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## Exploring the Epistemology of Illicit Drugs

Holly Linseman

### **Introduction**

Everyone has heard about the “War on Drugs.” If one simply watches the news for a few days, the media construes an image of an addicted world populace, with our government gallantly fighting a war that never ends. The United States has a long history with this apparent struggle: Prohibition, the counterculture movement of the 1960s, and the more recent policing of club drugs and methamphetamine use.

In this essay I explore the epistemology of drugs in America. That is, how Americans come to know and define drugs and their users; and, in turn, how those definitions manifest in social institutions. I argue that at the present moment, the cultural environment surrounding the ways in which Americans define and experience drug use—whether it is deemed as acceptable usage or a threat—is determined by three main institutions. The first and most predominant is the criminal justice system, which operates according to a regime of “narcopolitics.”

William Garriott defines narcopolitics as a “particular mode of political practice...which works to rationalize the practices of governance in terms of the problems associated with narcotics” (Garriott 2011, 3). It is worth noting that narcopolitics focuses predominantly on prevention, meaning that the most money and energy is dedicated towards law enforcement. The second apparatus that shapes how Americans define drugs and users is the Public Health sector, whose biomedical description of drug use narrowly outlines addiction as an incurable, chronic disease.

Lastly, for at least the last two decades, our neoliberal political economic system has been shifting the responsibility of health care away from the state and placing it onto the shoulders of individuals. More specifically, neoliberalism takes up a more *laissez-faire* approach when it comes to health care, and, beginning in the 2000s, began withdrawing funding for state health care, forcing citizens to turn to the private sector of health care. Unfortunately, treating addicts is not a profitable endeavor. Together these three institutions greatly influence the cultural environment surrounding drugs and drug use in the U.S., and, in turn, how the general public understands and defines drug use and addiction.

In what follows, I discuss how these three institutional factors intersect to shape mainstream understandings of, and approaches to, drug use in the United States today. First, however, I provide some historical context.

### **An Overview of the History Drug Use and Addiction**

Although it is not very obvious, it is possible that drug use, illicit and non-illicit, has been entwined with human beings since the development of writing and agriculture. Evidence suggests that Sumerians cultivated poppy and called it something equivalent to “joy-plant.” Therefore, it is not surprising that the “discovery” of America by Columbus was in fact partially influenced by the desire of Europeans for opiates, which were used for a plethora of ailments such as nervousness, TB, cancer, baldness, and the list goes on. Although Columbus failed to find a route to Asia, he did bring back a very powerful drug indeed—known to the world as tobacco. During the age of exploration, explorers sometimes brought teams of scientists to study the flora and fauna. Many European explorers brought back a diverse number of drugs from various areas of the world,

including, but not limited to caffeine, opiates, tobacco, cocaine, and hallucinogens (Singer 2005, 36). This is the first well-documented period of emergent global drug use, which has maintained itself to the present.

These substances, now known to most of the world as illicit, were once accepted as medication for ailments. Within this paper, I distinguish “illicit” drug use from “licit” drug use because of the array of multi-million dollar pharmaceutical companies producing drugs, many of which are addictive themselves. Those substances deemed illicit today have not always been categorized as such. During the colonial period, it was considered normal to treat your toothache with something extracted from the coca leaf, for example. Drawing from Booth, Merrill Singer suggests that, “Addiction, in fact, was common during this period but was not defined as a health problem nor as a social ill; rather, it was ‘accepted as the price one paid for the relief of pain’ (Booth 1996:30)” (Singer 2005, 44).

More recently, medical professionals posit addiction as a chronic illness, or a problem requiring treatment. Yet, despite the highly sophisticated medical improvements over the last century, addiction responds poorly to existing treatment options; that is, if the afflicted individual can gain access to treatment in the first place. This approach, which shapes drug treatment today, typically results in several relapses before users start changing their patterns of drug use. Many addicts are even told in treatment they will never be “normal” again and will always have the desire for illicit drugs. While many factors play into this phenomenon (such as the privatization of health clinics and the lack of agency of addicts in neoliberal political-economies), the conflicting nature of Public Healthcare and the criminal justice system pose a huge obstacle: it is very difficult for

users to be rehabilitated if they are imprisoned in facilities that do not offer any type of drug rehabilitation treatment.

