal symptoms, which seemed to placate him for the time being.

~

The next day I arrived for group and was greeted by a much calmer Blake.

“Yeah, I sorta freaked out yesterday,” he told me, as we took spots in the circle for therapy. “I was ready to leave. Had my dealer on speed dial and everything. But they gave me some stuff, so I think I’m gonna stick around and try to actually do this.” After the standard round of “feeling check-ins,” Chuck turned to address Blake directly.

“It’s good you decided to stay with us. But recovery is about so much more than not using drugs. You can sit in treatment and you can be sober, and that’s great. You’re really not in recovery until you start changing your thought patterns. Eventually you will relapse unless you deal with the underlying issues, so when you’re out there in the world again, you have a way to cope with those thoughts, and you don’t immediately go back and use.”

Chuck left the room and returned a few minutes later holding a thick, yellow rubber wrist band. “This is what you do. Every time you have one of those thoughts, take the band, and pull it back like this, and let it go!” He demonstrated on Blake, pulling the band back and snapping it loudly against his wrist.

“Ow!” yelled Blake, as the room erupted in laughter.

“I’m serious,” said Chuck. “Do this every time you have a thought about using. Every single time. Just keep doing it. It works. Will you try this out?”

“Um... yeah, I guess.” Blake looked confused.

“The other thing is exercise. Exercise will clear your head, rejuvenate your brain chemicals that got all out of whack when you were using. So, I want you to get down and give me twenty!” Chuck exclaimed.

“Right now?” Blake asked in disbelief.

“Yeah!” said Chuck. Blake dropped to the floor in the center of the circle and the group yelled out the counts as he did twenty push-ups. Blake barely pulled himself up at the end, his face red from exertion.

“Well, are you thinking about dope now?” asked Chuck. Again, the room was in stitches. “And the last thing is the Serenity Prayer. Anytime using comes into your head, take a minute, and recite the prayer. I do it all the time, and it redirects my thought process. Once, I did it 73 times in one day.”

After group, several members congratulated Blake on his decision to stick it out. Chuck cornered him in the hallway, placing a hand on his shoulder. “You’ve passed the first test, kid. Welcome to Bridges.”

“I Checked Myself In”

Heavily influenced by the Twelve Step tradition, the first step of Healing Bridges’ program was to admit powerlessness. Yet as patients submitted to the program, they often reframed their participation in rehab as a source of strength and wisdom, and as a “choice” they actively made on their own. While their treatment admission may not have been coerced by the state, many patients had been coerced by family, friends, employers, or failing health. Yet Bridges patients continually emphasized the voluntariness of their own recovery. Blake’s story is a prime example. While he proudly claimed to anyone who would listen that he “checked himself in,” I later learned that despite his brave initial efforts to kick heroin at home, his rehab entrance had been much more forced, following his mother’s elaborately staged interventions and a brief stay in jail which had seemed to “scare him straight.”

Outside the shadow of the criminal justice system, the choice “not to walk out the door” became evidence that Bridges men always, already possessed the capacity to self-manage, reinforcing the notion that self-control was “a middle class virtue” (Fox 1999). In fact, it was common across the field for addicts a few days into their program to frame their treatment as voluntary. The difference at Bridges was that staff not only allowed patients to make such claims, but encouraged the practice as part of the broader “agency seizing” that formed a pathway to middle-class empowerment in recovery. Blake’s “choice” to stick it out only after receiving medication that eased the worst of his opiate withdrawal effects reveals yet another contradiction in the “pure willpower” thesis of recovery.

Yet Bridges men constantly shored up a sense of personal control by emphasizing their own acts of “determined will” in the program. For example, patients often talked about the self-control they possessed to avoid visiting the strip of bars located just blocks from the facility. Aiden, a thin, wiry white man in his early 30s, summed this up perfectly when he told the group:

“When I came in, I didn’t want to say I was powerless, and I still have a problem with it... And it seems like we get conflicting messages here. On the one hand, we are supposed to be powerless against drugs and alcohol. But on the other hand, we’re told we have to take responsibility... I guess how I deal with that is that in a literal sense, when I start drinking, I am powerless. Once I’m at the bar and I take those first few drinks, it’s difficult, if not impossible, for me to stop. So clearly, I have an issue with alcohol. But am I totally powerless? I don’t know. I’ve stayed sober for 21 days in here. There’s a bar right down the street. I could have walked down there at any moment and had a drink. Nothing is forcing me to stay here. But it was a choice I made not to, and that makes me feel very powerful.”

Here, Aiden captures the paradox of the medical model—that the disease of addiction is conceptualized as a failure of the will, yet treatment calls upon addicts to harness willpower in order to kick the habit (Valverde 1997, Valverde 1998). A crucial component of treatment at Bridges then, cohered around eliciting patients’ inner self-managers. For men whose self-efficacy had been seriously compromised or destroyed by addiction, the construction of Bridges’ program as “voluntary,” and the relative absence of state coercion, was *essential* for producing them as desiring participants who could be successful in recovery. As he accepted his sobriety coin on graduation day, Wyatt, a 20-year-old, white, middle-class male, affirmed the “fit” of a program “based on free will” for his own lifestyle.

“I thought treatment was going to be like a total institution... You know, getting told what to do all the time with lots of rules and stuff, people getting in your face. But it’s not like that at all. This might not make sense, but I feel like this program was like a perfect fit for my lifestyle. Because I was raised on free will, and this program is all about free will, if you think about it. There’s nobody making you be here, and we’re all free to walk out the door at any time. It’s all about internal motivation, there’s no external thing pushing down on you, making you be here. So, I chose to be here. It’s almost like I gave myself that external control that I needed... It was a really good experience.”

Wyatt's reframing is especially revealing because he started at Bridges as one of the most resistant young opiate addicts. For the first week of programming, he mostly refused to leave his room, and when he did, he chain smoked in the outdoor courtyard and devised plans to use heroin on the premises undetected.⁶¹ Treatment was not easy for Wyatt. He threatened to leave multiple times, and it became much more difficult when two of the young patients he'd grown close with—both just a few days away from graduating themselves-- decided to follow a friend-turned-heroin-dealer out of the facility on visit day. Wyatt's interpretation that he ultimately "gave himself the control he needed" was a crucial shift in framing that kept him in the program until graduation day, and even left him feeling like the powerful *agent* in his own recovery. The lack of external coercion at Bridges became the evidence that Wyatt's internal self-manager was getting stronger and more developed, overpowering the sick addict within.

The Bridges model was a striking contrast with Arcadia's construction of the always resistant criminal-addict who had to submit for management by others and should remain indebted to the courts for "forcing the medicine."⁶² This classic distinction between "external" and "internal" control is at the core of the "separate governmentalities" framework that I unpack in more detail over the next two chapters. As I will argue, these separate logics had potentially far-reaching and powerful effects, as they contributed to reinforcing and reproducing participants' world-views, self-conceptions and drug-using behaviors.

While it is true that the vast majority of patients lacked the threat of incarceration should they fail at treatment, it was not as accurate to say that they entered Bridges "voluntarily." Indeed, the forced "intervention," popularized in television shows like A&E's *Intervention*, was a common pathway into the program. These controversial

⁶¹ This was theoretically possible, as long as Wyatt's behavior didn't visibly change too much. Patients could be drug tested randomly at Bridges, but this usually only happened when staff expected them of using on site, and it was a surprisingly rare occurrence. I did witness several incidents of patients' intoxication on the ward which staff did not detect.

⁶² Those Arcadia clients whose recovery narratives were infused with the greatest sense of "triumphant individualism" often attributed responsibility for their change to the institutions and agencies who had "forced" them into treatment. Many were dislocated, isolated, and fearful after rehab—which contributed to continued feelings of "powerlessness" even after they'd been successful in maintaining sobriety. Tony, whose story I detail in Chapter 5, is a prime examples of this.

forums, which were often led by paid professionals working directly with treatment facilities, could be quite coercive as they encouraged family and friends to withhold support from addicts who refused to enter a structured program.⁶³ The intervention also squared well with a core assumption of the Minnesota Model—that addicts, by definition, would deny the need to change, requiring a dramatic response from friends and relatives who could not afford to wait for “rock bottom” to arrive (Johnson 1980). And yet, the coercive conditions under which many had been routed into treatment could be quickly set aside for a program which focused on harnessing internal control, eliciting desire, and highlighting participants’ ability to choose treatment for themselves. The common assumption about Bridges patients was that they were better suited for the kind of program in which they found themselves because they *already* possessed the capacity to self-manage.

Blake’s story, and many others appearing in my field notes and interview transcripts, reveal otherwise though. Participants in fact had to be *produced* as willing subjects, and in many cases, convinced of their own desire to achieve sobriety. The program attempted to do this by constantly constructing participants as agents in their own recovery, and by providing “toolkits” for the expansion of a selfhood which both relied on and reinforced a sense of middle-class cultural capital. The fact that Bridges men were presented with a “Patient’s Bill of Rights,” while interested Arcadia men had to scrounge for an elusive “Client Survival Guide” is a powerful illustration of the “separate governmentalities” operating across the programs I studied.^{64,65}

While the cognitive coping strategies that Chuck offered Blake-- wrist bands, push-ups, and exercises to redirect thoughts-- might have seemed like weak weapons against the power of heroin addiction, they were intended to elicit Blake as an agent in his own recovery-- someone who could control and reroute his own thought processes.

⁶³ For a recent critique of the burgeoning “intervention industry” see: Hill, John. 2015. “The Rehab Racket: The Way We Treat Addiction Is a Costly, Dangerous Mess.” *Mother Jones*.

⁶⁴ “Client Survival Guides” at Arcadia were in notorious short supply. A curious “cost cutting” measure, Arcadia required clients to share copies during orientation. I finally tracked one down six months into my research, and several pages were torn or missing.

⁶⁵ I spell out the theoretical implications of the “separate governmentalities” framework in the following two chapters.

Other classes like “The Language of Assertiveness,” were also designed to bring about this transformation. Patients were told to practice forming “‘I’ statements-- ‘I think,’ ‘I feel,’ and ‘I want.’” Reinforcing the forms of socialization that many middle-class men had likely encountered in early interactions at school and at home, and later in their adult working lives, Bridges sought to reconstruct and redevelop the self-manager within (Lareau 2003). Those patients who lacked these forms of cultural capital, like working-class Clive, found these exercises to be extremely alienating. As he explained, “What the hell? We don’t talk like this! Maybe if you got a PhD or something!”

Still other exercises required the men to conjure detailed visualizations of past temptation, mentally rehearsing the events of relapse with a different end where they would victoriously abstain from temptation. As counselor Peggy explained in a morning lecture, “If we rehearse ‘Don’t drink, don’t take drugs’ enough times, then what we’re doing is actually rehearsing our drug behaviors, and that can affect what we do in the real world.” Embraced by counselors as “willpower strengthening techniques,” these same strategies at Arcadia would have been condemned as “war stories,” triggers that could rouse the sleeping addict.

The task of the Bridges addict was not to quiet his brain into submission, but rather to recover his own “natural” capacity for logical reasoning, delayed gratification, and strength of will which was only temporarily hijacked by addiction. On the other hand, Arcadia’s mantra of “stinking thinking” portrayed the addict as cognitively impaired, scheming, and not to be trusted in recovery. This core divide reinforced essentialist conceptions of middle-class character and disparaging beliefs about poor Americans, who mostly had to be coerced into meaningful change.

Wyatt’s remark then, “So, I chose to be here,” indicates that his choice to remake himself was not the decision that prompted his *entry* into Bridges’ reform project, but rather, the *outcome* or effect of doing recovery. Just as Arcadia men had to be produced

as treatment resistant to justify their coercion into a process of habilitation, Bridges men were produced as voluntary self-managers through the process itself.⁶⁶

Ethnographic work has shown that rehab programs for poor Americans carry high stakes, as clients' progress becomes the measure which determines their eligibility for scarce resources and coveted support-- or in the case of strong-arm rehab, release from prison (Carr 2010, Gowan and Whetstone 2012, Haney 2010, Kaye 2012, McCorkel 2013, McKim 2008, McKim 2014, Paik 2006, Skoll 1992, Weinberg 2005, Whetstone and Gowan 2011). As a form of poverty management then, rehab is a particularly charged site where overt power imbalances shape the relationships between counselors and participants, and between participants themselves. Language, as E. Summerson Carr has noted in her ethnographic analysis of a Midwestern rehab, is thus inherently political in recovery. As the outward sign of an inner transformation, language becomes the metric that determines the distribution of welfare state resources. But unlike the homeless women Carr observed whose participation in treatment was connected to the receipt of valuable goods and services, the men at Bridges had substantially less to lose and few material supports to gain from going to rehab (Carr 2006, Carr 2010). With the question of immediate material survival bracketed, a different kind of project unfolded at Bridges. Here, therapeutic tools were mobilized in the service of expanding a particularly middle-class sense of self (Illouz 2008).

The Circle of Trust

The way in which Bridges' therapeutic model functioned to reinforce the program's message stood in stark contrast with Arcadia's "report group" of state-backed mutual surveillance. Bridges' therapeutic circle was influenced by the "bottom up," peer-led structure of Alcoholics Anonymous' self-help movement. While patients still had to conform to the script of addiction-as-disease, they retained a high level of ownership over their narratives, which were much more individualized, fluid, and autonomous than

⁶⁶ This is not to say that some patients didn't enter treatment highly motivated, with a strong desire to get help. In both of the sites I studied, there were men who enrolled purely on their own accord, but they tended to be the exception.

Arcadia's homogenization of clients' "lifestyle addictions." The patient-directed drug history I described at the beginning of this chapter illustrates this-- While a client at Arcadia generally took ten minutes to read his "drug bio" at the end of the program, Ken's two-hour session occurred in the first week, so that staff and peers could refer back to it, using it to guide his unique recovery plan.

Moreover, AA's "no cross talk" rule structured feedback and dialogue between patients through the filter of subjective perception, with leading statements such as, "I heard," "I feel," or "I relate to." Direct interventions in others' narratives—giving advice—was strongly discouraged, and it functioned as a check on the power of counselors and peers to dominate, homogenize, or invalidate any one patient's story. Similarly, counselors shared the philosophy that the group belonged to the patients, often warning new staff or interns to "stop talking so much" during sessions. In general, counselors provided minimal directed feedback, and patients themselves had considerable control over the group process and content—and the direction of their own narratives.

Patients' investment in group therapy was also encouraged through a considerable effort to reframe emotional vulnerability as a source of strength rather than a threat to hegemonic masculinity. Staff believed addiction had destroyed patients' ability to feel and manage their own emotions. Crying and other forms of emotional display were thus key signs that the recovered person was taking back control. The program went even further, advancing its own critique of masculinity by asking patients to undo their socialization into "a culture with no time for grieving," the title of a popular reoccurring lecture given by counselor Joy:

"How many of the guys in the room were taught as a child that it's not okay to cry or show emotion? Our culture is a 'raise yourself up by your bootstraps' kind of culture, and we learn that we are supposed to be stoic and non-emotional... This affects the boys much more than the girls... That's why we realize there is a huge conflict between what you've been told your whole life, and what we ask you to do in treatment. Every day in group, you have to check in with your feelings, and that's to get you connected with your emotions. Feeling things is a huge part of the recovery process."

The message that vulnerability required strength and courage cohered with Bridges' general process of "rebuilding" the person, powerless in addiction but not in recovery. It also led to greater levels of trust, more genuine confession, and more solidarity in the circle. The notion that the program was mostly "voluntary" only bolstered this sense of trust with the perception that most everyone was motivated by a desire to get help and to help others.

While staff worked hard to design a program that would elicit a high level of trust and participation, the effect of Bridges' distance from criminal corrections cannot be underestimated. Patients felt more comfortable speaking in a space where their fates were not so directly tied to their words, or to the evaluations of counselors and peers. As I showed in the previous chapter, Arcadia's mandate of mutual surveillance and the active code against "snitching" fostered a culture of distrust and suspicion, where positioning addicts as criminals and predators only reinforced a tough "street masculinity" that undermined deeper therapeutic exchange. Bridges' portrayal of the addict as a victim of disease, and of men showing strength through vulnerability, had a profound effect on the character and content of therapy, producing more reflective exchanges and a stronger sense of patient solidarity.

(Bio)medicalization, Big Pharma & Medicated "Self-Management"

Healing Bridges' focus on the cognitive side of cognitive-behavioral therapy can be read as a product of the defining turn toward psychology and selfhood in the modern era of power and governance (Rose 1998, Rose 2003, Rose 2006, Rose, O'Malley and Valverde 2006). Yet as Nikolas Rose has further elaborated, these forms have taken on an increasingly biochemical character in the 21st century. Now, the latest developments in neuroscience promise not just to route addiction's pathways through the brain, but also to incorporate neurochemical treatments into rehab, offering direct fixes for faulty brain chemistry.

Claims that we are now "neurochemical selves" (Netherland 2011) and "pharmaceutical people" (Martin 2006) certainly found expression at Healing Bridges, where for all the talk therapy and emotional processing, it was the widespread use of anti-

depressants, anti-psychotics, heroin replacement therapies, and other pharmaceuticals which often helped patients become the recovered self-manager. Along with regular prescriptions for mood stabilizers, Bridges also approved the use of benzodiazepines-- discredited by many addiction specialists as habit forming-- and buprenorphine (suboxone), a synthetic opioid that is still a controversial treatment for heroin dependency.

Several years before my study, a schism had formed among staff when Thomas, the program director, proposed that Bridges incorporate a buprenorphine program to accommodate the rising numbers of suburban (white) youth developing opiate addictions in the metro area. One group of staff, the AA “hardliners,” contended that these “replacement therapies” were nothing but substitute addictions, band-aid solutions which simply exchanged heroin for other drugs. But the need to address what was being seen as an emerging “epidemic” won out, and the program added the unit. By the time I arrived, it was one of Bridges’ main selling points, and most of the staff I interviewed perceived no real conflict between the ideal of abstinence and the practice of prescribing drugs to recovering addicts. The idea that addiction was a neurochemical problem, so neurochemical solutions should be considered—was now mostly unquestioned. Indeed, buprenorphine—combined with talk therapy and other services-- is now seen as a first-line treatment for heroin addiction in well-funded treatment hospitals and facilities serving middle-class opiate addicts across the nation. Thomas described this crucial shift in the field, which mirrored his own shifting opinion on the matter.

“What we’re seeing now, is that families are starting to want the addict they love to stay on suboxone. They see it like they’re taking their medicine, you know, the thing that prevents them from getting too out of control. We see cases now where people want to get off, and they get resistance from the family... The thing is, some people will need to be on this for life, and what’s wrong with that? If the alternative is that you’re a mess and hurting everyone around you... if that’s what it’s going to take for you to stay in a place where you can be functional, and you know, have a normal life, then okay. I used to be a hardline abstinence person. If we weren’t working toward abstinence, then it wasn’t really recovery. Well, my attitude has changed a lot since then, after all the years I’ve spent in this work... I think that for some people, the best they can hope for is to be stabilized on a replacement drug, and follow their medication regimen. So we work toward, ‘How can we best manage this thing?’ Of course, we encourage full abstinence for those who can do it. But in some cases, it’s just not possible, and there is no

shame in that. It's about giving a person as much of a life as they can possibly have."

And yet, even within the highly medicalized program at Healing Bridges, a truly "medical" cure for addiction was still held suspect by some, who echoed concerns that Bridges' heroin replacement program would only motivate addicts to "come here, get their dope in a regulated form, and take it easy." Chuck was perhaps the most outspoken on this point, fearing that young opiate addicts opting for suboxone were probably just "working the system," likely an inflection of his background in corrections and its attachment to the "anti-social personality" model of addiction.⁶⁷

Chuck's view was increasingly the minority one though. Competition for dollars and treatment beds, the dominance of a "whatever works" attitude among treatment staff, and the general eclecticism which had taken hold of the Minnesota Model worked together to produce a shift toward a more medical cure. Yet recent research shows that biomedical models are still highly classed and racialized programs which are not universally applied. For example, buprenorphine is much more commonly used to treat white, middle-class addicts in doctor's offices and hospital settings, while methadone clinics continue to serve mostly poor, Black and Latino addicts.⁶⁸ Some scholars have argued that the resulting divide in heroin therapies creates a "two-tiered bio-medicalization" which further stigmatizes the urban poor in the highly disciplinary setting of the methadone clinic (Bourgeois 2000, Fox 1999, Hansen and Skinner 2012). Indeed, I didn't encounter a single opiate addict at Bridges who was pursuing methadone as a treatment option, and notions of methadone as "a trap," "a nasty drug," or "the last resort" were rampant. At Arcadia House, the use of buprenorphine—or any drug-assisted

⁶⁷ Yet Chuck's decision to supply Blake with medication to make rehab more comfortable illustrates how these attitudes were in the process of shifting when I was in the field—Even Chuck, the most "hardline" of all the counselors, was starting to embrace a more medicalized view of recovery.

⁶⁸ One such study found that residential areas with the least number of Black residents and the highest income levels also had the highest rates of buprenorphine use. See: Hansen, Helena B, Carole E Siegel, Brady G Case, David N Bertollo, Danae DiRocco and Marc Galanter. 2013. "Variation in Use of Buprenorphine and Methadone Treatment by Racial, Ethnic, and Income Characteristics of Residential Social Areas in New York City." *The journal of behavioral health services & research* 40(3):367-77.

recovery for that matter—was vehemently opposed, as it was too closely related to the constellation of pleasures and dependencies that formed the reviled “lifestyle addictions.”

While medication was fully institutionalized as part of recovery at Bridges, there was a clear demarcation between illicit or non-doctor-authorized intoxication, and the professionally approved use of prescription drugs. In one morning session, Chuck reminded the group that “self-medicating” was a deviant act that would not be tolerated.

“You need to be on the right medication. It’s amazing what sobriety, treatment, and the right meds can do for you. If you listen to the doctor and follow orders, it can really benefit you. Nobody in here should be self-diagnosing. Are you wearing one of these? [Grabs his name tag with credentials] I didn’t think so! So what makes you think you know more about your condition than a professional? There is a huge problem these days with people thinking they can diagnose themselves. And shows like ‘Dr Phil’ only makes things worse. Everybody thinks they’re their own doctor. Well, you’re not. Addicts should never self-diagnose, ever. People spend years in school for this stuff, and you think you know more? I’m telling you, listen to the professionals and get your medication right.”

To address patients’ potential resistance to a “drug-free” lifestyle with the aid of drugs, counselor Jean developed a lecture that distinguished between “mood-altering chemicals”—that is, alcohol, illegal drugs, and abused prescription drugs-- and “therapeutic medications”—that is, drugs used in accordance with a prescription from a medical professional. In a peculiar kind of logic, a drug could not be considered “mood-altering,” if it was prescribed by a doctor.

“So you might be thinking right now, ‘If I’m taking Zoloft or Paxil or Prozac, aren’t I still on a drug? Wow, I came here to get off drugs, and now you’re giving me all these pills. Isn’t that defeating the purpose?’ Well, not all drugs are the same. There is a big difference between what we call mood-altering chemicals and therapeutic medicine. Mood altering chemicals will cause your brain to become unbalanced—they will agitate symptoms of depression by causing too much or too little serotonin or dopamine. Therapeutic medication, on the other hand, keeps these chemicals in balance to one another, how they’re supposed to look in the brain. So that we don’t experience depression or excessive sadness or the highs and lows of mood disorders.”

Jean’s lecture was a stunning example of the kind of “pseudoscience” that has currently come under attack as addiction research experiences its latest “crisis of legitimacy.” It was also a reminder of the always-present role of medical authority in the

project of self-reinvention at Bridges. Recovery was a process of eliciting the self-manager who could strike just the right balance of talking, feeling, and medicating—under the watchful gaze of the medical establishment. Yet these disciplinary models were quite different from Arcadia’s brand of social control in that they were much more decentralized and diffuse—and the possibility of patient resistance was real. Several patients who were doctors themselves, for example, actively contested their diagnoses and oversaw changes to their individual treatment plans.

Perhaps unsurprisingly though, the ability of a patient to question the dominant recovery logic seemed to be most related to his social location. While doctors and lawyers used their status to do so quite successfully, others were in danger of being labeled non-compliant for refusing medication or resisting professional advice. Will, a working-class participant, attempted unsuccessfully to reject a nurse’s insistence that he begin taking trazodone, an anti-depressant with hypnotic properties, before bed every night. “She told Chuck I wasn’t that serious about getting healthy again,” Will said. “So I just figured it would be easier to take the pills... even though I don’t think I need them and I think giving a bunch of drug addicts more medication is stupid.” Others simply believed it was their role as the patient to defer to medical authority and rarely voiced any objection at all to the logic of recovery experts.

Part III: “Addiction Doesn’t Discriminate”

Introducing Clive

While other patients dressed in sweatpants, jeans, or the occasional button-down, Clive, a 58-year-old Black male, preferred to distinguish himself. He often arrived to group in sharp blazers and ties, pinstripe pants, or expensive leather boots. When I joined him outside for a cigarette one windy March afternoon, he was wearing a grey newsboy hat and square, black-rimmed glasses framed his friendly face. Clive was an instantly likeable man with a kind demeanor and a deep, hearty laugh. He knew almost every patient on a personal level—their names, their stories, and their plans for getting out. Today, I was interested in his. He shared with me that this was his eighth round of

treatment, but his first time at Healing Bridges. He had been to Arcadia House, “one of the hardcore ones,” twice before.

“I was there when they used to make grown men wear diapers,” he said. “They’d be doing all kinds of demeaning shit there. It was crazy. And they had that bench where if you did something wrong, you had to sit there... They still got that?” I said yes, and we both laughed uncomfortably.

Everyone believed Clive was sincere about kicking his addiction. He was glued to a worn copy of an AA meditations booklet, and he often strolled the halls with it, reciting passages out loud. A crack user for nearly two decades, he had recently relapsed after one of his longer periods of sobriety. But he generally had an upbeat attitude, presenting a positive outlook on his prospects to staff and other patients. Today though, he expressed doubt as to whether Healing Bridges could really help him, or if he was just “sick and tired of being sick and tired.”

“I just can’t keep doing this to my body,” Clive said. “I’ll be up all night smokin’, then I’ll be out sleeping for three, four days just to recover from it. I’m gettin’ too old for this shit, and I can’t handle it no more.” Clive’s “pride and joy” were his six daughters, two of whom had just graduated from college.

“One of them is about your age,” he told me. “I think about my girls all the time. I make sure they know I care. That’s why I gotta get it together on this one.”

Clive was a magnetic individual, and the more I got to know him, the more I was rooting for him along with the entire Bridges counseling team and most of the patients, hoping he could kick crack addiction for good this time. But the more I learned about the challenges of his life outside Bridges, and his violent and abusive past, the more I felt the sad, sinking reality that long-term sobriety was unlikely for Clive. His promising career in nursing had been cut short years before when he committed check fraud to fund his growing cocaine habit. After acquiring a criminal record, he was banned from working with “vulnerable adults,” and hasn’t been able to get a job in nursing or any related field since.

“I just can’t believe they do that to people... I mean, it’s been years and I been out of work, but I ain’t had no other charge at all. My record is clean now, and I still can’t get any work... They be tryin’ to really trip people up with all sorts of obstacles... I went back to the state and tried to get it expunged, this is almost ten years later, and they refused to do it.”

As I listened supportively to Clive’s dilemmas, the five-minute bell rang outside, alerting us it was time to head in for group. We rushed to put out our cigarettes and joined the line of men trudging inside for their afternoon sessions.

