Identity, Empathy, and Inequality in a Drug-Focused Therapeutic Community

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ABSTRACT

Matthew Brewer Ezzell: Identity, Empathy, and Inequality in a Drug-Focused Therapeutic Community
(Under the direction of Sherryl Kleinman)

Based on participant observation and in-depth interviews, this dissertation examines the processes involved in the treatment of drug use problems at a therapeutic community (TC)—a residential program for individuals seeking personal change—and the accounts that staff members used to justify their treatment methods.

In the Chapter II, I analyze the use of traditional TC treatment methods. I argue that staff members justified the use of these techniques by (a) defining addicts as personally irresponsible, (b) construing them as manipulative liars, and (c) claiming personal authority for themselves as former addicts. I show that although staff rhetoric centered on “personal responsibility,” the organization left little room for it among the residents. I argue that the focus in the organization on compliance and social control constrained the moral agency of the residents.

In Chapter III, I analyze the ways that male residents claimed a masculine self during group accountability sessions. I argue that in response to a loss of control in their lives, the men were encouraged to perform compensatory manhood acts through: 1) aggressive confrontation; 2) the subordination of women and non-conventional men; 3) gendered calls to account; and, 4) the control of emotional display. I argue that the men’s
identity performances drew on misogyny and homophobia for meaning, neglected the structural, and served as a means of social control by the organization.

In Chapter IV, I analyze the ways that staff responded to a threat to their identities. TC staff were historically drawn from the ranks of former residents. The implementation of a new therapeutic approach represented a threat: (1) it challenged their claim to personalized authority in the organization; (2) it threatened their sense of competence and made them uncomfortable; and, (3) it altered the methods that they believed had “worked” for them as residents. Staff members with professional degrees responded through: (a) appeals to professionalization, (b) appeals to biology and empowerment, and (c) appeals to effectiveness. This research aids our understanding of the processes of personal and professional identity threat, in addition to adding to an analysis of treatment practices in TCs.
To Hudson
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I.

INTRODUCTION

Drugs—substances designed or taken to induce some change in consciousness, experience, or bodily sensation—are big business in both the legal (Angell 2004) and illegal (ONDCP 2000) drug trade. Beyond the money spent on illegal drugs, the criminalization of drugs has been a source of huge profit for the privatized prison industry (Schlosser 1998). The “war on drugs” largely accounts for the skyrocketing prison population over the last several decades; currently, more than one in one hundred people in the United States is behind bars—the highest rate of incarceration in the world (Pew Center on the States 2008).

Drug enforcement agents and police officers have not targeted drug users across the board. Disproportionately, people in prison for drug offenses are poor people of color, despite similar rates of drug use across demographic groups (CJCJ 2000; Pew Center on the States 2008). For prisoners struggling with drug use problems, there is little treatment or support (Mumola 1999). For those who have access to it, one option for drug users is treatment in a therapeutic community (TC), a residential program designed to aid individuals seeking some form of therapy or personal growth (see De Leon 2000).

TCs have operated for several decades, but few sociological studies have been done on them. Researchers have conducted evaluative studies of TCs organized to address mental health issues (Belcher 1965; Doherty & Harry 1976); studied emotion
work in a mental-health TC (Wiley 1990); evaluated prison-based, drug-focused TCs
(Wilson & Snodgrass 1969; Welsh 2007); and, analyzed the experiences of women in
prison-based TCs (Eliason 2006; McCorkel 2003).

Descriptive and celebratory studies of community-based, drug-focused TCs are
the norm. For example, Barry Sugarman’s (1974) study of “Daytop Village” provides a
rich description of the day-to-day practices in a traditional TC. But he failed to analyze
the social implications of what he observed. Michael Bloor, Neil McKeeganey, and Dick
Fonkert (1988) studied the range of practices across eight TCs, again offering a detailed
description of their fieldsites as well as a thoughtful overview of the history of TC
treatment. But, they fall short of providing a critical analysis of their findings, concluding
that: “… therapeutic communities might well be thought to stand with one foot in Eden”
(202). Their uncritical celebration of TCs as a mode of treatment for problems of drug
use may reflect the personally transformative experience of conducting their research. In
an appendix, they state this clearly: “[O]ur lives have been touched and changed by our
experiences. Were we anthropologists, then therapeutic communities would be our
‘tribe.’ And we acknowledge that fact with gratitude” (227).

There is a gap in the sociological literature on community-based TCs, and my
research aims to fill that void. Based on participant observation and in-depth interviews at
SATH (Substance Abuse Treatment Headquarters)\(^1\), I analyze three questions: (a) how do
staff justify the traditional, confrontational TC approach to treatment; (b) how do the
traditional TC methods, specifically the sex-segregated group accountability sessions
called “games,” serve as a site of identity management and social control of male
residents; and, (c) how do professionalized new staff members sell an alternative
approach to treatment to the “old guard” in the face of resistance? The “old guard” of staff members were all former residents of SATH or another TC. The addition of new staff members with professional degrees occurred following pressure from state agencies on SATH to become licensed. The coerced nature of the licensure process, and the new staff members’ introduction of an alternative therapeutic approach, created tension and resistance on the part of the old guard.

In the first substantive chapter, I analyze the TC “theory” behind the treatment, what the approach looked like on the ground, and how TC-oriented staff talked about their methods. When a small group of newer staff members tried to introduce a method based on empathic listening instead of the aggressive “shaming and blaming” techniques of the traditional TC, the “addict” staff were put in the position of accounting for the traditional methods. In a contribution to our understanding of TCs and total institutions, I found that staff members justified the use of the TC approach by (a) defining addicts as personally irresponsible, (b) construing them as manipulative liars, and (c) claiming personal authority for themselves as former/recovering addicts. The framing of residents as untrustworthy liars justified the use of the traditional methods. If residents could not be trusted, they must be controlled. The primary role of the staff members in the traditional approach was to discipline residents through the strict enforcement of rules.

Beyond highlighting the justifications of the traditional TC approach to treatment, I show that although the staffs’ rhetoric centered on “personal responsibility,” the organizational arrangements left little room for it among the residents. I argue that the extreme focus in the organization on compliance and social control constrained the moral
agency of the residents, a finding with implications for the residents’ lives following graduation from the program.

In the second substantive chapter, I analyze the ways that male residents claimed a masculine self during sex-segregated group accountability sessions called “games.” I argue that in response to a loss of control in their lives and in their status as residents of a total institution (Goffman 1961), the men’s ability to claim a masculine self became compromised. At the “games,” however, the men were encouraged to perform compensatory masculinity—exaggerated performances of a masculine self (Babl 1979). I analyze four of the men’s strategies: (1) aggressive confrontation (compensatory manhood acts); (2) the subordination of women and non-conventional men; (3) gendered calls to account; and, (4) control of emotional display, what the residents called “keeping your head.” I argue that the male residents, with institutional support, constructed a contradictory masculine self; they relied on performances that, on the surface, appear at odds with one another—aggressive confrontation and deference to authority. I also analyze how the men navigated through this contradiction in ways that affirmed their identity as men. The men’s performance during the games promoted an affirmed sense of self, but only by drawing on misogyny and homophobia as its anchors. In addition, the arena and content of the games neglected the structural inequalities that enabled the patterns of substance use and incarceration that brought the men into the organization to begin with, and functioned as a means of social control.

In the third substantive chapter, I analyze the ways that staff responded to a threat to their professional and personal identity. TCs historically have drawn staff members from the ranks of former residents. SATH was no exception. But, when state agencies put
pressure on SATH to become licensed, the door was opened to bringing in staff with professional degrees. The new staff members attempted to implement an alternative approach, one based on empathy rather than discipline. The “old guard” had experienced the usual TC approach as residents, still considered it effective, and replicated it in their work.

The new approach represented an identity threat to the “addict” staff members in three ways. It (1) challenged their claim to personalized authority in the organization (as “recovering addicts” who had “been there”) by framing authority in professionalized terms, (2) threatened staff’s sense of competence and made them uncomfortable (outcomes of staff-resident interventions were less controllable with the new methods), and (3) altered the methods that they believed had worked for them as residents (staff defined “addict” as an essential identity, so changing the methods that staff believed helped them to recover was threatening). In response to “addict” staff members’ resistance, staff members supportive of the empathic approach made use of (a) appeals to professionalization (offering alternative routes to semi-professional authority), (b) appeals to biology and empowerment (reframing addiction as beyond the resident’s control and repositioning staff’s role as empowering the resident to make their own decisions), and (c) appeals to effectiveness (arguing that the new methods were better than the old methods in achieving desired results). The TC approach remained dominant throughout my study, and no “addict” staff members gave up the TC methods entirely; but, all of the people-staff, see below, came to use the empathic methods at least some of the time. This research aids our understanding of the processes of personal and professional identity threat, while adding to an analysis of treatment practices in TCs.
THERAPEUTIC COMMUNITIES

In some ways, therapeutic communities (TCs) are exactly what the name implies: people living in community with the purpose of fostering some form of therapeutic healing or growth. Therapeutic Communities of America (2008), a non-profit consortium representing over 650 TCs, notes that “[t]he primary goal of a Therapeutic Community is to foster individual change and positive growth … by changing an individual’s life style through a community of concerned people working together to help themselves and each other” (para 5). Although no organization was specifically identified as a “therapeutic community” until the 1940s (see Main 1989), people have been living in groups with the goal of fostering some type of growth or healing for most of recorded human history. For the last thirty years, George De Leon has been the most consistent advocate for, and voice of, the traditional TC approach to the treatment of drug use problems in the United States. Serving as the Director of the Center for Therapeutic Community Research in New York, De Leon (2000) literally “wrote the book” on TCs: The Therapeutic Community: Theory, Model, and Method. In this book, De Leon identifies the essential elements of the modern TC and laid out the theoretical framework of the TC movement, intending it to serve as a “single theoretical framework that presents the TC for addictions and related problems as a uniform approach … that can guide clinical practice, research, and program development” (30).

De Leon argues that the prototype of the modern TC can be found in ancient civilizations that focused on “diseases of the soul” with an eye toward treatment in communities of healing (14). He notes that the Dead Sea scrolls outline the communal
practices of religious ascetics who believed that “[a]dherence to the rules and teachings of the community” (14) was the key to a righteous and healthy life. Breaking the rules of the community, just as in modern TCs, was a transgression met with aggressive sanctions.

Similarly, researchers Michael Bloor, Neil McKeeganey, and Dick Fonkert (1988) used a comparative framework to outline the development and range of TC approaches to treatment. They highlight “foster family communities” (14) operating in the year 1250 and move through modern era approaches found in halfway houses and hospital centers. They note that there are:

many different kinds of institutions with claims to the title of therapeutic community; they differ radically in their staffing, their clientele, their social organisation [sic] and their approaches to treatment. There is no such thing as a single ‘representative’ therapeutic community (1-2).

According to De Leon (2000), there are common features of TC programs. For example, they use a self-help approach in which the community, itself, is the method of treatment—“individuals are taught to use the peer community to learn about themselves” (32). Addiction is viewed as a disorder of the whole person—“it is not the drug but the whole person that is the problem to be treated” (39). Recovery is viewed as “a change in lifestyle and identity” (65). And physical, social, organizational, and work elements of the program all combine to “foster a culture of therapeutic change” (99).

TCs have dealt with a range of mental and physical health concerns. Treatment of substance use problems, “addiction,” is a common feature of many modern TCs (see
NIDA n.d.). Three programs in the modern era set the stage for the emergence of contemporary TCs: the Oxford Group in the early 1920s, Alcoholics Anonymous (AA) in the 1930s, and Synanon in the 1950s (see De Leon 2000). The Oxford Group was an explicitly Christian organization and religious movement intent on curbing “spiritual erosion” (15). Although it did not focus specifically on issues of drug use, alcoholism was viewed within the movement as a sign of spiritual and moral failing. The group stressed “the work ethic, mutual concern, sharing guidance, and evangelical values of honesty, purity, unselfishness and love, self-examination, acknowledgement of character defects, making restitution for harm done, and working with others” (15) as the keys to salvation. The founders of AA, Bill Wilson and Bob Smith, were early members of the Oxford Group, and the focus in AA on self-examination and restitution for harm emerged from that experience.

Synanon was a drug rehabilitation program that started in California in the 1950s when Charles Dederich broke his relationship with the Santa Monica AA chapter to start a more aggressive and confrontational program. As historian Rod Janzen (2001) outlines, Synanon remained active in drug use treatment for several years, but tactics and procedures in the organization changed, becoming increasingly bizarre and violent. Dederich decreed that members could drink and smoke. He also pressured members to change marital partners, forced men to get vasectomies, and encouraged the use of physical violence. In time, leaders claimed the group was a religious organization in order to gain tax-exempt status. As tactics continued to change, more and more members left the organization. When a rattlesnake was placed in the mailbox of a lawyer
investigating the group, its external support dropped sharply. It lost tax-exempt status and was forced to close due to bankruptcy from IRS charges in 1991.

Despite Synanon’s sordid history, the “game,” an aggressive and confrontational accountability session developed in Synanon, forms the bedrock of the modern TC. And, as noted, the therapeutic approach of the modern TC makes the community itself the method of treatment for the individual. This approach, too, evolved out of the work of Synanon. Synanon broke with AA’s approach by addressing problems with drugs other than alcohol and by moving beyond the goal of maintaining sobriety. In Synanon, and in the modern TC, the goals of treatment are lifestyle changes that only begin with sobriety. The focus of treatment, hypothetically, is not drug addiction, but the whole person. Drug use, from this approach, is a symptom of a deeper problem with the person. And the point of the community is to change the individual.

THE PRISON INDUSTRIAL COMPLEX AND THE “WAR ON DRUGS”

To make sense of interaction and programming at SATH, it is helpful to understand the prison industrial complex (PIC). The PIC represents the privatization of the national criminal justice system. That system of governmental and private interests is driven by an ideology that views incarceration as not only a solution to social problems, but as a profitable business. Journalist Eric Schlosser (1988), writing for The Atlantic, observed:

The prison-industrial complex is not a conspiracy, guiding the nation's criminal-justice policy behind closed doors. It is a confluence of special interests that has given prison construction in the United States a seemingly unstoppable momentum. It is composed of politicians, both liberal and
conservative, who have used the fear of crime to gain votes; impoverished rural areas where prisons have become a cornerstone of economic development; private companies that regard the roughly $35 billion spent each year on corrections not as a burden on American taxpayers but as a lucrative market; and government officials whose fiefdoms have expanded along with the inmate population (para 7).

Rates of violent crime have been in an overall downward trend since the early 1970s (BJS 2006), yet incarceration rates have been steadily on the rise. From an estimated 110 inmates for every 100,000 people in the U.S. population in 1970 (Schlosser 1998), today there are over 750 inmates for every 100,000 people—an almost seven fold increase (Pew Center on the States 2008). As the Pew Center on the States summarizes, this rapid rise in the prison population “flows principally from a wave of policy choices that are sending more lawbreakers to prison and, through popular ‘three-strikes’ measures and other sentencing enhancements, keeping them there longer” (3). The rise in the prison population parallels the rise of the prison industrial complex. And the largest area of prison population growth, in the number of arrests, convictions, and sentences, is drug offenses. The Federal Bureau of Prisons (2008) reports that 53.6% of the prison population is there for a drug-related reason.

The rise in the prison population has not been representative of the wider population. Rather, it represents systems of power and oppression. Critical Resistance (n.d.), a national grassroots organization dedicated to resisting the PIC, argues that the PIC “depends upon the oppressive systems of racism, classism, sexism, and homophobia” in the United States (para 1). Indeed, including considerations of race, class, and gender provides a fuller picture of who is being targeted in the “war on drugs” (Pew Center on the States 2008). For example, one in thirty men between the ages of 20 and 34 is in
prison; for black men in this age group, the number is one in nine. And this does not reflect higher rates of drug use among black men. Although an estimated 13% of regular drug users in the United States are black, in 2000 they made up 62.7% of drug offenders in the prison system (CJCJ 2000). SAMHSA, the Substance Abuse and Mental Health Services Administration (2007), reports that the rates of black and white illegal drug users are roughly comparable: 9.8% of the black population compared to 8.5% of the white population. However, black men are “admitted to state prison for drug offenses at a rate that is 13.4 times greater than that of white men” (CJCJ 2000, para 9). All people admitted to prison, regardless of race or sex, are more likely to be poor than not (Reiman 2000). As many as 70% of inmates are illiterate, and 10% have a serious mental illness (Schlosser 1998). The prison population is filled with the already marginalized and dispossessed.

Many of the people who are in prison for drug offenses and other crimes are physically addicted when they enter the criminal justice system. It is estimated that as many as 70% of the 2.3 million people behind bars have “serious drug abuse problems” (TCA 2004, para 2). In this group of upwards of 1.6 million inmates, SAMHSA (2007) reports that only 420,000 received some form of substance abuse treatment in prison or jail in 2006. An even smaller group, fewer than 15% (345,000), received systematic treatment (Mumola 1999). The implications of this lack of treatment, given mandatory sentencing and “three strikes” policies (which require increasingly long sentences for repeat arrests), is that individuals struggling with chemical dependency may get life sentences in prison, but no treatment.
The backdrop of the PIC has immediate implications for SATH. Over 90% of the resident population has criminal convictions related to use of drugs. In addition, one out of three of the residents is probated to SATH—they join the program as a way to avoid immediate incarceration, or, as the residents said, to “duck time.” The resident population is also disproportionately poor and black. TCs may offer a way out of what one staff member referred to as the “revolving door” of the PIC.

COMPENSATORY MANHOOD ACTS

As Critical Resistance (n.d.) points out, making sense of the PIC means making sense of sexism, racism, and class inequality. Given the role of the PIC as a route into SATH, making sense of SATH also means making sense of patriarchy, white supremacy, and capitalism. Sociologist Allan G. Johnson (2005, 2006) argues that systems of privilege and oppression are dominated by, identified with, and centered on the powerful. Patriarchy, then, is a system that is male-dominated, male-identified, and male-centered. Similarly, white supremacy and capitalism are systems dominated by, identified with, and centered on, respectively, white people and economic elites.

Taking patriarchy as an example, men tend to be in positions of power and authority, what is seen as normative and valuable tends to be associated with men and masculinity, and the cultural focus of attention tends to be on men and the things that men do (Johnson 2005). This does not mean that every male in our society has equal access to the use of power over women or feels powerful in his life. Many men are dominated at work or outside it—typically by other men—and thus do not feel powerful. Working-class men and men of color may not reap what R.W. Connell (1987, 1995) calls
the full “patriarchal dividend”—the advantages typically conferred on males in a patriarchal society. When men’s access to patriarchal advantages is threatened in some way, or when their claim to a masculine self is discredited, they may resort to displays of compensatory masculinity (Babl 1979). In an effort to make up for their lack of access to the highest benefits and privileges of men in a white supremacist, capitalist, and patriarchal context, they may perform exaggerated “manhood acts”—acts which signify a masculine self and are “aimed at claiming privilege, eliciting deference, and resisting exploitation” (Schrock and Schwalbe 2009:281).

