

Self, substance, and society

Ethnographic explorations of addiction

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The article explores the role of addictive substances, and how they constitute the experience of pleasure and categories of addictions (Garriott & Raikhel 2015). In two separate studies, one of the users in heroin-assisted treatment of addiction in Denmark and the other of consumers' food perceptions, we became interested in the roles played by the addictive substance and the concept of addiction – as a cultural category with social, moral, and political significance (Keane 2002) – among our informants. More specifically, we focused on how pleasure is constrained, made, or enacted in societal responses and treatment practices by comparing the case of heroin and sugar. The juxtaposition of the two types of addiction serves to illustrate the relationship between a specific substance, cultural categories, and responses.

Analysis focuses on the interplay between the addict, the substance, social networks, and institutions. We argue that both the addict as a subject and the effect of the addictive substance are produced by a network of actors, experiences, moral values, societal institutions, and public discourses. The two cases show the importance of attending to substance effect in this context, and to variations in a single cultural setting – ultimately demonstra-

ting that substance use and the experience of pleasure are not simply matters of choice but rather results of embodied conditioning, whereby social forces constrain the experience of pleasure. In both cases, recovery becomes a means of finding what is perceived to be one's inner core in a society marked by industrial interference and artificiality, manifested in – among many other objects – certain chemical substances. In some situations, however, by regaining some degree of autonomy and by getting in touch with one's "inner core" the substance becomes a possible actant for the enjoyment of pleasure.

Introduction

Contemporary newspapers and government reports tend to offer the impression that the range of addictions is increasing: people can be addicted to shopping, sex, eating, fasting, healthy food, and exercise in addition to more classic addiction pathologies such as gambling, alcohol, and drugs (Cotte and Latour 2009; O'Guinn and Faber 1989; Hirschman 1992; Heishman, Kozlowski, and Henningfield 1997; Pedersen 2005). Critical examination of the concept indicates that although the modern meaning of the word is of quite recent origin, the notion of addiction has spread to become *"the structure that is philosophically and metaphysically at the basis of our culture"* (Brodie and Redfield 2002:5). Furthermore, it has been argued that addiction and modern consumer societies make each other and continue to rely on each other for meaning (Fraser et al. 2014).

In this article, we investigate the role of the addictive substance in the "making" of addiction and categories of people in Denmark (Garriott & Raikhel 2015; Hacking 1985). Our aim is to explore the relationship between specific substances, societal structures, moral values, and the experience of effects in a particular cultural setting. In two separate studies – one of treatment for heroin addiction and the other of sugar addiction – we became interested in the role that addiction played among our informants as a cultural category with social, moral, and political significance (Keane 2002). The two types of addiction tap into existing discourses about sugar and heroin – the first legal and the second condemned. The juxtaposition of an addiction that is not officially recognized with one that is the prototype of addiction in modern society (Fraser et al. 2014) serves to illustrate the relationship between a specific substance, cultural categories, and official recognition and response to it. Differences in the latter influence the individual experience of addiction and management of treatment, which has implications for the way the respective addicts position themselves.

In our understanding of addiction, we follow Fraser et al. in their recent work on 'Models of Addiction. When defining addiction, they start out by describing a range of practice:

"The use of psychoactive substances in order to alter mood or consciousness, alleviate suffering, improve performance or enhance social relations is characteristic of human cultures. For some individuals, the use of these substances becomes a pattern of habitual and persistent consumption that results in negative physical, emotional, relational and social effects" (Fraser et al. 2014: 26). This is however not a definition of addiction. Addiction is *"a culturally and historically specific set of ideas and practices that shapes the varied problems and predicaments of alcohol and other drug use [described above] into a singular and somewhat abstract entity: a disorder of compulsion located in the individual"* (ibid). And it is first when the practices of consuming psychoactive substances is defined as addiction, that it becomes the object of attempts to control it (Fraser et al. 2014: 27-28). We analyze the interplay between the person experiencing addiction, the substance, the experience of pleasure, the social network, and the institutions in a particular cultural setting through three analytical perspectives: 1) *the enactment* (the experience of the substance); 2) *the making of the addict*; and 3) *treatment of addiction*. Our empirical cases show that substances can be experienced very differently and attributed opposing moral values in the same cultural setting, illustrating that the experience of pleasure and other effects must be analyzed in terms of a network of actors, meanings, moral values, and institutions. The uses of substances in a particular cultural setting also highlight its joint overall cultural themes. In the following, we firstly position our theoretical perspective in the anthropological and sociological literature and then move on to present the two case studies of addiction.