“I’m ready for this new guy, Brad. I need a break from gettin’ told by Chuck. Already had my daily dose of Chuck,” Clive joked.

“Growing Up Too Fast”

First on the agenda in Brad’s group that day was to hear more from Demario about his early life. Demario is a 23-year-old Latino man whose quick sense of humor made him popular with the other patients. Raised by his single mother in “a rough neighborhood,” he shared with the group that by age fourteen, he was moving in and out of juvenile detention centers and “boy’s homes.” His family struggled to make rent and couldn’t afford the shoes, jackets or movie tickets that other neighborhood kids had. About twice a year, his father would visit, armed with the best new sneakers, and he soon learned that he could get these things for himself if he hustled. Through some school connections, he discovered a lucrative street market for prescription painkillers, and turned to hustling full time.

“I did it because I was good at it, and there was money to be made,” Demario said. “As a kid, I had to step up and support myself because nobody else would. I wanted to have things too, and my mom couldn’t do that... I thought I was becoming a man, following in my pop’s footsteps. You know, I thought he’d be proud, for real.”

Brad, a white counselor in his mid-30s, was co-leading the afternoon group with Chuck that day. His style was markedly different, typifying the softer, more nurturing tone of most Bridges staff.

“So what I’m hearing you say, Demario, is that you were missing guidance. You were filling the void of not having a positive role model, your dad wasn’t around to guide you down the right path. And sounds like your mom was too busy working to put food on the table to really keep track of you. You were probably left alone a lot... Drugs fill the void caused by what we’re not getting from people, what we’re not getting from our relationships.”

Demario nodded enthusiastically, supporting Brad’s assessment. An extended discussion ensued about the role that “absent fathers” and “broken families” played in the progression of addiction. Brad posed a question to the group: “Does anyone else in this room feel they have a parent who wasn’t there, or maybe the connection wasn’t what you wanted or needed it to be?” Hands shot up into the air.

Chuck took a turn with Demario next, saying, “Everything you do, you do it so well. And you’ve got a great heart. You’re a great person. I’ve seen a lot of that street slime... And you’re not that. You could get to that place, but you’re not there yet. You still have a chance to make it here.” Demario shrugged, looking uninspired by Chuck’s encouragement.

Clive spoke next, sharing that his upbringing had been very similar to Demario’s. In his father’s absence, he relied on older siblings to get what he needed before taking an under-the-table cash job at a gas station at age fourteen. His mother was clinically depressed, struggling to raise six children on a meager welfare check. Clive told the group how his father periodically returned to inflict violent abuse on the family.

“I thought dads were just there to beat you. ‘Cuz that’s all mine ever did. He never took us fishing, never taught us sports, none of that stuff dads are supposed to be around for. He’d show up drunk, beat us, then leave. So my dad was nothing to me... I do remember one time when he took us to the circus. But that’s really the only memory I have of my father doing anything for me... My older sister became like a mother to us. She had this boyfriend, and he kind of became the father figure. He took me in, made sure I had clothes for school and stuff like that.”

Clive saved up enough money working at the gas station to buy a used car by the time he was sixteen.

“Everyone in the neighborhood-- we grew up in a real poor area, and everyone wanted to ride in my ride. I was real cool there for a minute... I just had to grow up real quick. I had to step up and get things done because nobody else would.”

Demario nodded emphatically, relating how he was jumped by a neighborhood gang, which forced him to develop a tough exterior for self-protection, the skills to be self-sufficient, and a vigilant distrust of others at a young age.

Roscoe, a 20-year-old Latino male, shared a similar story, telling us about when he was attacked by a group of kids after school one day, an event that had convinced him joining a gang was necessary for protection.

“I basically just learned... you have to be tough. There’s no other alternative. You have to be ready to fight. You gotta have that attitude, or... you won’t survive. So especially, with the emotions, man. You could never let nobody see you cry, because then you really had something coming. I was alone, and if I didn’t protect myself, nobody would.”

Clive turned to Roscoe: “It’s the stuff I didn’t want to talk about that ended up being the stuff I really needed to talk about in here.” Others nodded in agreement. “That’s the poison. So if there is something you need to say, and you find it hard to say it, it probably needs to be said. When you’re using, you’re just stuffing all your emotions down.”

Others said they believed Roscoe needed to seek out new, positive roles models. Brad agreed.

“So, your dad was never there for you. And you sought out connections with this gang, because really, you just wanted to be loved. Deep down, you just wanted to be cared about... It sounds like you never really had a chance. You never got the ‘normal life.’”

The conversation turned back to drug dealing, and Alan, a middle-aged white patient and former surgeon, responded to a much younger Elliot's story from the previous day about how he began a career in drug sales.

"Wow, I just kept thinking after I heard your story about how you were basically running a small company at the age of fifteen... with the drug sales, I mean, you're like a Republican's dream. You've got those entrepreneurial skills that we all look for!" he exclaimed. "And I just wonder what it would be like if you applied those to a sober life. You could really make something of yourself."

Chuck agreed with Alan's point. "I'm always trying to get guys to see that a lot of who they were when they were addicted, they can move those skills into their recovery. It's called 'transferable skills.' Think about how much energy we put into getting our drugs, devising ways to stay high. If we applied those smarts and that kind of energy into good, positive pursuits, nothing could stop us then."

Alan continued his feedback to Elliot. "Your family history is like a blessing and a curse. On one hand, you can't deny that it shaped you. Anybody who comes from the background you came from, I'd be surprised if they didn't end up getting into drugs. You've been through so much and had a lot of pain at a young age. On the other side, your family is a great club to join because so many of them have lots of time in recovery. So that's something to learn from."

Brad offered some closing reflections on vulnerability. "Recovery requires vulnerability, and it requires that we share with each other, and let people in. That's how we get the help we need... It is actually a sign of strength to show emotion, not a sign of weakness."

"Healing Bridges Isn't for Everyone": Constructing Rehab's Racial Other

The group exchange above illustrates how the "the hustler" was problematized quite differently within Healing Bridges' medical model. Instead of criminalizing poverty or class-lived-through-race, Bridges medicalized it by focusing less on the dysfunctional cultures of "broken families" and more on the individual psychological and

emotional effects of early abuse or neglect. While they were in the minority of the facility's clientele, hustlers who found themselves at Bridges were able to claim identities as victims of childhood trauma, or agentic survivors of hardship. Their problem was not perpetual adolescence, but rather that they had missed adolescence altogether. According to staff, "growing up too fast" without proper guidance had hardened them and fueled their turn to drugs in a quest for love and acceptance.

While the notion of drugs-as-economic survival constantly surfaced, the absence of any real structural critique of economic inequality was illustrated by Alan's suggestion to Elliot that he "transfer his skills" into the licit economy. While Arcadia pushed men to give up dealing and submit to low-wage labor, Bridges encouraged and "empowered" them to reimagine themselves as managers, innovators, or entrepreneurs. For the marginalized dealer, both strategies were symbolically violent. While Arcadia denigrated the hustler identity, stripping it of any dignity, autonomy, or respect, their focus on low-wage labor was in many ways a more practical—even if sometimes overly optimistic—approach for men who lacked stable work history, education, and social capital. While Bridges allowed the hustlers to retain some dignity and self-respect, especially as providers, it came with the glaring inability to acknowledge economic and educational limitations, active job market discrimination, and deficits in cultural capital. Not to mention the system of hyper-criminalization and mass incarceration that was responsible for many of the "absentee fathers" in the men's stories. Like Alan, Bridges staff often seemed even *more* oblivious to structural inequality than Arcadia counselors, implying that the transition from street corner to Wall Street would take little more than "re-imagining" oneself.

As I explore further in concluding sections, Bridges' own "positivity addiction" blinded them to the very real challenges some of the patients would face after treatment (Ehrenreich 2009). Their tendency to see the positive in all things also extended to patients' generational histories of abuse, neglect, and addiction. Staff and other patients

went so far as to suggest that addicted family members could be re-envisioned as “built-in recovery clubs” or “reminders” of sobriety’s necessity.⁶⁹

The handful of poor patients, people of color, and marginalized dealers in the program often desperately wanted, and benefitted from, Bridges’ mission to destigmatize, build self-esteem, and encourage the expression of vulnerability in safe spaces. Clive’s own transformation over the course of the program was evidence that the reprieve of the disease model could harness real healing power. His graduation, one of the most heartfelt I witnessed, showed how strong emotional bonds could form between patients from vastly different social and cultural locations. Moving testimonies honored Clive as “wise, compassionate, and courageous.” Patients embraced, tears were shed, and Clive referred to the experience as “life changing.”

But for all the very real catharsis that seemed to be taking place, Clive’s status as outsider and racial Other was never fully erased. Consider a very troubling exchange that happened between Blake, Clive, and Chuck one afternoon in group, when Blake delivered a racist performance of what he believed to be Clive’s hidden “street” persona.

“Yeah, when you were reading your drug history yesterday, I thought you were so funny, the way you were talking. You’d be talking normal, and then all of a sudden, your hands would be goin’ and your voice would change to, like, a street voice, and you’d be like, [imitating Black slang] ‘And then I’s standin’ on that corner, stressin’ on some crack!’”

Other group members laughed, and Chuck added:

“Alright, alright. So we all know sometimes Clive’s ‘street’ comes out a little bit, right?” He waved his hands in the air, as if imitating Clive’s mannerisms. “And sometimes it’s seriously like an SNL character the way you do it, I don’t even know, it’s hilarious.”

Clive’s Blackness conferred a “street” identity. His years as a homeless addict were far behind him, and he now lived in a lower-middle class, suburban home with his

⁶⁹ In part, this was out of necessity. Most of younger patients would be returning home to live with their families, and most insurance plans wouldn’t cover the cost of transitional housing, meaning that only those wealthier patients who could afford to self-pay were able to go straight into sober housing after Bridges.

wife and two of his daughters. Scant labor market options meant that he worked odd jobs when he could, but was mostly a devoted stay-at-home dad. Occasionally, he still went on a crack binge at a friend's house. The last one had ended with a trip to Bridges, where regardless of his storyline, he would remain the token street addict, bringing to the fore racially charged images of "urban" and "crack." Here, we see a crucial caveat to the disease-as-reprieve model that arises when patients of color are the recipients of treatment. When Chuck says that Clive's "street still comes out," he implies that the racialized "street" within can never fully be erased. According to the "dual selves" model of disease though, when treatment "works," the "other inside" is successfully suppressed—but Clive's "other inside" was the street which always stubbornly lingered.

Interestingly, Chuck's comments came on the heels of Demario's early departure from the program. In the scene above, Chuck told Demario, "I've seen some street slime, and you're not it." The day after that, Demario revealed in group that he had checked himself into treatment as a last ditch attempt to swing a case in his favor and avoid jail time. When Chuck asked him if he had a warrant out for his arrest, or if the county knew he was in treatment, Demario evaded the questions at first. After more prodding from Chuck, as it became clear that he already knew the answers to his own questions, Demario revealed he had an active warrant out.

"We'll have to get this taken care of," Chuck had said. "After group, we have to call them and let them know you're getting yourself some help. And then it's in their hands." With Chuck basically threatening to turn Demario in, it wasn't surprising when he left the program unannounced shortly after. The incident was quite contrary to counselors' usual roles siding with patients against the criminal justice system and advocating for treatment instead of incarceration. Drawing up parallel images of Arcadia's "report group," it was the only occasion I witnessed at Bridges where a staff member seemed to be working directly with corrections. It was far more common for staff's testimony to keep patients out of the prison system, or at least in good graces with the courts for the duration of their treatment. But Chuck had made a public spectacle out of delivering Demario into the hands of law enforcement, sending a clear message to the

other patients that “Bridges wasn’t for everyone.” Perhaps he had decided that Demario was, after all, “street slime.”

While patient walk-outs are relatively common in any rehab, Demario’s sudden departure shook everyone up, creating anxiety around the power of “the street” that might still be lurking inside of some patients.⁷⁰ It even prompted counselor Luke to deliver a dramatic speech during a mandatory lecture, where he defined the Healing Bridges patient in opposition to the “street.”

“Bridges isn’t for everyone. We assume that when you come here, you have a higher degree of self-motivation to get things done, that you have a certain level of self-respect. This isn’t a locked facility. We aren’t breathing down your neck to come to group. Everyone knows when you come here, you have quite a bit of freedom to walk the grounds, to leave for appointments. And it’s your choice if you want to do the work... There is the expectation that you are going to rise to the occasion, you are going to control yourself and contribute. Whoever you were on the street, all that has to be left behind. Your street personality is not going to work here... I would urge you all to consider hanging out with new people while you’re here. That’s what treatment is, an opportunity to redefine who you are, to not be defined by your past but by what you’re doing now, and in the future. This is all about making a new identity.”

Bridges sought to maintain material and discursive separation from “the street,” and while they mostly succeeded, they couldn’t always keep “the street” from coming in. About half of Bridges’ clientele were white, working and middle-class alcoholics with stable jobs, and another quarter was comprised of white, suburban, typically younger, opiate addicts. The final quarter were mostly middle and working-class poly-drug users. Bridges only accepted a handful of poor, publicly-funded patients, most of whom were men of color and court-mandated. Because “poor,” “Black,” and “criminal” were thought to signify “addicts who need more structure,” patients identified as such were almost always sent to Chuck’s group, where his background in corrections could impart a “tougher love.”

⁷⁰ While Bridges’ walkout rate was comparable to other rehabs in the city, their discharge (kickout) rate was relatively lower, likely because they had few rules and restrictions, and strived to make rehab a generally comfortable experience.

But Chuck took on a new frontier of “the street,” when during my research, Bridges responded to the emergence of a “heroin epidemic” hitting the area’s white, suburban population. Drug-related emergency room visits and overdoses skyrocketed after the simultaneous closing of the city’s only harm reduction needle exchange program and the opening of a new drug market which offered extremely potent, affordable, and accessible heroin. Images of white, middle-class youth shooting up flooded local news media, provoking hysteria over addiction’s new grip on suburbia. In middle-class communities, anxiety that heroin was claiming “some of their own” took hold, and admissions for opiate addiction at Bridges quadrupled.⁷¹

The much less stigmatized alcoholics who made up the institution’s core demographic base when it opened as a research hospital in the 1950s were now joined by a new generation of suburban youth whose drug of choice was heroin. The alcoholics, marijuana smokers, cocaine users, and pill poppers distinguished themselves from the more “hardcore” crack, heroin and meth users, producing a heightened awareness of the subcultural divisions around drug of choice that in some ways transgressed the boundaries of race and class.

Like the urban hustlers and “hardcore” crack users, white suburban heroin addicts were becoming additional targets upon which middle-class fears and anxieties could be projected. Frequently, young opiate addicts were sent to Chuck’s group, where he would sometimes draw attention to their failure to attain the lifestyle markers of middle-class normality. Pete, a white, 28-year-old heroin addict with shaggy blonde hair and a penchant for colorful “jam band” attire, was one of those singled out as an “end of the line” patient. Supported by his family for most of his life, he had recently been cut off and forced to live in a friend’s car, where he began selling stolen prescription drugs to support his habit. Instructing him to “man up,” Chuck told Pete, “I can’t believe you’re twenty-eight years old, you’re a grown ass man, and you’ve never made a reservation at a

⁷¹ Official program statistics. The program responded by adding special “opiate groups” and expanding the suboxone tapering program which had been added several years before, one of only a handful of “Minnesota Model” programs to do so.

restaurant. That's what junk will do to you. You know, most guys your age are already married and have kids, a nice house and a career. Here you are, stealing ramen for a living."

Importantly, Chuck identified Pete's *addiction* as the culprit, the scapegoat for his failure to achieve the traditional markers of American adulthood. Although Pete was derided for "stealing ramen," the focus was mostly on his heroin dependency, and he retained a victim status. It was the predatory (Black) dealer, the specter of the criminal-addict, who was particularly charged with fear at Bridges. Discussing recent changes in the heroin scene, patients spoke of "genius, manipulative drug dealers" scrambling to fill the void left by addicts who could no longer access prescription pain medicine, wreaking havoc on "vulnerable communities." The story that emerged was one in which white, suburban youth had been led to heroin after experimenting with prescription opiates in "mom's medicine cabinet." And they were now being preyed upon and victimized by ruthless, urban (read: Latino and Black) drug dealers, desperate to get a piece of the market by enslaving a whole generation of "innocent" youth.

The cathartic narratives of "growing up too fast" that were so common in Brad's group could be quickly exchanged for condemnations of "street slime" in Chuck's group - revealing how easily medicalized discourses could "flip" back into moralistic ones, especially for Black and Latino patients who had worked in the drug trade.⁷² The local context of an emerging heroin epidemic in a city with extreme levels of economic and racial segregation brought to the fore the limits of medicalization's promise to destigmatize, and the heavily racialized conversion of badness into sickness. In an extremely medicalized setting, moralistic models were still "stuck" to people of color and the poor. Even *within* Healing Bridges then, a space had been carved out for the ones

⁷² My point here is that discursive "flips" were attached not to individual counselors' personalities, but rather, to the treatment models each counselor had been exposed to and used to guide therapeutic practice. As I previously mentioned, Chuck's background in corrections and his more strong-arm orientation made him an outlier at Bridges, and created tension with the Minnesota Model. But it also marked him as someone who could deal with those cases which did not seem to "fit" the program's target demographic.

who didn't really "belong" there, the ones who were considered dangerously close to "the street."

It became clear in my discussions with Bridges' white clientele that "dealer" referred to urban, poor and Black. "Hustling" was fantastically classed and raced, and white patients who had spent years selling drugs often refused to define themselves as "dealers." Like the privileged "dorm room dealers" Mohamed and Fritsvold studied, whose "racial, ethnic, and socioeconomic backgrounds allowed them and their clients to exist freely as anti-targets in the US drug war," some of my Bridges informants had sold large quantities of drugs without consequence and without taking on the dealer identity (Mohamed and Fritsvold 2010). Blake was the only one who had actually served some time for distribution. But when I interviewed him, he took pains to distinguish himself from a "real dealer," insisting that he only sold to "a few friends" or to "keep his own habit going." In treatment, these addicts' hustling activities remained invisible, never becoming an object of reform thought to be packaged with other addictions or illnesses.

While coded appeals to race, covert racism, and racial micro-aggressions were far more common at Bridges, instances of overt racism did surface. One example was Joe's reaction to finding out his roommate assignment would be Abel, an Eritrean immigrant in his early 40s and first-timer in treatment. Abel was a routine victim of mistaken identity, despite his many attempts to educate staff and other patients about his heritage. In one group dedicated to exploring Joe's "anger problem," Joe explained what had "set him off" about Abel.

"Yeah, I was going to be so angry if he didn't speak English! When I first found out he was my roommate, I was so angry. I mean, I was fucking livid. I saw him, and I was like, 'Oh no. Not gonna work.' I felt like punching a hole in the wall. But then I found out he spoke English good enough, and he's from Eritrea, which I found out is in the Northern part of Africa. Not Afghanistan, so he's one of the... well, he's okay. He's alright. So then I said, 'Hey, it's not so bad.' And what do you know, he turned out to be better than my last roommate, that filthy bastard. That guy was a mess. So... [turns toward Abel] I just want you to know that we're cool. It's all good now."

To make matters worse, Chuck contributed a horribly racist "joke," saying to Abel, "So you must be a good person then, because if you're from where our maid is from, I know you're a good one." Needless to say, Abel left the program before I had a

chance to interview him. The medicalization of racism draws on psychological and medical discourses to frame racism as “analogous to addiction as a disease,” rather than a structural issue rooted in histories of oppression (Dobbins and Skillings 2000, Thomas and Brunnsma 2014, Thomas 2014, Wellman 2000). Even more disturbing than Joe’s racism was the fact that it was never named as such. Instead, a racist incident was neutralized and medicalized as an “anger disorder” for which Joe should seek anger management therapy.

In drawing a line between Bridges and “the street,” the program simultaneously constructed the racial Other of rehab. Staff and patients “empowered” themselves through frequent comparisons to more “hardcore” and “out of control” clients, like those at Arcadia House. The assumption, following professional concepts like diagnostic criteria, “levels of need,” and the “continuum of care,” was that some addicts had just fallen further, and therefore required a more “intensive” treatment experience. The presence of a handful of “token” people of color in Bridges at any given time reinforced the notion that “addiction doesn’t discriminate”—that anyone could be an addict, and that some people, for some reason, just had the disease worse than others. Indeed, Healing Bridges was “not for everyone.” If you were one of the few court-mandated, non-white, or poor people to get in, the medical model’s promise of de-stigmatization came with the cost of deep misrecognition—and other understandings of your “disease” just might follow you through the door.

Race, Class, and “Rock Bottom”

“Isn’t it crazy that none of us have been to prison? I can’t believe that... I guess we’re lucky.” -- Kevin

As the men at Healing Bridges reflected on their pasts, they were encouraged to name the consequences of their addictions and define their “rock bottom”—the lowest depth to which the disease of addiction had taken them. Hitting rock bottom was turning points or “moment of clarity” often cited as the catalyst which prompted an addict to seek

out treatment. Long lists of physical and emotional tolls appeared-- trips to emergency rooms and detox facilities; hospitalizations for cirrhosis, kidney damage, ulcers, brain damage, and overdose; long-term mental health issues that were either caused or exacerbated by chronic drug use; shame, loss of self-respect, and strained relationships; hurting loved ones, becoming violent, damaging property, and causing car accidents; getting fired from work, losing out on promotions, squandering money, or simply “wasting potential.” There are many possible rock bottoms, but for the more advantaged addicts I studied, by far the most common was often the failure of the physical body and the resulting fear of proximity to death.

Because closeness to death was not immanent in the everyday realities of the white, middle-class, it provoked enough discomfort to see addiction as a problem that required professional intervention. Eventually, even this fear became normalized among the worst-case alcoholics at Bridges, whose hospitalizations had become routine, their rock bottoms extending ever deeper. What struck me most about these lists was that “legal troubles” almost never made the cut—not arrests, not convictions, and especially not jail or prison time. Significant or enduring economic strain was also rarely mentioned. Conflict at work was common, and to be sure, most had risked financial security financing their drug habits. Yet very few of these addicts had experienced desperate poverty, extended joblessness, or chronic homelessness.

My observations at Healing Bridges support the growing recognition that consequences for drug use are not evenly distributed across the population—that not all addictions are “created equal,” and that the relative depths of “rock bottom” are shaped by social location. The economic and social advantage of the typical Bridges patient was a powerful buffer against the hardships that frequently accompany the addictions of more marginalized Americans—extended unemployment, homelessness, violence and victimization in the drug trade, prostitution, and frequent incarceration. Of the 70 men I observed or interviewed at Healing Bridges, just eight reported that they had served any prison time in their lives. Five of them were men of color, four of whom had been court-

ordered to attend the program. I encountered only three white men who had ever served time in state or federal prison.⁷³

Gavin, a white male in his early thirties with tattooed sleeves and a “punk” aesthetic, was one of them. He had stumbled onto the meth scene in Colorado as a young truck driver, after a troubled childhood in the foster care system. He was at Healing Bridges on his probation from a previous case, awaiting sentencing for robbing a Burger King and writing a series of fraudulent checks in a desperate attempt to pay off a debt to a local dealer. Despite the serious charges he faced, he told the group one day that he was confident the system would work in his favor.

“Pretty low chance I’ll have to serve any time on these cases. I think they see that I’m serious about change. I mean, I’m in treatment right now, so they know I’m making an effort to get better. I really don’t think I’ll have to go to prison this time ‘round. Probably some fines, that’s all.”

Walter, a sixty-four-year-old lawyer in Gavin’s primary group, offered his expert services to help him “sort things out.”⁷⁴

Gavin’s confidence was not unfounded. In the many group sessions I attended, I heard no shortage of incredible tales of how addicts had dodged the criminal justice system. Their lack of involvement in the legal system was even more astonishing given that illegal, dangerous, or violent behavior was commonplace. While a few patients reported multiple arrests, most had managed to avoid incarceration. Take Ray’s story. After assaulting a flight attendant during an intoxicated rage (a federal offence), Ray walked away with a fine and some community service. He also demonstrated his incredible ability to make legal magic happen when he “called some friends at the county” to get his own psychiatric commitment lifted.

⁷³ I am confident that these numbers reflect overall patient demographic trends, as the facility estimates I obtained show (presented in Chapter 2). If anything, I was *overexposed* to patients who had legal troubles, as I spent a significant amount of time in Chuck’s group, and he worked with the most court-mandated clients and those with significant histories in the criminal justice system.

⁷⁴ Walter was Bridges’ infamous “rehab lawyer.” After drinking himself to an early retirement, he kept active by working on cases for patients in his recovery unit. Although most patients didn’t require his services, he had managed to accumulate a decent caseload over the course of his nine inpatient stays.

The Bridges' counselors were very aware of their patients' ability to avoid legal consequences, and some were even deeply frustrated by it. Yet instead of seeing it as a product of broader racial disparities in the war on drugs, they argued that a lack of external sanctions posed obstacles for some patients who simply "required more structure" in recovery. Thomas, the men's program director, explained it this way.

"There are times we wish people would have been locked up instead of sitting on their butts in here. Maybe that's what they need, and maybe they deserve it. Some of these people, that's the problem, is that they haven't had consequences, and maybe they need to be locked up. That might actually help."

While staff might have harbored "get tough" opinions about some of their own clients, they publicly advocated for the expansion of medical rather than criminal solutions for addiction. They sometimes worked actively with judges, court professionals, probation officers, and the police to keep their patients out of the system by emphasizing their treatment need and reporting their clinical progress. Such was the case for Wyatt, who managed to get a case dropped after Chuck "vouched" for his treatment progress in court. Wyatt, the white, upper middle-class son of a banker and a nutritionist, was infamous at Bridges for his tales of destructive "opiate blackouts." He told the group about one of the "worst," in which he wrecked his car after driving it into a highway median. Afterwards, he simply walked away from the scene, and was never questioned about the incident. He demonstrated how inconsequential this was for him when he nearly forgot to tell the group about it as he presented his list of "consequences"-- a very short one to begin with.

Wyatt's experience further revealed how access to resource-rich social networks made it possible for some addicts to avoid any serious risk of incarceration while sustaining expensive drug habits.

"I was in high school choir, and I was using almost every day. I would go in the back at choir practice and look through everyone's bags and take out their money and iPods and anything of value I could sell. That's how I got the heroin. I just stole from the people around me. Family and friends, people at school... I went to a rich school, so these kids always had something I could take. I'm not proud of it, but that's what I thought I had to do to get the drugs."

Stealing from his wealthy social networks enabled Wyatt to buy heroin for several years before exhausting financial resources or resorting to riskier crimes. High stakes and violent crimes tend to be the desperate crimes of addicts who lack other options for support. Few of the Arcadia men, for example, could depend on a friend's stuffed wallet or iPod for getting high.

Perhaps most instructive of all was Logan's story. Logan was a white, 22-year-old male from a suburban Minnesotan town whose drug experimentation had led to his failing out of school, dropping out of sports, and associating with a high school peer group made up mostly of other drug users.

"I thought I was too cool for the sports teams, even though that used to be a big part of my life. So I stopped hanging out with them, and then I started stealing from my parents and friends to buy cocaine. I was probably going through at least three, four hundred dollars of drugs every day by the time I was fifteen."

Things finally caught up with Logan when his parents had him arrested for stealing a laptop and selling it for drugs. After a few days stay in a juvenile detention center, he was transferred to an intensive inpatient rehab, where he stuck it out for one week, before leaving to embark on a four year period of daily heroin use. Logan marveled in group how, despite all the crimes he had committed, he had always been "lucky with the law."

