

“CRIPPING” ADDICTION AND LIBERATING PEOPLE WHO USE DRUGS:
A BIOETHICS OF DISEASE, DIAGNOSIS, DISABILITY, AND DIVINITY
IN SUBSTANCE USE AND HARM REDUCTION

BY

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LIST OF ABBREVIATIONS

AA	Alcoholics Anonymous
ACOG	American College of Obstetricians and Gynecologists
ADHD	Attention Deficit Hyperactivity Disorder
AMA	American Medical Association
APA	American Psychiatric Association
ASAM	American Society of Addiction Medicine
ASDAH	Association for Size Diversity and Health
BDMA	Brain Disease Model of Addiction
CBT	Cognitive Behavioral Therapy
DBT	Dialectical Behavioral Therapy
DNP	Do Not Prosecute
DNR	Do Not Resuscitate
DPA	Drug Policy Alliance
DSM	Diagnostic and Statistical Manual of Mental Disorders
EMDR	Eye Movement Desensitization and Reprocessing
EMT	Emergency Medical Technician
HAES	Health at Every Size
HRC	Harm Reduction Coalition
ICD	International Classification of Disease
IOP	Intensive Outpatient Program
IVDA	Intravenous Drug Abuser
LEAD	Law Enforcement Assisted Diversion
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual, etc.
MARA	Medication-Assisted Recovery Anonymous
MAT	Medication-Assisted Treatment
NA	Narcotics Anonymous
NIDA	National Institute on Drug Abuse
NIH	National Institutes of Health
NIMH	National Institute of Mental Health
NRSV	New Revised Standard Version
ODU	Opioid Use Disorder
POC	People of Color
PORT	Post-Overdose Response Team
PWUD	People Who Use Drugs
SAMHSA	Substance Abuse and Mental Health Services Administration
SUD	Substance Use Disorder
UPIAS	Union of Physically Impaired Against Segregation
USU	Urban Survivors Union
WHO	World Health Organization

ABSTRACT

In 2017, drug overdoses surpassed both car accidents and gun deaths as a cause of mortality in the United States (Scholl et al 2019). The overdose crisis has put the question of how to understand and treat addiction at the forefront of public discourse. The brain disease model of addiction (BDMA) dominates popular rhetoric, but medicalization remains entangled with criminalization and social control. Márcio Fabri Dos Anjos asserts, “The principal enemy faced by bioethics is thus not simply death but *premature death and suffering as the fruits of injustice*” (Dos Anjos 2012, p. 84). In my thesis, I argue that the current crisis of substance use and drug overdose emerged as the fruits of injustice, including racialized drug policies, biopolitics that enforce a prejudicial standard of health, and the moralization and condemnation of pleasurable deviance. In conversation with disability studies and social determinants of health, I interrogate current power regimes of medicalization and social control, offer alternative understandings of substance use and addiction, advocate for harm reduction as both a practical response and as a matter of justice, and articulate the beginning of a liberation theology for people who use drugs that demands a re-imagining of health writ large.

INTRODUCTION

A junkie walking through the twilight

I'm on my way home

I left three days ago, but no one seems to know I'm gone

Home is where the hatred is

Home is filled with pain and it

Might not be such a bad idea if I never, never went home again

In his song “Home Is Where the Hatred Is,” American soul and jazz poet Gil Scott-Heron paints a haunting picture of the displacement and isolation that many people who use drugs (PWUD) experience (Scott-Heron 1971):

Stand as far away from me as you can and ask me why

Hang on to your rosary beads

Close your eyes to watch me die

You keep saying, kick it, quit it, kick it, quit it

God, but did you ever try

To turn your sick soul inside out

So that the world, so that the world

Can watch you die

Scott-Heron's lyrics depict addiction as a lonely personal battle. Even compassionate responses to people experiencing addiction persist in individualizing the struggle and pain associated with chaotic drug use.

Home is where I live inside my white powder dreams

Home was once an empty vacuum that's filled now with my silent screams

Home is where the needle marks

Try to heal my broken heart

And it might not be such a bad idea if I never, if I never went home again

Buried in the words to this song is the acknowledgement that the pain PWUD experience is not just internally produced, it is also externally inflicted. After all, *home* is where the hatred is.

The experience of dislocation for PWUD may manifest in personal relationships, in employment opportunities (or lack thereof), in access to quality health care, in entanglements with the criminal justice system, and in internalized stigma and shame. Despite efforts on the part of public health and harm reduction advocates to move away from criminalizing PWUD, the criminal justice system continues to be the primary vehicle for dealing with problems related to substance use, perpetuating injustice and prejudice related to race and class in the United States. In my thesis, I aim to deconstruct the contradictory ways in which addiction has (or has not) been medicalized; to interrogate how the medicalization of substance use is deeply intertwined with biopower

and social control; to “crip” addiction by seeking wisdom and tools of resistance from disability studies; and finally, to employ a strain of Christian thought—liberation theology—in reorienting a theological understanding of and response to addiction and substance use that turns the tables on dominating power and advocates for a reconfiguration of the concept of health itself. While I strongly criticize the current state of affairs in regards to the way society treats PWUD, my aim is not wholly to dismiss dominant approaches to substance use and addiction, but to advocate for a broadening of our imagination when it comes to understanding and treating problems associated with substance use. As I will demonstrate, no approach to the complex problem of addiction is without limitations, but this truth makes a more diverse ethical, medical, sociological, and theological toolkit for framing, responding, and treating substance use and addiction an urgent necessity.

Bioethics as a field already has addressed several issues both directly and indirectly related to substance use and addiction. Systems for determining decision-making capacity and protecting informed consent are relevant to this discussion, especially in cases of coercion and involuntary treatment. Some framings of the philosophical and neuroethical questions of free will and agency illuminate an understanding of the valuing and decision-making processes of PWUD. Debates about maternal-fetal conflict and the challenge of substance use by pregnant women have been addressed by major ethical bodies, practitioners, and researchers alike. The practice of distributing unused syringes to injection drug users has been the subject of ethical debate among clinicians and harm reductionists. My project in part is to bring diverse strands of bioethical inquiry together

and synthesize them into a more coherent and holistic account of substance use and addiction; more importantly, my aim is to extend the reach of such inquiry to encompass a more explicitly social justice-oriented approach, insisting that what goes on in the clinic or the treatment center or the courtroom cannot be separated from what goes on in public policy and in communities.

In this thesis, I construct a bioethical framework for understanding, affirming, and implementing the principles of harm reduction in clinical settings as well as in community outreach and advocacy. There is a persistent disconnect between the grassroots advocacy work of harm reductionists and the efforts of clinicians, traditional outreach workers, and policy makers to seek a more compassionate approach to PWUD; academic study and medicalization of substance use often lacks a deeper understanding of the social justice implications of their publications and actions. Harm reductionists overwhelmed by the urgency of the current overdose crisis may not have the time or ability to stop and clearly articulate an ethical framework for their movement that is intelligible beyond circles of people who already speak their language and share their values. Part of the work of this thesis is the work of translation—of finding common linguistic and ethical ground between harm reduction and disability rights activism, between anti-racist movements and the affirmation of PWUD’s basic human dignity, between queer theory and models of morality and deviance. I illuminate how biopower works to control problematic bodies and communities, oppressing PWUD—especially marginalized groups whose members use drugs and/or are stereotyped as drug users—

and compounding the suffering already endured by individuals, families, and communities.

A word on language: I intentionally avoid terms like “addict” and “substance abuse” because they are loaded terms and often misapplied. Someone who uses illicit drugs often is presumed to be an “addict” but may not meet diagnostic criteria for substance use disorder (SUD) or experience their drug use as problematic. “Addict” has come to carry the same stigma as a term like “junkie” for many PWUD, and while some drug users reclaim either or both terms subversively, they are not for a non-user to deploy. I avoid “substance abuse” because it frequently is applied based more on the kind of drug being taken than on the actual pattern of behavior, and because it implies a value judgment in reference to what I will show can be a problematic, unexamined deference to medical authority. Terms like “clean” and “dirty” to describe abstinence, substance use, or the result of a drug test carry moral implications and harmful imagery. Unless specifically discussing the diagnosis of substance use disorder (SUD), I do not refer to it because of the challenges inherent in diagnosis that I explore in Chapter Two. Instead, I try to use person-centered language, speaking most frequently of people who use drugs (PWUD) and people experiencing addiction (and, when addressing SUD, people diagnosed with SUD). More reasons for these choices will become clear over the course of my thesis.

Chapter One focuses on the concept of disease as applied to substance use and addiction. I first address the subjectivity of the term “disease” itself, then cover the basics of the brain disease model of addiction (BDMA), trace the general contours of its historical

development, and examine how it is used in medicine and in recovery groups like Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and others. One of the main arguments for classifying addiction as a disease is the idea that doing so reduces stigma; I analyze this claim, compare it with similar historical arguments like the one regarding whether to include homosexuality in the Diagnostic and Statistical Manual of Mental Disorders (DSM), and question a broader moralization of health typical of American society today. Drawing on accounts by neurologist Marc Lewis and journalist Maia Szalavitz, I explore the limitations of the BDMA, present alternative models for understanding what is going on in the experience of addiction, and recommend a more nuanced approach to problems related to substance use. Finally, I interrogate the distinction between public health and medicine in relation to substance use and look to harm reduction for a different approach to PWUD and people experiencing addiction.

In Chapter Two, I explore the process and function of diagnosis in relation to substance use disorder (SUD), moving from a focus on the construct of addiction-as-disease to the effects of a diagnostic label on PWUD. I give an overview of common diagnostic tools, namely the DSM, and the pros and cons of popular forms of recommended treatment for people diagnosed with SUD. Despite the push to view addiction as a disease rather than a moral failing, substance use and addiction remain highly stigmatized, and PWUD frequently are subject to surveillance and control through the medical system. In this chapter, I question the way medicalization functions to control deviant communities and health behaviors, and I address the problematic relationship between the legal system and the medical world when it comes to substance use and addiction. Lastly, I address the

question of agency in PWUD, drawing on bioethical principles of autonomy and respect for persons to question assumptions about substance use and addiction and to offer an alternative approach to diagnosis and treatment for people whose relationship with substances becomes problematic.

Chapter Three turns to disability studies, particularly the social model of disability, engaging resonances between disability rights activism and the social justice movement of Harm Reduction. Here, I seek parallels between the impairment/disability distinction in the social model of disability and the argument that drug policies, not drug use itself, are responsible for much of the harm attributed to substance use. I assert that a failure to distinguish between harms directly related to substance use and harms caused by prohibition and racialized drug policy result in a deadly situation where PWUD are unnecessarily disabled and medicalized on the one hand and barred from access to urgently needed healthcare on the other. I argue that mass incarceration acts as a disabling force on marginalized communities and note that the contradictory ways in which we conceive of and punish addiction in our society create an unjust system that disproportionately punishes people of color (POC) and people who are poor. Drawing on the treatment vs. enhancement debate and a disability rights lens thereof, I examine the problem of pleasure in substance use and in relation to a broader conception of how medicine should and should not function. Ultimately, I advocate for an intersectional approach to enabling agency that honors the embodied experiences of PWUD, people with disabilities, and other marginalized communities.

My final chapter, Chapter Four, presents the beginning of a liberation theology for PWUD. I introduce liberation theology broadly and make an argument for why PWUD should be a population of concern for liberation theologians. Drawing on the work of Cyndi Suarez, I offer an alternative to biopower that shifts from dominating power to liberatory power, power that is available to marginalized persons even in the midst of oppression. With gratitude to Wendell Berry, I argue that liberation theology demands a shift from the individualized model of health that dominates the American imagination today to a communal ideal that challenges much of our thinking and practice related to substance use and addiction but which more authentically resonates with a Christian ethic of embodiment and wellness. With help from Jarrett Zigon's "anthropology of potentiality" (Zigon 2019, p. 13), I ask how resistance to the war on drugs and the act of overdose reversal represent resistance to and transformation of an unjust present into a liberated future, drawing on Christian eschatology and a theology of resurrection.

I conclude that the isolation Gil Scott-Heron sings about is reproduced and reinforced in common conceptions of health and medical practice, especially in regards to stigmatized behaviors and conditions like substance use and addiction. A bioethics of disease, diagnosis, disability, and divinity for PWUD requires re-imagining health, not as a moral achievement or a duty of citizenship for the individual, but as a capacity or resource (ASDAH 2013) that can only be accessed by and in community. If "home is where the hatred is," we must seek a transformation of the systems, assumptions, and interactions that make it so, building a world where people who embody difference can be made whole and welcomed home.

CHAPTER ONE: DISEASE

To understand the meaning of disease as applied to substance use, I will examine what it means to call something a “disease”; review the history of calling behaviors linked with substance use and dependence “disease”; assess the arguments for and the limitations of the brain disease model of addiction (BDMA); examine the interplay of moralization and disease; offer alternatives to the dichotomous question of whether addiction is a disease or a choice; and present harm reduction as a means of approaching substance use as a health issue without unnecessarily medicalizing it. Harm reduction against the background of deconstructing common conceptions of disease is a starting point for imagining potential guidelines for helping people who use drugs (PWUD) self-determine their need for medical intervention and support. Substance use and addiction can serve as examples of the complexities inherent in medical definitions of “disease” and as case studies in alternative ways of discerning the merits of medical intervention.

CHRONICALLY RELAPSING: THE BRAIN DISEASE MODEL OF ADDICTION

Definitions of the BDMA tend to be along these lines: “Drug addiction can be defined as a chronically relapsing disorder, characterised by compulsion to seek and take the drug, loss of control in limiting intake, and emergence of a negative emotional state...when access to the drug is prevented” (Koob & Volkow 2016). Or, according to the American Society of Addiction Medicine (ASAM), “Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry” (ASAM 2011). Substance use

disorder (SUD), according to Koob & Volkow, loops through three stages of disturbance in different neurocircuits: the binge/intoxication stage activates and sometimes overwhelms the brain's reward system; the withdrawal/negative affect stage brings with it unpleasant physical, emotional, and psychological symptoms that motivate continued use of the drug with the help of the amygdala; and the preoccupation/anticipation stage involves an attentiveness to obtaining more of the drug that is driven by the prefrontal cortex (Koob & Volkow 2016). Some addiction specialists characterize SUD as similar to other chronic, relapsing diseases like diabetes, asthma, and hypertension—and similarly difficult to treat (Koob & Volkow 2016).

This definition assumes, first and foremost, that we know what we mean when we label something a “disease.” Disease may be understood, in the most general terms, as a departure from normal species functioning, such that medical interventions designed to restore that functioning after a defect or infirmity are considered treatments, but interventions that aims to make improvements above and beyond that functioning are considered enhancements (Daniels 2000). All of these terms are value-laden and based on assumptions that often cannot hold up under scientific scrutiny. The definition of the disease of addiction rests on the same general concepts of disease broadly construed but is distinct in that it is established relative to the medical prescription of a substance. “Normal” ingestion of a drug is defined by compliance with a doctor's orders; consumption of a substance outside those parameters is deemed illicit and is one piece of defining that pattern of behavior as a disease or disorder. Tellingly, two of the diagnostic criteria put forth by the American Psychiatric Association (APA) for opioid use disorder

(OUD)—tolerance and withdrawal—are not considered fulfilled if those symptoms are the result of “taking opioids solely under appropriate medical supervision” (APA 2013). The way this plays out for PWUD presents problems for the standard itself.

A patient on medication-assisted treatment (MAT) for OUD may take 16mg of Suboxone (buprenorphine and naloxone) daily in adherence to his or her treatment plan. That patient would be expected to develop a tolerance to the Suboxone such that ingestion no longer results in the experience of a “high” but is more about maintaining a baseline. If the patient were to skip a few doses or stop treatment for any reason, he or she would experience withdrawal symptoms, including anxiety, restlessness, gastrointestinal discomfort, runny nose, and so on (APA 2013). A person not under medical supervision might purchase the same 16mg of Suboxone daily on the black market and experience the same tolerance and withdrawal as the patient on MAT. However, instead of a patient, that person is a criminal, and instead of expected side effects of medical treatment, his or her symptoms are signs of a mental disorder. This contradiction is made more salient by the reality that inappropriate manufacturing and prescribing practices—contrary to what the Diagnostic and Statistical Manual (DSM) calls “appropriate medical supervision” (APA 2013)—are a contributing factor to the current opioid overdose crisis. The line between substance use for medical treatment and drug consumption commonly termed “abuse” is unclear, and physician involvement may or may not elucidate it. The distinction between normal and abnormal, use and abuse, disorder and treatment is hazy at best and arbitrary to the point of meaninglessness at worst.