The U.S. criminal justice system has a long history with drugs. The first anti drug laws in America were passed at the state level. It was not until 1914 that the federal government passed The Harrison Narcotic Act, which restricted the sale of psychoactive substances. This act changed the population of the drug user from a self medicating middle class female drinking opium tincture to young male heroin snorters and gangs (Singer 2005, 58). The media covered the increase of arrests of addicts and, in no time, the addict became a criminal deviant rather than a sick person. The United States made a transition over the course of a century, from accepting the usage of substances like opiates and coca leaves as normal medicine, to viewing those who use these now illicit drugs as threats to society. The connection between drugs and crime became a social fact (Garriott 2011, 33).

The policing of what have come to be known as illicit drugs has important moral connotations. What people deem as “normal” is particular to the cultural environment of the said population, and in this case, through the criminalization of illicit drugs, the government solidified illicit drug use and those that partake in it as “bad”. The public now labels those that use illicit drugs as social deviants: individuals that are dangers to society. Howard Becker, who is mentioned in the text *Comprehending Drug Use* by Singer and Page (2010), describes how the definition of addiction transitioned to something that is both morally wrong and medically labeled as a disease. Becker developed a labeling theory to study deviance:

Labeling theory stresses that deviance is not an expression of an individual's internal qualities, but it is the result of someone else—someone with the necessary public authority—who labels specific behavior, such as smoking marijuana, as naturally bad” (Page and Singer 2010, 832).

As I discuss below, many of those addicted to substances deemed illicit have a very difficult time re-establishing themselves into society even if they achieve sobriety because of their position as criminals and social deviants.

Regardless of how the current definition of addiction has developed, and how it determines what behavior is acceptable, it shapes and is shaped by institutions such as the criminal justice system and the public healthcare system. These institutions, fueled by neoliberal incentives attempting to privatize the institutions meant to confront addiction, such as treatment, tend to act upon the individual lives of addicts rather than the social milieu in which they live. For example, wealthy addicts can afford the high performing, in-patient treatment centers. Impoverished street addicts do not have the same opportunity to gain access to high-quality treatment.

Unfortunately, attempts to address the present drug “epidemic” have been met largely with failure. The criminal justice and healthcare system have not been very successful in addressing the issue of addiction. This failure is due to the fact that healthcare and policing are often at odds with one another. Because the criminal justice system is trying to eliminate drug use through incarceration and occasional treatment, it is quite difficult for public health advocates to address this crisis. In what follows, I discuss the criminal justice and public healthcare systems' approaches to drug use in the United States in order to highlight the ways in which they operate at cross purposes.

### **The Criminal Justice System**

The criminal justice system that is in place is one that has shaped and been shaped by a focus on narcotics. This system operates on an understanding of certain drugs as things to be prohibited, and includes an umbrella of laws and legislation that pertain to both public health institutions and individuals. The dominance of drug laws is partially due to the amount of funding drug enforcement receives in comparison to treatment and education. According to William Garriott in his ethnography, *Policing Methamphetamine: Narcopolitics in Rural America*, “the focus on narcotics has transformed the workings of law, the exercise of police power, and the practice of politics in contemporary United States” (Garriott 2011, 1). Garriott’s ethnography is focused on the transition of an average Appalachian county into a region dotted with meth labs and traffickers. He focuses specifically on the policing of methamphetamine, because it was the most evident organized response to the appearance of widespread methamphetamine addiction. Garriott brings to the forefront how no part of the criminal justice system has been left untouched—everything has shifted orientation to drug enforcement. This shift in orientation is narcopolitics at work. In the United States specifically, the illicit drug apparatus is organized around enforcement, leaving little to no emphasis on treatment and education.

