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Addiction as accomplishment: The discursive construction of disease

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Abstract
The ubiquity of the disease concept of addiction obscures the fact that it did not emerge from the accretion of scientific discoveries. Addiction-as-disease has been continuously redefined, mostly in the direction of conceptual elasticity, such that it now yields an embarrassment of riches: a growing range of allegedly addictive phenomena which do not involve drugs. This article begins with questions that have been raised about whether "addiction" is a discrete disease entity with a distinct etiology. It then summarizes the historical and cultural conditions under which addiction-as-disease was constructed, the specific actors and institutions who promulgated it, and the discursive procedures through which it is reproduced and internalized by those said to be afflicted. Understanding how the dominance of additiction discourse was accomplished in these ways does not imply that the lived experience of what is called addiction is therefore any less acute or compelling. But it does invite attention to the contradictory uses of disease discourse: a humane warrant for necessary health services and legitimation of repressive drug policies.

Keywords: *Addiction, disease, social construction, history, discourse*

> An ideology is reluctant to believe that it was ever born, since to do so is to acknowledge that it can die.... It would prefer to think of itself as without parentage, sprung parthenogenetically from its own seed. It is equally embarrassed by the presence of sibling ideologies, since these mark out its own finite frontiers and so delimit its sway. To view an ideology from the outside is to recognize its limits.
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> Terry Eagleton (1991:58)

In the US and many other Western industrialized societies at the start of the 21st century, "addiction" is said to be a "disease". Virtually everyone in the treatment industry embraces the notion that "addiction" is a "disease", as do nearly all people who understand themselves to be "in recovery" from it. Officials of the US National Institute of Drug Abuse have adopted the claim that "addiction is a brain disease" as a kind of mantra

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(e.g., Enos, 2004; Leshner, 1997, 2001; Volkow, 2003). Even the drug policy reform movement, which advocates decriminalization of drugs, invokes the disease concept of addiction when advocating treatment in lieu of prison for drug offenders (see, e.g., Bertram, Blachman, Sharp & Andreas, 1996:233–41). The disease concept of addiction is now so widely believed, so taken for granted in public discourse about drug problems, it is difficult to imagine that it was not always part of the basic perceptual schema of human knowledge.

Yet addiction-as-disease did not emerge from the natural accumulation of scientific discoveries; its ubiquity is a different species of social accomplishment. The disease concept was invented under historically and culturally specific conditions, promulgated by particular actors and institutions, and internalized and reproduced by means of certain discursive practices. This article begins by briefly reviewing some of the questions that have been raised about whether it is a discrete empirical entity with an identifiable etiology. The core of the article then traces the social construction and cultural dissemination of addiction-as-disease to show how it achieved its status as the dominant framework for understanding drug problems. The concluding discussion attempts to situate the lived experience of problematic drug use within this construction, and notes the double-edged character of this discourse of disease: a humane strategy for gaining access to treatment and other services, but at the same time a justification for punitive drug policies.

Heretical doubts about entitivity and etiology

Addiction-as-disease is not as discrete or as readily identifiable an entity as many people believe it is. One of the principal reasons for this is that the user behaviors presumed to constitute it are protean, forged in interaction with features of users' environments. What are taken as empirical indicators of an underlying disease of addiction consist of a broad range of behaviors that are interpreted as "symptoms" only under some circumstances. They can be aggregated to fit under the heading of "addiction" only by means of some degree of epistemic force. As Room (1983) and others have shown in the case of alcoholism, these symptoms can be better described empirically and grasped theoretically if they are not conceptualized as constituent elements of a discrete disease entity, but instead disaggregated and understood as drinking practices and problems.

The etiology of addiction-as-disease has also been difficult to nail down. For most of the 19th century, it was widely believed that alcohol was inherently addicting and therefore that anyone who drank it would become addicted. We now know that most drinkers and drug users do not become addicts, so the pharmacological properties of the psychoactive substances cannot be the proximate cause of addiction-as-disease in the sense that tubercle bacillus is the cause of tuberculosis. This means that if addiction can be said to be a disease, it must be a person-specific disease, one that some people get but most do not (Levine, 1978). Yet despite decades of research, the biological basis for addiction-as-disease remains elusive. Addiction researchers thus far have been unable to identify either a gene as the source or an organ as the site of the core pathology of addiction in affected individuals.

In recent years, the brain is typically cited as the organ in which addiction-as-disease is said to reside, but this is not yet clear. Neuroscientists have done promising new research using magnetic resonance imaging (MRI) to show how the brain's so-called pleasure center or reward circuitry reacts and even makes longer-term adaptations to psychoactive substances (see Volkow, 2003, for a useful overview). While such studies confirm that there is a biological component in what is called addiction, they have yielded an embarrassment

of riches. The trend in neuropharmacological research is toward the "common pathway" hypothesis (e.g., Nestler & Malenka, 2004). Changes in brain function along this pathway occur with the use of a wide variety of very different drugs, licit and illicit, but also for many adrenaline-inducing and other pleasurable or merely satisfying activities involving no drugs at all. These activities include gambling (e.g., Blakeslee, 2002; Goleman, 1989); acts of cooperation, trust, and generosity (e.g., Angier, 2002); maternal support (e.g., Moles, Kieffer & D'Amato, 2004); talk therapy (e.g., Brody et al., 2001); and even looking at beautiful faces (e.g., Aharon et al., 2001). Indeed, Dr. Roy Wise, a NIDA addiction researcher, notes that people will like and thus tend to repeat "anything you can do that turns on these dopamine neurons" (Kolata, 2002).

