

Interpellating recovery: The politics of ‘identity’ in recovery-focused treatment

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Keywords

Recovery, treatment, subjects, social relationships, responsabilisation, Judith Butler

Abstract

Much research tends to treat alcohol and other drug ‘recovery’ as a process of positive identity change and development. In this article, we depart from this dominant approach by examining how the social and material practices of alcohol and other drug treatment are themselves active in the constitution of ‘recovery identity’. Using Judith Butler’s theorisation of interpellation, we examine the accounts of treatment experiences and practices provided in interviews with people who inject drugs. In contrast to the existing literature, we argue that the ‘recovering addict’ is a socially produced category rather than a coherent psychological identity. We consider the production of this category in relation to three dynamics identified in the data: 1) the tendency to materialise treatment subjects as both disordered *and* as ‘in control’ of these disorders; 2) the production of treatment subjects as enmeshed in suspect social relationships and therefore requiring surveillance as well as social support; and 3) treatment’s particular enactment of social context such that it erases stigmatisation and marginalisation and paradoxically performs subjects as entirely individually responsible for relinquishing drug use. These dynamics produce capacities and attributes often ascribed to identity but which are better understood as articulations of epistemological disorder in the state of knowledge about addiction, and its expression in treatment. By way of conclusion, we question the utility of ‘recovery identity’, conventionally defined, in providing a rationale for treatment.

Introduction

Sociological and psychological research on alcohol and other drug addiction tends to treat 'recovery' as a process of positive identity change and development. While the literature takes a range of approaches to identity, the term is generally used to mean a particular enduring sense of self. Early sociological studies of 'natural recovery' examined how people fashioned new 'non-addict' identities through participation in non-drug using social networks and activities. More recently, the 'social identity' approach has sought to illuminate the psychological and cognitive mechanisms of recovery by analysing how social relationships and participation in groups support the development of recovery identities. Although there are obvious differences between the two approaches, identity functions in both literatures as a conceptual vehicle for exploring continuities and changes in self-concept and drug-using practices, and the nexus between the individual and the social environment. In this article, we depart from this dominant approach by examining how the social and material practices of treatment are themselves active in the constitution of 'recovery identity'. Using Judith Butler's theorisation of interpellation and its recent mobilisation in science and technology studies, we examine the accounts of treatment experiences and practices provided in interviews conducted in Victoria, Australia with people who inject drugs. We argue that the 'recovering addict' is not a coherent psychological identity but rather a socially produced category. We consider the production of this category in relation to three dynamics identified in the data: 1) the tendency in therapeutic models of addiction to materialise treatment subjects as both disordered (because of unresolved trauma, unmanageable emotions or disease) *and* as 'in control' of these disorders; 2) the production of treatment subjects as enmeshed in suspect social relationships and therefore requiring surveillance as well as social support; and 3) treatment's particular enactment of social context such that it erases

stigmatisation and marginalisation and paradoxically performs individuals as entirely responsible for relinquishing drug use. As we will argue, these dynamics produce capacities and attributes often ascribed to identity but which are better understood as articulations of epistemological disorder in the state of knowledge about addiction, and its expression in treatment. By way of conclusion, we question the utility of ‘recovery identity’, conventionally defined, in providing a rationale for treatment.

Recovery-focused treatment in Victoria, Australia

In Australia, ‘recovery-oriented’ treatment approaches have a long unofficial history in residential services, therapeutic communities, and peer-based and self-help support services such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) (Ritter, Lancaster, Grech & Reuter, 2011). In the UK and elsewhere, definitions of recovery have been the subject of ongoing debate, but in Australia recovery-oriented treatment usually refers to treatment practices and programs that promote and facilitate abstinence or reduced drug use, measures to improve health and quality of life, and increased community and workforce engagement (Ministerial Council on Drug Strategy, 2011). It also often includes the promotion of ‘aspirational’ aims: individual empowerment, personal transformation, self-determination, personal growth, individual choice and freedom (Lancaster, 2016; Savic & Fomiatti, 2016).

In Victoria, a review of the effectiveness of alcohol and other drug prevention and treatment services was undertaken in 2011 (Victorian Auditor General’s Office, 2011). In response to the issues identified in the review, a reform of treatment services was undertaken by the state government in 2013-2014. The reform was oriented towards developing greater funding accountability (by reducing incentives for data manipulation to meet funding targets),

reducing fragmentation of services (by improving service collaborations and partnerships) and creating a centralised intake and assessment system (to ensure effective case management and continuity of care) (Berends & Ritter, 2014). The reform also advocated greater emphasis on ‘recovery-oriented’ practice. The inclusion of recovery principles and language in Australian and Victorian alcohol and other drug policy prompted heated debate among advocacy groups, sector peak bodies, researchers and harm reduction organisations (e.g. Australian Injecting and Illicit Drug Users League, 2012; Anex, 2012; Best & Lubman, 2012). According to Lancaster, Duke and Ritter, the sector was divided about ‘what recovery could mean for Australian drug policy and the “harm minimization” framework’ (2015:619). Ultimately, the subsequent policy reform contained few tangible interventions that might resolutely be characterised as ‘recovery-oriented’. The one noticeable intervention was the introduction of a ‘care and recovery coordination’ function as a ‘major feature of the treatment pathway’ (Berends & Ritter, 2014:17). In theory, care and recovery coordination was introduced to assess, monitor and coordinate the progress of all treatment clients. However, in Victoria, only clients assessed as ‘complex’ on the newly introduced screening and assessment tool (i.e. those defined as having an alcohol or other drug dependence and behavioural, legal, physical health and/or mental health issues) received this recovery-focused treatment coordination (funding for which was capped at 15 hours per ‘episode of care’). Limited in reach and funding, care and recovery coordination has been criticised as relatively ineffectual and as lacking detail and clarity (Berends & Ritter, 2014).