Self, substance, and society

Eve Sedgwick (1993) argues that the locus of addiction lies not only in the substance itself or in the body, but also in the overarching abstraction that governs the narrative relationship between them; another vein of research suggests that nineteenth-century accounts of addiction as "diseases of the will" have been translated into a "matter of choice" in modern capitalistic settings (Garriott and Raikhel 2015; Reith 2004). However, rather than providing a detailed historical account of the development of the concept of addiction, as provided by Reith (2004), Brodie and Redfield (2002), Levine (1978) and Sedgwick (1993), in this article we explore two

different types of addiction in order to highlight the relationship between self, substance, and society. We also build on the work of scholars who advocate that questions of materiality, embodiment, and biology should be taken more seriously (Weinberg 2011; Kushner 2010; Fraser 2013). We do this by combining an anthropological focus on experience with one on materiality, substance, and networks.

Rather than exploring the concept of addiction per se, the anthropological literature on drugs is richer in studies of the particularities of local contexts, particularly ethnographic description of the everyday life of the drug user, the role of drug use within it, and the logic of use from this perspective. The user has been defined as a social agent, trying to make sense of what his or her life has become, with the drug use or addiction being just one explanatory social fact among many (Bourgois 1995; Bourgois and Schonberg 2009; Taylor 1993; Lalander 2003; Dahl 2004; Trujillo 2004; Singer 2012). In other studies the notions of control and power have been more dominant, with researchers linking the micro world of personal experience and the macro world of political economy and globalization (Singer 2007). Examples can be found in critical medical anthropology (Singer 2012; 1986; Bourgois 1995) and in analyses of drug and alcohol policy that build on Foucault's concepts of biopower and disciplinary power (Bourgois 2000; Keane 2008; Duff 2004).

On the other hand, in more recent sociological literature we find analyses of addiction as a discourse within wider socio-historical processes of governance and control (Alexander 2008; Reith 2004; Binkley 2006; Keane 2002). These studies argue that capitalism and neoliberal governmentality have facilitated the increasing penetration of addiction into consumption behavior, revealing deep tensions within capitalism and the ideology of consumerism (Reith 2004; Lee and Mysyk 2004; Binkley 2006). Gerda Reith examines addiction in a context of advanced liberal societies, highlighting the discursive convergences and conflicts between practices of consumption and notions of addiction represented in oppositional categories of self-control vs. compulsion and freedom vs. determinism. She argues that "*addict identities*" and "*consumer pathologies*" are in opposition to core liberal values of freedom, autonomy, and choice (Reith 2004:284), observing that when the ideology of consumption proliferates and free choice is feted, the notion of dependency – that we might not be free at all – has a particular horror. For this reason, addiction is regarded as an individual pathology (Reith 2004). Similarly, Lee and Mysyk (2004) suggest that the attempt to categorize compulsive buying as an illness represents an ongoing trend to medicalize behavioral problems rather than acknowledging the social context of consumerism as an underlying cause

(2004:1709). Binkley (2006), meanwhile, argues that while governmentality theorists have claimed that modes of regulation and self-discipline lie at the heart of professional and institutional life, this is challenged by the logic of everyday consumption, which is characterized by a lack of self-constraint. We make use of this sociological approach to governmentality by focusing on how the addict emerges as a subject by positioning him/herself in relation to cultural values of autonomy, free choice, and control. However, we also integrate empirical analysis of the networks of actors, cultural meanings, and institutions that impinge on the worlds of addiction to include a more anthropological approach.

A return to materiality, substances, and network

In order to avoid choosing between an essentialist ascription of inherent fixed properties to the addictive substance (Keane 2008), or a social constructionist understanding in which addiction is cast as a historical and social construct (Kushner 2010), a number of scholars in the field build on Actor Network Analysis (ANT) – an approach that emerges from science and technology studies and takes in both material and semantic structures (Keane 2008; Demant 2009; Duff 2011; Sulkunen 2007; Schüll 2006; Gomart and Hennion 1999; 2002a; 2002b; 2004; Fraser and Valentine 2008; Weinberg 2011). In the cases at hand, ANT focuses on the network of relations that produces the particular actions, capacities, and effects of an addictive substance (Keane 2008:407). In the field of alcohol studies, the sociologist Sulkunen (2007) used a socio-semiotic model for analyzing beliefs about addiction which drew its data from images in films. Demant (2009) takes up the thread from Sulkunen and investigates the dynamic attachment between substances, bodies, and actants in specific networks through which subjectivity emerges (Demant 2009).

Inspired by the ANT approach, it is our aim to explore the meanings and effects of two different substances in a specific socio-cultural context and their connections to local networks of actors, experiences, values, and institutions. As we are more interested in networked *enactments* than mere mapping, we follow Mol's (2002) open approach to enacted realities, focusing on the practices, tensions, and dilemmas that arise in conjunction with perceived addiction. Taking as our point of departure the view that a given effect is not an a priori property; rather, it is seen as arising from the interplay of network elements (Gomart and Hennion 1999; Gomart 2002b; 2004; Keane 2008).