Men perform compensatory manhood acts in many social settings. Some men with physical disabilities, for example, may center their masculine identities on the control they exert over others occupationally, while others may (over)emphasize their physical strength, athleticism, or sexual prowess (Gerschick and Miller 1995). As one man put it: “I’ve overcompensated by trying to please my [sexual] partner and leave little room to allow my partner to please me….Some of my greatest pleasure is exhausting my partner while having sex” (356). For some urban, poor, young black men, the projection of a physically intimidating masculinity is the only source of power they perceive as available to them (Anderson 1990). C. Shawn McGuffey (2008) highlights the strategies that parents of male survivors of child sexual abuse use to “save [their sons’] masculinity”: promoting heterosexuality; pushing athletics; and, encouraging emotional disengagement. David A. Snow and Leon Anderson (1987: 1362) point out that some homeless men use “fanciful identity assertions”—future-oriented and fabricated assertions about the self—to promote a sense of themselves as sexually powerful and desirable: “Man, these chicks are going to be all over us when we come back into town
with our new suits and Corvettes. We'll have to get some cocaine too. Cocaine will get you women every time." Note, in this quote, the ways that hegemonic masculine norms intersect with class signifiers (“new suits and Corvettes”), risk-taking behavior (illegal drug use), and predatory heterosexuality (“getting” women).

The intersections of white supremacy, capitalism, and patriarchy imply that the same behavior by men or boys in different social locations can carry different meanings and have different consequences. Men with greater access to power based on their identities in multiple privileged groups have little need to resort to exaggerated manhood acts to claim authority, but they can get away with such acts more readily than men in marginalized and subordinated groups. White students, for example, report in greater numbers than black students that discipline in schools is fair and that it is okay to break the rules (Jencks & Philips 1998). This is because they are given the benefit of the doubt when they do break the rules. In Ann Arnett Ferguson’s (2001) study of an elementary school, a white teacher described her ideal (white, male) student:

He’s not really a Goody Two-Shoes, you know. He’s not quiet and perfect. He’ll take risks. He’ll say the wrong answer. He’ll fool around and have to be reprimanded in class. There’s a nice balance to him (91).

For teachers of white boys, misbehavior means “balance.” For black boys, misbehavior leads teachers to describe them as having “a jail cell with [their] name on it” (1). As Ferguson argues:

In a disturbing tautology, transgressive behavior is that which constitutes masculinity. Consequently, African American males in the very act of
identification, of signifying masculinity, are likely to be breaking rules…. [N]ormative male practices take on a different, more sinister inflection when carried out by African American boys (170, 172).

The stakes are higher, then, for the very men and boys who may feel they need to resort to compensatory manhood acts to begin with. The resident population at SATH—disproportionately poor black men with felony convictions—is a prime example.

ADDITION

“Addiction” is a term most often used to refer to physical or emotional dependence on drugs. However, addiction is a socially constructed concept without a uniform or static definition (Wincup 2007). A diabetic who is dependent on insulin to regulate her or his blood sugar is typically not viewed as an “addict,” nor is the middle class office worker who uses antidepressants daily. “Addict” has historically been a stigmatized identity. Indeed, folk understandings of addiction as well as professional views in the medical and psychiatric establishment have largely reflected moralistic and individualistic frames: “addicts” are deviants who make bad personal choices, who lack willpower and strength of character, or who have some trait which predisposes them to engage in maladaptive behaviors (Lindesmith 1938; see also Becker 1953).

But popular constructions of “addiction”—and the “addict”—have changed. In recent years, biomedical researchers have studied the impact of substance use on the brain as well as the impact of brain chemistry on patterns of substance use. This reframes “addiction” as an illness and grounds it in medicalized rhetorics of biology and brain chemistry. In 2008, Newsweek (Interlandi 2008:38) quoted Nora Volkow, then the
director of the National Institute on Drug Abuse (NIDA), on the direction that the
treatment of drug use problems is heading: “The future is clear. In 10 years we will be
treating addiction as a disease, and that means with medicine.” Researchers are currently
developing medical treatments to promote self-control, block the action of various drugs
on the brain, and even to prevent addiction through the use of vaccines. For instance,
Thomas Kosten, a doctor with the Baylor College of Medicine, is developing a vaccine
for cocaine addiction: “You could vaccinate high-risk teens,” he said, “until they matured
to an age of better decision-making” (41).

The medicalized view maintains an individualist understanding of “addiction,”
but it moves discussion away from “addicts” as deviants and degenerates and reframes
them as “sick.” Addiction, in this more sympathetic view, is not the addict’s fault. This
approach is gaining cultural cachet through such popular television shows as HBO’s
documentary series, “Addiction.” On this show, the current medicalized view of
addiction is stated simply: “Addiction is a chronic but treatable brain disorder in which
people lose the ability to control their need for alcohol or other drugs” (HBO 2009: para
1). Still framed in individualist terms, the success of this show may shift popular
discourse away from victim-blaming. Yet, blaming-the-addict persists in the culture
industry. Such voyeuristic and exploitative shows as A&E’s “Intervention” and VH1’s
“Celebrity Rehab” hold up “addicts” as objects for sympathy and ridicule.

Individualist accounts of addiction are sociologically unsound. The experience
and meanings of “addiction” vary depending on the social location of the “addict”; and,
patterns of drug use and criminalization say more about structural inequality than they do
individual pathology or decision-making. Who becomes an addict, and how? Even if
limited to the use of illegal drugs, not every person who ingests a controlled substance will develop a physical or emotional dependency. Howard Becker (1953), for example, highlighted the social process involved in becoming a marijuana user:

…the presence of a given kind of behavior [drug use] is the result of a sequence of social experiences during which the person acquires a conception of the meaning of the behavior, and perceptions and judgments of objects and situations, all of which make the activity possible and desirable (235).

Drug use, particularly continued drug use, is more than a physical process. It is a social and interpretive process of meaning-making which takes place in specific (sub)cultural contexts. More than this, the route to drug use and the meanings of and responses to individual drug users (in terms of arrest and/or treatment) can vary significantly depending on the user’s structural location.

At SATH, many residents framed drug use as something that had moved beyond their control. Yet many also told me that they started using drugs for fun or as a way of “escaping” from a traumatic event. For example, some residents told me they started using drugs to numb their feelings or to cope with losing a child, being abused physically or sexually as a child, or surviving the war in Vietnam. In the absence of other forms of support, their accounts suggest that these residents were “self-medicating” through drug use (see Eliason 2006; Friedman & Alicea 1995; Hawke, Jainchill, & De Leon 2000). This is similar to Becky Wansgaard Thompson’s (1992) argument that “eating problems begin as ways women cope with various traumas including sexual abuse, racism, classism, sexism, heterosexism, and poverty” (547). In the face of an oppressive and traumatic material reality, along with lack of access to other forms of support and coping
strategies, drug use makes sense. This is not to suggest that members of privileged social
groups never engage in drug use or “addictive” behavior, nor is it to suggest that such
individuals never experience trauma. However, members of privileged groups may have
more resources at their disposal for coping and support, and, as noted, they are less likely
to be targeted for arrest and incarceration.

Despite connections between structural conditions and patterns of drug use,
talking about the material realities of residents’ lives is discouraged in the traditional TC
approach to treatment because it is seen as offering an “excuse” for drug use. But,
residents’ drug use does not begin in a vacuum. To locate the onset of drug use in a
specific moment of the resident’s biography is not to eschew responsibility, but to
contextualize the experience. The residents’ accounts are consistent with Becker’s
analysis. The context of their first drug use provided shape for the meanings they placed
on the experience. Defining it as pleasurable, or effective as a means of “escape,” they
continued. However, in the accounts of these residents, as they continued using drugs the
meaning shifted—they came to define it as something beyond their control.

Not all of the residents thought they had lost control of their drug use. These
residents’ accounts of their initial drug use were similar to all other residents—something
fun, a way to make money in a depressed economic context, or an effective means of
escape. But the meaning they placed on their continued drug use did not take on an
association with dependency. The majority of these residents were men who came to
SATH as part of their probation. As one man said during a “game,” a sex-segregated
group accountability session, “[When I first came to SATH,] I didn’t want to be here. The
judge sent me here, and to be honest I was just ducking time, you know?” It was arrest
and the threat of incarceration—not feelings of dependency—that led these residents into a treatment program.

We must also consider the structural location of the drug user in understanding the meaning they place on their drug use and the consequences they may face. Middle class drug users may terminate (some forms of) drug use because they feel that they have more to lose. However, given the disproportionate targeting of poor people of color for arrest and incarceration related to drug offenses, middle class and white drug users have less to fear in the way of “losing everything” following an arrest. And, if an arrested drug offender has enough financial resources, they can afford high-end legal representation and often attend spa-like treatment centers in lieu of doing time. Poor people of color are more likely to do time with no treatment. Poor and black, Brandon, a staff member and former resident at SATH, said:

I always knew that I couldn’t afford to go to the Betty Ford, or the Lindsay Lohan Clinic [Lohan is an actor who, after two DUI convictions, attended short-term and high-end clinics in Malibu]. I would take the local clinic, and I made the best of it, and it worked for me. So, I accepted the treatment that was there for me. I could not afford, I knew, any other, so I had to accept it.

It is not a coincidence that the resident populations of TCs are disproportionately made up of poor people of color.

Beyond the experiences of the individual drug user, the social construction of addiction can be understood sociologically in the context of wider systems of privilege and oppression. As noted earlier, the criminalization of (particular) drugs, and the arrest and incarceration of (particular) drug users, is a profitable business venture and a means
of social control represented by the prison industrial complex (Schlosser 1998; Goldberg & Evans 2001). The growth of prisons exploded during the 1980s. In a period of social backlash to the gains of the Civil Rights and feminist movements of the 1960s and 70s, a period in which the “Red Scare” held less sway as a means of controlling the U.S. population through fear, politicians turned to a “tough on crime” approach to campaigning that constructed a home-grown bogey: the (poor, black) drug-addled violent criminal. At the same time, the Reagan administration’s policies of union-busting and corporate deregulation, coupled with the globalized flight of capital to foreign markets, dismantled the manufacturing sector of the United States. Prisons were privatized, creating an economic incentive to keep more people behind bars. This pitted urban and rural working people against one another. Economically depressed rural communities clamored to get the jobs and money that would come with building new prisons. And, the marginalized members of economically depressed urban communities turned to the illegal drug trade, thus becoming the population that would fill those prisons (both communities were resisting the structural barriers of a shrinking industrial economic sector). Poor people of color in cities, facing an economically untenable structural situation, were criminalized and disproportionately targeted for arrest and incarceration; and poor, rural, white people had an economic incentive to support the policies that kept them there.

As Philippe Bourgois (2008) points out, conceptions of masculinity also play a role in the social construction of “addiction,” patterns of drug use, and the drug trade. In a de-industrialized economy, young urban men’s conventional options for work typically consist of entry-level, service-sector positions that pay poorly and include strict oversight
with little room for autonomy. For the young men of color that Bourgois studied, these jobs and conditions flew in the face of their conceptions of masculinity and the respect they believed men deserved. In contrast, the illegal drug trade paid better and provided more avenues for the performance of a strong masculine self. The sale and consumption of illegal drugs emerged as a viable compensatory manhood act (Schrock and Schwalbe 2009).

“Addiction” is not a character trait of weak or pathological people. It is a concept forged in the crucible of white supremacy, global capitalism, and patriarchy. It serves as the backdrop of the interactions that took place at SATH between and among the residents and staff members, providing meaning and context to their identity work and emotional labor (see Schwalbe & Mason-Schrock 1996; Hochschild 1983).

SETTING AND METHODS

Substance Abuse Treatment Headquarters (SATH)

SATH is a secular, two-year, voluntary, and residential therapeutic community (TC) in the southeastern United States for individuals seeking help for drug use problems. Residents come to SATH in a variety of ways, but over ninety percent have criminal records and over a third come specifically to avoid immediate incarceration. Almost half of the residents left high school before graduating, and many have serious physical and mental health problems beyond the scope of their patterns of substance use. The resident population during my study was roughly 70% male, 80% black, and almost entirely from poor and working class backgrounds. An estimated 30-40% of the residents who make it one month in the program will go on to graduate.
SATH’s internal literature notes that it “assists residents in changing their attitudes and their addictive behaviors by promoting personal development.” SATH’s founder and president, James Carter, opened the organization in 1994. SATH is organized as a total institution (Goffman 1961), orchestrating every aspect of the residents’ lives and daily activities. In keeping with this model, the individual needs of residents are subordinated to the needs of the organization. For example, the largest income generator in the organization is the Moving Company (Mocom). During peak moving season (the summer), staff pulled residents out of therapeutic activities in order to have them work as movers. Three rules, made explicit in internal literature, were to be followed at all times: (1) no acts of violence; (2) no threats of violence; and, (3) no drugs or alcohol.

SATH is a graduated program; the “Resident Handbook,” given to all residents upon acceptance into the program, notes that residents earn privileges as they graduate to higher stages through “hard work and clean living.” They enter as “interns” and are matched with another intern, called a shadow, who has been in the program for a week or more. The shadow socializes the new resident into the norms of SATH, teaching them the functions, rules, and procedures of the organization. Interns are allowed to possess only a small religious text and five or fewer personal photographs until their internship program is over. All other items, including clothing, toiletries, and bed linens are supplied by SATH. Interns may not receive or send any mail, emails, or phone calls, except in emergencies or on holidays. Men must cut their hair in a crew-cut twice a month and remain clean-shaven. Women are not allowed to wear makeup or dye their hair. Male and female residents are prohibited from having any contact with each other. Interns work for
sixteen hours a day cleaning buildings, dorms, and offices at SATH and attend three “games”—group accountability sessions—per week.

After reaching thirty days in the program, and barring discipline problems, interns are promoted to “freshman” status. Freshmen may receive personal mail and use the telephone according to organizational protocol—one monitored, fifteen minute call, after ninety days in the program. Mail is checked for the first year of the program for contraband, which could include anything from disallowed personal items to drugs. Freshmen may apply for a driver’s license, and they have one business outfit (a suit) issued to them. Women are allowed to wear one pair of earrings, but no makeup. No hair dye is allowed, and men must continue to get two haircuts a month and remain clean-shaven. Men and women may only have contact as required by work. Freshmen status lasts through six months in the program.

After six months, freshmen are promoted to the status of “resident.” New residents are allowed to speak for two minutes at the beginning of a group session. They receive a personal and portable music-player and a watch. Residents may participate in in-house classes and team-outings. Women, according to the Resident Handbook, can wear “tasteful lipstick, mascara, and/or blush.” No hair-dye is allowed, and men must remain clean-shaven. Men and women may say “hello” and “goodbye” to each other, but are prohibited from having personal conversations that are unrelated to work.

Participants remain “residents” until they have spent twenty-one months in the program. However, they earn more privileges at the one-year and eighteen-month marks. After one year, residents are allowed to play computer games and card games. They may change the channel on the TV if they are off-duty (from work). They participate in a “24-
hour game”—an intensive and comprehensive accountability session that lasts twenty-four hours. They may attend one outside class, usually at a local community college, as long as they have received their GED or high school diploma. Men must remain clean-shaven. No resident is allowed to dye her or his hair. Women may wear perfume and add foundation to their list of allowable makeup. Two residents may submit a proposal to date in-house, but only on the premises. Residents can submit a proposal for a home visit (with an organizational chaperone). They may do their own laundry.

At eighteen months, women are allowed to dye their hair, and men can submit a proposal to grow a mustache. They are allowed to carry up to $30 of spending money to be used at their discretion. Staff members allow residents to submit a proposal to date outside the program at this point. Residents who are married or in a steady relationship when they enter the program must submit a proposal to resume regular contact and interaction in those relationships. They may leave the premises with graduates who are in good standing with the organization.

After twenty-one months in the program, residents go on “workout.” During this phase, they look for a job outside SATH. They can submit a proposal for a clothing upgrade to aid in their job search. They must submit a daily itinerary to the Aftercare Coordinator. Even after finding employment, the resident must continue to sign in and out daily. Paychecks are turned over to SATH, and monies are placed in a non-interest-bearing account (SATH does not make a profit from the residents’ earnings outside the organization). The money is held until the resident graduates. Residents in this phase attend one group meeting a week. They may submit a proposal to purchase a car from SATH for $1000.
At two years, the residents officially graduate from the program. If approved, they may remain at SATH in transitional housing and use transportation provided by the organization. If they do so, they must attend one relapse-prevention group meeting a week. Transitional housing is available for up to one year. Graduates are encouraged to attend events and eat at SATH, maintaining close ties for support and ease of transition. They must follow a good “code of conduct” to remain in good-standing and have access to SATH functions and events.

During their time in the program, residents must work. SATH operates five businesses, which largely fund the organization: a moving company (Mocom), a landscaping company, a construction company, a catering company, and a framing shop. Residents may also work in the motor pool as mechanics, on the premises as security officers, or as workers in any of the administrative offices in the organization. Residents work long hours. During peak moving season, it is not uncommon for residents to arrive at the moving warehouse at six in the morning and not return until after eleven that night. They receive no pay or overtime. Because SATH did not receive state or federal monies for most of the time I conducted research, it relied on its businesses for support of programming and day-to-day operations. Over the course of my research, however, administrators took SATH through the process of gaining licensure due to pressure from state licensing agencies and in order to have access to state and federal monies. The biggest income generator was the moving company, and most residents spent at least some of their time at SATH as Mocom workers.

There were approximately forty-five staff members and three hundred and seventy residents in the program at any point during the course of my research. Staff
members were split between, in the parlance of the organization, the “people-staff”—those dealing specifically with the mental and physical health of the residents—and the “business-staff”—those coordinating or contributing to the five income-generating businesses. SATH’s internal literature highlighted its work on education, communication, peer counseling, mentoring, leadership training, and aftercare.

Gaining entry to SATH

I first learned of SATH years ago when I saw one of their moving trucks on the highway. I was surprised to see that the name on the back of the truck identified the movers as a “substance abuse” treatment center. This was no usual moving company, I thought. Later, I knew of people who hired Mocom for personal moves, and they had positive experiences. They also said they felt good about supporting a group that provided job skills and opportunities to people trying to get their lives back in order. Then, an acquaintance in a helping profession did an internship at SATH. She had mixed things to say about her experiences, and I was intrigued.

When it came time for me to select a site for my dissertation research, I considered a few options. Knowing that I was interested broadly in issues of identity and inequality, SATH came to mind. I had not looked deeply into issues of “addiction” in the United States, but I knew that patterns of drug use, and especially patterns of incarceration related to drug use, reflected broader patterns of race, class, and gender inequality.