"I don't know how, but somehow, I always get off the hook. With all the times I've had drugs on me, I've never been arrested or had any offenses. It's amazing... I remember this one time I was driving in North Minneapolis, and I had all these dirty rigs on me, and the cops saw it all and they just let me go! I don't know why, maybe it was because my license said I lived in North at the time because I was stayin' up that way. And here I was, this white kid driving around North with a bunch of needles in my car. And maybe the cops just thought since I had an address there that I wasn't over there to buy drugs. But they let me go, and if they had searched me, it would have been really, really bad."

In one particularly difficult group session to sit through, I listened as seven out of the eight men present recounted horrifying stories of near escapes from intoxicated driving. Again, one of Logan's stories was illustrative.

“I went Wisconsin to chill with my girl, and I had to be at class the next morning, and it was like a six hour drive. I got up really early, and I must have been tired from all the partying the night before, because I fell asleep going eighty on the freeway. Woke up right as I was about to go in the ditch, and grabbed the wheel and swerved the car back and hit this huge sign, which caused me to spin out across traffic. My window was open, thank god, because if it hadn't been, my head would have gone through the window. I wouldn't be here. So that was scary.”

Ronald, a white patient in his fifties, was on his ninth attempt at rehab. He told the group about his public intoxication, property destruction, and violent behavior in a poor, crime-ridden North Minneapolis neighborhood where open air drug markets are heavily targeted by law enforcement.

“You know, I'm lucky nothing bad happened, and that I'm still alive. It is *North Minneapolis*, after all... The police are always good to me. Always look out for me, never gave me no trouble. Minneapolis cops are good, they're alright with me.”

These stories represent only a few of the accounts I collected of whites engaging in drug-related crime with near total impunity. White criminality remained invisible, and white addicts were shielded from the stigma of criminality. Over the course of my research, I was repeatedly struck by the stark and undeniable contrast between white, suburban youth consuming and selling cocaine, meth, and heroin with little to no consequence—and the mass criminalization and incarceration of urban Black youth. A common refrain among Arcadia clients, “I was just standing on the corner when they busted me”-- made clear the hyper-criminalization of poor people of color, while whites' racial and economic privilege was always working to label them as non-criminal, diverting them away from the system.

These disparities were all the more incredible when one considers how the relative “threat” to society posed by the affluent white men in my study at times seemed

so much greater. The number of car and boating accidents that had been caused by men at Bridges, for example, was a distinctly classed phenomenon—most of the working-class and poor men in recovery at Arcadia didn't own vehicles and lacked reliable transportation. Similarly, because Bridges' middle-class addicts were more likely to have careers which afforded them considerable control over others' lives, their relapses arguably had more far-reaching effects. The recovering doctors, lawyers, machine operators, teachers, financial advisers, social workers, truck drivers, dentists, and soccer coaches had done things, while addicted, which carried tragic human costs.

Since the crack wars of the 1980s, the “threat” of drugs in the public imagination has looked like a young, Black, male on an urban street corner (Keire 1998, Reinerman and Levine 1997). Perhaps more recently, it has looked like a poor, white meth addict in a rural trailer park (Linnemann and Wall 2013, Reding 2010). While critical accounts of drug war policing and the racial dimensions of the war on drugs have focused overwhelmingly on how and why people of color have become targets, this study provides one window into the seldom explored flipside—the invisibility of white deviance. Addiction and criminality have become inextricably linked, but only for those marginalized addicts who have become targets of the criminal justice system, while socially privileged addicts sustained their habits committing “invisible” crimes—or engaging in criminal behavior that is never labeled as such. Like a contemporary version of the classic sociological lesson “The Saints and the Roughnecks,” my research points to the processes by which deviant behavior is labeled, and the ways in which race and class shape that process (Chambliss 1973). To the extent that the criminalization of poverty and race defines only some drug use as deviant, it both promotes distinct understandings of “the addict” *and* routes people into different models of treatment where those understandings are reinforced and reproduced.

Medicalization & the Erasure of Social Difference

“I think we all have the same opportunities, and we all have the same advantages. I don’t think any one culture has a leg up on another. It’s even playing grounds. I don’t know the dope or the drinking to be racist or sexist. I just don’t.” - Nick

Many times during the course of my study, but especially at Healing Bridges, I heard people claim, “Addiction doesn’t discriminate.” The erasure of any difference among addicts was a key part of the treatment process. To staff, the assertion that one’s addiction was unique or “special” was evidence of an inflated ego that could cause patients to believe the program had nothing to offer them. To encourage the process of “opening up” and receiving feedback from others, counselors insisted patients find common ground with one another through sharing about their lives and realizing they’re really “all the same.” I witnessed many examples of how these evocations of unity worked in a therapeutic sense to foster community and bonds between men in recovery.

The trope of “addiction doesn’t discriminate” was also used to bust the cultural myth that alcohol and prescription drugs weren’t as dangerous as the more “hardcore” illicit drugs. Those “functional alcoholics” who might not have seen their drinking as problematic were instructed to “see the commonalities” between their own predilections and heroin or crack cocaine—which carried stereotypical associations with poverty, street criminals, and racial marginality. The idea that “anyone can get addicted” and to any type of drug, was a premise that emerged, in part, to combat the notion that addiction was only a problem in economically and racially marginalized communities. The concept was integral in the birth of the AA movement, which sought to destigmatize addiction by decoupling it from urban vice, shame, and moralism. In the process, the drug problems endemic to suburbia began to be exposed-- affluent, white Americans were not immune to getting “out of control.” At Bridges, this “discovery” was an important step toward the formation of a recovery community based on a universally shared experience of addiction. Consider the words of Randall, a 52-year-old white male, on the matter.

“I continue to be amazed at how I have so much in common with the addicts here... I came in as an alcoholic and I always just thought I was different from the

guys using heroin... But once you start talking to them, you realize we're all the same. Like Jude's story is just the same as mine, just switch heroin with alcohol."

While Randall and Jude really did have a lot in common—both were working-class white men who had actually grown up in the same suburb—other patients had much wider divides to bridge. Brooks, a white male in his early 50s, had a slightly more nuanced take, but basically agreed that addiction doesn't discriminate.

"I still think addiction is equal opportunity, you know? I mean, I think it can affect anyone, and it doesn't matter if you're a banker or living out on the streets... But I can see how some guys might have to deal with some stuff that would change up the game, or make it more difficult... I can definitely see how coming from where I came from, growing up in a good home and all, how I am at a certain place."

In a kind of colorblindness-via-medicalization, the mantra "addiction doesn't discriminate" silenced any explicit recognition of race or class, accomplishing an incredible erasure of structure which allowed countless racial micro-aggressions, as well as overt racism, to exist unchecked.⁷⁵ Its original intent—to debunk disparaging cultural stereotypes of the addict—had been subverted. Much in the same way colorblind rhetoric and the ideal of "equal opportunity" have been used to dismantle civil rights-era social and political gains, the idea that addiction affects everyone "equally" obscures the roots of addictive suffering in exploitation, oppression, inequality, or dislocation.

The lone critique of this idea came from an interview with Marcus. Although he still used "colorblind" language to characterize the pull of crack, he had strong opinions about the targeting of Black communities, as well as widespread social and economic disinvestment that left Black residents particularly vulnerable.

⁷⁵ These trends were only reinforced by Bridges' required trainings in "cultural competency" and "diversity," designed to prepare treatment staff and counselors for offering "culturally specific treatment." My observation of these trainings was limited, but suggests that they were far more invested in the "happy talk" of diversity, rather than any true grappling with race or class. See: Bell, Joyce M and Douglas Hartmann. 2007. "Diversity in Everyday Discourse: The Cultural Ambiguities and Consequences of "Happy Talk"." *American Sociological Review* 72(6):895-914.

“Crack has no respect for a person. It doesn’t care what color you are, it doesn’t care what ethnic background you come from, your age, who you are related to, or what state you are from. It’s ugly... I believe it was put out to destroy communities, which it did, but it didn’t become an ‘epidemic’ until... where politicians started using it, people in high-class lives, their daughters were getting strung out... Now it’s an epidemic because it has reached further than where we thought it was going to reach and now the Black people learn they can make money off of this, now the Black people are rising. To me, it was kind of racial when it first came out, and then it became an epidemic. Now it’s in every neighborhood, not just in the Black communities. Think about it, in the ‘hood, every other corner is a liquor store. There are more liquor stores than there are schools. There are more liquor stores than there are parks. You go to the suburb, you don’t see a liquor store on every corner. That’s the world we live in.”

The greatest “blind spot” in Bridges’ medicalized discourse was perhaps its erasure of privilege in discussions about drug-related crime and incarceration. The inability or unwillingness of staff and patients to name white privilege as a crucial factor in why so many of them managed to avoid the system further reinforced the notion that Bridges’ patients were simply just not as progressed in their disease as “those other addicts” who required the “tough love” of court-enforced rehab to recover. In a group discussion about “rock bottom,” for example, Brad posed the question, “Why do some addicts need to lose everything before they can change?” Blake provided an answer that everyone seemed to agree with.

“I think some addicts just have the disease worse than others. You know, it’s like when you get cancer or something—really any disease, you know? Some people can do a few rounds of treatment, and boom, they’re cancer-free. Some people have to do a lot more before they beat it, like, they need more aggressive treatment. And some people will just die because treatment won’t be strong enough. I sorta see addiction the same way.”

Blake’s commonsense understanding of addiction illustrates the disease metaphor’s massive success as a “vocabulary of attribution.” On its face, it seems valid enough—some people do have worse addictions, and they do require multiple treatments, or extended treatment, to recover. Unfortunately, some of us come to know firsthand the sad truth of Blake’s words-- that some people will lose the battle.

But understanding a phenomenon as complex as addiction within the narrow confines of disease has at least two undesirable effects. The first is based on a more general critique of medicalization. Addiction-as-disease becomes the universal and unquestioned explanation for *any* problems experienced by the afflicted—poverty, homelessness, criminality, violence and abuse, mental illness, social isolation, spiritual emptiness—the causal arrow always tends to point from addiction outward. The disease metaphor thus obscures the fact that some addicts deal with compounding marginalities—inequalities, injustices, and injuries that exist separate and apart from addiction, and could cause or exacerbate a drug problem. The diseasing of addiction then ultimately accomplishes a profound de-politicization. By obscuring the social conditions of addictive suffering, it contributes to a broader trend toward the medicalization of social problems, normal human states, and everyday life (Conrad 2007, Horwitz and Wakefield 2007, Szasz 2007). These phenomena are not unique to Bridges. They reflect the larger disconnection of addiction science from social theory, the colorblindness endemic to the rehab industry, and the narrow individualism that plagues the “psy disciplines.”

If the disease metaphor obscures social causes, it also promotes highly individualistic, single-bullet solutions which emphasize the patient’s personal responsibility to “think” and “feel” his way out of a number of social problems. Much like Barbara Ehrenreich’s analysis of how positivity undermines American culture, Bridges’ constant emphasis on “positive thinking” undercut any possible critique of how social systems might sustain addictions (Ehrenreich 2009). Staffer Marlene summed it up perfectly.

“Thoughts eventually become our behaviors, so if we can think positive, other things will follow. When I come to work, I put on a big, happy face, and just try to be as helpful as I possibly can at all times. No matter the situation, even if I’m having a bad day, I just keep on thinking positive. And I have a great life.”

The second undesirable effect of the disease discourse is the way in which it is unevenly distributed and applied-- that is, how it “sticks” to bodies differently across social space. The commonsense notion that some addicts simply have stronger forms of the disease, and thus must be forced, coerced, and controlled—both provides a rationale

for a two-tiered treatment system, and produces two essentially different kinds of people. More poor and working-class people of color are drawn into strong-arm rehab through court-led diagnosis, where the cognitively impaired “criminal-addict” is thought to be a more progressed iteration of disease-- further “in denial,” more out of control, and more dependent. Their identities as addicts have been fused with their alleged criminality, now understood to be essential characteristics of their personhood—there is nothing to be “recovered,” so they must be “habilitated,” erased and made anew. A few scratches beneath the surface logic of “lifestyle addiction,” a rather explicit cultural and racial condemnation is revealed.

The mostly white, middle-class addicts at Bridges still retain the capacity for self-control through the dual-self model, which allows for the recovery of the good self-manager who was only temporarily lost with the invasion of disease. A key difference at Bridges then, is the opportunity for reprieve through medicalization, as the addict goes through a process of de-stigmatization. But as Clive’s experience illustrates, the handful of marginalized men thought to represent “the street” at Bridges were never fully “unstuck” from the iconography of the criminal-addict. If reprieve did occur, it was not without cost. The biomedicalization of addiction brought on both a colorblind silencing of social critique and the potential biologization of race and poverty.

“To Fly Again”

In a popular lecture at Bridges, patients viewed ABC Nightline’s “To Fly Again,” a program about an alcoholic pilot’s successful efforts to turn his life around after losing his aviation license. The documentary is a triumphant story of rising from the ashes to put the pieces back together, a message that anyone can come back from the darkest hell, if only they would dedicate themselves to “working the program.” These inspirational stories helped ease the crippling shame that settled in as recovering addicts surveyed the damage in their lives. They also underlined the power of the individual, reinforcing the basic message that it was ultimately the addict’s responsibility to restore his life through a series of better choices and a steadfast commitment to recovery.

The film resonated strongly with many of the patients. In fact, after the video screening, Alan shared in group that his experience had been remarkably similar to the pilot's trajectory. Alan was a respected surgeon who was barred from practicing medicine after showing up to perform an operation intoxicated. With plans to reinstate his certification after treatment, Alan saw himself in the pilot's story—momentarily derailed but full of potential for second chances and starting over, once the truly good person within had been wrested from disease and recovered. For Alan, as for many Bridges men, there was life after addiction, and he had every reason to believe in the future.

For the most part, staff's assumptions about the kinds of recovered lives that were possible for Bridges patients "fit" reality. Most men would return to active roles at work and in their families. For those who didn't already have post-rehab opportunities, the after-treatment outpatient groups often functioned as valuable forms of social capital. Daryl, for example, was able to land a mid-level position at Wells Fargo with an accounting degree and the critical connections from his Monday night AA group. There were of course, exceptions to when and how these connections could be useful—like for those in particularly tough markets, such as the philosophy professor who had been looking for months with no luck.

Those whose social reality did not "fit" the Bridges' model were reminded often of the impossibility of the recovered ideal. The handful of patients who had always suffered chronic joblessness would continue to after treatment—especially because the public funding that brought most of them into Bridges would not continue to pay for the outpatient support program. The patients who would have benefited the most from using the recovery group as a form of social capital were thus not able to take advantage of it. I often wondered how Clive felt about the messages in "To Fly Again." Unable to get his nursing career back after his lone felony conviction, Clive had never been given a second chance like the documentary's pilot, or like some of his peers in rehab had been.

But on graduation day, everyone wanted to believe in second chances. Ken and Clive had entered the program together. They became roommates, formed a strong friendship, and now, they were graduating together. When it was Ken's turn to speak, he

teared up as he delivered a short speech and presented Clive with his 28-day sobriety coin.

“I found out Clive and I had so many things in common, it’s almost eerie. Who would have thought? At the end of the day, we’re very similar people. We’re both just two addicts trying to survive.”

Ken’s speech was heartfelt, and testament to the significant emotional bonds that could form between patients at Healing Bridges. Yet his echoing of “addiction doesn’t discriminate” enacted a deep “misrecognition.” Patients like Ken, Blake, and Alan had almost nothing in common with Clive, Marcus, and Demario. Indeed, that they had all spent time at Healing Bridges may have been the only thing they shared. And yet, the trope was a powerful one which often helped to produce the transformative experience that some patients reported. In our last interview together, Clive reflected on what he believed was the healing power of Bridges’ mission to destigmatize, empower, and create community.

“I’ve never been in a place with so many prominent men-- surgeons, professors, lawyers, engineers. None of the other places I went to had so many prominent men who were so successful in other areas of their lives, but still fell into this trap... One of my roommates managed and controlled a million dollar corporation! The guy I just met, Alan, was a surgeon for twenty years, you know? That guy Tony, he’s an author... It just lets me know that this shit isn’t prejudiced anymore. If you have issues and you don’t address it, it *will* get the best of you. Race, creed, financial status—it doesn’t matter. It lets me know I’m not alone. I see a lot of people sincere here. They even have to pay out of their own pocket to be here, you know? I’m experiencing a lot of different aspects of recovery I never experienced in other programs... Even the youngsters show a lot of sincerity. They are open to criticism, they listen... I’ve never been in a place where the guys got cabins in Minnetonka, their daddy drives a Maserati. I’m not used to hearing that from the treatment I’ve been in... It just kind of proves the fact that this drug thing is not prejudice. The deal is, we are all in here, and we are all equal. No matter who you are, what you got, we are all equal now, you know what I mean? We are all equal, trying to get off all this madness and accept who we are.”

Clive’s words strike at the heart of Bridges’ project—the erasure of addiction’s association with “badness” and its conversion into an “equal opportunity” sickness.

Despite the inequalities that clearly shaped these patients' experiences, in treatment Clive saw a level playing field and an opportunity to connect with other men through the shared experience of addiction. In asserting that "we are all in this together," rehab became the great equalizer for Clive, regardless of the social and cultural divides that existed. Coming to see himself as "equal" was also the way he dealt with much of the shame and the stigma produced by his crack addiction. At Bridges, Clive saw himself not as a monstrous "crackhead"—but as a suffering human, as someone struggling with a disease. He was successful in recovery, and he was likeable. For Clive, the model had real healing potential.

And yet, life on the outside was another reminder that it was *only* disease which could bridge these divides. Later that day, after a small celebration for the graduates, Ken's best friend and local car salesman picked him up from Bridges in a luxury vehicle to enjoy a lakeside drive before dropping him off at a posh "three-quarters" house. For most of the next year, Ken would use part of his savings to live there as he focused solely on his recovery, returning to Bridges three times every week for the second-phase outpatient meetings.

Back on the unit, I gave Clive some bus fare for his long ride back home. His partner Cindy worked double shifts to support the two of them, and she couldn't afford to miss any hours to pick him up that day. Clive had been very excited to attend the second phase of the program, as staff frequently reminded patients that doing so would "increase the chances of long-term sobriety by sixty percent." He had even arranged a carpool with some of his new friends from the program. But he had been disappointed several days before when he learned that his public treatment funding wouldn't pay for any additional programming, and his only option for post-rehab support was to attend one of the Narcotics Anonymous meetings scattered across the metro area. Lacking reliable transportation and needing to fit in odd jobs whenever possible to help Cindy, it would be difficult if not impossible for him to make regular meetings. In his last therapy session, the group had urged him to get a sponsor. He did, but he grew discouraged after several failed attempts to meet him for coffee. These obstacles didn't seem to bother Clive

though, whose relentless positivity was a shining example of Bridges' mandate to "look on the bright side."

As he waved goodbye to us, smiling through the revolving glass doors, I thought I detected some fear in his eyes. "One day at a time!" he yelled back.

Chapter 5: Recovery Narratives across the Social Structure

“Every time I relapse, it becomes more like a short binge. Like this last time, I was only out drinking for maybe ten days, and then I came straight in here. Seems like the more treatment I do, the easier it gets to go the next time... Something seems to be sticking, you know? Even though I am relapsing, I am getting the help I need, I guess. I’m realizing each time what I need to do.” – Brooks, Healing Bridges

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“If anyone in here picks up and uses again, do you know where it will take you? Sooner or later, you will either end up in treatment again, prison, or in the grave.” -- Mike, Arcadia House

Cross-Class Comparisons: Reconciling Treatment Logics & Lived Experience

The previous two chapters have shown how staff and clients put recovery discourse into everyday practice, producing participants either as treatment-resistant criminal-addicts, or sick patients capable of harnessing the self-manager within. The distinct “treatment logics” operating across the programs at Arcadia House and Healing Bridges were powerful discursive frameworks organizing vastly different projects in self-making and social control. While other studies have similarly theorized the power of discourse to “produce” recovered subjects through the “purification” of their self-narratives (Carr 2010), Darin Weinberg’s work reminds us that addiction is also always a profoundly physical, embodied experience (Weinberg 2002). Articulating the problems inherent in these false divides, Weinberg argues:

“Objectivist researchers must acknowledge that actual empirical instances of mental health and illness are inextricable from the locally meaningful activities in and through which social actors perceive them. However, subjectivists must themselves acknowledge that to the extent they are understood to influence human behavior and experience in any way at all, mental disorders must be

understood to exist beyond the boundaries of human subjectivity” (Weinberg 2005)

I attempt to resolve these divides by recognizing that participants always entered the “scripted” worlds of treatment with fully developed “habitus” (Bourdieu 1977, Weinberg 2002). Not reducing addiction to either a purely symbolic construction or a purely neurobiological phenomenon, an embodied approach theorizes addictions as *particular kinds of habitus*—rooted in the patterned social experiences of work and family arrangements, and manifest as bodily, physical habits (Bourgois and Schonberg 2009, Weinberg 2005). Indeed, the goal of any successful rehab is to reshape participants’ habitus for successful social reintegration, although it is rarely stated in those terms.

My first goal in this chapter is to develop our understanding of the link between social inequality and addiction by examining how the roots of compulsion and control lie in the ways that everyday orientations to work, family, leisure, and community are inscribed on the body. To do this, I focus on the recovery narratives of study participants across the social structure, drawing on 70 life history interviews conducted with men in the residential programs at Arcadia House and Healing Bridges to explore how the patterning of addiction was classed and raced *prior to* and *outside* of treatment.⁷⁶ I complicate the notion that “addiction doesn’t discriminate” by demonstrating how addictions were patterned through socialization, shaped by socioeconomic status, and rooted in gendered orientations to work and family. There are striking differences in how middle-class, working-class, and poor men across the study developed addictions and took up the project of recovery.⁷⁷ While I make every effort to highlight significant

⁷⁶ 36 interviews were conducted at Healing Bridges, and 34 at Arcadia House. Demographic composition was roughly equal by class: middle-class (35%), working class (32%), and poor (33%). Racial identification of men in the total sample was 64% white, 32% Black or African-American, 3% Native American or American Indian, and 1% Latino.

⁷⁷ I used socioeconomic and occupational indicators to group study participants by social class, while recognizing that “class” is a fluid, highly contextual phenomenon that encompasses multiple aspects of identity. In cases where class identity was more ambiguous, I address it directly in the analysis.

outliers, the “profiles” I lay out in the following sections capture the broad patterns and trends that characterize the majority of my informants’ experiences.⁷⁸

A second goal of this chapter is to examine the tensions between treatment logics, lived experience, and “take-up.” Treatment logics had the power to reorganize addiction by advancing particular interpretations of the past, and shaping future behaviors. And yet, the success of treatment in “producing” people—the potential power of discourse--cannot be divorced from participants’ habitus. As I showed in the previous two chapters, participants’ past experiences conditioned their receptivity to both therapeutic intervention and the logics of institutional control. At times, the logics of treatment were highly resonant, offering recovery discourses that “fit” with participants’ own lived experience. In other cases, “doing recovery” clashed significantly with the realities of participants’ lives on the outside, producing a profound “misrecognition” of the structural roots of addictive suffering.

Here, I sketch out some of the social forces that shaped participants’ habitus in order to better understand how they encountered treatment logics. To what extent did the logics offered in treatment “make sense” to participants as frameworks that adequately captured their experiences? How and why did participants’ preexisting habitus “fit” with the self-making projects they encountered in treatment?

Bourdieu’s notion of “symbolic violence” refers to the way in which dominant meaning systems are imposed upon groups and thus experienced as legitimate (Bourdieu and Wacquant 1992). It is a form of violence that social agents themselves are complicit in, reinforcing the “legitimacy” that obscures existing power relations—and making them unrecognizable or “misrecognized.” I draw on Bourdieu’s concepts of symbolic violence and misrecognition to situate my work within larger traditions seeking to overcome the opposition between “interpretivist” and “structuralist” social science, establishing a

⁷⁸ In this chapter, I focus on those who self-identified as “addict,” and whose own narratives displayed considerable evidence of problematic addiction, bracketing out the questionably addicted “hustlers” I examined in Chapter 3. In general, the analog to Arcadia’s “hustler” wasn’t present at Bridges-- that is, middle-class dealers were far less likely to be coerced into rehab.

“dialectical view” of the relationship between discourses and the external social world (Chouliaraki and Fairclough 1999).

The symbolic violence produced through addiction recovery cannot be understated. As addictions were naturalized through the logic and practice of treatment, the power relations that produce and sustain addictive suffering were obscured—creating a series of profound “misrecognitions” (Bourdieu 2001). Bourdieu’s sociology gives us a powerful way to understand why rehab—an attempt to reorient habitus mostly through talk therapy—so often fails. “Almost impossible to learn, imitate, or eradicate because they may never come fully under self-surveillance or control,” the practices expressed through habitus are thus “as difficult to shift as any natural attribute” (Lovell 2000). Bourdieu’s social reality then is one that continually reproduces its own structures of domination.

Yet Bourdieu’s sociology is not incompatible with recognition of agentic performance insofar as we consider how agentic capacities for self-making are themselves socially conditioned and distributed. Research on the development of class habitus considers how cultural values such as assertiveness or restraint; obedience to authority; creativity; or particular modes of reasoning, negotiation, or self-reflection are socialized along class lines (Lareau 2003). This early conditioning of habitus, reinforced by encounters with institutions across the life course, shapes participants’ capacities for self-control, and their receptivity to “therapeutic self-reinvention.”

As Terry Lovell has usefully argued, it is ultimately a *combination* of Bourdieuvian theoretical paradigms and notions of subjectivity which can best serve to describe the social world (Lovell 2000). While Foucauldian discourse analysis risks “disembodying” subjects in the act of self-making, I privilege neither narrative nor habitus in my analysis—instead arguing that the “selves” people fashion in treatment are never bound to institutional sites themselves, but always reflecting the previous accumulation of embodied social structure. My comparative framework affords a unique opportunity to examine how “self-control” is both written onto bodily practice via social structure *and* institutionally produced across different classed and raced social control projects.

Life History Interviews

As sites of intersection between individual and historical processes, personal narratives are powerful tools for exploring the “black box of subjectivity,” exposing the social conditions that make “selves” possible (Maynes, Pierce and Laslett 2007). The “life history” interviews for this project were conducted to allow participants to “tell their own stories,” while placing their addictions within in a larger social context— drawing out the links between drug use and cultural backgrounds, social connections, family lives, and occupational histories.

Above all, I wanted to capture a sense of who people were outside the spaces of formal group therapy, although I often used their therapeutic encounters as supplemental data that informed some of the questions I asked. I made every effort to break the over-determining “script” of rehab by getting to know clients fairly well before conducting interviews, sharing my own experience with drug use, and offering my fairly critical take on the drug war in more intimate conversations. These interactions were crucial for separating my project from the determinations of staff and counselors, and for distancing—at least to some degree—from the powerful “script” of treatment logic.⁷⁹ Although my interviews could never escape program discourse, framing these interviews as “life history” projects rather than addiction interviews seemed to offer informants more flexibility to narrate their experiences outside the confines of narrow institutional frameworks.