Method

The two studies presented in this article use ethnographic methods. The study of sugar addiction originated in a study of citizens' healthy eating strategies, which examined manifestations of health in everyday life alongside informants' food choices and practices. Throughout the interviews, sugar addiction was in some cases a common theme, resulting in an additional study of the concept via online health communities and blogs that provide the empirical data for this study. Fifteen additional informants were recruited via the Internet (i.e., informal channels evolving from the search for validation of personal experience)¹. Some responded to a notice about our study on a sugar addiction blog, while others were contacted through internet forums or self-help groups concerned with healthy eating.

The interviews with the self-defined sugar addicts (or "sensitives") were semi-structured and revolved around the themes of their experience, diagnosis, and recovery. This was linked to a theoretical concern with how the experience of the substance related to socially inscribed identities, cultural values, and societal responses (Sointu 2006). Furthermore, we conducted four interviews with health practitioners – a psychiatrist specializing in the treatment of eating disorders and three therapists working with sugar addiction – which contextualized links between the experience of addiction and the process of diagnosis and recovery (Sointu 2006).

The study of heroin-assisted treatment of addiction examined the introduction and implementation of this new treatment mode in Denmark. Data collection included intensive participant observation in two heroin clinics over almost two years, additional three-day visits to the remaining three Danish heroin clinics, and interviews with fifty participating users and thirty staff members. The aim of the study was three-fold: Firstly, to research users' motives for seeking this type of treatment, and the positive/negative changes they experienced as a result; secondly, to examine how clinic staff perceived and managed the new mode of treatment and the dilemmas they faced when working with heroin; thirdly, to observe the physical layout of the clinics, the differences between them, and the construction of various types of space (for treatment, pleasure, and social interaction). In this article, we primarily draw on the data regarding users. The analytical approach was inspired by studies of governmentality and control in drug-treatment settings (Bourgois 2000; Jöncke 2009), the cultural construction of illness and treatment (Kleinman 1980; 1989), and the social meaning of drugs (Whyte et al. 2002).

All procedures performed in the two studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki Declaration and its later amendments, or comparable ethical standards. Informed consent was obtained from all the individual participants in the study. Both studies are situated within the tradition of critical medical anthropology and its interest in the lived experience of people and their physical, psychological, and social sufferings. As the material was originally gathered for a different purpose, we recoded it to address how informants experience pleasure and addiction and, through iteration between the coded material and the literature, selected three analytical perspectives: 1) enactment (the experience of addiction); 2) the “making” of addiction; and 3) addiction treatment. The first two perspectives overlap, and explore how the addictive substance, pleasure, moral values, and categories of addictions are experienced in terms of the socio-material network in which they are embedded; the third examines the notions of effects, treatment, and recovery emerging from this constellation.

The case of sugar addiction

More than 35 years ago, it was claimed that sugar was as addictive as heroin and nicotine (Dufty 1975). A more recent claim (see, e.g., DesMaisons 2008) is that sugar consumption has a neuro-chemical effect in that, like alcohol, it triggers the release of beta-endorphins that can reduce physical and emotional pain. According to DesMaisons, normal people can enjoy sugar without ill effect, but sugar-sensitive individuals respond more strongly because their brains naturally have more beta-endorphin receptors (DesMaisons 2008:76). Despite the fact that the term “sugar addiction” often appears in the popular press, DesMaisons’ tests are not recognized in wider scientific circles, although experiments with rats seem to suggest that the intake of sugar produces a chemical reaction, which in turn supports the assumption that sugar might create addictions (Avena et al. 2008, 2009). Yet, while the claim that sugar is an addiction-creating chemical is widely disputed, there is a general consensus that some people might develop a psychological dependence on it in line with other addictions. Furthermore, the idea that food-related pathologies are related to brain circuits has become widespread in neuroscientific addiction literature (Fraser 2013).

While there is scant medical evidence supporting physiological sugar addiction, the phenomenon is mentioned in numerous self-help books and regularly appears in the consumer vernacular. In Denmark the term had a revival with a best-selling book about a super healthy family (Mauritson 2007; Kristensen et al. 2011), and consequently has increasingly become accepted and used as a diagnosis and an explanation of a range of symptoms including depression, headaches, and mood swings. By becoming an object of popular theories of contemporary addiction, sugar has moved beyond the normal type of nutritional policing promoted by state institutions. In addition to the moral and political dimensions, another more alarming dimension of risk has appeared – that of uncontrollable desire and of bodily and mental enslavement.

Sugar: Enactment in the Realm of a Hidden Danger

As already noted, sugar addiction is not an officially recognized diagnosis. For this reason the sharing of psychological and physical symptoms related to the addiction is pivotal in the informants' self-representation on internet forums and blogs, and in conversations in self-help groups, where they engage with their peers, discuss their symptoms and ups and downs, and share information on restaurants, cafés, and websites guaranteeing products free of sugar and chemicals.