I contacted the acquaintance who had interned at SATH. I told her of my interest in doing an ethnographic study of the organization, and she offered to get the ball rolling.
She emailed James Carter, the founder and president of SATH, and vouched for me. He emailed me to set up a meeting to discuss the possibility of my doing a project there. We met for two hours, and he talked throughout most of it in what I would come to learn was his signature stream-of-consciousness, profanity-laced style. From my fieldnotes:

I honestly cannot map out our conversation as it was all over the place. We talked for roughly two hours, and I may have said ten to fifteen minutes worth of words during that time. James had said “shit” and “fuck” within the first minute of the talk, and continued to do so throughout. He was quick to laugh, and his brown eyes had a seeming twinkle that made him appear as if he was “up to something” or about to crack a joke.

In our meeting, Carter relayed much of his personal story of drug use, jail time, and treatment in a TC. He expressed to me that his story informed his work at SATH. After two hours of talking, he said, “[Your acquaintance] told me you were a good guy, and that’s enough for me.” He didn’t want to know anything about my plans for the research, but told me to talk to lots of people to get lots of perspectives. He said I should have “carte blanche” to get the “real” story. As the substantive chapters in the dissertation will reveal, Carter maintained strict control over all aspects of the program. He never said no to any of my requests, but he did require his approval for every interview that I conducted and every email I sent to staff members asking for programmatic details. At the time, I was surprised that Carter agreed so readily to let me begin the project. However, I came to learn that “loyalty” was of the utmost importance to him. That I had been vouched for as “good guy” by someone he trusted was indeed “good enough.”
Data Collection

From April 2006 to October 2007, I conducted six to twenty hours of fieldwork per week at SATH. I continued my involvement with the agency after that, more as a peripheral observer and through interviews, until September of 2008. In addition to numerous informal interviews (Lofland et al. 2006) conducted with staff members and residents, I completed twenty-two in-depth, semi-structured interviews. The interviews ranged from thirty minutes to two and one-half hours in length. I cast a wide net in seeking interviews, eventually sitting down with the founder and President of SATH, current staff members, residents, staff-in-training (SIT’s—graduates of the program asked by existing staff members to stay on with the organization), a former staff member, and a former resident.

My participant observer roles varied: I filed papers in the In-Take and Finance offices; I rode along in Medical Clinic transports; I assisted in a records-review in the In-Kind Donations office; I worked a fourteen-hour shift at a Christmas Tree Lot run by SATH between Thanksgiving and Christmas; and, I worked as a crew-member with Mocom. Additionally, I sat in on men’s “games” (resident-run group accountability sessions, described in more detail in Chapter III), “groups” (mixed-sex support groups for residents transitioning into positions of greater responsibility or into “staff-in-training” or “post-graduate” roles), residence hall management sessions (evening meetings between residence hall managers and residents), and clinical meetings (meetings for staff members offering clinical services and support to residents). I attended and assisted with four graduation ceremonies and participated in some holiday celebrations. I also practiced with SATH’s jazz and blues band and attended and helped out with six band
performances. The largest chunk of my time was spent working in Mocom on local moves with a crew of residents ranging from three to fourteen people. Moves started at 6:30 a.m. and finished between 7 p.m. and 11 p.m.

Working on moves proved to be important for gaining deeper access to the organization. By working and sweating alongside the residents and some staff members, they started to open up more. Tommy, a staff member who worked in Mocom, said the following about me to James Carter backstage at a graduation ceremony: “I love this guy. We were on a move and we were out there for sixteen hours. I told him about half way through, ‘You can leave if you want to.’ But, he said, ‘Nah, I’ll stay and work.’”

Given the strict regulations governing interaction between men and women, the majority of my fieldwork focused on interaction with, between, and around men. I attempted to introduce myself to a female resident while working on a move one day. Looking frightened, she peered over both shoulders to see if any staff members were present before whispering to me, “We aren’t allowed to talk to one another.” I told her that I was not a resident, but a “student volunteer” who was writing a paper about SATH. She nodded and looked relieved, but then went back to work without continuing the interaction. Despite limited access, I did work alongside women in Mocom and some administrative offices, and I sat in on mixed-sex groups. In addition, I interacted with and interviewed some female staff members and staff-in-training.

I jotted notes, when appropriate, during fieldwork. Immediately following my time in the field, or the next morning following late-night events, I typed detailed fieldnotes. I also wrote “notes-on-notes” (Kleinman and Copp 1993), thoughts and reflections on analytic themes that I discovered in my fieldnotes. I audio-recorded and
transcribed all interviews. I coded my notes and transcriptions along the way and wrote analytic memos and freewrites to build my analyses (see Charmaz 2000). I used Atlas.ti Qualitative Data Analysis (QDA) software as a tool to address emergent themes, questions, and analytic issues.

**Symbolic Interactionism, Feminism, and Grounded Theory**

I approached this research from a symbolic interactionist (SI) (Mead 1934; Blumer 1969), feminist (Kleinman 2007), and grounded theory (Charmaz 2000) perspective. Symbolic interactionists view people as social agents interacting within specific contexts that inform the meanings that social objects hold for them. Circumstances and context shape interaction, but people can act back on them—we are both shapers and shaped. George Herbert Mead (1934), for example, highlighted structural constraints (the usual fare for sociology) as well as individual agency:

…we must not forget this other capacity, that of replying to the community and insisting on the gesture of the community changing. We can reform the order of things; we can insist on making the community standards better standards. . . . [O]ne is continually affecting society by his [or her] own attitude because he [or she] does bring up the attitude of the group toward himself [or herself], responds to it, and through that response changes the attitude of the group (168, 180).

As a symbolic interactionist fieldworker, I notice patterns in speech, emotions, interaction, meanings, and identities, and I view all of these things as social products. Human behavior, as Herbert Blumer (1969) argued, is a “vast interpretive process in which people, singly and collectively, guide themselves by defining the objects, events
and situations they encounter” (132). Rooted philosophically in pragmatism (see Dewey 1929/1984), symbolic interactionism views society as “an emergent process continuously produced by human beings” (Shalin 1991:221). Interactionists, then, highlight the dynamic interplay of structure and agency (Strauss 1997).

As a feminist ethnographer, I strive to connect interactionist concerns to the reproduction of race, class, and gender inequality as well as to strategies of resistance (see Kleinman 2007). Entering the field, I knew that I was interested in interactions informed by, and consequential for, broader considerations of racism, sexism, class inequality, heterosexism, and so on. I also knew that as a young, middle-class, white, male, graduate student, I approached participants in this particular setting from a position of substantial relative privilege. Trained in grounded theory, however, my perspective and structural location did not determine the themes and analysis of the data, which emerged inductively. My perspective served as a jumping off point (Charmaz 2000). Given the demographics of the resident population of SATH, I expected to find a “race, class, gender” story. But I could not have anticipated the findings or the analysis that follow. As Dmitri Shalin (1986) argues:

The solution to the problem of the integrity of science implicit in pragmatist premises is not in ridding science of ideological biases, but in spelling them out, turning them into acknowledged premises, and letting the audience judge how these might have affected the inquiry (26).

By recognizing my perspective and concerns, I could check how my expectations might influence ongoing analysis. And, my readers have more information with which to make their own judgments.
A note on terminology

Although the graduated stages for individuals progressing through SATH are associated with a variety of names (interns, freshman, residents, etc.), I use “residents” unless the person’s stage is relevant for analysis.
END NOTES

1 All names of people, places, and organizations are pseudonyms.

2 http://www.hbo.com/addiction/

3 http://www.aetv.com/intervention/index.jsp

4 http://www.vh1.com/shows/celebrity_rehab_with_dr_drew/season_1/series.jhtml

5 No resident is required to stay at SATH in the sense that any resident can choose to leave at any time. However, given that one-third of the residents were probated to the organization, sent as a way to avoid incarceration, if they “chose” to leave there were serious repercussions.
REFERENCES


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Erving Goffman (1961) defined total institutions as organizations in which “a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life” (xiii). His landmark study exposed what he called the “mortification of the self” (28)—the stripping away of the self tied to the outside world so that an “inmate” is defined solely by and through the institution. His concept of total institutions included mental hospitals, prisons, concentration camps, monasteries, and Navy ships. Highlighting social arrangements likely to produce conformist behavior, Goffman argued that total institutions “present themselves to the public as rational organizations” but function more often as “storage dumps for inmates” (74).

Goffman intended his description of total institutions to serve as an “ideal type” (5), a description of common features from which particular cases might deviate. Therapeutic communities (TCs)—residential programs for people struggling, most often, with problems of drug use—vary in social organization, but generally fit the model of total institutions as described by Goffman. For example, residents (“inmates”) are insulated from the outside world and are expected to undergo a reformulation of the self; organizational rules govern all aspects of daily life; and, staff-resident interaction tends to
be confrontational and promote social control (see De Leon 2000 for an overview of the traditional TC approach to treatment).

TCs maintain a clear division between staff and residents, as Goffman (1961) suggests is characteristic of total institutions. However, the majority of TC staff come from the ranks of former residents, and this circumstance is not typical of total institutions. It is hard to imagine a prisoner promoted to the status of “guard” or a patient in a mental hospital promoted to the rank of therapist (Davies 1989). Moreover, many TCs are time-bound organizations, meaning that residents enter for a specific and fixed period of time. Although there is an historic trend in the TC movement to “break down” (mortify) the existing self, the stated purpose of such organizations is not to serve as a “storage dump,” but to “build up” a new self that is prepared to re-enter society (De Leon 2000). A TC may achieve this stated purpose to a greater or lesser degree.

Traditionally, the focus of “treatment” in TCs is the individual, with an emphasis on personal responsibility. “Addiction” reflects poor decisions on the part of the “addict,” and recovery lies in taking responsibility for one’s actions and decisions. Treatment in this focus tends to be aggressive and confrontational. In this chapter, I analyze the implementation of the traditional TC approach to treatment in a specific therapeutic community I call SATH (Substance Abuse Treatment Headquarters). When a small group of staff members attempted to introduce an alternative method of treatment based on empathic listening instead of the aggressive “shaming and blaming” techniques of the traditional TC approach, the other staff were put in the position of accounting for the traditional methods. In a contribution to our understanding of TCs and total institutions, I argue that staff members justified the use of the TC approach by (a) defining addicts as
personally irresponsible, (b) construing them as manipulative liars, and (c) claiming personal authority for themselves as former/recovering addicts (and as former residents at SATH or another TC). Further, I show that although the staffs’ rhetoric centered on “personal responsibility,” the organization left little room for it among the residents. I argue that the extreme focus in the organization on compliance and social control constrained the moral agency of the residents, a finding with implications for the residents’ lives following graduation from the program.

**THERAPEUTIC COMMUNITIES**

Modern therapeutic communities (TCs) are organizations in which people come together to live and participate in group-based efforts to address substance use and mental health “problems.” Therapeutic Communities of America (2008), a non-profit consortium representing over 650 TCs, notes that “[t]he primary goal of a Therapeutic Community is to foster individual change and positive growth … by changing an individual’s life style through a community of concerned people working together to help themselves and each other” (para 5). Although no organization was specifically identified as a “therapeutic community” until the 1940s (see Main 1989), people have been living in groups with the goal of fostering some type of growth or healing for most of recorded human history. George De Leon (2000) is perhaps the most consistent advocate for, and voice of, the traditional TC approach to the treatment of drug use problems in the United States over the last thirty years. Serving as the Director of the Center for Therapeutic Community Research, he is a long-time researcher and practitioner in the TC movement. In his book outlining the theory and method of TCs, he argues that the prototype of the modern TC
can be found in ancient civilizations that focused on “diseases of the soul” with an eye toward treatment in communities of healing (14). Michael Bloor, Neil McKeeganey, and Dick Fonkert (1988) outlined the development and range of TC approaches to treatment starting with “foster family communities” (14) in the year 1250 and moving through the modern era approaches found in halfway houses and hospital centers.

TCs have dealt with a range of mental and physical health concerns. Treatment of substance use problems, “addiction,” is a common feature of many modern TCs (see NIDA n.d.). Such programs emerged out of the work of the Oxford Group in the early 1920s, Alcoholics Anonymous (AA) in the 1930s, and Synanon in the 1950s (see De Leon 2000). The Oxford Group was an explicitly Christian organization and religious movement intent on curbing “spiritual erosion” (15). Although it did not focus specifically on issues of drug use, alcoholism was viewed within the movement as a sign of spiritual and moral failing. The group stressed “the work ethic, mutual concern, sharing guidance, and evangelical values of honesty, purity, unselfishness and love, self-examination, acknowledgement of character defects, making restitution for harm done, and working with others” (15) as the keys to salvation. The founders of AA, Bill Wilson and Bob Smith, were early members of the Oxford Group, and the focus in AA on self-examination and restitution for harm emerged from that experience.

Synanon was a drug rehabilitation program that started in California in the 1950s. It remained active in drug use treatment for several years. In time, leaders claimed the group was a religious organization in order to gain tax-exempt status. Tactics and procedures in the organization changed, becoming increasingly violent, and Synanon lost tax-exempt status and then was forced to close due to bankruptcy from IRS charges in
Like the Oxford Group, both AA and Synanon are spiritually oriented, but neither organization requires participants’ belief in a Christian god. All three organizations—the Oxford Group, AA, and Synanon—emphasize a strong work ethic, the importance of the individual’s admission of loss of control over a substance, making amends, seeking help from a higher power (the Christian god, the community itself, or the individual’s interpretation of a “higher power”), and a personal conviction to change. These features form the bedrock of the modern TC.

The therapeutic approach of the modern TC makes the community itself the method of treatment for the individual: “Community as method means teaching individuals to use the context of a community life to learn about themselves” (De Leon 2000:93). This approach evolved out of the work of Synanon. Synanon broke with AA’s approach by addressing problems with drugs other than alcohol and by moving beyond maintaining sobriety. In Synanon, and in the modern TC, the goals of treatment are lifestyle changes that only begin with sobriety. The focus of treatment, hypothetically, is not drug addiction, but the whole person. Drug use, from this approach, is a symptom of a deeper problem with the person. And the point of the community is to change the individual.

**THE TC APPROACH IN ACTION**

The demands of the modern TC—making amends, admission of a loss of control, a conviction to change—are anchored in personal responsibility. What does this look like in practice? At SATH, TC treatment was aggressive and confrontational. Many of the residents described the approach to me as “tear you down to build you up.” Several staff
members called it “shaming and blaming,” and one noted that the goal was to “shatter the person entirely.” As I will discuss in Chapter III, this approach was on display during the male residents’ “games,” group-based and resident-run accountability and free-association sessions that served as the residents’ primary form of treatment. It was also evident in staff-resident disciplinary “interventions.” For the men in the program, interventions usually took place in “the Blue Room,” a room in the men’s main residence hall into which residents were called following rule infractions. In an interview, Malcolm, at the time a recent graduate of the program, described the interactions in the Blue Room:

> It’s done by a really aggressive approach most of the time. Not all of the time. A lot of the time, it’s a really aggressive approach, kind of. When they [residents] have reached that point, a lot of times they have broken a rule, so they have to be held accountable. So, they’re kind of like the ones that wasn’t listening to what has already been offered, so [staff are] kind of, not having to force it to [the residents], but having to be more aggressive with them. Letting them know that there are consequences [pause] in life. You know, there are consequences here, there are consequences in life. Some people get it easier than others. So, therefore, in a Blue Room setting, for this therapeutic community, it’s kind of like you have to force that and have strict rules for it all to work.

Although Malcolm opened his explanation by hedging on the level of aggressiveness in the disciplinary interactions (adding “kind of”), he closed with strong language (“you have to force that and have strict rules”). As I will discuss later, strict rules were an important feature of the organization.

The extreme version of the TC approach to treatment occurred in an aggressive form of “verbal corrective” known as the “haircut.” This practice serves as a degradation ritual (Garfinkel 1956) in TCs—a ceremony in which an individual’s status is demeaned
and lowered in the context of a group. According to De Leon (2000), haircuts are the most severe form of verbal reprimand in the TC. They are planned and orchestrated by staff members “for repeated negative behavior or attitudes” (220). The traditional format of the procedure is as follows: a resident is called before a group of peers and staff members in order to be yelled at for a period of time about the behavior in question. The resident is not allowed to respond. The public performance of the haircut is intended to “maximize the vicarious learning concerning community expectations” (221), setting an example for the other residents. The reprimand is often harsh, but the content “should remain illuminating and instructive” (221). The name “haircut” comes from the early use of this reprimand in the modern TC movement, in which the “verbal corrective” would be followed by the shaving of the resident’s head. The shaved head could then be used as a stigma and cautionary example for residents not present at the performance.

Staff members told me that they were trying to move away from haircuts as an organizational procedure. Tina, a former resident and staff member working in the Women’s Program, noted in an interview: “The one tactic that we don’t use now—we really used to blast people and give people haircuts, which were [using fingers to make quotation marks] ‘verbal correctives’ that were really aggressive and could be demeaning. I never really liked that.” In practice, though, some staff members still used them. Even Tina went on to say, “But, you know what, sometimes—sometimes, depending on who it is—that’s helpful.” Other staff members made light of the continued use of the practice. In a Clinical Meeting, a meeting for staff members who worked with residents beyond the resident’s vocational work and training, a staff member mentioned using a disciplinary procedure called a “strong pull-up.” Another staff member asked
what this was, and Janice, who worked in the Women’s Program, responded, “I think a strong pull-up is telling [residents] what the rules are and giving them a haircut—excuse me, giving them a [using fingers to make quotation marks] ‘verbal corrective.’ I learned that from you, Rocky! If we’re talking to outsiders, it’s a ‘verbal corrective’” (people laughed). Although perhaps less frequent than in earlier times, the haircut was far from a thing of the past.

From residents’ reports and my own observations, the format of the haircut rarely followed the prescribed method outlined by De Leon. Haircuts appeared unplanned by the “haircutter,” arising instead out of a moment of frustration. The “negative behavior,” from my observations, need not have been “persistent” to warrant the haircut. Residents reported feeling publicly shamed and embarrassed rather than “corrected”—they did not report a lesson learned. John, a former resident who worked as staff-in-training (SIT), told me that SATH founder and president James Carter once mistook him for a resident at a distance and, in front of a crowd of people, gave him a haircut for a rule infraction Carter believed the resident had committed. John was angry and embarrassed. Carter realized his mistake, but turned and walked away, never apologizing. Years later, John was still angry.

