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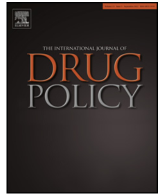
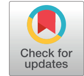


Ordering clinical realities: Controversy and multiplicity in alcohol and other drug treatment for young adults



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ABSTRACT

Background: Although young adults receiving treatment for alcohol and other drug (AOD) use often experience disadvantaged life circumstances, there has been little qualitative research into how treatment agencies understand and respond to intersections between these life circumstances and the AOD use of their clients.

Methods: This article draws on analytic techniques from science and technology studies to detail how treatment clinicians become sensitive to client life circumstances; how therapeutic plans of action are formed; and how clients respond to these processes. Ethnographic data were gathered through interviews with clinicians and agency staff, documentary analysis and field observations in a public AOD clinic treating young adults in Melbourne, Australia.

Results: Findings detail emerging controversies concerning dependence, dosage, mental health and AOD comorbidities, forensic treatment, and resumption of use after treatment.

Conclusion: I argue that each controversy can be understood as a contest between *aggregated*,*humanist* and *situated* modes of ordering clinical phenomena. Aggregated modes of ordering are crafted for coherence at a population level and position AOD use as the primary problem in clients' lives. Humanist modes of ordering foreground clients' poor life circumstances and lack of resources, and frame treatment to address AOD use as benevolent. In situated modes of ordering, the effects of AOD use are transformed by emotional, social and material entanglements and AOD use is no longer necessarily *the* problem in clients' lives. I conclude that, since clinicians seem to readily abandon aggregated approaches in favour of humanist ones, and humanist modes of ordering are often ineffective insofar as they are politically disempowering and engender client resistance, the scientific task of constructing practice tools for more situated approaches in clinical AOD treatment settings seems to be a priority.

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Introduction

Australia's use of publicly-funded alcohol and other drug (AOD) treatment agencies is increasing, with 118,741 individual clients entering treatment in 2013–14, an 8% increase from the previous year. Of these clients, 40% were aged under 30 years (Australian Institute of Health & Welfare, 2015). That young adults receiving treatment for AOD use experience material disadvantage and complex social problems is well known (e.g., Howard 1993; MacLean, Kutin, Best, Bruun, & Green, 2013), but there has been little qualitative research into how Australian treatment agencies respond to intersections between the life circumstances and AOD use of their clients. In light of these complexities, this article considers some controversies about the use of AOD, and about the young adults who receive clinical treatment for their AOD use. I focus on the different modes of ordering reality at work, and how clinicians and clients respond to these multiplicities. I argue that the modes of ordering in the clinic can be categorised as *aggregated*, *humanist* and *situated*. Aggregated modes of ordering emerge from clinical science, and are held in place by diagnostic nosologies, guidelines, disciplinary demarcations, and devices for inscribing conditions such as mental health problems. They have the political consequence of positioning AOD use as the *sine qua non* of difficult life circumstances. Aggregated modes of ordering are often set aside by clinicians who prefer *humanist* modes of ordering in which their service provision is rendered as a benevolent response to clients' unmet material and psychological needs. Humanist approaches open channels of resources for clients, and acknowledge more fluid interactions between AOD use and difficult life circumstances. However, clinical interventions

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remain limited to addressing AOD use, either directly or indirectly. This has the consequence of making humanist modes of ordering complicit in relegating disadvantage to the background, while foregrounding AOD as the primary source of life problems. Clients sometimes resist both aggregated and humanist modes of ordering and advocate for fully *situated* accounts of their circumstances. These understand the effects of AOD use to be transformed by emotional, social and material entanglements and resist the foregrounding of AOD use as *the* problem in their lives. Each of these ways of knowing represents a political claim about the nature of AOD use and disadvantage.

To develop these arguments, I draw on analytical techniques from science and technology studies. One text has been particularly influential in my analysis – Annemarie Mol's (2002) *The body multiple: Ontology in medical practice.* Mol studies the different *modes of ordering* atherosclerosis in a single Dutch hospital. Mol's analysis describes an ontological proposition where existing realities of disease are not 'discovered' by diagnostic practice, but performed through them. Clinical modes of ordering are the means through which doctors make sense of their patients' discomfort and suffering, and through which they determine a course of therapeutic action. The resulting realities might have emerged differently had the technological and material practices of the clinic been otherwise. My study similarly documents different clinical modes of ordering problematic AOD use. These are the means through which clinicians become sensitive to the forces that mediate events of consumption and harm, and through which they determine a course of therapeutic action. The analysis follows the use of psychometric instruments, lists, protocols, clinical wisdom, disciplinary paradigms and heuristics. Mol argues that different technological and embodied instruments for ordering reality do not describe a single entity with more or less accuracy, but enact that entity multiply. As multiple enactments accrue, they generate controversies about the ontology of their entities of concern. Analysing the controversies surrounding clinical phenomena is useful for AOD treatment research because it highlights the interests and politics at play, and because it prompts stakeholders to consider what kind of entities are being treated. Rather than arguing that dominant modes of ordering AOD treatment for young adults are incorrect, or trying to resolve the controversies they generate, my aim is to identify and examine these modes and controversies in order to generate productive insights into alternative potential formulations of AOD treatment for young adults.

