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Contingencies of the will: Uses of harm reduction and the disease model of addiction among health care practitioners

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Abstract

The concept of addiction as a disease is becoming firmly established in medical knowledge and practice at the same time as the logics of the harm reduction approach are gaining broader acceptance. How health care practitioners understand and intervene upon drug use among their patients is complicated by these two models. While harm reduction can be understood as a form of governmentality wherein drug-taking individuals express their regulated autonomy through self-governance, the notion of addiction as a disease removes the option of self-governance through negating the will of the individual. Through analysis of qualitative interviews conducted with 13 health care practitioners who provide care for economically marginalized people who use drugs in New York City, it was found that the absence of will articulated in constructions of addiction as disease offered a gateway through which health care practitioners could bring in ideological commitments associated with harm reduction, such as the de-stigmatization of drug use. Despite differences in the attribution of agency, sewing together these two approaches allowed health care practitioners to work with drug-using patients in practical and compassionate ways. This resembles the strategic deployment of diverse subjectivities found in feminist, post-structural liberatory projects wherein differential subjectification proves tactical and productive. Although drug-using patients may enjoy the benefits of practical and compassionate health care, the conjoint facilitation and denouncement of their will occasioned by the use of both harm reduction and the disease model of addiction imply their management by both pastoral and disciplinary technologies of power.

Keywords

addiction; governmentality; harm reduction; health care practitioners; subjectivity

Introduction

For health care practitioners, understanding drug use among their patients is complicated by at least two conflicting yet overlapping frameworks from which to draw. The harm reduction approach offers practitioners a picture of drug users at risk for infectious disease and other harms associated with drug use but willing and able to protect their health given the right tools, such as new syringes, and risk information (Fraser, 2004; O'Malley, 1999).

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The disease model of addiction, which is firmly embedded within established medical knowledge, positions drug users as pathologic and excessive consumers. This article will show how these two approaches toward defining and intervening upon the health of drug injecting patients take shape and overlap in the medical practices and discourses of a group of health care providers in New York City by examining qualitative interviews conducted with them in 2012. Despite harm reduction's philosophical differences with the medical model of care, which largely hinge on the attribution of autonomy (Heller et al., 2004), a harm reduction approach to care was embraced by all in this group. This did not prevent them from also holding a disease concept of addiction and, in fact, allowed interviewees to articulate rationales *for* the disease concept. Harm reduction principles were evident in descriptions of the disease model of addiction offered by several health care practitioners. In the discourses and practices of the health care practitioners, an affinity emerged between the "objective" medicalized discourse of addiction as disease and the non-judgmental approach of harm reduction. Placing commitments to harm reduction alongside the discourse of disease including that which drew in neuroscience, this article offers a window into the ongoing and conjoint constructions of both harm reduction philosophy and the disease model of addiction in the context of health care.

Harm reduction has been analyzed through the lens of governmentality wherein drug-taking individuals express their regulated autonomy through technologies of the self that accord with ideologies and calculations of risk emanating from diffuse sets of institutions, experts, and other health promotion organizations (Campbell and Shaw, 2008; Fischer et al., 2004; McLean, 2011; O'Malley, 1999). In contrast, notions of addiction as disease, which denote excessive and troubled consumption associated with a lack of autonomy, remove the option of self-governance and place responsibility for care in the hands of addiction experts and health care professionals. The absence of will symbolized by addiction as a disease offers the gateway through which health care practitioners can bring in ideological commitments associated with harm reduction, such as the de-stigmatization of drug use. However, harm reduction in practice and discourse places great emphasis on drug user autonomy. It has been posited that discourses of self-governance or personal responsibility sow the seeds for contradictory discourses of excessive consumption such as addiction (Reith, 2004), but the health care practitioners articulated no great conflict between the seeming opposition between the facilitation of autonomy found in harm reduction discourse and practice and the refusal of autonomy expressed by discourses of addiction. Rather, both approaches to the health care of people who use drugs were deployed and in some ways intertwined, although they addressed the will of the drug user in distinct and contingent ways. While the presence of contradiction is not surprising given depictions of fragmented and fluid subjectivity in post-structural theory, *how* conflicting discourses and practices are sewn together in medical settings provides insights on the contradictions of power present in practices of care.