A staff member mistook me for a resident in one situation and gave me a small version of a “verbal corrective.” On my first day with Mocom I was working on a large job that involved moving a corporate warehouse. I dressed like all the residents, in a Mocom t-shirt and blue shorts, and, with my shaved head, I did not stand out. I arranged this work over email with one of the high-level Mocom administrators, Ray, who had graduated years earlier, along with James Carter (also a “recovering addict”), from
Recovery Place, a TC in another area of the country. I was using a pallet-jack to move huge bundles of equipment and merchandise from the warehouse into a large trailer. A man I did not recognize, wearing khaki pants and a blue collared shirt, approached me. I assumed that he worked for the corporation, and he asked me something that I couldn’t hear above the squeaking wheels of the pallet-jack. I stopped and asked for clarification. He asked me, angrily, if we were loading the trucks. I said that we were, and he screamed at me that we needed to “get them moving.” I thought he meant the trucks themselves, and, because I wasn’t sure how or when the trucks would be moved, I turned around to see if I could locate one of the drivers to answer his questions. He exploded, yelling at me that I was incompetent. Caught off-guard, I stared back at him silently for a moment. He screamed, “Don’t just stand there, get that on the truck! We’ve got to keep a pace going! You can’t just stand around!” I said, “Yes, sir,” not wanting to upset one of the corporate employees who had hired SATH for this work, and I pushed the pallet-jack toward the loading bay.

I felt embarrassed and angry as I got back to work, thinking, “You just earned a spot in my fieldnotes, buddy.” As I placed the cargo in the truck, I heard the man’s voice behind me. To my surprise, his voice now sounded cordial and apologetic: “Hi Matt, I’m Ray. I just learned who you are. Thank you for helping us out today.” I told him it was my pleasure to help out. For the rest of the day, he bent over backwards to be nice to me, showering me with compliments for how hard I was working and how quickly I had learned to operate the machinery. After relating this experience to a “straight” (non-addict) staff member with a background in Public Relations, she compared it to the typical haircut in the organization: “Take that and magnify it by about a thousand—and
I’m not exaggerating. It’s totally understandable how someone could hear that and want to come back with aggression: ‘Who do you think you’re talking to?!’” Tear you down to build you up, shaming and blaming—these aspects of the traditional TC, while reportedly on the decline, were still very much a part of staff-resident interactions at SATH.

JUSTIFYING THE TC APPROACH

As I will discuss in detail in Chapter IV, during my study a small group of staff members with professional degrees attempted to implement an alternative therapeutic approach to the TC model, based more on empathic listening and a technique known as the “Motivational Interview” (MI). The TC approach remained dominant in the organization, but in the face of an alternative approach presented to them by people with formal credentials, the non-professional staff members were put in the position of accounting for their continuation of traditional methods. They justified the use of “shaming and blaming” techniques by (a) defining addicts as personally irresponsible, (b) construing them as manipulative liars, and (c) claiming personal authority for themselves as former/recovering addicts.

Addicts as personally (ir)responsible

George De Leon (2000) notes that “addiction,” in the traditional TC view, is a physical, emotional, cognitive, and behavioral process. It involves an “escalating tolerance for the drug of choice” in addition to emotional and behavioral “preoccupation with drug use” (42). Beyond this, addiction is viewed as an indicator of a deeper problem within the individual: “[A]ddiction is a symptom, not the essence of the disorder. The
problem is the person, not the drug” (48). Instead of a resident having a problem with cocaine or alcohol, that resident presumably has a problem with behaviors, values, and a self-defeating lifestyle of which drug use is only a part. Addiction, then, is a “disorder of the whole person” (37). This view focuses attention on “how individuals behave, think, manage emotions, interact, and communicate with others, and how they perceive and experience themselves and the world” (49). The disorder presents as a life in crisis, the inability to maintain sobriety, social and interpersonal dysfunction, and an antisocial lifestyle. The focus of treatment is on getting residents to take responsibility for their decisions and actions; and, residents are expected to take ownership of the role they play in perpetuating the problems in their lives. The social and material circumstances of someone’s life may be beyond their control, but “they are responsible for their actions and for the choices they make, particularly with respect to drug use” (41).

The framing of addiction as a “disorder of the whole person” puts the emphasis of both substance use and treatment on personal (ir)responsibility. Reflecting this, residents at SATH were encouraged to take responsibility for their actions and decisions. This was reflected in the views of the residents and former residents I interviewed. When I asked what was essential for succeeding in the program, they all noted some version of the concept of personal responsibility. Malcolm, who started drinking at the age of eight, and who moved from being a resident to a staff member during my research, answered the question quickly: "honesty and accountability." He reflected on this:

Oh yeah. It’s kind of amazing how it’s such a complex thing—addiction and recovery—but, to sum it up with just a couple of words, that’s amazing to me. But, really, that’s all that it is [honesty and accountability]. And, I think that’s the key to just being successful, period. It’s not that hard.
John, a former resident and staff member working with the Aftercare Program (providing services and support to residents following graduation), also emphasized honesty as crucial to recovery:

[T]o recover, you’ve got to be honest. You have to be so honest to the point that you’re honest not just with others but with yourself, so that if you’re faced with something that you know you can’t handle you’ve got to say, “I can’t go over there,” no matter how bad you want to go. It could be your girls sitting there wanting you to come over. If you’re an alcoholic, there’s no way you can go sit over there with them and have a good time. It’s impossible. You have to be just that rigid with yourself. And a lot of people think that they can still go out and hang out in those places. But you cannot do it. You have to change the way you look at things, your whole set of behaviors and life. People think, “Well, I’m never gonna pick up [use drugs] no more.” But what are you going do about those behaviors you’ve been doing since before you came into SATH. That’s what you’ve got to change. It’s not about the drugs.

Regardless of the circumstances of the resident’s life, treatment at SATH focused on the residents’ acceptance of individual responsibility. Discussing a childhood in poverty or life experiences with violence might help a resident make sense of their drug use, but it was not acceptable as an explanation for their behavior. At a Memorial Day observance, Wilson, an older resident with fifteen months in the program, told me:

Some of the folks here had hard lives from the get go. Some started using when they were just kids. Some were abused. Sometimes they’ll use that as an excuse…[Y]ou’ve got to do what you can with where you are.
In the SATH view, the conditions of a resident’s family life or other circumstances may have been beyond their control, but the residents were responsible for the decisions they made in those circumstances.

The emphasis on personal responsibility was also reflected in staff members’ accounts of “recovering addicts” who had quit using drugs but began again—individuals who “relapsed.” For example, Ricky, the head of the Men’s Program, explained relapse as the result of seemingly small decisions that could have dangerous repercussions down the road:

Your relapse happens a long time before you ever pick up drugs. It happens way before that. Picking up is just the end result. That stuff happened a long time ago. You made a compromise somewhere, you know, that changed everything. I always tell ’em about a poem I used to know. It's called “The Nail,” you ever heard of it? I can't remember who wrote it. I read it when I was in prison, but I can't remember who wrote it. But it goes:

For want of a nail
The shoe was lost.
For want of a shoe
The horse was lost.
For want of a horse
The knight was lost.
For want of a knight
The battle was lost.
And so it was that a kingdom was lost,
All for the want of a nail.

You know what I'm saying? So, I tell them, you know, one blacksmith puts five nails in the shoe instead of six, something he thought was so small and insignificant! You know? And that let loose a chain of events that destroyed a kingdom.

For Ricky, this highlighted the importance of following the rules: “Nothing is small, no compromises. If it needs six nails, you put six nails. You know, that's the bottom line.”
Ricky’s comments, which came in an interview, reflect the centrality of rule-following in the TC approach to the path of sobriety. Relapse, in this view, is the result of compromises and cutting corners. Demanding that residents follow the rules was a common focus of staff-resident interactions. One evening, Jack, a “re-start”—a resident who had gone through the program before, left or graduated, used drugs again, then returned to SATH—was brought into the house-managers’ office because he had made coffee in the resident meeting hall without staff approval. Rocky, one of the house managers, addressed him:

“Isn’t there a sign right there that says something about the coffee-makers, man?” demanded Rocky.

“Yeah,” said Jack.

“And what the fuck does it say?” demanded Rocky, angrily.

“Kitchen staff only.”

“That’s right,” said Rocky, his voice rising in intensity. “I don’t care if you do know how to make it, there’s a sign right there telling you that you’re not supposed to do it. You may think you know something about being here because you’re a re-start, but you’re at the same damn level as every other intern, man. Nobody sees you any different. You got to start right where they are. Do you understand? Man, you didn’t learn anything or you wouldn’t be here now! You missed something! You missed something! If you go through this program and you take it seriously and do everything you’re supposed to do, there is no reason that you shouldn’t stay clean.”

“I didn’t miss anything, Rocky, I just wanted to get high again, that’s all,” explained Jack.

“But you wouldn’t do it if you hadn’t missed something the first time, do you understand?” demanded Rocky.

“Yes, sir,” said Jack, staring at the floor.
This example highlights the “shaming” and the “blaming” of the traditional TC approach. For Rocky, that Jack started using drugs again was evidence of Jack’s bad decisions. Jack had to come back to SATH not because he had re-entered the structural conditions that enabled his pattern of drug use previously nor because he had encountered personally difficult situations. Rather, Jack’s “problem” was that he “didn’t learn anything” his first time through. Jack shouldered all the blame. Note that Jack resisted Rocky’s framing of his personal failings, but still took responsibility for using drugs again: “I just wanted to get high again, that’s all.” But Rocky rejected Jack’s mea culpa at face value, and shamed Jack further. It was not enough for Jack to accept responsibility for his drug use; Rocky wanted Jack to accept personal responsibility for having failed to learn the lessons of the organization.

The example of Jack making coffee exposes another important aspect of the TC approach to treatment: the importance of rigid rule-following in the implementation of the “disordered person” frame. Jack made coffee despite a sign clearly stating that he was violating a rule in doing so. It doesn’t matter that he may have made coffee many times before. He may even have made a better pot of coffee than the kitchen staff. To do so was a violation of the rules and, more than that, a sign of Jack’s personal shortcomings as an addict, i.e., as a person. This “small” decision was viewed as a reflection of his bad (and more consequential) decisions on the outside.

Addicts as manipulative

In addition to thinking of residents as personally irresponsible, staff members labeled the residents ("addicts") as manipulative liars. Staff used this frame to further
justify the “shaming and blaming” approach to treatment. For example, John said bluntly: “Addicts are some of the most manipulative and conniving people you’d ever want to meet.” And Malcolm, a former resident who worked as a staff member in the Medical Clinic with Mary, a “straight” (non-addict) staff member, commented on the different ways that they were able to relate to residents: “[T]here’s a lot of things that I can pick up on, that she doesn’t, because she doesn’t have that in her, that characteristic of being an addict—you know, being a liar and manipulating the rules.” And Mary, for her part, hesitantly used such rhetoric herself. When I asked her what the hardest part of coming to work at SATH had been, she paused and then replied: “The hardest piece of it for me [pause] has been regularly [pause] working with people who [pause] are likely to be [pause] manipulating a situation.” Mary, who had worked in the rape crisis movement—a movement built on empathy for victims/clients—prior to joining SATH, struggled against the TC staff’s belief that all the residents were essentially manipulative. Instead, she painted them as people who might situationally engage in manipulative behavior.

Most of the staff members, though, had no such hesitation. Similar to the bill collectors Hochschild (1983) studied, who called up images of debtors as “loafer” and “cheats” (143) in order to curtail feelings of sympathy that could impede their ability to do their work, TC-oriented staff at SATH cultivated feelings of distrust and anger toward the residents. Staff members told me that residents would try to “compromise” their programs and “take shortcuts.” One told me emphatically not to trust anything a resident said to me. Tommy, a staff member who worked in Mocom, said the following after we passed a resident in the parking lot: “I like that guy a lot, but he’s a slimeball. He’s really nice, but he’s lazy and he’ll try to pull one over on you every chance he gets.” And, in
speaking about Mary, Tommy dismissed the empathic approach to treatment endorsed in professional schools of counseling and social work, stating that being “nice” was contrary to the TC approach:

I like Mary a lot, and she’s very nice, but I can tell you right now that the residents try to walk all over her. She comes from a social work background, and she wants to help and be nice, but you just can’t do that too much here. And it can be hard, because sometimes you know that they’re telling the truth, or you think that they might be, but you just don’t know. You have to approach everything with skepticism.

In this account, residents could not—and thus should not—be trusted.

I was in a different position at SATH than the staff members, but I never had an experience with a resident in which I felt manipulated, nor learned later that I had been. Staff’s reference to manipulation came up so often during my research that I asked Malcolm for an example. Again using Mary as a foil who did not “pick up on” the manipulation of addicts, he provided the following example, quoted at length:

A male resident came to [Mary] recently and he, uh, he claimed that he hurt himself. He was trying to get bed-rest [a medically necessary reprieve from work]. And, me and Mary, we didn’t give him bed-rest, we told him to continue working and push through, and later on in the day we would, we’d go from there. And what brought us on to that decision was his behavior here lately. Like, he’s been starting to go backwards instead of going forwards. He’s accumulated a lot of time in the program, but he’s starting to go backwards instead of forwards. And, uh, so, later on that day when I had left he waited and then came at her. He, he waited till I wasn’t here, because when I was here earlier that day he seen the result. So, he come at her and she told him he could go on bed-rest after five o’clock. So, he told her, “Well, okay, but you don’t have to,” you know, he’s like, “I don’t have any house responsibilities,” you know, he’s got almost twenty-one months in the program. So, he technically wasn’t put on bed-rest. But, he was telling her this because, uh, he was saying that he may have to go to a hospital. But, all along, he was only telling her this
shit because he had hours [of disciplinary work] to do, and he was trying to get out of doing those hours, right? But, he smoked, and he knew if she put him on bed-rest he couldn’t smoke. So, he was trying to manipulate her into saying that he could go home, that that was not a problem. So, he worded it a little different so that he technically wasn’t on bed-rest so he could continue to smoke. So, he got bold about it and went to S-North to get his cigarettes. And, he’s not even supposed to smoke for twenty-four hours while he’s on bed-rest. He manipulated that, thinking that he could slide by. And, one of the house managers caught him, they seen him. Then he came in saying, “Malcolm and Mary put me on bed-rest, I can’t do my hours.” But, then when it all come down, to where she said, “Okay, so I’m going to give you hours for not following your bed-rest orders.” Then he said, “Oh, but I wasn’t on bed-rest, you didn’t put me on bed-rest.” So, I helped her to see through what he really wanted. She didn’t really pick up on that. I was able to dissect if for her.

To summarize this example, the resident in question was attempting to get permission from staff to avoid work (by getting a designation of being on bed-rest) without losing his rights to smoke (by avoiding the official bed-rest designation). This is an example of a “contained secondary adjustment” (Goffman 1961:200), an attempt by an “inmate” in the total institution to “work the system” for some personal gain. In the face of the pervasive control of the residents, such attempts are to be expected and are understandable. In Malcolm’s account of the episode, though, the resident was sneaky, lazy, and untruthful, characteristics that reflect irresponsibility. He saw this example as emblematic of SATH residents’ behavior.

Were the residents manipulative liars? Arguably, many of them had relied on manipulation and deceit as coping and survival strategies in the course of their drug use. Some of them, like the resident Malcolm described in his example, may well have used such strategies as coping resources at SATH—particularly in an attempt to maintain a positive sense of self. This would be unsurprising in the face of aggressive and belittling treatment from staff members, or as an attempt to exercise some semblance of autonomy.
in the face of the all-encompassing rules of the organization. As noted, such attempts to “work the system” are not uncommon in total institutions (Goffman 1961). Yet, any “inmate” who resists or questions the rules is cast as “manipulative” in that context, and that label, in turn, is used by staff to justify the methods of social control to which the “inmate” reacted in the first place.

Regardless of whether residents at SATH were “manipulative,” staff members’ construction of the addict as a manipulative liar served as a form of emotional labor (Hochschild 1983) that supported the traditional TC approach to treatment. If the staff members empathized with the residents, if they saw the residents’ personal decisions in light of the subordinated structural conditions in which almost all of them grew up and lived, or if they were “nice,” their ability to “shame and blame” the residents might have been compromised. Moreover, because the majority of the staff members were former residents at SATH or another TC, labeling addicts as essentially manipulative justified the belittling treatment they received at the hands of staff when they went through the program. Finally, this frame functioned as social control in the organization. If residents were “slimeballs” who could not be trusted, they must be controlled.

**Staff as (recovering) addicts**

The overwhelming majority of staff members at SATH were former residents. They did not rely solely on their structural role as staff in the organization in order to claim authority, as the wardens or guards in a prison might. Instead, they relied on their identities as “recovering addicts” to claim authority, using biography to demand deference and respect. Their authority claims also legitimated the use of the “shaming
and blaming” approach to treatment. Not only did they “know” that the residents were manipulative liars because they had “been there” themselves, they “knew” the TC approach “worked” because they believed it had worked for them. For example, in response to the introduction of the empathic approach to treatment, Colleen, the head of the Women’s Program, said, “Yeah, it’s hard to give up what worked for you!…[W]e all have been there and this is what worked for us. And so it’s really hard for us to not do it.” Whether or not the TC methods were the cause of the staff’s “success,” they used their identities as graduates of such a program to justify replicating the approach of total control and rule enforcement.

Personalized authority claims were central to the identity of the TC-oriented staff. SATH president and founder James Carter made efforts in our interviews, despite his conventional success in opening and running SATH, to distance himself from professionalized claims to authority. He joked with me in our first meeting that he “hustled” the local colleges for services and items that SATH needed and said that prior to opening SATH he had never raised money without a gun in his hand. He joked further that although he had never gone to college, he often put “MF” after his name. He said many people assumed it was for a degree, but if asked he would tell them it stood for “Motherfucker.” Speaking in an interview about a graduate student who had given a theoretical presentation on addiction to the staff, he distanced himself from the label “intellectual”:

It’s another world, you know, how she’s talking and using every goddamn word in the dictionary. And, I’d tell her, “What the fuck are you talking about?!” [laughs] “Why don’t you speak English?!” I said, “I don’t know all those words, you got to slow it down for me.” She’s a good person. But, that’s what I figure,
if I don’t understand something I just tell someone. And, I don’t think it’s bad, because then I learn new words, you know what I mean? But, I think, “God, these fuckers are intellectual.” I mean, not everybody, you talk normal. They have their little cocktail parties and, you know, they’re into this theoretical shit, which ain’t bad. But, it really trips—it interests me, actually, you know, because I haven’t ever been in those circles. So, I asked her once, “What do you think I am?” She said, “Intellectual.” I said, “Are you fucking kidding me? You’re really gone, I ain’t a intellectual at all!”

And, in one memorable and uncomfortable Clinical Meeting, Carter burst in during a discussion about “boundaries.” He was agitated and angry, and he shifted the discussion to the topic of new rules being created in the organization by the “professionals.” He derisively singled out Jamie, a School of Social Work intern whose summer placement was at SATH:

“Look, these rules get created, and we got no way to follow up on ‘em. It’s just like, MSW1—which means [said derisively] first year for those of you who don’t know—MSW1 has created all these fucking rules for In-Take this summer and she’s leaving us. She’s ain’t gonna be volunteering 20 hours a week to follow up on that.” He cut his eyes toward Jamie as he said this. She looked horrified and seemed to sink into her chair.