So how did we get here? Conrad and Schneider summarize the history of how opiates have been viewed in society, from not being considered a problem (and in fact being used as a panacea for all sorts of maladies), to becoming a medical problem, to criminalization, and finally to (what I argue is only partial) remedicalization (Conrad & Schneider 1980). Other substances also have been subjected to changing attitudes and approaches over time, both in degree and in kind. Historically, technological advancements including alcohol distillation, the refinement of morphine, and so on have accompanied increases in patterns of consumption often characterized as drug abuse. Alcohol was enjoyed for millennia before the advent of liquor, and opium was smoked and consumed widely before its cousin morphine met the invention of the hypodermic needle; but the introduction of more potent forms of psychoactive substances has over time gone hand-in-hand with increasing problems of overuse and dependence. As Courtwright writes, “When familiar drugs are processed in unfamiliar ways, increasing their potency to unprecedented levels, heightened abuse inevitably, if not always evenly, follows” (Courtwright 2001). As human relationships with substances changed, perceptions of drugs also shifted, and explanations were sought for their potency, not only chemically but also in terms of the sway they seemed to hold over those who used them. In 1785, Benjamin Rush published ‘An Inquiry Into the Effects of Ardent Spirits Upon the Body and Mind,’ proposing that addiction to alcohol be conceived of as a “disease of the will” (Conrad & Schneider 1980, 79-81). This laid the groundwork for a popular interpretation of PWUD’s perceived loss of control as a disorder or disease.

12-Step recovery groups have been a force for promulgating the idea of addiction as a disease in recent history. The language of “disease” is common in 12-Step meetings, and acceptance of the BDMA is all but a requirement for membership in 12-Step groups. However, even the founder of Alcoholics Anonymous (AA), Bill Wilson, was leery of medicalizing the condition he sought to remedy. According to Ernest Kurtz, Bill Wilson and other early members of Alcoholics Anonymous “generally avoided the quasi-technical term *disease*, using in its stead some synonym such as ‘malady’” (Kurtz 1979, p. 22). They stressed that alcoholism was physical, mental, and spiritual, and their support groups were designed to address deep spiritual issues in community rather than to treat a medical disorder. Within AA, alcoholism is described as a physical allergy to alcohol (AA 2001, p. xxviii), but the organization “treated the problem of alcoholism as disease as an ‘outside issue’” (Kurtz 1979, p. 34). AA’s 12 Traditions, the corollary to the 12 Steps designed to guide each group’s self-governance, include the 10th tradition, which states, “Alcoholics Anonymous has no opinions on outside issues, hence the A.A. name ought never be drawn into public controversy” (AA 2001, p.562). AA exists to help people who identify as alcoholics, not to change laws, advocate for drug policy, or push for systemic medical interventions. However, its members are free to do so independently, and many do. While AA does not take an official stand on addiction as a disease when it comes to public policy, 12-Step methods and ideology are common in popular discourse on addiction and recovery as well as in both inpatient and outpatient addiction treatment, where the BDMA often is presented as medical fact.

While AA's promotion of the BDMA may be a mixed bag in terms of how problematic it can become, its founders understood what today's advocates of the model do not always note: that calling addiction a *primary* disease fails to acknowledge underlying issues such as trauma and mental illness that often accompany addictive behaviors. A young woman with an eating disorder may also exhibit all the signs of alcoholism but, upon further questioning, reveal that drinking is the only thing that keeps her from thinking about food—how, then, could her dependence on alcohol be a *primary* disease? And a young man experiencing food insecurity may similarly show signs of alcohol use disorder, but a closer look may make it clear, somewhat similarly to the young woman with the eating disorder, that drinking numbs his hunger and the stress of being unable to access basic goods—how, then, could a “primary” disease of alcoholism be treated in such a patient, if the root of the problem is something else entirely?

BETTER SICK THAN CRIMINAL? MORALIZATION, STIGMA, AND DISEASE

Heavy substance use changes the brain—“Not in one or two systems, but in dozens” (Lewis 2011, p. 154). What the DSM describes as SUD is a complex, multifaceted phenomenon involving multiple brain systems along with genetic and environmental factors. The changes wrought in the brain by addiction do not go away with the removal of the drug; some drugs of dependence cause cravings long after they have completely left the body, and triggers, far from being simply an ominous warning in recovery circles, have a neurobiological basis. Flashing a picture of drug paraphernalia on a screen causes brain activity to spike in people recovering from addiction, and while some of these reactions lessen or disappear overtime, some may persist for years (Lewis 2011, p. 155).

Not all addiction experts agree that such brain changes are evidence of disease, and some of the key components of the BDMA—the loss of control, the chronic nature—have been challenged. For most people diagnosed with SUD, their drug consumption does not meet a strict definition of compulsivity. They do not use drugs at all times and in all places (for example, even longtime drug users tend not to consume illicit substances while in court), and they often stop using for periods of time. Moreover, the process by which a person locates, acquires, purchases, and consumes substances, especially illicit ones, is so complex and requires so many decisions along the way that it cannot rightly be said to be compelled in the truest sense of the word (Frank & Nagel 2016). A study of Vietnam veterans is regularly cited as a challenge to the claim of addiction’s chronic nature, since so many service members who were dependent on narcotics while abroad seem spontaneously to have recovered upon returning home: although 45% of American troops used illicit drugs and 20% reported being addicted while abroad, only 10% of former soldiers who used drugs in Vietnam did so after coming home and only 1% were re-addicted (Robins 1973). The classic symptom of loss of control in addiction can be influenced by expectations about the behavior of PWUD: “cultures in which people do not believe drugs can cause ‘loss of control’ exhibit very little of it” (Reinarman 2013). Another problem with the BDMA is that, although most accounts of it at least mention environmental factors, it risks a form of neuroessentialism that results in clinical approaches that focus too narrowly on the brain, failing to take into account important psychological and social factors (Satel & Lilienfeld 2013, p. 58). In Chapter Three, I will take a deeper dive into the social constructs that can be disabling for PWUD.

Despite its scientific challenges, the BDMA enjoys popularity as a more compassionate approach to addiction than outright criminalization. For some who struggle with a problematic relationship to substances, understanding their experience as a disease may be helpful and liberating, giving them hope for a “cure” or at least a sign that perhaps it isn’t all their fault. Because shame is an integral part of the addiction cycle, reframing one’s own substance use problem or that of a loved one’s as a disease may help mitigate some of the blame that so often makes the problem worse. As neuroscientist and former drug user Marc Lewis notes, the BDMA “makes sense of the helplessness addicts feel and encourages them to expiate their guilt and shame, by validating their belief that they are unable to get better by themselves” (Lewis 2015). However, the hope that the BDMA gives some turns sour and can be destructive for others. Describing addiction as a disease just like cancer or pneumonia may offer false hope that a medical cure can relieve the suffering caused by chaotic substance use just as it might for an infection or tumor (Satel & Lilienfeld 2013, p. 58). Destructive substance-related behavior cycles can be exceedingly difficult to change and interrupt, and although medication-assisted treatment (MAT) is an option for some, it is far from a magic bullet or simple medical cure. Too much false hope, when thwarted, can lead to deeper despair and a worsening cycle.

Another problem with the BDMA is that it can lead to paternalistic attitudes toward people diagnosed with SUD and may fail accurately to describe or give credence to some people’s experiences of recovery. While some may derive a personal and spiritual benefit from AA’s assertion that the alcoholic is powerless before his or her disease, others

may be harmed by such rhetoric and would benefit more from feeling empowered. Some who experience addiction come to a place where they feel they have outgrown their addictions and wish, not to “recover”—to go back—but to move forward. Most people who meet the diagnostic criteria for SUD do eventually move forward and manage not to be re-addicted—which, in the context of a chronic, relapsing brain disease, sounds like a miraculous, spontaneous remission. For people like this, “the disease label may be an unnecessary, even harmful, burden” (Lewis 2015). Calling addiction a “disease” as a metaphor for the actual dis-ease felt by people whose relationship to substances is a struggle may prove liberating for some, but as a category of medicalization, it may be inaccurate and unhelpful.

Proponents of the BDMA argue that accepting addiction as a disease reduces stigma and paves the way for policy changes and access to treatment for people who are struggling. Reducing stigma is an important piece of a broader societal approach to mitigating the harms of substance use and addiction, because the resulting shame and isolation can drive and worsen problems related to substance use. Shame and self-abuse are tangled up in the brain changes that happen in addiction. Marc Lewis addresses this inner critic in the context of the neurobiology of addiction:

...drug addiction is enormously ugly... The internal dialogue fed by that ugliness is usually in the red zone, even *before* addiction sets in. Messages of self-rebuke resonate in the orbitofrontal cortex (OFC), which is in charge of anticipating what others think of us and preparing to react. Which means that the enemy is within,

and that further justifies the logic of self destruction—another self-reinforcing cycle through which calamities of the mind arise from vulnerabilities of the brain (Lewis 2011, p. 304).

As Brené Brown puts it, “Shame is the fear of disconnection” (Brown 2012).

Disconnection and isolation can be deadly for anyone, but especially for PWUD.

A hard-nosed “tough love” rhetoric would have us believe that PWUD need to “hit bottom” before they can get help. Besides the fact that in the current climate of the overdose crisis, a “bottom” may mean death, such an approach only heaps shame on a person who in all likelihood already is stigmatized, marginalized, and isolated. Maia Szalavitz, a journalist who went through her own struggle with addiction, reflects on her experience with such “tough love” at the hands of the criminal justice system: “the disgrace of my arrest and incarceration did not push me to seek recovery; it only made the cravings worse. Shame and guilt didn’t provide any new tools that would allow me to change” (Szalavitz 2016, p. 176). This is precisely how shame works. The fear of disconnection at the root of shame is rarely a source of motivation to change; more often, it dampens a person’s hope that change is possible. As Brown says, “shame corrodes the very part of us that believes we can change and do better” (Brown 2012). Combatting stigma, shame, and isolation is a vital component of the response to the ongoing overdose crisis and to problems related to substance use more broadly.

Therefore, say proponents of the BDMA, we must hammer it into the public psyche that addiction is a disease. A similar argument was made in 1973 during debates within the APA over whether to remove homosexuality from the DSM. Before it was defined as a mental disorder, homosexuality was viewed as either a sin or a crime, or both; once it became a disorder, theoretically it merited treatment rather than punishment. Some argued that this was progress—once homosexuality was in the DSM, people who were gay could receive medical attention rather than prison time or religious penance. As some who pushed to keep homosexuality in the DSM during the debates preceding the 1973 removal quipped, “Better ‘sick’ than criminal” (Bayer 1987). But was it? Perhaps it represented improvement in some ways, but “the negative moral patina remained (at least for some) despite the medicalization” (Frank & Nagel 2016). During the debates over homosexuality’s inclusion in the DSM,

the protestors highlighted cases of social discrimination based on sexual orientation that were ‘justified’ by claims that homosexuality was a mental disorder. This shocked some psychiatrists, who viewed their profession as playing a progressive role in defining homosexuality as a disorder rather than a moral failing subject to prosecution and imprisonment (Zachar & Kendler 2012).

Similarly, more common use of the term “disease” to describe addiction has not made the moralization of substance use disappear (Frank & Nagel 2016). As the late comedian Mitch Hedberg put it, “Alcoholism is a disease, but it’s the only disease you can get yelled at for having” (Hedberg 1999). Both the broader public as well as health care

providers still carry stigma against PWUD and people diagnosed with SUD, despite the BDMA's prominence in the DSM and other diagnostic conventions (Frank & Nagel 2016).

It may be unsurprising that such morally charged topics whose status as diseases have been or are debated would struggle to escape the stigma attached to them, but classification as a disease does not necessarily de-moralize anything, even conditions that are rightly medicalized and which enjoy broad consensus that they are deserving of treatment. The smoker who gets lung cancer is known to have a disease but is condemned for bringing it on herself, as is the diabetic who lives on fast food and soda (and social determinants of health are rarely considered in evaluating either's choices and behaviors). Even diseases whose etiology is random, unknown, or otherwise out of the patient's control can be moralized, if in subtle ways. When theology professor Kate Bowler talks about being diagnosed with Stage IV colon cancer in her 30s, people often ask about things like her diet, habits, anything they think might have brought this on (Bowler 2018). In a forthcoming book, Andrea Lingle shares her experience of delivering a stillborn child, and how no less than three people asked her if she thought *Listeria*—a bacterial infection that can cause fetal death in pregnant women and can be found in deli meats and unpasteurized milk products—killed her baby (Lingle 2019).

What lies beneath these kinds of assumptions and questions is a subtle moralization and a quiet hunt for blame. When we moralize, we are searching for a moral to the story: don't smoke. Don't eat bacon. Don't have deli meat while pregnant. If addiction is a disease, it

seems simple to avoid: Just Say No. But underneath is the blame assigned to the person experiencing addiction for failing to take the steps needed to avoid their unenviable fate. Efforts to explain and blame are really efforts to control, for, as Susan Wendell said, “Suffering caused by the body, and the inability to control the body, are despised, pitied, and above all, feared” (Wendell 1989). If addiction is a disease whose etiology is known, and if we can avoid the action that brings it about, we won’t have to experience the suffering and lack of control—or so we long to believe when we persistently, unconsciously moralize diseases of all kinds.

IF NOT A DISEASE, THEN WHAT? ALTERNATIVE MODELS OF ADDICTION

Discourse concerning addiction often revolves around the question of whether it is a disease or a choice. Implied in this dichotomy is the idea that if it is a disease, the person’s blameworthiness is at least mitigated, if not erased; but if it is a choice, the person is wholly responsible for his or her actions and may be subject to punishment. Of course, there are many diseases brought on by choices, and even in those cases, there may be disagreement over how much agency an individual has and to what extent life circumstances like poverty, trauma, and lack of access to quality healthcare influence those choices and their outcomes and what difference that makes. It is problematic to assume that a person always deserves the natural consequences of his or her choices, and I question just how “natural” those consequences are—and how free the choices—in many instances. There are a multiplicity of factors beyond simple brain chemistry and structure that contribute to what manifests as addiction. For now, we explore alternatives to the binary of addiction-as-disease or addiction-as-choice.

The BDMA focuses on the neurology of substance use and addiction as evidence for it being a disease. Marc Lewis points out that brain change is not sufficient to determine disorder, because everything we do changes the brain. He writes, “One of the key premises of the disease model is that addiction changes the brain. Yet brains are supposed to change. They are designed to change” (Lewis 2016). In regards to observations of brain changes in addiction, Lewis says,

We shouldn't be surprised. Learning to play the piano or violin changes your brain permanently. For example, violin players show increased volume in the part of the motor cortex that controls the left hand. Driving a taxi changes your brain. A famous study using MRI imaging showed that the hippocampus of a typical London cab driver is quite a bit bigger than average (Lewis 2011, p. 155).

A spike in brain activity may be an indicator of pathology, or it may mean a person is eating dinner. Changes in brain structure may be the result of learning a skill or acquiring a bad habit. Lewis points out that the brain self-organizes in response to stimuli, that bad habits are no exception to this rule, and that a label like “disease” is unnecessary to explain the development of such habits (Lewis 2016, p. 155).

On the other hand, addiction is not wholly a choice, and yet choice is an important piece of substance use. Neither madness or badness explains a person's decision to use drugs—it's the simple fact that they experience pleasure, relief, or some other desired outcome

from using drugs (Foote et al 2014). The first time using a drug may be a relatively free choice, as may the second or third, but in the condition we describe as addiction, the person's capacity to choose freely is compromised, though true compulsion cannot be said to be present (as addressed previously). There is still rationality and some degree of choice involved, but it is as if the person who is addicted is acting under duress.

Dependence on a substance may also compromise a person's ability to order desires and values, creating a conflict between first- and second-order desires, as when someone who is addicted to alcohol both wants to drink and has a higher desire not to (Beauchamp & Childress 2013, p. 103). This value conflict may lead people experiencing addiction to make choices they regret later, choices which harm them or the people they love in pursuit of the drug. As Lewis puts it, in addiction, "The brain's condensation of value is an error. Addiction is a neural mistake, a distortion, an attempted shortcut... The drug (or other substance) *stands for* a cluster of needs... Then it becomes *too* valuable, and you cannot live without it" (Lewis 2011, p. 305). This process certainly involves choice, but it also entails a compromise in how much freedom of choice a person comes to experience.