Self-identified sugar addicts often note that some people have stronger “receptors” than others and are, therefore, more vulnerable to the effects of sugar, which is used as an explanation for mood swings, depression, and a host of other symptoms including tremors, flu, and headache. Thus, the consumption of sugar is perceived to influence social, psychological, and physical well-being. As argued by Domen Bajde, any human, artificial, or inanimate entity becomes an actor, or actant in Actor-Network-Theory terminology, as soon as it can be shown to exert a force on others (Bajde 2013:229). The consumption of sugar supplies an emotional fulcrum in the daily existence of informants, experienced as producing a chemical effect that rapidly raises and lowers blood sugar levels. Some describe the immediate effect as intoxication, as a rush, or as getting “high”, while for others it is like a “kick” that is followed by feelings of happiness, comfort, safety, and contentment. When describing their affliction it is hardly surprising that sugar sensitives use a vocabulary closely associated with drug use. As one woman stated, “It is like a drug addict who needs his drugs. Basically you just need your drug. You think of it until you get it.” One expression used by an informant is *heissunger*, the

desire “to kill” to get the daily dose of sugar. Another informant described herself as a “sugar junkie” and confessed, *“I just knew I needed sugar every day. Sometimes I even ate it directly; it was really crazy [laughs]: plain sugar on a teaspoon, or several teaspoons. I mostly went ‘amok’ in the evening...it was rather violent.”*

Sugar sensitive informants were aware of the strength and temporal rhythm of their reactions to sugar intake, and articulate on the subject. Sugar serves as a means to manage and to suppress feelings of sadness, loneliness, boredom, and pain, and a way to “treat” oneself and to celebrate; this, however, is transitory, as contentment and pleasure is immediately replaced by a repertoire of negative feelings. Thus sugar first produces a sense of well-being, but afterwards, when the first “rush” has vanished, its negative effects starts to become manifest. As one informant described it, “The sugar has an immediate effect on you. I myself become very tired, apathetic, and less energetic; I get palpitations; I go into my own little world.” The most severe effect of sugar consumption is the pronounced mood shift associated with the fall and rise of blood sugar. Another informant describes her hysteria when her blood sugar is low, and characterizes her personality as Dr. Jekyll and Mr. Hyde, a split personality within the same body. Thus sugar consumption is associated with an experience of being disconnected from one’s own feelings.

The amount of sugar some participants consumed is impressive and forms part of a daily, private, and solitary struggle often centered on an ongoing oscillation between resisting and burning calories, and being “overtaken” by the craving for sugar. One woman described how she hardly ate at meals in order to leave room for candy and chocolate, which she then “burned” through compulsive exercising. Thus sugar addiction is not necessarily associated with obesity, as many informants calculate how much exercise is needed to work it off, but long term excess is often reported as causing other physical symptoms such as hair loss, constipation, coughing, and itching eyes. To summarize, sugar has become an actant that leads to an imbalance in the natural body and produces a sense of the self as needing discipline and control, as untrustworthy, and as incapable of experiencing long lasting pleasure and well-being.

The making of a sugar addict

The consumption of sugar was perceived as a chemical dependence by sugar-sensitive persons, and as a “real” addiction comparable to that of an alcoholic

or a drug user. Interestingly, sugar addiction borrows its terminology from the discourse on heroin addiction, indicating a sort of intertextuality² between it and the “traditional” addictions of alcohol and heroin, that means that sugar addiction builds on and borrows from the terminology of official discourses of addiction. The language of sugar addiction to a large degree serves to “make up” (Hacking 1985) a human subject, clearly anchoring the process in metaphors of control and more “traditional” discourses of addiction. The addicted self is perceived as unhealthy, morally out of control, and out of touch with the “real” self, as sugar has undermined and destroyed the natural balance. For this reason, some refer to themselves as having an “abuser brain”, using metaphors of addiction when they refer to themselves. One woman described her increasing realization that her use of sugar can be compared to that of an alcoholic, noting that every time she goes shopping she buys something containing sugar in small, “innocent” amounts so nobody will notice how much she actually consumes. *“At one moment I thought to myself, I really do behave like an alcoholic. And I realized that I was not capable of controlling it. I felt my body worked against my mind. Therefore I call it abuse.”*

By tapping into existing discourses on addiction, specifically to heroin and alcohol, their experience of losing control becomes one that has an explanation and a possible cure. The sugar as a substance becomes an actant in the sugar addict’s relationship to him/herself and to his/her social surroundings (Demant 2009). Hardly surprisingly, excessive intake of sugar is perceived as a signal that a situation is unbalanced or out of control and that the substance has taken over the control of the self in a form often described as a negative “power” or even a monster. As one informant expressed it: *“Firstly it gives you a feeling of well-being. In the beginning. But then the shame follows and all those kinds of things. That is why they talk about ‘sugar junkies’, because that is what we are.”*