Jamie and other members of the field of social work and counseling, people with book knowledge, could “talk the talk.” In contrast, Carter’s claim to authority, and the claim of most of the SATH staff, was personal—they had “been there” and were now “clean.” The “dinosaurs,” as Carter referred to them, “walked the walk.” As Carter’s quotes point out, staff presented their personalized claims as not only a different form of authority to professionalized claims, but as a more legitimate claim. Henry, a graduate of the program who worked on staff in the office that processed donations to the
organization, compared SATH to one program he had gone through that did not use recovering addicts as staff members:

[The SATH staff] showed us, you know, you know, they showed me what you gonna do if you use drugs again. It wasn't all like that, but that's the difference between this program and a fifteen thousand dollar program that I went to—it was all books and reading and church every Wednesday….And, SATH shows you. They absolutely show you each and every consequence.

As I discuss more in Chapter IV, for the former “addict” staff members and many of the residents, street knowledge trumped book knowledge.

Henry’s comments reflect the ways that residents reinforced the legitimacy of staff members’ personalized claims to authority. For residents, it was powerful to see “addicts” who were now “clean and sober.” I asked Malcolm what helped him to commit to the program. He responded:

Hearing people, like James Carter, hearing other people that were as bad as me, succeeding [pause] because I'd used [drugs] my whole entire life, I thought that was it for me…So, really I picked up on several people, like Rocky—I was really able to key in on him. And, uh, and it'd give me hope, you know? I mean, hope that I could do it if I really wanted to. And then I just had to trust—which was the hardest part—trust that it could work for me if I listened to what they said, for a change, listen to what someone else said instead of trying to do it myself.

Malcolm then went further, highlighting the importance of the staff’s personal stories in convincing him to follow the organization’s rules without question:
So, I just had to say, “Alright, if this man tells me to get on top of my head and spin around, I will, because, you know, it worked for him. He’s bald-headed and loud [laughs], but he’s clean and he’s not in prison anymore, and it’ll work for me.”

Henry also talked about seeing staff members who had become clean as a powerful message of hope: “Even the president, he told us his story that made my addiction look like I was eatin' candy. And, look at 'em now, they're buying homes, they've got investments, they got families.” This highlights another way that the personal biographies of the staff members worked to justify the traditional TC approach: it allowed staff to claim in-group status as “addicts” without being dismissed for being “no better than” or “the same as” the “addict” residents because of this. Henry said:

James Carter can't be but four or five years older than me, and my supervisor is about four years younger than me. And, I still, it comes out of my mouth to say, “Sir,” or, “Mister”—it’s a part of respect, but it's also a part of [pause] I couldn't call my father by his first name, either. I couldn't call my father by his first name, either. And, that's what I look at those guys, that's what I look at, even—golly, if I could run off a staff member in his twenties. Even with Richard, the Caucasian guy?

[Interviewer: Yeah.]

Even with Richard, I have a respect as a father, because he was a staff member when I was a resident, and he taught me things (emphasis added).

Staff garnered the respect and deference conferred on “recovering addicts;” their status as “clean and sober” also justified the “shaming and blaming” methods.

This claim to authority through personal experience buttressed other aspects of the traditional SATH culture. As I noted earlier, personalized authority and the
expectation that residents follow rules without question were mutually reinforcing aspects of the organization. Beyond this, the personalized authority claims supported the normalization of anger and aggression in staff-resident interventions (it “worked” for them, and they replicated it). Finally, this all occurred in a total institution that forbade residents from challenging staff openly. Because staff members had “been there,” they’d earned a place beyond questioning, challenge, or reproach. Not raised by TC staff was whether a different approach might work better, a challenge put forward by the “professionals.” The content of the enforced rules didn’t matter to the “addict” staff (“if this man tells me to get on top of my head and spin around, I will”). All that mattered was following the rules.

ENFORCING RULES, ERODING PERSONAL RESPONSIBILITY

The importance of following rules was emphasized by both staff and residents.

Consider the following comments:

You have to really do this if you’re going to do it. You have to commit to the program and follow the rules, even the ones that don’t make sense. They’re there for a reason (Kenneth, former resident, staff member; fieldnotes from a discussion among staff and residents in the Mocom office).

I was [at another TC] for about seven years before I figured out that you have to just accept the program for what it is and follow the rules, even when they don’t make sense to you. At first, I would listen and say to myself, “Well, that [one] makes sense but that [one] doesn’t; I won’t follow that rule.” And that doesn’t work, you have to really be ready and willing to change, man (Tommy, staff member; interview).

I used to get in my feelings [feel overwhelmed by emotions] about the things I didn’t understand, and I thought it was all personal. But now I know that these
rules didn’t start when I got here. They were here long before me and they’ll be here when I’m gone. And, I know that there are reasons for the rules, even if I don’t understand them. So, now I just do the program and stay positive (Rodney, resident; fieldnotes of a one-to-one discussion between Rodney and me following a moving job; emphasis added).

Over and again, I heard from residents and staff members that the key to success in the program was following the rules. As the quotes above point out, this applied to rules that “don’t make sense” or that residents “don’t understand.”

The expectation that residents should follow the rules without question or exception exposes an ironic aspect of the implementation of the “personal responsibility” frame: it largely removed personal responsibility from the residents. Recall Malcolm’s comments concerning the authority claims of staff members: “I just had to trust…that it could work for me if I listened to what they said, for a change, listen to what someone else said instead of trying to do it myself” (emphasis added). Here, “personal responsibility” means doing what you’re told to do. This approach—built on the rhetoric of individual responsibility and accountability—robbed the residents of the opportunity to be moral actors and decision-makers. Carol Gilligan (1982) identified two orientations for moral decision-making. One involves morality through a lens of duty, obligation, and justice. The other views morality through a relational lens, considering the potential harm of a decision for oneself or others. At SATH, the focus on following the rules without exception could be viewed as a simplistic version of morality through duty: the morally “right” decision is to follow SATH rules. However, as Sarah Hoagland (1988) has argued, moral agency involves more than following rules:

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Choice is at the very core of the concept of “moral agency.” It is not because we are free and moral agents that we are able to make moral choices. Rather, it is because we make choices, choose from among alternatives, act in the face of limits, that we declare ourselves moral beings (231).

At SATH, residents were forbidden from challenging or even discussing the rules or the reasoning behind them. In the all-encompassing control of the total institution, they could not exercise choice. For example, in a game one evening, a resident named Albert relayed a story about the importance of doing what staff demand:

[The staff] asked me to go pick up an incoming resident from the bus-station in [another town], and I didn’t know how to get there, so I got a resident from [that town] to be my escort. We got off of the interstate, and he’s telling me where to turn. Right, left, right, left, and before I know it, he says, “My mama lives right there.” I couldn’t believe this motherfucker. I said, “Look, man, I’m not about to drop you off there. I don’t know where we are, and you need to tell me how to get to the damn bus-station.” I think he respected me for sticking up for myself, and he told me how to get there, we picked up the resident, and that was that. I should have passed on him [told staff members what happened] when I got back, but I didn’t. I felt good about myself for standing firm, but I thought that was that. Two months later he tried to leave [the program], just walked away to a gas-station. They chased him down and brought him back, and he cleaned his slate [disclosed all of his rule violations] and [told] on me that I didn’t tell. I got a 20-day contract [period of disciplinary work detail] for that shit. I was mad at first, but then I realized that that’s how [relapse] could start. That I would let something like that slide, and then it would build up from there. Even though I stood firm, I should have passed that information. Not because I think it’s the right thing to do, necessarily, but because they say it’s the right thing to do and I’m in this program.

Albert was able to relate the demand to follow the rules to his drug use and sobriety. However, his comments expose the lack of moral authority granted to the residents in this process. Importantly, he had exercised moral agency on his own when he stood up to the other resident and refused to drop him off at his mother’s house. Further, he made a
moral decision not to “pass” on the resident to SATH staff, thinking that he had stood up for what he thought was right, and “that was that.” However, the personal growth such choices might engender was cut short by the denial of Albert’s moral agency in the context of the organization.

In the place of organizational support for residents’ practice of moral agency and “personal responsibility,” the focus of staff-resident interaction at SATH was on discipline and punishment. In an interview, Henry, a staff member and former resident, stated his approach to addressing residents: “These are the rules! And you're gonna follow 'em!” Brandon, another staff member, told me what approach residents should take to the program: “Do what you’re asked to do. It’s not your time to make decisions, this is just follow [the rules].” In the midst of disciplinary interventions built around obedience, the residents were not encouraged to understand the rules in order to make sense of them or to implement them into their lives. They were, instead, encouraged (forced) to comply or leave the organization. During a Clinical Meeting, a former resident and house-manager in the Men’s Program, Reggie, joked about residents who tried to challenge him during an intervention: “I tell ‘em, ‘You can say whatever you want to me as long as you’re packing to leave’” (some other staff members laughed). The program was “voluntary” in that residents could leave at any time. But for the one-third of residents who were probated to the organization (those residents who would face jail-time if they left the program early) the “voluntary” aspect of their participation in the program was more complicated. The situation was not much better for the rest of the residents, many of whom were indigent and saw the program as a last resort.
During interviews, staff members sometimes connected organizational rules to life on the outside. Most often, this involved some version of the explanation given to me by John, a former resident working in the Medical Clinic: “Anywhere you go there’s going to be rules you have to follow.” A comment from Malcolm, quoted earlier, echoes this sentiment: “You know, there are consequences here, there are consequences in life.” Residents, then, were supposed to learn to comply with rules at SATH in order to comply with rules elsewhere. Ricky made the connection explicit. He explained “passing information,” the SATH rule that residents disclose any and all violations of rules by themselves or other residents:

It's like I tell the whole house [the male residents pulled together for evening meetings in the main residence hall], we're not here trying to breed an army of informers, you know what I'm saying? That's not what we're doing!...Passing information is about being able to stand up to your peers, look them in the eyes, and standing up to your peers and letting them know what you're going to allow in your world and what you're not going to allow in your world, and that you really don't care how they feel about that. You know what I'm saying? That's all that passing information is about….Because, once they leave here passing information is all internal. It's all internal. It's a huge thing, you know? When you're uncle comes in your house with a six-pack of Budweiser, you got to say, “Hold up! You got to bring that up out of here!” And, you got to be okay with doing that. It's not a compromise.

I never witnessed such an explanation of the rules at the house meetings I observed. However, taking Ricky’s account at face value, it is important to point out that his explanation was made in a group setting. It did not come in the midst of a disciplinary intervention, when an individual resident came up against the rule in question. The goal of the interventions in the organization was not on understanding but compliance. Not making coffee, for example, is unrelated to sobriety (it’s not as if residents should avoid
making coffee for themselves after they graduate). But, residents at SATH shouldn’t make coffee only because that was the rule (“there’s a sign right there telling you that you’re not supposed to do it”). Some rules, like “passing information” (in Ricky’s account), were designed to translate into skills on the outside that would promote sobriety; other rules, however, like not making coffee, were designed only in order to be followed.

How did the residents respond to the staff’s use of the TC approach? Some became angry. Many talked about “getting in their feelings” over things, feeling overwhelmed by the strength of their emotional responses to staff members’ treatment of them. However, as noted, organizational rules forbade confronting staff members. During moves, when staff were out of earshot, residents sometimes complained to me. For example, a young resident named Michael waited until a staff member had left a room we were packing before saying to me, under his breath and in an angry tone, “I had to work with him all day yesterday. I’m about ready to slap him upside his head.” With more time in the program, others learned to suppress their feelings:

It takes about six months for someone to slow down. When you first get here, you’re just go! go! go! Somebody says something to you, and you want to get in their face and argue. You finally realize that the best thing you can do is just slow down and say, “Okay.” Whatever it is, just let it go [from a resident working on a move].

Tina, who worked as a staff member in the Women’s Program, echoed such frustration in her reflection on her time as a resident:
It’s kind of belittling, the way that, you know, some staff members would deal with a resident. Just call them out and confront them—and that was part of the message, to do it right there in front of everybody. And, it’s kind of demeaning and would make a person feel bad….And you never know where people are coming from. ‘Cause they used to holler at me, and I remember looking at them, and it was my defense mechanism to think of them as something was wrong with them: “What is wrong with these people?!” You know? So, whatever message they were trying to give me, I wasn’t getting it.

For some residents then, surface acting—“pretending to feel what we do not” (Hochschild 1983:33)—provided a means to get through an interaction with staff members. Others submitted to the rules because they felt beaten down. Malcolm said:

I think I really grasped onto [the rules], because I had surrendered. I couldn’t go no other way. I had been knocked out by all the championship fighters [laughs].

Yet, it’s hard to imagine how surface acting to get through an interaction or clinging to the rules out of despondency—in the absence of clearly delineated connections—could help the residents learn lessons that would aid them “on the outside.” Some staff members suggested that residents could follow all of the rules, graduate from the program, and still feel unprepared to address the problems that TC proponents claim are the basis for drug use (poor choices, lack of accountability and honesty, etc.) For example, John talked about why he stayed on to become a staff member after graduating from the program:

I made the decision to stay on because I felt like there were things that I missed while I was coming through. I didn’t get many [disciplinary] contracts. Matter of fact, I only did one. I was so rigid, just following the rules. That’s what I did. I loved my free time; I wasn’t trying to do anything to lose that! I loved
smoking my cigarettes, and you couldn’t do that on contract! That was my motto. So, when I finished I still felt like there were things I needed to learn. My main reason for staying on was because I felt like there were things I still needed to do for me (interview).

Another staff member referred to “flying under the radar”—when a resident follows the rules so closely that they never come to the attention of staff through disciplinary interventions, and thus never get any personalized attention (even in the form of a reprimand). Malcolm, too, felt that he had made his greatest personal progress after graduating: “I’ve learned more about myself and my education since I graduated. I’ve been here [following my graduation from the program] about ten months, eleven months. I’ve accomplished more in that period of time than I did in my program.” Malcolm felt this post-graduation growth was related to three things: the courses he took in the empathic treatment methods that professional staff introduced as an alternative to the TC approach (see Chapter IV for more on this approach); working in the Medical Clinic with Mary, a clinical social worker and one of the staff members pushing the alternative approach; and, having more autonomy in his life than he did as a resident.

In Malcolm’s and John’s accounts of their growth following their graduation from the program, it appears that the program functioned as a reprieve from decision-making. In the absence of an explicit effort to have the residents take an active role in their recovery process—instead of making them into passive recipients of enforced rules—the program functioned essentially as a two-year, drug-free period of rule following. Without providing opportunities for residents to exercise moral reasoning, the residents’ comments suggest, they felt little-equipped to make “better” decisions in their lives post-graduation, including decisions regarding drug-use.
CONCLUSION

Staff members at SATH relied primarily on the traditional TC approach to treatment. Faced with the introduction of an alternative approach, they offered accounts of their “shaming and blaming” of residents. Staff members portrayed residents as personally irresponsible, manipulative liars. If the residents were solely to blame for their drug use and the consequences of that drug use, and if they could not be trusted, what follows is that they must be controlled. Further, staff justified the traditional approach through their claims of personal authority. As former residents and “recovering addicts,” the staff said they had “been there” and become “clean” using the traditional methods. Their very presence in the organization worked as an endorsement of a “proven” method. Yet, despite the heavy emphasis on “personal responsibility,” the forced compliance of residents largely denied the residents’ moral agency. With no opportunities to practice making tough choices, the residents were left with the simplistic moral “choice” of following predetermined rules or receiving punishment.

Adding to the denial of residents’ moral agency, it was rare in my observations for staff members to bring outside contexts to bear on interventions. Ricky talked with me about “passing information” and how learning to do that at SATH could help graduates of the program stand up to a family member who tried to bring alcohol into their house. But most of the time, an intervention focused on the resident’s transgression of a specific rule at SATH, without any attempt to generalize that rule beyond the organization. Thus, residents learned how to get through SATH’s program, but the
lessons learned were unlikely to translate into increased skills in navigating the outside world.

Additionally, the denial of residents’ moral agency could leave them unprepared to leave SATH. Many of the staff members told me that they stayed on at SATH after graduation because they were afraid to leave. Given the two-year time limit for participation as a resident of SATH, this is probably not an example of “disculturation” (Sommer 1959, quoted in Goffman 1961:13), the process whereby an “inmate” stays in a total institution for so long that she or he is no longer capable of living on the outside. Instead, it may reflect a lack of full “(re)habilitation” through participation in the program. The TC approach, as practiced at SATH, may well “tear you down,” but it may not do much to “build you up.” Staff used themselves as evidence of the success of the traditional TC approach. Yet, the overwhelming number of staff members who were former residents, coupled with the fact that only 30-40% of the residents who made it one month in the program would go on to graduate, could be taken as evidence of the failure of those very methods to achieve the stated goals of the organization: pushing residents to not only achieve sobriety, but to maintain that sobriety and support themselves in the world outside SATH.

This research has implications for those administering or navigating total institutions designed to “rehabilitate” “inmates.” Intimately connected to the residents at SATH, the criminal justice system is failing to prepare its inmates to reenter the social world outside its walls. With over 1 in 100 people in the United States behind bars today, representing a near seven-fold increase in incarceration in the last four decades (Pew Center on the States 2008), and with an estimated 70% of those who leave prison
returning to it (Visher and Travis 2003), considerations of humane and effective
treatment are of interest to us all. With the wide reach of total institutions—including
prisons (James 2002; Sabo, Kupers, & London 2001; Sudberry 2005), mental hospitals
(Goffman 1961; Mechanic & Rochefort 1990), the military industrial complex (Enloe
2007; Lutz 2006; Moskos 1974), and nursing homes (Hendel-Sebestyen 1979; Wallace
1990), to name a few—who among us will not have some experience with such an
organization at some point in our lives?
END NOTES

1 All names of persons, places, and organizations are pseudonyms.

2 For more on the history of Synanon, see Janzen (2001).
REFERENCES


III.

“I’m in Control”:
Claiming Masculinity in a Therapeutic Community

Identity claims are “indexes of the self” (Schwalbe and Mason-Schrock 1996:115), the signs individuals use to evoke meanings in others. As Gregory P. Stone (1962) notes, “One’s identity is established when others place [him or her] as a social object by assigning [him or her] the same words of identity that [he or she] appropriates for [him or herself] or announces” (p. 93, emphasis in original). What happens when such a claim is challenged or discredited by the individual’s participation in a particular setting or group? I address this question in this chapter. Specifically, through an ethnographic analysis of a residential substance abuse treatment program, I address what happens when men attempt to claim an identity as men in a context in which they have had to forfeit control. As Allan G. Johnson (2005) argues, control is a central tenet of patriarchal masculinity:

What drives patriarchy as a system—what fuels competition, aggression, and oppression—is a dynamic relationship between control and fear. Patriarchy encourages men to seek security, status, and other rewards through control; to fear other men’s ability to control and harm them; and to identify being in control as both their best defense against loss and humiliation and the surest route to what they need and desire (26).
Johnson is not saying that women are unconcerned with control. But for men, a threat to control is also a threat to their ability to claim a masculine (i.e., privileged) self.