In tracing implications of the will of the drug user as it was expressed in discourse and practice, the findings of this article offer an examination of the incorporation of harm reduction into medical practice. The term "harm reduction" signifies an assemblage of beliefs and practices, and thus, the analysis of its inclusion in medical care will focus on both harm reduction discourse and practice. The findings of this article also offer an

examination of how the health care practitioners articulated various constructions of the disease model of addiction drawing in harm reduction principles.

Any analysis of the disease model of addiction must recognize that it is a social construction linked to historical conditions, cultural standards of normative behavior, and advances in biotechnology (Campbell, 2010; Kaye, 2012a; Keane, 2003; Reinarman, 2005). To contextualize this, a discussion of the medicalization of addiction and various critiques of the disease model of addiction is offered. In scrutinizing the inclusion of harm reduction philosophy in the construction of addiction as disease, points of conflict between the medical approach to providing care and that of harm reduction will be discussed. A discussion of post-structural theories of subjectivity and particularly that found in feminist theory will be offered to call attention to the productive potential of contradiction.

Harm reduction philosophy

The philosophy of harm reduction is seen as revolutionizing the way we respond to human problems, namely, addiction and AIDS, and as a middle-road alternative to the moral model (as exhibited by the War on Drugs) and the disease model of addiction. Harm reduction is rooted in a "bottom-up" approach based on drug user advocacy and accepts alternatives to abstinence that reduce harm (Marlatt, 1996: 779). An amoral or neutral stance toward drug use is often adopted, despite the difficulty of enacting this approach (Keane, 2003). In contrast to criminal and medical approaches to managing drug users, harm reduction recognizes and respects drug user autonomy, although this autonomy may be regulated by risk calculations (O'Malley, 1999) and the neo-liberal logic of individual responsibility (Fraser, 2004).

While there have been calls for the use of the harm reduction approach in medical settings, its successful inclusion is quite rare (Rachlis et al., 2009; Strike et al., 2014). In describing philosophical clashes between harm reduction and the medical model of care, Heller et al. (2004) note that many of them stem from differences in where authority lies and who creates knowledge. Heller et al. (2004) see harm reduction as centered on the autonomy of the drug user and thus valuing of self-knowledge and individual choice. Medicine, on the other hand, places the locus of authority in the physician and his or her discrete and stable medical knowledge. Another difference lies in the theoretical framework for understanding drug use where harm reduction uses a model (referred to as "drug, set, and setting" (Zinberg, 1984)) that encompasses pharmacology, psychology, and social setting to aid drug users in assessing the benefits and harms of their drug use, as well as finding strategies for changing risky practices. In the field of medicine, the disease model is employed to understand drug use. Active drug use is given a formal psychiatric diagnosis—in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-V), it is called "substance use disorder," (American Psychiatric Association, 2013) and patients who use drugs are referred for drug treatment that usually requires abstinence (Heller et al., 2004: 37). While the DSM-V diagnosis of "substance use disorder" takes into account pharmacology, psychology, and social context (although in a more limited way), it is the authoritative way in which the diagnosis is applied that differentiates it from the "drug, set, and setting" model. The diagnosis is not used as a way to guide drug users toward self-assessment of the various

components of their drug use practices and to find places where adjustment might decrease riskiness. Rather, it is applied in a definitive manner backed by the authority of medical knowledge and serves as the initiation point for a pathway to abstinence-based treatment. This accords with the belief that the will of the drug user has been compromised and its restoration is dependent on abstinence. In recognition of the autonomy of the individual who uses drugs, harm reduction practitioners simply provide a way to understand drug use and information about the health risks it poses.

In the United States, one of the key stewards of harm reduction, the Harm Reduction Coalition, sets out eight principles that define their construction of the approach. Notably, the first principle states that harm reduction "Accepts, for better and or worse, that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them" (Harm Reduction Coalition, n.d.). The fourth principle states that harm reduction "Calls for the non-judgmental, non-coercive provision of services to people who use drugs …" (Harm Reduction Coalition, n.d.). This principle alludes to an amoral stance toward drug use in calling for a non-judgmental approach. While Keane (2003) asserts the identity of harm reduction is best articulated as pragmatic rhetoric and flexible practices, the principles set down by the key harm reduction organization in the United States allude to ideals of acceptance and non-judgment. Both constructions conflict with the established model of medical care in the United States in that medicine approaches the provision of care with a stable and discrete, rather than flexible set of knowledge which gives way to standardized treatment prescriptions (drug treatment requiring abstinence) that leave little room for patient autonomy and symbolically denounce the use of drugs.