Despite the attenuation of recovery ideology in the reformed treatment system, recovery ideals continue to shape the lives of many people who seek residential, therapeutic-community and self-help treatment. For example, therapeutic communities place great emphasis on recovery-oriented interventions (Yates, 2011). In these settings ‘peer

community' is used to facilitate social and psychological change in individuals (De Leon, 2000). The daily routine and structure of these communities is marked by rigidity, pressure, hierarchy and the strict deployment of rules (Yates, 2011). These rules are thought to provide healthy behavioural cues and motivate positive identity change among residents (Best, Haslam, Staiger, Dingle, Savic, Bathis, et al., 2016; Yates, 2011). Recovery-focused ideals and practices are also found in other residential treatment settings, withdrawal services, counselling and self-help groups. While several studies have been conducted on clinicians' attitudes to addiction recovery in Victoria (Best, Savic, Mugavin, Manning & Lubman, 2016; Pillay, Best, & Lubman, 2016), to our knowledge, very little research has examined how those enrolled in treatment in Australia view and experience recovery. Our article begins to address this absence by examining experiences of recovery-focused treatment. We contend that treatment is an active site of knowledge production about addiction and recovery as well as a key resource for the cultivation of drug-using and recovery identities.

Literature review

An interest in identity has long been central to sociological and scientific research on addiction recovery. Up until the last decade, much of the research had been located within the symbolic interactionist tradition (Nettleton, Neale & Pickering, 2011). Here the dominant research focus was 'natural recovery' – drug use cessation without participation in formal treatment (e.g. Biernacki, 1986; Cloud & Granfield, 2001; Klingemann, 1992; Waldorf & Biernacki, 1981; Winick, 1962). This research was influential in establishing recovery as a process of individual identity change involving a now familiar narrative arc: motivated by 'rock bottom' experiences, individuals come to reject their drug-using lifestyles and gradually develop 'non-addict' identities through participation in 'normal' social relationships, practices and responsibilities (Dahl, 2014; Neale, Nettleton & Pickering, 2011). While

influential, the effectiveness of this research was limited by dated sociological notions of drug use as intrinsically pathological and deviant. An effect of this framing is that drugs (unlike other consumables, habits and social influences) are attributed exaggerated agency and force in shaping identity. As Dahl (2014) notes, this approach conflates actions with a ‘master’ identity, such that the ‘recovering addict’ identity is assumed to define individuals and explain ‘all their actions’ (Keane, 2002:161). Similarly, the recovery identity encourages blanket interpretations of the drug-using identity as ‘spoiled’ (Biernacki, 1986; Goffman 1963; McIntosh & McKeganey, 2001). A risk of linking recovery to the reparation of ‘spoiled identity’ is that the focus on the cognitive and rational dimensions of identity change can reduce and collapse the particularity of embodied experiences (Nettleton, Neale & Pickering, 2011). It can also obscure the broader social and material practices that shape drug-using encounters and contribute to the desire and capacity for change (Neale, Nettleton & Pickering, 2011).

Although psychological research has increasingly attempted to develop less individualising accounts of recovery, the emerging ‘social identity approach’ (Beckwith, Best, Dingle, Perryman & Lubman, 2015; Best, Beckwith, Haslam, Haslam, Jetten, Mawson & Lubman, 2015; Frings & Albery, 2015; Mawson, Beckwith, Dingle & Lubman, 2015) reproduces many of the normative tropes of pathology, deviance and transformation evident in the earlier recovery literature. This approach emphasises the social dynamics of identity formation and the multiplicity of identities available to people through their participation in different social groups (Jetten, Haslam & Haslam, 2012; Beckwith et al., 2016). Notwithstanding its aim to illuminate the ‘social’ dynamics of drug cessation and identity, the approach oversimplifies identity and the social environment in a number of troubling ways. Like the earlier literature, it largely treats the ‘drug-using’ identity as self-evident, conflates drug-using practices with

identity, and frames the salient social identity as singular and unified (examples include Best, et al., 2015; Buckingham, Frings & Albery, 2013). Moreover, central to the Social Identity Model of Recovery (Best et al., 2015) and the Social Identity Model of Cessation Management (Frings & Albery, 2015) is a tendency to assume homogeneity within drug-using or non-drug using ‘groups’: the assumption that they share similar norms, values and *a priori* assumptions about the ‘positive’ or ‘negative’ effects of participation in non-drug using or recovery focused groups. In these ways, this research has the potential to reproduce stigmatising ideas about people who consume drugs and a normative commitment to individual use reduction.

Poststructuralist alcohol and other drug research offers much in the way of important conceptual tools for challenging some of the unexamined foundations of recovery research. The concept of identity has, for example, been challenged by an interest in the discursive production of subjectivity (e.g., Fraser & valentine, 2008; Keane, 2002; Moore & Fraser, 2006; Sedgwick, 1994; Valverde, 1997). Influenced by the work of Foucault and feminist critical engagement with notions of power, governmentality and subjectivity, this work illuminates the ways in which subjectivity and experiences of health, illness and disease are politically produced. In this formulation, subjectivities are seen as socially produced and ascribed to bodies, rather than as essential psychological properties. Sedgwick (1993), for example, links the development of addicted subjectivity to 20th century late capitalism. In her influential piece published in 1993, she investigates the dualism of free will and compulsion that is central to notions of addiction in consumer culture (Fraser & valentine, 2008). Drawing on Sedgwick’s work, Keane (2002) provides a detailed study of the proliferation of contemporary discourses of addiction, arguing that these and the resulting variety of addicted subjectivities are necessary foils to the constitution of the ideal modern subject: autonomous,

rational and healthy. In what Fraser, Moore and Keane (2014) call a process of ‘addicting’, contemporary neoliberal citizenship is constituted through the successful management of issues of health, desire, pleasure and freedom. Apparently paradoxically, the addict has become a founding figure of the rational, free society.