That the brain is centrally involved in drug use behaviors is not in question; but whether this new neuroscience research has identified a specific locus of addiction-as-disease in the brain is another matter. At present, it is not clear if there is a site of pathology in the brain that distinguishes repetitive drug taking from, say, sex, sailing, symphonies, and other activities people learn to repeat because they provide pleasure. For purposes of understanding how addiction-as-disease achieved its hegemonic status, however, such questions have little relevance, for the disease concept preceded this brain research by decades and took hold for reasons unrelated to neuroscience.

Numerous alcohol and drug scholars voiced the blasphemy of doubt about addiction-as-disease well before the new brain research. As early as 1962, for example, Seeley noted that "The statement that 'alcoholism is a disease' is most misleading, since it conceals that a step in public policy is being recommended, not a scientific discovery announced" (1962:587). He supported strongly the notion that drinkers who needed help should have it, but he balked when this sort of compassion made its case by masquerading as science. Zinberg's study of controlled heroin users, *Drug, Set, and Setting* (1984), demonstrated that "loss of control," which many consider the *sine qua non* of addiction-as-disease, was not the inevitable outcome of regular use but rather contingent upon social and psychological variables (see also Hanson, Beschner, Walters & Bovelle, 1985; Prebble & Casey, 1969; and Waldorf, 1973, all of whom make parallel points about heroin users). Similarly, in *Heavy Drinking: The Myth of Alcoholism as Disease* (1988), Fingarette shows that neither tolerance nor withdrawal, the two most traditional and basic criteria for addiction, are actually manifest in many so-called alcoholics. He advanced instead the notion of heavy drinking as a "way of life" – an often unhealthy and problematic way of life, to be sure, but not technically a disease state. In *The Diseasing of America* (1989) and several other books, Peele documents numerous empirical inadequacies in the disease concept of addiction and delineates the interests behind its promulgation.

Questions of entitivity and etiology aside, Davies' *The Myth of Addiction* (1992) employs attribution theory to show that people choose to interpret habitual drug taking as an addictive disease that is beyond the control of the user not because this interpretation best fits the observable facts, but because it is a view that serves useful purposes for users themselves and for society in general. Addiction-as-disease functions, for example, as an excuse for bad behavior, a means of absolving blame, an explanation of otherwise "irrational" behavior, and as legitimation for punishment and/or treatment (see also Davies, 1997, on drug discourse). The giving of accounts for actions is a behavior in its own right, independent of the actions they purport to explain (Mills, 1940). For example, Room has observed that "We are living at a historic moment when the rate of alcohol dependence as a cognitive and existential experience is rising, although the rate of alcohol consumption and of heavy drinking is falling" (1991:154).

Numerous critiques of addiction-as-disease have been published in *Addiction Research and Theory* (see, e.g., Volume 5, Number 1, 1997). One of the broadest and most sharply posed was by Cohen (2000). He argues that addiction-as-disease is essentially a religious notion in that it functions to manage our fears about how firmly we are in control of our behaviors and destinies – a myth-like social construction of no greater scientific validity than the pre-Galilean cosmology of flat-earthers. Once the Protestant Reformation and market capitalism gave rise to the notion of "the autonomous individual" in the West somewhere around the 17th century, Cohen suggests, we began to see the development of its *opposite* – a modern sort of devil which takes the form of people who are thought to have lost the capacity for the self-regulation, independence, and entrepreneurial activity which were considered the essence of the autonomous individual.

While these and many other scholars have raised profound questions about the ontological status of addiction-as-disease, this does not appear to have slowed its march. In what follows, I address the more modest question of how addiction-as-disease came to be so widely adopted for so many different problems. *Specifically, by what historical, institutional, and interactional processes was the concept of addictive disease rendered culturally available such that it could become the dominant framework for understanding drug problems?*

Addiction as an historical accomplishment

As Room has argued, "addiction" is "a set of ideas which have a history and a cultural location" (2004:221). In his famous painting of 1559, "The Fight between Carnival and Lent," Peter Breugel depicts an agrarian village in pre-industrial Europe in full celebration. Feasting, drinking, and even drunkenness are seen everywhere, as was the case with numerous peasant holidays that were traditionally passed in varying degrees of intoxicated revelry. Drinking was a common part of everyday life, engaged in by most people, with the exception of the few monk-like figures from ascetic Protestant sects who, in the painting, can be seen in dark robes solemnly stepping toward the church while their fellow villagers frolic in drink-crazed abandon. Breugel gives us a liminal moment, a glimpse of an historic shift – the beginning of the problematization of intoxication at the dawn of Western modernity (see Burke, 1978). The ancient Bacchanalian drinking traditions that persisted from at least classical antiquity through the Middle Ages began to be contested by ascetic Protestantism and early capitalism, each of which helped create the modern Western "individual" and at the same time demanded the renunciation of pleasure for the sake of piety and productivity. As Levine (1978), Cohen (2000), and Room (2004) all note, it was in this historical and cultural context that the notion that a substance might "cause" one to "lose" self-control became thinkable.