International literature reviews in the field of AOD treatment ethnography have suggested that the field is only sparsely covered (Carr 2010; Hunt & Barker 1999; Zigon 2010). One small corpus concentrates on pharmacotherapy users and their treatment settings (e.g. Koester, Anderson, & Hoffer 1999; Kolind 2007; Meyers 2009; Saris 2008) while another focuses on therapeutic communities (e.g. Erdos, Gabor, & Brettner 2009; Seltzer & Gabor 2009; Zigon 2010, 2011). Studies in these areas detail how culturally and historically specific ideas about addiction translate into particular forms of therapy. The studies by Koester et al. (1999) and Kolind (2007) focused on representing clinical practices from the users' point of view, and developed situationally based understandings which contrasted with the reductionist definitions applied by dominant clinical literature. In Zigon's (2010) study of an Orthodox Christian therapeutic community in Russia, 'egoism' is the central malady that is identified and treated (p. 331). Central malady is a concern of my study too, but no single theory was evident, and I instead identified controversy, contradiction and multiplicity. One text sharing Zigon's concern with a unified theory of therapeutic action is Carr's (2010) book, *Scripting Addiction: The Politics of Therapeutic Talk and American Sobriety*. Carr gives a detailed rendering of the therapeutic practices used in a women-only therapeutic community in the United States. She characterises the representational economy which naturalises the different roles within the therapeutic institution and uses clinical training materials, diagnostic practices and therapeutic interactions as evidence. In the case study clinic, clinicians and clients each take roles in getting beneath clients' successive layers of denial and anger, and then authentically discover pre-existing inner feelings, as a path to healing personally and from substance dependence. 'Denial' of the 'realities' of addiction is taken to be a definitive aspect of addiction itself (p. 86). It is a study of the deployment, accommodation and disingenuous manipulation of this particular script of addiction and recovery. The argument is generalised to reflect more broadly on the constitution of language, ideology and personhood in the contemporary United States. Finally, Carr argues for an 'ethnographic method' of social work. While my work has much in common with Carr's, it features an important departure. My analysis concentrates on controversial topics negotiated between the clients, clinicians and various rituals of clinical science and policy. In contrast, Carr (2010) presents clinicians as 'trained adherents to a set of professional norms' (p. 94). In my study, the professional norms and realities of addiction are given as fluxing interrelations rather than as definitive aspects.

Two further ethnographic studies from the United States have made substantial contributions to the field. Bourgois and Schonberg's (2009) study of homeless 'dopefiends' in San Francisco details the 'ricochets' between high-tech medical treatments and the struggle to survive during a local law and order offensive to erase the homeless and indigent from the landscape. Garcia (2007) attends to the strands of history, politics, culture and family gathered within a rural heroin withdrawal clinic in New Mexico, detailing how each acts to constitute the heroin problem in the region. She argues that, in their indifference to these elements, the medical and juridical systems perpetuate chronic addiction. Garcia joins with Bourgois and Schonberg in arguing for more substantive housing and social services; and for a transformative ethics of care.

Several ethnographic studies of Australian AOD treatment settings have also been published. Chenhall (2008) examines the informal aspects of a treatment program in an Indigenous residential AOD rehabilitation service. The study aimed to inform evaluation designs that typically measure abstinence, length of treatment, or other officially recorded information; and to detail more complex and layered meanings of treatment for clients. In particular, the study identified oscillating periods of mutual support and discipline as significant dimensions of treatment currently overlooked in evaluations. A study by Foster, Nathan, and Ferry (2010) also sought to contribute more nuance and qualitative depth to understanding of what constitutes 'success' among AOD treatment clients. Their study of a therapeutic community for AOD using adolescents considered a number of areas of program operation that are not typically considered in evaluation design. For example, they developed concepts of 'navigating' and 'engagement', which have been used as binaries in evaluation literature, and proposed that they be thought of as two ends of a 'continuum with residents moving between the two at different times and with different activities' (p. 537). Roarty et al. (2012, 2014) used ethnographic research in a youth AOD treatment setting to construct a qualitative tool for measuring young people's progress in treatment. While there are numerous treatment measures for adults, the authors note a paucity of measures that provide 'developmentally informed approaches to treatment research with alcohol abusing teens' (Roarty et al. 2012, p. 718). The study details a rubric for tracking behaviour change, similar in some ways to Prochaska and Diclemente's 'transtheoretical model' (1986) but developed specifically for adolescents. My study engages with Prochaska and Diclemente's work too, but rather than proposing further refinements, I suggest that such rubrics

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