Critiques of addiction as disease

The process of defining addiction as a disease began over 200 years ago with the emergence of a new paradigm that defined addiction as a central problem of drug use and diagnosed it as a disease or disease-like (Levine, 1978). Members of the temperance movement argued that habitual drunkenness was a disease and found the source of addiction in the drug itself, while post-prohibition thought located the source in the individual body (Levine, 1978). The disease concept of addiction gained significant traction with the 1935 opening of the Addiction Research Center, a congressionally mandated narcotics farm that sought to investigate physiological components of addiction (Campbell, 2007). The development of methadone maintenance treatment in the 1960s further medicalized addiction by using a so-called medication to aid addicts in stabilizing their relationship to opiates. The idea behind methadone treatment was partially based on the belief that opiate addicts created a permanent biochemical change in their physiology (Conrad and Schneider, 1992: 135). The current approach to understanding addiction focuses on brain function and neurochemistry. Campbell (2010) writes, "Placing addiction in the brain—effectively displacing it from the social body—has been the culmination of a long social process by which addiction was redefined as a CRBD [Chronic Relapsing Brain Disease] in the mid-1990s" (p. 90).

Although it may be framed as the natural and logical progression of science, the application of neuroscience to the study of addiction is strongly tied to advances in technoscience and institutional structures (Campbell, 2010; Hammer et al., 2013; Vrecko, 2010). Neuroscience

in the 1990s produced “an expansion of the biological” allowing addiction to be seen in the brain and undermining previous distinctions between physical and psychological drug dependence (Keane and Hamill, 2010: 55–56). Neuroimaging research on addiction has resulted in new ways of envisioning the relationships between brain images, “brain types,” and perceptions of individualized disease (Dingel et al., 2011). Tiger (2013) sums up the use of technology to forward certain claims about addiction: “Brain scans and medical diagnoses tell us little about the values of sobriety and abstinence from drugs, but they are products of these values” (p. 35).

The National Institute on Drug Abuse (NIDA) attempted to clarify the status of addiction by referring to it as a brain disease in its 2007 (revised in 2010) publication *Drugs, Brains and Behavior: The Science of Addiction*. The report explains how addiction changes the structure and function of the brain and has long-lasting neurobiological effects. Scientists estimate that genetic factors account for between 40 and 60 percent of a person’s vulnerability to addiction (NIDA, 2007). This formulation of addiction is known as the NIDA paradigm and remains hegemonic in many addiction research circles (Dingel et al., 2011). The signification of addiction as a disease aligns with the ongoing trend of the technoscientization of biomedicine “… where interventions for treatment and enhancement are progressively more reliant on sciences and technologies, are conceived in those terms and are ever more promptly applied” (Clarke et al., 2010: 2). The NIDA paradigm and its “molecularization” and “geneticization” (Clarke et al., 2010) do not track with notions of regulated agency apparent in discourses and practices of harm reduction. Rather, it embeds addiction deeper within the body and thus intensifies the erasure of will.

Normative judgment with regard to human behavior and the intake of substances inheres within medical constructions of disease. Despite its scientific sheen, a medical framing of addiction still has social normalization and improvement as its goal (Keane, 2002). Medical discourse constructs parameters of addictive desire that work to judge behavior as diseased or healthy and in doing so operationalizes a variety of profoundly normative hierarchical dichotomies such as natural/chemical, internal/external, and order/disorder (Keane, 2002: 6). The disease of addiction is initially recognized through violations of culturally created behavioral norms wherein addiction is seen in the body when an individual fails to accomplish certain tasks (Kaye, 2012a: 36).

Looking more broadly at the social management of addiction reveals that the complete medicalization of addiction has not occurred (Campbell, 2013; Courtwright, 2010; Meurk et al., 2013), as many people who use drugs are managed through the criminal justice system and 12-step addiction treatment programs (Gowan and Whetstone, 2012; Kaye, 2012b; Tiger, 2013). Tracking the rise of drug courts in the United States, Tiger (2013) found that their advocates draw on medical theories of addiction to advocate for enhanced criminal justice and in doing so contribute to the medicalization of addiction in a way that de-emphasizes the jurisdiction of the medical system. Criminal justice approaches including coercive therapeutics such as mandated drug treatment imply a loss of will among drug users who must be forced into disciplinary treatment settings.

