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Medicalized addiction, self-medication, or nonmedical prescription drug use? How trust figures into incarcerated women's conceptualization of illicit prescription drug use

Michelle Smirnova, PhD Assistant Professor of Sociology [a, *],
Jennifer Gatewood Owens, PhD Assistant Professor of Criminology & Criminal Justice [b]

[a] University of Missouri-Kansas City, 5100 Rockhill Drive, Haag 208, Kansas City, MO 64112, USA
[b] University of Missouri-Kansas City, USA

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ABSTRACT

Trust is crucial to optimal care. When trust is compromised, patients, doctors, and others involved in the provision of health care may not act in patients' best interests, particularly when dealing with prescription (Rx) drugs. Patients must trust that doctors are giving them the proper treatment, including access to Rx drugs only when medically necessary. They must also trust themselves to use these drugs properly. Likewise, doctors must trust the patient's ability to use medications appropriately. Given the recent rise in illicit Rx drug use in the U.S., we seek to understand how women articulate levels of trust in doctors and themselves and if different combinations of trust and distrust impact how they acquire, use, and articulate their experiences with Rx drugs. To this end, we identified and interviewed 40 women incarcerated in the U.S., who were deeply entrenched in illicit Rx drug use prior to prison. Based upon this research, we argue that illicit Rx drug use may be tied to different combinations of trust and distrust in individual doctors (interpersonal trust), the field of medicine (institutional trust), and the users themselves (self trust). How these women acquire Rx drugs: through doctors, friends, family, or the street market are influenced by combinations of interpersonal, institutional, and self trust.

1. Introduction

In the U.S., almost 19 million people ages 12 or older had misused prescription psychotherepuetic drugs in 2015 (Hughes et al., 2016). Nonmedical use of prescription psychotherapeutic drugs is second only to marijuana as the U.S's most prevalent illicit drug used (Hughes et al., 2016) and the Centers for Disease Control (CDC) has called the illicit use of opioid painkillers such as oxycodone, hydrocodone, morphine, and methadone a "national epidemic." Nonmedical prescription (Rx) drug use exists at the intersection of the medical field, the pharmaceutical industry, doctors, government, drug legislation, and patients, each with their own interests and interpretation of drug use.

Mutual trust between doctors, patients, hospitals, and other actors and entities part of the healthcare industry is integral to effective Rx drug use. Trust is "the expectation that arises within a community of regular, honest and cooperative behavior, based on commonly shared norms, on the part of members of that community" (Fukuyama, 1995: 26). While we are taught not to invest trust blindly in strangers, a certain amount of trust is necessary for even the most basic cooperation in our economic, political, and social relationships. For example, when doctors and patients do not share the same notions of "proper" Rx use, their mutual trust can be compromised. Doctors mistrust so-called "addicts" or "guileful consumers" who are perceived to manipulate and abuse the medical system, whereas patients mistrust aloof doctors who are perceived to "push" pills and care more about their paycheck than optimal care (Quinones, 2015; Szalavitz, 2016; Wailoo, 2014). As such, deficits of trust may lie at the heart of the Rx drug epidemic.

In the following paper, we explore the role of trust in motivating the interpretations and subsequent actions of a particularly vulnerable population: women who prior to incarceration used Rx drugs without the prescription of a doctor and/or knowingly overused their prescriptions. Through a series of interviews with women in prison, we find that the ways by which users

* Corresponding author.
E-mail address: smirnovam@umkc.edu (M. Smirnova).

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conceptualize their drug use—as medicalized addiction, self-medication, or nonmedical use—can be understood as a product of particular configurations of trust and distrust in themselves and/or doctors. Patients who comply with doctors' orders do so because they either trust the field of medicine in general, doctors in particular, or their ability to take care of themselves. These factors also shape initiation and acquisition behaviors. We begin below by outlining three social and political processes that arguably contribute to the rise in both licit and illicit Rx drug use in the U.S., particularly among women.

1.1. Medicalization, pharmaceuticalization & illicit prescription (Rx) drug use

The rapid increase in Rx use in the U.S. can be attributed, in part, to the combined processes of medicalization and pharmaceuticalization. Medicalization is the process by which non-medical physical, social, emotional, economic, or political problems become defined and treated as medical problems, usually as illnesses or disorders (Conrad, 1992, 2007). Childbirth is a clear example of medicalization in that it has moved over time from the social realm of the home and the midwife to the medical realm of the hospital and the obstetrician (Almeling, 2015; Epstein et al., 2008).

Pharmaceuticalization involves the redefinition and reconstruction of certain problems as having a pharmaceutical solution (Smirnova, 2012; Williams et al., 2011), such as restless children being diagnosed with Attention Deficit Disorder and prescribed Ritalin to manage their symptoms. Pharmaceuticalization may be attributed to the rise of the autonomous consumer-patients (Conrad, 2007), the use of Rx drugs beyond the prescribed influence of healthcare professionals through more products becoming available over-the-counter (Abraham, 2010), the use of certain Rx drugs for "enhancement" purposes (e.g., Viagra) (Clarke et al., 2003; Loe, 2004; Smirnova, 2012), and the increasing marketing influence of pharmaceutical companies, amidst lighter media regulation (Abraham, 2010).

