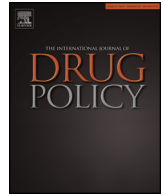




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Addiction stigma and the biopolitics of liberal modernity: A qualitative analysis

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ABSTRACT

Definitions of addiction have never been more hotly contested. The advance of neuroscientific accounts has not only placed into public awareness a highly controversial explanatory approach, it has also shed new light on the absence of agreement among the many experts who contest it. Proponents argue that calling addiction a 'brain disease' is important because it is destigmatising. Many critics of the neuroscientific approach also agree on this point. Considered from the point of view of the sociology of health and illness, the idea that labelling something a disease will alleviate stigma is a surprising one. Disease, as demonstrated in that field of research, is routinely stigmatised. In this article we take up the issue of stigma as it plays out in relation to addiction, seeking to clarify and challenge the claims made about the progress associated with disease models. To do so, we draw on Erving Goffman's classic work on stigma, reconsidering it in light of more recent, process oriented, theoretical resources, and posing stigmatisation as a performative biopolitical process. Analysing recently collected interviews conducted with 60 people in Australia who consider themselves to have an alcohol or other drug addiction, dependence or habit, we explore their accounts of stigma, finding experiences of stigma to be common, multiple and strikingly diverse. We argue that by treating stigma as politically productive – as a *contingent biopolitically performative process* rather than as a stable marker of some kind of anterior difference – we can better understand what it achieves. This allows us to consider not simply how the 'disease' of addiction can be destigmatised, or even whether the 'diseasing' of addiction is itself stigmatising (although this would seem a key question), but whether the very problematisation of 'addiction' in the first place constitutes a stigma process.

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Introduction

Definitions of addiction have never been more hotly contested. The advance of neuroscientific accounts has not only placed into public awareness a highly controversial explanatory approach, it has also shed new light on the absence of agreement among the many experts who contest it. Key neuroscience proponent Nora Volkow (Director of NIDA) argues that the approach allows us to

understand that addiction is a 'brain disease' and that this disease approach is important because it is destigmatising. The conviction that disease labels destigmatise addiction is also evident among many of NIDA's critics, although the disease models they use do not emphasise the 'brain' in the same way. Considered from the point of view of the sociology of health and illness, the idea that labelling something a disease will alleviate stigma is a surprising one. Disease, as demonstrated in that field of research, is routinely stigmatised (see, for example, [Jutel, 2011](#); for stigma and medical diagnosis). In this article we take up the issue of stigma as it plays out in relation to addiction, seeking to clarify and challenge the claims made about the progress associated with disease models. To

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do so, we revisit the conceptual terrain established in Goffman's classic work on stigma, reconsidering it in light of more recent, process oriented, theoretical resources, and posing stigmatisation as a performative biopolitical process. Analysing recently collected interviews conducted with 60 people in Australia who consider themselves to have an alcohol or other drug addiction, dependence or habit, we explore their accounts of stigma, finding experiences of stigma to be common, multiple and strikingly diverse. Stigma, it seems, emerges in and through countless activities, relationships and circumstances and plays out in an almost infinite range of ways. This reach and ubiquity invites analysis, especially from the point of view of process given its constant presence. What are the operations of addiction stigma in these instances? What, since it is hardly rare, does it achieve politically? Taking the accounts together, what does it say about drug use per se in Western liberal democratic settings? By treating stigma as politically productive – as a *contingent biopolitically performative process* rather than as a stable marker of some kind of anterior difference – we can better understand what it achieves. In turn this allows us to consider not simply how the 'disease' of addiction can be destigmatised, or even whether the 'diseasing' of addiction is itself stigmatising (although this would seem a key question), but whether the very problematisation of 'addiction' in the first place constitutes a stigma process—a process that for specific biopolitical reasons in need of further, ongoing, examination, remains indispensable to contemporary liberal societies.

Background

Definitions of addiction and views on the best ways to respond to it have varied significantly over time, and remain multiple and contested. The social science literature on the history and contemporary trajectory of the concept is extensive and has diversified over time to acknowledge the rather different articulations of addiction that occur depending upon the substance under discussion, other issues such as race and gender, and political and cultural variation across time and place (including variations in terminology such as 'dependence', 'substance use disorder' and so on) (see Fraser, Moore, & Keane, 2014 for a detailed discussion of this history). The most influential form taken by the idea of addiction recently is that offered by neuroscience. While social and cultural factors are sometimes acknowledged within neuroscientific approaches as contributing to addiction (Fraser, 2013), the 'brain reward system' is their main focus. According to NIDA scientists Volkow and Li (2004, p. 163), addiction is 'the neurobiology of behaviour gone awry'. As Volkow (2015) explains in a speech entitled 'Addiction: A disease of free will',

If we embrace the concept of addiction as a chronic disease where drugs have disrupted the most fundamental circuits that enable us to do something that we take for granted—make a decision and follow it through—we will be able to decrease the stigma, not just in the lay public, but in the health care system, among providers and insurers.