Post-structural subjectivity

Post-structural theorizations of subjectivity proffer the flexible use of contradictory discourses and practices in examinations of the fragmentation and multiplicity of the self. Previously conceived in humanism as a unified, self-contained individual and locus of authorial intention and natural attributes (Alcoff, 1988), the self of post-structural theory wields a diverse assortment of discourses and even subjectivities. Some of the most compelling representations and applications of a post-structural analysis of subjectivity have come from feminist theorists of color. In her hybrid literary-academic exposition on the borderland, Anzaldúa (1999) demonstrates through personal experience and identification with Chicano culture and language what it means to occupy the space of both/and and to speak with a "forked tongue" (p. 77). She writes, "In the Borderland … you are at home, a stranger …" (Anzaldúa, 1999: 216). Hill Collins (1986) also provides a clear example of differential subjectivity through theorizing the position of the "outsider within" who can epistemically exploit her multiple identifications to gain a perspective not available in mainstream sociological analyses. Conflicting subjectivities emerge in these spaces of difference and demonstrate that subjectivity is neither singular nor unified. Given these critical interventions into the humanist, unified subject, it is unsurprising that contradiction emerges as health care practitioners discern ways of understanding and caring for their patients. Examining these conflicts in approach leads to discussions of both the productivity and implications of fragmented deployments of drug user subjectivity.

Looking at feminist examinations of differential deployments of subjectivity reveals the strategic use of multiplicity toward the achievement of certain goals. One of these goals—understanding—is an aim also apparent in the mixing of the harm reduction and disease model approaches by health care practitioners. For example, Lugones (1996) suggests "playful" acts of "'world'-traveling" in which one purposefully shifts from the mainstream construction of life to that of the margins. During this flexible shifting, there is no experience of an underlying "I." Rather, this "traveling" is done to maintain an openness to self-construction and facilitate understanding of that which is constructed as different. Similarly, Harding (1991) calls for the adoption of "perverse identities," or adopting the view of a marginalized "other" as a political act to facilitate understanding of the politics underlying cultural products. This act opens a field of visibility that enables thorough criticism of claims to universalism. Through shifts in subjectivity, normative structures of thought are more readily recognized and one can then flexibly mobilize a variety of positionalities to oppositionally address the symbolic violence of universalized norms (see Sandoval, 1991). By mobilizing differing inscriptions of drug user subjectivity, health care practitioners can critically address stigmatizing norms that proscribe drug use and are more able to compassionately engage their drug-taking patients through improved understanding of the chronicity of drug use practices.

Just as health care practitioners may adopt variable discourses in caring for their patients, research literature may mobilize differing subject positions in describing the responsibilities and capacities of drug users. Noting a tendency in harm reduction policy and practice to inscribe the drug-using subject with a rational, self-determined, and self-governing (i.e. neo-liberal) subjectivity, Moore and Fraser (2006) explore the prospects of alternate, post-

structural significations of drug user subjectivity. While noting that "[a] pproximating the neo-liberal subject offers political benefits in terms of recognition, trust and legitimation," they caution that this approach may ignore the contextual and structural constraints to realizing the ideals of neo-liberal subjecthood (Moore and Fraser, 2006: 3036–3037). Also finding productive insights in the field of feminist scholarship, Moore and Fraser (2006) suggest that post-structural critiques of the neo-liberal subject open a space for strategic acceptance of this subject for the political benefits it can offer alongside oppositional inscriptions of the subject that underscore its dispersed and inter-subjective capacities. Although Moore and Fraser (2006) offer their analysis as a way to examine the political implications of variable models of the subject of harm reduction and prompt further discussion and debate, their analysis could also be useful for those who provide care for people who use drugs as they craft ways to address the agential capacities of their patients.