A third way between addiction as a disease and addiction as a choice is presented similarly by both Marc Lewis and Maia Szalavitz:

addiction is not a sin or a choice. But it's not a chronic, progressive brain disease like Alzheimer's, either. Instead, addiction is a developmental disorder—a problem involving timing and learning, more similar to autism, attention deficit

hyperactivity disorder (ADHD), and dyslexia than it is to mumps or cancer (Szalavitz 2016, p. 3).

This is how Szalavitz interprets the acquisition of the potentially destructive habit of addiction and how Lewis categorizes the kinds of brain changes seen in a person addicted to drugs—as more about learning and development than about a primary disease that can be medicalized or a choice that can be punished. The way the memory systems of the brain play into and support the persistence of addictive behaviors is a function of learning (Lewis 2011). For Szalavitz, people with addiction may still benefit from their condition being understood as a learning disorder; for Lewis, addiction is an exaggeration or amplification of the brain’s natural processes of learning and development. In any case, severe addiction eventually interferes with a person’s ability to learn other habits or coping mechanisms, but Szalavitz and Lewis argue that the capacity to grow and change is not lost, even in extreme cases. Neuroplasticity is how people learn, and neuroplasticity is how addictions develop. Though some plasticity is lost in the throes of addiction, recovery is a process of changing habits and the brain systems associated with them, and a person in recovery experiences a renewed level of neuroplasticity (Lewis 2016). A person who emerges from severe addiction is a person who has grown and continues to grow despite temporarily compromised decision-making abilities (Lewis 2015).

Most important to acknowledge, addiction is not a monolith. What I advocate here is not a shift from one way of defining addiction to another, but a broadening of the all-too-narrow categories we have used to assign meaning to behaviors we do not understand,

whether in ourselves or in others. Despite the problems with the BDMA, it may be helpful in some ways to think of addiction as a disease if it helps to mitigate stigma, as limited as its power to do so may be. Were it not for the value judgments and criminal consequences that come with viewing addiction as a choice in our society today, that perspective, too, might be valuable in giving back some agency to PWUD, and in drug user organizing circles, it is an empowering narrative of resistance. Conceiving of addiction as a learning disorder offers the possibility that, rather being victimized by a lifelong, chronic condition, a person might be able to learn new ways of coping and using substances. All of these models have their merits and their shortcomings. The point is not to say definitively what addiction is, but to recognize that there is much more going on than can be explained by either disease or choice. There may be other models of addiction that have been articulated or that one day will emerge, and we would do well to do research and listen to the experiences of PWUD as we continue to develop a shared understanding of substance use and addiction.

HARM REDUCTION: HEALTH, NOT MEDICALIZATION

Marilou Gagnon is a professor in the School of Nursing at the University of Victoria and president of the Harm Reduction Nurses Association. She participated in an unsanctioned pop-up safe consumption site for PWUD in Ottawa in 2017 in response to a growing overdose crisis. In an interview, she made an assertion and a clear distinction: substance use is a health issue, but it should not be medicalized (Dunn & Yanke 2018). In this statement, Gagnon draws the fuzzy line between public health—disease prevention and

health promotion at a population level—and medicine—the treatment, care, and cure of disease and disorder at the individual level. Like many harm reductionists, Gagnon believes that changing our approach to substance use and addiction from one of disease or crime to one of public health can prevent many of the problems commonly associated with substance use. The category of disease may be helpful in some ways to explain the experiences and behaviors of people deep in chaotic substance use, but most PWUD, including most people who would describe their relationship with substances as problematic, would benefit from less intrusive interventions earlier on. This could prevent them from ever needing their condition to be fully medicalized.

This emphasis on health but not medicalization calls into question common ideas about health. Too often, we narrowly associate health with medicine, as something we might lose and need to have restored by way of medical cure. Public health and preventive health often are overlooked or seen as optional, and rarely is a person's social network considered a part of primary health care. However, according to the World Health Organization (WHO), "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health Organization 1946). Especially if medicine is just about treating disease, it is inadequate to the task of offering dignity and wellbeing to PWUD, or to any person who desires a life of health and wellness, broadly speaking.

Gagnon and others like her promote harm reduction (lowercase "h," lowercase "r"), "a set of practical strategies and ideas aimed at reducing negative consequences associated

with drug use,” and Harm Reduction (uppercase “H,” uppercase “R”), “a movement for social justice built on a belief in, and respect for, the rights of people who use drugs” (HRC 2018). Harm Reduction generally is wary of the BDMA and engages in practices designed to combat racialized drug policy and to give PWUD more choices, not fewer. Harm Reduction is less interested in categories of disease and disorder (except in the case of communicable diseases like HIV and Hepatitis C, for which injection drug users are at a higher risk of contracting) and more interested in dignity, respect, and autonomy—things that an overly medicalized approach often struggles to accommodate. In Chapter Three, we will tease out these distinctions further, acknowledging that there are some stages and circumstances in which PWUD require medicalization, but that often the reasons they come to that place of need are preventable problems related to public health.

Kristina Gupta argues in a forthcoming book that instead of determining a person’s worthiness of and need for medical intervention on the basis of categorization by disease or disorder, we should take a more contextual approach to an individual to determine whether a medical intervention can contribute to that person’s flourishing within his or her community and the broader society (Gupta 2020). Some people experiencing addiction do need medical intervention and may have conditions resulting from, or co-occurring with, their substance use that would benefit from diagnosis and treatment. Others have no desire to change their circumstances and believe they should be free to live their life as they know it. Are these people diseased? Perhaps instead of asking that question, we might look instead to ways society could shift to better promote people’s flourishing and wellbeing regardless of their choices, challenges, or conditions.

CHAPTER TWO: DIAGNOSIS

In her memoir *The Collected Schizophrenias*, Esmé Weijun Wang writes, “Some people dislike diagnoses, disagreeably calling them boxes and labels, but I’ve always found comfort in preexisting conditions. I like to know that I’m not pioneering an inexplicable experience” (Wang 2019). Among the people with problematic relationships with drugs for whom 12-Step recovery is effective, this is precisely what it offers: a sense of clarity and community, an explanation for one’s struggles and company to keep in facing them. To receive a diagnosis that others have carried and perhaps even have found a cure or treatment for can give an individual hope and support, a sense of not-alone-ness in what can be a very isolating experience, no matter the nature of the malady.

However, Wang acknowledges that diagnosis is never a neutral process; it is always political. Even in regards to the elements of a substance use disorder (SUD) diagnosis whose belonging in the realm of medicine is largely uncontested—like the act of putting a chemical into one’s body, measurable intoxication, alcohol poisoning or other drug overdose, and withdrawal—that jurisdiction is still political (Conrad & Schneider 1980).

Eli Clare untangles the complex uses, for good and for ill, of diagnosis:

It is impossible to name all the ways in which diagnosis is useful. It propels eradication and affirms what we know about our own bodyminds. It extends the reach of genocide and makes meaning of the pain that keeps us up night after night. It allows for violence in the name of care and creates access to medical

technology, human services, and essential care. It sets in motion social control and guides treatment that provides comfort. It takes away self-determination and saves lives... Diagnosis is useful, but for whom and to what ends? (Clare 2019, p. 48).

Diagnosis opens the door for access to treatment—but sometimes, it leads to coercive and even involuntary treatment, regardless of the person’s needs and wishes. Diagnosis can give an individual a sense of clarity that may diminish internalized stigma, but sometimes it is accompanied by increased societal stigma. Diagnosis may empower a patient to make treatment decisions, or it may justify the exercise of power—whether by a doctor or by the state, or both—over his or her choices. Disease discourse may have some effect on shifting concerns about addiction from the criminal justice realm to the field of public health (or does it?), but it also has been wielded as a weapon by the state against PWUD (Reinarman 2013). In this chapter, I turn my attention from the concept of disease as applied to substance use to the diagnosis of disease in PWUD.

TOOLS OF THE TRADE: METHODS OF DIAGNOSIS AND TREATMENT

When discussing the diagnosis of SUD, it is important to define and clarify terms. Sometimes the word “addiction” is used in reference to any consumption of illicit substances, regardless of the person’s actual experience of dependence, chaos, or harm. We have means for (imperfectly) delineating alcoholism or problem drinking from moderation or social drinking, but when it comes to heroin, cocaine, methamphetamines, or other illegal drugs, it is more challenging for non-users to make a distinction. Harm

reduction advocates argue that substance use happens on a spectrum. Denning et al break down functional categories along this spectrum, from least to most concern: experimentation, regular use, heavy use, substance abuse, substance dependence (both biological and psychological), and chaotic use (Denning et al 2013, p. 29). The authors point out that “substance abuse” is often labelled as “addiction,” but they argue that “chaotic use” is a more appropriate stage at which to introduce that loaded term (Denning et al 2013, p. 30). Especially because addiction is often closely associated with deviant behavior that is considered irrational, bizarre, and primitive (Conrad & Schneider 1980), applying that term to behavior that lies further from the most dangerous end of the spectrum of substance use can be harmful to PWUD and may lead to an inappropriate clinical diagnosis.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) has included alcoholism and addiction in one form or another since it was first released by the American Psychiatric Association (APA) in 1952, where it categorized addiction as a kind of sociopathic personality disturbance (Nathan et al 2016). The DSM-II, published in 1968, subdivided some of the categories outlined in the DSM-I, but neither of these early editions provided much clinical guidance on the diagnostic process (Nathan et al 2016). In 1980, the DSM-III included triple the number of diagnoses as the DSM-I, and substance dependence was separated out from other stigmatized diagnoses like sexual deviations and personality disorders (Nathan et al 2016). The DSM-III Revised came out in 1987, adding behavioral symptoms to the physiological ones previously described for SUD, and the DSM-IV in 1994 broadened the category by relabeling it “Substance-

Related Disorders” (Nathan et al 2016). The DSM-5, which has been widely criticized for promoting overdiagnosis, came out in 2013 and emphasized the neurobiological dimension of SUD, aligning closely with the BDMA, and separating disorders into substance use and substance-induced disorders (Nathan et al 2016). SUD in the DSM-5 is defined as “a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems” (APA 2013). In short, disordered substance use is substance use that persists despite negative consequences or punishment. The International Classification of Diseases (ICD) manual, released by the World Health Organization (WHO), uses a similar definition for addictive behaviors, categorizing them as impulse control disorders and noting the persistence of a failure to control impulses despite negative consequences (Grant & Chamberlain 2016).

Negative consequences, far from being a neutral category that can be deployed in diagnostic discourse, vary wildly based not only on the individual drug user’s substance use and lack of impulse control but also—and perhaps even primarily—on socioeconomic and racial factors. A wealthy person may have a more robust and personally destructive cocaine habit than a poor person in terms of how much cocaine is consumed and how that affects his or her behavior toward others, but the poor person may face negative consequences more quickly and in greater extremes than one whose wealth insulates him or her from them. Although African Americans do not use or sell illicit drugs any more than whites, they are criminalized at much higher rates for the exact same conduct (Alexander 2016), making them much more likely to come into contact

with systems that document and make meaning of drug-related behavior. I will address these and other social factors further in chapter 3, but in the context of diagnosis, a failure to acknowledge the ways in which social location can affect how diagnostic criteria do or do not manifest from similar behavior or even pathology represents one problematic aspect of diagnosing SUD.

Once SUD is diagnosed, it follows that a treatment will be prescribed. Here it turns out that the medicalization of addiction is only partial in many ways. There remains a high regard of Alcoholics Anonymous (AA) among physicians, who are likely to refer a patient diagnosed with SUD to AA or Narcotics Anonymous (NA). Although the community support of a 12-Step group can serve an important role in some people's rehabilitation, not all people who meet the diagnostic criteria for SUD want or are ready to commit to abstinence-based recovery, and 12-Step group participation, though a vital social support for many, is not a medical treatment. A more cynical take on this partial medicalization is that the availability and accessibility of AA may seem to relieve the medical provider of the responsibility of treating someone diagnosed with SUD (Conrad & Schneider 1990). Many inpatient and outpatient drug treatment programs use a 12-Step model and rely heavily on community AA and NA groups as part of the treatment regimen. If these groups treat a "disease," they do so in a metaphorical sense, as they are spiritually-based programs. While this may be an important component of treatment for those seeking abstinence-based recovery, it cannot be a substitute for evidence-based treatment.

An increasingly important tool in helping people cope with opioid dependence is Medication-Assisted Treatment (MAT). A person on MAT takes regular doses of an opioid agonist, partial agonist, or blocker, usually methadone (a long-acting opioid), buprenorphine (a partial opioid agonist), or naltrexone (an opioid blocker). He or she takes the drug on a regular basis with the goal of reducing cravings and preventing more dangerous use. In combination with therapy and community support, MAT has been shown to be an effective means of treating people diagnosed with opioid use disorder (OUD); it has also been used for alcohol and tobacco dependence (SAMHSA). However, MAT, especially with an opioid agonist, has been stigmatized as simply trading one addiction for another. Especially in 12-Step groups like AA and NA, people on MAT sometimes are considered not to be truly “clean” or sober (Goodnough Dec. 2018), making it difficult for them to find community support while they stabilize and make changes.

This anti-MAT stigma can have deadly consequences. In her memoir *The Big Fix*, Tracey Helton Mitchell recounts her own climb out of heroin addiction and includes the tragic story of her friend Jake. Jake had been in chaotic drug use for many years and finally got stable on methadone, but after fellow 12-Step group members repeatedly told him that he was not really “clean,” he weaned off methadone—only to relapse and, as is so often the case for PWUD who start using again after a period of sobriety, overdose and die (Mitchell 2016). Although the current systems under which MAT programs operate has a dark side, access to MAT is a matter of life or death for many PWUD. A few signs of hope are that some AA and NA groups are becoming more open to accepting members

on MAT, and a new kind of 12-Step group, Medication-Assisted Recovery Anonymous (MARA) has sprung up specifically to meet this need. Another positive sign is that emergency departments at some hospitals are beginning to offer MAT on demand (Goodnough Aug. 2018). Too often, PWUD who come to the emergency department are refused what they need either for pain management or to prevent withdrawal, increasing the likelihood of risky behavior in the hospital itself. Ironically, the system tends to react to such unfortunate circumstances by punishing the people caught up in it, increasing control and surveillance of people whose autonomy is already unjustly limited by their circumstances.

Other common courses of treatment for SUD include hospitalization (inpatient detoxification and/or drug treatment) and intensive outpatient programs (IOP). Many of these programs center on an abstinence-based approach to recovery, and therapies often are built around the 12 Steps—about 80% of addiction treatment programs require the 12-Step curriculum (Szalavitz 2016, p. 180). This one-size-fits-all, abstinence-only approach is problematic in and of itself, and studies have found that believing abstinence is the only way a person experiencing addiction can change predicts higher rates of relapse (Foote et al 2014, p. 16). The common belief that a person who has a problematic relationship with drugs needs to go away for 21 days, or 90 days, or longer results in disruptions to people’s lives that may be unnecessary and even harmful to long-term stability. The American Society of Addiction Medicine (ASAM) has long recommended “starting with the *least* intensive treatment that is safe” (Foote et al 2014, p. 5)—but few

options exist for people who may need help but are not yet in the throes of chaotic substance use.

As Foote et al put it, “the vast majority of people who could benefit from help don’t get it, in part because the system is designed to treat the most severe problems” (Foote et al 2014, p. 5). Many MAT programs requires participation in IOP, which may be beneficial—but if that person has a good job and is seeking help to prevent a worsening problem and potential loss of employment, an MAT program that offers methadone or buprenorphine on the condition that he or she attends 20 hours of IOP a week may be putting up barriers to treatment rather than offering real help. This lack of nuance in an understanding of substance use and addiction and in treatment options stems from persistent stigma of PWUD that leads to assumptions about their autonomy and need for surveillance and control.

DOCTOR’S ORDERS: MEDICALIZATION AND SOCIAL CONTROL

At Mission Health in Asheville, North Carolina, when what the hospital refers to as an intravenous drug abuser (IVDA) is admitted, a drug abuse prevention protocol may be put into effect. The protocol mandates that the patient be assigned a sitter to watch him or her, that access to personal belongings be monitored or curtailed, and that the patient’s visitors be restricted and sometimes not allowed at all (Daffron 2019). The logic is simple: the hospital has had problems with family members bringing illicit drugs into the hospital for an admitted patient, and in some cases that patient has overdosed. This is a serious liability for the hospital, so it is understandable that the institution would put a

policy in place to try and prevent this from happening. However, such practices are demeaning and disrespectful of the patient, and in fact may occlude a more accurate understanding of his or her situation, instead reinforcing a toxic relationship between PWUD and those who wield medical authority.