Historically, prescription drugs have been more frequently aimed at treating women than men (Bartky, 2003; Blum and Stracuzzi, 2004; Clarke et al., 2003). This includes the construction of women's bodies (e.g., menopause) and emotions (e.g., stress) as unhealthy and warranting medical intervention. Women are almost twice as likely as men to be prescribed a psychotropic opiate (CASA, 2003) or anti-anxiety drug (CDC, 2013) and are more likely to become addicted (Cotto et al., 2010). While pharmaceutical opiate production has increased worldwide, the United States is responsible for the consumption of 83 percent of the world's oxycodone and 99 percent of the world's hydrocodone (the opiate in Vicodin and Lortab). Sales of oxycodone—the drug in OxyContin©—increased almost ninefold between 1999 and 2010. Drugs containing hydrocodone are the most prescribed drugs in the U.S., and opiate painkillers the most prescribed class of drugs (Quinones, 2015).

While pharmaceuticalization does not always involve medical professionals directly, medicine as an institution, and doctors and nurses who advise on pharmaceutical use, remain powerful arbiters of medical knowledge and pharmaceutical use, even when Rx drugs are used outside medical contexts (Coveney et al., 2011). For example, conditions such as "anxiety," "depression," and "Post-Traumatic Stress Disorder" are psychological diagnoses that have become so ingrained in our lexicon that it is common for people to discuss and self-diagnose these terms without medical consultation. The concept of "self-medication" may reflect this cultural shift, where people "self-diagnose" and "self-treat" with a variety of behaviors or substances. The increasing ubiquity of Rx drugs coupled with the shift to self-care arguably contributed to the steep rise in nonmedical Rx drug use.

1.2. Rise in Rx use as a form of substance abuse

The Greek term *pharmakon*, from which the term "pharmaceutical" is derived, refers to both remedies and poisons. Such etymology reflects the ambivalent nature of such Rx substances that may be constructed as a licit remedy in some contexts or individuals, but an illicit toxin in others (Garriott and Raikhel, 2015). It is this latter category – of an illicit toxin – that warrants the construction of the medical category of the "addict" as legally one cannot be "addicted" to a licit remedy, such as regular insulin treatment for diabetes. The incorporation of addiction knowledge into criminal justice practice showcases how fundamental the criminal addict has become to the governance of crime, health, and to the broader articulation of state power (Garriott and Raikhel, 2015; Moore, 2007). In order to justify the addict's criminalization, treatment, and punishment, the American criminal justice system must constitute characters such as the criminal addict "as problems of order in need of solutions" (Moore, 2007: 2). The "problem" is that of drug use. The term "junkie" particularly highlights this conflation of drug use and crime, in that it refers to 1920s New York City "junkmen," heroin users who supported their habits by selling scrap metal they collected from industrial dumps. Hence, the term "junkie" creates an association between a drug user with trash and criminality (Radcliffe and Stevens, 2008: 1066).

The criminal addict narrative not only casts a shadow of shame and irresponsibility upon drug users, but also constructs any nonmedical Rx drug use as "abuse" and "criminal" in absolute, unqualified terms. In doing so, governing institutions and popular media "create cultural correspondences between illicit 'hard' drugs and pharmaceuticals, and they emphasize the user's intent to 'get high' as the primary factor motivating use" (Quintero, 2012: 494). This framing makes it impossible to explore alternative motives, conceptualizations, and consequences of nonmedical Rx drug use, which may not be so different from the medical establishment's intended use of Rx drugs. Communication and respect between patients and doctors are paramount to understanding the motives, conceptualizations, and consequences of nonmedical Rx drug use, given that neither can act most effectively without mutual cooperation.

1.3. Interpersonal, institutional, and self-trust

Medical Rx drug use requires mutual trust between doctors and patients, given that patients must trust that doctors are prescribing drugs in their best interest and doctors must trust that patients will follow their directions once they leave the office with a script (Gilson, 2003; Lee and Lin, 2009). Trust plays a fundamental role in health care, where patients must trust health care providers (Russell, 2005), particularly with serious health conditions where patients exclusively rely upon the physician's intentions and decisions (Mechanic and Meyer, 2000). Trust can be directed toward specific individuals with whom one is familiar and has a personal relationship, such as doctors or nurses (Gilson, 2003; Mechanic and Meyer, 2000), or towards impersonal entities such as a hospital, its workers, or the institution of medicine more broadly (Aryee et al., 2002). Despite the difficulty in operationalizing and measuring trust, it is important to study given that generalized trust is associated with better self-reported health (Armstrong et al., 2006; Kawachi et al., 1997; Mohseni and Lindstrom, 2007). Specifically, trust in doctors and medicine is associated with better access to and utilization of medical care (Russell, 2005), is highly correlated with satisfaction with particular physicians (Safran et al., 1998), and