Methods

Between January and December 2012, semi-structured, qualitative interviews were conducted with 13 health care practitioners who provide primary care and in some instances buprenorphine and/or methadone treatment to people who inject drugs. These interviews were collected as part of a larger project on the health care experiences of people who inject drugs in New York City. The health care practitioners were recruited through a combination of snowball sampling and use of personal and professional contacts of the author. Conducting research with those in socially elite positions, also known as "studying up," (Nader, 1969/1974) can present barriers of accessibility as often people in these positions are quite busy and may be wary of research (Gusterson, 1997; Ortner, 2010; Smith, 2005). For these reasons, the choice was made to contact only potential interviewees that the author knew personally or with whom the author was linked through another person. This recruitment technique created a sample of health care practitioners who provide care in a range of institutional contexts, which may have affected how they interpret the relevance and meaning of harm reduction, as well as the disease model of addiction.

Potential interviewees were contacted through an email which described the research and invited them to interview. The email stated that questions would be asked about experiences and perspective of providing care to patients who inject drugs. In total, 20 health care practitioners were emailed. Six did not respond after two to three recruitment emails and one responded that he did not provide care for patients who inject drugs. For the 13 health care practitioners who were interviewed, written informed consent was secured prior to the interview. The interviews were conducted by the author and typically lasted 1 hour. The interview location was selected by the interviewee. Most chose to be interviewed in their office, although three chose their home and one, a coffee shop. The interviews were digitally recorded and transcribed in full by the author and a professional transcription service. This research project was approved by the institutional review board at the author's institution.

During the interviews, discussions of harm reduction and the disease model of addiction were brought out through direct and indirect questions. For instance, the indirect question "What do you think of drug use?" tended to bring forward disease discourse, and the direct question, "Have you been introduced to the harm reduction approach to working with drug

users?" brought out discussions of harm reduction practice. Thus, while direct questions were asked about the disease model of addiction and harm reduction, both concepts also came up spontaneously.

The interview transcripts were initially coded openly, and interview sections that specifically mentioned the terms "harm reduction" or "disease" (with regard to drug use) or used neuroscientific language to explain drug use were highlighted. Excerpts that were coded as "harm reduction," "disease," or "neuroscience" were further analyzed and divided into descriptive categories. Harm reduction beliefs and practices were both coded under "harm reduction," while only beliefs about the disease model were coded under "disease" since there was scant mention of care practices based on the disease model. Thus, the analysis that follows is an exploration into both discourse and practice or, more specifically, descriptions of practice. The qualitative data analysis software, HyperRESEARCH, was used for data organization, coding, and storage. The interview extracts presented in this article were chosen for their representativeness, as well as clear articulation of harm reduction principles and practice and the disease model.

The health care practitioners

The interviewees presented an array of professional backgrounds and were located in a variety of institutions. Of the health care practitioners, 10 are medical doctors, 2 are nurse practitioners, and 1 is a physician's assistant. While they all provide primary care to economically marginalized patients in New York City, two of the practitioners work at a residential drug treatment center, two practitioners work at a methadone clinic where buprenorphine is also prescribed, four practitioners work in a hospital primary care clinic where buprenorphine is prescribed, four work at a community health care clinic, and one works in a primary care clinic at a university medical center.[1] Additionally, 7 of the 13 health care practitioners devote a portion of their professional time to various research endeavors broadly related to disease, substance use, and health care which situates them in a field of knowledge consumption and production that undoubtedly shapes their perspectives and suggests they had thought extensively about the health of drug users. The use of harm reduction was claimed by all of the health care practitioners, although they articulated its meaning and usage in differing ways.

The health care practitioners interviewed may not necessarily represent the typical doctor encountered by a low-income person who injects drugs. A particular community of health care practitioners who had purposefully chosen the career track of working with underserved populations was tapped into during the recruitment process. Furthermore, a majority of interviewees specifically sought to serve people who use drugs. The health care practitioners interviewed were particularly sympathetic to the plight of drug users and made efforts to treat them respectfully.

[1]Since some of the health care practitioners worked in unique institutional settings within New York City, some specificities of their institutional location have been changed or omitted to provide for confidentiality. An attempt was made to preserve the breadth of institutional variety presented by the interviewees.

Findings

Discourses and practices of harm reduction

Looking at the ways the health care practitioners described their harm reduction practices reveals their understanding of where harm reduction can fit within biomedical practice. While some of the uses of harm reduction strictly addressed the risks of injection drug use, other practices sought to retain people who use drugs in care or treatment. Harm reduction implemented in the context of methadone or buprenorphine treatment took on particular attributes that aligned with the goals of treating a chronic disease.