Levine's classic article, "The Discovery of Addiction" (1978), documents the emergence in the Western world of a discursive formation in which the self was understood in a new way, an understanding that began to emerge in the U.S. only at the end of the 18th century. Before this, Levine shows, drunks were assumed to have a will, to have the capacity to make choices; they did not have a disease which robbed them of volition, they just loved drink too much. In the early 19th century, industrialization and its attendant mobility were transforming US society – straining family ties and traditional community support networks such that the economic fate of families increasingly depended upon self-control (Room, 2004). The moral enterprise of Dr. Benjamin Rush and the early temperance crusaders gave a specific form to this spreading concern over self-control: drunks were reconceptualized as people stricken with a *disease of the will* (cf. Valverde, 1998) – a disease which rendered them powerless (prefiguring the first of the 12 steps of Alcoholics Anonymous).

In a few decades in the early 19th century, the growing Temperance movement transformed alcohol from what even leading Puritan preachers had called "the good creature of God" into a "demon destroyer" held to be the direct cause of crime, violence, poverty, divorce, and virtually all other problems in America.

The notion that an intoxicating substance could cripple self-control and thus cause bad behavior that would not otherwise occur is a culturally specific attribution; "not all cultures make this kind of causal connection" (Room, 2004:225; see also Davies, 1992, 1997; MacAndrew & Edgerton, 1969; Peele, 1989). It is a notion that made sense and took hold at a point in history and in those societies in which social life was organized such that individualism had become the taken-for-granted frame of reference. The notion that drinking or drug use can cause the neglect of other activities makes sense in "the context of a culture attuned to the clock, a cultural frame in which time is viewed as a commodity which is used or spent rather than simply experienced" (Room, 2004:226).

A chronicle of conceptual acrobatics

Physicians now claim ownership of addiction-as-disease, but this was not always so. In the latter half of the 19th century, the fledgling profession of psychiatry mostly resisted the attribution of disease to habitual drinkers; they were not, it seems, considered desirable patients. Toward the end of the 19th century in England, some of the leaders of the British Society for the Scientific Study of Inebriety tried to popularize "inebriety" as a concept covering all the drug-taking phenomena now aggregated under the heading of addiction-as-disease. But through the 1880s "smoking and drug taking" were not classified under "any scientific definition" of inebriety or addiction (Valverde, 1998:51). Indeed, the definition of addiction-as-disease has been regularly reworked – and *not* in the direction of greater focus and precision as is typically the case with other diseases.[1]

In the early part of the 20th century, opiate addiction came to be defined as physiological dependence as indicated by tolerance and withdrawal symptoms. But this definition eventually proved too restrictive. For one thing, tolerance and withdrawal are not universal even among regular heroin users (e.g., Blackwell, 1983, 1985; Hanson et al., 1985; Zinberg, 1984). Moreover, the habitual or problematic use of many other illicit drugs does not necessarily lead to such symptoms. Even among extreme users of a so-called hard drug like crack cocaine, for example, what is called addiction is sociologically contingent rather than physiologically inevitable as the disease model implies (Morgan & Zimmer, 1997; Reinarman, Waldorf & Murphy, 1994; Reinarman, Waldorf, Murphy & Levine, 1997).

In 1950, a World Health Organization (WHO) committee defined "drug addiction" as a state of chronic or periodic intoxication due to regular use of a drug, including a compulsion to continue, a tendency to increase dose, both psychic and physical dependence, and detrimental effects on the user as well as society. Faced with the recalcitrant fact that lots of illicit drug use did not entail these characteristics, the WHO added a new concept to its armamentarium in 1957: "drug habituation". Drug habituation was defined much the same way as drug addiction but without compulsion, increasing doses, or societal consequences. By the 1960s, WHO's search for some common denominator of addiction led them to drop both these concepts in favor of the looser "drug dependence," defined

[1] For an insightful analysis of these processes of re-definition, see Woolgar and Pawluch's (1985) discussion of "ontological gerrymandering".

simply as psychic and/or physical dependence on a drug, the characteristics of which varying by drug type (Christie & Bruun, 1968:66–7). By 1981, the WHO definition of "dependence" was redefined still more loosely as a syndrome in which drug taking is "given a much higher priority than other behaviors that once had a higher value" (Shaffer & Jones, 1989:42). Yet this broader definition leads back to the embarrassment of riches problem noted earlier, for it fits virtually any behavior that is substituted for a prior behavior – even behaviors that entail no use of psychoactive substances.

Like their counterparts at the WHO, other addiction researchers continued to hunt for a definition malleable enough to encompass both the growing range of illicit drug taking practices and stubborn empirical anomalies. For example, in 1972, the American Psychiatric Association (APA) shifted away from "addiction" toward a broader concept of "drug abuse," which they defined as the non-medical use of drugs that alter consciousness in ways that "are considered by social norms and defined by statute [as] inappropriate, undesirable, harmful... or culture-alien" (cited in Zinberg, 1984:39). But most of these terms were normative, not scientific, and the definition itself was marked by a revealing circularity: Lawmakers justify laws against drug abuse in terms of medical evidence, but here the medical experts framed their definition of drug abuse in terms of laws.

This repeated redrawing of the definitional boundaries of addiction is one reason for the essential elasticity of addiction-as-disease, which is evidenced by the extraordinary range of phenomena to which it has been applied. The disease of addiction is now used to describe not merely the habitual use of alcohol and other drugs but the over- and under-consumption of food, gambling, shopping, credit card use, sex, love, attachment to and need for other people ("co-dependency" [Rice, 1992, 1996]), and even shades into forms of obsessive–compulsive disorder such as pulling out one's hair (tricotillomania), a form of addictive disease for which there are treatment and recovery centers (Reinarman, 1995).

