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From wanting to willing – controlled drug use as a treatment goal

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ABSTRACT

This paper uses rational choice theory to analyse a new – and controversial – treatment approach to drug problems: services aimed at making clients capable of controlled use of illegal drugs. The paper highlights three mechanisms used in control-focused treatment: attempts to move drug use from the sphere of "wanting" to the sphere of "willing"; temporal framing of illegal drug use; and a therapeutic focus on clients' resources rather than their problems. Furthermore, the paper identifies some of the main challenges associated with this kind of treatment. The paper is based on 30 qualitative interviews with young people (aged 18–25) enrolled in drug treatment in Copenhagen, Denmark.

In recent years, controlled use of illegal drugs has emerged as an officially sanctioned treatment goal for cannabis users and users of "party drugs" (cocaine, amphetamine, MDMA/ecstasy) in Denmark. This paper analyses treatment aimed at use moderation as it is practised at two centres for young drug users in Copenhagen. Both centres define themselves in opposition to "traditional" drug treatment – especially treatment based on an illness model of addiction. Instead, they work with a rational actor model of drug users, defining them as normal young people who (in most cases) are capable of developing their drug use pattern in accordance with their own will.

The aim of the paper is to discuss the potentials and challenges associated with this alternative treatment model. I use rational choice theory to investigate the centres' approach to drug use and drug users, most importantly 1) their attempts at transforming the youths' "intentions" to reduce their drug use into "resolutions" (Holton and Berridge, 2013) and 2) their work with temporal regulation of the youths' drug intake. I also show 3) how the focus on drug users' resources rather than their problems is intended as a normalisation strategy that makes clients believe in, and hopefully use, their "willpower" (Holton, 2009).

One of the challenges related to this treatment approach is the vagueness of the concept of controlled drug use; another challenge is the unwillingness of staff members to differentiate between degrees of problem severity among their young clients. This tendency is – as I will show in the paper – related to the centres' self-identification as being an alternative to a "pathologising" illness model of addiction.

The paper is framed within rational choice theory because this is the analytical model of drug use and drug users that staff members at the two centres work with. The idea of the paper is to relate the treatment model of the centres to the theoretical literature on rational choice, or more specifically: to use rational choice theory to understand and critically discuss the work at the centres. I hope to show that there is much to gain from the positive, non-defeatist understanding of "the competent drug user" that inspires treatment at the centres. Yet the strictly dichotomous understanding of "drug use as a choice" vs. "addiction as illness" and the insistence on the ability of all drug users to exercise self-control may also impede the further development of this treatment approach.

The data to be analysed comprise 30 qualitative interviews with young drug users (aged 18 to 25) in treatment at two outpatient centres in Copenhagen.

The following section gives a short review of research on controlled substance use, after which I present some of the most central contributions to the rational choice literature on addiction. While rational choice theory is the main analytical perspective in the paper, I will also draw on Zerubavel's (1991) work when describing the centres' attempts at drug use regulation. I use Zerubavel – introduced later – to show how this regulation operates through temporal framing of the youths' drug intake, aimed at creating distinctions between reasonable and unreasonable use of cannabis, ecstasy, cocaine and/or amphetamine.

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1. Controlled substance use as a treatment goal

Most research on controlled substance use – or reduced use, or use moderation – as a treatment goal concerns controlled drinking, and not controlled use of illegal drugs. The two fields of research are related, though, which is why I will briefly discuss them both.

The debate on *controlled drinking* has a long history. It was especially intense in the 1980s with researchers and treatment staff dividing into two camps. Proponents of controlled use defended moderate drinking as a sensible and realistic treatment goal, especially for people who are not severely dependent on alcohol. Opponents claimed that controlled drinking was a dangerous treatment goal that could lure problem drinkers into risky experiments and eventually ruin their lives. The debate subsided in the 1990s and 2000s, but as late as in 2011, an editorial in the journal *Addiction* described reduced drinking as a "closet treatment goal" (Sobell and Sobell, 2011). By this Sobell & Sobell meant that low-risk drinking outcomes are very common – within and outside of treatment – but that reduced drinking is still a disputed treatment goal that few treatment facilities advertise. International research confirms this picture, also showing that resistance to controlled drinking goals is greater in the US treatment system than in several other countries, e.g. the UK, Switzerland and Australia (Rosenberg and Melville, 2005; Klingemann and Rosenberg, 2009; Dawe and Richmond, 1997; Davis and Rosenberg, 2013; Rosenberg and Davis, 2014). One reason for these country differences is the strength of the illness model of addiction in the USA. According to this model, addiction is a progressive and irreversible condition which can only be held in check if the addict becomes an abstainer. Controlled drinking as a treatment goal, has therefore traditionally been regarded as incompatible with the very essence of addiction, understood as a state of compulsion and loss-of-control.