Many of the health care practitioners reported that they incorporated assessments and education around opiate and needle use practices in their care for patients who inject drugs. Julia,[2] a medical doctor, reflected on the time she spent several years ago caring for drug users at a syringe exchange:

> I would talk to them about appropriate skin care and wound care and ways to not make themselves sick when they were injecting. And so rather than being like, "You should really just stop injecting drugs all together," it makes a lot more sense to be like, "If you're going to inject, you use alcohol [swabs on the injection site] before—not after."

Julia's approach reflects the core tenet of harm reduction to avoid exhortations to abstinence and accept that "… licit and illicit drug use is part of our world … and that some ways of using drugs are clearly safer than others" (Harm Reduction Coalition, n.d.).

One of the common refrains of harm reduction discourse is to meet drug users "where they're at," meaning to accept the current drug use practices of individuals without judgment. The Harm Reduction Coalition's (n.d.) *Principles of Harm Reduction* defines the harm reduction approach in part as incorporating "… a spectrum of strategies from safer use, to managed use, to abstinence to meet drug users 'where they're at,' addressing conditions of use along with the use itself." This refrain was found among the health care practitioners' inclusions of harm reduction in their medical practices, although with slightly different meanings. Andrew, a physician who provides primary care for drug users and methadone and buprenorphine patients under the auspices of a well-respected hospital, framed this approach as a way to guide drug users toward treatment:

> I think that's also one of the things for people who are actively using, if you get them into medical care, develop a relationship with them and you are non-judgmental about their use and are like, "Okay, what can we do to make you healthier and much safer when you're using?" and you build that level of trust, I think it's easier to make that progression to like, "Okay, let's try buprenorphine or methadone or some sort of treatment." But you have to get them to trust you and be willing to do that. I think that also helps engage this population but you have to be willing to not do "STOP USING!" sort of thing. You have to be willing to meet them where they are and help them where they are. A closed door can stop them.

[2]Names of the health care practitioners have been changed to pseudonyms to protect confidentiality.

Doctors who provided pharmaceutically mediated addiction treatment, whether methadone or buprenorphine, incorporated practices of harm reduction into their approach toward providing addiction treatment by refusing to terminate their patients' treatment if they continued to use licit and illicit substances. Nisha, a medical doctor who provides primary care and directs a buprenorphine treatment program at a hospital, explained that in creating the buprenorphine program at her hospital, she and her colleagues had to determine a policy regarding allowable substance use during treatment with buprenorphine. Asked to describe their approach, she stated,

> It's like they say, things can't be perfect. In an ideal world, there would be no problems with addiction and everybody would be able to be abstinent, but that's not the reality, so I have patients who are dependent on alcohol and heroin and are injecting heroin, and if I can get them off the heroin and give them Suboxone, then if they're still drinking, I'm not going to withhold treatment for the heroin addiction, because then they have two problems instead of the one. I'm definitely a proponent of the harm reduction model.

Other health care practitioners enacted harm reduction in the context of drug treatment by allowing the continued use of any drug including opiates despite receiving treatment that specifically targets opiate addiction. Monica, a primary care doctor and buprenorphine prescriber who works at a community health care clinic, stated,

> I provide drug treatment and people relapse and people still use drugs. It's part of the conversation and I try to figure out new goals for treatment. I certainly don't kick people out because they use drugs because they've come to me because they use drugs. So I think a lot of it is trying to understand what people's goals are and try to work with them on their goals.

Monica's approach of refiguring goals is also an enactment of the "meet them where they're at" approach in that she recognizes that people relapse and continue to use drugs and she meets them at that stage to rework goals.

The use of what the health care practitioners themselves termed harm reduction was consistent throughout the interviews with each practitioner revealing what harm reduction meant in their context of care. Whether it was education around injection techniques or refusing to terminate patients for continued opiate use, the health care practitioners made attempts to reduce the harms associated with injecting and oriented themselves to the acceptance of drug use. Two overlapping philosophical principles of harm reduction were apparent in the care these practitioners provided—the "meet them where they're at" approach and the acceptance of drug use. Both principles are supportive of a regulated autonomy for people who use drugs by acknowledging the choice to take drugs, but also constructing space for interventions into the modes of drug use.