Lastly, the currently dominant definition of addiction-as-disease derives from a series of criteria listed in the *Diagnostic and Statistical Manual* (DSM) published by the American Psychiatric Association. To be diagnosed as having what is now termed "dependence", a drug user must meet any three of seven criteria that range from vague and context-dependent behavioral indicators such as using more of a drug than intended to classical tolerance and withdrawal. One common sense indicator that is also a key DSM-IV criteria is persistent use despite harmful consequences, but this, too, is problematic. Such harms are not always present in habitual users and even when present are not always attributable to drug use alone. Many of the harms taken as key indicators of addiction are not caused directly by repeated use of a drug; rather they are a function of the *interaction* between the various characteristics of users' psychological sets and those of the social settings of use (e.g., deviant subcultures that arose under and are sustained by prohibitionist policies), the relative social stability or marginalization of the user, as well as dosage, chronicity of use, and other, more standard variables which are themselves influenced by such sets and settings (Zinberg, 1984).

Despite this long history of conceptual acrobatics, the complexities of drug-using behaviors continue to defy rigorous categorization under the heading of addiction-as-disease. After decades of diligent scientific labor we still await a truly uniform set of symptoms and a distinct site, source, and course of pathology that are necessary and sufficient for the presence of the disease of addiction. In this sense, addiction-as-disease may be a little like the Loch Ness Monster: the indigenous faithful swear they have seen

it and know exactly what it looks like, but skeptical outsiders have only seen shadows of something for which they have no more compelling explanation available.

Nonetheless, this latest definition of addiction-as-disease using the flexible DSM-IV diagnostic criteria has been widely adopted.

Addiction as a political-institutional accomplishment

In the US, the Temperance movement and the early alcohol prohibitionists had claimed throughout the 19th and into the 20th century that the evil was in the bottle (Levine, 1978), that all who touched alcoholic beverages were vulnerable to addiction. By the time the Prohibition amendment was repealed in 1932, however, it had become clear once again that most people drank in moderation and did not become drunks. The Temperance crusaders and prohibitionists had lost credibility; a new formulation was needed. In 1935, a new, lay organization of former "drunks," Alcoholics Anonymous (AA), took one of the first steps toward the modern version of addiction-as-disease. AA drew a clear "distinction between the alcoholic and the non-alcoholic" in these terms:

> "If, when you honestly want to, you find you cannot quit entirely, or if when drinking, you have little control over the amount you take, you are probably an alcoholic. If that be the case, you may be suffering from an illness which only a spiritual experience will conquer." (Alcoholics Anonymous, 1976:44)

A key principle in AA was the importance of reaching out and providing support to other alcoholics, which helped spread the disease concept. As noted earlier, the AA model was subsequently adopted by dozens of offshoots, some concerned with other forms of drug use (Narcotics Anonymous, Cocaine Anonymous), others having nothing to do with drugs (Sex and Love Addicts Anonymous, Shopaholics Anonymous).

In 1942, the Alcoholism Movement was founded by Marty Mann, a public relations executive and former "drunk", and others. By 1944, she joined with Dr. E.M. Jellinek at Yale to create an organization whose purpose was to *popularize* the disease concept by putting it on a scientific footing. Note the chronology: science was not the source of the concept but a resource for promoting it. This organization later became the National Council on Alcoholism (NCA). Their goal was to create a new "scientific" approach that would allow them to get beyond the old, moralistic "wet" *versus* "dry" battle lines of the Temperance and Prohibition period (Roizen, 1991). While there were a few scientists doing research on alcohol in the 1930s, the bulk of the scientific research that Mann and her allies hoped would be the basis for their new disease concept had not yet been done. Indeed, they hoped the NCA would generate contributions needed to fund that research. The 1942 "Manifesto" of the Alcoholism Movement clearly stated that they sought to "inculcate" into public opinion the idea that alcoholics were "sick", and therefore "not responsible" for their drinking and its consequences, and were thus deserving of medical treatment (Anderson, 1942; Roizen, 1991; Room & Collins, 1983).

As Schneider (1978) among others has shown, AA, the Yale Center for Alcohol Studies, and the National Council on Alcoholism provided the institutional foundation on which the disease concept of alcoholism was constructed. All of them attempted to shape public opinion and public policy to accept the disease concept. By the early 1970s, the movement had succeeded in persuading the US government to spin off from the National Institute of Mental Health an autonomous National Institute of Alcohol Abuse and Alcoholism, which for the first time gave the disease of alcoholism the official imprimatur of the state and a large research funding base. This in turn gave crucial institutional support, political legitimacy, and cultural momentum to the more general concept of addiction-as-disease.

Other institutions have played supporting roles in promulgating the disease concept. Since the 1980s, drug courts have adopted addiction-as-disease as the core rationale for sentencing drug offenders into treatment (on penalty of prison). They have since been joined by the "strange bedfellow" of the drug policy reform movement, which has found it politically useful to rely, implicitly or explicitly, upon the disease model in order to pass ballot initiatives mandating treatment instead of jail (e.g., in Arizona and California). This endorsement of addiction-as-disease by the leading critics of national drug policy has further broadened its cultural currency.

A final institution warrants brief mention here, the mass media. The countless temperance tales that appeared in pulp fiction form in the 19th century depicted drunks as powerless before alcohol. In the early 20th century, the so-called yellow journalism of the Hearst newspapers included hundreds of ruin-and-redemption stories which exaggerated the evils of drink and drugs. Early films like "The Dividend" and "Man with the Golden Arm" used the same stock depictions. More recently, there have been numerous studies of how the news media have created or abetted various drug scares that construct chemical bogymen of one sort or another, nearly all such scares implying that addiction-as-disease was the inevitable and tragic result of use of the demon drug *du jour* (e.g., Becker, 1963; Brecher, 1972; Gusfield, 1963; Lindesmith, 1947, 1965; Reeves & Campbell, 1994; Reinarman & Levine, 1989, 1997).