Generally, sugar addicts feel embarrassed about their misuse of sugar and consider it a sign of their moral weakness. So, while they talk about enjoying cake and sugar in their childhood, increasingly shame and condemnation take over, as they feel controlled by the substance. Some informants describe how they try to conceal their use of sugar, eating when they are alone and the kids are in bed, for instance, or hiding candy wrappers at the bottom of the garbage. Another woman said:

“I have been so ashamed. I used to work in a high school, and when we had these meetings then I could not control myself; I went around to different tables to get

one thing from each so they did not notice how much I took. People always said: 'You are so healthy.' And then I would think to myself, 'If you only knew...'"

Informants define the addiction on the basis that they are fully aware that sugar is bad for their health, but they continue consuming it in large quantities anyway; the condition is therefore characterized by a constant craving that takes over their consciousness, or an inner voice leading the body into temptation and moral decay. One participant described it as like having a reptile inside one's body screaming, "Give me sugar." These descriptions demonstrate how the sugar addicts link their sugar consumption with moral statements and also why the term "addiction" provides an explanation for their "improper" behavior: sugar is a substance actively exerting force on their lives. By labeling their behavior "addiction," the locus of responsibility is transferred from the moral character of the individual to the chemical substance preventing the individuals in living a balanced life, thereby producing a particular experience and material effect that is part of a larger social/institutional network (Keane 2007:407). By drawing on discourses of addiction, the sugar addict finds an explanation for the loss of control, a possible solution as well as a way of coping with experiences of shame.

"Sugar-addicted" treatment and society

Although self-designated sugar addicts perceive their consumption of sugar as an addiction comparable to that of alcoholism and heroin abuse and as a sickness that needs to be treated, they face serious challenges accessing treatment. In contrast to the heroin addict, the sugar addict has to struggle even to get the addiction acknowledged as such. Therefore, the official biomedical paradigm does not offer a solution, and sugar addicts instead seek their own information and strive to regulate and control their food consumption by themselves. As one woman says "*I have looked on the normal page [official pages of health authorities]. They write that sugar is bad for you. But not a word about how to get help.*"

None of the informants had consulted a general practitioner, and all had arrived at the diagnosis of sugar addiction through a combination of information retrieved from the Internet and self-help books and groups. In addition, some had consulted an alternative practitioner, such as a sugar coach or a hypnotist, to help them break free of the addiction, often by confronting feelings of unworthiness and insecurity that many associated with the abuse. Most respondents did not

discuss the diagnosis with their close network, aside, perhaps, from other people struggling with the same problem. Many identified the specific day that they decided to give up sugar, as in the case of a woman who told us how she came across a book that helped her:

"I just turned around and by accident this book was lying there. I took it and I read. And the tears started running down my cheeks and I thought, God! Then this is not who I really am. This is all caused by unstable blood sugar. The book listed all the symptoms. The difficulties concentrating. That you pop up like a jack-in-the-box. Have problems controlling what you eat. And it then listed all the other symptoms. And I knew every single one of them. So I said to myself, I need to stabilize my blood sugar. There was a 28-day food plan in the book. So I took it and implemented it."

Treatment consists in many cases of being given a tool to transform the relationship between self and substance, to gain a consciousness of the role that sugar plays, and to enter into a relationship with the "inner" core. Addressing their behavior as an addiction relieves the user of responsibility for their actions, as the substance rather than the individual becomes the destructive actor. An important step in the treatment process is to acquire some well-defined standards and criteria for "good food," (i.e., food without chemicals and sugars) in order to steer clear of the temptation of the market. When they fail to resist, they suffer withdrawal symptoms like headaches, sore throat, tremors, and diarrhea, which provide them with the clear sign that they are actually suffering from a "real" chemical dependency.

Recovery from sugar addiction is often associated with a kind of spiritual awakening, as the addicts leave what they call "the mental bubble" and start to reconnect with themselves and their surroundings. It is interesting how this "return" is associated with an increased capacity to experience gustatory pleasure. As one woman explains:

"It all changes as the taste buds return. Before when we were eating, I thought about it as something I just had to get through. Then I had a bar of chocolate and a bag of chips to comfort me afterwards. Now I have a bag of carrots. This means that I have started to enjoy the food much more."