Alongside this literature on broad issues of addiction have also arisen more narrowly focused critical studies of treatment. Mobilising insights from STS, and feminist and cultural theory, they examine how addiction treatment produces and mobilises particular subjects (Anderson, 2015; Aston, 2009; Fraser & valentine, 2008; Radcliffe, 2011; Fraser & Seear, 2013).

Importantly, gender is identified as a key dimension in these processes. Aston (2009), for example, shows how authoritative medical and treatment discourses intersect with gender to shape women’s accommodation to and performance of recovering addict identities (see also Friedman & Alicea, 2001; Summerson Carr, 2011). Taking a feminist science studies approach, Fraser & valentine (2008) examine methadone maintenance treatment in Australia, mapping its intersections with notions of addiction, health, citizenship and gender. They argue that the organisation and governance of methadone treatment produces specific treatment identities – the ‘dissatisfied customer’, ‘stable user’, client ‘in need of guidance’ and the ‘lay carer’ – and examine the ways in which common modes of treatment provision (such as lengthy queueing for dosing) produce the very problems the treatment purports to tackle. They also show how gender directly shapes treatment experiences and relations between treatment service providers and clients. Similarly, Fraser and Seear (2013) argue that treatment for hepatitis C (a virus almost exclusively transmitted in Australia through injecting drug use) socio-materially performs ill, irresponsible and failed subjects through its reliance on binary oppositions of order/chaos, clean/diseased and success/failure. In these studies, the particular agencies and contours of subjectivity are understood to emerge *through* the social

and material practices of treatment, rather than existing prior to them. Here we build on and extend this work by drawing on cognate theoretical tools from feminist theory and STS to examine recovery-focused treatment.

Approach

One of the key contributions of poststructuralist feminist theory to the social sciences is its dismantling of the standard Enlightenment subject: the universal, unified and rational subject seen to underpin socio-material relations, practices and discourse (Fraser & Seear, 2013; Seear, 2014). For theorist Judith Butler, subjects are *produced through* iterative socio-material practices, and these are characterised by dynamics of inclusion and exclusion. As Butler explains, it is only through the identification, production and exclusion of a range of abjected Others who ‘circumscribe the domain of the subject’, that the legitimate and intelligible subject comes to be formed (1993:3). But this abjected Other haunts the domain of legitimate subjectivity. As Fraser and Seear argue, ‘The abject is a “site of dreaded identification” for the subject, thus the abject exists in counterpoise to the subject, against whom it is produced through forces of exclusion’ (2013:118). These processes of mutual constitution can be drawn on to illuminate the issues under scrutiny in this article: the role and function of recovery discourse. They remind us that the ‘the addict’ and the subject of recovery are thoroughly entwined, remaking each other across the cultural and symbolic poles of virtue and vice, health and sickness, legality and deviance, freedom and coercion, self and other.

Exactly how are subjects made in these processes? Butler makes use of Louis Althusser’s term ‘interpellation’ [1971] to describe the way in which subjects are inaugurated into discourse. According to Althusser, subjects come to recognise themselves through the

ubiquitous process of being ‘hailed’ (as when a policeman calls out, ‘Hey, you there!’ and we automatically turn in response – that is, we recognise ourselves as the objects of regulatory discourse). As Butler explains, however, ‘the interpellative name may arrive without a speaker – on bureaucratic forms, the census, adoption papers, employment applications’ (1997:34). Here, interpellation is not a single performative act but rather a socio-material ‘circuit of recognition’ (Youngblood Jackson & Mezzei, 2011:74) in which the subject is materialised via repetitive and interrelated acts of hailing, many of which are abstracted and bureaucratic in nature. Adopting what they call an ‘ontological politics’ approach, John Law (2000, 2004) and Annemarie Mol (2002) also work with (and adapt) interpellation, relating it to ‘modes of ordering’. For Law, interpellation needs to be disarticulated from Althusser’s notion of ‘false consciousness’, that is, from his belief in the distinction between science and ideology, and in the idea that oppressed subjects can be freed of false beliefs through science’s ability to tell us, finally, the truth of our social and political conditions. According to Law, interpellation relates to particular modes of knowing, none of which are true as opposed to false. Instead, all are ‘arrangements that run through and perform material relations, arrangements with a pattern and their own logic’ (2000:23). These socio-material arrangements are reframed by Law as ‘modes of ordering’ that generate complex patterns of interpellation and perform multiple, and often contradictory, subject positions, objects and other phenomena too. One mode of ordering does not cancel out the other; they co-exist but also interfere with one another. Reorienting research using these ideas brings into view how social and political arrangements ‘recursively perform themselves through different materials— speech, subjectivities, organizations, technical artifacts’ (Law, 2000:23). Here, it is important to note that modes of ordering do not necessarily solidify and become unassailable or preclude dissent or resistance. According to Butler, the recursive process that maintains social and political arrangements – ‘iteration’ – always ‘produce[s] a set of

consequences that exceed and confound what appears to be the disciplining intention’ (Butler, 1993:82). The spaces between repetitions, she argues, can allow error, disarticulation and novel formations (Butler, 1993:82).