The uses of disease

One way the health care practitioners envisioned the health of drug-using patients was by defining drug use, addiction, and dependence as a disease. The health care practitioners mobilized both the disease model and neuroscience to explain drug addiction and

dependence, sometimes simultaneously and other times independently. Several of the health care practitioners who asserted their belief in the disease model also remarked that this model could be strategically deployed to reduce the stigma of addiction for less sympathetic audiences of colleagues. Attempts by health care practitioners to remove blame and reduce stigma through use of the disease model coincide with principles of acceptance and non-judgment found in constructions of harm reduction.

Andrew, the primary care physician mentioned earlier, articulated a clear explanation of how he understands addiction:

> I firmly believe in the biological model, that it is like any other sort of disease. In this case you lack the natural production of endorphins when it's heroin or opiates. So I explain it to people like it's diabetes. Like your body can no longer make insulin, you have a sort of dependence, you need medication, you need help to do that. If you treat it like any other disease, it makes it easier to understand that it is actually a chemical imbalance. There's a lack of a chemical in your body and that explains why you have cravings or why you sort of have those feelings and it's not just your psychological will or psychological decision. There's nothing wrong with you anymore than there's something wrong with someone who has diabetes.

In describing his understanding of opiate addiction, Andrew states that he believes opiate addiction is *like* a disease. His explanation is neurochemical, and as found among other health care practitioners, Andrew describes addiction as similar to diabetes in that the body cannot produce a certain chemical (insulin or endorphins) that it needs. In Andrew's explanation, the assignment of a chemical imbalance to the drug-using body releases it from governance over its own psychological will.

Julia provides a similar explanation although she specifically refers to chronic drug use as a disease. Additionally, she is more explicit about the effects of drug use on the brain:

> When I think about like chronic use, so sort of leaving aside casual pot smokers, and chronic drug use as a medical problem, it's a disease. That's what I've been taught and it's clearly the case from working with drug users, clearly a disease, not a choice. It's just not people deciding to do this for kicks. My understanding of the physiological effects on the brain is that when people use drugs their brain and body chemistry changes and then they become physically addicted but also psychologically different. Their brains respond differently to the drugs than people who haven't used the drugs. Dealing with it as a problem requires a medical model the way that we deal with diabetes. It's a chronic disease.

Julia directly associates what she characterizes as a disease with the will of drug users when she says drug use is "not a choice," pointing out the lack of agency inherent in constructions of disease.

Within both Julia's and Andrew's explanations of addiction, the lack of "psychological will" or "choice" is evident and works to remove responsibility for drug use from the patient. In describing the use of harm reduction in their medical practices, both Julia and Andrew expressed the importance of avoiding exhortations of abstinence when caring for drug-using

patients. Deploying a formulation of the disease model which releases the drug user from control over the usage of drugs means that drug use can now be accepted and moral judgment avoided—two core principles of harm reduction. As proponents of harm reduction, Julia and Andrew can practice their commitments to harm reduction through the use of the disease model by a contingent negation of the will.

Elizabeth, a primary care physician, who prescribes buprenorphine, described how she uses certain language to discuss drug use with her colleagues in order to reduce stigma:

> … when I talk to my medical colleagues about it [drug use], I do emphasize what we know about the neurochemical aspects of substance use disorders because it's a language that they understand … And I think it is de-stigmatizing for them.

Elizabeth is interested in de-stigmatizing drug use for her colleagues and thus deploys neurochemical vernacular when talking to them. Elizabeth's deliberate and strategic use of a biological explanation aims to increase the acceptance and reduce the judgment surrounding illicit drug use among her medical colleagues.

Elizabeth also offered a nuanced description of when in providing health care to drug users it is appropriate to use the disease model and when a harm reduction approach is more relevant. Her differentiated uses of the two models reveal a contingent recognition of autonomy—in some contexts, the will of the drug user is relevant, while in others it is not. She explained,

> If I was counseling someone in a harm reduction program, I'm not sure I'd spend my time on the disease model or think of them in that way necessarily. But where it's most meaningful to me is in the primary care context. There are people with unhealthy or risky patterns of use who do not have a substance use disorder, who do not have maybe the disease of dependence, whether abuse is a disease or not, I truly don't know, but who don't have dependence. I think dependence is something that is palpable and evidence-based and distinguishes the level of treatment or the level of intervention that it might take for that person to make changes in their substance use. So in that context, I think it [the disease model] works. But for the full spectrum, I'm not sure that it does.