Most recently, the Oscar-winning film, "Traffic", took the arguably courageous step of asserting that the drug war has not worked and was unlikely ever to do so. But the director apparently felt that in order to make this controversial point acceptable to mass American audiences, it was necessary to employ a traditional drug scare narrative. In the film, a fictional Drug Czar's daughter – an upper middle-class, top-ranked student with all manner of healthy involvements in school, sports, and the community – smokes some cannabis and a few scenes later is a heroin addict having sex with a gun-wielding African-American drug dealer. In the film's denouement, she is shown with her father and mother in a 12-Step meeting reciting the scripted text of recovery: admitting that she is powerless before her addictive disease.

I do not mean to suggest that affluent, accomplished youth with extraordinary life chances *never* find themselves in trouble with drugs, only that such a caricatured depiction inverts the well-known probabilities regarding what sorts of people under what sorts of conditions are *most likely* to end up in that situation or suffer its worst consequences. Whether news or film, the media tend to frame their addiction stories as if it is a disease that "can happen to anyone." This is true enough as far as it goes, but it ignores all the sociological variables that make such an outcome far less likely for such a privileged person. As Best (1999) shows, the it-can-happen-to-anyone frame is preferred by the media not because it is statistically accurate but because it attracts the broadest interest in the story and thus the largest market share of audience.

Addiction as an interactional accomplishment

In his seminal 1953 article, "Becoming a Marijuana User", Becker showed that the marijuana high did not result from the mere mechanical ingestion of the smoke but had to be learned in interaction with experienced users. Much the same may be said for addiction-as-disease. There are at least two processes involved in becoming a person who is afflicted with addiction-as-disease. First, there is what might be called the *pedagogical* process, in which addicts-to-be learn the lexicon of disease/recovery from counselors, therapists, judges, probation and parole officers, treatment providers, and other addicts

(see Phillips, 1990; Rapping, 1996; Reinarman, 1995). They are taught to retrospectively reinterpret their lives and behavior in terms of addiction-as-disease.

As Weinberg shows in rich ethnographic detail, those drawn or forced into a treatment setting are typically required to "admit that they suffer from a disease that prevents them from controlling their drug use". Since many are at first reluctant to make such an admission, the initial therapeutic objective becomes "break[ing] down the putative denial that keeps the addicted person . . . unconsciously complicit with his or her disease". And to accomplish this, "a good deal of treatment discourse is taken up with inducing and offering confessions of the depths to which one's disease has forced one to sink" (Weinberg, 2000:611). Rice similarly shows that the group processes of Codependents Anonymous function to induce members to "select [codependency, or the disease of being addicted to other people] as a narrative of their lives to acquire a new and more satisfying sense of identity" (1992:338; see also Rice, 1996). In effect, the accounts that putative "addicts" give of their behaviors are not naturally occurring, objective descriptions of an unambiguous reality. Rather, accounts that get accepted as adequate, i.e., those which begin with the admission of "addiction," are *produced* when the messy details of life histories are organized by the discursive procedures (e.g., typification) applied in social control and therapeutic settings (cf. Zimmerman, 1969).

Second, almost immediately there is the *performative* process, in which addicts tell and retell their newly reconstituted life stories according to the grammatical and syntactical rules of disease discourse that they have come to learn. In so doing they not only spread the word (e.g., "carry this message to other" addicts) but also help to "save" themselves from relapsing back "into" their "disease".

One can observe these processes in almost any 12-Step meeting, in most treatment programs, and even on a syndicated cable television show called "The Recovery Network". In one recent broadcast of "The Recovery Network", for example, a "recovering addict" explained his savagely bad behavior as "my disease talking". Likewise, a member of the treatment group observed by Weinberg rhetorically distanced himself from his own addicted self and past behavior by means of disease discourse: "When I was out there in my addiction, I fucked over a lot of people" (2000:611).

In this sense, as Davies (1992) suggests, addiction-as-disease is functional for the now-"recovering" addict in that it provides a narrative that allows him or her simultaneously to "own" and yet disown deviant acts committed while addicted. In this manner, they admit the sins of the old addicted self while laying claim to a new self-in-the-making. The etiology implicit in such disease discourse shares certain similarities in logical structure with 17th century theological narratives in which demonic possession was thought to be causal; in disease discourse, addiction is a kind of "secular possession" (Room, 2004:231). In each case, an exogenous force or foreign agent ("the devil", "the disease") is held to be the effective cause of the individual's bad behavior.

It should also be noted that once "in recovery", such "addicts" are often called upon to speak in the community, in schools, and in the media as experts on addiction. Their accounts are afforded respect, legitimacy, and authority because they have "been there".[2] This completes the loop and conceals, like a good magic trick, the actual procedures by which it was accomplished.

[2] Ethan Nadelmann has suggested that the media asking addicts to serve as experts on drug use is rather like asking those who have gone bankrupt to serve as experts on business.

What about the lived experience of problematic drug use?