Together these insights allow us to trouble the key regulatory assumption underlying alcohol and other drug treatment: that a singular anterior reality of addiction resides within, or authorises, the disordered identities of clients. In the analysis to follow we draw out the otherwise ignored multiplicity of addiction, examining and mapping the particular socio-material sites and practices constituting recovery-focused treatment. In doing so we ask the following questions: How does recovery-focused treatment interpellate those in its purview and what kinds of subjects are inaugurated in this process of interpellation? What modes of ordering addiction are mobilised in ‘successful’ treatment? And what unintended consequences emerge from the contradictions between and within the modes of ordering with which the drug-using subject must engage, and from which must arise new subjects?

Method

This article analyses material from in-depth, semi-structured interviews conducted in Melbourne in 2014 and 2015 by the first author (RF). The interviews were undertaken for a study on the emergence of ‘recovery’ in Australia. This study had two main aims: to identify how recovery-focused policy, scientific research and service provision problematise injecting drug use and people who inject drugs, and to understand how people who inject drugs adopt, accommodate, resist or otherwise engage with recovery discourse in their treatment experiences and everyday lives. The project was granted ethics approval by the Curtin University Human Research Ethics Committee (HR 165/2013).

Two different groups of participants were recruited for the study. The first comprised 26 people who had past or current experience of injecting drugs (one interviewee withdrew from the study and is therefore excluded from the analysis). These participants were recruited from a variety of inner-city treatment services including detoxification and withdrawal facilities, and residential rehabilitation services. Recruitment also relied on the pre-existing professional and personal contacts established by the first author during her previous employment in the Victorian alcohol and other drug and homelessness sectors. These contacts generated referrals and assisted in locating participants who were not enrolled in treatment. Purposive data collection (taking into consideration age, gender, duration of injecting career, recent treatment history, current treatment status, types of services attended and involvement in mutual aid groups) was used to recruit a diverse range of people. Participants ranged in age from 20 to 61 years old. Of the 25 participants, 15 were men. At the time of the interview, seven of these men were not engaged in treatment although most had accessed multiple treatment modalities in the past. The other eight male participants were engaged in residential rehabilitation, case management, opioid substitution treatment, Narcotics Anonymous (NA) and counselling. Of the ten female participants, five were engaged in a range of treatment services, including day programs, counselling, NA and opioid substitution treatment. The other five women were not formally involved in treatment at the time of the interview although, like the men, all had accessed withdrawal and rehabilitation services in the past. The majority of participants identified themselves as Anglo-Australian, with the remainder identifying with a wide range of ethnic backgrounds. Approximately half of the participants were employed, with several working casually in hospitality, information technology, the arts and sex work, and three participants were studying. The interviews explored a variety of topics including participants' experiences of drug use, cessation and recovery-oriented treatment, and understandings of recovery. In line

with Australian alcohol and other drug research practice, participants were reimbursed \$40 for their time and out of pocket expenses (Fry, Hall, Ritter & Jenkinson, 2006).

The second group of interview participants comprised 11 professionals working in policy, treatment provision and/or research. Participants were drawn from therapeutic communities, detoxification and withdrawal services, non-government organisations delivering advocacy and policy advice, and the research sector. Interviews explored the nature of participants' work, their reflections on the recent reform of the Victorian treatment sector and on recovery-focused treatment practices, and their understandings of key concepts informing recovery-focused policy and treatment. Given the recruitment frame, the politicised domain of policy research and the limited number of recovery-focused services in Victoria, we have excluded descriptive and potentially identifying data (such as gender, role and organisational affiliation) when introducing quotations in order to maintain participants' confidentiality. Instead we use anonymised pseudonyms (for example, 'Professional 1') throughout the article. We also use the broad term 'residential rehabilitation' to refer to different types of residential treatment and exclude the names of particular treatment practices which might be recognised by other professionals and service users. The interviews with both groups of participants ranged from 35 to 60 minutes and were digitally recorded and transcribed verbatim.

The resulting interview transcripts were read closely by RF and coded thematically using NVivo 10. The themes were generated with reference to the theoretical frameworks outlined above and the literature on addiction and recovery. As the aim of the interviews was to map participants' concepts and experiences of recovery-focused treatment, particular attention was

paid to coding socio-material practices, contradictions and ambiguities, and issues of subjectivity and agency.

Analysis

We begin our analysis of the data by considering how modes of ordering addiction materialise treatment subjects as both disordered and as ‘in control’. In the next section we consider the interpellative logics of social connection, the injunctions they produce and the ‘insecure’ and ‘hyper-vigilant’ subject positions they engender. Finally we examine how the simplistic mode of ordering ‘social context’ in treatment interpellates a responsabilised subject as entirely responsible for avoiding and managing threats to recovery. We briefly examine some accounts of ‘triggers’ and ‘relapse’ to counterpoise these enactments.

Disorder and control

As we suggested above, modes of ordering addiction interpellate consumers of alcohol and other drugs as ‘disordered’ in various ways (e.g., as compulsive, chaotic, isolated, deviant, traumatised or diseased) and mobilise treatment as a way of reinstating ‘order’ (e.g., as leading to stability, recovery and productive citizenship) (Fox & Ward, 2009; Fraser & Moore, 2008; Seear & Fraser, 2010). This interpellative logic is evident in the therapeutic technologies that order treatment group work and counselling. One participant, George (male, 47, service user, residential rehabilitation), described being interpellated into a particular view of his drug use during a three-month stay at a residential rehabilitation service. Here he learned about the ‘cycle of addiction’ in a ‘relapse prevention’ group:

To be shown the cycle of addiction put on a board in front of you ... you can actually really understand how the cycle works and if you’ve been through that cycle enough times, you can actually picture the stages that you’ve been in. So that’s a good way to

recognise what stage you are in your cycle at the time [...] Why would they have – what’s it called – ‘Relapse Prevention’, if it wasn’t a relapsing condition?