Interviews were 2-3 hours in length, semi-structured and wide ranging, designed to elicit deeper reflection and let topics unfold organically as salient themes and struggles were identified. The questions were organized to establish the general rhythm of a person’s drug use across the life course, including longer periods of sobriety and key relapses. In addition to basic demographic factors, topics included early childhood and

⁷⁹ In both groups, the prevailing script of addiction seemed to prevent more nuanced investigations of individual using patterns—although this was much more than case in Arcadia House. This is reinforced in different ways by both programs’ insistence not to “dig too deep,” but rather to focus on the here and now, and moving toward a sober future.

school experiences, family life and relationships, labor market experiences, and previous episodes of treatment or incarceration.⁸⁰ Each interview included an interactive “time line,” and interviewees were invited to chart the progression of their addictions alongside changes in primary relationships or living situations, past episodes of treatment or incarceration, and key life transitions or turning points. After getting a basic sense of who interviewees were prior to treatment, I asked them to discuss their reactions to the program itself, and to share some of their opinions on current drug policy.

My informants had been exposed to a number of competing, sometimes contradictory, cultural messages about addiction-- generating messy narrative arcs that reflected the “crisis of legitimacy” in addiction science. Sorting out the “program effect” of a specific treatment intervention on long-term sobriety or successful resocialization is thus a difficult, if not impossible, task. Yet the men I interviewed displayed surprising consistency in terms of “model exposure.” While the vast majority had at least one prior episode of treatment, most had remained firmly on one “treatment track”—testament to the divisions in treatment access that inspired my original interest in this project. While white, middle-class men tended to have more episodes of treatment overall, they had almost never been court-mandated to rehab in a “strong-arm” facility. And while middle-class addicts had sometimes been exposed to an eclectic mix of treatment models, they were for the most part overexposed to the Minnesota Model I described in Chapter 4, drawing on its logic to frame their recovery stories.

Poor and working-class men in the sample had much stronger exposure to the strong-arm model. Most of the poor and working-class men had spent time in both coerced and “voluntary” forms of treatment—including strong-arm, Twelve-Step groups, Minnesota Model residential and outpatient, and others. Poor men of color had the least exposure to any other model outside of “strong-arm” rehab— and for many, court-mandated rehab was their *only* exposure to treatment. These divisions in treatment access among interviewees were not surprising given my project’s design and focus—but the fact that they captured trends *across* men’s lives only reaffirmed that a “two-track”

⁸⁰ My interview guide is available to view in an attached Appendix.

treatment system was shaping divergent realities. There was of course a small but significant group of men who had substantial exposure to both models, and a few were enrolled at both Healing Bridges and Arcadia House during the course of my study. It was often these men who provided the most theoretical traction for the project, revealing the shaping powers of “shifting governmentalities”—and their limitations.⁸¹

Middle-Class Addicts: Managed Binger to “Better Self-Manager”

The “Managed” Addictions of Middle-Class Life

For the middle and upper class addicts in my sample, privilege clearly had a “multiplier effect.”⁸² Socioeconomic status, education, family support, and whiteness provided a powerful buffer zone against some of the worst effects of addiction. But while racial and economic advantage might have shielded them from drug-related poverty, homelessness, and correctional confinement-- the social contexts of their lives shaped their addictions in other ways. The relatively stable, predictable, and secure rhythms of their work and family arrangements gave rise to a deeper integration of regular drug and alcohol use within everyday schedules and routines. Self-described “weekend warriors,” many of the middle-class men I interviewed spoke of addictions characterized by modulated—yet intense-- “binge-like” periods interspersed with numerous periods of sobriety and multiple attempts at treatment.⁸³ The arc of addiction across their lives had

⁸¹ For a more in-depth discussion of the life history interview methodology and demographic information from the interview sample, please see the attached Methods Appendix.

⁸² As I described earlier, my use of “middle class” pertains to the overwhelming identification among men in my sample with the professional middle-class, as opposed to men working in the trades or the more precarious service sector jobs. Indeed, as I discuss in Chapter 2, many of these more precarious middle-class men had been “squeezed out” of residential treatment, instead entering the more affordable outpatient version of Bridges program, or forgoing treatment altogether.

⁸³ The vast majority of my interviewees cited daily use as a feature of their addictions. I use the term “binge” here to capture my informants’ segmented, shorter “bursts” of *more intense* drug activity, and not in any clinical or diagnostic sense. While numerous studies contribute to knowledge on the predictors and health consequences of binge drinking and drugging, they often disagree on what constitutes “binge” activity. For the purposes of this study, “bingeing” emerges in the context of an interviewee’s reported

assumed a “whiplash” pattern of “getting too out of control,” quickly “cleaning up” and repeating the cycle. A key characteristic of this pattern was the consistent attempt to manage a fine line between “work” and “party” identities, confining the heaviest periods of drug consumption to weekends or other demarcated “off” times.

While obligations to work and family might have functioned to enforce a more “managed” pattern of consumption, as Adam’s story illustrates below, middle-class addictions were no less harmful, dangerous, or any less “all-consuming” than those of other men in the sample. In fact, economic and other supports enabled them nearly unabated access to their “drug of choice,” and they reported some of the most spectacular binges in terms of the sheer volume of drugs or alcohol they had consumed in short periods of just days or weeks. They also reported some of the most severe health effects across the sample that could be linked directly to drug consumption. Even as their consumption escalated, they seemed to have a remarkable ability to *regulate* it, constantly adjusting toward the achievement of “functional addiction.” But rather than possessing any innate ability to self-manage, their narratives suggest that their lives already contained the “built-in structures,” privileges, and various capitals that made long-term, heavy drug use more possible. With access to stable jobs that afforded a considerable level of autonomy, they had learned to “dose out” drug consumption in a carefully balanced, highly routinized calibration of their habit.

Adam, a Healing Bridges patient, was a middle-class car salesman who was introduced to heavy drinking and cocaine use at weekend football events with his friends and co-workers. While alcohol helped relax the harsher edges of his demanding job, cocaine brought out his livelier and more sociable side-- and made him feel accepted as “one of the guys.” Soon, he was using both regularly as part of his socializing routine. While he managed to confine drinking just to weekends at first, over time his addiction evolved into the careful integration of daily drinking within his work schedule. He

drug use pattern across the life course—moving from periods of lower level use into heavy use stretched across several days or weeks, and back again.

described how this progressed, as he balanced alcohol and cocaine within his everyday routine:

Adam: “Stress is intense in the car business. You don’t know if you have a job one month to the next, and it’s all based on performance... I could go one month making a thousand dollars, and the next month I could make fifteen thousand dollars. It’s just like gambling and intermittent reinforcement, it’s very addictive... I got addicted to that lifestyle, that adrenaline rush, and pretty soon alcohol and cocaine just fed that. I remember that adrenaline rush, and never knowing when the big one was going to hit, and I thrived on it for years like that. Then the stress from it is overwhelming and I couldn’t relax at night. I’d toss, turn, flip, and worry. And drinking alleviated that...”

Here, Adam describes his own brand of “lifestyle addiction”-- the “adrenaline rush” of cocaine use both complemented and reinforced by his high stakes sales position. His depiction was set firmly in a more medicalized register referencing adrenaline, “intermittent reinforcement,” and the “self-medication” of chronic stress. Adam’s narrative departed considerably from the moralistic constructions of “lifestyle addiction” within strong-arm rehab, instead mobilizing the more valorized identity of the “workaholic,” our culture’s more “respectable addict” (Killinger 1992).

Adam went on to describe how he carefully managed his addiction down to the minute, striking an increasingly precarious balance between work and consumption.

Adam: “I never drank at work but the thoughts consumed me. I would take my lunch break and I’d go buy my bottle-- and this is over the past 6 years—I’d look at the clock and I couldn’t wait until I was done working and the instant I was done working, I would go the bathroom. I’d pour a huge drink and slam it... I wouldn’t drink on my breaks, I knew better than to do that. I would wait until I got home, and all I can describe to you is feeling the anticipation-- I call it the “urges.” It would make me cough up foam and stuff from my mouth, I had so much anticipation and excitement to do it. I would feel twenty minutes of pleasure and then I’d go right to sleep... On my days off, I’d wake up feeling sick, and I’d be at the liquor store at 9 in the morning, and I would start. And then how I was scheduled, if I had a day off, I’d drink all day...I’ve probably been in the emergency room eight or ten times because of that.”

It was not uncommon for participants like Adam to report these patterns stretching across decades before prompting a trip to treatment. They had the financial resources to sustain even the most expensive drug habits for long periods of time, and they weren’t likely to see their use as problematic. After all, they were more or less

“functioning” on the surface, meeting deadlines at work and fulfilling family obligations. Their relative privilege, as revealed in Chapter 4, set them outside the widely cast net of correctional control-- and they were rarely forced into treatment by any state agency, or even by an employer. In fact, far from positioning drug use as problematic, their stories reveal that drugs had been packaged with a number of social and cultural functions that actually made them *more* successful at home and in their careers. Several interviewees, for example, used meth or cocaine to fuel ever-longer hours at the office, describing how their pathways to addiction were littered with promotions, awards, recognition, and annual bonuses.

Resonating deeply with one of the Minnesota Model’s foundational texts on alcoholism, excessive drug use among many of my middle-class interviewees was strongly associated with high achievement (Johnson 1980). Yet often masked in these discussions is an understanding of how the roots of compulsion lie in the arrangements of middle-class life. In particular, high occupational status immersed many of my middle-class interviewees in work cultures that normalized intoxication, promoted drug use an effective coping strategy, or introduced extreme forms of “workaholism” which were readily channeled into other kinds of addictions. Despite diversity in their occupational cultures, most reported that their jobs had institutionalized extreme overwork, anxiety and stress as standard aspects of the work environment.⁸⁴

Ray is a white male in his late 40s whose storyline provides another illustration of the “managed binge” pattern common among more affluent addicts. Unaffected by the recession that had hit some of the other affluent addicts in the sample, he remained solidly upper to upper-middle-class during the course of his adult life and throughout his addiction.⁸⁵ A “weekend warrior” in college, Ray was first introduced to heavy drinking

⁸⁴ Occupations among the middle-class addicts in my sample were diverse, but can be broadly categorized as “white-collar,” managerial and professional jobs marked by a high degree of autonomy and flexibility, middle-class salaries and benefits, and relative job security. The vast majority of men in this group had been stably employed throughout life, and included doctors, lawyers, educators, financial executives, business owners and entrepreneurs, accountants, nonprofit administrators, IT professionals, software developers and office supervisors.

⁸⁵ Ray’s reported income placed him just in the lower portion of upper-class earners, based on state data for Minnesota from the year I interviewed him. See: (Pew Center 2013).

in the beer-soaked fraternity parties he frequented as an undergraduate. Despite telling me that he “probably lost a few brains cells” playing “beer pong” and other popular drinking games, he managed to graduate with a business degree and quickly progressed to making six figures in a high-profile finance job. A self-described “high-achieving alcoholic,” the escalation of Ray’s drinking was deeply intertwined with his immersion in a fast-paced work environment that demanded long hours and normalized a “business entertainment” culture of illicit drug use and drinking with clientele. In his attempts to balance work and family life as a “functional alcoholic,” Ray related that drinking was “basically a part of his job description.” He described the high-powered executive lifestyle that fueled his drinking, as he rose through the ranks at work.

Ray: “When I worked for Merrill Lynch, the company at that time... was really on top. I rose quickly through the ranks, and uh... I did very well. Eventually, I was leading a division, and I was making a lot of money. Drinking was a huge part of the business culture. You know, we’d constantly be taking big clients out to lunch, to expensive dinners, entertaining the wives, all that... and drinking was a part of that. You had to entertain, you had to make people feel comfortable. You had to be... well, the life of the party? It was about building those relationships. So I started partying and drinking more because it came with the territory of my job.”

As he was groomed by management for the upper echelons of the corporate hierarchy, Ray drank his way to incredible success-- eventually gaining access to private company jets, lavish business accounts, and new company cars. While work and drinking had consumed more of his life, by his mid-twenties Ray was living comfortably and providing for his wife and three children on an expanding salary. About a decade into his lucrative career, “functional alcoholism” caught up with him. He slowly became less able to balance frequent intoxication with the everyday demands of work, a reality that was publicly revealed when he delivered a presentation during one of his routine “blackouts.” Getting fired from work was a key turning point for Ray:

Ray: “That’s when I really went over the edge... Everything was just a blur. Forget about weekend warrior. I started drinking daily, around the clock. I was drinking at least a case of beer a day, sometimes more... It was pretty normal for me to drink two liters of vodka every day. Needless to say, I completely wrecked my body during that time.”

For the next several years, Ray faced considerable pressure from his family to enter treatment, and his wife threatened to divorce him. But it was ultimately his hospitalization for cirrhosis of the liver that brought him into the program at Healing Bridges. As he explains, “I just figured, hell, I’m already at the hospital. I guess I’ll just come down here and give this a try.”

Like other affluent addicts, Ray divides his life into two broad periods—a phase of “functional alcoholism” in which he was seemingly still dependent on alcohol but “managing” it alongside other obligations, and a breaking point that signaled movement into a phase of unchecked and more “out of control” use. In Ray’s case, getting fired might have been a result of his beginning to “fall out of balance.” In other instances, the causal arrow seemed to point more directly from unemployment to escalating drug consumption. Indeed, Ray shares that it wasn’t until losing his job that he “really went over the edge,” moving from “weekend warrior” status to full-time drinker.

Ray’s story illuminates a common theme in the middle-class interviews, and a crucial paradox. Occupational culture could spark a drug problem or exacerbate an existing one through either normalizing excessive consumption, or promoting it as a response to ever-increasing stressors and anxieties. But paradoxically, work was also the anchoring force that allowed addicts to “manage” and “calculate” drug use, carefully confining it to particular “zones.” The occupational structure attached to middle-class life seemed to enact a moderating influence on addiction, and the loss of that structure was often the “break” that resulted in less demarcated consumption.

Of course, Ray’s *Wolf of Wall Street*-themed work experience was in some ways a much more unique subcultural form.⁸⁶ Widespread tolerance of more “hardcore” drug use at work was certainly uncommon in other patients’ narratives, and Ray was an economic outlier in the sample with an income placing him more firmly in the upper

⁸⁶ *Wolf of Wall Street* is a 2013 film starring Leonardo DiCaprio that depicts a New York stockbroker’s rapid rise to multi-millionaire status—and subsequent downfall—through Wall Street corruption, fraud, and greed. The film was released and popular among patients when I was in the field. Although it portrays far more exaggerated, excessive drug use than was the norm among the men I interviewed, several of them (including Ray) used it as a cultural touchstone to describe how their addictions were intimately tied to their working lives.

class. Yet while Ray's story might be an extreme case, it reflects common themes in the narratives of many middle-class interviewees, who described addictions that were intimately tied to working lives.

Ken, who is solidly middle-class and whose story I introduced in Chapter 4, was a more typical case. By his own admission, he had used alcohol "functionally" for years before, although he often expressed confusion as to when, exactly, he "truly became an addict." For Ken, drinking culture was synonymous with work culture in the form of "letting off steam" after hours, which helped him cope with the many stressors and uncomfortable realities of his IT job in the banking industry. Consuming alcohol was woven into the fabric of everyday work life, but Ken's stricter separation between "work" and "intoxication" enabled him to "manage" his alcoholism more successfully on a long-term basis than Ray.

Indeed, Ken was able to walk the fine line between moderate consumption during the work week and excessive "weekend warriorhood" for years, confining his heaviest binges to scheduled leisure periods and "off times." In retirement, Ken found it much more difficult to stay away from alcohol-- underscoring the powerful effect of stable employment on more segmented consumption and "scheduled excess." Similarly, Adam's more managed drinking gave way to total abandon when he left his job as a car salesman. He relates:

"I decided to get out of the car business, and I took six months off. My drinking during that 6 months got totally out of control... I'd go through withdrawals and sometimes got to the point where I'd call the ambulance myself because I thought I was going to die."

Alan's account is another illustration of the "bounded excess" that middle-class addicts pursued. A white, middle-class man who grew up in a suburban Minnesotan town, Alan was on his first stay at Healing Bridges. In his interview, he shared that he started drinking whiskey regularly when he began the rigorous medical school training required to become a surgeon. In contrast to Ray though, Alan's medical profession was much less tolerant of open alcohol abuse, relegating his drinking to the home sphere. He describes how he settled into regular drinking patterns by his mid-twenties:

“I was not passing out at that point, still able to function. Watching TV, working at the computer, stuff like that. But it was pretty regular, and as I might have mentioned in group, on weekends, or at family events, or anything that was worthy of videotaping, you could tell in my voice that I'd had too much to drink, be it on a boat, or at the beach, or in our apartment at a birthday party or family event... I was drinking to excess whenever I got the opportunity.

Sarah: Can you tell me what it was about alcohol that you enjoyed so much?

Alan: I liked the taste. I liked the feel. It was a respite. It was a little cave I could climb into when I was stressed out at the hospital.... And I could escape that when I got home. Alcohol was definitely a part of my escape from the stress of medicine.”

Up until age 45, Alan drank a “standard dose” of six strong Manhattans every night, striking a careful—albeit increasingly tenuous-- balance between drinking and his demanding “on-call” schedule.

“I should not have been on the phone talking to patients or other doctors... I honestly don't think I ever operated compromised, but it took me a couple hours to get in... I'd go to bed after drinking at 10 and get called at 4 in the morning. By the time you're in the OR, it's like the next day anyway. But it's one of the things that made being on-call even more stressful because I was balancing these-- I was, you know, almost compelled, or it was my routine to continue to drink, and I was rolling the dice, hoping that the phone didn't ring... It got to the point where even if I was drinking every night, during the day my hands would be quite shaky. I've cared for patients that have had DTs and seen how awful that is. And so I was deathly, not only afraid but mortified, of the embarrassment if that ever happened and I would then be exposed for what I was... So I was careful to make sure that I didn't have a point where all of a sudden I went cold turkey for two or three days, and run the risk of going into some sort of withdrawal...But I definitely, my handwriting got worse... Surgery got more difficult because, I mean, I could get the job done, but it wasn't pretty.”

For many Americans, and according to much of the criminological literature, “pro-social” attachments would serve to route people away from drugs entirely, positioning them more toward the bonds and goals of “conventional life” (Gardner and Shoemaker 1989, Gottfredson and Hirschi 1990, Hirschi 2002, Krohn et al. 1983). While the relationship between chronic or sudden unemployment and addiction is extensively documented, my interviews underscore the crucial role of work culture in the development and progression of middle-class addictions. For the men in my study with high occupational status, attachments to conventional life were like incubators for

addiction—providing “blueprints” for balancing excessive dedication to work, labor, and production—on the one hand—with outlets for excessive consumption, on the other.⁸⁷

Middle-class men said curiously little about how family life had shaped their addictions, which I came to see as a gendered and classed contrast with the working-class dramas unfolding around “codependency” that I address in the next section. When asked about it in interviews, many informants shared that their families had for the most part been supportive of their recoveries, showing up for the “family program” portion of treatment and providing financial assistance and other support. Yet if middle-class men were able to “balance” their addictions with other competing demands, gendered family and domestic arrangements might have provided additional supportive structure. Alan’s wife, for example, worked the “second shift” at home, despite having her own busy law career.

Alan: “A phone, a fax machine, and a computer is all she needs to practice law. Her clients are all over the country. And so it’s dovetailed nicely into my drinking. She can work at night, and she works usually until 2 or 3 in the morning. And then comes to bed, sleeps late... and is awake when the kids are home for dinner and choir and whatever.

Sarah: That’s something that you had mentioned in group, right? That she was kind of picking up the slack with the children’s schedules?

Alan: Yeah, she stepped up when I was mentally absent and was the one that took the lead in organizing music lessons and organizing transportation and stuff like that.”

Like Alan, many middle-class men described partners who were similarly overworked, overscheduled, and overstressed—either “picking up the slack” as their addictions took over, or striking their own fine balance between work and consumption.

⁸⁷ Important departures to these patterns of middle-class addiction are the mostly white, suburban, middle-class and college-age youth in the sample, whose experiences I examined more in Chapter 4. The vast majority were at Healing Bridges, although some of them did turn up at Arcadia—usually those whose parents hoped that Arcadia’s “hardcore” reputation would “scare them straight.” Sheltered from the realities of the job market through their parents’ financial support, they engaged in the heaviest drug use. Indeed, unpunctuated by work or family demands—and with a sometimes uninterrupted supplies of drugs and secure, “invisible” spaces in which to get high-- the advantaged middle-class kids in my study reported levels of drug use that far surpassed other addicts in the sample.

Several interviewees shared that their wives or girlfriends were simultaneously seeking treatment for their own addictions. Perhaps family life was a less developed theme in the recovery narratives of middle-class men because their addictions were far less likely to have seriously compromised their ability to fulfill the gendered provider role. While almost all of the fathers in the sample expressed deep regret over being emotionally or physically absent in their children's lives, they were still, for the most part, assuming the economic responsibilities of "family men." Their ability to perform masculinity through their status as successful breadwinners had only been temporarily eclipsed by addiction. Alan, for example, planned to leave treatment early to attend his daughter's performance with the New York Philharmonic Orchestra, before heading straight back into the operating room.

Recovering Good Self-Managers

The experiences I document here were far more typical of Bridges' clientele, capturing the salient themes in the recovery narratives of most of the middle-class men I interviewed in the residential program there. The careful dance of calibrated drug use could not last forever though. For the men in my sample anyway, attempts to harness the "self-manager" within had finally become unbalanced. There were a wide range of reasons why men reported entering treatment for the first time, but most commonly cited was the unavoidable, severe health complications that arose from chronic drug use. In the absence of run-ins with the law or significant economic problems, it was often their failing bodies that alerted them that "something had to change," as was the case with Ray's hospitalization.

Middle-class recovery narratives were infused with an ethos of self-empowerment, a focus on emotional and psychic conflict, and a "dual self" conception of addiction that salvaged an untarnished person within (Weinberg 2005). If the logics of "self-management" seemed to "make sense" to some participants, it was because they mapped onto their experiences at work, at home, and in their interactions with other institutions. Middle-class addicts experienced a high degree of resonance between the neoliberal models of "self-management" circulating in Bridges' medicalized program and

the ways in which they managed drug consumption, buttressed by considerable economic and material supports.

Take the experience of Brooks, the Healing Bridges patient whose quote opens this chapter. Brooks was a white, middle-class former pilot in his early 50s who had struggled with alcoholism for decades. Seeing each of his relapses as “a part of recovery” offered a powerful reframing of his past failures and time spent in rehab as “accumulated wisdom”—which he eagerly mobilized in his own recovery narrative. Viewing rehab as a “credential” of sorts, rather than as another instance of submission to institutional control, had a profound effect on his general outlook. On his fourth cycle through the program, Brooks seemed to be doing better than ever, and was eagerly pursuing his “squash addiction” which he had come to define as “one of the healthy pleasures”—and as a crucial alternative to extended drinking. He was also completely comfortable positioning himself as an agent in his own recovery, harnessing middle-class cultural repertoires of assertiveness to propel his personal reinvention forward (Lareau 2003). “*I am realizing what I need to do,*” he says.

That Brooks viewed rehab as just another “tool” in his extended project of self-reinvention—flowed from deep reserves of middle-class cultural capital which afforded him a sense of personal control, autonomy and self-efficacy. As middle-class participants sought to re-balance their inner self-managers, they constructed addiction as a valuable life lesson and turning point, rather than a constant threat of looming danger. Mirroring the classing of aspirations and future outlooks documented in other ethnographies, there was a high degree of hope among middle-class recovering men (Bettie 2003, Lareau 2003, MacLeod 1995, Willis 1977). Consider Alan’s projection for the future:

Alan: “I’m not trying to demonize myself more than I already deserve. My bottom, compared to a lot of the bottoms in this room, is not very deep. You know, the bottom that I hit... As common as they are for everybody here, I can’t see myself getting on that merry-go-round. And so I don’t have that far to get back to where I was. But I think I also had lowered expectations. And I think I can get back even better than where I was. And that’s what’s motivating me, and that’s what drives me. I don’t just wanna get back to high functioning. I wanna get back to, as I said during my drug history-- I think I missed a lot of opportunities... some of which I’ll never be able to regain. But I think it’ll motivate me to try.”

A similar hopeful reflection came from Jude, a 23-year-old white, upper-middle-class patient at Healing Bridges. The lone middle-class dealer I interviewed, Jude had developed an expensive heroin addiction after moving to California for college and getting immersed in the Hollywood party scene selling ecstasy and cocaine. His post-treatment goals included re-enrolling in school to study engineering and pursuing a fascination with magnetic technology. As he says:

Jude: “Yeah, and I want to use my addiction towards it, get addicted to learning about it, because I think addiction can be really positive. I’ve used it for working out, and for sports I would stand in my yard for like nine hours in the middle of the summer and just shoot lacrosse balls at the net all day. Or I’d work out like 3-5 times a week every day for a year. So if you just have an addictive personality, you just have to learn to use that towards good instead of bad... Because it’s true having all that energy channeling into something it can end up being an asset and can end up working to your advantage.”

Echoing the suggestion that Bridges’ patients “transfer their skills” from addiction into recovery which I examined in Chapter 4, Jude eagerly capitalized on his “addictive personality”—reframing it as the fuel for his next endeavor in life. And given Jude’s ready access to socioeconomic support, it was not unlikely that he could achieve his vision. These positive re-framings of addiction were much more common among middle-class addicts. But while hopeful, their narratives were also tempered by the medicalized discourse of addiction-as-brain-disease—leading many to resist an overly optimistic view of what was possible in recovery. Giving the group advice on “how to do recovery,” Bridges speaker Marlene, a former addict herself, espoused a fairly radical view when she cautioned against the dangers of “all or nothing” sobriety.

Marlene: “Maybe we want to kick drugs, and stop smoking, and lose weight, and start eating healthy... I can tell you from experience, it won’t work to try to take on too much at once. It’s good to have goals, but maybe pick the thing that will kill you first, and get that under control. Make a list and rank them all. If you’re on drugs or alcohol, that’s probably going to kill you first. So take some time to get that in order. Then start on the next thing. Maybe quit smoking after you’ve made progress with the harder stuff.”

This more moderate and tolerant approach organized the recovery narratives of middle-class treatment goers *across* field sites. Similarly, Jonathon, a white, middle-class client at Arcadia House, described the “reward” he gained from treatment in a much more sobering light: “The fact that I’m more aware of my limitations now is, I think, my

reward for having gone through the program.” He pushed back on the notion that he would *never* drink again, seeing it as ultimately unhelpful for his long-term sobriety.

Jonathon: “I don’t know, I can’t say I’m not ever gonna drink again. I suspect that I probably will. But I think I’m more aware of what the consequences are than I was before. You know, and I’ve done enough damage as it is... So it’s not worth it.”

Even among those men whose upbringings made the “all or nothing” logic of total abstinence more convincing—relapsing was a much more deliberated process, involving multiple steps and a series of choices one could enact to make things go differently. Middle-class addicts were the least likely to perceive relapse as a matter of “flipping a switch,” a notion that had wide support within Arcadia’s brand of “street or straight” recovery. Instead, they offered a more nuanced notion of bounded control, even as they clung tightly to the logic of personal responsibility.

Consider Adam’s thoughts on relapse—the car salesman whose alcoholism and cocaine use had resulted in multiple hospitalizations. Adam’s strict Catholic upbringing had left him with a crippling sense of guilt over what he saw as his intensely stigmatized cocaine use. His narrative conceptualized addiction as a disease, but also hinged on the idea of “first drink”—the moment of choice that always exists.