Historically, self-administration of drugs and medicine was a common means of dealing with ailments and sicknesses. As the medical and pharmaceutical industries evolved, some kinds of medicine and treatment came more under the purview of physician authority—for example, prescription drugs—for safety and regulatory reasons. In the diagnosis of SUD, self-administration of regulated or banned substances is a primary problem, and such behavior is measured against medicine as the definitive authority on appropriateness (Race 2009). Some argue that the exercise of authority over certain substances, while officially intended to promote health and safety in the population, is responsible at least in part for our current problems with substance use. Szasz claims that drug abuse as we know it today “is one of the inevitable consequences of the medical monopoly over drugs” (Szasz 2013). Doctors become the gatekeepers of certain substances, and people who seek out or consume these substances in an unsanctioned manner are exhibiting subordinate behavior worthy of punishment. Szalavitz points out that one way in which the power of medical providers is expressed in the lives of PWUD is in forcing people to “hit bottom” (Szalavitz 2016)—a concept often found in 12-Step groups—sometimes refusing to treat them until their problem gets truly dangerous. Unfortunately, for too many, an overdose death comes before—or simply is—the proverbial “bottom.”

Efforts to medicalize substance use and addiction have claimed as their rationale a desire to reduce stigma and to make a shift from punishment to rehabilitation. However, in some cases the medical treatments themselves have come to be used as a new form of punishment and social control (Conrad & Schneider 1990). Some argue that medicine is being used to create public order and exercise control over a misbehaving segment of the population (Race 2009), and PWUD themselves report experiences with the treatment system that resemble punitive criminal justice practices more than they do medical interventions. Szalavitz describes her experience of going to the hospital to seek treatment for addiction. Even though she was already in withdrawal from heroin and cocaine, one of the first things that happened was that she was administered naloxone, an opioid antagonist. She was not overdosing, so the naloxone's only effect was to put her deeper into withdrawal. Besides having been given without her consent and for no medical reason, Szalavitz noted that the treatment felt purely punitive, and she would come to find that, in her words, "Though treatment and punishment were supposed to be opposite approaches, in fact, harsh moralistic tactics were the rule, not the exception, when I sought help" (Szalavitz 2016, p. 21). Such tactics reinforce the stigma that the diagnosis of a disease supposedly erases or at least mitigates.

MAT, an important form of treatment for OUD, has its own problematic side of social control. It is common practice for methadone clinics to raise a patient's dose, sometimes without talking to him or her about it, when heroin or another unsanctioned opioid is found in his or her system; but the higher the dose, the harder it is for a person to leave an

MAT program, as tapering becomes more difficult and time-consuming (Gelpi-Acosta 2014). MAT can create medical dependence, disrupt a patient's work schedule, and creep into managing the person's life and habits beyond the scope of the clinic's treatment. People seeking access to MAT are often required to participate in IOP programs that can make it difficult or impossible to keep a normal work schedule. For these reasons, and because of the long half-life of methadone, one of the most commonly used replacement therapy drugs, MAT often is referred to as "liquid cuffs" (Gelpi-Acosta 2014). Because methadone is a Schedule II drug under the Control Substance Act, it requires strict monitoring under federal law, which means patients usually have to go to a clinic on a daily basis in order to dose (Gelpi-Acosta 2014). At methadone clinics, there is often a visible police presence, medicine is presented as a form of discipline, and the bodies of patients are separated by diagnosis and prescription (Bourgeois 2000). The many restrictions can be a problem for people without reliable transportation or whose work and family commitments conflict with the clinic or IOP schedule. The way many MAT programs function assumes that a person has "hit bottom" and does not have a job or life outside of treatment, and makes it difficult for a patient to continue to do so if he or she does.

However, these problems of power do not mean that MAT should be done away with. Some critics of MAT fall into the camp of those who encouraged Jake to get off methadone, to his untimely demise. Gelpi-Acosta's critique, while astute, sounds different when considering that funding for that research came from the National Institute on Drug Abuse (NIDA) and the National Institutes of Health (NIH). Both NIDA and the

NIH promote the BDMA, which tends to come into conflict with MAT as anything but a step-down treatment for opioid withdrawal.¹ Perhaps more interesting in Bourgois' suggestion that the distinction between the legal (if heavily restricted) drug methadone and the illegal (and therefore unregulated, but very chemically similar) drug heroin is an example of the state's disciplinary biopower at work (Bourgois 2000). Bourgois outlines the many negative side effects of methadone and notes that heroin—in unadulterated form—may be less harmful than methadone (Bourgois 2000). In Chapter Three, I will explore one of Bourgois' suspicions as to why methadone has been accepted as a legal drug in America while heroin remains illegal despite some countries' success with prescription heroin programs—namely, that heroin is more pleasurable than methadone.

The function of biopower, as outlined by Michel Foucault, is to regulate the human body around a specific definition of health (Foucault 1990). The diagnosis of SUD can serve the purposes of enforcing biopower over persons whose health behaviors do not meet society's expectations. The interplay between healthism and biases about what is “natural” versus “unnatural” show up in negative attitudes toward drugs, which become fetishized symbols of the natural-unnatural divide. Race point out that this divide is not as objective as it may seem and that value judgments attached to it are political, asking, “who or what gets crushed or distorted in the mad rush to occupy the space of the natural?” (Race 2009, p. 30). Health, narrowly defined as a particular vision of physical health, is presumed to be an objective good. Assumptions about the morality of people

¹ If it seems curious that a medicalized approach to addiction would eschew a medical treatment for it, that is because a core tenet of the BDMA is that addiction is treatable only through abstinence.

with certain health behaviors or health outcomes are far from scientific and often have roots in racism and xenophobia.

Moralization of health behaviors, especially the stigmatization of ones with harmful health outcomes (like smoking), are part of a larger, subtler push to shift the focus from social determinants of health to individual preferences that are blameworthy and deserving of punishment, not just from a public health perspective, but from a moral one as well (Frank & Nagel 2016). As Keane put it, “the diagnosis of the medical disorder [of substance dependence] is inseparable from judgments about what a normal and healthy life should look like and the way time and priorities should be organized” (Keane 2005). The process of diagnosing a person with a SUD is a process, not of de-stigmatization, but of stigmatization and moralization, ostensibly for the purpose of motivating changes in health behaviors. However, it may be more likely to increase isolation and internalized stigma than to inspire positive change. The entanglement of medicine and law when it comes to PWUD further complicates the diagnostic gaze that problematizes substance use above and beyond its material realities.

THE THERAPEUTIC PUNISHMENT: THE LAW AND THE DIAGNOSTIC GAZE

In the diagnosis of SUD, and sometimes in the presumption of its presence in a person who uses illegal drugs, there is a complex interweaving of medical discourse on patient compliance and legal discourse on drug abuse (Race 2009, p. 15). Even as the BDMA has been promoted, in theory to shift an approach to PWUD as criminals meriting punishment to sick patients in need of treatment, there has been less of a shift and more

of an entanglement. As Keane writes, “medical and therapeutic approaches currently coexist with the legal structures and rhetoric of the ‘war on drugs’... Moreover, medical models of addiction do not necessarily undermine visions of the addict as a uniquely compromised subject who requires surveillance, management, and control” (Keane 2005). This, Michelle Alexander argues, is the purpose of today’s criminal justice system: not to prevent and punish crime, but to manage and control the dispossessed (Alexander 2012), especially PWUD and people of color (POC). The diagnostic gaze in the context of law and order does little to reduce stigma, sometimes actually heightening the perceived need for use of force, whether physical force or prosecutorial coercion, not for the purpose of rehabilitation, but for the purpose of discipline and punishment. Race writes,

the status of certain substances as ‘illicit’ provides an occasion for the state to engage in what can be described as a disciplinary performance of moral sovereignty. This performance bears little relation to the actual dangers of drug consumption—in fact it exacerbates them... It is an exercise in the politics of *sending a message* (Race 2009, p. 12).

Here, Race refers specifically to an instance in which a recreational drug was laced with a dangerous substance, and rather than warning PWUD about the potential dangers of this particular substance, the police worked to keep descriptions of the pill secret in an effort to discourage substance use entirely. This simply does not work, and it gives PWUD fewer choices, as does a militaristic enforcement of drug laws, which drives use

underground, making it riskier on many levels (Race 2009, p. 14). This is biopower at work in the diagnosis of a potentially harmful health behavior and punitive efforts at prevention that, unfortunately, do more to raise the risks than to mitigate them.

The sordid history of the war on drugs in America makes the relationship between police and PWUD, especially POC who use or sell drugs, fraught and tense. The question of who is an expert on the overdose crisis illuminates unexamined biases about the nature of substance use and addiction. Whether an organization invites the sheriff or a public health official to address a room about the overdose epidemic is telling, as are assumptions about who is on the front lines of the overdose crisis—Emergency Medical Technicians (EMTs) or PWUD themselves. Similar questions arise when considering who should lead new efforts like Post-Overdose Response Teams (PORTs), which follow up with people after an overdose to offer resources and services. Drug courts are being presented as a potential solution to the nation’s drug problem, but they reinforce a punitive approach to dealing with PWUD, and they sometimes put a judge in the position of making medical decisions for a person under his or her jurisdiction. All these assumptions and issues should at the very least give us pause, especially after decades of waging a drug war only to see overdose rates skyrocket.

The entanglement of the medical and legal industrial complexes creates an ethical and systemic dilemma as to what role, if any, police officers and other agents of the law should play in responding to the overdose crisis. In Law Enforcement Assisted Diversion (LEAD) programs, police officers may have the option to divert low-level drug offenders

to drug treatment and social services in lieu of jail. Recognizing that many people who are arrested for possession are more in need of help than of prison time is a positive step. However, some argue that programs like LEAD expand police power and set up PWUD for a problematic relationship with treatment itself (Castillo 2018). Mitigating the harms of policing is one important aspect of harm reduction, but distrust of police among POC, PWUD, and other marginalized groups can seem insurmountable, and there are questions as to when collaborating with law enforcement helps and when it actually increases harm. In some places, police officers carry naloxone; while this is a positive change, some harm reduction advocates note that in some jurisdictions, that shift led to funds for the overdose crisis being funneled to police departments rather than to community-based advocacy groups led and supported by directly impacted persons (Castillo 2018). Maurice Byrd, a therapist at the Harm Reduction Therapy Center in San Francisco, says, “It is problematic to have police involved, because they are the foot soldiers for the drug war” (Castillo 2018). However pure and even harm reduction-oriented an individual police officer’s intentions might be, he or she is part of a system that has waged war on PWUD.

One way in which a contradictory disease diagnosis of addiction is weaponized against PWUD—and through which problematic relationships with law enforcement are reinforced—and is through drug-induced homicide laws. Drug-induced homicide laws make it possible for people who provide drugs to someone who dies of an overdose to be charged with murder. These laws misunderstand the nature of relationships between most users and dealers, and they paradoxically assume zero agency on the part of the person who overdosed (presumably due to their disease) and complete responsibility on the part

of the person who supplied the drug (as a crime). Drug-induced homicide charges in the United States have increased from just one or two a year between 1980 and 2000, to 49 in 2010, to 591 in 2017 (Health in Justice 2017). While some lawmakers see this kind of legislation as a necessary means of combatting the current overdose crisis, harm reduction advocates argue that such laws make PWUD more likely to use alone and less willing to call 911 in the event of an overdose—factors that contribute to higher rates of overdose deaths, not lower ones.

The Urban Survivor’s Union (USU) has spearheaded a campaign called #ReframetheBlame that aims to bring awareness to the rise in drug-induced homicide charges, the injustice they believe is inherent in the system, and the true desires of PWUD whose deaths could be the occasion for bringing such charges (Szalavitz 2018). #ReframetheBlame opposes the increasingly popularity of drug-induced homicide laws and is mobilizing PWUD and allies to work against them. On Overdose Awareness Day (August 31) of 2018, thousands of PWUD across the country signed a Do Not Prosecute (DNP) order. The DNP is play on advance directive forms (specifically a Do Not Resuscitate (DNR) order) that invites PWUD to say explicitly that if they were to die of an overdose, they would not want anyone to be charged in their death. The DNP emphasizes USU’s stand against the drug war and prohibition, forces they believe are the primary drivers of a contaminated drug supply and therefore of the overdose crisis itself. By signing the DNP, PWUD take a symbolic stand against decisions being made after their death that not only run contrary to their wishes but also, in their view, both undermine their autonomy and misplace blame in a way that fails to make any real

difference in the complex problem of drug-related deaths. #ReframetheBlame argues that the law has no place in a public health matter. When a person's health behavior or diagnosis thrusts them simultaneously into the realm of medicine and the law, there is no guarantee—and he or she has no reason to believe—that his or her autonomy will be respected or even considered, and USU's work stands in opposition to that reality.

A WAR ON PEOPLE: DRUG USER AUTONOMY

Part of the goal of the #ReframetheBlame campaign is to combat the stereotype of PWUD as mindless, out-of-control slaves of a substance they must ingest compulsively and perhaps even involuntarily. The organizers argue that PWUD do have agency and control, but that agency is undermined, not primarily by substance use itself, but by the war on drugs. The organizers of #ReframetheBlame argue that the black market that exists secondary to prohibition makes it hard for PWUD to know whether they are getting the product they have paid for or something completely different—and that something completely different could either merely fail to deliver the high they are seeking, or it could kill them. The person providing the drugs often has no way to know, either—and yet her or she may be blamed.

Drug user autonomy is relevant at every step along the way of defining and treating addiction. The diagnosis of SUD, or even of problematic or illicit substance use, usually signals, as mentioned already, that a person requires surveillance or control. This can lead to varying kinds of paternalism among medical providers as well as among friends and family where people who use drugs are concerned. Beauchamp and Childress distinguish

between harm and soft paternalism in medicine (Beauchamp & Childress 2013, p. 216-17). While outright force may not always be used (though sometimes it is), coercion, whether by pushing a person to choose a particular course of treatment or by simply limiting his or her options, is par for the course in many approaches to PWUD and people diagnosed with SUD. Stigmatization for the purpose of enforcing social norms is itself a form of soft paternalism (Beauchamp & Childress 2013, p. 219), bringing up ethical questions of autonomy, beneficence, and justice.

In *The Collected Schizophrenias*, Wang addresses the ethically fraught question of involuntary commitment for people with mental illness. The same questions arise for PWUD, especially those whose drug use is chaotic or disruptive to their family, work, or community. Wang reflects on a bill filed in California in 2002 regarding mental health and involuntary treatment, noting that it rests on the assumption that a person with a certain kind of mental illness cannot choose treatment for himself or herself and therefore must be forced to do so (Wang 2019). This is the image of addiction and, in much popular rhetoric surrounding it, of the BDMA: a person whose brain has been “hijacked” by drugs, who acts compulsively and destructively against his or her own will, who cannot make good choices and must be forced to face consequences and get help. The diagnosis of SUD can label someone as un-free, coerced by drugs, and therefore in need of liberation—although that liberation tends to come in new forms of coercion and even punishment.

As in conversion therapy for gay teens, who are told they cannot trust their wants, desires, and decisions, PWUD who end up in abstinence-based treatment programs without freely choosing that path may be told they cannot trust themselves. The unintended consequence is to create self-fulfilling prophecies, undermining rather than shoring up a person's capacity to make good decisions for himself or herself. For example, if it only takes one drink to set off a chain of events leading to a bender, a person who decides to take a drink or use a drug after a period of sobriety may dive in head-first, following those expectations rather than what he or she wants. The conflict here is that society walks a fine line as to whether a person experiencing addiction is viewed as responsible for his or her actions. There is never a clear sense of whether a person who uses drugs ought to be punished—suggesting that he or she has some degree of autonomy and responsibility—or treated—suggesting that perhaps he or she is not capable of making rational choices. This is the complexity of biopower at work in the diagnosis of SUD, and differences in attitudes and outcomes for people of different socioeconomic or racial backgrounds reveal it further:

Power never knows whether it wants to punish or save the drug user, incarcerate or treat this figure. Instead, both strategies are kept in reserve as mutually reinforcing alternatives. It is almost always the underprivileged—those marked by class or race—that bear the brunt of the sterner form of discipline. Meanwhile, if not electing rehabilitation and treatment for themselves, the more privileged are ushered in its general direction in concerned but insistent tones (Race 2009, p. 69).

The delineation of how much punishment or treatment (or what kinds and by what access points) a person deserves based on class and race makes clear the inconsistency in regards to assumptions about who has capacity for reason, choice, and autonomy.