In this passage, George describes taking part in structured group work, a common, sometimes daily, practice in recovery-focused residential treatment (Yates, 2011). The focus and purpose of the group are unclear in George’s interview, but therapeutic groups commonly focus on learning how to regulate emotions (such as anger), prevent relapse, develop life skills, build relationships and communicate effectively. According to George, this particular group teaches him about the mechanisms of addiction and how they relate to his thoughts and behaviour. Given the many models of addiction currently deployed in policy, research and practice (Karasaki, Fraser, Moore & Dietze, 2013; Moore & Fraser, 2013), it is difficult to know which model of addiction was at work in this group. Several widely used therapeutic models represent addiction as a ‘cycle’ of ‘stages’ involving emotional triggers, uncontrollable or overwhelming feelings of craving or compulsion, relapse into ritualised or repetitive drug use, and feelings of guilt and shame. It is possible that George encountered the common ‘stages of change’ model of drug use (Prochaska & DiClemente, 1985), which posits five stages: pre-contemplation, contemplation, preparation, action and maintenance, and ‘classif[ies] people according to [...] their readiness for change’ (Thomson, 2014:180). Whichever model is in operation here, the key point is that the therapeutic encounter interpellates George to order his past (and future) behaviour and self in the terms provided by a ‘relapsing’ model of addiction.

As we noted earlier, however, interpellation and the kinds of subjects it inaugurates are not established forever by single events but unfold in repetitive and interrelated acts of hailing and iteration (Aston, 2007). Thus moments after George describes the group he goes on to describe a different treatment setting – ‘counselling’ – explaining that he came into contact

with recovery through counselling and learnt ‘why [he] drank and ways to deal with [his] anxiety’:

I didn’t even know what anxiety was until five years ago [...] I learnt what it was. I thought the feelings that I was having when I was lying in bed, I didn’t even know it was anxiety [...] Once I got the anxiety, I would use [alcohol] to stop the anxiety, because I’d rather be drunk than deal with the anxiety, but only now, in the last couple of years, I’ve found out that [drinking] brings on the anxiety so much worse.

While the therapeutic group George encountered in residential rehabilitation treatment rendered addiction as a broad ‘relapsing condition’, his clinical counselling experience offered a distinctly psychological mode of ordering addiction. Here he was taught how to link his drinking to unmanageable feelings, and through this formulation, ‘found out’ that his drinking further compounded these feelings. Both treatment modes perform versions of a disordered subject: individual behaviour (a relapsing condition) and emotions (anxiety) are the primary causes of addiction and the primary objects of treatment.

George also described encountering a different disease concept of addiction in NA and AA. While self-help programs are not a central component of publicly funded alcohol and other drug treatment in Australia (Ritter, Lancaster, Grech & Reuter, 2011), many participants had attended self-help programs such as NA, AA and to a lesser extent SMART (Self Management and Recovery Training) Recovery. For George, it was in the ‘AA and NA rooms’ that he ‘really did learn that addiction was a disease’:

George: Well, I didn’t really think it was worth giving it [recovery] a really hard shot, until I really did learn that addiction was a disease. So I think if you’ve got the disease, it can be treated or managed and maybe you can get rid of the disease, do you know what I mean? So once I came to believe, or [was] brainwashed into believing it

was a disease, then it gave me, in my mind, [the idea that] ‘right, this can be fought against’.

RF: You said you believe it’s a disease but you just said then ‘brainwashed’ into believing it was a disease. What do you mean?

George: Because I’ve heard more about it being a disease in the [AA and NA] rooms than I have from clinical doctors or counsellors [...] I wouldn’t say I was brainwashed into it, but if I was, good, because now I believe it’s a disease and it can be treated.

RF: So knowing it’s a disease allows you to think that there’s a kind of possibility to treat it?

George: 100%. Before that I had given up on thinking it was.

RF: Right, because beforehand what did you think?

George: I’m just screwed. Yeah, just screwed, pretty much, and I’m going to die like that, and I was quite willing to, yeah, quite willing to for sure.

In this excerpt, George expresses a complicated relationship to the multiple and contradictory modes of ordering addiction to which he had been exposed in treatment. Prior to attending NA or AA, George thought he was ‘just screwed’. This is perhaps unsurprising given the subject positions made available to him were chronic relapser or anxious drinker. Both modes of ordering rely on circular interpellative logics that foreclose the types of change, choice and ‘positive movement’ to which recovery aspires. Thus, in order for George to feel he could

recover, he first needed to recognise himself as diseased (a hailing central to recovery discourse). In order to make addiction *treatable* – or, as George says, something that can ‘be fought against’ – he needed first to make addiction a treatable object. To do this, he privileged the disease concept of addiction over other concepts to which he had been exposed (invoking in passing a notion of ‘brainwashing’ very close to the Althusserian ‘false consciousness’ Law rejects). Here, the interferences between co-existing modes of ordering addiction are momentarily settled through George’s acceptance of the terms of addiction laid out in 12-step fellowships – that he has a ‘disease’. Through his identification with a diseased addict identity, George manages the various tensions and subjectivities they inaugurate. His options are limited, however, in that *all* of the available interpellative logics of addiction downplay his agency and produce him as disordered.