Recovery means breaking the links between craving, “the rush”, and the accompanying feeling of shame, referred to by some as “a complete transformation” where they start to take “full” responsibility for their own wellbeing. Addiction becomes a key to understanding their own personality and actively changing their lives. This echoes the recovery model of Alcoholics Anonymous which builds on self-help and empowerment, framing the “addicted” as people suffering from a disease and concurrently as experts taking matters into their own hands (Shepherd et al. 2008): resisting and confronting internalized feelings of guilt and shame as they cannot be blamed for something that is a chemical reaction. Consequently, a part of the coping strategy is to redefine the internal struggle with blame and stigmatization, removing the locus of responsibility from the individual to the marketplace. Today several of the informants have become role models for other sugar addicts and give advice through blogs, articles, and talks on how to deal with sugar addiction.

Hence the sugar addict sees a close link between well-being and food consumption in both a physical and a psychological sense, but also from a broader social perspective as sugar is associated with an industry producing unnatural food that is bad for the body, thereby “polluting” consumers in return for profit. Sugar addiction thus becomes a metaphor for the temptations and moral decay of consumer society, linking the addict’s recovery to an increasing consciousness of the economic interests of the food industry and the marketplace.

The heroin user in heroin-assisted treatment

The other empirical example is supplied by long-term heroin users³, who better conform to societal images of addicts as individuals who consume illegal drugs through health-hazardous practices and consequently live on the edge of society (Weinberg 2000). Neither they, nor society at large, questioned whether they were addicted; both sides recognize and accept that if they were not addicted, they would not have been in treatment.

Heroin is publicly perceived as one of the most dangerous and addictive of drugs and its use (“abuse” is a synonym in public discourse) is associated with social derailment and poor health. A heroin user is commonly perceived as completely taken over by the drug, unable to think about anything except the next “hit” and ready to do anything to get more drugs. Even though treatment is offered to users, they still comprise one of the most stigmatized groups in Danish

society. The danger of the drug led to it being completely forbidden in Denmark (and many other countries throughout the world) until its use as part of the treatment program described here was legalized, but on very strict terms. It can only be administered at the clinics under strict supervision, and the daily residue must be destroyed – also under supervision. Users can be discharged if they do not cooperate with the rules – for example, if they try to smuggle heroin out of the clinic.

The heroin users eligible for medically prescribed heroin have for the most part a long, unsuccessful history of attending conventional substance-abuse treatment – usually methadone substitution combined with different kinds of social interventions (Benjaminsen et al. 2009) – while continuing to use heroin as a supplement or as an alternative to the prescribed methadone. The program for heroin-assisted treatment was established in Denmark in 2010 following other European countries (Strang et al. 2012) and operates on the principal of offering heroin users their drug of choice, thereby making treatment more attractive (Houborg 2012) and motivating users to attend treatment and commit less crime as they no longer need to buy their drugs on the illegal market. The program departs from other treatment programs in that the users' desires for a particular drug are a legitimate aspect of it.

Heroin users enrolled in treatment must show up at the clinics twice a day. Before receiving the prescribed dose, the users are screened by a nurse to ascertain whether they have already ingested drugs or alcohol, whereupon further heroin might be counter-indicated. The nurse also chats with users to ensure that they are stable and can cooperate with staff during the injection; if not, the user is refused the heroin and offered a dose of methadone instead. Stable clients – and most are – receive a syringe of medically prescribed, pharmaceutically clean heroin with which they inject themselves under the supervision of a nurse. There follows a short period of surveillance – normally ten to fifteen minutes – until the immediate effect of the drug (described by the users as the “high” or the “rush”) decreases. This whole procedure happens twice a day. Besides the two injections with heroin most users will also receive a small dose of methadone to prevent them from getting withdrawal symptoms during the evening and night, as the effect of the injected heroin decreases after four to six hours.

Heroin: Enactment of a drug of choice

The people enrolled in heroin-assisted treatment have long-term experience of living with heroin both illegally and while under treatment. For many of them the pleasurable effect of the heroin is the reason for joining the program: *“Now, I am not the kind of person who wants to walk the world straight – I want to be high, at least some of the time,”* one user told us during an interview. Another stated:

“We want to get high, we want the rush; that’s why we come here. If we just wanted not to get ill, methadone would be fine, but we want more. That’s also why we have continued through all these years despite being in treatment. We want to get high!”

All the informants had tried methadone – often for several years – as part of former drug treatments, and comparisons between heroin and methadone took up considerable time during the interviews when discussing why they had wanted to be part of this particular treatment program. Many shared experiences of methadone side effects often not addressed or acknowledged by the drug treatment system (see also Bourgois 2000). Others pointed out that they had chosen heroin because the drug worked for them, and that methadone was a poor substitute. One must bear in mind that the stories were told by users who had continued their use of heroin despite receiving methadone for several years, and told in a setting where they were trying to make sense of the new treatment.

One metaphor for the effect of the methadone used by several informants was a feeling of being trapped inside a bubble; they also reported a lack of energy and sexual desire. Some stated that methadone was synthetic, unlike heroin which derives from the opium poppy and which they described as “pure nature.” They claimed that their bodies had been destroyed by methadone, complaining that it stayed in their bones and ruined their teeth. Some said that methadone was synthesized by the Germans during WWII – which is true – and was, therefore, “evil.”