However, the benefits of the brain disease model have also been questioned. As Rose and Abi-Rached (2014) point out about neuroscience in general, the promise that it would revolutionise medicine has so far failed to materialise. Courtwright (2010) makes a similar observation about its approach to addiction, stating that the view that neuroscience would destigmatise drug use and challenge prohibitionist drug policy is not proving correct. It is becoming evident that labelling addiction a brain disease and then attempting to 'educate' the public about this disease is not producing any consistent change in stigmatising perspectives (see, for example, Meurk, Carter, Partridge, Lucke, and Hall (2014) for attitudes research on the brain disease model

of addiction).¹ Indeed, while some may consider Volkow's intervention motivated by a desire to replace a more severe stigma (criminalisation) with a less severe one (pathologisation), this hierarchy of severity too is questionable. In this article we consider these issues of stigma as they relate to addiction. While our data do not allow an extended examination of the neuroscientific approach and its reception, we situate our analysis in its claims about the destigmatising potential of the brain disease model because it represents the principal (highly influential) mode in which more general assertions about the benefits of pathologisation are currently articulated. In turn this allows us to ask bigger questions about stigma and its operations. In our analysis we explore the many manifestations of stigma described by our interview participants, thinking through the political operations of stigma more closely than is customary in this field. Finally, we speculate on the kinds of conceptual changes necessary if overcoming stigma really is a societal goal.

Literature review

Research that takes in experiences and practices of stigma in relation to drug use is extensive and diverse. Along with differences in disciplinary and methodological approaches, there are differences in scale and specificity. In this latter respect the literature takes two main forms (although see, for example, Room, 2005). One form comprises highly specific studies on stigmatising practices in particular settings such as drug treatment services, hospitals and workplaces, on how individuals cope with stigma, and meta-analyses of these bodies of work (Barratt, 2011; Cama, Brener, Wilson, & von Hippel, 2016; Hathaway, Comeau, & Erickson, 2011; Keyes et al., 2010; Kulesza, Larimer, & Rao, 2013; Livingston, Milne, Lan Fang, & Amari, 2011; Luoma et al., 2007; Radcliffe & Stevens, 2008; Rivera, DeCuir, Crawford, Amesty, & Fuller Lewis, 2014; Simmonds & Coomber, 2009; Treloar & Holt, 2006). This work explores and documents experiences of stigma, and the operations of stigmatising perspectives, and considers the impact of stigma on individuals as well as ways of tackling it. Much of the work is based in broadly psychological or social psychological approaches that tend to attend most closely to the individual or local level, tracking intra-psychic and local dynamics and effects.

The second form comprises broader research projects that incorporate into their analyses the operations of power, marginalisation and inequality in the lives of consumers of drugs. This work offers important, often highly nuanced and contextualised, insights into lives and settings inflected by forces largely inseparable from stigma (e.g. discrimination and exclusion). Ethnographic studies of communities, treatment services and drug markets are excellent examples of this (Bourgeois, 2003, 2011; Carr, 2010; Dwyer, 2011; Dwyer & Moore, 2010; Maher, 1997; Raikhel, 2016; Weinberg, 2005), along with sociological studies of drug-related issues and settings (Fraser & Valentine, 2008; Fraser & Seear, 2011; Pennay & Moore, 2010; Race, 2008; Rhodes et al., 2007). This body of work is often driven by an explicit awareness of the operations of power and inequality that form the basis for stigma and discrimination, illuminating the political terrain on which individuals are obliged to act and prompting questions about the scale on which change is required if lasting improvements in the standing of people who use drugs are to be achieved. Illuminating the diverse forms of disadvantage and discrimination people who use drugs experience, it analyses the role of gender, race, economic status, neighbourhood, sexuality and many other

¹ Whether this is because encounters with neuroscientific accounts are limited, or fail to persuade, or because attitudes are simply inconsistent, remains incompletely researched, but see Meurk, Hall, Morphett, Carter, and Lucke (2013).

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