The notion that addiction-as-disease is a historically and culturally specific social construction and political accomplishment should not be taken to mean that the lived experience of what is called addiction is therefore somehow less "real", less powerful, or less deserving of attention. The related critiques noted earlier to the effect that the physiological–pharmacological dimension of what is called addiction has been overemphasized and is not the sufficient cause of addiction does not imply that pharmacology and physiology are unimportant parts of the puzzle that is called addiction. Users decide to ingest drugs in part because they are psychoactive, consciousness-altering chemicals that make us feel different in some way (Room & Collins, 1983:v–vi). But again, this material substratum where molecules meet receptor sites cannot by itself explain drug-using behaviors. Regular ingestion may or may not lead to the sorts of habitual or problematic use patterns that diseasists call addiction, and even physiological dependence may or may not lead to desperate "junkie" behavior that is so often taken as a clear indicator of the disease.

What are taken to be physiological–pharmacological effects do not present themselves to users in some raw, pre-categorical form, without the linguistic encasements provided prior to ingestion by culture. Becker (1967), Weil (1972), Davies (1992) and others have shown that the subjective effects reported by drug users are produced in important part by users' active interpretation of the often ambiguous physiological cues produced by ingestion of a drug. Such interpretations are assembled from the conceptual categories available in culture. The particular features of and the meanings attributed to drug experiences, as well as the behavior thought to follow from them, are culturally specific. For example, MacAndrew and Edgerton's (1969) pioneering cross-cultural research on drunken behavior demonstrated that people come to understand their experience of altered states – and learn how to behave in those states – from their culture. As Peele has argued, the cultural belief that "alcohol has the power to addict a person goes hand in hand with more alcoholism" (1989:170). Conversely, cultures in which people do not believe drugs can cause the "loss of control" exhibit very little of it. But just because "loss of control" is as much a cultural construct as a physiological fact should not be taken to imply that users' *feelings* of "loss of control" are any less acute.

Most of those who get defined as addicts and come to adopt the addict identity (especially in treatment and/or recovery) find that addiction-as-disease resonates with their experience. This suggests that there is a reasonable cognitive fit between the discourse of disease and their experience of drug use. But such resonance and cognitive fit are matters of culture, too, not an external validation of the concept of addiction-as-disease. The question of which came first, phenomenological experience or the cultural-cognitive frameworks available for making sense of it, is, like the proverbial chicken and egg question to which it is cousin, very difficult to disentangle. From birth, human beings are raised *inside* their culture, and there is no simple way to separate their lived experience from the discursive practices operating in that culture which name it and give it specific shape and valence.

Discussion: Disease as a double-edged sword

In this article, I have tried to sketch some of the processes by which addiction-as-disease was socially constructed and made culturally available as a framework for

understanding drinking, drug use, and other behaviors involving self-regulation, and how this framework then gets inscribed upon lived experience. If this disease discourse was only a rhetorical strategy for gaining the right to various services for people who need them, as most proponents of addiction-as-disease claim, then all this might not matter much. But addiction-as-disease has been put to other, arguably less noble uses.

In 1975, British historian E.P. Thompson wrote *Whigs and Hunters*, a book about the origins of the Black Act, a law passed without debate by the English Parliament in the early 18th century. This strange law created some 50 new capital offenses, including traditional practices of foresters like hunting, fishing, gathering wood in royal forests, and especially painting one's face black in disguise to be able to get away with these activities. It seems that the ruling Whig government found such agrarian rule-breaking to be a form of dissent that threatened the "delicate structure of patronage" on which the legitimacy of the English state then depended (Sutton, 2001:90). Walpole and company needed the support of officers, courtiers, and other newly moneyed types to whom the Crown had given large swaths of the common forests as deer parks and country estates. The Black Act was a harsh over-reaction that was vitiated in its administration and thus remained largely ineffectual. But it was intended to serve as a weapon in defense of the Whig regime at a precarious moment in England's transition from feudalism to capitalism. In the cool clear light of retrospect, it is easier to see that the excessive punitiveness of this law undermined the very legitimacy it was designed to buttress.

How will 20th-century US drug laws be read a century or two into the new millennium? Since the 1980s, the US has imprisoned a higher proportion of its citizens than any other nation, and drug offenses have been the largest single category of crimes in what has been the most massive wave of imprisonment in US history. Those who have ended up behind bars for drug offenses are overwhelmingly poor people and people of color. Many leading judges, high officials from closely allied nations, and a growing chorus of international human rights organizations look upon the US drug war and imprisonment wave of 1986–2003 as not only ineffective but inhumane and unjust. And in response to the many cries for reform, the reply in Congressional hearings, in medical science conferences, and on television talk shows has been to invoke the dreaded "disease of addiction" as justification.

Addiction-as-disease, then, is something of a double-edged sword. When attached to sympathetic (Betty Ford) or well-connected (Rush Limbaugh) individuals, it becomes part of the larger, positive gestalt surrounding them. But when addiction-as-disease gets attached to less reputable individuals ("street junkies", "ghetto crackheads"), it becomes part of a larger, very negative gestalt. Thus, the disease concept sometimes serves as a humane warrant for the right of access to services, but it also serves, paradoxically, as a key justification for punitive prohibition. It is at least partly on the grounds of avoiding or reducing this dread "disease" that the US government passes and enforces a modern American version of the Black Act, and then pressures other governments and the UN to follow their example (Bewley-Taylor, 1999; Levine, 2003).