Most significantly, our analysis suggests that the disorder and contradiction so readily located in ‘addiction’ and those defined as ‘addicted’ emerges just as forcefully or more so between and within professional modes of ordering in the contradictions, incoherencies, uncertainties and interferences they enact. This has significant implications for how we understand the agency of drug-using subjects. As has been identified in other contexts (e.g., Fraser & Seear, 2011; Seear, 2014), medical and scientific knowledge tends to assume that any apparent disorder, incoherence and instability in an object of study arises from that object of study. Framing uncertainty in this way obscures the *limitations* of medical and scientific knowledge and, indeed, authorises the ongoing need for new theories to establish the ‘truth’ of any given object of concern. One way coherence is achieved in treatment modes is through the interpellation and performance of damaged subjecthood. Unlike the rhetorical devices lodged in medical strategies that function to legitimise the ‘heroic’ and scientific character of medicine (Fraser & Seear, 2011), George’s description of himself as brainwashed reconciles

scientific and professional differences via a self-characterisation that hints at many of the assumptions so closely aligned with addiction – that he is coerced, without free will and not fully in control – a disordered subject. In treatment, it is not researchers and scientists who must manage the ambiguities and contradictions of modes of ordering addiction, but service providers and the already devalued and stigmatised drug-using subject.

Suspect social relationships and surveillance

So far, we have examined how modes of ordering addiction interpellate an unstable, emotional or diseased treatment subject, and how those enrolled in treatment must manage the interferences between these modes. We now turn to a second dynamic evident in our data. The social relationships of drug users, like those of other marginalised and stigmatised groups, have long been considered deviant, and therefore ripe for governmental and public health intervention (Lancaster, Santana, Madden & Ritter, 2015). Concerns about the suspect sociality of those who consume drugs acquire a particular valence in recovery discourse given policy's attentiveness to social connections and to community reconnection and reintegration following treatment (Ministerial Council on Drug Strategy, 2011; Department of Health, 2012). This attentiveness is reproduced in formal expectations that those enrolled in treatment will develop 'non-drug using' social relationships and 'supports'. One service provider explained how developing 'social connections' was a key topic of discussion in the planning groups convened to assist people with 'their reintegration back into the community':

In their planning groups [... clients were always] having to demonstrate the levels of supports that they had, demonstrate the plans that they had in place to strengthen some of the relationships, including families, and what steps they were making towards developing new ones, as well as all those fundamental skills that we thought

were critical to people being able to build good social connections. (Professional 4, service provider)

This account offers important insights into how a recovery-focused treatment mode of ordering materialises ‘recovering addict’ subjects and their social relationships. In its emphasis on strengthening non-drug-using social relationships as an aid to recovery, it implicitly defines the social relationships of drug users as suspect and as a target of therapeutic concern and rehabilitation (Yates, 2011). Through the interpellation to continually *demonstrate* evidence of recovery-focused social relationships, and the ‘steps they were making toward developing new ones’, treatment clients are performed as marginalised from civic life (Lancaster, Santana, Madden & Ritter, 2015) and embedded in dubious social relationships. The treatment subject must recognise and accept the need to develop ‘good social connections’ as a key step in recovery.

Within this mode of ordering, self-knowledge, forward planning and the development of skills are considered to be important elements of treatment retention and the achievement of wellbeing and recovery. However, the widespread stigmatisation of people who use drugs is perhaps even more significant in shaping people’s access to social support and improved health outcomes (Fraser & Treloar, 2006; Lloyd, 2013). People who use drugs are highly stigmatised by the general public and non-specialist professionals alike. This has the potential to lower self-esteem and to make participating in the community and securing stable employment difficult (Lancaster, Santana, Madden & Ritter, 2014; Lloyd, 2013). Yet, the interpellative logic underlying the injunction that individuals must cultivate social support obscures the social and political forces that make the creation of these ‘social connections’ challenging. Although treatment interventions designed to encourage increased social support

might be intended to ameliorate the isolation felt by many people after leaving treatment, they also downplay the stigma associated with drug use and treatment.

In addition to problematising the social relationships of people who use drugs, the treatment focus on developing social connections sometimes engenders feelings of anxiety and a propensity for self-surveillance among those enrolled in treatment. For example, Calev (male, 47, service user, NA) began to question whether his relationships with people were ‘good enough’:

[Treatment staff] kind of drill it into us that we have to be talking about our feelings and have these emotional[ly] close bonds and make real friends. It was almost like you couldn’t just muck around with people and have fun [...] Every time I was speaking to people, I was really analysing [the communication] because I wanted to be close with people and I wanted to have good friendships [...] I was just constantly having these deep conversations [and] I was always thinking ‘this relationship’s not good enough, because we are just talking about random stuff’.

Here, Calev reports feeling intense pressure and increasing insecurity about the authenticity of his social relationships. As he explained, the heightened practices of self-surveillance engendered an anxiety that his relationships were ‘not good enough’.

Like Calev, Matt (male, 25, service user, residential rehabilitation) also described treatment demands to cultivate appropriate social relationships. However, unlike Calev, who emphasises the emotional and intimate elements of social relationships, Matt explains that communication in treatment is central to holding people ‘accountable’ to the aims and objectives of recovery.

Everyone goes in there [residential treatment] in a really negative head space and all you can really [do to] connect with one another is to talk about what you used to do and how you used to score and use drugs and [commit] crime [...] You know, people like to connect and be able to relate to one another and I guess when you first go in there, that's all you've really got. So it's all about holding one another accountable and trying to talk about good, positive things to look forward to in the future. Because if you sit around talking about all that [past] stuff, it can cause people to leave and want to use. [If] you talk negative, you're going to be negative.