The patterns and consequences of substance use and “abuse” are gendered, raced, and classed. Although the rates of illegal drug use, for example, are roughly comparable between black and white men (SAMHSA 2007), black men are arrested for drug offenses at a rate dwarfing that of white men (CJCJ 2000). In fact, drug arrests, combined with the implementation of mandatory sentencing and “three strikes” policies, are the primary reasons for the nearly seven-fold increase in the size of the prison population in the United States over the last four decades (Pew Center on the States 2008). The Federal Bureau of Prisons (2008) reports that the majority of people incarcerated today are there for drug crimes. Men are much more likely to be in prison than women, although the rate of women in prison is increasing (Pew Center on the States 2008). And, poor people are disproportionately represented in the prison population (Reiman 2000).¹

As a total institution (Goffman 1961), all participants (men and women) in the program at the heart of this study had lost control. As Johnson would predict, the male residents’ loss of control threatened them as men. These (mostly) poor black men had lost control in key aspects of their lives outside of the program: most of them were members of multiple subordinated social groups; they all had an “addiction” to illegal drugs; they had lost financial and structural stability as a result of their drug use; and, most of them had histories of arrest and incarceration for drug use. Further, all of the men, by coming into a total institution, forfeited control of their day-to-day lives for the duration of their time in the program. For these reasons, the men’s ability to claim a masculine self was put into question. In response, the organization provided the men a space in which they
could engage in manhood acts—acts which signify a masculine self and are “aimed at claiming privilege, eliciting deference, and resisting exploitation” (Schrock and Schwalbe 2009:281). During sex-segregated group accountability sessions called “games,” the men were encouraged to perform compensatory masculinity, exaggerated performances of a masculine self. I argue that the men’s performances (individually and collectively) in this context promoted an affirmed and creditable sense of self; but, the men’s performances, scripted and supported by organizational norms, also had unintended harmful consequences. This research adds to our understanding of the social construction of gender from an intersectional perspective, and it highlights the ways that organizations can structure men’s collective gender performances both as a form of compensation for a collective masculinity “deficit” and as a form of institutional control. The “games” served as an opportunity for the men to perform a masculine self tied to anger and aggression but did not challenge institutional norms or policies that fueled the men’s frustration. In addition, the games may have contributed to conditioning these marginalized men to accept exploitative working conditions.

Below, I describe the therapeutic program known as “the game.” I then outline four themes that emerged out of my observations related to the men’s identity claims during the games: (1) aggressive confrontation (compensatory manhood acts); (2) the subordination of women and non-conventional men; (3) gendered calls to account; and, (4) the control of emotional display (what the residents called “keeping your head”). I argue that the men, with staff and institutional support, constructed a contradictory masculine self. On the one hand, staff gave the men room to engage in aggressive confrontation in keeping with hegemonic norms of masculinity. On the other hand, staff
demanded that the men defer to staff authority and do what they were told, a challenge to conventional expectations of a masculine self. The men found ways to navigate through and respond to the seeming contradiction. I argue that their resulting performances drew on misogyny and homophobia for meaning, neglected the structural inequalities that enabled the patterns of substance use and incarceration that brought the men into the organization to begin with, and served as a means of social control by the organization.

**GAMES**

Charles Dederich started Synanon, a community-based drug rehabilitation program, in 1958 when he convened a group of friends, all self-identified recovering alcoholics, for weekly “free association” meetings in his apartment (see De Leon 2000). These sessions involved more than sharing stories anonymously in a group or one-to-one with a sponsor. They became a confrontational group process that focused on accountability, self-exploration, and personal change. “The game,” as the participants called it, set the stage for the creation of a residential community that opened a year later. Individuals who self-identified as addicts, or as having a problem with substance use, were welcome. The residential setting was deemed important because it removed participants from the social and interpersonal circumstances of their lives outside the group.

“The game” forms the basis of the therapeutic approach of the modern drug-focused therapeutic community (TC). George De Leon (2000), an advocate for and voice of the TC movement in the United States, notes that the format of the game is marked by “intense mutual confrontation designed to expose and weaken defenses against personal
honesty and to encourage the disclosure and expression of authentic feelings” (20). The emphasis, in theory, is on “dissolving defenses, personal exploration, teaching, and training” (21).

At SATH², residents started attending and participating in games during their first few days in the program. Internal literature provided the following account: “Games allow interns, freshmen, and residents the opportunity to express their feelings, laugh together, gain better and deeper relationships with others, practice speaking, and hopefully gain some awareness.” It continued:

A good game includes: a few tears, some sorrow, some anger, a lot of laughs, a little data, and a good deal of interaction…. Game playing is an action, not a thought…. Being honest is crucial. As long as the rules are followed, this is the place that you can tell others how you feel about them without fearing retribution.

The display of emotions was encouraged at the games. Staff justified the practice as being the only place in which residents were allowed to “vent” or confront one another. Confronting each other or staff members was prohibited in other areas of the program. According to resident and staff reports, staff members rarely participated in the games; apart from my first time attending a game, staff members never made an appearance.

The Resident Handbook outlined eleven explicit rules for the games:

1. No threats of violence.
2. No physical violence.
3. No border-line threats.
4. No talking about features that cannot be changed.
5. No racial slurs of any kind.
6. No getting out of your seat while the game is on you, or while you are playing the game.
7. No talking about somebody’s family.
8. No gaming anyone on their sexual preference or orientation.
9. No gaming anyone on mental health issues.
10. No grabbing your private parts.
11. No intentional falsehoods should be brought to the game.

In practice, however, the rules were usually shortened and expressed verbally by the “game strength,” a resident game-leader with experience in the program and in the games: “Y’all know the rules—stay in your seat, no gaming anyone on things they can’t change, no threats.” Game strengths opened and were supposed to police the games for rule infractions, but they tended to participate like the other residents once the game was under way.

Residents were sorted into games based on their length of time in the program. Interns met, in groups of up to sixty, three nights a week. “Older” residents had their own games, and graduates could attend these games as well. All games were sex-segregated. What was “gamed” (i.e., challenged) between the residents covered a range of issues, but tended to focus on personal frustrations between residents and rule infractions in the organization. For example, in a typical game, residents might challenge one another for being too loud in the mornings, for being unfriendly at work, for being too friendly (i.e., not dealing with their frustrations openly), for leaving personal belongings in shared bathrooms, for sleeping on the job, for “passing a note” (passing written information for two other
residents in secret), and for getting a contract (period of disciplinary action) from staff members.

**COMPENSATORY MANHOOD ACTS**

To make sense of interactions at SATH, we must make sense of patriarchy, white supremacy, and capitalism. As Allan G. Johnson (2005, 2006) notes, systems of privilege and oppression are dominated by, identified with, and centered on the powerful. A patriarchal system, for example, is male-dominated, male-identified, and male-centered. Similarly, a white supremacist system and a capitalist system are dominated by, identified with, and centered on, respectively, white people and economic elites. In a patriarchal system, then, men tend to be in positions of power and authority, what is seen as normative and valuable tends to be associated with men and masculinity, and the cultural focus of attention tends to be on men and the things that men do. This reflects patterns, and does not mean that every male in U.S. society has equal access to the use of power over women or feels powerful in his life. Many men, in fact, do not feel powerful. Reflecting the intersections of systems of privilege and oppression, working class men and men of color may not reap the full “patriarchal dividend”—the advantages typically conferred on males in a patriarchal culture for enacting dominant norms of masculinity (Connell 1987, 1995). When men’s access to patriarchal advantages is threatened in some way, or when their claim to a masculine self is discredited, they may resort to displays of compensatory masculinity (Babl 1979). In an effort to make up for their lack of access to the highest benefits of men in a white supremacist, capitalist, and patriarchal context, they may exaggerate their performance of “manhood acts”—acts which signify a
masculine self and are “aimed at claiming privilege, eliciting deference, and resisting exploitation” (Schrock and Schwalbe 2009:281).

Men engage in compensatory manhood acts in many areas of the social world. Some males with physical disabilities, for example, focus their masculine identities on the control they have over others through their occupations, while others (over)emphasize their physical strength, athleticism, or sexual prowess (Gerschick and Miller 1995). Elijah Anderson (1990) argues that for some urban, poor, young black men, appearing threatening is the only source of power they perceive as available to them. C. Shawn McGuffey (2008) highlights the ways that some parents of male survivors of child sexual abuse try to “save [their sons’] masculinity” by promoting heterosexuality and by pushing their sons to engage in athletics and disengage emotionally. And, as David A. Snow and Leon Anderson (1987: 1362) point out, some homeless men use “fanciful identity assertions”—future-oriented and fabricated assertions about the self—to promote a sense of themselves as sexually powerful and desirable: “Man, these chicks are going to be all over us when we come back into town with our new suits and Corvettes. We'll have to get some cocaine too. Cocaine will get you women every time." This last quote highlights the ways that hegemonic masculine norms intersect with class signifiers (“new suits and Corvettes”), risk-taking behavior (illegal drug use), and predatory heterosexuality (“getting” women).

STRATEGIES

The games at SATH, organized around competition and confrontation in a larger patriarchal, white supremacist, and capitalist social order, set the stage for the male
residents to engage in compensatory manhood acts. The biographies and structural location of the male residents—largely poor, black, convicted felons—further supported and encouraged such interaction. Below, I outline four themes that emerged out of my observations of male games at SATH: (1) aggressive confrontation; (2) the subordination of women and non-conventional men; (3) gendered calls to account; and, (4) the control of emotional display, or “keeping your head.”

Aggressive confrontation

Many men at SATH resorted to displays of compensatory manhood acts at the games through verbal aggression and confrontation, hallmarks of TC games in general (De Leon 2000). Male residents’ performances focused on toughness, pride, strength, and control. In other contexts, the interaction would likely be read as a challenge to fight or as a lead-up to a physical altercation. Many of the residents experienced the games in this way until they were socialized into group norms. For example, when I asked Herbert, a black man in his mid-twenties working as an SIT (staff-in-training), what he thought when he first arrived as a resident, he responded:

“What the hell have I stepped into?” I came here on a Friday; I came in late Friday evening. And the next thing I know, I’m sitting in a game that night and I’m like, “What the hell?!” It was a zoo! People were yelling and screaming and, I mean, I’m still in the prison mentality, and there were things being said that you just did not say to people, period. And they were just coming out of their mouths.

[Interviewer: Like what?]

I mean, well, you’ve been in games, you know the nature of what’s being said. And there are just certain things you don’t say to people without looking for a
fight. And these people are freely cussing each other out back and forth, and I’m like [stares with wide eyes, as if in disbelief].

As an example of “the nature of what’s being said,” consider the following excerpt from my fieldnotes:

Things started off when an older black man in nice slacks and a button-up shirt asked another resident, a younger black man in a red “contract” shirt [meaning that he was being disciplined], “So, John, what are you doing in that red shirt?”

“Man, fuck you! I’m not sayin’ anything about that!” The room erupted into shouts and laughter at this point, and Reggie [a staff-in-training who was sitting beside me during the game] leaned over and said excitedly, “Here they go!”

The man in the red shirt was being gamed, and he did not want to say what he had done to get his contract. There were four or five other men yelling at him at the same time, with him yelling back.

John screamed back, “Fuck you, motherfucker, I ain’t sayin’ nothing about why I got this contract. That’s my fucking business and you can go fuck yourself!”

Another man shouted, “Fuck you, man, I know why you got the contract, and if you don’t tell ‘em, I will!”

The first man, starting calmly but with increasing anger, said, “Man, I don’t know what you did; tell me what you fucking did so that I know not to do it myself.”

John replied angrily, jabbing his finger in the first man’s direction, “Fuck you, man. There are some motherfuckers that just get on my last goddamn nerve, and you’re fucking one of ‘em, man! Fuck you! Shut the fuck up!”

Such displays of anger, aggression, and (verbally) violent interaction were the norm at the men’s games.

The focus of the men’s interaction often pivoted around notions of masculine individualism. Sometimes, for example, when a man was being gamed by others in the
group, another resident would come to his defense or encourage him to stand up for himself. This often occurred between “peer brothers”—residents who entered the program at the same time and were placed in the same living setting and eating rotations. Men who supported other men in this way were often then gamed for giving that support. For example, although residents are supposed to follow the rules of the organization without question, residents gamed Martin Small, a black man in his forties, one evening for “doing exactly what they [the staff] tell [him] to do.” Other men came to his defense:

“Man, Small, tell that fucker to shut the fuck up! Tell him to go stuff it, man!”

Another man jumped in, also supporting Small. “Man, I’m just going to say that whenever I’ve needed something, Small has been there for me, man. I’ve got nothing bad to say about you, man.”

Immediately, another resident screamed above the others, challenging the display of support for Small: “Man, why are you wiping his ass?! [Small] don’t need that! He don’t need you to wipe his ass!” Here, the supportive residents were disparaged for supporting Small, a potentially feminine act of nurturance in this context. Additionally, the challenge reflects a put-down of the supportive men for positioning Small as a child (“why are you wiping his ass?”)—an emasculating act—and a veiled put-down of Small for allowing himself to be emasculated.

In another instance, a resident challenged a black man named Gene for a perceived pattern of supporting another resident’s comments in the games: “Man, why is it that whenever Lee says something, you cosign it? Why are you all over his ass?” Gene responded angrily, casting the other man as out of touch and out of control:
“Man, fuck you! What do you have to say to me? You’re a damn re-start [a graduate of the program who relapsed and returned]! You couldn’t figure this all out in two years and you’re going to tell me what to do?!”

Aggression. Anger. Competition. Control. These concepts, all of which fit into hegemonic formations of masculinity, were the hallmarks of the men’s games.

**The subordination of women and non-conventional men**

No women were present during the men’s games. However, at times women made an appearance in the men’s talk. When this happened, in an echo of the treatment of women Anderson (1990) found among poor and working class men of color, the women were usually presented as manipulative or only good for sex. In the following example, a white man named Jeremy is challenged about his recent laziness at work. Another resident, a black man named Albert, suggested that Jeremy’s behavior resulted from his desire to start dating one of the women in the program. Jeremy responded:

“I know, you’re talking about Caroline, but that’s not what’s going on, man. I hear that all the time, but I promise you that’s not going to happen.”

“Look man,” said Albert, “that’s what they got that room for, the ‘boom-boom room’ [a room in the dormitory set aside for residents who are granted permission by staff to spend the night together]. It’s just about pussy, man! That’s all this is about! They’re all bitches, and they’re all interchangeable! There’s 50 women and, what, 270 men, and they just play with us, man. They’re all the same!”

“They are, you’re right,” said Jeremy.
Women, thus, were othered.

In the absence of women, and along with their enactment and performance of compensatory manhood acts outlined above, the men often used homophobic rhetoric as a way of positioning themselves as “real men” and policing the gender performances of one another. Despite the explicit rule that forbade residents from gaming others on their “sexual preference or orientation,” it was not uncommon—and was acceptable—for a resident to clearly approach or cross this line and then back down. In the following excerpt, for example, Brad and Trip, both black men in their twenties, are going back-and-forth in a game. Brad encourages Trip to talk about his feelings. Trip resists, saying that he has to do the work himself. All that he can do for someone else, he asserts, is travel the road to recovery alongside him:

“Look, Brad, I can’t do this for you, you can’t do it for me. All that I can do is offer you companionship—”

Brad cut him off, saying, “You can’t offer me companionship, ‘cause I don’t swing that way.” People chuckled, including Trip, and Brad continued, “But, we won’t get into that.”

Other times, residents were more direct. In the following example, a man calls into question the sexuality of a man who challenged the sexual objectification of women:

“John, you called me out the other day for checking out a woman, saying that I didn’t need to be doing that, didn’t need to be looking at women. So, I just want to ask, no disrespect or anything, I just want to know, would you rather I looked at you? Do you want me to look at you instead?” People laughed loudly at this, some slapping their legs exuberantly as they did so.
In this instance, the man othered women, discredited another man’s claim to being a “real man,” policed masculine transgressions in others, and performed an aggressive, masculine heterosexuality. Recall Jeremy, who in the interaction above was “gamed” for having a bad attitude at work because of his feelings for a woman. In an earlier one-to-one interaction he told me that he did, in fact, have feelings for Caroline, the women in question. However, in the game, he did not challenge the presentation of women as manipulative and only good for sex. More than that, he endorsed the view. Perhaps it was the homophobic policing of conventional masculinity at the games that kept him from doing so.

Only one resident, Herbert, was openly gay and out to the organization during the time of my research. I asked him about homophobia in the games in the face of the written rule ostensibly prohibiting it:

There’s a lot of undertones, and wording that people will use, and who they’ll use that wording to, you know? There are other guys that I know in the program who are gay or bi, and people have gamed them, pushed those boundaries in the games just far enough so they don’t get an infraction, but you know what they’re trying to get at. And, it’s about, it’s all about how they say things and the wording they use. And if you confront them, they’ll say it doesn’t have anything to do with that. Because if a person never comes right out and says it directly, then how can you say that’s what they’re gaming them on?

Direct or indirect, such transgressions of the written rule forbidding the gaming of sexual identity were common.

In other instances, the men made frequent reference to one another as “bitches.” This mirrors the use of words like “bitch” to feminize and subordinate men in traditionally patriarchal institutions like sport (Messner 2002; see also Kleinman, Ezzell,
& Frost 2009). The word “bitch” does not necessarily suggest homosexuality, but it does
call to mind the use of the word in the prison industrial complex to subordinate men who
have been sexually assaulted by another man or men (see Sabo, Kupers, & London
2001). The high number of men at SATH who came from, or spent time in, the criminal
justice system lends weight to such a reading.

The men’s use, in these instances, of the label “bitch” worked to place other men
in the symbolic role of women. This happened repeatedly in every game that I attended.
In the following excerpt from my fieldnotes, a resident challenged Elijah, a young black
man in the early stages of his program, to talk about his feelings. This surprised me:
talking about emotions outside of anger or lust is generally proscribed for men in
hegemonic conceptions of masculinity (Sattel 1976). In this context, Elijah resisted the
call to emote, saying that he didn’t “bitch about his problems.” Thus positioned as
encouraging “bitching,” the man challenging Elijah angrily reinterpreted the act of
talking about one’s feelings as “venting,” distancing himself from a suggestion that he
was a “bitch.” But, he extended the use of the label “bitch” as a warning:

“Only bitches bitch,” said the man, with rising anger. He yelled, “Are you a
bitch?”

Elijah said that he wasn’t.

“Then you’re not bitching, motherfucker,” screamed the man. “You’re just
venting! Only bitches bitch!”
In another instance, a new resident, who is black, responded angrily, using the word “bitch” in doing so, when Stan, who is white, asked him his name. Stan flipped the label back onto the man:

“Hey man, you’re new here. What’s your name?” asked Stan.