Harm reduction psychotherapy relies on the psycho-biosocial model of substance use and addiction, and at the core of its philosophy is the return of autonomy and choice to the person who uses drugs. The Harm Reduction Coalition (HRC) distinguishes between the practices of harm reduction and the social justice movement of Harm Reduction (HRC 2018). This definition aligns with Powers and Faden’s “negative, or remedial, point of justice and the positive, or aspirational, point of justice” (Powers and Faden 2006, p. 87).

The remedial point of justice for PWUD entails mitigating the harms of substance use itself—the practical strategies and ideas that HRC promotes, like syringe exchange, naloxone distribution, and access to evidence-based, non-punitive treatment. The aspirational point of justice pushes communities to move beyond disease and death prevention to embrace a social justice movement promoting the dignity of PWUD—one important piece of which is respect for autonomy.

Harm reduction psychotherapy represents “a radical redefinition of the relationship between the client and the clinician, a departure from the paternalistic model associated with more traditional substance use treatment” (Tatarsky 2002, p. 2). Denning et al frame this approach as assuring the patient, “You are your own expert” (Denning et al 2003, p. 33). To return to the example of Mission Health in Asheville and the institution’s drug

abuse prevention protocol, what many clinicians fail to recognize when they react to the patient's use of illicit drugs while admitted is that he or she likely is not being medicated adequately for pain or discomfort. PWUD frequently report physicians being parsimonious with pain medications out of fear of exacerbating a substance use problem, but sometimes that withholding can motivate more use—and more dangerous use—rather than preventing it. This approach stems from a paternalistic approach to medicine and from the image of PWUD as lacking decision-making capacity and autonomy. PWUD tend to know very well which substances will have what effects on their bodies—yet they are rarely, if ever, treated like the experts they are.

Although respect for the autonomy of PWUD may seem like an abstract concept reaching for Powers & Faden's idea of aspirational justice, it can be implemented even in the remedial, practical aspects of harm reduction. In a study of physicians' practice of prescribing syringes to injection drug users, Lazzarini argues, "physicians can work to 'enhance' their patients' autonomy by offering them support for stopping drug use, but also giving them the means to protect themselves from deadly diseases" (Lazzarini 2001). When we can let go of the image of PWUD and people experiencing addiction as mindless slaves to a drug, we see that dispensing syringes—and other harm reduction strategies—provides support that gives PWUD more choices, not fewer. Harm reduction psychotherapy shifts the power from the provider to the patient, understanding that both parties bring their own expertise to the table and that PWUD are capable of making decisions and positive change if they are given the chance and the tools.

Of course, addiction is a complex phenomenon, and as with many forms of mental illness, there may be limits to how much positive change a person is able to make even when equipped with the tools necessary to do so. Mental illness may conspire with circumstances such that people become a danger to themselves or to others, thereby justifying intervention that may take the form of paternalism and even coercion, for the sake of that person's safety and the safety of others. Similarly, there may be cases in which addiction may become so dangerous as to warrant the community stepping in. Common exceptions to informed consent such as emergency treatment apply to PWUD as to any other person experiencing a health crisis—for example, in the case of administering naloxone to a person experiencing an opioid overdose—and the reality of potential public health risks, though often overstated, cannot be ignored. I argue, not that personal autonomy is an absolute, but that with PWUD there often is greater autonomy than commonly is ascribed to them, especially when they are surrounded by supportive community. Substance use and addiction in and of themselves do not necessarily warrant intervention or coercion, nor does being under the influence of a drug mean that a person lacks capacity. No diagnosis, not even of dementia, schizophrenia, or any other potentially debilitating mental illness, automatically renders a person incapable of making medical decisions; rather, each individual must be assessed for capacity without prejudice as to their diagnostic label. Substance use and addiction should not be exceptions to this rule, and even if capacity is diminished or lacking, the duty to make an effort to restore a patient's capacity before pursuing a course of treatment (Moskop 2016, p. 110) applies to the treatment PWUD as to any other patient.

Despite the widespread idea that if a person develops an addiction, he or she must go to long-term, inpatient treatment, current guidance from the American Society of Addiction Medicine (ASAM) is that a person should engage with the least intrusive form of treatment that is effective (Foote et al 2014, p. 5). As a clinician would consider the side effects of a prescribed medication for a physical illness, or a psychiatrist would weigh the potential harms and benefits of a psychotropic medication, harm reduction asks providers and support persons to do a cost-benefit analysis when considering treatment options that may disrupt a person's work, leisure, or family life. "The argument can be made that the term 'harm reduction' really stands for the re-introduction of basic principles of good clinical practice in an area where they have often been absent" (Tatarsky 2002, p. 4). This shift of power in the process of diagnosis and treatment is an important first step in changing the problematic relationship between PWUD and the medical and legal establishments that often exercise control over them.

CHAPTER THREE: DISABILITY

In her book *Blue Nights*, Joan Didion writes, “I have not yet seen that care where a ‘diagnosis’ led to a ‘cure,’ or in fact to any outcome other than a confirmed, and therefore an enforced, debility” (Didion 2011, p. 47). Wang cites Didion’s observation in her memoir *The Collected Schizophrenias* as she wrestles with the cost-benefit analysis of being given a diagnostic label. On the one hand, receiving a diagnosis of schizoaffective disorder gave Wang clarity and a course of treatment; on the other hand, it opened the door to stigma and a new wave of uncertainty (Wang 2019). For people who use drugs (PWUD) who receive a diagnostic label of substance use disorder (SUD), it is unlikely that there was much mystery to what was going on, but diagnosis is the doorway to treatment—whether effective or not. Far from reducing stigma, the diagnostic label and the popular narrative surrounding it conspire to create a disability that is not inherent to the person who uses drugs but is a function of the society in which this person lives and acts. For this reason, I turn to disability studies as a conversation partner for exploring the function of addiction in society and its multivalence for the intersecting problems of racism and mass incarceration; sexism and reproductive health; and fatphobia and a neoliberal, capitalist vision of health as moral duty and individual achievement.

I do not argue that addiction is itself a disability, although my writing and thinking is informed by Maia Szalavitz’s description of addiction as a learning disorder, which comes close (Szalavitz 2016). Rather, I will engage the social model of disability as helpful framework in deconstructing assumptions about how addiction functions in the

lives of PWUD and in the broader community. Also, I will show that similar (and sometimes the same) kinds of power work against people with disabilities and PWUD, and that there are deep resonances in the ways biopower functions in relation to race, sex/gender, and body size, all of which have implications for an ableist, racist, sexist, and healthist vision of wellbeing that the anti-drug war movement aims to overthrow and re-imagine. In this way, I am “cripping”—a defiant reclamation of the derogatory term “cripple” by people with disabilities—addiction in the tradition of the disability rights movement.

ENFORCED DEBILITY: IMPAIRMENT AND DISABILITY IN THE WAR ON DRUGS

The social model of disability emerged as a counter to the medical model, which focuses on the individual person with a disability. The medical model locates any problems a person with a disability might face in that individual body and, as medicalization tends to do, concerns itself primarily with the pursuit of treatment or a cure for what ails that individual body. The social model of disability shifts the focus from problematizing the body of a person with a disability to questioning the way that societal structures place limitations on persons of diverse physical and mental abilities. The inability to access a building that has no wheelchair ramp is not a problem inherent to the body of a person who cannot walk; if that building had a wheelchair ramp, the problem would disappear. The problem is in the design of a society that does not account for differences in mobility.

As Susan Wendell puts it, “Disability is not a biological given; like gender, it is socially constructed from biological reality” (Wendell 1989). The social model of disability makes a distinction between disability (social exclusion) and impairment (physical limitation) (Shakespeare 2013). The 1975 Statement of Aims put forward by the Union of Physically Impaired Against Segregation (UPIAS) noted this distinction and laid out the claim that people with disabilities are an oppressed group (Shakespeare 2013). The social model of disability argues that impairment is individual and private while disability is structural and public, and while medicine may be an appropriate response to some forms of impairment, disability demands a response that accepts impairment and seeks to remedy disability through civil rights and social justice (Shakespeare 2013).

The social model of disability provides a helpful framework for unpacking the challenges faced by PWUD. When addiction is categorized as a disease, and when a person is given that diagnostic label, he or she becomes the focus of the problem and an object of medicalization aimed at finding a cure. The BDMA assumes that alcoholism is a disease that causes trouble, but a harm reduction approach points out that trouble usually comes first for a person wrestling with chaotic substance use (Denning et al 2003, p. 32), and that trouble is reinforced not purely by individual behavior but also by social structures. Early diagnostic labels for alcohol and addiction acknowledged that the location of an addicted person’s “illness” was not primarily within his or her body or mind: the DSM-1 notes, “Individuals to be placed in this category are ill primarily in terms of society and with the prevailing cultural milieu, and not only in terms of personal discomfort and relations with other individuals” (APA 1952). However, even that acknowledgement of

the social component of addiction fails to truly locate the source of the problem anywhere but in the behavior and presumed pathology of the individual being diagnosed, and subsequent revisions of the DSM have only further narrowed the medicalization of substance use and addiction.

The BDMA views addiction as primarily a problem of biology, just as the medical model of disability sees disability as a problem of biology, while the social model pushes us to examine the social context that creates its own problems. Harm reduction psychotherapists like Andrew Tatarsky, Pat Denning, and others describe addiction as a psycho-biosocial process that cannot be addressed as an individual pathology because it only finds its full expression in the context of social relationships and cultural systems (Tatarsky 2019). In fact, those relationships and systems in part produce what many assume to be the reality and consequences of substance use and addiction itself. In an article called “The Invisible Majority: People Whose Drug Use Is Not Problematic,” Tessie Castillo tells the story of a 33-year-old man who had been injecting heroin four times a day for six years—all while married, caring for children with his wife, and maintaining a job (Castillo 2019). He kept his habit secret from his wife until one day he finally told her, at which point she became unwilling to live with him. This man eventually became homeless after his wife divorced him.

Questions of marital trust aside, it is tempting to attribute this man’s fate of homelessness directly to his drug use. However, using heroin did not directly cause him to become homeless—after all, he had been using for years with a roof over his head—the discovery

of his use led to him becoming homeless. Many PWUD feel forced to keep their use a secret, leading to damaged trust in personal relationships and potentially to negative outcomes for their own lives—but this is in large part because the dominant culture’s attitudes toward illicit drugs (and the illegality of those drugs) creates the stigma that makes people unwilling or unable to be honest about their substance use. This stigma can lead to isolation that may be dangerous, placing people more at risk not only for homelessness but also for overdose and other negative outcomes secondary to an unregulated drug supply. What’s more, the stigma and risk that prohibition places on PWUD is not shared equally among different racial, cultural, and social groups.

CRIMES OF POWER: MASS INCARCERATION DISABLES MARGINALIZED COMMUNITIES

“Nothing has contributed more to the systematic mass incarceration of people of color in the United States than the War on Drugs” (Alexander 2012, p. 60). So claims Michelle Alexander in her book *The New Jim Crow*. The social construction of drug abuse and addiction has unjustly saddled already marginalized communities with the additional burden of high rates of incarceration and probation, as well as barriers to employment, housing, social services, and participation in our democracy that often accompany criminal, and especially felony, convictions. The systems that have a disabling effect on people who use drugs disproportionately affect people of color (POC) and their communities. Any challenge to these systems is incomplete—and even historically disingenuous—without attention not only to substance use but also to intersectional issues of race and class. Criminalization is itself a disabling force in the lives of PWUD,

but that disability is applied and enforced disproportionately according to the color of one's skin.

The racism inherent in the United States' drug policy is not new; the very first drug laws in this country were tinged with racial bias. The earliest anti-drug law, passed in 1875 in San Francisco, concerned opium and the Chinese importers of that drug, and shifting attitudes toward opium track with the anti-Chinese movement that emerged in the late 19th and early 20th centuries in the U.S. (Mark 1975). Also in the early 20th century, rumors of "Negro Cocaine 'Fiends'" were making headlines in *The New York Times*, with fears of the drug's energizing effects on a person mingling with racist views of black men as animalistic and aggressive (Williams 1914). Some advocates of the temperance movement framed alcohol and drugs as problems of foreigners threatening Americans. As Mexican immigration to the U.S. spiked in the wake of the Mexican Revolution of 1910, marijuana became the scapegoat for anti-immigration sentiment and, after being outlawed in many states, was banned by federal law (Waxman 2019). Newspaper reports from around the time each of these measures were passed are difficult to read for their blatant racism and classism, although such attitudes have by no means disappeared.

These and other efforts at legislating certain substances emerged from and reinforced narratives about race and class that persist today. For example, much was made over Trayvon Martin's suspension from school for marijuana possession before the 17-year-old was killed by George Zimmerman, who said he thought Martin looked "drugged out and suspicious" (Szalavitz 2012). Although over half of Americans favor legalizing

marijuana (Motel 2015), attitudes toward the drug and its effects vary based on who is consuming it, consistently to the detriment of young black men (Sekaran 2014).

Alexander notes that young black men, on a massive scale, “have been rounded up for engaging in precisely the same crimes that go largely ignored in middle-and upper-class white communities—possession and the sale of illegal drugs” (Alexander 2012, p. 172).

This rounding up has had a devastating impact on black communities in the U.S. Mass incarceration of young black men disrupts the function of their families and communities, and not only while these men are in prison. Black men with a felony record are the least likely demographic group to receive job offers once they are released (Alexander 2012, p. 151). The war on drugs has created an enforced debility for already disadvantaged communities on the basis of race and class.

Historical artifacts that reveal the racial origins of American drug policy show clearly the concern for control and discipline over populations assumed to require these interventions—as the article on the “Negro Cocaine ‘Fiend’” states:

In many States in the South the negro population constitutes from 30 to 60 per cent of the total population. Most of the negroes are poor, illiterate, and shiftless. If we include in this class the poor whites, who are on a par with the average negro in poverty, ignorance, and general lack of thrift, we may reckon the aggregate number as representing about one person in three in the entire population. Governing, or even keeping in reasonable control, such a host is an

onerous task, even when most of the individuals of the host are sober. The inevitable number of alcoholics adds to this task enormously (Williams 1914).

The concern here is not public health or addiction prevention, but control of races and classes considered unruly and unproductive. Certain drugs were associated with people groups considered problematic—opium with the Chinese, cocaine with blacks, marijuana with Mexican immigrants, and so on—and mandatory sentencing guidelines today remain in thrall to racist stereotypes about certain drugs. Cocaine and crack, despite being chemically identical (the difference is in how they are prepared and consumed), carry vastly different sentences—the drug associated with upper-class whites (cocaine) inviting a far lesser punishment than the drug associated with blacks (crack) (McCurdy & Vagins 2006). Kane Race claims that the practice of drug raids is aimed primarily, not at curtailing drug use or improving the health and safety of all, but at groups whose identity and practices are offensive or threatening to the dominant culture: “The drug raid seizes upon and intercepts deviant groups and liminal practices, but, cloaking itself in the generality of drug law, claims not to target them specifically” (Race 2009, p. 14).

Drug laws cloak the exercise of disciplinary power over minorities and marginalized groups. Foucault claims that power over life has evolved to two poles—disciplinary power over the body as machine and regulatory control of the population as a whole (Foucault 1990)—both of which are revealed in drug law and policy. In 1914, Williams criticized blacks and poor whites for being lazy—for having bodies that do not contribute to the machinations of neoliberal capitalism in the way he believes they should—and

raised the specter of drug abuse as a force that exacerbated not only their non-participation in the economy but also their criminal and violent danger to the broader population. His solution to the problem was to regulate alcohol and drugs out of existence, insisting that more civilized upper-class whites would be willing to refrain from partaking if it meant removing this element of temptation from blacks and poor whites (Williams 1914).

Following Foucault, Deleuze argues that societies of control have replaced societies of discipline as institutions like prisons, hospitals, school, factories, and so on have waned (Deleuze 1992)—but in light of mass incarceration and the extension of the carceral state into the realm of probation, forced treatment, involuntary hospitalization, and drug testing for people who use drugs, I would counter that rather than control replacing discipline, it is expanding its reach. Clothed in the guise of punishing dangerous crime, in truth, these systems act as efforts to control groups of people deemed problematic, sometimes for their drug use but often also for their skin color, nationality, sexual orientation, or class, manufacturing an enforced debility for already marginalized populations.