Adam: “And how I think of my addiction now is that I’m going to struggle, and I know that. I think of it as my brain at this point, doesn’t work normally-- that pleasure center... I have some cravings and thoughts when I get nervous, but nothing really happens until I take that first sip... I just don’t buy the idea that when you have a craving, you can’t deal with it or stop... Nothing physically takes over my body or my mind that all of a sudden I am at the liquor store, buying it, not knowing what I’m doing. I make that choice. Because last time I had that relapse, I was walking to the liquor store and I talked so hard to God, and I had about six weeks sober before I had done that. I remembered my promise I made to God, and it came right into my head and I totally blanked out those thoughts until I got there. I almost stopped and turned around. I said, ‘Turn around, just turn around! You don’t need to!’ And I said, ‘Nope.’ And I made an excuse, ‘I’m just going to buy a little bottle.’ And then I bought a liter. And I said, ‘I’m just doing to drink a little bit.’ There is choice involved, there is definitely choice.”

Even as Adam accepts the brain disease model, he refuses to construct his relapse as the product of overwhelming pathology, asserting “nothing physically takes over my body.” He relates a failed attempt to stay sober, but holds firm to the conviction that there are numerous “choices” along the way to “the first sip.” Although Adam claims that “something happens” after that first sip, the addict retains a great deal of agency to reroute a potential relapse. The process of becoming better self-managers then, for Adam and for other advantaged addicts, entailed taking active roles as desiring participants in their own recoveries. Their middle-class cultural toolkits had been forged by the neoliberal logics of self-management, making therapeutic reinvention a project that they “recognized.” With Bridges model of self-making, they could conquer and tame the addict within, guiding themselves toward a sober future.

Working-Class Addicts & “Recovering Co-Dependents”

Working-Class Addictions in an Uncertain World

Unlike the middle-class “weekend warriors” whose drug use was closely calibrated to the rhythms of the work week, working-class men’s addictions were tied to their fluctuations in an uncertain labor market. Those addicts in the sample hardest hit by the recession had experienced downward mobility from middle-class status. Others, like the younger working-class addicts, had simply “failed to launch,” resembling Jennifer Silva’s anxious working-class youth stuck in perpetual adolescence (Silva 2013). For both groups, the anxieties and uncertainties of low-wage, temporary labor shaped and patterned drug use. Trapped in increasingly precarious positions within the labor market and lacking a dependable resource flow to fund their addictions, their drug use mirrored the fluctuating instabilities and chaotic temporal arrangements of their lives. Their experiences illustrate the effects of economic instability on both poor and working-class men—mounting stress and failing health; a profound distrust in authority, institutions, and relationships; and a sense of hopelessness and despair about the future (MacLeod 1995, Putnam 2000, Silva 2013). The men who assumed these patterns and narratives were more racially mixed, and included a wider age range-- both college-age participants

and men in their 50s—although there are important generational divides that I will discuss in the following sections.

Cory's story provides an illustrative account. Cory is a 25-year-old, working-class, white male who grew up in the Minnesotan city of Maplewood. His father, who had been physically abusive to his mother, left when he was young to deal methamphetamine. A string of abusive men subsequently entered their lives, as Cory's mother struggled to make ends meet on her meager pay as a school lunch lady while waging her own battles against alcoholism and depression. Cory was deeply anxious about the future when I interviewed him at Healing Bridges in the spring of 2014. After a failed attempt at community college, he had moved back in with his mother, bouncing in between various low-wage jobs to supplement the household income. "Family dysfunction" resurfaced repeatedly as a lens through which Cory made sense of his addiction.

"It's a big dysfunctional family. My grandparents they try to be there, but I don't think they get it so much. They say, 'Just stop drinking, just get out of that house.' I wish it was that easy, or I would have done it. I think for that reason, I can't stay motivated and I'm really hard on myself. I don't even like the way I look in the mirror most of the time... It's just too much, but yeah, it's stressful. I guess that's why I'm more reserved... I have low self-esteem. I think that's why I drink so much."

Like other addicts in the sample, Cory framed his drinking as a form of "self-medication"—salve for failing physical and mental health, daily stressors, and emotional pain. Consider his reflection about how he used alcohol not to dampen the stress of too much activity, but to rouse himself from a more depressed state.

Cory: "I got fired from both my jobs going in drunk too many times. I was going to the bar on my break, sneaking vodka in these tiny little flasks, just something to keep me motivated... Just kind of, I don't know, the liquid courage thing. I'm not afraid to speak my mind, I really like that. Some people say it calms them down but it gets me, like, hyper and I feel more motivated like Superman kind of."

Sarah: Where were you working?

Cory: Spencer's Gifts in Fawndale Mall as an assistant manager and Payless Shoes in Mosswood Mall. It's just exhausting. When I got fired, I was like 'I can't afford this,' but you always find a way and stuff. I'd be taking the bus to the

Half Price Books, digging out of their trash because they don't destroy anything. Find DVDs, CDs, vinyl, video games all that stuff, fill up a garbage bag, walk right in the front door and sell it back to them. Get at least eight bucks, go to the liquor store, buy a bottle, and take the bus back home. Put in a movie, drink, and pass out. Every day. It's just exhausting.

Sarah: When you were working steadily and making money, did you try to keep your drinking contained to your off hours?

Cory: I tried to get home, and I tried to monitor it, like, limit myself. I was like, 'Okay, I'm just going to have a couple, you know, but that never worked. The next day I'd be going in late, calling in sick, or just going in completely shit faced. I wasn't the only one though. Just the kind of jobs I worked at, like when I got the job at Spencer's, I got hired in as a seasonal associate, but they kept me on and I got promoted and all that. First time I got in, the boss brought in a 24 pack of Bud Light for a new employee. So right away I didn't take that job seriously at all because if she's not, then why should I? And just places like that, where they support drinking like that.'

A general malaise seemed to have taken hold of Cory's co-workers, which was perhaps a factor in normalizing workplace drug use. Tacit approval given by entry level shift managers sent ambivalent messages about workplace intoxication. Other times, their statements were much more direct—as was the case with Cory's boss. Indeed, there were several incidents of alcoholism among low-wage shift bosses in my sample, like Will-- a white, working-class man who managed the afternoon shift at a popular pizza chain. He described how he would routinely show up for work "tanked" and proceed to hole up in his closet sized "office," drinking for the duration of his shift. When questioned by employees, he would simply offer them some beer—and was not often turned down.

In other working-class jobs, drinking was more openly integrated into workday culture. Such was the case for Jonas, whose drinking escalated rapidly after taking a construction job in a small, rural Montana town.

Jonas: "If the guys were drinking at work, we'd go to the bar and it was alright. Boss would buy you a couple shots and a beer, and then we'd go back. And sometimes we wouldn't go back. We'd end up spending all afternoon at the bar."

Similarly, Clive, an African-American man who worked for twenty years in the Chicago steel mills and as a forklift operator, shared that it was common for employees to smoke marijuana throughout their shifts at the plant. He used cocaine and marijuana regularly at work for two decades, convinced that it “made him a whiz on the lift.” While it was more common for middle-class addicts to report that drug use helped them numb the pressure of ever increasing expectations, working-class addicts framed intoxication as a much-needed break in monotony or as a “performance enhancer” that would quicken the pace of routinized work. I talked to delivery drivers who smoked meth “to make their shifts go faster,” for example, or supermarket cashiers who ate psychedelic mushrooms at work “to make things more interesting.” These reflections reinforce, again, the importance of occupational cultures and work norms in disciplining addictions across the class structure.

While instances of workplace intoxication among the working-class might have seemed brazen and could even have been read as active “resistance,” there were crucial departures from the integration of drug use and work culture reported by some middle-class addicts. The limited autonomy of low-skill service work, and the generally greater level of surveillance and policing of employee behavior, meant that working-class addicts were far more likely to lose their jobs due to minor drug-related transgressions. Indeed, Cory had to “sneak” his drinking, and was fired more than once for failing to conceal his intoxication successfully. The working-class men in the study seemed to face a much higher risk of getting sanctioned for workplace drug use or drug-related absence. By comparison, Alan—the surgeon I introduced in the last section—was given multiple verbal warnings across a five-year period before he was finally asked to enter treatment—never actually losing his job. Perhaps the greater *visibility* of working-class addictions on the job can help to explain the much higher rates of alcoholism, illicit drug use, and substance use disorder that have been reported in the working-class occupations of construction, accommodations, food service, and retail sales (Bush and Lipari 2015).

For addicts across the social structure, drug consumption was inseparable from the rhythms of work. But unlike the middle-class “managers,” working-class drug patterns were far less segmented, and less likely to be marked as distinct from scheduled

work periods. The instabilities and uncertainties of their positions in a highly precarious labor market shaped more “unmanaged” patterns of use-- especially among the most besieged working-class occupations. The temporary, expendable nature of low-wage, low-skill labor combined with the often deadening monotony of the workday to make “using on the job” more prevalent among working-class addicts.

Cory, for example, was constantly moving from one job to the next. In our interview, he counted that he had held over 11 different positions in the five years since he’d dropped out of college. While he’d been fired from some of these positions for drinking, most of them had simply ended-- forcing him to find another low-paying job, usually lacking benefits. Cory’s many seasonal or “temp” positions in the service economy shaped his more unchecked consumption. As he says, they imparted a message: “Why should I take it seriously?” He described an unpredictable pattern of drug consumption—one that mirrored the many shifts from stability to instability in his work and school arrangements.

Cory: “I wouldn’t drink like every single day... You know, like ‘I already drank last week, I’m not going to drink this week.’ It was like alternating weekends for a while, but then I had quite a bit of friends and stuff going on. This group had a party one night, and then they’d all be like sobering up to go to work and school, and so I’d be doing the same thing. But then this group of people were having a party, so then I’d go with them. So it was just touch and go.

Sarah: Over time, did you increase the amount?

Cory: I think it mainly went downhill after I dropped out of school. That, and then my ma is like my biggest trigger of all. She’d walk to the store and buy me some as long as I paid for her to get something... It was just kind of depressing. I wasn’t doing anything. Dropped out of school, no motivation, a crappy job and all that. Just nothing.”

Cory’s alcohol consumption vacillated between somewhat more managed periods of drinking and more intensive, “all-in” benders. While he regularly drank on the job, getting pulled further away from meaningful activities in work and school only seemed to exacerbate his addiction, leading to more unpredictable and extended binging. While Cory’s despondent “lack of motivation” was almost certainly a response to what seemed like the impossible task of adulthood, it is important to note that many working-class men

compensated for labor market inactivity by pursuing “informal” or other kinds of work obsessively.

For example, Jim, a working-class Arcadia participant recovering from meth addiction, had worked for a trucking company for twenty-five years. Laid off and without work for the first time in decades, he started accumulating “junk” on his girlfriend’s property—old car radios, broken refrigerators, and defunct laptops—convinced that he could refurbish them for eventual profit. Isolating from friends and family, he became more focused on collecting as his meth use increased. Even though many unemployed working-class men could be equally work “obsessed,” they almost never claimed identities as “workaholics,” as the middle-class addicts did. Instead, their behaviors—set firmly outside the formal labor market—were overwhelmingly pathologized by treatment staff and counselors.

Unlike their middle-class counterparts, extended bingeing among the working-class could be constrained by the increasingly lower wage of working-class labor. Yet the heavy economic burden of low-skill, contingent work was repeatedly cited as a reason why working-class participants’ turned to intoxicants in the first place. As more working-class men slid into working poor status, the attendant financial stress compounded their desires to “self-medicate” with drugs or alcohol. Will, a white, working-class male, explained it this way:

Will: “Yeah, so like, I’d have 200 dollars and the rent was due in four days and it’s 500 dollars but if I spent 20 of those dollars on alcohol, I wouldn’t have to think about the fact that the rent was due [laughing]. And for some people it’s a subconscious thing-- they don’t know that they are drinking because shitty things are happening... I know very consciously that drinking is going to make me feel better, and that’s why I just kept drinking and drinking...”

For working-class addicts, job market insecurities were often compounded by other uncertainties and anxieties. Cory, for example, was constantly changing not only jobs but also living situations, his economic fortunes fluctuating further with his mother’s unstable romantic attachments. One of his mother’s most enduring relationships was with a man who worked in a printing warehouse, who provided Cory and his mother with

a stable lower-middle-class income for a couple years. But Cory hated him, and they often fought when he derided Cory for being “a lazy no-good.”

Cory: “Yeah, he’s kicked me out of the house like three, four times because of my drinking. Even when I’m sober, I’ve always kind of been his scapegoat, like if something goes wrong, I’m always the first to blame. He’s always been hard on me. I think it’s because I’m kind of lazy and I don’t really do anything... It’s just hard for me to get motivated. I got depression, I got anxiety. I’m scared of him...”

Sarah: Did you have any pressure from family or friends to come to treatment?

Cory: You’d think that would kind of scare me, but you just build up... You become so numb to all that bull crap over time, just growing up in stuff like that, getting screwed over by people. That doesn’t really phase me anymore.”

“Hardened” by the outside world, Cory was prone to isolation at Bridges, and did not form friendships with the other patients easily. Highly distrustful of others’ motives, he refused to participate in the Serenity prayer or join hands with others in the therapeutic “circle” during the first week of the program. Cory’s initial resistance to both treatment and medication was rooted in his much larger fear of institutions and authority figures, whose constant betrayals mirrored the personal betrayals of family and intimate relationships. He eventually came around, seeing the counselors’ softer style as much more helpful than the “tough love” of other treatments he’d been in: “They seem really compassionate and actually take an interest in my life... They seem like they actually do care and that’s really helpful to me because I’m not too used to that. I guess that’s kind of what I need.”

Indeed, he did seem to be “opening up,” and he became increasingly reflective about the social contexts of his alcoholism as he progressed through the program. On the day of our interview, he was especially excited to share his “aha” moment with me.

Sarah: What do you think is the real reason why you drink?

Cory: Easy question for me. I’m unhappy with my life and how everything turned out with not finishing school. The friends I do have moved on, and I’ve been doing the exact same thing since I was sixteen. People are having kids, people are getting married. They have good jobs and have their own places and I’m stuck here, still doing nothing. It’s just...usually when things get overwhelming like that I tend to just shut down, block everything out completely. I never really challenge myself, because I’m always afraid I’m going to fail, so I

never really try. I lose interest, or it's just like, 'Oh, I'm not going to be able to do that. Just drink, forget it.' Or sometimes it's just the liquid courage, like, 'Okay, I'm going to drink a little bit of this and then I'm going to go fill out a bunch of applications, go meet the manager. But they can smell it on you, so dumb idea.'"

For many working-class men, like Cory, the pathway to addiction was shaped by the challenges facing young adults in the neoliberal era.

Recovering “Co-Dependents”

The middle-class addicts in my study seemed far more comfortable narrating their lives within a highly medicalized therapeutic lens, reinforcing the notion that therapeutic exchange is a “middle-class cultural repertoire” (Illouz 1997, Illouz 2008). Yet scholars have noted that working-class men and women are increasingly remaking themselves in an alternate “mood economy”—one in which the currency is emotional self-management and progress is marked by the ability to triumph over a life of pain and disappointment (Silva 2013). Indeed, as Cory’s focus on family trauma and mental health illustrates, therapeutic narratives have emerged as central coping mechanisms for combating the chaos, hopelessness, and insecurity of the neoliberal order. When institutions fail people-- the labor market, family, marriage—they turn inward, clinging tightly to the therapeutic narratives of *self*-transformation.

Reflecting the broadening of therapeutic sensibilities among the working-class, these men in my study readily grasped onto therapeutic frameworks as they faced a seemingly unending series of economic anxieties and setbacks. Post-industrial working-class identity challenges past understandings of (white, male) industrial working-class adulthood rooted in economic self-sufficiency, rugged individualism, moral order, commitment to God, country and family; and hyper-masculinity (Lamont 2000, Rubin 1976, Silva 2012, Silva 2013, Willis 1977).⁸⁸ Caught between a more traditional

⁸⁸ These important generational divides played out in my interview sample. While some of the older working-class participants had assumed stable, working-class jobs in traditionally masculine fields with strict gender divides – the younger participants, like Cory, were far more likely to have experienced only

working-class masculinity and the post-industrial, more “therapeutic” version of adulthood was the anxious logic of “codependency.”

A pop psychology phenomenon, “codependency” discourse dovetailed with the proliferation of addictions in the neoliberal era (Rice 1996). Codependent relationships are defined as “dysfunctional helping relationships.” A strong desire to provide support, connection, or nurturance—especially if one or both parties are diagnosed addicts—is reinterpreted as a sign of dysfunction, mental illness, abnormal love, or possible “relationship addiction” (Beattie 2013, Schaeffer 2009). Codependency provides a widely resonant framework for understanding addict relationships—there is an endless giver and a compulsive taker, and together, they mutually reinforce disease. Helping an addicted friend or family member with economic support, housing, or emotional care is thus reframed as “enabling addiction,” despite the fact that “cutting addicts off” is just as likely to harm them as it is to support recovery. Like AA, codependency has by now become the pervasive, unquestioned logic of American rehab. A highly flexible discourse, it is mobilized to very different aims and with different outcomes across institutional settings. At Bridges, counselors eagerly took up the language of codependency to address what they saw as the ultimately unhelpful support systems of the more advantaged addicts—widening the net of “disease” beyond addicted men to include their families and primary partners.⁸⁹

“Codependency” emerged in the narratives of many working-class men in part because it offered a way to make sense of the fall from working-class to working poor that many of them experienced. Recall how Cory, economically dependent on his mother, had framed her as “his biggest trigger.” It was not uncommon for the working-class men I interviewed to rely more on family members, domestic partners, or wives as they faced increasing economic marginalization. Unlike the middle-class addicts, whose occupational stability allowed them to mostly keep the masculine “good provider” role

the post-industrial labor market. There were observable differences in amenability to therapeutic orientations between these groups.

⁸⁹ Healing Bridges even ran a shorter, outpatient version of its program designed to treat the “co-dependencies” of the family members and romantic partners of the addicts enrolled there. Arcadia’s “family program” was consistently underfunded, reduced to a single “family visit day.”

intact (although their ability to do so was often conditioned by the “invisible” support of their partners), working-class men found themselves struggling much more. They turned to romantic partners, parents, extended family and close friends to help shoulder the burden of various reoccurring crises— sudden unemployment, loss of housing, or lack of healthcare. As they tried and failed to assume the gendered demands of “providing,” their addictions often escalated—which in turn made them more reliant on primary relationships.

I argue here that the logics of codependency circulating among working-class men in my study were enrolled in broader efforts to shore up the Recession era’s so-called “crisis of masculinity” (Green and Van Oort 2013). By providing a way to talk about working-class men’s increasing economic dependence on women within the medicalized registers of the disease model, any potential or perceived threats to hegemonic masculinity were mitigated. A key aspect of co-dependency’s logic is its mutually constitutive structure. Because it necessarily involved another party in the construction of the “disease,” in this case, it allowed for the partial displacement of responsibility for both economic failure and addiction onto female partners.

The men’s addict status would seemingly cast them in the “taker” role of the codependent relationship. Some men did portray themselves this way, like Richie-- a 43-year-old, white, working-class male from Stillwater, Minnesota. Ostracized and relentlessly teased by his middle school peers, he eventually found acceptance as a guitarist working the local bar scene-- where he also found alcohol, marijuana, meth, and cocaine. A struggling musician, he drifted in between low-wage jobs, working as a telemarketer, a janitor, and a customer service rep for a paper company. After divorcing from his first wife, most of his income went to supporting their two children. Growing increasingly frustrated by his lack of prospects, a third failed marriage and many failed attempts at long-term cohabitation, he began to see romantic attachments as just another one of his many addictions.

“I was codependent, and I didn’t know it at the time... I was kind of depending on women to give me the feelings that I need. The acceptance, the... whatever you get from alcohol and drugs.”

While Richie's narrative focused on his own purported dependence, it was far more common for family relationships and romantic partnerships with women-- who had often become the primary providers in working-class men's lives—to be re-imagined and recast as “triggers” or “toxic enablers” who could make men more vulnerable to both the disease of co-dependency *and* the disease of addiction. Such was the case with Jonas, who was much more resentful in framing his mother as his biggest “enabler” as his economic fortunes declined and his addiction escalated. He saw his own alcoholism as an extension of his father's, a shift worker at a cement plant who inflicted years of physical and emotional abuse on the family. While his story reveals that he and his mother had both been victims of his father's routine abuse, he casts his mother as partially responsible for everyone's disease.

Jonas: “You know, mom, she had to deal with three alcoholics—me, my brother, and my father-- and she enabled me a lot... Well, she enabled us all, you know. Me and my dad were real close, and she is real close with my brother. My brother still calls her ‘mommy’ which I think is ridiculous, but whatever... She is fairly passive aggressive. She'd get pissed, she was tired of the drinking at the end there, but I mean, people didn't get divorced then and they rode it out. I know she misses my dad a lot. We all do.”

Beyond its dubiousness as a clinical concept, feminist critiques of “codependency” have noted that its much stronger association with women only captures enduring gender stereotypes and gendered power imbalances (Bepko 2014, Collins 1993, Cowan, Bommersbach and Curtis 1995). Here, working-class men used the discourse to restore masculine identity by constructing heterosexual romantic partnerships with women as dangerous “intoxicants.”

Melvin's story is an excellent reflection of the codependency narrative within expressions of working-class masculinity. Melvin was a 48-year-old white male who grew up in a working-class Catholic family in Glenwood, Minnesota. An occasional partier for most of his young life, he followed in both his father and grandfather's footsteps by joining the military after high school. He describes a heightened devotion to sports across his life—mountain biking, skiing, and running—which seemed to mirror the

“turbo endorphin rush” he loved about speed and alcohol. Both provided a boost of energy that helped him “forget life’s problems.”

By age 30, Melvin was divorced and living a fairly stable working-class life as a tile worker. His drinking had steadily increased, culminating in his first DUI charge. Shortly after, he met Lynn—the woman who would become his “co-dependent,” and a central figure in his recovery narrative.

“When I first met Lynn, she... let me move in her house. She helped with the boys, she cooked for me, we had great sex, and she smoked and drank with me. Today she would never do that, so I kind of feel she wooed me in there. But that didn’t last long. We stopped being intimate around ’99 because of my drinking. There would be times when she’d pull in 30 cases of empty beer. I had a beer belly because I was self-employed at the time, not only taking care of my boys, but then I would work at night doing tile work and that paid for my car-- I mean, I had money.”

Despite her role as a supportive partner, like he did with his ex-wife before her, Melvin constructs Lynn as a “temptress” who “lured” him into alcoholism, vacillating between blaming her for his drinking and calling her “his best friend.” Lynn provided Melvin with substantial financial support, paying most of the bills and cleaning up after his many benders. While Melvin repeatedly asserts a respectable identity as a “functional alcoholic” who “never lost a job to the drink” and “always had cash on hand,” in reality it seems like his success was more limited. He described a cycle that unfolded as he drank for four or five days, cleaned up for two, and went back to work for the week.

A key turning point came when the small tiling business he worked for was bought out and consolidated by a much larger corporate outfit. Combined with rent increases on the duplex he briefly maintained apart from Lynn, economic struggles forced him to move back in with her. Frustrated and increasingly anxious about his prospects, he isolated on Lynn’s remote wooded lot, building fires at night and continuing to consume thirty-pack cases of beer at a time.

Sarah: “Why do you think [your drinking] started to get more frequent then?”

Melvin: (hesitates) Why did it get that way?... I don’t know, I just-- I isolated, and why did it get that way?... Because I get comfortable with drinking. I get to forget the pain of my divorce, I get to forget how I’m not married and living a normal life as a family. I get to forget the pain that I don’t have my own house,

and that I'm not living where I want to be. It's probably a little self-pity, but I'm a happy drunk. It's not like I'm out there causing trouble or anything."

While it was clear that economic pressures played a key role in the escalation of his drinking, Melvin also affords Lynn more and more agency in his demise, framing her as a dangerous "trigger." Here, Melvin reflects on the nature of his "codependent" relationship with Lynn, which he identifies as the primary source of his problem:

Melvin: "Toxicity in this relationship is killing me. It has taken away who I am and my dreams, my ambition, my integrity... When you have a woman that comes and gives you a ride and you've known her for 19 years-- certain things on her car need to be fixed and I'm offering advice, and she tells me that I'm so controlling about it... She's just like, way negative energy. Granted, she has done some good things for me, but I just don't need it anymore. I want my freedom, and I want to be away from her. She doesn't think I can make it-- she calls me a loser, says I can't get a job because I'm an alcoholic. A loser, are you kidding me? I've done over \$40,000 worth of work on her house, and she says to me, 'You haven't done anything to my house.' I'm going, 'Are you kidding me?' She has a guy come over who does 3 days of work, one of which I spent with him, and he charges \$2,500 because he is getting \$100 an hour, and she has no problem writing out a check, and I could have done that same thing. No, that is toxic... She held a check that I needed to deposit so I could pay my credit card, and I could not pay my bill on time... She probably can't even find the check because her house is chaos. She's a workaholic who can't even walk her own dog. Toxic."

For Melvin, Lynn was not just a detriment to his recovery—she was a "toxin" in her own right. His use of the "codependency" frame here both ignites anxieties surrounding the so-called "crisis of masculinity" in the context of recession-era economic change, and offers a potentially restorative discourse. In this "crisis," men find themselves stripped of the provider role, and a loss of respect and power gets mapped onto both addiction and codependency. In identifying codependent partners—overwhelmingly women—working-class men defined the "real source" of their problems, stoking much deeper cultural anxieties surrounding gender, class and racial transformations. As they salvaged self-respect as men, they "misrecognized" the role of market forces in their addictions.

Addictions were packaged with masculine identity in different ways across my interview sample. Some men, for example, constructed drug use as a refuge from family life-- an activity that enabled them to “just be one of the guys.” In a fascinating classing of drug using “space,” several of my working-class interviewees described the spaces they carved out for “drinking in the garage” or “smoking in the shed,” which posed striking contrasts to the basement or office “man caves” within the homes described by middle-class addicts, and the expeditions “out to the street” described by the poorest addicts in the study. The more their gendered provider roles were compromised, the further their addictions took them outside the spaces of domestic life, illustrating the deep interconnections between gender, class, drugs, and social space.

To a much greater extent than the middle-class addicts, the working-class men saw recovery as a response to emasculation on two levels-- both their economic dependency on female partners and the feminization of their drug dependence (Fraser and Gordon 1997, Keire 1998). As working-class men reacted to decreasing economic power and increasing reliance on domestic partners, the process of treatment was in many ways centered on restoring a compromised masculinity. In framing codependent women as “triggers,” they could reassert themselves, but the transformation should not be read as a simple case of “backlash masculinity.” Healing Bridges attempted to rework masculinity, for example, through emphasizing “softer,” alternative masculinities based on emotional vulnerability (Irvine and Klocke 2001).

As working-class men worked to make new selves in recovery, they often mobilized the most developed critiques of the unquestioned logic of Alcoholics Anonymous. Their reflections seemed to be rooted in a much deeper distrust of institutions. Like Cory, many were suspicious of the motives and agendas of AA’s “helping community,” expressing fears that too much reliance on the recovery world would be detrimental for longer-term sobriety. Will, a working-class, white male, is one example. Will was a young father who was working two full-time jobs in the service industry—one as a delivery driver and one as a gas station attendant-- after financial troubles put his plans to pursue college art on hold. He was one of the more cynical patients at Bridges, and was often openly critical of the program, evidenced by the many

times I glanced over and caught him smirking or laughing at another group member's story. He argued that relying on AA alone would not keep him sober, pushing back on what he saw as an overly authoritarian lifestyle mandate.