“Fuck you! My name is Greg, bitch!” screamed the man.

“Whoa!” some people said, sounding surprised. Stan had not asked the man’s name aggressively.

“Well, Greg-Bitch,” said Stan, “why the fuck did you grill me [look at me with anger] earlier when I was gaming that man over there?” People laughed and looked a bit excited as this developed.

“Fuck you, man! Fuck you! What the fuck are you talking about?!” exploded Greg.

“I asked that man a question, Greg-Bitch, and you looked at me like you’d like to kill me. You mean-mugged me [stared angrily], man, what the fuck is that about?”

“Man, you don’t know what the fuck you’re talking about! Fuck you! Who the fuck are you?!”

In these ways, the men used women and allusions to homosexual identity and performance to construct a feminized Other, cast aspersions on the masculinity claims of other men, and claim creditable masculine selves. These interactions may have kept some men closeted, and they may have kept other men from openly challenging misogyny and other normative displays of patriarchal masculinity.
Gendered calls to account

At SATH, staff and residents promoted recovery by highlighting the importance of residents “choosing to change.” As I discussed in Chapter II, they framed recovery in individualist terms, highlighting personal accountability and responsibility. The male residents endorsed the ideas of accountability and responsibility with a twist, usually framing their endorsement as “being a man.” In the example below, a black man is being challenged about “passing a note”—a transgression of organizational policy. It opens with another man discussing, in an angry tone, the slippery slope of concessions that can lead, in his account, to relapse:

“Look here, motherfucker, you already relapsed into the same behavior you had on the outside, because you passed a note for someone when you know you’re not supposed to do that. That’s how it starts, motherfucker. I thought I could make those little concessions when I got out the first time, and it didn’t take long before I was fucking smoking crack again, motherfucker!”

The man yelled back that he could take care of himself and that he was in control. A thin black man with light skin and tattoos all the way down his arms said, “Hey, no one can make me do anything, right, because I’m a man. But I know I’ve got to change myself and be accountable. You need to grow some nuts, motherfucker, and do the same. They don’t sell ‘em on the street, so you better start growing ‘em here.”

The directive to “grow some nuts” was common. In the following example, quoted at length to provide more of a sense of how the interaction unfolded, a group of residents challenged the masculine performance and identity of a black man named Bradley:
“Okay,” started one man, white, “I’ve got an indictment for you, Bradley. Why is it that the other day when we were playing Monopoly—”

“Oh, here it goes, this is true!” interrupted another man excitedly. Others jumped in to second that sentiment.

“—when I landed in jail and then got out you got so mad you just quit playin’, man? What the fuck is up with that? Why are you so goddamn immature?!”

“Man, fuck you! It’s a goddamn game, fuck you!” erupted Bradley, at the same time that many other men started yelling. The following things were all being yelled simultaneously:

“Do not pass go, motherfucker! Do not pass go!”

“You’re such a damn baby, man!”

“You got to fall back some, bitch.”

This all went on for a few minutes, and Bradley yelled back, pointing angrily and then smiling broadly at other times in defiance.

“Look man,” said a black man, cutting through the din and claiming the floor, “you walk around here with this hard front all the damn time. Why do you think you’re so hard?”

“Oh, that’s the truth! Damn!” said another.

The first man continued, “You’ve got this front, but you’re really just soft and insecure, man.”

“Fuck you!” yelled Bradley. “Fuck you, motherfucker! That’s the stupidest damn thing I’ve ever heard in my goddamned life!”

The cacophony of yelling started in again. A black man closer to me yelled loudly, cutting through some of the other yells, “Look here, motherfucker, I got an indictment for you. Why is it that I hear from someone else that you’ve been talking shit about me?! If you got something to say to me, you need to fucking say it to my face. You need to be a man, motherfucker. You need to grow some nuts and be a man!”

In this one instance, which includes examples of the first two strategies as well, Bradley was “gamed” for being immature, for masculine posturing the other men discredited, and
for not being “man enough” to address an issue directly with another man. It closes with the familiar invective to “grow some nuts and be a man.” In the men’s games, “right living”—the TC focus on “truth and honesty (in word and deed), the work ethic, the necessity of earning rewards, the value of learning, personal accountability, economic self-reliance, responsible concern toward peers and family, community involvement, and good citizenry” (De Leon 2000: 76-77)—was gendered masculine.

In a related example, the men sometimes were called to account for their previous drug use. Despite the fact that “addiction” suggests a lack of control and despite the fact that, as discussed in Chapter II, the traditional TC approach to “addiction” was built around residents’ admission of a loss of control, the men would often offer an account of their patterns of substance use that highlighted masculine (re)articulations of that very concept. For example, one evening during games Trip was challenged for “passing a note” for another resident. As the cacophony of yelling and shouting increased, Trip’s voice rose above the others as he shouted that he was a man and didn’t need to be at SATH to “get clean” (off drugs). Albert screamed at Trip that both of them were probated to SATH (there to avoid incarceration or to get a reduced sentence). He pointed out that Trip had been in jail for drug crimes once, gotten out, relapsed and been arrested again. He noted, angrily, that Trip was not always in control. Trip exploded:

I made that decision, motherfucker! I knew what I was doing! I knew I would either end up back in jail or dead, and that was okay with me. I’m doing this now, and I’m in control! If I don’t want to use again, I won’t!
Trip’s assertions of control mirror the organizational focus on personal responsibility and accountability—whether he uses or not, in this account, is a result of his choices and he is willing to take the consequences. In the setting of the game, however, Trip conveys that message through a conventionally masculinist and individualist assertion of control and a denial of the importance of the community and interdependence in the therapeutic process. As such, in the games, both the route to sober living and the route to addiction were framed as an explicitly masculine act. This happened again and again during the men’s games.

**The control of emotional display: “Keeping your head”**

Residents delighted in making one another angry in the games. This is evidenced by the frequent laughter elicited by the men’s interaction and by Reggie’s excited comment at the beginning of the game discussed above: “Here they go!” This exposes the entertainment function of the games, in addition to the intended function, also referenced in SATH’s internal literature, of “emotional release” (structured and scripted performances of anger and aggression). But the games were doing more than this; they were conditioning the residents to do emotion work (see Hochschild 1983).

In the games, residents pushed one another to “bite” and respond with anger to their confrontational challenges. As soon as a resident responded with anger, other residents would mime reeling in a fish. They would sometimes yell, "Bite, motherfucker! Bite!" or "Come on, catfish!" I asked Malcolm, a white resident with eighteen months in the program, about these comments, and he answered immediately:
Yeah, they’re trying to see if they can make you lose your cool. Because when you get out of here, people aren’t always going to be nice and professional with you, and you’ve got to learn how to deal with that and keep your head.

Another resident made a similar point to me one day while we worked on a move:

It takes about six months for someone to slow down. When you first get here, you’re just go! go! go! Somebody says something to you, and you want to get in their face and argue. You finally realize that the best thing you can do is just slow down and say, “Okay.” Whatever it is, just let it go. “Okay.” It freaks ‘em out, because they expect you to get in their face. That’s the best thing you can do, just let it go.

The focus of the games and lessons learned, in these accounts, is on emotion and impulse control. As Lee, another (white) resident halfway through his program, told me, this is done with an eye toward the future:

Out on the street it’s always about the right now, the immediate gratification. Here, you have to earn your way up to everything. You start with nothing, and you have to see where you’re going and get there step by step. It teaches you to plan and think about the future.

The goal of the games, it would seem, is not to bite, but to “keep your head.”

It was rare during my observations, however, for a resident not to “take the bait.” Despite Malcolm’s assertions that this was one of the goals of such interactions, when a resident didn’t respond in anger it usually made the other participants even angrier. During one game, Simon, a white resident with six months in the program, was being gamed forcefully about his experiences at SATH. He calmly asserted that he couldn’t say
anything positive about his experience up to that point. As the other residents yelled at him, growing louder and getting more personal, he remained calm. Finally, another resident pleaded angrily with Simon to bite, instructing him in how to play the game with his challengers: “Tell him to shut the fuck up. Yell back at him!” Simon refused. After a few more minutes of yelling, a resident shifted the game to another man.

Simon’s refusal to bite was the exception to the general pattern. As another example of the norm, consider the following comments from a game in which a white resident named Rick is challenged by a group of other men about his “bad attitude.” Once challenged, Rick rolled his eyes and stared at the ceiling. This elicited a loud and angry response from a muscular black man in the group:

“Grow up, Rick! You’re actin’ like a child! Grow up!”

Rick exploded, staring intensely at the man and yelling, stressing each syllable, “Foot-Ball! Foot-Ball! Can you say, ‘Foot-Ball’?” suggesting [with perhaps racist overtones] that this man was stupid and was only good for physical work in activities like football.

The man yelled back: "Grow up! Grow up, baby! Grow the fuck up!"

At the same time, another man was yelling at Rick: “Fuck you, motherfucker. You may have sold cars on the outside, but you ain’t shit here, man. You’re no better than anyone else here, motherfucker!”

“Fuck you,” screamed Rick, “you’re like one of those yappy little dogs. You’re good for nothing and you’re just annoying!” As Rick yelled, he pointed and turned quite red, the veins in his neck bulging ...

At one point, the muscular man screamed, “That’s right, Rick! Get angry! Get angry! I control you! I control you!”
This last comment (“I control you!”) positioned Rick below the muscular man, who pointed out that Rick was not in emotional control of himself. As Malcolm had explained, this served the manifest function of encouraging “impulse control,” something De Leon (2000) and almost every staff member with whom I had any interaction stressed as a specific problem for addicts. As I will discuss below, these patterns of interaction served the latent function of social control by conditioning the residents to channel their anger laterally and, in a seeming contradiction to their claims to a masculine self, to defer to authority.

**MASCULINE (RE)HABILITATION**

The men’s interaction in games, notably their aggressive and competitive presentation of self, their othering of women in addition to men who violate conventional masculine norms, and their construction of “right living” as a specifically masculine act (“you need to grow some nuts and be a man”), can be read as compensatory and adaptive within the larger capitalist, patriarchal and white supremacist context in which the men lived and interacted. Lacking financial and, for most of the men, race privileges tied to dominant norms of masculinity in the larger culture, they turned to those aspects of masculine performance to which they had access: aggression, (verbal) violence, homophobia, and heterosexual display. As such, these performances can be seen as a version of what Richard Majors and Janet Mancini Billson (1992) termed the “cool pose”—“a ritualized form of masculinity that entails behaviors, scripts, physical posturing, expression management, and carefully crafted performances that deliver a single, critical message: pride, strength and control” (4). Further, the men’s identity
displays shared some similarities to the manhood acts performed in the prison industrial complex (Sabo et al. 2001). In prisons, a homosocial and hierarchical setting, patriarchal masculinity tied to violence, aggression, and control is reproduced alongside heterosexism and white supremacy.

The male residents engaged in compensatory manhood acts, yes, but there is more to be said on this point. I argue that, as men, the male residents at SATH were both successes and failures in the wider culture. They were successes in the sense that, through compensatory manhood acts, they had accomplished certain hegemonic masculine ideals—many had histories of violence, many were successful athletes as students, and they all had experience with risk-taking behavior in the form of illegal drug use. But in another sense, and beyond their subordinated status as (predominantly) men of color and poor men, they were manhood failures. By getting so deep into their addictions that they had “lost everything,” being arrested and incarcerated, or simply by entering a total institution like SATH, they had lost control, a central tenet of patriarchal masculinity (Johnson 2005). SATH, as an institution, offered the men, and encouraged them to perform, a (re)habilitated masculine self tied to verbal competition, the creation of a feminized Other, and “masculine” control in the guise of “right living” and impulse control. This represents a contradictory masculine self tied both to “giving it” (aggressive confrontation and heterosexual display) and “taking it” (deference to authority). These qualities seem to be at odds on the surface—“taking it,” or taking abuse from others without challenge, would seem to go against notions of conventional masculinity. The men’s positioning of deference as an explicitly masculine act (“taking it like a man”) allowed them to make simultaneous appeals to masculinity through these seemingly
disparate qualities. At the games, the men found ways of merging these concepts.

Consider the following comments from a resident about “biting” (encouraging impulse control):

Yeah, biting, we try and get people to lose it, you know? Sometimes I’ll come up with stuff I know isn’t even true just to see how people will respond. What it is is that you’ve got to learn how to control yourself when people come at you with anything. When we get people to bite it’s like, “Yeah, I just rented space in your head, I control your head for a little while.” And we can’t do that, we have to learn to control ourselves. We can’t lose control in a job in the real world, you know?

As they condition others to control themselves, taking abuse from one another and explicitly framing that act as an expression of masculinity, the men also get to exert control over others.

THE GAME AS SOCIAL CONTROL

As I have argued, the games serve many functions. The explicit purpose is to “expose and weaken defenses against personal honesty and to encourage the disclosure and expression of authentic feelings” (De Leon 2000:20). Most of the residents with whom I spoke enjoyed the games and felt that they were helpful in promoting their personal growth. Residents watching others engaged in playing the game observed excitedly and cheered the others on, as if this were a sporting event. Laughter, in the midst of intensely angry and confrontational interaction, was common. The games could also confer status for particularly aggressive performances. Trip, after successfully deflecting indictments from many other men in one game, crowed loudly, “Somebody
bring me some game! Somebody bring me some game!” But after claiming this position as a superior game player, he was immediately brought down by another man, also black, who then was lauded for his skills:

“You need to shut up and listen, man! You’ve got something to say to everybody! You tell everybody else what to do, but you don’t do it yourself! You need to start applying that shit to your own self. You ain’t got a BA—you’re full of BS, but you ain’t got a BA—you ain’t got an MA, but you act like you’re a goddamned psychologist. You don’t know shit, man! You’ve got to walk the walk before you can say anything to anybody. You walk around here like you’re a gorilla ‘cause you’ve been through the penitentiary twice, but you ain’t built like that, you damn chimpanzee!” People exploded with laughter. Trip seemed at a loss for words and laughed along.

Another man said, “You’re the only person I’ve seen who can out-shout him, man. Get him again!”

In addition to being entertaining and conferring status, many residents told me that they found the games helpful. After noting the importance of the games in conditioning impulse control, Malcolm said, “I know they’ve helped me a lot.” In a white supremacist capitalist patriarchy, the potential importance of emotional display for these men was real. As noted, residents at SATH were disproportionately poor and black. Most were homeless and indigent before entering, most were convicted felons, and almost half did not have high school diplomas. As such, they had little social capital or marketable job skills. The job skills they learned at SATH—moving, catering, construction, landscaping—were largely working class skills that could help support them “on the outside.” But if the residents could not control their “impulses,” they might have a hard time keeping a job. “Keeping your head,” in this context, is a coping strategy that could protect graduates’ material support.
In this sense, the SATH games have similarities to “playing the dozens,” a ritualized verbal competition common among adolescent black males in urban settings (and beyond) (see Abrahams 1962; Chimezie 1976; Dollard 1939; Foster 1986). Like the games, “the dozens” serves many functions. It works as a form of entertainment, an opportunity for emotional release, an opportunity to develop verbal skills, and as a mechanism of conferred status (demonstrating “the best” at verbal sparring). As Harry G. Lefever (1981) points out, the dozens also functions as a mechanism of social control, a space in which marginalized black men and boys could learn to “develop self control and to handle [their] temper” (76). As an example, Lefever cites the memoir of Ossie Guffy (1971). Guffy recounts an episode from her youth when a neighborhood boy engaged in verbal sparring with another boy instead of resorting to physical violence. Guffy’s grandfather stopped the interaction when the verbal sparring got more intense. The boy who instigated the interaction explained that they were playing a game. Guffy describes her grandfather’s response:

“When I was coming up,” Grandpa said, “I heard about that game, only I heard about it the way it used to be, and I heard how it started. It was a game slaves used to play, only they wasn’t just playing for fun. They was playing to teach themselves and their sons how to stay alive. The whole idea was to learn to take whatever the master said to you without answering back or hitting him, ’cause that was the way a slave has to be, so he could go on living. It maybe was a bad game, but it was necessary” (Guffy 1971:48, quoted in Lefever 1981:79).

Not controlling one’s emotions, particularly for members of subordinated and oppressed groups, can have serious consequences. In a relapse prevention meeting, a less confrontational and sex-integrated meeting for residents with eighteen months or more in
the program, a black woman made this point explicit when another resident, also black, complained about what he felt was unfair treatment from his supervisor: “Andy, you’ve got to just learn to say ‘Okay.’ My boss now, I can’t stand him. I think he’s an idiot. But he says all this shit to me and I just say ‘Okay.’” Recall the similar comment made to me by a resident on a moving job: “You finally realize that the best thing you can do is just slow down and say, ‘Okay.’ Whatever it is, just let it go.” Through playing the game, residents learn to take abusive and exploitative behavior, “whatever it is,” without challenge. They learn to “let it go.”

Learning to “take whatever the master said to you” is a survival strategy. Although the potential consequences for the residents at SATH may not have been as immediately threatening or severe as the consequences for enslaved peoples who did not control their emotional display, learning to “let it go” could similarly aid residents’ survival on the outside. With felony convictions and a G.E.D., most of the residents were unlikely to find work that offers a great deal of structural support or conferred status. Moreover, SATH operated in a state that, during the time of my research, did not recognize collective bargaining; and, most residents remained in the state following graduation from the program. This means that the residents were not likely to find external support against exploitation and abuse in the form of unions. As felons, most residents had lost the right to vote, so their voices were not represented even symbolically by elected officials. There were social, political, and economic constraints on residents’ and graduates’ lives, and those constraints carried serious material consequences. The individual focus of TC treatment, however, coupled with the conditioning of residents to accept abuse and exploitative conditions, carried an unintended negative consequence:
reproducing the class structure and potentially undermining residents’ ability to promote a valued and affirmed sense of self.

Highlighting another aspect of the games, Allan, a white professional counselor who worked part-time with the agency as a clinical consultant, noted in an interview that the “value of games … is really more about giving people a forum to safely vent.” As an account, this may have been particularly important given that residents were not allowed to confront staff or one another outside of the games. However, given that staff almost never participated in the games, this meant that residents had no real outlet to directly challenge staff’s abusive treatment of them. Their anger and frustration, instead, was trained on one another. In this sense, the “venting” that occurs in the games is not for the benefit of the individual residents, but for the organization as a whole. SATH policy denied residents the opportunity to confront abuse directly or challenge institutional norms and rules, and the games served as a space for the residents to “release” their frustrations against one another. The games, then, functioned as a form of social control both inside and outside the organization.