To the heroin users who told these stories heroin was perceived as a better, lighter, cleaner, and more natural drug, and one of the great assets of the treatment program was that they were given access to it – their favorite drug – for free. To some of the users heroin also had associations with the more innocent, original, and pleasurable experiences of their early drug use (see also Lalander 2003), which seemed to dominate their stories and overshadow the negative experiences that many of them must also have had with heroin. In their minds, the negative expe-

riences were linked to methadone rather than heroin. To medical experts, staff, and bureaucrats, methadone might be a substitute for heroin (the logic behind methadone substitution treatment), but to the users involved in heroin-assisted treatment there was a huge difference between the two.

The making of the government supported heroin addict

In this section we turn to how the program creates or “makes up” a specific type of users, a central element of which is the strikingly different framing of the concrete process of injection enacted in the clinics. Before entering treatment, heroin users would often “shoot up” at home – either alone or with friends who also used drugs – where they were solely responsible for the injection process and the amount taken; this would be accompanied by a sense of excited expectation of the pleasurable effect to come. Conversely, the clinics are highly medicalized places, and the actual drug intake is surrounded by objects (e.g. different kinds of medical equipment), smells (of disinfectant), images (of the human vein system), and staff (nurses and doctors) that stage the drug injection as a medical treatment event, transforming the heroin from an illegal substance into a prescribed medicine and the heroin user from an addict into a patient (Johansen and Johansen 2015; see also Demant 2009).

Many of the users perceived this medicalization of their drug intake with some ambivalence. On the one hand, they appreciated the steady, publicly guaranteed supply of the drug, its cleanness, and the supervision of qualified health care staff during the potentially dangerous practice of injecting it. On the other hand, many dreaded the supervision of the nurses before, during, and after intake, and the whole system of control that surrounds the program of heroin-assisted treatment including the rule that users must attend the clinic twice a day to perform the injection under supervision. As one user said, *“It’s like trying to have sexual intercourse while a nurse is standing next to you and asking how you’re doing. I just want to do the injection on my own.”* The comparison with intercourse reveals that at least some users perceive the actual injection as an intimate situation and the presence of the nurse as disturbing. Many users describe the program as very stressful and demanding due to the twice daily attendance: *“It feels like they own me now at the*

clinic – I spend just as much time now on the treatment as I used to on making money for drugs. So in that way not much has changed.”

The users, thus, experience a tension between freedom and control (Reith 2004; Keane 2007). There is an overwhelming sense of relief to be certain of the pleasure of their favored drug twice a day; yet it comes at the cost of being subjected to an extensive control system aimed at limiting and delimiting the pleasure of taking the drug in both time (twice a day) and space (at the clinic). Some described themselves as “state-sponsored addicts” and the heroin injection as their “municipality hit,” thereby distancing themselves from their former lives as “free” drug users, and acknowledging that the institutional frames influenced how they perceived themselves as persons (Hacking 1985).

Heroin-assisted treatment and society

When the first users entered the program for heroin-assisted treatment many of them expressed an immense gratitude to society for making this type of treatment available. Some had waited for this possibility for several years while the pros and cons were being debated in the Danish Parliament and by the public. A few users had even been politically active in this process – for example, by telling their stories of failed treatment and its consequences to journalists.

The program was introduced in Denmark after a period of critique that claimed that existing treatment modes were not efficient and did not meet addicts’ needs (Houborg 2012; Johansen 2013). In addition, users are often ambivalent about seeking treatment; many want to quit drugs and would like to live more ordinary (and – in their own words – boring) lives, yet they are anxious about what a life without drugs would mean to them. In one sense heroin-assisted treatment offers a middle position where they can enter treatment and with that a normalization process, but without giving up drugs altogether. We, thus, see the creation of a new kind of user (Gomart 2002b) who, rather than taking illegal heroin and living on the edge of society, ingests a legal drug within a strong medical-institutional context that frames the experience of the drug and the perspective of what addiction is (Keane 2008).

The program for medically prescribed heroin not only creates a new kind of heroin user – is also stirs up disturbances in the treatment system by introducing “pleasure” as a legitimate reason for seeking this type of program (Johansen 2015). As Keane has pointed out in an article on Ritalin and amphetamines, the

legitimization of Ritalin treatment is only possible because the pleasurable effects are not part of the treatment discourse (2007; see also O'Maley and Valverde 2004). But when it comes to heroin treatment, this division no longer holds. Users seek out the ground-breaking program exactly because of the pleasurable effects of the heroin – and staff members acknowledge this as a legitimate reason. Therefore society suddenly needs to handle a new phenomenon in relation to the treatment of heroin addiction: the pleasure associated with the intake of the drug. The response of the treatment system has been to make a sharp distinction between where this pleasure can be enjoyed – in the injection room – and where it cannot – the rest of the clinic and society at large. The strict control regimen of the heroin clinics can be understood as an attempt to fence in the pleasure in time and space, thereby rendering it manageable (see also Johansen and Johansen 2015).