The narcopolitical approach is one that is met with criticism from most anthropologists, whose main foci are drug use and/or public health. All three ethnographies mentioned in this paper contain misgivings about how drug addiction is addressed. The criticism is no doubt related to the fact that the criminal justice system targets substances specifically, not individuals. Therefore, when police are enforcing the law, they are more focused on neutralizing a potential threat rather than helping the

offender, who is clearly struggling with addiction (Garriott 2011, 8). Here then is an understanding of drugs as at least somewhat disconnected from their users. As evidenced by the never ending War on Drugs, addressing this issue in such a way does not solve it. By combining medicine, law and social services into one apparatus—the criminal justice system—drug use and the crimes and health issues associated with it are still flourishing. For example, a quick scan of the Seacoast Online website reveals exponential growth of heroin addiction in the seacoast area (NH, MA, ME). Heroin is cheaper and more mainstream now than it ever has been, despite all the efforts of the DEA and local law enforcement. Even the police officials Garriott spoke with during his research, and recounted in his ethnography, are disillusioned with the lack of effect their enforcement has played upon the network of methamphetamine production, sale, and use in Baker County.

### **Biomedical and Public Health Care**

Against the legal and moral connotations of drug use, the public healthcare system struggles to work efficiently in the treatment of addicts. The public health system comes to know about and act upon drugs in their social setting, as things to make safer by changing people's behavior. For many years, needle exchanges, safe facilities, and providing basic amenities to addicts were announced in the political arena as “advocating” drug use. Yet, such programs threaten to step on the toes of a criminal justice system that seeks to *prevent* drug use. As such, the harsh laws concerning illicit drug use facilitate risky, unsafe, and unsanitary behaviors. For example, a heroin addict does not carry his own “rig” for fear of being caught and searched by police, so s/he shares one with acquaintances when the opportunity arises. Philippe Bourgois and Jeff



Schonberg's 2009 ethnography, *Righteous Dopefiend*, brings together twelve years of research among San Francisco's homeless heroin addicts. One of their research subjects, Sonny, consistently chose not to carry any paraphernalia on his person. He did this to avoid being arrested for parole violation if he gets frisked and searched by police. As a consequence, he was forced to stave his addiction throughout the day by sharing with acquaintances (Bourgois and Schonberg 2009, 79–116).

In addition, it is extremely difficult to provide treatment for individuals who are constantly fluctuating in and out of jail. The criminal justice system extends far enough into public healthcare that it sentences drug offenders to treatment, typically with the promise of imprisonment if the treatment is not completed. Many of the women Angela Garcia interviewed during her ethnographic research for *The Pastoral Clinic: Addiction and Dispossession along the Rio Grande*, were court-appointed to attend treatment at Nueva Dia (New Day facility). Unfortunately, waiting lists for affordable in-patient clinics are so extensive in many areas that drug offenders must wait in jail until they are accepted.

What is more, many of the clinics themselves are overrun and the staff overworked. Garcia worked as an aid in a detoxification center in New Mexico and recounted prevalent disillusionment among both the staff and the patients, at Nuevo Dia. The rampant disillusionment surrounding the subject of rehabilitation is partially due to the current neurological science, which claims that drug addiction is a chronic disease. On top of the taboo of social deviance and legal criminalization surrounding drug use, people do not actually think that an addict can make a complete recovery:

Recent developments point to the neurological basis of addiction, whereby repeated use of addictive substances, such as heroin, alter the neurological circuitry for dopamine.... According to this model, such changes in the dopamine system (described as “adaptive changes or “habituation”), involve states of dopamine deprivation, which produce...feelings of pain, depression, and a persistent, worsening, and *chronic* need for more of the drug (Garcia 2010, 14).