The discourse of disease may have potentially progressive effects insofar as it has helped trigger a shift of gaze in which drug use comes to be seen as properly belonging in the realm of public health rather than criminal law. But addiction-as-disease has just as often been a discursive weapon wielded by a state that has declared war upon citizens who ingest disapproved substances. It is a weapon that helps to justify – "*for their own good*" – the suspension of the Bill of Rights under what the Supreme Court openly calls "the drug exception" and the mass incarceration of the powerless.

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References

Aharon, I., Etcoff, N., Ariely, D., Chabris, C., O'Connor, E., & Breiter, H. C. (2001). Beautiful faces have variable reward value: fMRI and behavioral evidence. *Neuron*, *32*, 537–551.

Alcoholics Anonymous (1976). *Alcoholics anonymous: The story of how many thousands of men and women have recovered from alcoholism* (3rd Edn). New York: Alcoholics Anonymous World Services.

Anderson, D. (1942). Alcohol and public opinion. *Quarterly Journal of Studies on Alcohol*, *3*(3), 376–392.

Angier, N. (2002). Why we're nice: The feel-good factor. *International Herald Tribune*, July 25, 2002, p. 8.

Becker, H. S. (1953). Becoming a Marijuana user. *American Journal of Sociology*, *59*, 235–242.

Becker, H. S. (1963). *Outsiders: Studies in the sociology of deviance*. New York: Free Press.

Becker, H. S. (1967). History, culture, and subjective experience: An exploration of the social bases of drug-induced experiences. *Journal of Health and Social Behavior*, *8*, 162–176.

Bertram, E., Blachman, M., Sharp, K., & Andreas, P. (1996). *Drug war politics: The price of denial*. Berkeley, CA: University of California Press.

Best, J. (1999). *Random violence: How we talk about new crimes and new victims*. Berkeley, CA: University of California Press.

Bewley-Taylor, D. R. (1999). *The United States and international drug control, 1909–1997*. London: Pinter.

Blackwell, J. S. (1983). Drifting, controlling, and overcoming: Opiate users who avoid becoming chronically dependent. *Journal of Drug Issues*, *13*, 219–236.

Blackwell, J. S. (1985). Opiate dependence as a psychophysical event: Users' reports of subjective experience. *Contemporary Drug Problems*, *12*, 331–350.

Blakeslee, S. (2002). Hijacking the brain circuits with a nickel slot machine. *New York Times*, Feb. 19, 2002, p. D1.

Brecher, E. M. (1972). *Licit and illicit drugs*. Boston, MA: Little Brown.

Brody, A. et al. (2001). Regional brain metabolic changes in patients with major depression treated with either paroxetine or interpersonal therapy. *Archives of General Psychiatry*, *58*, 631–640.

Burke, P. (1978). *Popular culture in early modern Europe*. New York: Harper and Row.

Christie, N., & Bruun, K. (1968). The conceptual framework. In M. Keller & T. C. Coffey (Eds), *Proceedings of the 28th International Congress on Alcohol and Alcoholism* (Vol. 2, pp. 65–73). Highland Park, NJ: Hillhouse Press.

Cohen, P. (2000). Is the addiction doctor the voodoo priest of western man? *Addiction Research and Theory*, *8*, 589–598.

Davies, J. B. (1992). *The myth of addiction: An application of the psychological theory of attribution to illicit drug use*. Chur, Switz.: Harwood Academic Publishers.

Davies, J. B. (1997). *Drugspeak: The analysis of drug discourse*. Reading, Eng.: Harwood Academic Publishers.

Eagleton, T. (1991). *Ideology*. London: Verso.

Enos, G. (2004). The future of addiction services: It's in the science. *Addiction Professional*, *2*(6), 17–21.

Fingarette, H. (1988). *Heavy drinking: The myth of alcoholism as a disease*. Berkeley, CA: University of California Press.

Goleman, D. (1989). Biology of brain may hold key for gamblers. *New York Times*, October 5, 1989, p. B1.

Gusfield, J. (1963). *Symbolic crusade: Status politics and the American temperance movement*. Urbana, IL: University of Illinois Press.

Hanson, B., Beschner, G., Walters, J., & Bovelle, E. (Eds) (1985). *Life with heroin: Voices from the inner city*. Lexington, MA: D.C. Health.

Kolata, G. (2002). Runner's high? Endorphins? Fiction, some scientists say. *New York Times*, May 21, 2002, p. D1.

Leshner, A. I. (1997). Addiction is a brain disease, and it matters. *Science*, *278*, 45–57.

Leshner, A. I. (2001). Countering abuse and addiction with information audiences can use. *NIDA Notes*, *16/4*, 4–5.

Levine, H. G. (1978). The discovery of addiction: Changing conceptions of habitual drunkenness in America. *Journal of Studies on Alcohol*, *39*, 143–174.