Restriction, constraining and the enabling of pleasure

In this article we have probed the role of substances in the construction of self through the cases of heroin and sugar addiction. The juxtaposition has served as a lens to explore relations between society, institutional structures, and moral values that produce certain actions and material effects (Keane 2002). It is suggested that addictive substances generate subjectivity within a specific cultural setting (Bettany 2007), fueled by the experiences of effects, societal responses, and moral meanings.

What we see in both cases is that the users of the given substance have divergent and complex perceptions of the drug compared to official accounts, with resulting and rather strong feelings of alienation because of the lack of public recognition of their problems. Indeed, a sort of inter-textuality seems to exist between different discourses on addiction that can be associated with both new and traditional addictive substances. Both sugar addicts and heroin users describe pleasure in ways that contradict official discourse, and in the same breath tap into traditional understandings and discourses of addiction. For example, the two types of addiction resonate with existing discourses about sugar and heroin – that one is perfectly legal while the other is condemned. Yet in both cases, the category of the addict was, we argued, constructed through perceptions of the substance that contradict official public perceptions. Sugar, generally considered a relatively innocent substance, was associated with danger, artificiality, and dirt by self-designated sugar addicts, and considered a substance that “pollutes” the self. On the other hand, in

the official discourse heroin is considered a malevolent drug that leads to severe addiction and serious health problems yet it was regarded by some of those undergoing heroin-assisted treatment as a pure, natural substance, through which the user was granted the experience of pleasure and self-realization. In contrast, methadone was seen as an artificial chemical that pollutes the user, destroys the body, and imprisons the brain.

The comparison has the almost opposite experiences of substance, pleasure and addition in the same cultural context. By so doing it has confirmed and ethnographically explored the point made by Gomart (2002a), namely that effect and experience emerge out of a network of actors, moral meanings and institutions. What we have added in this article through our comparative case is the exploration of overall structures that enable and constrain experience and pleasure. In this context, the addictive substance becomes an actant that constrains the experience of pleasure when the substance is controlled by forces in society. On the other hand, when the addicted manage to break free of these bonds – the temptation of the market, or the restriction of the authorities – the substances become an enabling actant for the pursuit of pleasure as evidenced by the enhanced pleasure of taste when sugar is removed from the diet, and the greater pleasure gained from heroin taken outside of institutional constraints. In both cases recovery becomes a means of finding one's inner core in a society marked by industrial interference and artificiality – whether it is in the officially supported use of intoxicating drugs or in the continued fight to not be polluted by excessive sugar consumption.

The article has also pointed towards some of the complexity and ambivalence of late modern consumer culture and society: the use of natural substances offers the possibility of greater contact with one's "real" needs, whereas chemicals "pollute" the self. In both cases we see that the artificial substance is regarded as a metaphor for the potential danger of the moral and bodily decay of the proper human in modern consumer society. Meanwhile, the category of addiction serves to move the responsibility from the individual to the substances, and therefore undermines the notion of rational decision and self-control, as well as providing a way to deal with feelings of shame. This "making up" of addiction shows that the use of substances is not necessarily a matter of choice but rather a matter of embodied conditions.

The empirical examples confirm Gerda Reith's point that "addict identities" and "consumer pathologies" are in opposition to core liberal values of freedom, autonomy, and choice (Reith 2004: 284). Hence, addiction to substances becomes a template for explaining and dealing with human vulnerability, and in both cases it

becomes an emic category that the users actively employ. The addictive metaphor relieves the consumer of responsibility, “liberating” the individual from the ever-present presence of the moral imperative of control and autonomy. Paradoxically, the metaphor of addiction also provides an opportunity for personal salvation and realization, offering a solution if the addicted is able to gain some degree of autonomy in relation to forces that restrict – in both cases a regulated environment paves the way – for users’ to indulge in and enjoy the addictive substance of choice.

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Notes

- 1: We use the concept “sugar addicts” or “sugar sensitives” when referring to our informants, as this was the term they used to refer to themselves.
- 2: The term “intertextuality” was originally coined by Julia Kristeva (1980) and refers to the shaping of a text’s meaning by another text. In this article the term refers to the ways in which the sugar addiction discourse is shaped by and builds on more traditional and officially recognized discourses of addiction as those of alcohol and heroin addiction.
- 3: Again, we use the term “heroin user” as this is how the people in the treatment program refer to themselves in the treatment context where we met them.

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