Will: "There is a lot of reliance on AA. Some of the speakers tell you everything will be okay if you work the steps, talk to your sponsor and go to AA. And it's like yeah, if you spend your entire life doing that, you'll be lucky to fucking fit in enough time to have a beer, so yeah, you're going to stay sober. But you need to stay sober and resume your life. People were talking about sober dances, sober-- and it's like, 'No!'-- I don't need everything I do in my life to begin with the word sober. I can go to a regular club, or like, a regular concert. I don't need to sit in the fucking sober section at the Metrodome and not drink... There are sober barbecues, sober picnics, sober sports. It's like, I would like to have my own life back minus the drinking."

In addition to critiquing AA, many working-class men questioned the "all or nothing" model of sobriety that was so common at Arcadia, refusing to take up the "never again" mantra of drug use. For example, Douglas, a thirty-year-old, working-class Arcadia participant, had a more "sobering" vision of the future than the hopeful projections of many middle-class addicts.

Douglas: "Right now, in the near future plans, I'm saying I don't want to use. I'm not going to say I won't, because I think that's where I really fucked up every other time, in saying I won't. For now, I'm just going to say I'm not going to, and I don't plan to, and I'm just going to keep it at that. See how long that goes for. I've learned to never, ever say 'never' again, just because life is on life's terms... I can say I'm going to try my best to show up, but someday I might not show up, and life might take over... I had 18 months of sobriety once, and I was never going to use again. I was done. Done. Well then I went out, and relapsed, and that humility kept me from going back to get-- I mean, I had cut everybody off, man. I was done. They were never going to see me again. It was like, 'I fucked up, so now fuck it.'"

While Douglas desired to stay sober, he hesitated to confirm that he *absolutely* would. Like the staff at Healing Bridges, he feared that trying to take on too much in recovery could backfire, leading to disappointment and paralysis—or worse, a self-fulfilling prophecy in which the crippling shame of one relapse would leave him unable, or unwilling, to seek help. Indeed, his last relapse had done just that, convincing him to

embrace a more “realistic” vision of the future. Similarly, Will rejected the logic of all-powerful “triggers” for a more reasonable approach that would allow for proximity to drugs in recovered life.

Will: “I think triggers are bullshit to be honest... Just because I see a beer commercial doesn’t mean I have to drink a beer. I have to go through the physical motions of finding a beer, and opening a beer, and putting the beer up to my lips... My sponsor keeps a twelve-pack of beer in the fridge, and when his buddies come over, he’s like, ‘Can I offer you a beer?’ He’s like, ‘I don’t drink, but would you like one?’ He’s not lying in bed with his mind on that case of beer every minute reminding himself not to drink.”

Working-class projections of the future were more skeptical than middle-class narratives-- the promises of recovery tempered by the reality of instability and uncertainty in their lives.

Treatment, Prison or Death: Recovering the Marginalized Poor

Chronic Poverty, Addiction & Habitus

The chronically homeless, unemployed and impoverished addicts in the study had formed quite a different “addict habitus.” In many ways, their lives reflected insights gleaned from the sociological research, which finds that the poor are more likely to be exposed to violent drug markets (Waterston 1993), view drugs as vital to economic survival (Bourgois 1995), and experience social hardships that intensify the consequences of chronic drug use (Cooper et al. 2005, Friedman 2002, Lovell 2002). The men I interviewed spoke in matter-of-fact, dispassionate terms as they recounted extreme disadvantage and told stories of people getting gunned down on their front porch, witnessing relatives overdose in front of them, and seeing neighborhood friends turn to sex work to obtain drugs. Of all the addicts in the study, they were exposed to the most drug-related violence and victimization-- brutalizing neighborhood despair, entrenched poverty, homelessness, racial discrimination and institutional confinement had become normalized. Addiction was just another inflection of life’s many struggles.

Poor people of color faced compounded obstacles. A lack of opportunities for regular work, the mass criminalization of their poverty and homelessness, and racial bias at every level of the criminal justice system had trapped many of the Black informants in a cycle of prison, homelessness, and addiction. Davon's story is a case in point. Coming of age in Southside Chicago in the 1980s, he witnessed the devastating impact of the crack epidemic on his social networks. It quickly engulfed most of his family-- his aunts, his uncles, and his father—all longtime steel workers who had been displaced as the city was rapidly deindustrialized. His family devastated by economic decline, he followed his grandfather's lead and entered the drug trade, eventually supplying the addictions of his own family members. While he avoided crack at first—determined to work his way up in the dealer hierarchy—he eventually did “pick up,” progressing to full blown cocaine addiction. As addiction set in, he lost his foothold in the local drug economy, and started selling only to support his own habit. In our interview, Davon described the terror that underlie every moment of his active addiction, as smoking crack consumed more of his life:

Davon: “You definitely get a euphoria from using it, and it's just, ‘Wow this feels good,’ you know. But mine was always coupled with the fact that I was always in danger and stuff, too. I was always in danger, and so I always had the damn paranoia... Danger was always following me, even if I was I was sober. I have gotten shot at going into the wrong neighborhood and I've been kidnapped because of drugs and stuff... Hell, even if I wasn't ever using the shit, somebody is going to want to get a piece of it anyways, so somebody is going to come kicking in the door... or the police are going to come, you are going to do twenty years. You are aware of the chances you are taking, but the lifestyle is addicting and stuff.”

In his description of smoking crack, Davon, a Bridges patient, draws on the trope of “lifestyle addiction”—a discourse mobilized by poor addicts of color across the field sites. He relates a sense of painful urgency that is less present in the consumption narratives of more advantaged users.

Davon: “All the time I'm getting high, I'm sitting up there like, ‘Ain't this a bitch, I'm gonna smoke up all this money, not going to pay my bills, these motherfuckers don't care about me, my heart racing like hell, I can't even hold the pipe and stuff, I'm thinking I'm going to die off this next pull, I really won't quit. That was my experience with getting high...I'm trying to relay the feeling to you

so that you can comprehend, I'm paranoid. But I'm peaceful because the dope is here... For a few seconds when I'm hitting it and it's here, I'm safe as long as the drug is there. But now I know for a fact I'm going to run out, and that is the frightening part. What am I going to do when it's gone?"

Davon's nightmarish portrayal of crack use was a raced and classed reflection of the much wider availability of crack in poverty-stricken communities (Acker 2010, Reinerman and Levine 1997). His proximity to violence, incarceration, death and "danger" was a powerful illustration of how addiction was patterned differently across the divides of race and class (Bourgois and Schonberg 2009, Murphy and Rosenbaum 1997). Extreme disadvantage and a deep seated fear of systemic and interpersonal violence intensified the more unpleasant effects of his daily crack use. Other marginalized addicts shared similarly hellish accounts of drug use.

It was also clear that drugs were much more woven into the everyday economic survival strategies of the poor. This chapter focuses on those poor men in the sample who had primary "addict" identities, and whose narratives display considerable evidence of addiction, rather than the Arcadia men whose primary hustling identities were centered in the strong-arm process I examined in Chapter 3. Yet the user-"dealer" distinction was far more blurred among the most economically vulnerable across the study. Almost all had sold drugs at some point, even if only to fund their own habits. Their narratives revealed that even when they were mostly uninvolved in the drug trade, other primary men in their life—fathers, uncles, or friends—had occupied more central roles.

For many, drug economies were crucial for family survival, supplementing household income along with other informal work and low-wage labor. Their stories—like those of Demario, Andre, and Clive featured in previous chapters-- explained initial contact with drugs through narratives of economic deprivation, parental absence, and the gendered expectations to provide. While these motives were enrolled into "lifestyle addiction" at Arcadia, they were interpreted within the more medicalized frames of "growing up too fast" at Bridges. Across the field though, it was far more common for white, working and middle-class addicts to *attribute* their addictions to family trauma, early childhood abuse, or neglect. Even the more privileged clients who were exposed to

the strong logic of “deviant lifestyles” at Arcadia mostly rejected it in favor of a “victim” narrative.

It was the most disadvantaged addicts—and often the most traumatized—who resisted the notion of “victimhood,” instead mobilizing narratives of pleasure and normality around drug use that were highly suppressed within institutional discourse. Although poor addicts had suffered considerable domestic violence and family abuse, often they didn’t see themselves as victims or survivors of trauma. Lenny’s first drug experiences were with marijuana and alcohol on the street corners of Chicago’s Robert Taylor Homes, where he spent most of his young life. By age fifteen, he was regularly snorting heroin, which he said was “just the normal thing to do” in his peer group. Attending “basement parties” in high school, he learned that drugs were just a part of “hanging out.” He described the easy access to drugs “on every corner” that was part of routine social interaction.

Sarah: One of the things I was going say to you when you were talking about growing up and your childhood-- it seemed like you had a rough life in Chicago. Do you think some of that might have affected your drug use?

Lenny: No.

Sarah: Why not?

Lenny: In my groups, we discuss this. They say something in your past might make you use drugs... That’s not true. Ain’t nothing wrong-- that was normal to me! I saw a whole lot of shooting and killing at a young age. That didn’t bring me back thirty years, twenty years ago saying, ‘I’m gonna use this drug to block this memory out.’ The memory is gone anyway.

Sarah: You were around a lot of violence. Do you feel like when you *first* started using drugs, could it have been so you could get away from that?

Lenny: Nope. Like I said before, a group of us just wanted to go out and party. On Friday nights, we just hooked up. It wasn’t like, ‘Man, I need something to block this bad scene out.’

Sarah: So it was just part of what everybody did?

Lenny: Hanging out, yep.

One reading of this passage is that Lenny was resisting a therapeutic interpretation, refusing to medicalize what he saw as the reality of his everyday life. But

without any recognition of structural context, Lenny's remarks on the centrality of drugs in the culture of "hanging out" were quickly enrolled into Arcadia's disparaging version of "lifestyle addiction." Indeed, narratives of personal responsibility for addiction were the strongest and most developed among the folks with the least agency. Poor addicts described being violently victimized by gangs, other drug users, and "the system" to a far greater extent than working or middle-class addicts did, yet they were the least likely to claim identities as "victims" or "survivors" of trauma. In part because of their greater exposure to the strong-arm model, they saw themselves as making choices to engage in deviant acts, not as victims of a disease. Even the handful of poor patients at Healing Bridges struggled with this. For example, while Clive and Demario been drawn into a more medicalized "victim" discourse in their Bridges group, they struggled to articulate it on their own in the interview study.

There were some important exceptions though—like Arcadia participant Avis, who described using marijuana to self-medicate against the violent, emotional strictures of street masculinity.

Avis: "It was like a stress reliever. I done dealt with a lot of issues in my life, growing up. I had experienced a lot of deaths growing up. So I got a real bad case of depression, and PTSD... Seen a lot of my friends get shot and killed. When I smoked weed, it was just like a calming thing... and that was my medication... I could have a sense of humor now because before then, it was always about being hard. I gotta keep up a straight face, I gotta keep this image going. I can't break. But when I smoked weed, it was like... it gave me my sense of humor back."

Poor addicts described lives marked by unpredictability and instability, on the one hand—and the fatalistic knowledge of their higher likelihood of experiencing violence, death or early incarceration—on the other. As other work illustrates, those who anticipate early death are less likely to delay present gratification for some far away, future payoff perceived as rather unlikely (Brezina, Tekin and Topalli 2009, Topalli, Brezina and Bernhardt 2013). In general, poor addicts lacked other "consuming" projects-- and a dearth of regularly scheduled employment or educational opportunities meant there were far fewer clearly demarcated lines between work and leisure. This, combined with the fact that drugs were readily available in poor neighborhoods-- but less

financially accessible—meant that the desire to go “all out” when drugs were within reach was heightened. Poor addicts’ consumption was thus shaped to fit a pattern of more regular, daily drug use punctuated by incarceration or institutionalization. When I asked Davon to describe “a typical day” during the height of his addiction, he mapped out its chaotic temporal arrangement, saying:

Davon: “A lot of the time, I didn’t know where one part of a day ends, and another part begins, to be honest. You know what I mean, there was no regular business day, like nine to five. It wasn’t like, ‘I’m going to stop selling now, and I’m going to go relax and smoke.’ It was just kind of, ‘Okay, I’m going to go here and while I’m over here selling, I’m going to dip out in one of these little junkie houses... And I’d smoke me up some dope too, and try to sit around and calm down, but I can’t calm down because I have all this damn dope I want to smoke, but I know I need to go out and take care of business. It was hell... I mean, no day was typical. I’d get a smoke in whenever the hell I could, and as often as I could. There was nothing normal about a typical day... It was sell drugs, smoke drugs, get more drugs, and that was a typical day. A rational person wouldn’t understand.”

Drugs were woven into Davon’s daily mode. Lengthy periods of unstructured time; few work, family, or school obligations; and constant stressors resulted in extended daily use, limited only by financial constraints or institutionalization.

Many poor study participants understood Arcadia’s mission to “habilitate” by focusing on routine, order, menial chores and small-scale behavioral modification as one way of responding to this lack of “structure” in their lives. Zeshawn, a 21-year-old poor, Black male who was sent to Arcadia after his first drug conviction, told us that the inculcation of structure in rehab had begun to reform the habits he’d developed through years of “having nothing to do”:

“The structure keeps you busy, the classes keep you busy... If they didn’t have no structure, people would just be running wild, and probably wouldn’t care. But when you got structure, you start actually looking forward to doing things and you want to continue going down the same path. As long as you know what you’re going to do, you get used to being on the time line, so you know what to expect... Before, I didn’t even care about structure. I didn’t even care what time it was. I didn’t really ask for the time, because I was never expected to do things. I’d have nothing to do, so I was just living.”

Zeshawn's own life experience meant that the logic of "habilitation" resonated deeply with him—and it seemed like a sensible way to begin installing the structure he thought he needed. But as I explored in Chapter 3, Arcadia's efforts to "keep clients busy" were ultimately futile in the context of the much greater obstacles poor addicts faced—blocked labor market access, a lack of educational opportunity, neighborhood decline, hyper-criminalization, and numerous other forms of systemic violence. Yet the logic of habilitation was not only undesirable because it so often failed to produce meaningful results. To the extent that Zeshawn and other men bought into "habilitation," they would believe that overcoming these obstacles was merely a matter of tucking in shirts and "keeping busy"—and any failure to do so would only reflect their inability or unwillingness to diligently "work the program."

Ahmik's story is instructive of many of the themes that characterized poor addicts' accounts. Ahmik, a Native American man originally from Bemidji, struggled to survive with his five siblings on the welfare check and food stamps allotted to his single mother. At 14, he moved out of his mother's home in South Minneapolis and went to stay with cousins who lived on a Grand Portage reservation. For Ahmik, drinking and smoking weed was integral to hanging out with family and friends, an activity that filled up long periods of unstructured "down time":

Ahmik: "All my cousins, we all went to the same school. I've always hung out with family after I moved away from Bemidji. We all smoked weed, and I got drunk for the first time and I liked it up until a point, but I didn't start drinking everyday or nothing like that. But I did start smoking weed like my first day up there, and that turned into a habit, you know... It's so small, that is the only thing up there to do. That's why I started smoking weed everyday-- it was either that or there was nowhere to go, nothing to do. The nearest town is Duluth and that's three hours away, and it's ten minutes away from the Canadian border."

Ahmik found life on "the res" to be "tame" compared to the time he spent in South Minneapolis. But residents of the nearby town where he went to school felt otherwise. In our interview, he described his early experiences with racism:

Ahmik: "They would kind of talk shit, and people would give us dirty looks. The only Natives that were up there were from the res, and everybody knew that, but we would have to come into town to go to school, and everybody just looked at us

as drug users and alcoholics, shit like that. I mean, that's pretty much the statistics or whatever of Natives, but... we had to come into this town and they just looked at the res as being a bad place to be, but it's one of the most beautiful reservations that I've ever seen...I was loving it, being a city boy and shit going up there I was like, 'Damn!' It was nice to me, but then we had to put up with the racism and shit, and I didn't understand it because that was the first time I have ever dealt with it."

With few job opportunities and active discrimination, Ahmik turned to drug sales to get by, fulfilling the stereotypes of teachers, administrators, and town residents.

Ahmik: "Yep, and that started being the only reason I would go to school, to sell weed. I would supply the res and then I would go into town to go to school, and I wouldn't even fucking go to school-- I'd just ride the bus in and be getting high all day or selling weed up at some kid's house that lived in town."

Selling weed eventually got him banned from the reservation and sent to a juvenile detention center, but he still managed to get his GED and decided to head to Duluth to make a new start with his newborn daughter and his girlfriend, Sheena. Ahmik tried to "go legit" with a construction gig, but after weeks of searching had turned up nothing, he decided to go back to marijuana sales to supplement the housing and welfare supports Sheena was able to scrape together. Soon, he was propositioned by a friend to transition into the methamphetamine market, and desperate to provide extra cash for his family, he accepted.

Ahmik: "I was kind of proud of it—I'd always say, 'Damn, I used to sell meth, sold meth for two years before I even tried it,' shit like that, but I don't know what it was. To tell you the truth, I just looked at it as fucking being a source of money. I didn't look at it as anything fun to do or anything. That's just what I did... That's why it amazes me that when I started doing heroin, that it just fucking took a hold of me."

Ahmik had been introduced to heroin by Sheena. He had finally found work back in South Minneapolis as a roofer, and for awhile, he used heroin or prescription opiates in small amounts to deal with the intense physical pain wrought by long hours of manual labor. Sheena, increasingly erratic due to her own heroin addiction, took their children back to Duluth without him. But the desperate poverty of Ahmik's extended family in

Minneapolis had trapped him there. They eventually moved in with him, an event that led to Ahmik's full-blown heroin addiction.

“My sister, my mom, and my sister's five kids and I were all living in a one-bedroom apartment, and I am the only one that's working, and going to work every day. Everybody's sitting around fucking higher than hell on heroin. We had no furniture, no table, nothing-- just the bed in my room. So I just got sick of it, and I started using. Like, ‘Well, if you guys aren't gonna fucking listen to me, respect that I ask you go to do it somewhere else, then fuck it, you guys are gonna give me some. That how it all started.’”

Laid off after the roofing season, Ahmik was out of work once again. But this time, his escalating heroin habit made turning to dealing less viable as a long-term solution. Frequent injection drug use left him mostly incapacitated, his consumption curbed only by financial constraints. With no more income, no prospects for work, and his habit spiraling out of control, Ahmik's family left him to fend for himself.

Ahmik: “I was fucking four months behind in rent, and uh, sometimes I didn't have any food... Whenever I had the money, I would spend whatever I did have on the dope. I sat in that apartment by myself, and this time, I was off the chain. I started doing meth and drinking, fucking still had a dope habit, doing all that in between parties, and I sat there for like two months... I went to my dad's house in Cass Lake, and his house is rugged as hell. He doesn't have any water or any plumbing or nothing, and I went up there just to get away, out of my apartment and be by myself. But I didn't know, he had kind of fell off a long time ago and had started selling meth, so he's a meth head now.”

Ahmik's story illustrates the shift from “functional” using and dealing, where drugs were positioned primarily as economic supports—to daily use, unsegmented by routine work obligations. The only “buffer” against constant use for Ahmik eventually became his lack of funds. His family—overwhelmed by poverty and drugs themselves—were unable to provide the economic or emotional supports that many of the more advantaged addicts in the study had. Indeed, his family connections seemed to generate new stressors, compromising the few resources he did possess. He eventually became homeless, drifting for several years in the city's heroin market before reuniting with

Sheena and using Minnesota's public treatment fund to enroll in the program at Healing Bridges.⁹⁰

Ahmik and Sheena were undergoing treatment together, determined to turn things around for their family and restore order to their children's lives. They had chosen Bridges because of its buprenorphine program, and after waiting over one month for two spots to open on the unit, they were initially quite optimistic about another chance at recovery.⁹¹ But as the weeks slipped by and with few prospects for post-treatment work, Ahmik grew increasingly anxious and depressed, fearful of leaving the facility.

Across the sample, poor addicts were by far the most fearful to leave treatment and return to the cycles of prison and homelessness that were far more likely to typify their experience. The criminalization of their poverty, homelessness, and drug use made frequent incarceration and state surveillance commonplace in their lives. As violent as their incarcerations had been, many had come to see institutional confinement as a temporary refuge from the stressful "chaos" of life on the streets, the crushing weight of poverty, and other social injuries.

The most "prisonized" poor men were the least likely to see treatment—or time spent in any institution—as a cathartic opportunity for reflection, least of all as a springboard for "self-reinvention." Lenny, whose story I introduced in Chapter 3, is one example. He spent a significant portion of his youth and his adult life in institutions, having been through "more treatments than he can count"-- he estimated 30-- and accumulating numerous criminal charges, mostly related to his chronic homelessness and drug use. According to Lenny, the many stints in treatment and lengthier periods of incarceration were never the catalyst that caused him to stop using heroin, or even to

⁹⁰ Ahmik was one of the few public-fund patients Healing Bridges accepted every year. Given his funding situation, the scarce openings in the buprenorphine program when he applied, and his precarious situation on the street—it was astonishing that he made it into treatment at all.

⁹¹ As the city's heroin crisis escalated, Healing Bridges had become inundated with new admits to the heroin replacement program. During the period of my observations in the facility, the waitlist was never cleared and opiate addicts had to wait an average of three weeks to get in—a fact that deterred many, but especially those struggling with homelessness.

“reflect” on his life. Instead, they functioned as short-term opportunities to “dry out,” connect to desperately needed services, and perhaps receive limited medical care.

The most disadvantaged addicts in the study perhaps not surprisingly tended to project the least hope about their future prospects—exhibiting skepticism that “doing recovery” could bring about any lasting change. Their distrust of “helping professionals” and a lack of faith in other institutions had naturally seeped into their hopeless outlooks on treatment. As I showed in Chapter 3, these suspicions were more often than not reinforced by Arcadia counselors and staff who, despite their best intentions, were still seen by clients as extensions of the carceral state who might be obstacles to their progress instead of helpful supports. Poor addicts were acutely aware that the decks were stacked against them. Consider the reflections of Leroy, a 52-year-old African American man whose one drug felony in the early 1990s left him unable to find work.

Leroy: “It’s about the environment and the struggle. Not having anything to look forward to. You might be lonely and see somebody that you want to be friends with, and they get high... You feel like, ‘What the hell, I ain’t got nothing to lose.’ I got no job now, and when I do clean up, they won’t even hire me. Because you can check people’s criminal backgrounds so easy now. At my age and with the discriminatory practices, my background has a lot to do with whether or not they will hire me.”

Many poor addicts perceived treatment not as an opportunity for personal transformation, but as a cruel test that they were bound to fail—or as just another instance of “doing time.”

“All or Nothing” Moral Dramas

In previous work on Arcadia House, I described strong-arm rehab’s popular relapse prevention technique based on teaching clients to “play the tape out,” or summon up the inevitable outcomes of relapse (Gowan and Whetstone 2012). These exercises were meant to forge an unbreakable link between drug consumption and devastating consequences, continually reminding clients that abstinence was the only workable solution to their problems. Consideration of the possibility of any other outcome was

firmly suppressed, constructed as evidence of the lingering addict-pathology. The second quote that opened this chapter captures Arcadia counselor Mike's exhortation that even one drink was a sign of impending "prison or death." The maintenance of an "all or nothing" moral drama was constantly policed within these facilities, such as when Mike took back control after client Lamar hesitated to "play the tape out."

Mike: "A dope fiend's prayer is 'fuck it!' but we can't live that way anymore. Now I want to hear each of you go around the room and start the sentence 'If I pick up and use again,' and then I want to hear you *get real and get honest*."

Lamar: Well, I don't really know what would happen to me if I used again... I guess something bad could happen.

Mike: Like what?

Lamar: I don't really know... Maybe jail or death... I guess.

Mike: Well, now you're just rationalizing! You *know* what would happen. Some people want to joke and laugh and don't want to deal with the emotional intensity in the room right now, but I'm trying to create an emotion here. It's a life or death issue... I think we all want the friends, family, wife that loves you, dog, and white picket fence here. I think we all want the same stuff here. So don't fool yourself, because chasing the high *always* turns into pain."

Strong-arm logic played on a highly moralistic binary, setting the "straight" world of recovery in direct opposition to the evil "streets" of the criminal-addict's lifestyle addiction. It was a model that poor addicts and people of color in particular were overexposed to, both by virtue of their higher representation in the criminal justice system and their lack of access to treatment outside the public-funded strong-arm system. While Lamar hesitated to embrace the "sobriety or death" mentality in this exchange with Mike, the emotional intensity of all-or-nothing recovery made sense to many of the poor addicts I interviewed. Evocations of "sobriety or death" resonated with the urgent miseries of their everyday lives, capturing the immediacy of their deprivation and the much higher likelihood of violent victimization or early death. As a result, many of them mobilized the "street-or-straight" orientation beyond just "talking the talk," even when they were deeply skeptical about the likelihood of future life change.

It was true that drugs had been correlated with disastrous life outcomes for the poorest addicts across the field. But correlation is not causation, and while addiction had

certainly exacerbated the problems of many poor clients, the causal arrow often seemed to flow in the other direction. Yet the “all or nothing” moral dramas enacted in treatment encouraged them to commit fully to sobriety with little consideration of how the roots of their compulsions might lie in larger social arrangements and inequalities. Mike offered the alluring promise of a “straight life” when he suggested that working the program would somehow lead to the middle-class “normality” he presumed everyone wanted. Any failure to achieve the idealized recovery would be attributed to the fact that clients had failed to play the tape out—evidence of their commitment to “continue chasing the high.”

The “street or straight” discourse could have effects far beyond the silencing of structural critique, potentially reinforcing the very social inequalities that shape addictive suffering. While these techniques were designed to prevent relapse, strong-arm rehab’s dramatic binary was in danger of reinforcing a lack of self-efficacy among vulnerable recovering addicts—mirroring and intensifying the powerlessness the poor already experienced in other realms of life. Understanding addiction as “total enslavement” and viewing any relapse as a sign that the pathological addict had returned led some men to equate even the slightest drug consumption with total lost control. Participants who believed that relapsing was like “flipping a switch” back into madness were setting a potentially dangerous precedent for any future bingeing. Consider this exchange between client Damon and counselor Silas at Arcadia House.

Damon: “But when I get out of here, I still might use.

Silas: Well, what would you do then?

Damon: I don’t know... Let it overtake me, I guess....

Silas: See, these things change your personality. When you go back out there and use, what will it trigger? It will trigger the addict mechanism. Your chemistry doesn’t change. You will go right back to where you were before. It will pull you right back in.”

Like Lamar above, Damon hesitates to mobilize the “all or nothing” discourse, but offers that he might just “let it overtake him,” indicating the potential power of treatment logic for shaping the interpretation, and behaviors, attached to future relapse.

Silas reinforces this idea by reaffirming that Damon’s “chemistry doesn’t change,” encouraging him to see any slip as a sign that the “addict mechanism” has been triggered. Importantly, strong-arm logic constructed the addict as perpetually flawed, rather than “split” into a sick part and an authentic person always fighting to reinstate control. Regardless of time spent in rehab or days sober, once the addict was re-activated, he had transformed into something fundamentally different and all-consuming.

Compared to poor addicts’ accounts of relapse, working and middle-class addicts’ narratives were much more agentic, drawing on the idea of the “authentic self” within who may not always win against disease, but who could still put up a decent fight. In medicalized treatment, they were encouraged to harness the inner self manager, an act reinforced by the relatively higher levels of power they possessed outside of treatment. For example, working-class Will’s rejection of the “triggers” logic and his determination to avoid full immersion in “sober culture” informed his post-treatment plans to “get his own life back.” Similarly, middle-class Jude’s idea that he could transition the same qualities that made him an addict into something constructive was a difficult if not impossible position to take within strong-arm logic. Middle and working class addicts were navigating their own recoveries to a far greater degree than the poor addicts—many of them coerced into treatment-- who were more firmly tied to the logics of institutional control and submission, and deeply fearful of “people, places and things”—even of themselves.