Levine, H. G. (2003). Global drug prohibition: Its uses and crises. *International Journal of Drug Policy*, *14*, 145–153.
Lindesmith, A. R. (1947). *Opiate addiction*. Evanston, IL: Principia Publishers.
Lindesmith, A. R. (1965). *The addict and the law*. Bloomington, IN: Indiana University Press.
MacAndrew, C., & Edgerton, R. (1969). *Drunken Compartment*, Chicago, IL: Aldine.
Mills, C. W. (1940). Situated actions and vocabularies of motive. *American Sociological Review*, *5*, 904–913.
Moles, A., Kieffer, B. L., & D'Amato, F. R. (2004). Deficit in attachment behavior in mice lacking the mu-opiod receptor gene. *Science*, *304*(5679), 1983–1986.
Morgan, J. P., & Zimmer, L. (1997). The social pharmacology of smokeable cocaine. In C. Reinarman & H. G. Levine (Eds), *Crack in America: Demon drugs and social justice* (pp. 131–170). Berkeley, CA: University of California Press.
Nestler, E. J., & Malenka, R. C. (2004). The addicted brain. *Scientific American*, *290*(3), 78–85.
Peele, S. (1989). *Diseasing of America: Addiction treatment out of control.* Lexington, MA: Lexington Books.
Phillips, M. D. (1990). Breaking the code: Toward a lexicon of recovery. Paper presented at the Kettil Bruun Society Alcohol Epidemiology Meetings, Budapest.
Prebble, E., & Casey, J. H. (1969). Taking care of business: The heroin user's life on the street. *International Journal of the Addictions*, *4*, 1–24.
Rapping, E. (1996). *The culture of recovery.* Boston, MA: Beacon Press.
Reeves, J. L., & Campbell, R. (1994). *Cracked coverage: Television news, the anti-cocaine crusade, and the Reagan legacy*. Durham, NC: Duke University Press.
Reinarman, C. (1995). Twelve-step movements and advanced capitalist culture: On the politics of self-control in postmodernity. In M. Darnovsky, B. Epstein & R. Flacks (Eds), *Cultural politics and social movements* (pp. 90–109). Philadelphia, PA: Temple University Press.
Reinarman, C., & Levine, H. G. (1989). Crack in context: Politics and media in the making of a drug scare. *Contemporary Drug Problems*, *16*, 535–577.
Reinarman, C., Waldorf, D., & Murphy, S. (1994). Pharmacology is not destiny: The contingent character of cocaine abuse and addiction. *Addiction Research*, *2*, 21–36.
Reinarman, C., Waldorf, D., Murphy, S., & Levine, H. G. (1997). The contingent call of the pipe: Bingeing and addiction among heavy cocaine smokers. In C. Reinarman & H. G. Levine (Eds), *Crack in America: Demon drugs and social justice* (pp. 77–97). Berkeley, CA: University of California Press.
Reinarman, C., & Levine, H. G. (1997). Crack in context: America's latest drug demon. In C. Reinarman & H. G. Levine (Eds), *Crack in America: Demon drugs and social justice* (pp. 1–17). Berkeley, CA: University of California Press.
Rice, J. S. (1992). Discursive formation, life stories, and the emergence of co-dependency. *Sociological Quarterly*, *33*, 337–364.
Rice, J. S. (1996). *A disease of one's own: Psychotherapy, addiction, and the emergence of co-dependency*. New Brunswick, NJ: Transaction Publishers.
Roizen, R. (1991). *The American Discovery of Alcoholism, 1933–1939*, PhD Dissertation, Department of Sociology, University of California, Berkeley.
Room, R. (1983). Sociological aspects of the disease concept of alcoholism. *Research Advances in Alcohol and Drug Problems*, *7*, 47–91.
Room, R. (1991). Cultural changes in drinking and trends in alcohol problems indicators: Recent U.S. experience. In W. Clark & M. Hilton (Eds), *Alcohol in America: Drinking practices and problems* (pp. 149–162). Albany, NY: State University of New York Press.
Room, R. (2004). The cultural framing of addiction. *Janus Head*, *6*(2), 221–234.
Room, R., & Collins, G. (1983). *Alcohol and disinhibition: The nature and meaning of the link*. National Institute of Alcoholism and Alcohol Abuse, Research Monograph 12. Washington, DC: U.S. Department of Health and Human Services.
Schneider, J. (1978). Deviant drinking as disease: Alcoholism as a social accomplishment. *Social Problems*, *25*, 361–372.
Seeley, J. R. (1962). Alcoholism is a disease: Implications for social policy. In D. J. Pittman & C. R. Snyder (Eds), *Society, culture, and drinking patterns* (pp. 586–593). New York: Wiley.
Shaffer, H. J., & Jones, S. B. (1989). *Quitting cocaine: The struggle against impulse*. Lexington, MA: Lexington Books.
Sutton, J. R. (2001). *Law/Society*. Thousand Oaks, CA: Sage.
Thompson, E. P. (1975). *Whigs and hunters: The origins of the Black Act*. New York: Pantheon.
Valverde, M. (1998). *Diseases of the will: Alcohol and the dilemmas of freedom*. Cambridge, Eng.: Cambridge University Press.
Volkow, N. (2003). The addicted brain: Why such poor decisions? *NIDA Notes*, *18*, 3–4.
Waldorf, D. (1973). *Careers in dope*. Englewood Cliffs, NJ: Prentice Hall.
Waldorf, D., Reinarman, C., & Murphy, S. (1991). *Cocaine changes: The experience of using and quitting*. Philadelphia, PA: Temple University Press.
Weil, A. (1972). *The natural mind.* Boston, MA: Houghton Mifflin.
Weinberg, D. (2000). 'Out there': The ecology of addiction in drug abuse treatment discourse. *Social Problems*. *47*, 606–621.

Woolgar, S., & Pawluch, D. (1985). Ontological gerrymandering: The anatomy of social problems explanations. *Social Problems*, *32*, 214–227.
Zimmerman, D. H. (1969). Fact as practical accomplishment. In S. Wheeler (Ed.), *On record: Files and dossiers in American life* (pp. 319–354). New York: Russell Sage.
Zinberg, N. E. (1984). *Drug, set, and setting: The basis for controlled intoxicant use*. New Haven, CT: Yale University Press.

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