RF: And when you say 'it's about holding people accountable', what does that mean in practice?

Matt: Well, you know, if I see a peer flirting with a girl or [who] just does nothing but wants to talk about jail or talk about how much they used to use, it's all irrelevant, you know. We're all there to kick-start a new life. So to sit around and talk about our old life, we're still in it.

Matt's account offers important clues about the logics operating in treatment modes of ordering. One of the central tenets of recovery-focused treatment is to improve social connection, a particular and partial version of connection as 'positive', forward-oriented and recovery-focused. Matt's description shares much with conventional understandings of drug users as disordered. In this sense, Matt reproduces the conventional notion that people enter treatment in a 'really negative head space' and with narrow interests such as buying drugs and committing crime. In offering this account he enacts himself as responsible for monitoring social relationships in relation to key issues for treatment progress: gendered moral codes and visions of a positive future. His account, and that of Caley, suggest a tension

around sociality: social connection is enacted as normal and desirable, yet the social relationships between people who use drugs are suspect and in need of ongoing monitoring and surveillance. As we have outlined here, one consequence of the focus on social connection in treatment is that, in *'doing recovery'*, clients can become acutely concerned about the quality of their relationships and in turn increase their surveillance of themselves and others. Thus, insecurity and concern are standard, possibly even deemed appropriate or necessary, effects of treatment modes of ordering addiction recovery.

The treatment provider quoted above (Professional 4) makes this point especially clearly in suggesting that if people *'choose to drink'* (after residential treatment), they should be *'asking themselves a series of questions'* focused on their social context and relationships:

Who am I with? Where am I? Is this connected to a particular mood or feeling? Am I using this to avoid? Am I using it just to want to be a part of a fit-in or am I just drinking because [I am] in this particular context, I'm feeling good, I'm with people I trust [and] love. So yeah, there are discussions and strategies around that.

Clearly, participants' insecurity and concern about the emotional authenticity of their relationships, along with close surveillance of their health-promoting capacities, are mobilised as successful *'strategies'* to ensure recovery in treatment and beyond.

The politics of responsabilisation

Thus far, we have addressed two of the ways in which recovery-focused treatment interpellates clients in different ways according to particular modes of ordering: in the assignment of agency to treatment subjects constituted as simultaneously *'disordered'* and *'in control'*, and in the enactment of treatment subjects as needing to develop *'good [non-drug] relationships'*, thus rendering them insecure and hyper-vigilant. The final theme in our

analysis of treatment interpellation and modes of ordering concerns the particular model of social context enacted in residential treatment settings. This has significant implications for the constitution and distribution of responsibility for drug consumption and drug-related harm.

One of the most routine yet rarely mentioned features of residential treatment (but see Weinberg, 2000 for an exception) is the physical separation of people from the social contexts of drug use. Although the ‘closed’ environment is a taken-for-granted element of the spatiotemporal organisation of residential treatment, it deserves consideration as a practice that *participates in*, rather than precedes, the production of a recovery identity. This is because it enacts a controlled and disciplined social context. As Aidan (male, 31, service user, residential rehabilitation) explains:

You come in with no responsibility, you know. Basically it's just about getting yourself acquainted with the place and getting yourself comfortable and getting up on time, you know, doing the chores and all that sort of stuff [...] When you first get there, you do the house run and you go around, tick everybody's name off, and account for everyone every two hours. You do the phone desk, which is the reception job; do vehicle checks, making sure all vehicles are locked; and there is night work where you vacuum all the rooms when everybody else is in bed. So, yeah, there's those responsibilities. [...] Later in the program], you get more serious responsibilities like taking people to court for their [...] appointments].

As is evident in Aidan's opening comment, ‘You come in with no responsibility’, he understands the organisation of treatment to be related to responsabilisation. The authoritarian and regulatory technologies of pre-established wake-up times, roll call, chores and work

constitute a highly regimented social environment. Within this environment, treatment subjects are interpellated as orderly, disciplined and (increasingly) responsible.

In the next extract from his interview, Aidan explicitly takes up the enactment of responsibility in his account of scenarios involving new residents and those who have been in the residential program longer (and have been allocated more responsibility):

Basically [you] have to memorise a piece of paper with, say, that much [gestures approximately 10cm] text on it and then you give [other residents] three [...scenarios], where, say, one of the responsibilities [is, for example,] ‘A [... new] resident finds a bag of contraband in one of the vehicles. What do you do?’ And then the [... more experienced] person has to go to you and tell you what you got to do. You gotta ‘Stop, don’t touch, have a peer have your back, get the [... new resident] to return, follow the [new resident] back to vehicle, get them to place the contraband exactly where they found it, close the vehicle, lock the vehicle’.

Seemingly, these exercises are designed to teach clients how to identify ‘contraband’ objects and how to respond to them safely and ‘responsibly’. However, there are evident problems with this approach. First, as we have already noted, these tests posit a disordered subject: one who is deviant and chaotic. More importantly, the hypothetical enactments of proscribed objects and responsibility rely upon a specific ordering of the individual, the environment and the encounter. First, the threat to recovery addressed here is simple and obvious in that it relates to ‘contraband’; substances clearly defined by their illegality and proscribed status. In this sense, the threat is easily identifiable and patently undesirable. In turn, the instructions for acting responsibly take the form of rote-learning of simple, manageable steps. Here, identifying and responding to objects or situations that threaten recovery require none of the skills and agency demanded of people operating in the complex social contexts of drug use.