Epistemologically speaking, the “chronicity” theory, labeling addiction as a disease, is seemingly supported by the weak recovery rates among treatment centers, many of which use variations of the 12-step Narcotics Anonymous program. The high walk out rates and failed treatments of Nuevo Dia, for instance, resulted in a lack of confidence among clinic workers regarding the successful rehabilitation of their patients. Garcia was even warned by many of them to take a “tough love” approach and avoid becoming too involved with patients. A significant reason for this crisis of confidence, however, is not only the scientific information labeling addiction as a chronic disease; it is also encouraged by the fact that many of those attending treatment are not rehabilitated. It is worth noting that 12-step programs, which advocate for the individual patient to step up mentally and “say no to drugs”, do not address the social and structural forces at work in the realm of drug use. According to Bourgois and Schonberg, “Twelve-step Narcotics Anonymous self-help meetings were the only free and accessible form of post-detox treatment in the United States in the 1990s and 2000s, and they rely on individual willpower and spiritual solidarity.” But, “without substantial institutional resources, it is difficult for long-term chronic users to figure out how to pass the time of day. They have to construct a new personal sense of meaning and dignity” (Bourgois and Schonberg 2009, 281).

These institutional shortfalls may be attributed at least somewhat to the presumption that, because of the “chronic” nature of addiction, rehabilitated addicts are at a constant risk of relapsing, which limits their ability not only to attain access to ongoing treatment, but also to carve out new social identities. Alma, a woman Garcia spoke often with about her heroin addiction, felt like the twelve step program and the focus on mistakes of the past were obstacles towards rehabilitation. She found refuge at a religious fellowship that focused on her *future* and *wellness* rather than her past habit (Garcia 2010, 87).

This discussion has shown that, although they diverge in their aims and approaches, the public healthcare and criminal justice systems in the U.S. both fail to address the broader social factors that engender drug use and preclude rehabilitation. In what follows, I suggest that these failures stem from a neoliberal political-economic system that focuses on the individual (rather than their social milieu) as the primary site of governance.

### **Neoliberal Economic System and Individual Responsibility**

The final apparatus that influences the cultural environment that defines how drugs and users are categorized in the U.S. is the neoliberal political-economic system that posits model citizens as self-sustaining and largely independent from state support (Rose and Miller 1996). The clinic where Garcia worked was closed not long after she completed her research. The early 2000’s saw transformations within the Medicaid system—the health care system meant to help the poor. These transformations went from federally funded aid for at-risk poor to restructuring the system into a for-profit managed care model. Nueva Dia was one of the clinics struck by these transformations. This

shifted the responsibility of health care from public to family: members of the community Garcia studied were trained in overdose prevention and needle exchanges were the main provisions of care in the area. Interestingly enough, Garcia states:

The political economy of addiction comes into stark relief when one considers that in the region most devastated by heroin, overdose prevention training and needle exchange perform the duties of “treatment,” whereas in the affluent neighboring communities of Santa Fe and Taos there are several exclusive residential treatment centers, with exorbitant price tags to ensure a clientele of the wealthy few. These parallel modes of treatment and profiteering reveal much about the entanglements of neoliberal health care and the dynamics of therapeutic processes, of forms of inclusion and exclusion (2010, 193).

This notion of “neoliberal health care” is one that provides huge obstacles for individuals to gain access to properly funded and effective treatment. According to Bourgois and Schonberg, the “historical turn” taken by public health as a result of neoliberalism results in the framing of health as an individual concern: it is the individual’s moral responsibility to select a lifestyle that does not include risks (Bourgois and Schonberg 2009, 109). Even addicts who personally desire to access treatment find it almost impossible to gain access. According to Garcia, “limitation is promoted as a strategy of “responsibilization” of individuals and communities deemed over dependent on the state. It rests on the claim that the sick can be forced to become like the managed care system itself, “rational” economic actors—unless, like Nuevo Dia and its patients, they cannot” (2010, 188). Treatment centers set up ridiculous obstacles in an attempt to weed out the “riskier” addicts in favor of addicts who show better recovery promise. In *Righteous Dopefiend*, one homeless individual was required to call a treatment center at 9am every day for a determined amount of time before being considered for treatment—the claim being one must show promise of commitment before the center apparently

“wastes time” on an addict who probably will not recover (Bourgois and Schonberg 2009, 279).

While treatment centers that feature a high price tag are more likely to accept all who apply, the free and low cost treatment centers contain obstacles like those listed above. Homeless and poverty stricken drug users, individuals who have markedly less advocacy and personal agency than an individual that can, say, own a phone or a car, are therefore confronted with complications that hugely limit their ability to gain treatment. This type of ostracism is a theme that runs through all the institutions and cultural codes that define illicit drugs and users and occlude the experience of an addict.