If controlled drinking has been debated as a treatment goal, *controlled use of illegal drugs* is even more conflict-ridden. Indeed, Decorte (2001) states that, for many opponents, controlled use of illegal substances is a contradiction in terms; how could a controlled version of an illegal activity ever be a legitimate treatment goal? Yet surveys among treatment professionals in different countries show that non-abstinence is defined as an acceptable treatment goal by a relatively large proportion of respondents, especially when it comes to cannabis use, and especially if controlled use is described as an intermediate rather than an ultimate goal (Rosenberg and Davis, 2014). Controlled use of other illicit drugs, such as cocaine and MDMA/Ecstasy, and controlled use as a final treatment goal is surrounded by far more skepticism (Rosenberg and Davis, 2014). Research also indicates that acceptance of non-abstinence goals has grown with time, in parallel with an increased focus on harm reduction measures in relation to illegal drug use, such as methadone treatment, needle exchange programmes and drug injection rooms (Ogborne and Birchmore-Timney, 1998; Rhodes and Hedrich, 2010; Järvinen, 2008; Järvinen and Miller, 2010). Yet there is a surprising lack of research on the actual existence of treatment programmes aiming at controlled use of illegal drugs – this goes for cannabis as well as other illegal drugs – and on the treatment contents, methods and results of such programmes.

One of very few studies in this field is Lozano et al. (2006) analysis of US adult cannabis users in treatment. The aim of the study was to examine personal treatment goals (abstinence or moderation) among treatment seekers. The study showed that about one third of the 285 participants had moderation as their treatment goal at baseline; that this goal was more common among participants with less severe cannabis problems; and that participants were more likely to achieve outcomes consistent with their personal goals than goals defined by others. Another study (Stea et al., 2015) focused on moderation vs. abstinence goals among 119 Canadian cannabis users who had recovered from cannabis problems (with or without the help of treatment). The study confirmed the findings of Lozano et al. (2006) showing that moderation goals were associated with less severe cannabis problems than abstinence goals. Other differences were that the moderation group had more often changed their drug use without the help of treatment and that they tended to see cannabis as less harmful (to the individual and society) than the abstinence group. The study also showed that participants' goal selection was often fluid, changing several times during the recovery process (Stea et al., 2015).

The present research picks up the thread from these studies on moderation goals in treatment. In contrast to them, however, this paper is based on qualitative interviews. I analyse drug treatment not with the help of numerical measures of treatment outcomes and participant characteristics, but with the help of interview accounts where participants describe their treatment experiences with controlled use goals. Qualitative social science research on drug treatment and recovery is limited: examples include McIntosh and McKeganey, 2000; Holt, 2006; Hughes, 2007; Radcliffe and Stevens, 2008; Rivera-Suazo et al., 2015; Järvinen and Ravn, 2014. This paper contributes to this sparse tradition of studies analysing drug problems – here problems with cannabis and party drugs – from the point of view of the users themselves.

2. Theoretical frame

In rational choice theory, addiction has (at least partly) been incorporated into the area of human control. People suffering from addiction have been described as "rational" on their own terms. Like other people, they try to maximise their preferences by choosing the most attractive line of action among the alternatives available to them. However, according to classical rational choice theory, problem drinkers and drug users gradually change their relationship to alcohol and drug consumption. After a period of use, the substance used by the addict starts to reinforce its own consumption (due to the development of tolerance) (Becker and Murphy, 1988). Also, people who have developed a problematic substance use tend to weigh the goods of the present more heavily than those of the future, hereby "discounting the future" to a higher degree than people with an unproblematic use (Becker and Murphy, 1988). The result is often that they choose the pleasures of substance use in the present at the expense of their long-term goal of avoiding excessive use.

Other contributors to rational choice theory on addiction have distinguished between cognitively mediated motivations and visceral influences (drives, emotions, bodily sensations) to describe why addicts often go with the "wrong alternative" when choosing between abstinence and continued substance use (Loewenstein, 1999; Elster and Skog, 1999; Yaffe, 2001). In this perspective, the difference between addicts and non-addicts lies in the vulnerability of the former to visceral influences. When cognitive and visceral factors compete to influence an addict, drives and bodily sensations win and steer him or her into continued drug use. Characteristic of addiction is that visceral factors crowd out all goals other than the ones related to addiction and that addicted individuals experience "biased expectations", overestimating their future ability to stop drinking or taking drugs (Loewenstein, 1999: 236).

Holton (2009) and Holton and Berridge (2013) continue this tradition of differentiating between cognitive long-term strategies for action and visceral influences anchored in the present. Their aim is to develop a middle path between illness theories of addiction (emphasising loss-of-control) and rational choice theory (Holton and Berridge, 2013). In their view, addiction is a struggle between