Furthermore, this enactment of social context performs abstinence from drug use as simply a matter of responsible decision-making and identifying and avoiding threats. As already noted in relation to the injunction to develop social connections, learning to be ‘responsible’ does not address the politics of stigmatisation nor the complex and unpredictable challenges of social life outside residential treatment settings. The shortcomings of a focus on responsabilisation are clearly demonstrated in Rachael’s (female, 33, service user, NA) account of repeatedly ‘relapsing’ after treatment:

So I remember doing little plans with them. I’d been there for three weeks and I’d be like, ‘oh cool, when I leave, I’m going to do Tai Chi’ [...But] I would walk out the door and half an hour later, I’d have the fit in my arm and there goes my Tai Chi. And I did that over and over and over again.

Another participant, Adam (male, 40, service user, counselling), identified how the feelings associated with particular cities ‘triggered’ his heroin use:

I find that Melbourne is a massive trigger for me [...] It’s so in your face here [...] I moved to Perth for nearly five years, didn’t have a problem in Perth at all. Only when I came back to Melbourne for my one or two-week holiday from work, I’d blow out for two weeks and spend a couple of thousand dollars and then I’d go back and be straight for six months. In Queensland, when I’m around good people that are doing the right thing, it’s sort of OK.

Rachael and Adam’s accounts trouble the simplistic enactment of social context in treatment, and highlight its poor correspondence with the competing demands and emergent desires of life outside treatment settings. Noticeably, in both accounts, the capacity to identify and respond to threats to recovery is limited because these threats are complex, diffuse and rarely manageable through recourse to the skills acquired in treatment. For Adam, the rhythms and textures of the city itself were loaded with temptations and ‘triggers’ (Dennis, 2016). For

Rachael, opportunities to use drugs emerged quickly after leaving treatment. Within ‘half an hour’ Rachael was injecting heroin again. Although a highly regulated treatment environment could interpellate her as someone who does ‘Tai Chi’, this interpellation was quickly superseded by another in the complex and dynamic social environment she re-entered after treatment. The speed at which this occurs for Rachael suggests that notions of rational decision-making and responsabilisation are a poor fit for understanding the textures, desires and forces of her everyday life.

The failure of recovery-focused treatment to enact useful and relevant social contexts of drug use is troubling. As has been noted many times in the literature on drug use, the rhythms of everyday life are shaped by dynamic social and material configurations – including politics, knowledges, bodies, technologies and emotions – that are not always readily amenable to the individualised management of risk or ‘responsible’ behaviour (Fraser, 2004; Moore & Fraser, 2006; Race, 2012). This is particularly the case for those people who use drugs entangled in configurations of poverty, homelessness, trauma, inequality, stigmatisation and gendered violence. Despite a now lengthy history of critical research highlighting these issues, harm reduction and recovery-focused treatment routinely emphasises individual responsabilisation at the expense of other concerns. As others have highlighted (Fraser, 2004, 2013; Moore & Fraser, 2006; Moore, 2009; Race, 2012), the politics of responsabilisation are produced and reproduced across many material-discursive sites. Although the existence of publicly funded alcohol and other drug treatment suggests there is a degree of recognition that responsibility for addressing problems associated with alcohol and other drugs is, in part, a public one, recovery-focused treatment produces subjects as entirely responsible for managing complex social concerns.

Conclusion

This article has critically examined the ontological politics of and rationale for recovery-focused research and treatment. Drawing on feminist theory and STS scholarship, we have identified three key dynamics at work in the ontological politics of recovery-oriented addiction treatment. First, we have shown how addiction treatment ‘modes of ordering’ enact disordered subjects yet simultaneously interpellate these devalued and stigmatised subjects as responsible for managing the many interferences between modes. Second, we have traced how the interpellative logics of social connection produce the social relationships of people who use drugs as suspect and render them insecure, anxious and hyper-vigilant about the quality of their relationships. Third, we have argued that simplistic enactments of ‘social context’ in treatment interpellate a responsabilised subject easily able to identify and respond to threats to recovery. In sum, the drug using subject is enacted in recovery-focused treatment as disordered, enmeshed in suspect relationships, and potentially irresponsible. Recovery identities are built here through the cultivation of order, healthy relationships and responsible management of threats. Of course, in some respects recovery approaches overlap with other approaches to research and treatment. However, recovery can be distinguished from the main alternatives by its prescriptive focus on identity transformation via participation in ‘normal’ (i.e., non-drug) social relationships, practices and responsibilities. As such the stakes for those interpellated through recovery might be said to be higher: in its prescriptiveness lies the potential to reproduce stigmatising ideas about people who consume drugs and, many have argued, an implicit normative commitment to abstinence.

Our findings raise some important questions regarding how the organisation of treatment can more adequately account for drug-using experiences above and beyond the arguably stigmatising lens of ‘identity’. To this end, we question the utility and ethics of the concept of

identity as it is conventionally mobilised in recovery-focused research and treatment. If recovery-focused treatment currently relies on a ‘recovering addict identity’ in which the drug-using subject is poorly placed to articulate agency and which eclipses the political, economic and social challenges of life outside the treatment setting, what are the alternatives? To begin, we need to rethink the development of alcohol and other drug policy, and its expression in service provision, to consider how ‘addiction’ concepts and treatments can incorporate issues of poverty, family violence, historical dispossession and homelessness (Fraser, 2016:13; see also Weinberg, 2000). These issues were prominent across the interview accounts but were routinely disregarded or downplayed in treatment – likely because of treatment funding arrangements or system goal setting that focuses on alcohol and other drug use (Moore and Fraser, 2013). So long as addiction is treated as something subjects *have* and must *recover from*, the pathologising category of ‘identity’, and specific, limiting, identity interpellations, will likely be deployed to authorise and secure this ‘recovery’.

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