TREATMENT VS. ENHANCEMENT: THE PROBLEM OF PLEASURE

In the world of disability studies—as in the fields of gene editing, biotechnology, and medicine itself—a debate persists about the line between treatment and enhancement. Many bioethical debates come down to a tenuous agreement that interventions aimed to treat a disorder or illness are appropriate while those geared toward enhancement are ethically questionable—although it is never so clear where the line between treatment and

enhancement is. In the world of disability studies, the very notion of treatment, even in the case of true impairment, can be controversial. The question of treatment vs. enhancement reveals assumptions about the role of medicine that are informative to an examination of substance use and addiction, especially related to the problem of pleasure.

The very notion of treatment goes hand in hand with cure, which Eli Clare claims is inherently violent, even as it may be helpful, because it is predicated on a kind of eradication (Clare 2017, p. 26). The definition and diagnosis of a defect, disease, or disorder demands a remedy; as Clare writes, “Defectiveness justifies cure and makes it essential” (Clare 2017, p. 23). Clare named white female suffragists, black slaves, immigrants, LGBTQIA+ persons, and more who have over the years been declared defective and subjected to the violence of cure. In the disability world, cochlear implants are considered a form of cultural eradication by some in the Deaf community (Byrd et al 2011), and prenatal diagnosis has nearly eliminated births of babies with Down syndrome in Iceland (Lajka & Quinones 2017). If deafness and Down syndrome are defects, then cochlear implants and selective abortion are treatments. If deafness is a culture and Down syndrome is a difference rather than a disability, they are, some claim, genocide—and even if the elimination of these conditions can be considered a cure, Clare’s assessment of cure’s violence as eradication remains relevant.

The “cure” for addiction and substance use disorder (SUD) often is violent. Insisting that a person hit “rock bottom” before receiving help can be dangerous, and many forms of treatment available to people experiencing addiction resemble psychologically abusive

conversion therapy for LGBTQIA+ persons. In a parallel study of drug courts and drug treatment programs, Jennifer Murphy observed that punitive measures are often prescribed as if they themselves were curative; what she calls “therapeutic punishment” is standard in both drug courts and treatment (Murphy 2015, p. 19). Substance use may also determine whether a person can get treatment for an actual medical condition if it is determined that the patient’s drug use contributed to the problem—like the classic case of an alcoholic with liver failure, or the increasingly common cases of injection drug users requiring heart surgery for endocarditis, an infection of the heart valve. In a *New York Times* article examining the ethical questions related to PWUD who repeatedly present with endocarditis, reporters interviewed 28-year-old Jerika Whitefield, who underwent surgery after developing the infection from shooting meth. Before she went under anesthesia, the doctors said they would not perform this surgery for her again—threatening the punishment of withholding treatment based on her substance use. In Whitefield’s case, the violence of cure also included the threat of it not being offered again in the future. As the article asked, “Is a heart ever not worth fixing?” (Goodnough 2018).

Approaches to treatment and cure in regards to addiction reveal deeper assumptions about the nature of medicine and health itself. Medicine is framed as a bitter pill; health is about austerity, giving things up, taking on strenuous activity, undergoing unpleasant treatments, and so on (Race 2009, p. 1). Pleasure does not figure in to health and often is considered antithetical to it, and questions of deserving become stumbling blocks to values like beneficence and social justice. Kane Race claims that part of the threat that

illicit substance use presents to the medical establishment is that it sometimes seeks the cure without the cost—and sometimes it isn't curative at all but “only” recreational (Race 2009, p. 9). Clare notes that our ideology of health contradicts itself, at once supporting medication for people in chronic pain and refusing that same medicine to people with drug problems (Clare 2017, p. 14)—the concern being that PWUD might enjoy the treatment a little too much (even if that person truly is in pain).

People use drugs to treat physical, mental, and emotional ailments, and people take drugs to enhance their mood, alertness, and sense of euphoria. When this consumption takes place outside the bounds of medical authority, or to a degree that wanders out of treatment into enhancement, it is deemed problematic. Denning et al describe the situation of a woman who was prescribed opioids for chronic pain but found herself taking more than what the doctor would allow—not to get high, but because the prescribed amount failed to adequately treat her pain. When her efforts to treat herself within the constraints given by the medical authorities led to her doctor-shopping for supplementary scripts, her drug use became a problem—but was the problem her use, or was it insufficient treatment of her pain? As the authors write, “it is natural to look for comfort in an uncomfortable world” (Denning et al 2003, p. 30), but the bitter pill of medicine is not supposed to be so easy to swallow.

An interesting case of something like treatment versus enhancement in the world of drugs and pleasure is the Swiss prescription heroin program. In his examination of the biopolitics of methadone maintenance, Bourgois points out that methadone is harder to

wean off and sometimes has worse side effects than heroin—yet it is methadone that is often prescribed to people diagnosed with opioid use disorder (OUD) who seek medication-assisted treatment (MAT) (Bourgois 2000). He points out that perhaps the most significant difference between the two chemically similar drugs is that heroin is more pleasurable than methadone—in fact, methadone blocks pleasure receptors and is intended not only to curb cravings but also to prevent a high should the patient decide to use other opioids (Bourgois 2000). Studies in several European nations have shown increased success rates among people who experience heroin addiction and are resistant to treatment with methadone when they are prescribed a maintenance dose of diamorphine (heroin) (Uchtenhagen 2011). Supervised injection or inhalation of diamorphine is far safer than illicit use whether with or without methadone, but the U.S. has remained resistant to the idea of heroin maintenance. As Uchtenhagen noted in reference to a shift away from previous practices of prescribing morphine or heroin after heroin was made illegal, “The concept of maintaining patients on an otherwise illegal or unwelcome consumption was incompatible with the puritan idea of prohibition” (Uchtenhagen 2011). People who experience heroin addiction are expected to swallow the bitter pill of methadone—a lifesaver for many but an inadequate treatment for some—rather than enjoy the drug they desire in safety.

INTERSECTIONAL EMBODIMENT: ENABLING AGENCY

Underlying many of the cultural assumptions and legal policies related to substance use are assumptions about morality and health that are propped up by an unexamined ableism. Much of the same rhetoric that oppresses people with disabilities is deployed

against PWUD. Sunaura Taylor details problematic ways in which people with disabilities are compared to or even equated with animals, from the use of derogatory terms like “monkey” to describe a person with a condition like her (arthrogryposis), to the display of people with various medical conditions and disabilities as circus freaks, to the dehumanization of persons with intellectual disabilities (Taylor 2017).² Similarly, PWUD often are described disparagingly as animalistic in their desires and actions. People in chaotic drug use are depicted as mindlessly subhuman in their loss of control. Some neurological models of the BDMA point to compromised decision-making because of how substance use can affect the prefrontal cortex, describing the effect in quasi-evolutionary, animalistic terms. One literature review depicted people experiencing addiction as “controlled by their more primitive, reptilian midbrains” (Hammer et al 2013). Sometimes neurological descriptors can be weaponized against people to justify coercive and punitive treatment.

The oppression of people with disabilities and PWUD also intersects in the way medical professionals and society as a whole tend to infantilize them. Gaelynn Lea, who has osteogenesis imperfecta (“brittle bone syndrome”), resulting in a shortened stature and requiring use of a wheelchair, writes about being treated like a child or being called “sweetie” despite being a competent, adult, touring musician (Lea 2017). Helen Keane notes that people in chaotic drug use are “infantilized and placed outside the realm of normative adulthood” (Keane 2005). PWUD, especially people who exhibit addictive

² Taylor notes that such comparisons are insulting and oppressive not only to people with disabilities but also to animals themselves, an important bioethical inquiry for another time and place.

behavior, “are situated as subjects about whom the truth is known, and who cannot speak their own truth” (Keane 2005). This is a common justification for coercive treatment of people experiencing addiction. According to John Moskop, coercion may be justified when one party has legitimate authority over another, like a parent and a child (Moskop 2016). Substance use often is believed to have compromised a person’s decision-making capacity to the extent that exercising such authority becomes legitimized, but it is not at all clear that this authority is applied reasonably or rationally. Some people in chaotic drug use may need interventions to mitigate harm to themselves or to others, but often fears of potential harm are rooted more in stigma than in reality and emerge out of unconscious—or sometimes blatant—infantilizing. People with disabilities and PWUD are vulnerable in many ways, but an appropriate response is to support their agency rather than to assume they have none or to attempt to remove it.

Fears about addictive behavior and substance use resonate with—and, some argue, are similar to or the same as—concerns related to neurological differences like autism and other intellectual disabilities. The social model of disability can be applied to some extent to the diagnosis of Attention Deficit Hyperactivity Disorder (ADHD)—most American educational systems are designed for children and youth who can sit still and pay attention for extended periods of time. Those who struggle in such a system may be punished for bad behavior, but rarely is the system itself examined for ways to be more inclusive of neurodiverse kids. Stimulant use among adults may in some cases be an effort to self-treat undiagnosed or untreated ADHD. Some people who use either illicitly procured medications like Adderall or illegal stimulants like methamphetamine report

that it has the same effect as ADHD prescriptions they once had, that it enables them to make it through a day in a world that puts demands on their attention that they have a difficult time meeting without pharmaceutical assistance (Siegal 2018). Maia Szalavitz argues that the growing movement for accepting neurodiversity as a counter to intellectual and developmental ableism must include people who experience addiction. Szalavitz notes that chaotic drug use sometimes is self-medication for an underlying problem that is going unaddressed, and that some people seem more susceptible to dependence on a substance whether due to genetics (though this piece is often overemphasized in popular rhetoric about addiction), developmental trauma, or other neurological differences. Szalavitz notes that just as people with autism may have strengths that neurotypical people might not, people who are prone to addictive behaviors often have a focus and drive that, when channeled positively, can bring remarkable creativity and productivity to the fore (Szalavitz 2016, p. 281-284).

Many of these concerns stemming from ableism echo in issues of racism and fatphobia, which are intertwined in the American subconscious and in assumptions about what it means to live a healthy life and why that matters. While rhetoric around substance use tends to focus on drugs as a unique situation, addiction and illicit substance use may be better understood in the broader context of how health, morality, and discipline intersect. The concerns raised in caricatures of PWUD—especially images of lazy, self-destructive drug users failing to engage on society’s terms—are rooted not only in their actual behavior but in a neoliberal, capitalist vision of health directed toward productivity. Sabrina Strings argues that current ideas about health related to body size are rooted in

fear of the black body and an effort to discipline the white female body for the betterment of the white race—an application of Foucault’s biopolitics and disciplinary control of the population (Strings 2019). The same kinds of power that oppress people with disabilities and PWUD also conceive the biopolitics that ascribe deviance to black bodies, fat bodies, and bodies deemed unhealthy by any number of measures.

While the social model of disability provides a vital framework within which to understand and dismantle the forces and systems that oppress people with disabilities—and can be a helpful hermeneutic for approaching the social problem of substance use and addiction—it is not without its faults and criticisms. Some people with disabilities do, in fact, need medical attention for their impairment. In an effort to dismantle disabling social structures, it may be tempting to overlook or even diminish the importance of that embodied need. In her analysis of the difference (and overlap) between disability and illness, Wendell notes that some people with disabilities “experience physical or psychological burdens that no amount of social justice can eliminate. Therefore, some very much want to have their bodies cured, not as a substitute for curing ableism, but in addition to it” (Wendell 2013). However, that tension is not always held in pursuit of social justice and civil rights for people with disabilities. As Justin Hancock puts it, “The social model focuses so intensely on the physical and societal barriers placed in front of physically and mentally impaired individuals that it almost wholly divorces itself from their physical reality” (Hancock 2018, p. 9).

Just as real bodies of people with disabilities may experience pain or discomfort that cannot be remedied by civil rights or accessibility, so, too, do many PWUD require competent, compassionate medical intervention at times. Medicalization may be appropriate for specific problems related directly to their substance use, for underlying issues, or for problems secondary to problematic use within a prohibitionist society. Attention to systemic problems should not erase the needs of individual bodies, lest social justice movements fall into the same trap as the systems they stand against—as Kane Race points out, our “formulation of healthy citizenship has very little time for the actual bodies impacted by drugs” (Race 2009, p. 17). The biopolitics of healthy citizenship must be dismantled systemically, but that is accomplished precisely through attention to the actual bodies affected.

At the root of this is the question of to whom our bodies belong. Reflecting on the imprisonment, forced labor, and extermination of people whose bodies could not or would not adhere to the Third Reich’s standard of health and morality—Jewish people, primarily, but also LGBTQIA+ persons, Roma, people with disabilities, PWUD, people experiencing addiction, and more—Norman Ohler notes the way that rhetoric employed by the Nazis still lingers in new forms:

While we have driven out other Nazi verbal monstrosities, the terminology of the war on drugs has lingered. It’s no longer a matter of Jews—the dangerous dealers are now said to be part of different cultural circles. The extremely political

question of whether our bodies belong to us or to a legal-social network of social and health-related interests remains a virulent one even today (Ohler 2015, p. 20).

Through disease, diagnosis, and disability, PWUD are determined to have bodies that do not belong to them—both as a supposedly direct cause of and as a moral-legal consequence to their substance use.

One realm in which the problem of a person's body not belonging to them can be seen most acutely is in the area of reproductive health. Current debates over abortion make this evident, and although the American College of Obstetricians and Gynecologists (ACOG) is clear that “the obstetrician-gynecologist's primary duty is to the pregnant woman” (ACOG 2016), popular rhetoric around pregnancy and abortion makes that statement controversial at times. This rhetoric is only heightened in the case of a pregnant woman who uses drugs. As of September 2015, ProPublica reports that three states (Tennessee, Alabama, and South Carolina) have made illicit substance use during pregnancy a crime; at least 45 states have brought charges against women who used drugs during pregnancy since 1973; 18 states have laws equating drug use during pregnancy with child abuse; three states (Minnesota, South Dakota, and Wisconsin) allow the involuntary commitment of pregnant women who use drugs; 15 states mandate reporting of drug use in pregnancy by health care providers; and four states (North Dakota, Minnesota, Iowa, and Kentucky) require drug testing if a pregnant woman is suspected of using (Miranda et al 2005). Many people assume that illicit substance use during pregnancy causes irreparable harm to a fetus—recall the “crack babies” hysteria in

the 1980s, which is echoed in today's concerns over babies born "addicted" to opioids—but this is not at all clear from the science.

According to Bishop et al, using certain kinds of substances—namely high rates of legal ones like alcohol and tobacco—during pregnancy causes known harms to a developing fetus. However, there is little empirical evidence on the effects of other kinds of drug use in pregnancy (Bishop et al 2017). This is for several reasons: it is virtually impossible to study this ethically; pregnant women who use substances often use more than one; and women who use drugs during pregnancy frequently also experience poverty, violence, and many other health risks—so it can be impossible to know whether a negative health outcome experienced by a newborn is due to the mother's perinatal substance use or any other possible causes, including heredity (Bishop et al 2017). There is no evidence that use of cocaine or heroin during pregnancy is itself associated with long-term negative health outcomes for children. Harm reduction—including, in the case of opioid use, MAT—is a more effective means of delivering prenatal care and supporting the health of both mother and baby than prosecuting the woman for her perinatal substance use (Nathoo et al 2015). Harm reduction acknowledges that pregnant women who use drugs are often at risk for other factors that can harm her and her future child's health and presents a non-judgmental opportunity to attend to those factors alongside her substance use (Nathoo et al., 2015).

The laws punishing substance use during pregnancy are themselves barriers to care that could improve outcomes for both mother and baby. According to ACOG, "Legally

mandated testing and reporting puts the therapeutic relationship between the obstetrician–gynecologist and the patient at risk, potentially placing the physician in an adversarial relationship with the patient” (ACOG 2011). A study that interviewed 30 women who were or recently had been pregnant and used substance during pregnancy revealed that most of them avoided having their substance use found out and reported by simply avoiding prenatal or other medical care (Stone 2015). Not only do these policies fail to improve health outcomes for mother and fetus, they can contribute to worse outcomes by discouraging any care at all, compounding potential risks already being faced by both mother and child. Moreover, these policies disproportionately affect poor women and women of color; the disturbing case of the Medical University of South Carolina’s arrest of 39 women who used drugs during pregnancy—all but one of whom were African-American—put this on display when brought to light by bioethicist and former critical care nurse Mary Faith Marshall (Marshall 2016). If a woman’s body is not her own, and PWUD are considered to have forfeited control of their own bodies, then a pregnant woman who uses drugs—and especially a pregnant woman of color who uses drugs—is given even fewer rights and even less respect for autonomy.