The emphasis on personal agency and using individual will power to achieve goals that exists in the United States is at odds with the actual experiences of individual drug addicts. In countries like the United States, neoliberal incentives expect individuals to use their personal agency and will power to achieve their goals (Rose 2006). Typically, when addicts go into treatment, they are expected to “get clean” and join the ranks of “regular people” through these means: taking responsibility, and utilizing their personal agency and will power to make better choices. However, as seen from the discussion above, even among those in possession of the will power to enter treatment, personal agency (thought to reside inside every good American) is inadequate. Neoliberal structures allow impoverished individuals to be marginalized and fall through the cracks—an occurrence that happens often, with or without the involvement of illicit drugs and addiction.

Furthermore, individuals who do gain access to treatment are once again told to employ their will power and personal agency to recover from their sickness. In *Righteous*

*Dopefiend*, Schonberg and Bourgois note, “Polite councilors taught long-term street-based addicts to take personal responsibility for damaging their bodies” (Bourgois and Schonberg 2009, 109). The claim that one is responsible for the degradation of their addicted body, their lack of access to treatment, and their failure to use will power to recover from addiction results in the internalization of blame, which casts addiction as an individual failing. Ostracism of the drug addict further alienates individuals from recovering, and continues the pattern of negative internalization of the addict experience.

### **Conclusion**

How we as Americans define and approach drug use is a result of the cultural environment in which we reside. This epistemological analysis has shown that the ways in which Americans come to know and define addiction and illicit drugs are highly influenced by institutions that have been formed in response to drug use. Public knowledge is directly informed by the criminal justice system, which outlaws illicit drugs. Such knowledge is also highly with a sense of morality: the average licit drug user sees the illicit drug user as a social deviant who threatens the American way of life. But what constitutes licit and illicit drugs is not naturally given; rather, what defines a licit and therefore morally sanctioned drug is a matter of social habit. Ruth Benedict, author of *Anthropology and the Abnormal*, states:

We recognize that morality differs in every society, and is a convenient term for socially approved habits. Mankind has always preferred to say, “It is morally good,” rather than “It is habitual,” and the fact of this preference is matter enough for a critical science of ethics. But historically the two phases are synonymous (1934, 62).

Benedict’s point is made ever more strong when one takes into account the history of our country, which once saw the ubiquitous medical use of now illicit drugs

derived from poppy flowers and coca leaves. Individuals addicted to these substances transitioned from a sick person to a threat to society following the criminalization of illicit drugs. These individuals deemed threats to society are ever more marginalized and socially doomed by the medical world, which coins addiction (to certain substances) as a chronic disease, promising addicts that they will never fully recover from their addiction. Lastly, the cycle of marginalization and social deviance is supported by the neoliberal incentives of the United States, which require individuals to utilize their own agency to get through life, allowing those who do not have agency—the impoverished and addicted—to fall through the cracks of social support.

While I do not attempt to advocate for the legalization of any drugs, it is clear that our society can survive drug use and has the capability to deem certain substances acceptable. This is made evident by the explosion of prescribed pharmaceuticals over the last decade, the long-term sanctioning of alcohol, and Colorado’s recent legalization of marijuana. Most Americans are far from sober every day. Instead of treating addicts like social pariahs, branding them as victims of a chronic disease known as addiction, and dumping them into our already bursting prisons, it would behoove Americans to approach addiction to illicit substances in a more sustainable, and less judgmental, way. As Bourgois and Schonberg announce in their introduction to *Righteous Dopefiend*, “The intellectual debates addressing poverty, addiction, and individual responsibility in the United States need to break out of the confines of moral judgment” (Bourgois and Schonberg 2009, 24). Through restructuring the apparatus that approaches illicit drug use, most significantly toning down the enforcement of the law and emphasizing

dynamic, attainable, and available treatment, the “War on Drugs” would cease to exist and actual rehabilitation can begin.

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