The “all or nothing” binary also betrayed the fact that poor addicts exhibited considerably more control over their drug use than institutional narratives would allow for. Lenny, for example, described using heroin regularly at his part-time job as a parking attendant in Chicago for nearly two decades. After I expressed some amazement that he was able to sustain work for so long while regularly using heroin, he explained to me that he “never took more than he could handle,” and that he always snorted—never injected-- a trend common among other Black heroin users in the sample.

For Lenny, the intensity of “nodding out” brought on by shooting up was a further compromise to control that he couldn’t risk. Early experiences witnessing the overdoses of friends and relatives had instilled a fear of injection drug use in him, and despite being

a lifelong heroin user, he had never progressed to injecting. The slower onset and relatively weaker intensity of snorting heroin had contributed to his ability to be a “functional user” for years. But without a language to conceptualize control as incremental or conditional, many of the poor addicts, including Lenny, framed their recoveries within highly moralistic binaries of “street or straight.”

When the Binary Backfires: The Dangerous Compromise of Triumphant Individualism

While I was not able to conduct a systematic study of how men fared after treatment, the follow-up interviews I was able to conduct suggest that the material realities faced by the more disadvantaged addicts overwhelmed the project of cognitive and behavioral restructuring undertaken in rehab. Men across the study desired the same things in recovery—staying sober, obtaining purposeful work, addressing medical issues, reconnecting with wives or girlfriends, making amends with friends, and being good fathers. Yet it was clear that the poorest addicts stood little chance of achieving the recovered ideal. In the face of unlikely transformation, one position men took was to view rehab as just another form of incarceration, dutifully “talking the talk” while passing drug tests and making court appearances—in order to escape institutional control and the looming threat of re-incarceration.

Another strategy entailed full acceptance of the logic of “lifestyle addictions,” and belief in strong-arm’s program of habilitation. There were many incentives for taking on treatment logic with sincerity. Most staff had become quite skilled at detecting “the fakers,” and court-mandated clients had to prove that they were among the “truly recovered” to stay out of prison. Beyond these immediate incentives, many were sincerely attracted to the hopeful promise of habilitation for radical life transformation, even if those promises were unlikely to pan out.

Those participants who pursued the “street-straight” binary with the most intensity, however, struck a dangerous compromise. Consider Tony’s story. Tony, a 50-year-old African-American male, was another one of Arcadia’s “celebrated graduates,” like KJ—whose story opened Chapter 2. In fact, the two men knew each other well, and

counted each other on a very small list of trusted “sober companions.” Two years after successfully graduating Arcadia’s program, Tony reflected on his experience.

Tony: “I think that the most important thing they taught me is that I’m responsible for me... I’m in control of me. If you just...do what you’re supposed to and stay focused on doing the right thing, you will get the right results. And I got the evidence. ‘Cause I changed so much in the last three years, and I don’t associate with none of the things that I used to... I don’t go to parties... I’m not interested in nothing that I know is chaotic or negative.”

The street-straight binary made the most sense to Tony as a way of thinking about his recovery. He went to great lengths to maintain these divides, equating sobriety with control, responsibility, and “right living.” But his achievement had come at a very high cost—the wholesale avoidance of family, friends, and entire neighborhoods that he associated with the “evil streets” of active addiction. It was best, Tony told me, to avoid any potential “triggers” at all costs and “focus on the good,” lest he fall back into complete and overpowering lifestyle addiction.

To do so, he became highly involved in the local recovery community and embraced a new life full of “people, places, and things” that cut him off from old associates. Like other addicts who vigorously worked the program, he threw himself into recovery meetings and the world of AA sponsorship. But in between NA meetings and sober outings, he suffered severe social isolation. His efforts to build relationships through sponsoring other men in recovery were not as successful as he’d hoped—they often stopped returning his phone calls, or as he put it, “just went back to the bad.”

Tony was so fearful that a negative influence would destabilize his own sobriety, he sometimes dropped potential sponsees himself, refusing to help anyone he deemed as “not really ready for change.” His loneliness was apparent. After our first interview, he looked for ways to stay involved with the project, often calling me to see if there were opportunities for follow-up interviews or if I needed help locating other informants. I saw these repeated attempts to reach out as part of his larger struggle to find purpose and meaning in post-treatment life.

Like so many of the Arcadia men, Tony was chronically unemployed with no real prospects for stable work. His lack of success on the low-wage job market was only compounded by his reluctance to leave the twelve-block radius he referred to as his “safe zone”—the area directly around Arcadia House which encompassed his sober living facility, his three weekly NA meetings, a day program where he often ate lunch, and a small café where men in recovery congregated. From there, he could access the main public transit lines which would take him to and from meetings with his probation officer.

Ironically, Tony’s “safe zone” was in fact stretched across one of the city’s largest open air drug markets. But so devoted was he to Arcadia’s promise of a “straight life,” that he confined himself to a small section of the city with easy access to the handful of institutions which he was convinced would keep him sober. Even if he had wanted to venture beyond these confines, crushing poverty, dependence on area housing supports, and lack of transportation made it unlikely that he could. The “independence” that Arcadia’s model had promised exacted the high price of isolation and dislocation.

Restricted mobility also deeply affected Lenny, who I interviewed three times over the course of the study, both during and after one of his stints at Arcadia. He’d had more success finding temporary employment than most, and in fact was doing better than ever, working at a local farmer’s market during the summers and selling Christmas trees from the same location in the winters. He was still searching for stable work though, after a job he had really enjoyed at a trail mix packing plant had ended. One of the biggest challenges to Lenny’s sobriety was his geographic confinement to the sections of the city with the most active open-air drug markets. There were a stretch of neighborhood blocks directly adjacent to Arcadia that the men referred to as “the plank” because walking them dramatically increased the chances of relapse, especially for those who were fresh out of rehab. This is how Lenny had relapsed after an earlier release from Arcadia. Like many other poor addicts, it was nearly impossible for Lenny to shield himself from neighborhood drug activity, yet he continued to reject the notion that it couldn’t be done.

Lenny: “No, it’s not hard... Shit, you can’t run from it. ‘Cause it’s here, in your neighborhood. Every day, I walk down [the street], there it is. In this building right now, there are drugs in this building. It doesn’t bother me anymore, because I got my mind made up.”

Lenny had been despondent in our first two interviews, stressing that he only ever saw rehab as a place to rest for a bit. But the last time we talked, he had begun to express a change of heart, echoing Arcadia’s individualistic mandate to “choose the straight life.” In the context of Lenny’s life, I began to see how his assertion that he merely had to “make up his mind” to stay sober was a highly appealing logic. Indeed, there was little else he *could* do beyond making the linguistic shifts that he hoped would turn him into “a new person.” Like KJ, he had already moved from Chicago to Minneapolis in the 1980s to escape environmental “triggers,” only to find a similar fate waiting for him on the streets in Minnesota. Even the transitional housing he lived in, one of staff’s recommended “sobriety measures,” was awash in drugs—and many Arcadia clients were afraid of relapsing there.

Facing potentially insurmountable odds in recovery, perhaps mobilizing a discourse of “incredible will” made him a little less fearful, even if he didn’t really believe in it. Among some of the poorest clients then, a “blind devotion” to strong-arm logic was in many ways a reaction to the reality that pitfalls were everywhere and escape was rare, if not impossible. Life had most often left them deeply atomized, fearful of the violence inflicted by institutions and other people. The logic of triumphant individualism was in many ways the only tool they had.

Yet despite the allure of its logic, and its resonance with clients’ lives outside of treatment, the triumphant individualism mobilized by so many poor addicts struck a dangerous compromise. Ultimately, it was based on an “all or nothing” submission to *external* control, making it quite different from middle-class notions of empowerment. While middle-class “self-managers” could harness a sense of control from within, the pathway to recovery for poor addicts, was paradoxically, through coercion and disciplinary submission. This crucial difference meant that when relapse did happen, as

it likely would, the poor were far less able to draw on the logics on self-management that seemed so instrumental in the recovery narratives of more advantaged addicts.

Symbolic Violence: Treatment Logics, Lived Experience, and Misrecognition

My interviews illustrate the ways in which the addictions of men *across* the social structure were escalating, sketching out the social “pushes” toward and “pulls” away from drug use that had patterned their addictions in particular ways. Their addictions were never “created equal.” Instead, they were distinctly patterned by work and family arrangements rooted in social structure. Men who shared similar socioeconomic markers—access to stable employment, steady performance of the gendered “good provider” role, and high occupational status—tended to develop particular kinds of addictions. Through habitus, social structure shaped “the self” at the most intimate level, regulating or conditioning capacities for “self-control” across the life course.

The agency-seizing that typified middle-class addicts’ recovery narratives was both reinforced through dominant treatment logics *and* rooted in the privileges and powers they possessed to shape their own lives in their families, in the education system, and in the labor market. Their social location afforded them a higher degree of self-efficacy and a greater power to effect life change, translating into their understanding of addiction—and their experience of it. As participants’ class and gender identities were compromised, so too was their sense of control, shaping markedly different consumption patterns—and alternate understandings of the recovery project.

Treatment logics were never merely institutionally imposed “productions,” but were always in interaction with addicts’ habitus. For the middle-class, recovery was a highly medicalized process of harnessing the manager within. It was a project that “fit” their location in social space, offering “blueprints” for managing life in a world they actually lived in—one of increasing insecurities, anxieties, and isolation which required the installment of ever more effective self-management techniques.

The working class men in my sample were perhaps more primed for therapeutic self-making than earlier generations, but the process of treatment obscured how their addictions—and their increasing reliance on domestic partners—were both tied to the fluctuating instabilities of the labor market. Rather than capturing the effects of economic marginalization in their lives, the logic of treatment encouraged them to see addiction—and its twin manifestation, “codependency”—as the likely culprits. “Co-dependency” was in many ways a gendered and classed articulation, shoring up the so-called “crisis of masculinity” by recasting men’s economic vulnerability as a kind of dependence that was triggered in part by their addictions, and in part by their codependent partners. A powerful neoliberal discourse, “codependency” succeeded in pathologizing even everyday acts of caring, convincing working-class men that the project of recovery should cohere around the restoration of an independent masculine identity. Despite the power of treatment logic in shaping their narratives, like the middle-class addicts, working-class men were highly invested in the process of navigating their own recoveries, and many were deeply suspicious of claims about the “power of AA.”

The notion of “codependency” did not work to produce the same effects when it was tied to more deeply marginalized addicts. Addicts of color, those court-mandated into treatment, and those who identified strongly with the “hustler” persona were more likely to castigate themselves for failing to assume the masculine ideal, seeing themselves as making deviant choices to participate in “lifestyle addiction.” For those addicts whose “dependencies” extended beyond the realm of family and romantic partnerships to encompass a purported dependence on the state—the language of codependency no longer carried the potentially dignifying and destigmatizing effect. Rather, both counselors and participants applied a much more punitive orientation, seeing the men as fully responsible.⁹²

The external control of strong-arm rehab mirrored and reinforced many clients’ relative powerlessness outside of treatment—in the punitive and paternalistic disciplinary cultures of carceral schools and juvenile detention centers, the low-wage labor market,

⁹² Meanwhile, white affluent men who were legitimate dealers escaped rehab processing altogether, a product of their status as “anti-targets” in the drug war.

various social service agencies, and even family life (Goffman 2009, Lareau 2003, Rios 2011). While resistance was common in strong-arm, poor addicts were less likely to question the basis of its treatment logic and counter it with new or different visions of recovery for themselves-- management by others made sense. Resistance instead meant not snitching, “talking the talk” to get by, or rejecting treatment altogether. The poor were the least likely to see rehab as an opportunity for deep personal transformation—and indeed, the treatment they were overwhelmingly exposed to was mostly unable to offer such an opportunity.

The binary of “street-straight” and the logic of coercion might have resonated with poor participants’ experiences outside treatment, but it also offered a model of recovery with nearly impossible choices. The “straight” world of the recovered ideal was highly incongruent with the realities of everyday life for marginalized men. The skills and tools offered in strong-arm rehab were designed to produce the disciplined subject of low-wage labor, a world which most of these men only precariously occupied. As they took on “lifestyle addiction,” even as “resistance,” they walked right into the culture of poverty trap, validating staff’s interpretation of them as culturally pathological.

For all of the addicts in the study, treatment logics accomplished a profound symbolic violence by naturalizing different forms of social suffering. But the most disadvantaged men experienced the deepest levels of “misrecognition,” and typically had fewer discursive “options” within which to narrate experience. Poor addicts of color, almost exclusively exposed to “strong-arm” logic, had the least amount of material or discursive “freedom.” When they did end up in programs like Bridges, the destigmatizing reprieve of the medical model was only partially extended—and they rarely mobilized its logic in their own recovery narratives. The most marginalized addicts were not called on to do the work of managing themselves, so much as they were being shaped for management by others-- a model of recovery which may have reflected their larger social world, but which did not ultimately shape them for new lives. Ultimately, treatment logics naturalized “addict types” from what were structurally produced and distributed dispositions. In drawing on capacities forged through habitus, they were potentially reproducing the same class-based inequalities in self-making they obscured.

Conclusion: Shifting Governmentalities

Addicts are easy targets in a postindustrial culture so fixated on self-control. Whether punitive or therapeutic, the logics of addiction recovery continually revive and reconstruct American anxieties over the limits of free will. The popular AA maxim “one day at a time”—or as some of the men in this study would say, “one minute at a time”—plays on these anxieties by encouraging recovering addicts to see each and every moment of life as another opportunity to “freely choose.” The spectacular growth of addictions makes sense then, in a post-WWII era characterized by a pervasive “agency panic” which constantly calls into question the boundaries of individual control (Melley 2002). Yet the addicts among us threaten to expose how fragile our notions of autonomy really are—challenging the “free” individual and destabilizing the ideals of autonomy, security, and risk containment at the heart of postindustrial social projects (Lenson 1995, Ronell 2004, Valverde 1998).

It is no mistake that addictions—and the logics of addiction—have proliferated along with the rise of American neoliberal ideology and policy. Privatization and state retrenchment, the destruction of the social safety net, and an increasingly flexible and uncertain labor market have thrust more Americans across the class structure into lives marked by insecurity and dislocation (Alexander 2008, Beck 1992, Hacker 2006, Harvey 2007, Silva 2013). As more people are unable to become flexible self-managers, bending themselves to the relentless demands of a precarious economy and an uncertain future—addiction is a tidy explanation for their failures which both individualizes and pathologizes their social suffering.

It is in this sense that rehab can be considered a central hub of what Jennifer Silva calls the “mood economy”—the therapeutic self-work that is replacing the more unobtainable markers of adulthood such as marriages, stable careers, and families (Silva 2013). The mainstream labor market traps more Americans in a perpetual adolescence and locks them out of economic progress, and in response, they enter the mood economy of psychological fulfillment and emotional triumph. They find the meaning of work in *working on themselves*—battling demons, conquering fears, and overcoming addictions.

Addiction, then, is both a *response* to social and economic failures and frustrations, and a powerful *explanation* for them. The addiction trope works spectacularly well as a “vocabulary of attribution,” providing ready explanations for poverty, crime, unemployment, racial disadvantage, “broken families,” domestic violence, and homelessness (Reinarman 2008a).

The most economically disadvantaged Americans have more urgently material reasons for taking on the logic of addiction. What is left of the social safety net is increasingly distributed through the diagnosis and treatment of various compulsions, and one must adopt the right language—that is, “talk the talk”—before gaining access to crucial resources (Skoll 1992). Drug and alcohol counselors thus become gatekeepers for the state, closely monitoring language and behavior before providing access to housing, educational assistance, employment programs, and limited economic assistance (Carr 2006, Carr 2010, Haney 2010).

Still, the material resources treatment can extend are generally limited. Rehab focuses overwhelmingly on “talk” in part because that is all that many programs can offer participants. Rehab is also a victim of the mass dismantling of the social safety net in the neoliberal era, and it has only recently started to regain some of its public funding priority. Lower-middle-class, working-class, and working poor Americans have been squeezed out of long-term residential programs, and the forms of extended rehab available to poor Americans are increasingly of the punitive variety. Those who need *material* supports to kick addiction—housing, transportation, job training, and healthcare—are all too often those who stand to gain the least from rehab.

It is not surprising then, that the least funded programs often seem to cling tightest to the most moralistic versions of “disease.” In the treatment world, even an “extended” program is usually not long enough to set new habits, let alone “rewire” the addicted brain. With little else to offer participants, programs focus mostly on instilling the right language and effecting small behavioral change. As one of the men in my study humorously remarked, “What does cleaning the microwave have to do with my addiction?” Indeed, rehabbing poor Americans seems to be overwhelmingly focused on their micro-behavioral control. In the context of recession-era labor market crises,

cleaning the microwave has everything to do with addiction recovery, which becomes centered firmly on the project of “habilitation”-- the disciplinary conditioning of marginal men’s habitus for the routines and mundanities of low-wage labor.

Yet missing in this reading of rehab is a recognition of how addiction recovery has been explicitly racialized through the hyper-criminalization of low-level drug offenders and their mass routing into strong-arm rehab. American experiments in governmentality have always “shifted” across the structures of class, race, and the criminal justice system-- but the simultaneous retreat of the American welfare state and the intensification of the drug war since the 1970s has left deeper grooves in the contemporary “tracks” of American rehab. These “tracks” represent more than just separate pathways through the burgeoning network of recovery options. My work develops the insight that the particular “treatment logics” organizing the two-track system are rife with “ideological implications” about their target populations (Carr 2010, Fox 1999, Haney 2010, Hansen and Roberts 2012, Hansen and Skinner 2012, Hart 2013). I analyze the vastly different logics produced by strong-arm rehab and Minnesota Model rehab as reflections of broader shifts and divides in contemporary governance—and as distinct forms of social control working to manage addicts across the social structure.

At Arcadia, addiction was thought to be caused by an underlying “criminal personality” manifest as impulsivity, diminished cognitive functioning, and irresponsible immersion in a “deviant lifestyle.” The innately flawed criminal-addict required shaming and taming, and Arcadia worked with the correctional system under the guiding logic that “force was the best medicine.” Mapped onto poor, marginalized, and largely court-mandated people of color, the not-so-hidden implication was that men in recovery at Arcadia lacked an inherent capacity for self-control—constituting a dangerous threat in need of containment and surveillance.

Yet internal control could be installed through coerced habilitation—a process of behavioral modification that would replace dysfunctional “lifestyle addictions” with “right living,” transforming the state dependent “boy” into the personally responsible low-wage laborer. I examined how this model was put into practice and its effects on the therapeutic process-- namely that it fostered an “anti-therapeutic” environment which

forestalled emotional vulnerability, reinforced a widespread sense of distrust and suspicion, and undermined any real sense of solidarity between clients. Ultimately, strong-arm rehab hyper-criminalized the addict, amplifying and reinforcing stigmatized identity.

Studying prison rehabilitation for women, sociologist Jill McCorkel argues, along with others, that the prison is a key institutional site in the reproduction of racial caste (Alexander 2012, McCorkel 2013, Wacquant 2000, Wacquant 2008). In her work, race was central to the distinction staff and counselors drew between “good girls” and “real criminals”— and by conflating Blackness with “real criminality,” thought to be incapable of reform, historically unprecedented levels of state surveillance and punitive control were justified (McCorkel 2013). While my work draws similar conclusions regarding the racialization of criminality and “treatment resistance,” I argue that these projects extend far beyond the prison walls into what is now the “fuzzy edge” of the criminal justice system— the thousands of “strong-arm” rehab facilities across the country working to habilitate criminal-addicts. That the Black street hustler, who often had the least problematic drug dependency, was the primary object of reform at Arcadia reveals the racial logics of the drug war operating beneath the surface of “habilitation.”

McCorkel’s work also points to some possible limitations in extending my analysis to the treatment of women in strong-arm facilities. Unlike McCorkel’s prison staff who saw addiction among female inmates as a disease that could never be cured, but only managed under constant surveillance, the men’s strong-arm rehab I studied offered the promise—indeed, the mandate-- of the full habilitation and reintegration of the criminal-addict (McCorkel 2013). Arcadia participants were charged with the formidable task of remaking themselves, no matter how unobtainable the recovered ideal was, or how violently the logics of recovery denied their own lived experiences.

In addition to its disciplinary control which sought to modify movement, mannerism, behavior and bodily affect, Arcadia House was also an apt illustration of Foucault’s concept of “sovereign power” – the more forcible iterations of power which have not faded away with the transition to modernity (Foucault 1975, Foucault and Rabinow 1984, Foucault et al. 2003). The threat of re-incarceration reminded

participants of the brutalizing, violent backup which was always present, should efforts to “discipline” in the classic sense fail. As Arcadia staff denied clients available medication-assisted-therapies to ease the more painful effects of heroin withdrawal, or the potentially fatal effects of alcohol withdrawal, some clients endured physical torture as well. This conflict between “therapeutic” and “forceful” discipline reinforced the dramas of resistance and submission playing out within strong-arm rehab-- helping to explain why some Arcadia men were fully “produced” by the discourse of lifestyle addiction, while others steadfastly resisted the label.

Far away from the shadow of the criminal justice system, the men at Bridges were viewed and treated as “different” kinds of addicts. Even as evidence suggested otherwise, they claimed to have come to Bridges “voluntarily” for the treatment of a brain disease which had only temporarily hijacked an otherwise intact capacity for self-control. The medicalized, “dual self” Minnesota Model quickly advanced them from the powerless state of disease to agents in their own recoveries. With the help of talk therapy, medication, and a supportive recovery community, they could transform back into good self-managers. It was a model that considerably destigmatized the addict, offering some reprieve through the sick role that came packaged with a highly developed “disease concept.”

Healing Bridges more solidly exhibited Foucault’s notion of “biopolitical” control-- signaling the more autonomous and self-managing individual of the neoliberal era (Foucault 1978, Foucault 2008, Rabinow and Rose 2006). Bridges sought to produce recovering people who were always on guard-- self-managing a growing number of addictions, vigilantly moderating dysfunctional behaviors, and actively pursuing healthy pleasures and desires. While the Arcadia addict should submit to management by others, the Bridges’ addict could recover his inner self-manager.

Bridges’ notion that the addict already had the capacity for self-management—which had only been temporarily derailed by illness-- was mapped much more extensively onto the white, working and middle-classes—revealing a crucial classing and

ricing of “empowerment,” agency and self-control.⁹³ As more working and middle-class whites than ever remake themselves in addiction treatment, they construct their new selves in opposition to the racial *other* of rehab. While *other* addicts might need coercion, containment, or “tough love” to stay sober, motivated (white) addicts are fully capable of becoming good self-managers by simply mobilizing the agency they already possess. The self-making projects that are so central in the process of addiction recovery have thus become important sites in the construction and reproduction of whiteness and white privilege. The many potential “self-transformations” enacted by the men at Healing Bridges were intimately attached to their whiteness, which afforded them, among other things, the far greater ability to avoid getting labeled as *criminal*-addicts.

Rehab was an ideal space in which to study the production and crystallization of these treatment logics, but the models were never bound to the sites themselves. Indeed, “strong arm” and Minnesota Model reflect much broader discursive orientations enrolled in larger social projects of criminalization and medicalization. I ultimately came to see these separate governmentalities as always “shifting” along with the social identities of treatment participants. The logics that defined how, when, and why addicts should be governed in particular ways morphed as their “target populations” changed. Treatment logics, and the various assumptions they contained about race, class and criminality, “followed” addicts across the field.

The demographic “outliers” I presented in each of my field sites illustrate this well. For example, Justin, the white suburbanite court-mandated into treatment at Arcadia, was able to escape the label of “treatment resistant” that was regularly applied to his Black peers. Similarly, that the white, middle-aged Jonathon was able to align

⁹³ Other scholars have done important work on instances of poor, homeless, and dually-diagnosed men and women receiving treatment under closer approximations of the Minnesota Model. In these instances, the logics of “self-empowerment” or “dual selves” were mobilized in different registers, and these studies are important complements to the analysis here. See: Weinberg, Darin. 2005. *Of Others Inside: Insanity, Addiction and Belonging in America*. Philadelphia, Pennsylvania: Temple University Press. And: Carr, E. Summerson. 2010. *Scripting Addiction: The Politics of Therapeutic Talk and American Sobriety*. Princeton, New Jersey: Princeton University Press.

himself more closely with the predominantly white Arcadia House staff suggests that the project of disciplinary control underway there was not truly meant for him.

While less explicit or exaggerated than Arcadia's versions, anxieties about the dangerous zones of "street" pathology were enacted at Healing Bridges too—meant to construct the racial Other of rehab which stood in opposition to the "ready and willing" Bridges addict. Demario's story, for example, revealed the limits of the medical model's power of reprieve when applied to poor, people of color—and especially those caught up in the criminal justice system. Clive, Demario, and others' alienating experiences at Healing Bridges signaled that they did not, in some sense, align with the institution's script of empowering "self-managers." The mere presence of their bodies elicited the "street" within the largely white, middle-class space of Bridges—exposing the ways in which race and class profoundly shaped the shifting logics of treatment.

Extreme racial and economic inequalities in the Twin Cities combined with the simultaneous "whitening" of the heroin crisis in the programs I studied to provide a stark portrait of the "shifting governmentalities" at work in American rehab. Growing numbers of white opiate addicts were getting "gentler treatment" in the war on drugs, while those labeled criminal-addicts—many marginalized men of color—were being coerced into a punitive, confrontational style of rehab backed by the constant threat of re-incarceration. Historically, more advantaged white Americans have always marked themselves as "differently" addicted. Yet the proliferating addictions of postmodernity, the vast numbers of people remaking themselves in rehab, and the widening gap between voluntary and coerced treatment—all suggest the growing and much more central importance of addiction recovery as a race-making institution.

The broad medicalization of social life shapes much of our knowledge about addictions, masking its other uses behind the neutral "front" of brain disease. Analyses of addiction science can draw fruitfully from Foucault's notion of "the gaze"—the transformation of bodies into medical objects to be classified, examined, and manipulated by medical expertise (Foucault 1989). Instead of whole people with lives and identities outside of rehab, the men across my field sites were, to varying degrees, produced as their diagnoses-- "criminal personalities" or "sick people." The de-stigmatization of the addict

and the limited restoration of autonomy at Healing Bridges were processes that occurred simultaneously with the medical objectification of “the patient.” As both medicine and corrections have diagnosed addictions, addicts themselves have been silenced and disconnected from the social contexts of their conditions.

Many times during the course of this study, I heard people say, “Addiction doesn’t discriminate.” But my work revealed another reality entirely-- one in which class, race, and involvement in the criminal justice system profoundly altered both the ways in which addictions were embodied, and the ways in which they were enrolled into the broader “shifting governmentalities” of medicalization and criminalization. The globalization of free market capitalism is escalating the addictions of dislocated people across the social structure, as they embody the anxieties, uncertainties, and suffering of neoliberalism (Alexander 2008). Yet for addicts at the bottom of economic and racial hierarchies, addictive suffering is compounded by the high likelihood of co-occurring miseries—criminalization, institutional racism, chronic poverty, and homelessness. As my research reveals, addicts entered rehab with fully developed habitus, shaped by the inequalities that structured their positions in social space. From the “managed bingeing” of the middle classes to the uncertainties and dislocations of the precarious working class, to the multiple layers of vulnerability suffered by the poorest addicts—it is clear that addiction does, in fact, discriminate.