Much of how the medical, cultural, and legal systems create and enforce disability for people who use drugs relies on an understanding of health as an individual moral achievement. This understanding gives people credit (often moral credit) for good health and blames them for negative health outcomes, and it makes broad assumptions about what constitutes good or bad health. The example of body size as a problematic indicator of health is rampant in today’s American society. A more helpful framework may be the

definition of health put forward by the Association for Size Diversity and Health (ASDAH) and the Health at Every Size (HAES) movement. The HAES definition of health frames it less as an accomplishment and more as a capacity or resource:

Health should be conceived as a resource or capacity available to all regardless of health condition or ability level, and not as an outcome or objective of living. Pursuing health is neither a moral imperative nor an individual obligation, and health status should never be used to judge, oppress, or determine the value of an individual (ASDAH 2013).

From this starting point, the question for PWUD—or any person whose body and behavior do not conform to normative standards of “health”—is not what they can do (or stop doing) to achieve better health as a moral duty, but how society and communities can support and enhance their agency in accessing and pursuing health as a resource and capacity. Harm reduction psychotherapy works to offer this kind of enabling to PWUD—enabling that helps rather than hurts, that offers respect for autonomy and recognizes that while whatever impairment substance use may cause can compromise agency, the heavier burden may be the disabling effect of social structures on a person’s capacity to make positive change.

In his 1980 criticism of the BDMA and what he saw as drug treatment gone awry, Stanton Peele writes, “we cannot begin to confront the social problem of addiction unless we take account of what it says about us” (Peele 1989). Much has been said about PWUD

and people who experience addiction, but much more needs to be said and done about a culture that has in many ways produced the problems of addiction, mass incarceration, and rising overdose deaths. Questions of power, privilege, access, and capacity need to be faced in the treatment of PWUD in the media, in our communities, and in medical and juridical settings, and unpacking stigma against PWUD also requires confronting racism, sexism, homophobia, fatphobia, and more.

CHAPTER FOUR: DIVINITY

In his essay “Bioethics in a Liberationist Key,” Márcio Fabri Dos Anjos asks the justice-oriented question of who are the subjects and objects of bioethical discourse today (Dos Anjos 2012, p. 90). Especially from the perspective of theological bioethics—most of all when grounded in liberation theology—the subjects and objects of bioethical discourse ought to be not primarily cutting-edge biotechnology and medical treatments available only to the very wealthy but first and foremost the poor, the oppressed, and the disenfranchised. Dos Anjos articulates the purpose of bioethics in terms of what foe it seeks to vanquish: “The principal enemy faced by bioethics is thus not simply death but *premature death and suffering as the fruits of injustice*” (Dos Anjos 2012, p. 84)—what the Haitian people, who know something of such death and suffering, would call “stupid deaths” (Farmer 2012, p. 142). Liberation theology, having been applied in clear ways to people in material poverty, to people of color (POC), and to the queer community, has something to say to people who use drugs (PWUD) as well. To culminate my exploration of substance use and harm reduction through disease, diagnosis, and disability, I turn to theology for a declaration of drug users’ divinity, their sacred worth and their nascent eschatological agency.

A PREFERENTIAL OPTION: LIBERATION THEOLOGY FOR PEOPLE WHO USE DRUGS

One of the hallmarks of liberation theology is its emphasis on a preferential option for the poor. This preference is articulated and acted on by individuals and by communities of faith but is attributed first and foremost to God. Proximity to suffering and oppression is

central to God's nature and being for liberation theologians. As Howard Thurman declares, "in his poverty [Jesus] was more truly Son of man than he would have been if the incident of family or birth had made him a rich son of Israel" (Thurman 1976, p. 7). Such a claim may be uncomfortable at best or offensive at worst to many who proclaim a Christian faith and inhabit the dominant culture and class, but liberation theologians claim that Jesus' life and teaching is clearly aimed, not at the well-to-do, but at those in need. In their book *Introducing Liberation Theology*, Leonardo and Clodovis Boff state, "The gospel is not aimed chiefly at 'modern' men and women with their critical spirit, but first and foremost at 'nonpersons,' those whose basic dignity and rights are denied them" (Boff & Boff 1987, p. 8). This sentiment echoes James Cone's bitter observation in his seminal *Black Theology and Black Power* that "The structure of white society attempts to make 'black being' into 'nonbeing' or 'nothingness'" (Cone 1969, p. 7). This pattern of erasure and domination occurs not only in secular society but also within the church, often rendering entire segments of the populations functionally invisible to the dominant culture. Vincent Harding asserts as much in this compelling indictment of the church's failure to share God's preferential option for the poor:

those people who live most obviously with their backs against the wall—for instance, the homeless, the working and jobless poor, the substance abused and abusers, the alienated, misguided, and essentially abandoned young people—are rarely within hearing or seeing range of the company of Jesus' proclaimed followers. The keepers of the faith of the master often find it very difficult, and

very dangerous, to follow him into the hard places inhabited by the disinherited of America (Thurman 1976, p. xiv).

The “substance abused and abusers”—or, in my terms today, PWUD and people experiencing addiction—also may be the materially poor, those traditionally considered in liberation theology’s preferential option. Sometimes, they are not materially poor, and wealthy PWUD may be able to avoid some, but not all, of the supposedly natural consequences of substance use—but stigmatization and isolation of PWUD, at the hands of a biopolitical system that rarely treats them as fully human, marks them as ranking among those in need of liberation.

Considering liberation theology in the context of public health and social justice, Paul Farmer notes, “most often, diseases themselves make a preferential option for the poor” (Farmer 2012, p. 140). Chaotic drug use and addiction, and the negative consequences of substance use under prohibition and stigma, also make a preferential option for the poor—and that preference is only more pronounced if that poor person is also a person of color or a LGBTQIA+ person. Liberation theology attends to the unjust divisions in our society that have negative mental and physical health consequences, up to and including death, for people who are stigmatized and oppressed. PWUD, though not a monolith by any means, are among the communities that Justo and Catherine González call “the internal colonies of our society” (González & González 1994, p. 14). Far from a moral evil that must be expunged—as some Christian traditions have treated it—substance use

is part of people's lives, a part that too often marks them for incarceration, stigmatization, and isolation.

Jarrett Zigon presents a compelling—and alarming—vision of the function of biopower and safety in the war on drugs, which he argues is, in fact, a war on people:

When representatives of governments, states, and international institutions speak of the drug war, they speak as though it is a quasimetaphorical description of the benevolent attempt on their part to protect national and global populations from apparently dangerous substances. This rhetoric suggests that the war is waged on these substances, and this, along with the medicalization of the disease model of addiction and its therapeutic treatment, results in the contemporary dominant discourse of the war on drugs as protective policies more akin to public health initiatives than any actually fought war. When, on occasion, the drug war is articulated as an actual war, the enemy is, for the most part, officially marked as the dealers, the cartels, and the bad guys who threaten communities. Populations, in this narrative, must be protected.

This is *not* how the anti-drug war movement understands the drug war, and it is not how innumerable drug users around the globe experience it. For them it is indeed a war on people. This war, as far as they can tell, does not protect a population as much as it *creates* two populations—one to be 'protectively' normalized, the other to be inclusively excluded. For it is only by means of the

discursive, structural, and physical violence enacted against certain kinds of people—in this case, drug users—that a normalized and protectable population comes into being. Put another way: a protectable population never exists prior to the enactment of a biopolitical will that creates that population through acts of exclusionary violence against another and covers over that violence with the rhetorical discourse of security (Zigon 2019, p. 5-6).

The line between the “‘protectively’ normalized” population and the population of PWUD is not always so clear. That line is becoming blurrier as some U.S. states legalize marijuana, and it becomes blurrier still when we acknowledge that alcohol, tobacco, and caffeine are all drugs, all legal and widely used. Nevertheless, the war on drugs creates these two separate, segregated populations in the imagination of our society, and as Howard Thurman warns, “Within the walls of separateness death keeps watch” (Thurman 1976, p, 35-6). If one population is to be protected, the other is to be either absorbed back into the first population through behavior modification or to be incarcerated, separated from society, and even left to die. An opioid overdose can be reversed, but only if someone is present and ready to administer naloxone to the person using opioids; the isolation many PWUD experience secondary to their segregation and stigmatization is a major contributing factor to overdose death.

The “exclusionary violence” Zigon describes may not always be overt or physical violence (though sometimes it is), but as Thurman states, “The underprivileged in any society are the victims of a perpetual war of nerves. The logic of the state of affairs is

physical violence, but it need not fulfill itself in order to work its perfect havoc in the souls of the poor” (Thurman 1976, p. 29). PWUD, when separated out by the creation of a normalized group to be protected, are victimized not only by violence but by the threat of it in a war supposedly waged against drugs but whose hand falls heavy on people. As a people oppressed by the powers that be, PWUD are among those for whom a liberation theology should attribute God’s—and the church’s—preferential option. However, liberation theology refuses to see the oppressed as mere objects of liberation; they are subjects of it, and true change is rooted in small communities of poor people (Farmer 2012, p. 140). For PWUD to be disentangled from the biopolitical systems that segregate and punish them, they need to be empowered—which requires me to examine more closely the nature and function of power itself.

BEYOND BIOPOWER: FROM DOMINANCE TO LIBERATION

Biopower, as a system deployed by a state to govern the bodies of a population, is not the answer to the oppression of PWUD or any group in need of liberation. Simply to shift power from one group to another is not liberation, it is simply more biopolitics in search of another group to control. The answer is not more biopolitics but a transformation of our understanding and use of power. My thinking on power has been informed by Cyndi Suarez’s book *The Power Manual*, which draws on Michel Foucault, Audre Lorde, and others to distinguish between two kinds of power. What follows is a brief summary of her account and my wrestling with it in the context of the social model of disability and black power, and a gesture toward what it might have to offer to the liberation of PWUD.

Suarez distinguishes between two types of power: dominating power and liberatory power. Dominating power “reflects a supremacist way of thinking—an acceptance of relationships of domination and submission” and is “related to scarcity consciousness, or the belief that the world holds limited supplies of the things we want—love, power, recognition” (Suarez 2018, p. 13). Liberatory power is “the ability to create what we want” and “stems from abundance consciousness” (Suarez 2018, p. 13). Biopower, however well-intended, runs on dominating power. Oppression of all kinds is fueled by dominating power. Suarez observes that often social justice movements either seek to seize this power or to lay it down completely, but power is always at work—the question is, what kind. Suarez notes that these two forms of power can be distinguished in the way they deal with difference: dominating power sees difference and will “ignore it or view it as a cause for separation; liberatory power sees difference as a strength and ‘entertains interdependence as an option’” (Suarez 2018, p. 15). For PWUD, their difference is constructed in part by the delineation of the two populations that Zigon posits; their difference is expressed, too, in the way they pursue pleasure or relief, in how they organize their time and finances, and in their engagement with deviant or liminal practices. The war on drugs draws on dominating power, seeing these differences as a threat, separating PWUD from the normative population and seeking to modify or stamp out the behaviors that distinguish them. Drug user unions reach for liberatory power that embraces difference and makes PWUD both objects and subjects of liberation.

“Power is a force field of relationships based on inequality” (Suarez 2018, p. 12). While the social model of disability helped us to look beyond individual behavior for the source

of problems that emerge secondary to substance use, Suarez's account of power brings the systemic and the personal together. Suarez argues, "the locus of power, the place where it can be transformed, is interactions" (Suarez 2018, p. 8). Her account of where power is enacted and may be changed aligns with liberation theologian Jon Sobrino's account of poverty, which he claims "results from the actions of other human beings" (Sobrino 1988, p. 31). What role do systems play in this version of power and poverty? Suarez describes laws, institutions, society, and the state as "simply the dead forms, or artifacts, that result from past power-laden interactions, or confrontations" (Suarez 2018, p. 11). These systems are not without meaning—to act in accordance with past actions is, in fact, to exercise power, and these artifacts often lend legitimacy to dominant ways of interacting that are oppressive.

A corollary to this concept exists, though the comparison is imperfect, in many forms of Christian theology. The concept of original sin, though articulated differently in different traditions, describes sin as inherited, or passed down, from Adam and Eve to today. Joyce Schuld compares inherited guilt, or original sin, as described by 4th-century bishop Augustine of Hippo, to Foucault's industrial machinery and interactive networks (Schuld 2003, p. 51). If taken in the context of Suarez's framework for power, original sin (as attributed to communities, societies, and systems, not just individuals) and biopower are dead artifacts of past power-laden interactions. Jim Wallis closes the gap between the concept of original sin and the oppressive structures of the nation-state by calling racism America's original sin (Wallis 2015), a national artifact of the power interactions that brought African people to America and subjugated them to slavery for centuries. Wendell

Berry describes sin as wounds—a metaphor common to eastern forms of Christianity—and posits that racism is passed down as an inherited wound, both in the harms done to black people and in a mirror wound to white people who also are harmed by the perpetuation of dominating power over POC (Berry 2010, p. 3). Schuld notes that systems of control and domination—as well as original sin—are perpetuated by present actions: “The machinery and general mechanics of original sin cannot live off past energies and simply run on an accumulated momentum of prior injustices. It is absolutely dependent on the continued participation of every active social component” (Schuld 2003, p. 52). Applied to the war on drugs, past efforts at controlling groups (namely POC and immigrants) seen as a threat to the dominant society by legislating substances associated with these groups left behind laws and structures whose legitimacy is taken for granted and on which ordinary people form opinions and take actions today, thereby perpetuating a system of biopower that condemns and oppresses PWUD under the guise of preserving law and order.

These artifacts of past power-laden interactions shape not only the imagination of the heirs of the culture that first enacted them but also the self-perception of those who were and are objects of suppression and oppression. Suarez describes hegemony as a state in which people believe that dominating power is the only kind of power and therefore that they will never have access to power: “In hegemony, one has internalized the dominant ideology. One is powerless because one has internalized the idea of power as dominance” (Suarez 2018, p. 37). Schuld also notes, by way of Foucault and Augustine, that “distorted power relations...can be the most deeply disruptive as they govern an

individual's relation to his or her own existence and identity" (Schuld 2003, p. 12). When PWUD are believed to have no control or agency, they may internalize that idea, which may affect their choices in relation to substance use and in other areas. As a population constantly subject to coercive governance both in law and in medicine, PWUD may come to see themselves as powerless in the face of those who wage the drug war and enforce its ideology.

However, Suarez argues that an understanding of two kinds of power offers an alternative to the powerful-powerless dichotomy, and Zigon argues that the anti-drug war movement is already engaging in resistance to that binary. Suarez asserts that liberation can be pursued by focusing on "interactions that disrupt dominating behavior...and generate mutuality" (Suarez 2018, p. 13). This transformation requires the refusal of powerless identities in interactions—dismantling the internalized powerlessness and choosing instead to embody empowerment—and building capacity for effective interactions (Suarez 2018, p. 13). This echoes James Cone's account of Black Power: "Black Power means black freedom, black self-determination, wherein black people no longer view themselves as without human dignity but as men, human beings with the ability to carve out their own destiny" (Cone 1969, p. 6). This is liberatory power in action. However, refusing powerless identities and building capacity for effective interactions—interactions that engage freedom and self-determination—is not an individual accomplishment but requires consciousness-raising and capacity-building of oppressed persons in community with one another.

In my first chapter, I alluded to Gupta's suggestion that the question of whether medical intervention is appropriate for a person be determined not by the diagnosis of disease but by the standard of whether it will contribute to that person's flourishing, not only individually but within his or her community (Gupta 2020). From a theological standpoint, that final piece—the community context—is vital, though western forms of Christianity often neglect it. Joel Shuman notes that a Cartesian modernity has relegated the church to the realm of the immaterial soul rather than the material body, and some Christian traditions exhibit this attention to “the life to come, rather than this life” (Shuman 1999, p. 80-1). Wendell Berry speculates that the church's efforts to spiritualize the physical emerges from the idea that what is physical is corruptible and “low” in the moral order (Berry 2012, p. 420). This idea echoes in AA and many Christian recovery programs that treat addiction as a spiritual sickness, often teaching participants to distrust their bodies and their brains as prone to sin and evil. However, pitting mind against matter, though common in western Christianity, has lingering traces of a theology long declared heretical by the Catholic Church: Gnosticism. Emerging shortly after the Christian gospel began to spread through the Mediterranean, the Gnostic tradition asserted that the soul was inherently good but was trapped in a physical form that was naturally evil (Arendzen 1909). This line of thinking had—and still has—profound implications for how the church deals with sex, pleasure, and health itself.