For Elizabeth, the disease model does not have a place when counseling someone at a harm reduction program, someone who may have "risky patterns of use." Where it does belong, according to Elizabeth, is in determining the "level of intervention" needed to change the patient's substance use. Elizabeth describes the palpable presence of opioid dependence and refers to it as a disease. While discussing the disease model and harm reduction, Elizabeth also noted that she feels she does not need to adopt a harm reduction perspective when treating patients for addiction:

> So I think that from my perspective, I buy it [harm reduction], but I don't feel like I need to employ it in every case. If a patient is seeing me for [drug] treatment in clinic, then that's my perspective towards them.

Using a contextual approach, Elizabeth reserves the disease concept for patients she is treating with buprenorphine and uses harm reduction to counsel those with risky patterns of

drug use. Both types of patients, the diseased patient and the risky drug user, will be met with interventions, the levels of which differ along with the gradations of autonomy.

As Elizabeth, Andrew, and Julia show, use of the disease model is deliberate and strategic, while what disease means and where it should and can be applied is flexible. Although mobilizing it in different ways, all three physicians maintain their usage of the concept of disease to describe addiction (Andrew), chronic use (Julia), or drug dependence (Elizabeth). Flexibility in meaning and usage allows the disease concept to maintain its relevance through continuous re-constructions. Through deploying the model, some health care practitioners can bring their ideological commitment to the de-stigmatization of drug use into the medical context.

Conclusion

In revealing uses of the disease model of addiction among health care practitioners who embrace and practice harm reduction, this analysis notices a conflicted, as well as contingent, mobilization of drug user autonomy. The health care practitioners activated harm reduction in their medical practice by educating their patients about safer drug use practices and accepting ongoing drug use. When practicing harm reduction, the health care practitioners implicitly acknowledged their patients autonomy in decision making about taking drugs. In discussing their use of the disease model of addiction, the health care practitioners noted that addiction negated “psychological will” and “choice” and that it required a certain level of medical intervention. The lack of will in these constructions of addiction as disease served as the mechanism through which harm reduction ideological principles of acceptance and non-judgment were made visible. The disease model was used by the health care practitioners to excuse drug users from responsibility over their use of drugs and to de-stigmatize drug use when speaking to medical colleagues. The stitching together of the two approaches allowed the health care practitioners to provide care that was practical in terms of risk avoidance and continuity of care, and compassionate and understanding toward their patients’ continued drug use.

Post-structural deployments of fragmented and differential subjectivity described by feminist theorists demonstrate the productivity of strategic multiplicity in prompting understanding of others (Harding, 1991; Lugones, 1996). The tactical use of multiple subjectivities aids in recognizing underlying humanistic norms that label and stigmatize certain individuals and practices. Thus, contradiction may be re-understood as an act that promotes understanding and facilitates critical assessment of obscured normative assumptions. Health care practitioners’ use of discourses and practices that inscribe drug user will in contradictory ways may be seen as practical efforts to strategically use the available schematics for understanding and de-stigmatizing drug use.

At the same time, the use of models of care that simultaneously recognize and negate the will of people who use drugs is indicative of the operation of two technologies of power—pastoral and disciplinary. Both Foucauldian constructs, pastoral power denotes the devolution of care to the individual such that technologies of the self, such as personal risk reduction and psychological therapeutics, are voluntarily practiced at the level of the

individual (Orr, 2010), and disciplinary power marks the reformation of docile bodies through internalized institutional power (Foucault, 1977). With the recognition that "addiction treatment has become a primary site for the reeducation and reform of poor people," the connection between addiction and "old-fashioned" disciplinary institutions becomes clearer (Gowan, 2013). The attenuation of will constructed by notions of addiction as disease is the discursive technique that lends reason to disciplinary technologies of power. The analysis in this article reveals that within biomedicine, drug users are subject to two forms of normalizing power—one enacted through selfcare and the other through disciplinary reformation.

Although people who use drugs are subject to multiple technologies of power through the use of differing discourses and practices by their care providers, the strategic and contingent deployment of discourse and practice can be crafted to militate against deployments of power that pin the drug user down as a certain type of subject who must participate in certain kinds of self-care or must submit to certain types of interventions. The recommendation is not to choose one or the other type of subject inscription. Instead, it is preferable to keep drug user positionality open so that it can be strategically inscribed in a manner contingent on the context and potential benefits.

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Biography

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