Recovery programs and their dedicated staff do indispensable work, helping countless men and women heal deep wounds. Yet as they mobilized treatment logics to make sense of their addictions, rehab staff and participants contributed to the reproduction of inequality by naturalizing the social distinctions between addicts. While addiction recovery may have offered limited opportunities for self-transformation, by individualizing social suffering in distinct ways, rehab prevented any critical assessment of the role of systemic forces in producing and sustaining addictions. The unequal social distribution of suffering was ultimately made to appear “natural” through the shifting logics of addiction-- advancing both the notion that addiction is an “equal opportunity sickness” and the idea that some addicts are just “sicker” than others, requiring a more “forceful” dose of the medicine to recover. The logic of addiction thus provides

neoliberalism with more tools for masking itself by ensuring that we will all turn inward on ourselves and our habits, disconnecting addictions from the structures in which they were produced and “proliferated.” The work of recovery must be accompanied by a greater effort to excavate the structural roots of addictive suffering—an acknowledgment that healing the social injuries inflicted on our communities is inseparable from healing ourselves.

Notes on Methodology

To understand how the “treatment logics” at work in Healing Bridges and Arcadia House shaped recovery across the social structure, I conducted approximately three years of ethnography in the men’s residential portions of these programs. In addition to my fieldwork in these core therapeutic spaces, I also observed related outpatient groups, AA/NA meetings, transitional housing, day shelters, and various recovery events to get some sense of how participants navigated the broader “field” of addiction treatment services. While outpatient treatment is far more typical of how most Americans encounter rehab, I elected to locate my study within extended residential treatment for several reasons. For one, observing men who lived and formed relationships on site enabled me to see more clearly how treatment logics were mobilized through everyday acts of “doing recovery,” illuminating the complex interplay between “discourse” and “practice.” One of my central objectives was to understand how treatment logics were constructed and negotiated by participants—and these processes were likely to be significantly more charged and visible in residential, institutional spaces where the daily organization of life was constantly being articulated through the logics of recovery.

Studying residential treatment also afforded me access to rehabbers for much longer periods of time—which I soon realized was absolutely essential for understanding the recovery process beyond superficial acts of “talking the talk” in group therapy. I had the opportunity to form the relationships and sustained interactions with participants that were crucial for rapport building—and which would have been much more difficult to form in outpatient settings. The stronger connections I formed with participants over time also made it easier to check in with them after rehab. Indeed, several informants contacted me voluntarily after they left the facility to let me know how they were doing or invite me to personal celebrations and recovery events.

There were substantial costs involved in restricting my study mostly to residential programs, however. My observations of social structure—particularly as structure played out through class—were more likely to be polarized at either end of the class spectrum than if I had also examined men getting treatment in outpatient programs. As I’ve

discussed and documented in earlier chapters-- working poor, working-class and lower-middle class Minnesotans are likely to get pushed out of extended rehab into the more affordable, flexible outpatient programs—if they go to treatment at all. Restricting my study to inpatient settings also meant that I was rarely able to follow participants very far outside the spaces of rehab. My sense of who they had been prior to and outside of treatment then, was mostly informed by what I learned about them in the program, and of course, the crucial life history interviews—which I conducted to correct for some of these limiting factors.

As a result of my collaboration with Dr. Gowan and a team of researchers from the *Perspectives on Addiction* project, I began my doctoral work with access to a wealth of contacts, ethnographic data, and interviews gathered from the Arcadia House Men's Program—and several of its related transitional housing programs, shelters, and drop-in centers. By holding gender constant in this project, I was thus able to contribute to and build on a rich existing data source. The vast majority of mainstream rehabilitation programs offer gender-segregated treatment-- meaning that I would have to further divide my time in the field among separate programs in order to study recovery experiences across gender. While studying men's treatment had practical implications at first, I soon discovered how constructions of masculinity were central to the recovery projects unfolding across both of my field sites. While my work can contribute to the contemporary study of masculinity and addiction recovery, further study would be necessary to extend this analysis to women's recovery experiences, which are likely to be shaped in profoundly different ways.

Striving for a good sense of the full spectrum of institutional life, I tried to observe almost all aspects of men's programming—the weekly group therapy schedule, organized daily activities, educational lectures, recreational outings, on-site and off-site AA/NA meetings, staff meetings, family visits, meals, chores, unstructured “hanging out” time, and passes to leave the facility. During group therapy sessions, I mostly acted as a passive observer, unless I was called upon to participate. While it is impossible to expect that my presence did not shape the dynamics of treatment, I tried disrupt scheduled therapy routines as little as possible. For this reason, I opted not to ask permission to tape

record therapy sessions or random conversations in order to avoid any resulting feelings of intrusion among clientele. Instead, I relied heavily on informal jottings during group therapy, interspersed with opportunities to get fuller documentation, and followed up by tape recording or typing a full set of notes after each visit to the field. At the more resourced Healing Bridges, I was generously given a small office space that I used after group sessions to reconstruct dialogue to the fullest extent possible. I also had generous funding support for transcription through the University of Minnesota Department of Sociology.

Throughout my fieldwork, I was cognizant that my role as ethnographer was likely to be interpreted differently across my two sites, and I was sensitive to the implications of conducting observations and interviews with highly marginalized men who had historically been “made visible” through similar processes of data collection. Coerced participants were especially likely to be conscious and distrustful of the presence of staff-- understanding that the production of particular self-narratives could determine their fates. I faced heightened dilemmas in separating myself from staff at Arcadia, but because of the institution’s punitive character, it was even more necessary that I do so.

I consciously sought to diminish my identification with staff by putting distance between myself and the counselors, and by aligning myself with participants as they moved through the program. My gender and my status as “non-staff” initially made my presence hanging out on the men’s treatment unit suspect in both of my field sites. At Healing Bridges, for example, even with my “security badge,” a small office space, and my repeated efforts to introduce my project to any new faces, I still encountered puzzled glances as I interacted with participants in ways that staff and counselors did not—eating lunch with them, sitting with their groups during presentations and activities, hanging out in their open lounge spaces, going on smoke breaks, and walking the grounds with them.

Gender segregation was less strictly policed at Healing Bridges, where men and women ate lunch together and congregated in the same lecture hall during facility-wide presentations. At Arcadia House, men and women were confined to separate wings of the building, isolated from each other for the duration of their treatment. Any attempt to “fraternize with female clients” could trigger a program violation-- and possibly a trip

back to prison—for the court-mandated clientele. That said, Arcadia was a relatively small facility with no more than five full-time counselors staffed for each unit, and within my first full week of observations, most everyone knew who I was. At Bridges, it was easier to blend in with the many people who access the hospital’s public services every day. While my status as an outsider was more pronounced at first, I gradually became known and recognized in both field sites as “that researcher girl.”

Establishing good rapport—one of the hallmarks of good ethnography—was essential for separating myself from staff and counselors. Many clients would inevitably see my presence as an opportunity to “talk the talk.” Consider the following field note excerpt from Arcadia House, describing some of my interactions with client Jamil, who took it upon himself to become my personal “program ambassador,” in my first days on site:

Jamil pointed to the bench in the hallway I was sitting on, outside of the main group room. “It looks kinda funny that you’re sittin’ on that,” he said.

“Why is that?” I ask.

“Because that is the ‘bench,’ you know, the place where people have to sit in humiliation when they break a rule here. Nobody just sits there, because then everyone will think you’re on restriction or you messed up or something... Even worse is when someone has to carry around their luggage—that is the next step after getting the bench. It is supposed to mean ‘you on your way out,’ you know, so everyone can see you’re about to get kicked out if you don’t clean your act up.”

Jamil got quiet and stared at me intently. “I know what you tryin’ to do here. I understand what you’re tryin’ to do. So, I’m gonna help you out, fill you in on things while you are here.”

Later on at the health fair, I stood with everyone outside on a smoke break, where a man everyone calls “Squeak” was talking excitedly to Freddie, Lamar, and Jamil.

“Man, Arcadia is worse than prison,” he says. “I wish I would have just taken the time instead.”

Lamar agrees. “Yeah, just like prison!”

Steve reaches in his wallet and produces a picture of his daughter, which he hands to me with pride. She looks about three or four years old, and is dressed in a fairy costume. I ask Steve how he thinks Arcadia compares to other program.

“Easily the worst of all, it’s the harshest.” He is at Arcadia for a DWI and faces prison time if he fails out of the program. “But I have to do this for my daughter,” he says.

I overheard two women in front of the Health Fair approaching Jamil and offering compliments, saying that he resembled Tupac. Jamil seemed embarrassed, but flattered. “You can still blush if you’re black!” they say, bursting into fits of laughter. They asked him where he was from, and he shared that he was in the Arcadia House program. They immediately interject, offering their strong opinions that Arcadia is “the worst. Worse than Brookside. Worse than Metro Services. Worse than all of them! They be trippin’ over there! They tried to get me in there, and I said, ‘No way.’”

Back on the unit, Jamil made it a point to pull me aside right away, and requested that I tape record his reflections regarding the earlier incident at the health fair:

“Look, I know some people are talking bad about Arcadia, but it really does change your behavior. It is a good program that works for a lot of people and it is just trying to get you to see that your behavior needs to change before anything else can happen. Some people just aren’t tryin’ to see that, you know?”

The fact that Jamil was so eager to extoll the virtues of Arcadia’s model of habilitation—and distance himself from any negative evaluations of the program articulated by other clients—was later revealed to be largely strategic. He had received several negative “logs” from other men in the program, which resulted in his primary counselors relaying a less-than-favorable report to the drug court judge. Jamil had been given a warning—“get with the program,” or risk going back to prison. Fearing that I

might be colluding with staff as well, he made sure to recite the “script” of recovery in any of our recorded sessions. This is just one example of how clients mobilized treatment logics in strategic ways, and it underscores the challenges of accessing and understanding institutional spaces-- especially when those spaces are backed by state coercion which creates high levels of distrust and suspicion.

As an ethnographer, I also faced the far greater challenges that plague sociological knowledge production, especially within highly marginalized or vulnerable communities. It was clear that as a white, relatively privileged, female graduate student, my body was in little danger of being “mistaken,” as Jamil had warned. An “embodied ethnography” demands reflexivity, calling attention to the structured positionality of the researcher’s body as an essential component of the research itself (Holmes 2013, Wacquant 2004). That my informants frequently associated my presence with staff highlighted my relative privilege and social distance from my research subjects—which inevitably shaped the research process, and the extent to which I was able to “know” anything about the suffering of my informants. In addition, although I attempted to gain access to live in the facilities along with participants, it was never granted. Indeed, just gaining access to daily program operations proved to be a challenge. I therefore had the ability—indeed, the privilege—of returning to my home at the end of the day.

Ultimately, I could never “traverse” the distances between myself and my informants forged by race, class, gender, and the criminal justice system. Yet the “life history” interview component of the project provided one way to develop a deeper understanding of the context of participants’ lives, and an opportunity to initiate a more open dialogue about the relationship between social inequality and addiction recovery. The vast majority of the research participants did ask me questions about my own drug use, and I usually shared these personal details in the life history interviews, as they shared information about their lives with me. I tried to use these more intimate conversations as opportunities to build rapport with my informants by sharing some details about my own drug consumption, as well as the addictions of family members and close friends. Yet instead of building rapport through reinforcing the idea that “addiction doesn’t discriminate,” I instead shared that I had been able to accomplish a “natural

recovery” without formal treatment, and like many of the Healing Bridges patients, I had managed to avoid the criminal justice system despite my heavy drug use as a college undergraduate. Sharing these details opened up discussions about my own relative privilege as researcher/observer, as well as the larger role of social structures in addiction recovery. These moments of exchange served to build rapport by establishing a shared human struggle, while also contextualizing my interest in the study in ways that distinguished my work from other kinds of addiction research. Perhaps more importantly, these exchanges helped to create a space of critical distance from each program’s own logic of addiction and recovery.

In most cases, I conducted interviews with clients on site in empty group rooms, and they typically lasted from two to three hours, covering a range of drug and non-drug-related topics.⁹⁴ The first half took more of a “free form” approach, as the men told stories about their childhood and adolescence, major transition periods, and adult lives. Gradually, I asked more questions about their involvement with drugs, taking care not to problematize that involvement, but rather, letting them offer their own assessments of the role of drugs in their lives. In the second half of the interview, I turned to the treatment process, asking them to offer their own evaluations of the program, as well as their opinions about what causes addiction and how it should be treated.

Interviews were conducted with clients who had finished—or were near finishing—the residential portion of their treatment. I interviewed clients with no fewer than two weeks time in the program, and with no more than 3 days until discharge. I also restricted interviews to only those clients whose primary therapy groups I had observed so that I could have some context of how they were faring in the program. The timing of these interviews mattered in important ways. Obviously, I wanted to ensure that participants had at least some long-term exposure to treatment logic before conducting an interview, so they could articulate their responses more effectively. Second, I wanted some time to get to know them first through the ethnography. By the time I sat down with an interviewee, I usually knew him quite well already through what had been shared in

⁹⁴ See the Interview Guide Appendix for a detailed list.

group and in informal conversations. This allowed me to compare their “performance” in group therapy with any discrepancies that might arise in their interview narratives. Not surprisingly, I found that people often felt quite differently about their prospects for recovery, the various institutional dynamics at play, and their relationships with counselors and other clients than what they were willing to reveal in the group circle.

In the case of Arcadia clients, conducting an interview after graduation—or as close to graduation as possible—was crucial for distancing from the pressure that many felt to read the “script” of recovery in order to demonstrate “true change” and avoid re-incarceration. By the time they were in the aftercare portion, many felt they’d “made it” through the toughest part of residential treatment, and their reflections on addiction and on the program would be less tied to institutional pressures. Further removed from the trials of inpatient treatment, I hoped they’d feel more freedom to critique the program or offer competing explanations for their problems.

Conducting interviews after an extended period of ethnographic field work also increased the likelihood that informants would not identify us as staff members or authority figures, or fear the information they offered could jeopardize their status in the program. A good interview depended on good initial rapport, but the interview itself was also an opportunity to create or strengthen a sense of trust. The interview was a sanctioned space, and one of the few which allowed me to spend several hours alone with a client without arousing suspicion. As such, it provided valuable one-on-one time and some critical distance from the program. While I expected program participation to shape their narratives in important ways, the “life history interview” also provided a space for participants to unpack their biographies in a way that did not require them to speak as “the addict.” The stories they shared were sometimes radical departures from how they spoke about their lives in other contexts.

I came to see my interviews as absolutely crucial supplementation to my ethnography. In fact, many of my key insights would not have emerged without them. Beyond providing a useful way to compare participants’ narratives with observations of their behavior, they also helped me establish a connection to participants outside the

confines of the institutions—enabling me to examine the interactions between treatment logics and habitus.

The inability to conduct interviews with very many men who had dropped out or been kicked out of the program constitutes a limitation to this study. I soon learned how difficult it would be to keep tabs on folks after they left treatment. Many of the Bridges clients were eager to get back to family and work, and some also wanted to cut any potentially stigmatizing ties with the program. For the Arcadia men, the same challenges that had shaped their pathways into treatment were waiting for them on the other side. They struggled to find work, they became homeless, many ended up back in the drug trade, and many went back to prison. I did have a few invaluable informants across my sites—like KJ, Justin, Kevin, Tony, and Lenny—who I was able to interview multiple times and in different contexts.

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Appendix A: Interview Guide

Unequal Treatment Interview Guide

Combined Arcadia House and Healing Bridges Guide

Introduce project—show them the areas we’re going to talk about.

1. Get informed consent signed, explain confidentiality. Give copy to interviewee for records.
2. “This interview will have no impact on your relationship with this institution or with the University of Minnesota. You will be protected with full anonymity.”
3. This will take around two hours—make sure they have enough time.
4. Explain interactive chart, invite informant to participate.
5. Provide date of birth, current age, and contact information.

Part I: Biography

A. Origins & Early Life

Fill out **graphic chronology sheet** as you go, marking either years or ages.

So, I'd like to start out by getting a basic sense of who you are and what your life has been like up to now.

1. *What kind of world did this person grow up in?*
Let's go back to your childhood. Tell me about growing up. What was your home life like? What struggles did you face where you grew up?
Tell me about your parents. Occupation, education, income? What was your relationship with your parents like? (Communication, discipline, authority roles?)
What social class do you think your family was when you were growing up?
2. *Isolation vs Community, Early Socialization and Routines*
Did you have a good sense of community growing up? Tell me about your friends growing up. Would you say you had a lot in common with them? What neighborhood did you grow up in? What was it like? What sort of activities did you do as a kid? How did you spend your time? Was your family religious? Were you involved in religious activities?
3. *Educational Experiences*
Tell me about the school you attended. What was school like for you? What was the last time you attended any kind of school? Did you graduate high school? What happened after high school? What were your aspirations around that age?

B. Entry into Drug Use

1. How old were you when you first used drugs or alcohol? Tell me the story of how that happened. Which drug, how much, who with? From what you remember, what did getting high for the first time feel like?
2. When you first started using drugs, did you use alone, or in a group? What were you doing when you were using-- did it revolve around any activity? Who with?
3. When did you switch to using other drugs? (What drug, how much, method of intake, when and how long?) What were the circumstances? As your use progressed, did you usually use drugs alone, or in a group? Do you think your social group has changed since you started using? How?

Preamble into the experience of using drugs...

Now let's talk a bit about your experience of using drugs/alcohol.

1. How did you first feel when you got high? How was this different from when you were not high?
2. If you were to take a typical day or week during this period, can you describe how using fit into your routine, or got into the way of it?
3. What would you say your "drug of choice" is? Why that drug in particular? In your periods of heaviest use, what did that look like? What would you say the physical/emotional effects of using were?
4. What did a typical day look like when you were in your period(s) of heaviest use? What time(s) of the day did you use? Were you working during these times? How was family life/relationships?
5. How did you pay for drugs? Who/where did you generally buy them from? Were you ever involved in selling drugs?
6. Capture important changes over time in feelings experienced, and get a sense of key physical/emotional effects: relaxation, confidence (lessened inhibition), feeling of connection to others, pleasure, escape, excitement (thrill-seeking), intensified taste, vision, music, "tripping"/ altered perception, comfort/safety, increased concentration, staying awake, going to sleep.
7. Any positive effects of drugs/alcohol? Is there anything positive that you want to say about your experience using or experimenting with drugs? Did it make you do some things better? Did it help you to avoid some kinds of problems?
8. Negative effects of drug/alcohol? When did it turn into a negative experience?
9. Changing/expanding drugs of choice? Why did you transition to using these other drugs? Did drug x do something different for you?
10. What drug would you say appeals to you most now?

C. Adult Life and Drug Use

(To what extent were patterns of drug/alcohol use "packaged" with other aspects of life? i.e. work, peer groups, orientation towards institutions like church, school, family, or "the system?")

1. Now tell me a little bit about working as an adult. What kinds of jobs have you had? What was work like for you?
2. How predictable would you say your daily routine was?
3. Do you think your drug use had any effect on your employment (if employed)? Did you ever go to work high or use drugs at work? How often? Any changes over time?
4. What has your living situation been like-- alone, roommates, parents, or family?
5. Tell me about your family. What is your relationship with them like/ how often do you see them? What has been your role within the family? Does your family provide any support?
6. Were you ever married/in a long-term relationship? Do you have children? What is your relationship like with them?
7. [If you lived with your family] Did you use drugs within the home? When/where did you use?
8. Does your family know you're in treatment now? How have they reacted to your drug use? Has that changed over time?
9. Tell me about your friends. How often do you seem them?
10. Tell me about what you would typically do in your free time. Did you have any hobbies, or were you involved with any groups or organizations outside work/school?
11. On a typical day or week, how did using fit into your routine, or get in the way of it? Were there times when you tended to use more? Were there any times when you wouldn't use at all?

D. Turning Points & Relapse

1. When was the first time you remember having a negative experience with drugs? How did you deal with that experience?
2. When did you first start seeing your drug use as a problem? Self-identifying as an addict? What led to that?
3. Would you link your drug use to any negative outcomes? What were they? Would you say you had a "rock bottom?"
4. Looking back, were there any major periods of sobriety for you? When, how long? What was life like during those times?
5. Do you feel you have relapses? What happens when you do?
6. What does "relapse" mean to you? Do you see any patterns to your relapses over the years? Do you think anything in particular "triggered" you? (Identify most common pattern, "triggers," micro conditions [e.g. hooking up with using friend, going to particular places, relationship problems, etc.] and macro conditions [e.g. change in living situation, unemployment, getting paycheck.])
7. What did your relapses typically look like? What is a relapse, for you? (Try to understand if every lapse becomes a dramatic relapse, or if there is some sense of being able to pull back from small slips.)

E. Criminal Justice

1. Query about episodes of incarceration and notate on the chart as carefully as possible, again getting field partner to take an active role if possible.

Possible segues: Did that get you into trouble with the law? I'd also like to know if you've ever been to prison or jail. Can you tell me when those times were?

2. Experience of prison, effects on person during and after
What kind of experience was that? Do you think doing time changed you? In what ways?

F. Treatment History

1. Give me a brief sketch of your treatment history. How many/where? Outpatient/residential? Do any of them stand out to you as particularly helpful or not helpful?
2. Did you manage to maintain sobriety while in those treatments? What about after?
3. Did any of these treatments hook you up with resources that you needed? (Housing, training, a source of income)?
4. Have you been very involved in AA/NA prior to coming here? What about other recovery groups?
5. Have you ever been court mandated to treatment? Have you ever been arrested? For a drug offence? Have you ever spent time in jail? Prison? How long? Drug court? Are legal troubles impacting your life right now? How?

Part II: Inside the Program

(Re-emphasize confidentiality, and the importance of getting an honest evaluation of program-- its best and its worst-- from the client's perspective. Encourage them to talk through how their perspectives might have changed.)

Your identity will not be revealed to staff.

G. Arrival and First Days in Treatment

1. Was this your first treatment here? Why here? Had you heard much about the program before coming here? Did you know anyone who had been here?
2. Describe the events that led up to you coming to here. (Self-referred, family, or employment/criminal justice?)
3. In the 30 days before you came to here: Were you arrested at all? Did you spend any time in jail? Were you homeless? Were you working? Living situation?
4. Are you here through drug court? Other criminal justice? What would have been your time if not for treatment option?
5. In the 30 days before you came here, which drugs were you using? How much and how often?
6. How did you pay for treatment?
7. Did you detox here? Tell me about that.

8. Were you given any mental health screenings or services while here? Are you taking any prescribed medication now?
9. Tell me about your first day in the program. First impressions?
10. Describe a typical day in this program. What are you expected to do?

H. Assessing the Program

1. Tell me about your relationship with your counselor(s). How often do you see him/her? How helpful have they been for your recovery?
2. What are your impressions of other clients? Have you developed any close relationships here? Do you relate to the other people here-- do you think they're like you?
3. What aspects of this program would you say are most beneficial to you? Is there anything that is not working for you? If you were running the program, would you change anything?
4. (For Arcadia) Were you ever a coord here? What's that like?
5. (For Arcadia) What do you think of "report group"?
6. (For Bridges) Do you think 21 days of the Phase I treatment is enough time for you?
7. How much personal freedom would you say you have here? Should it be more or less?
8. Rate each of the following program aspects on how helpful they were for you, -3 for having a very negative impact on your recovery, 0 for being neutral (no effect either way), and +3 for having a very positive impact on your recovery.

- Structure and daily routine
- Relationships with other clients
- One-on-one time with counselor(s)
- Group therapy
- Report group (Arcadia only)
- Criminal Thinking groups (Arcadia only)
- Addiction assignments
- Lectures
- Workshops
- AA meetings
- Family Program (Healing Bridges)
- Visiting hours
- Mental health services
- Free time/leisure activities
- Amenities: food services, living quarters

9. Why do you think (x) had a positive/negative impact on you?
10. How often have you been drug tested here? Have you stayed sober in the program so far?

11. Did you encounter any problems in treatment here? Problems following rules, negative interactions with staff or clients, etc?
12. Do you think this program changed you? *Behaviors? Thoughts* about drug use or addiction?
13. Has the way you see yourself or your past changed at all? Did you have any "aha" moments here-- any conversations, stories, lectures, or interactions that stick out in your mind?
14. What do you think of the process of group therapy? Has it been difficult to share with the group? Is it hard to talk about certain things? Do you feel you had to adjust to the process at all?
15. Try to get at (a) the uniqueness of the program, and (b) any strong sense of conversion or turning point within treatment. *Has this program had a big effect on your way of understanding addiction? How did your experience here compare to other treatments you'd been to?*
16. Do you think this place is a good fit for you? Do you think this program works better for some kinds of people rather than others? (Who?) Why might that be?
17. *What do you think addiction is? What causes it, and how should it be treated? What kinds of behaviors can be addictive?*
18. Do you think addicts are fully responsible for their actions when they're using? Is addiction a choice people make? Is addiction a brain disease? Why do you have these views?
19. What about Arcadia/Healing Bridges' model of addiction-- same? Would you say you learned anything new here?
20. Were you involved with AA before coming here? How important are the Twelve Steps to you? Why/why not?

I. Social Stigma, Public Policy Perspectives

1. How do people make you feel when they find out that you have used drugs? (landlords, social service providers, old friends/family)
2. What is your opinion on US drug policy? What do you think of arguments for decriminalization or legalization? Should dealing be punished? How harshly? What about possession? Do you think drug courts should send drug offenders to treatment instead of jail/prison? Do you think injection drug users should have access to clean needles? As a society, how should we treat addicts?
3. If drugs were legal, would drugs have affected your life more or less? Do you think your relationship with drugs would have been different if your life had been significantly different? How?

J. Transition to the "Outside"

1. Do you plan to go to any post-treatment groups? How important do you think continuing in outpatient or sober groups is for your recovery?
2. What was your counselor's recommendation for when you leave? Do you agree?
3. What are your plans for when you get out? Where will you be living-- what neighborhood, with who? Do you think that will be helpful for your sobriety?

4. What about employment-- plans for that? Do you think having a job helps you stay clean? What kind of job do you think you'll get? (*Get rough sense of what kind of job—temporary, agency work, day labor, skill, status, wage?*) Are you getting any kind of state support at the moment, like GA, GRH, or SSI?
5. How involved do you think you'll be in AA? Other sober networks? Do you think these networks will provide any kind of support? Emotional, economic, other?
6. What role do you think your family will play? Friends? Co-workers? Other groups?
7. How do you think you'll spend your time when you're not using drugs?
8. How confident are you that you'll be able to stay sober? Are you worried about anything in particular? Do you foresee any obstacles-- what are they? How do you think you'll deal with those things?

K. Recovery/Wrap-Up

1. Can you say something about what it means to be in recovery, for you?
2. Is recovery about just staying sober from drugs/alcohol, or is it more than that? Do you think you have to be totally clean to be doing well? Are you trying to maintain total abstinence?
3. Do you think it is possible to control some aspects of drug use?
4. What do you think would happen if you used again?
5. What do you see as being most important to your recovery?
6. When you think about your relationship to drugs in the future, where would you like it to be? What are your plans for the future? The next year? What about ten years from now-- where would you like to be then? Ultimately, what kind of life would you like to have?

END – THANK YOU!

Distribute gift card. Do you have any friends we can talk to who didn't finish the program?

FILLING OUT THE CHART

- For drug use, record names of drugs they were using and method of intake.
- For treatment history, record facility name and model, source of referral.
- For incarceration, record the name of facility.
- For relationships and home situation, record who they were living with at different times. For homelessness, record helter use and current neighborhood.
- For post-treatment groups, record how often they were coming and what other services they were using (counseling, case management, group, etc.)