A reductive view of health dominates medicine in general and the treatment of addiction in particular. A gnostic view of the material world only reinforces an approach to health

that Berry describes as “almost fanatically individualistic. The body is seen as a defective or potentially defective machine, singular, solitary, and displaced” (Berry 2012, p. 419). Ironically, this reductive approach parallels disease in how it isolates people (Berry 2012, p. 419). This isolation is a central element of most drug treatment programs, which usually require that a person diagnosed with SUD (or, because of the entanglement with the justice system, are facing drug charges) must be removed from his or her family, friends, and community, either for many hours a day or for many weeks, even months, at a time. As mentioned in a previous chapter, some hospitals disallow visitors for patients determined to have a drug problem. While there are reasons for these practices, and at times PWUD may want and even request separation from the world as a self-binding practice to escape chaotic use, defaulting to isolation only reinforces a reductive, individualistic view of health and casts family and friends as accomplices in the person’s self-degradation rather than as potential allies to his or her flourishing.

Modern medicine’s approach to health perpetuates the narrowing of its definition, contrary to the way most people understand and live into what it means to be healthy. Shuman argues, “the physical health of a person may be *finally* considered only in relationship to the goods of her life as she and those to whom she is morally bound have come to understand them” (Shuman 1999, p. 83). Physical health, Shuman claims, is “necessarily both subordinate to and dependent on” a person’s determination, in the context of community, of what he or she defines as a good life (Shuman 1999, p. 83). Ultimately, Berry says, “I believe that health is wholeness” (Berry 2012, p. 419)—and, taken with Shuman’s assessment, each person defines wholeness for himself or herself.

However, that definition is not created in the same isolation that produced the problem but is shaped by and refined in community. Berry argues that health cannot be defined apart from those relational ties: “I believe that the community...is the smallest unit of health and that to speak of the health of an isolated individual is a contradiction in terms” (Berry 2012, p. 420). 12-Step programs for family and friends of problem drinkers and PWUD refer to addiction as a family disease, but rarely do we conceive of health itself as a shared good rather than as an individual moral achievement.

For those whose choices, condition, or struggle have isolated them, community may be not just the locus of health but the manifestation of it. In a popular TED Talk on addiction, Johann Hari says that the opposite of addiction is not sobriety, but community (Hari 2015). If health is wholeness, and health cannot be considered in isolation from community, then a “double sense of singular integrity and of communal belonging is our personal standard of health” (Berry 2012, p. 419). In Christian theology, this standard has two corollary dogmas: one, the incarnation, where God becomes human in Jesus, repudiating attempts to declare the material inherently evil; and two, the Trinity, which describes God as three-in-one, a singular divine being in community within Godself. In Christianity, to be a child of God is to be part of a family or a community, and salvation includes not only a promise of eternal life but an opportunity for a full life in the here and now. Liberation theology refuses to offer those who are oppressed in this world the promise of heaven without striving for their wholeness and healing on earth.

OUR KIN-DOM COME: EMBODYING AN INCIPIENT OTHERWISE

The Harm Reduction Coalition’s distinction between harm reduction practices and the Harm Reduction social justice movement parallels the distinction between charity, or aid, and justice, or liberation. In liberation theology, charity, while it may be helpful and even merciful in the short term, reinforces unequal power relationships in the long term. As Boff & Boff put it, “aid remains a strategy for helping the poor, but treating them as (collective) objects of charity, not as subjects of their own liberation” (Boff & Boff 1987, p. 4). Focusing too heavily on charity can, in fact, make an unjust situation worse: “Aid increases the dependence of the poor, tying them to help from others, to decisions made by others: again, not enabling them to become their own liberators” (Boff & Boff 1987, p. 5). The practical strategies outlined in harm reduction are necessary and life-saving in the midst of an overdose crisis; however, without Harm Reduction, these practices may reinforce a status quo that casts PWUD as helpless and without agency. A program can distribute syringes or naloxone without promoting the dignity—and therefore, the wholeness—of PWUD, and liberation may remain unthinkable. James Cone points out how this functions in the realm of race and racism and names a different way forward:

It seems that whites forget about the necessary interrelatedness of love, justice, and power when they encounter black people. Love becomes emotional and sentimental. This sentimental, condescending love accounts for their desire to ‘help’ by relieving the physical pains of the suffering blacks so they can satisfy their own religious piety and keep the poor powerless. But the new blacks, redeemed in Christ, must refuse their ‘help’ and demand that blacks be confronted

as persons. They must say to whites that authentic love is not ‘help,’ not giving Christmas baskets but working for political, social, and economic justice, which always means a redistribution of power (Cone 1969, p. 54-5).

Liberation theologians assert that loving the poor and oppressed must go beyond charity and center instead on justice. As Jon Sobrino put it, “There is no doubt that the only correct way to love the poor will be to struggle for their liberation” (Sobrino 1988, p. 32). To love PWUD is to seek justice for victims of mass incarceration, to find systemic solutions to an unregulated and polluted drug supply, to change how the medical world treats PWUD, and to seek changes to laws that demonize and criminalize them. Most of all, to love PWUD is to shift away from dominating power toward liberatory power that gives all people, especially the marginalized, the opportunity to create a new kind of world.

An important element of Christian theology is the image of the kingdom of God. The kingdom is described as breaking through but not yet fully manifested—a paradox of “already-but-not-yet.” Jarrett Zigon’s account of drug user politics echoes this paradox from the position of what he calls “an anthropology of potentiality” (Zigon 2019, p. 13). He writes, “What I call the *anti-drug war movement* is a plurality assemblage of diverse—and sometimes seemingly contradictory—groups and organizations that have created a counterhegemonic alternative to what I describe...as the global condition of war as governance” (Zigon 2019, p. 3). Zigon’s account of resistance on the part of the anti-drug war movement—a resistance that yields moments of incipient justice while

continuing to strive for its goals to be realized in full—parallels the image of a kingdom that is already-but-not-yet. And, in order to set aside forms of faith indebted to patriarchal systems of dominating power, many advocates within liberation theology—in the anti-drug war movement, the anti-poverty movement, the anti-racism movement, the movement for gender justice, and more—in lieu of the “kingdom of God,” the term “kin-dom of God” is often used. “Kin-dom” suggests relationality and liberation from empire and patriarchy, leaning into a new reality even as that empire continues to exert control.

As an alternative approach to PWUD and addiction from the vantage point of public health and harm reduction resists the deployment of biopower against vulnerable persons, liberation theology resists collusion between the Church and the power of the state, standing always with the poor and (supposedly) powerless. A liberation theology for PWUD must deconstruct a system of power that law and medicine, as well as religion, have participated in and perpetuated to the detriment of those most vulnerable to its machinations.

As formerly the Church regulated man’s relations to God, so Medicine now regulates his relations to his body. Deviation from the rules set forth by the Church was then considered heresy and was punished by appropriate theological sanctions, called penance; deviation from the rules set forth by Medicine is now considered drug abuse...and is punished by appropriate medical sanctions, called treatment (Szasz 2013).

This take on religion and medicine is cynical but not inaccurate, and its core claim about the Church was at the center of the Protestant Reformation. Though this summary oversimplifies the Reformation and its consequences, many of the primary problems with the Catholic Church at the time that Martin Luther and others sought to change had to do with the way the Church mediated the ordinary Christian's relations to God. Along with the Reformation came the translation of the Bible into the vernacular so that not only the priests who read Latin but also the commoner who spoke German could access, interpret, and apply the Word of God. A parallel in the history of harm reduction was the work of the late Dan Bigg, a co-founder of the Chicago Recovery Alliance and a pioneer in the distribution of naloxone, the opioid overdose reversal drug. Where once naloxone was a drug carried mainly by anesthesiologists in operating rooms, Bigg led the way in accessing and distributing this lifesaving drug, not just to medical professionals, but to the people on the front lines of the overdose crisis: PWUD themselves. The image of Bigg showing up to harm reduction conferences with duffel bags full of naloxone to hand out is one that has stayed with his admirers after his death, and many credit him directly with the current progress being made in many places regarding access to naloxone—for example, in North Carolina, naloxone requires a prescription, but there is a standing physician's order that makes it available at any pharmacy, and syringe exchange programs give it out for free. Much as Luther asserted that the common man should have access to the words of life contained in scripture without having his relationship to God mediated through a religious authority, Bigg embodied the belief that the lifesaving overdose reversal drug should be available to those who need it most without the control of a medical professional.

Blyth Barnow lost her first friend to overdose at age 15, and her heart for PWUD carried her first to seminary and recently to the position of Harm Reduction Coordinator Ohio with Faith in Public Life. Barnow developed a worship service and training opportunity called “Naloxone Saves,” in which she depicts overdose reversal as resurrection—a profoundly Christian framing—equips participants to administer naloxone, and distributes kits to those in proximity with PWUD (Barnow). Zigon describes the work of the anti-drug war movement and harm reductionists like Barnow as “enactments of an incipient otherwise in the here and now of everyday life” (Zigon 2019, p. 14). That sounds to me like Paul’s letter to the Corinthians calling the resurrected Christ “the first fruits of the dead” (1 Corinthians 15:20, NRSV), alluding to the resurrection to come for all, and like the peculiar moment in Matthew’s Gospel where Jesus’ crucifixion is accompanied by this scene:

At that moment the curtain of the temple was torn in two, from top to bottom. The earth shook, and the rocks were split. The tombs also were opened, and many bodies of the saints who had fallen asleep were raised. After his resurrection they came out of the tombs and entered the holy city and appeared to many (Matthew 27:52-53, NRSV).

The act of reversing an overdose is itself an embodiment of an incipient otherwise and of resurrection. All Christian hope is an enactment of an incipient otherwise, and PWUD and their allies in the anti-drug war movement engage that hope every time they use

safely or help someone else to do so, reverse an overdose, or resist the dominating power interactions of those still waging the war on drugs.

Building a kin-dom here and now is about creating a world one can live in despite the prevailing cultural milieu. For people who have been oppressed and traumatized, as most PWUD have been, this world must feel like a place that is hospitable, a place in which they have agency and freedom; as Serene Jones writes, “trauma survivors desperately need to believe that the world is fundamentally ordered and trustworthy if they, in turn, are to have the capacity to imagine themselves as meaningful actors within it again” (Jones 2009, p. 57). Harm reduction offers PWUD opportunities to make choices and changes in defiance of a dominant attitude that tells them they cannot change or that they are not worthy of positive change. Zigon argues that “The anti-drug war movement is actually changing worlds, slowly but surely” (Zigon 2019, p. 4), and that this change is taking place beyond biopolitics (Zigon 2019, p. 10). This world-changing aligns with Nancy Eiesland’s assertion in her book *The Disabled God* that, “As a communion of struggle, the church’s first challenge is a willingness to risk conversion” (Eiesland 1994, p. 109). Liberation theology offers an alternative to hegemonic power, opening up the possibility of freedom, change, and a new world, not just in the life to come, but in the life of the world today.

A favorite New Testament passage for Christians reaching out in service to the world is Matthew 25, where Jesus tells the parable of the sheep and the goats. The sheep—those bound to eternal life with God—have fed the hungry, given drink to the thirsty,

welcomed the stranger, clothed the naked, and visited the sick and in prison. To them, Jesus says, “Solidarity that comes from making an option for the poor is crucial not because Christ is with the marginalized, but because Christ *is* the marginalized” (De La Torre 2014, p. 46). In the Gospels, Jesus consistently identifies himself with the most vulnerable in society. He doesn’t just go to them—he appears *in* them. A liberation theology account says that if we were to look for Jesus today, we would see him most clearly at the margins—in the LGBTQIA+ community; in people of color; among persecuted Muslims; among refugees and immigrants; in the prisons and among those on probation; in the homeless and the poor; among sex workers and PWUD and everyone the dominant society treats as disposable or undesirable. A theological bioethics of substance use and addiction must resist the medicalization and social control of PWUD and point toward liberation from the disabling forces of the war on drugs—through and with the power of love.

Love is powerful; in fact, Schuld argues that power cannot be separated from relationality (Schuld 2003, p. 11). But what kind of power? The dominating power of discipline and control that has been wielded against PWUD has done nothing to slow the current overdose crisis, and our prisons overflow with drug offenders, with the poor, and with POC. Liberation theology announces a reality imbued with a different kind of power, calling the church “not to reestablish the rule of Constantine, but rather to live out the rule of Christ, the one who sat on the margins of society with those whom the world deemed to be unlovable” (Swinton 2012, p. 526). A Christian emphasis on being drug-free or “healthy” in terms of the dominant society does nothing but exclude those at the

margins, those whose choices or challenges place them in spaces of deviance and render them disabled at the hands of a normative society. What is needed is not only a shift in power but a re-imagining of it in the context of love and wholeness in community—and the possibility of someone like Gil Scott-Heron’s “junkie walking through the twilight” finding welcome rather than hatred at home, both in his family and in his community. Far from the moralistic, puritanical Christianity whose roots are entangled in the history of America’s draconian drug policies, this kind of Christianity calls all people toward liberatory wholeness, opening the door to healing and to a new world.

CONCLUSION

The North Carolina band The Collection released an album in 2018 with a song entitled “Becoming My Own Home” (Wimbish 2018). If “Home Is Where the Hatred Is” (Scott-Heron 1971), PWUD and members of the anti-drug war movement have looked elsewhere and found love, safety, and belonging in their midst and in the harm reduction community—becoming their own home. Kane Race notes that communities of risk, whether sexual or drug-related, seldom have benefited from interventions on the part of traditional authorities; rather, they have created their own safety by modifying practices of risk (Race 2009, p. 138). Harm reduction practices—and Harm Reduction principles of justice—emerged out of the wisdom and experience, not primarily of medical professionals, but of PWUD and their allies. Harm reduction, not medicalization or social control, has shown itself to be not only practical but also aspirational in claiming both the validity of the lives of PWUD and also their dignity and humanity. Especially in a time when those lives are threatened by the risk of overdose and punitive treatment at the hands of both law and medicine, bioethics should be concerned with the wellbeing of PWUD, with the prevention of their suffering and untimely death, and with respect for their autonomy and access to healthcare when they need it and choose it.

In practice, a shift in our approach to substance use and addiction would require the repeal of laws that take a punitive approach to PWUD—particularly drug-induced homicide laws—and many harm reduction advocates argue that at least decriminalizing possession and use of small amounts of now-illicit drugs could have a profound impact

on the wellbeing of PWUD and, by extension, on their communities. The changes I advocate would require a radical change to, even abolition of, the current prison-industrial complex and the mass incarceration of POC and poor people, not just PWUD. Policy already has begun to shift in relation to marijuana, but such changes must attend to the racialized roots of American drug policy, acknowledging that many people, especially POC, may be unable to benefit from this burgeoning market because they are saddled with outdated felony charges for marijuana sale and possession. On the clinical and therapeutic level, the changes that the anti-drug war movement reaches for would require greater accessibility to evidence-based forms of treatment like MAT, cognitive-behavioral therapy (CBT), dialectical-behavioral therapy (DBT), eye movement desensitization and reprocessing (EMDR), and other proven forms of treatment for trauma and other bio-psychosocial processes that accompany and sometimes cause addiction. Treatment of any kind today is difficult to access and even more difficult to evaluate for effectiveness; harm reduction psychotherapy demands greater accountability from the field, specifically greater accountability to PWUD and people experiencing addiction. In general terms, a shift like the one I describe would require greater respect for autonomy on the part of medical professionals whose patients are PWUD, recognizing that to respect their autonomy is not to release them from personal responsibility but to equip them more authentically to accept it.

This thesis has been about substance use and addiction, and it has been about health and moralization more broadly. As a society, we would do well to interrogate our assumptions about the meaning of health and to resist the individualizing, pathologizing

models that lead to more isolation and that neglect the social goods of a person's life in relation to his or her physical health. A concept of health that is about access to a resource or capacity, that focuses on wholeness in community, that relies not on prescribed treatments for diagnostic labels but on support for human flourishing, may seem too much to hope for in a society obsessed with thinness, largely silent on climate change, and facing a resurgence of white supremacy. And perhaps it is. But if the alternative is to acquiesce to the dominating power of a status quo that condemns PWUD to die for their challenges and choices, then the only real option is to hope for too much. A bioethics of difference in regards to substance use and addiction re-orientes the concerns of medicine, health, and justice to the dispossessed and the deviant, engaging difference with the option of liberation rather than automatic domination. Harm Reduction casts a lofty vision for someday but also offers practical tools for embodying an incipient otherwise today.

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- Music & Worship Coordinator* Green Street United Methodist Church
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PUBLICATIONS

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