EXCEPTIONS AND IMPLICATIONS

As noted, many of the residents did see benefits from their participation in games. They saw the games as entertaining and appreciated what they saw as a strategy of emotion work (“keeping your head”) that could offer material benefits, albeit in a context of exploitation, on the outside. But, others did not enjoy the games or see them as uniformly positive. I asked a white resident named Scott how he felt about the games. He paused, staring into space for a few moments, and then said:
Well, I don’t think that verbal abuse is therapy, you know? [pause] Some good can come out of them, though. I see my role in the games as trying to support people, to let them know how others are seeing them, where they might have messed up, and how they might do things differently.

Although most of the interactions at the games that I observed focused on confrontation, competition, and trying to get residents to “bite,” at times, as Scott suggested, the men would break the pattern and address an issue directly. This happened one evening when Stan addressed a young black man with twelve days in the program:

“Game on you—what’s your name, man?”

“Randy,” he replied, warily.

“Game on Randy. Man, what’s going on with you and your attitude, man? You were complaining at Mocom today when you got in from working. As soon as you walked in you started complaining about food.”

“Fuck you, motherfucker,” said Randy.

“Nah, fuck you,” yelled Stan. “You were complaining as soon as you walked in about food, and when you were out smokin’ crack you’d go a week without eating, so what’s up with that?”

“I never smoked crack, motherfucker. You don’t know me!” screamed Randy.

“Then you were sniffin’ powder, whatever.”

“Yeah, so?”

“So, it’s the same damn drug,” yelled Stan. “It’s all cocaine. What the fuck is up with your attitude, man? You need to shape the fuck up!”

Randy exploded, “Man, fuck you! Fuck you! You don’t know me! Fuck you and fuck SATH! Fuck SATH!”
At this point, the game appeared similar to every other game I witnessed. However, it took a turn and shifted away from open confrontation. A young black man named Michael calmly asked Randy why he was there. Randy replied, “To get off drugs.” Michael said that that wasn’t enough, and Randy looked confused. Stan continued:

“Hey, look, I’m done yelling at you, but I got something to say to you. Look, you got a bad attitude right now. I came in the same way. I didn’t want to be here. The judge sent me here, and to be honest I was just ducking time, you know? I had a horrible attitude when I started. But you got to push through that, you got to shape up and get into this program.”

“That’s true, man,” said Michael. “That’s why I asked you what SATH is. It’s okay that you don’t know. But do you want to hear what I think SATH is?”

Randy looked uncertain, but said, “Yeah.”

“SATH is everyone in this room, man. Without us, it’s just a building. It wouldn’t exist without [founder and president] James Carter, he started this thing up, but it’s the people that make it happen. SATH is us, man. SATH is every person in this room. SATH is you, man. So when you say ‘fuck SATH’ you’re saying fuck yourself. You get what I’m saying?”

The challenge to the dominant pattern in this instance was two-fold: Stan and Michael stopped screaming to address an issue directly with a younger resident and Michael explicitly challenged the individualist focus on personal responsibility to highlight the importance of community and interdependence in SATH programming. This instance also served to teach others in the group not to challenge the organization as a whole. In this sense, it may have supported the more general pattern of conditioning the men to defer to staff’s authority.

I have argued that the games served as a mechanism of social control (both within and without the organization) by conditioning the residents to defer to authority and by
channeling their anger to their peers. As noted, this not only set the residents up to accept abusive and exploitative working conditions, but it also reinforced the existing class structure. In addition to this, the games could backfire therapeutically. A resident quoted above referred to them as “verbal abuse,” and Allan, the professional counselor, ultimately agreed. In an interview, he reflected on the games:

[Y]ou could argue, as I guess De Leon does in his book, that with an addictive personality you can’t get through any other way, you know, you have to “break ‘em down to build ‘em up,” that old approach. Okay, is there truth in that? Maybe so for some people; but, I’ve got to tell you, the people coming to SATH don’t need our help figuring out they’ve got problems, they need our help figuring out that they’ve got solutions. And, they really don’t need our help taking stock of how they’ve wronged themselves and other people in their lives. They already know that. They need our help figuring out that they have done something right and can do something right, and that the bad that they’ve done hasn’t been done with a healthy brain. That’s what they need our help with. That’s what recovery, I think, is based on.

Allan’s comments here, as I discuss more in Chapter IV, critique the traditional TC approach, in part, from a neurobiological perspective. In another interaction, he put it simply: “[A]t a biological level, we’re getting in our own way.” Comments from a “re-start” (residents who have graduated from the program, used drugs again, and come back) named Lefty, a white man in his fifties, suggest that the traditional approach may be “getting in the way” from a social perspective as well. When I met Lefty the first time, he gave me an account of how he ended up back at SATH after successfully completing the program once:
I started having trouble and I made some bad decisions, some really bad decisions. I was struggling, and I thought, “SATH tells us to be men, so I’m going to be a man and suck this up and just deal with it myself.” That was a mistake, I should have talked to somebody about it, you know?

Although the male residents framed “right living” and accountability as “masculine” pursuits in the games, Lefty’s comments suggest that traditional manhood acts can also be part of the problem.

Allan referred to “that old approach” as the “break ‘em down to build ‘em up” model. In addition to being “old,” it was the norm at SATH. However, I only witnessed one instance in which a resident truly “broke down” during a game. In an interaction that unfolded quite differently from the example with Stan and Michael, above, a white eighteen-year-old resident with two weeks in the program, named Truck, attempted to join in during a game by praising another resident, a black man named Bruce. As in other instances, this praise of another resident was met with derision. At the end of the evening, Bruce gamed Truck for his support, again gendering the process of recovery as explicitly masculine:

“Game on Truck, man. Why were you kissing my ass before, like they said? Why are you so soft, motherfucker?! You got to toughen up and be a man!”

Truck looked uncomfortable and smiled nervously, shrugging his shoulders. He attempted to play the game: “Look, ladies, what do you want to know?” Some people laughed.

Gary [a black man in his twenties] said, “Man, you’re eighteen-years-old and this isn’t your first program, right? You said the other day you’ve been in, what, six programs?”

“Fifteen,” said Truck.
“Fifteen programs?! Damn!” said Gary.

“Why are you here?” demanded Horace [a black man in his thirties] angrily.

Truck just sort of shrugged and smiled nervously.

“You need to answer the man, motherfucker. We’re trying to save your life here! Why are you here?!” screamed another man.

“Look, man,” said Horace aggressively, “if you’re eighteen and you’ve been on drugs since you were twelve you need to know why you’re here! I’m going to give you the same challenge I gave someone last week—tonight when you’re laying in bed in that gym [interns slept in bunk-beds packed tightly into a gymnasium within the residence hall] I want you to think about why you’re here and what you want to do with your time. You hear me? And then tomorrow come and find me. No, I’m going to come and find you. I’m going to come and find you and ask you what you thought about!”

“Man, I was a miserable child, man, I don’t know,” said Truck. I couldn’t see his face, but I could tell that he was getting upset. Some other residents saw this, too, and said, “Take the game off of him, man! Put the game on someone else!” Trip said, “Shit, man, game on me!”

Truck put his head in his hands. I could see his hands and his back shaking with sobs. He was clearly upset. As the game switched to check in with two new interns, Horace got up and came over to Truck, putting his hand on Truck’s back and leaning down to talk to him. I could not hear what he said.

The game shut down at ten p.m., right after checking in with the two interns. A number of the men swarmed around Truck, patting him on the back and leaning down to talk with him. His friend, Bruce, said, “Hey man, it’s okay to cry. Real men can cry, man!” as Truck sat up and wiped his eyes.

This incident was difficult to witness. Truck appeared fragile and clearly upset, but the men did not let up until he had been pushed over the edge. After opening the interaction with a challenge to Truck’s masculinity, Bruce closed the interaction by trying to save it (“Real men can cry, man!”). This example exposes one of the limits of this therapeutic approach. Despite the overall focus on individualism, what we might call the masculinist “scream first, ask questions later” approach neglects the individual biographies and needs
of the residents. Two weeks after this incident, Truck and I talked one-to-one while we were working the same shift at a Christmas Tree Lot for SATH. I did not bring up the games I had observed, but I did listen and respond reflectively as Truck talked. He sought me out a few times during the shift, finally saying:

You’re really easy to talk to, you really listen. I haven’t opened up much to any of the guys here because they don’t really listen. I’m scared if I open up that they’ll use that against me. I’ve tried to do that once with someone, and he brought up what I had told him in games.

The games, especially for residents who had not received support for trauma in the past, failed to provide a "forum to safely vent." As Truck talked and I listened, he alluded to a history of sexual and physical abuse. As a former staff member in a rape crisis center, I was familiar with disclosures of trauma. I said simply that, particularly for children, such issues could be difficult to talk about. I noted that something many children never heard was that, no matter what happened, it was not their fault. Truck’s eyes filled with tears as I said this, and he then disclosed a long history of extreme physical and sexual abuse. He told me that he had been sent to social workers through the Department of Social Services, but their emotional distance continually frustrated him. He said:

I’ve even tried asking them things, not even overly personal things, just like how they’re doing, and they’ll say, “Oh, we’re here to talk about you.” That’s why it’s so nice to talk to you. You’re a really great listener, but you’re not shutting me out either.
Truck’s crew left immediately after this. I never saw him again, but I heard that he quit the program shortly thereafter. Only an estimated 30-40% percent of residents who make it to one month in the program will go on to graduate. In the world of TCs, this is not uncommon. Although the purpose of this study was not to evaluate the “success” of the therapeutic methods, meeting residents like Truck left me wondering how many more residents might stay in the organization if, as Allan suggested, therapeutic programming focused on solutions rather than problems?

What of the men who did not fit the norm, the white men or men with greater class resources? Although there were fewer of these men in my observations, for the most part, as evidenced in the examples above, they played the game in the same style and with the same intensity as the other men. Given the structure of the games and the larger program, the formal and informal “rules of the game,” and the intense and quick socialization into game norms, this is not surprising. When men like Simon, mentioned above, refused to get angry, they were met with resistance and frustration. Another white resident, a man named John who grew up middle class and lost everything he owned in Hurricane Katrina, took a different strategy of resistance. Instead of refusing to engage, John tried to get the other men to laugh by making himself appear foolish or silly. In the following example, a group of men gamed John for “acting crazy,” and angrily pushed him to be “real”:

“Game on John, man,” said a man, getting louder as he talked. “Why the fuck are you always being foolish, man? Why do you put up that front?”

“Shut up, lollipop!” said John, with apparent glee.

“See, man, you can’t even listen here!” yelled the man.
Another man joined in, asking loudly “Yeah, man, why are you always acting crazy?”

“Because I’m like Roger Rabbit!” said John.

“Why, man?!” said the man, angrily.

“Because I love carrots!” yelled John.

“Man,” yelled another man, “why is my six year old son more mature than you?!”

“Because he’s smart and he’s got good genes from you!” yelled John. People laughed.

“Man,” said that same man, “you’re always doing that. It’s a front. It’s a defense, man. You need to be real.”

Few of the men in the program grew up middle-class or had achieved middle-class status before coming to SATH. For those who had, most had “lost everything” in their pursuit of drugs or acquired their wealth through illegal activities and subsequently “lost everything” through arrest and incarceration. This, too, is not surprising. People with greater class resources who seek treatment for substance use problems may seek out paid programs in more comfortable settings. Residents at SATH are more likely to come through the criminal justice system. In this context, the men in the games often pushed the idea that “everyone was the same” at SATH, or that no one was “better than” anyone else. Such a response can be seen in the example of Rick, discussed above (“You may have sold cars on the outside, but you ain’t shit here, man. You’re no better than anyone else here, motherfucker!”). It is also in evidence in another interaction involving Simon. Simon noted in one game that he felt different from most of the other residents because he had never used drugs other than alcohol, whereas most of the residents had used
cocaine and crack. Evan, another (black) resident, responded, “But you’re not any different. Most of us started where you are now. It started with alcohol, and then it moved on from there, you know what I’m saying?”

And what of the women’s games? I was able to interview several female staff members and SITs (staff-in-training), but the strict policing of interaction between male and female residents at SATH kept me from gaining access to the women’s games. I did ask staff members and former residents about the women’s games, though. Colleen, the head of the women’s program, said jokingly that “women are probably meaner and more confrontational [than the men]” in games. During a meeting for graduates of the program who were transitioning to work as staff members, two of the group attendees, Charlee and Lloyd, were discussing games. I asked them what a “game whip” was, an expression I had heard in passing but did not understand. Charlee answered:

“A whip is basically a person in the game who pushes people while they’re telling their story, or who keeps things moving. Like, someone might say, ‘Even though I was smoking crack I was still a good mom.’ And, I might say, ‘No you weren’t, bitch, crack-heads ain’t good mothers!’ It doesn’t have to be that confrontational, or anything, but you get the point,” she said, and laughed.

And, I asked Tina, a staff member and former resident, about the women’s games in an interview. She noted that as a resident she was intimidated by the intense confrontations in the women’s games. In fact, when I asked her more generally about what the hardest aspect of the program had been for her as a resident, she responded:

[pause] Hmm. The hardest part for me was games. That was the hardest part for me, the house games that they have on Mondays, Wednesdays, and Fridays.
[Interviewer: What was hard about them?]

Confrontation. I was intimidated by them, or, I was one who would get realllllly, very angry. So, that was the hardest part.

She noted, though, that the games had changed over the years:

They’re not as loud, and they’re not as confrontational as they have been. And, you know, we’ve [staff] learned that, um, that, you know, being real vocal [yelling] is helpful at times, but other times they learn just as much if you’re just [pause] speaking. But, it does allow them, it is a place for them to let out some aggressions and hostilities and things like that. But, it’s not, when I came through the program, it’s nowhere near where it was. You would think that those people were going to fight, that’s what I used to think. It’s kind of amusing once you get used to it.

Allan, reflecting on the women’s games, said simply, “I think the women’s games are awful.”

These accounts are similar to the patterns of interaction Jill McCorkel (2003) found among female inmates and staff in a prison-based TC. The core therapeutic program with Project Rehabilitate Women (PRW) was the Encounter Group (EG), a scripted group process very similar in design to games at SATH except that EGs were orchestrated and facilitated by staff members instead of residents/inmates. McCorkel highlights, specifically, a variation of the typical EG called “pinball” in which a single resident deemed a “troublemaker” (54) is pulled into the center of a circle and aggressively confronted. EGs allowed inmates to “blow off steam” and taught the women how to “control their emotions” (53). As with the men’s games at SATH, the emphasis was more on shaming and blaming than supporting and encouraging. Staff actively
promoted conventional gender socialization for the women and confronted them aggressively for gender and sexual transgressions. Although McCorkel does not highlight a process of gendering “right living” for the female inmates as either masculine or feminine, she does note staff’s conception that female addicts were missing something essentially feminine: “Something in their nature is not right, you know? They run out and leave their kids alone, babies, while they score drugs or go over to their boyfriend’s house, you know?” (69). This is similar to the example that Charlee gave, above (“crackheads ain’t good mothers!”).

As stated, I do not have data from the women’s games at SATH. However, based on the accounts of women at SATH, and given the broad similarities between the EGs in a women’s prison-based TC and the men’s games at SATH, it seems as if the women’s games at SATH may have been marked by similar patterns of confrontation and aggression to the men’s games, with potentially similar consequences in terms of social control. The women may even have engaged in othering talk in regards to men, casting men as manipulative and controlling. An interaction I witnessed in a sex-integrated group one evening suggests that this may be the case. A recent female graduate of SATH attended and was seeking advice about whether she should move in with her ex. Another woman responded: “Look, Ellen, you know that you can trust yourself, but you can’t trust him. He’s a man. He’s a man, Ellen. You can’t trust him.” If this does, in fact, reflect a pattern in the organization, the women’s interaction could still be read as compensatory and adaptive within a larger patriarchal, white supremacist, and capitalist social order. However, some of the consequences would be different from the men’s interaction in games. Whereas the men’s interaction shored up patriarchal power to which they did
have access by performing an aggressive and (verbally) violent masculinity in contrast to a subordinated femininity, the account of the women’s interaction could be read as a reaction to that very power that neither challenges nor resists it. The women, like the men, had lost control coming into the total institution. Yet, even as it may have meant that they were “not good women/mothers,” the loss of control did not threaten their identities as women in the way the men’s identities as men were threatened by a similar loss of control. More research on women’s games at TCs, inside and outside the criminal justice system, is needed to speak to these issues.

CONCLUSION
Games are designed as a core therapeutic program in the modern TC. Although the games at SATH encouraged the men to express anger toward and to berate one another (“emotional release”) with the goal of suppressing their expression of anger if others berated them (“impulse control”), there were unintended negative consequences as well. The men’s patterns of interaction at the games, which were orchestrated by larger organizational policies and norms, reinforced an aggressive and controlling masculinity built around the subordination of women and non-conventional men. Further, by conditioning the men to defer to authority, the games may have encouraged the residents to accept abusive and exploitative working conditions outside the organization. Game norms encouraged the men to target individuals, but they did not take individual biographies into account. This could prove counter-productive for the promotion of recovery.
The structured interaction in the men’s games exposes something deeper. I opened this chapter with a quote from sociologist Allan G. Johnson (2005) concerning the dynamic relationship between fear and control that drives patriarchy as a system. Men in patriarchal systems tend to seek power through the control of others, fear being controlled by others, and see control as the means through which they can achieve desired ends. The cycle of seeking to control others and fearing others’ control is ongoing in patriarchal systems, and the men’s patterns of using manhood acts to claim control in the face of a loss of control at SATH is reflective of similar processes at larger levels:

Corporate leaders alternate between arrogant optimism and panic, while governments lurch from one crisis to another, barely managing to stay in office, much less solving major social problems such as poverty, violence, health care, middle-class angst, and the excesses of global capitalism. Computer technology supposedly makes life and work more efficient, but it does so by chaining people to an escalating pace of work and giving them less rather than more control over their lives. The loss of control in pursuit of control is happening on a larger level, as well. As the patriarchal obsession with control deepens its grip on everything from governments and corporations to schools and religion, the overall degree of control actually becomes less, not more. The scale on which systems are out of control simply increases. The stakes are higher and the capacity for harm is greater, and together they fuel an upward spiral of worry, anxiety, and fear (234).

Given the links between substance use, in and of itself, as a manhood act that fulfills the “risk taking” ideals of patriarchal masculinity (Bourgois 2008; Royster et al. 2006), and given the male residents’ subordinated status as (mostly) poor men of color, it is arguable that their drug use was driven in part by the same cycle of fear and control that SATH replicates in the men’s games. Perpetuating that cycle does not offer these men a way out.
They may learn how to “be men” without being high when they do so, but being men is part of the problem.

This research adds to our understanding of the social construction of gender from an intersectional and interactionist perspective. Additionally, it adds to research on the ways that identity work, specifically identity work tied to manhood and masculinity claims, can reinforce inequality while promoting an affirmed sense of self (see Schwalbe et al. 2000). The identity work of men at SATH has similarities to the identity work of men in other contexts in which their claim to a masculine self is discredited. For example, men in batterer intervention programs (Schrock and Padavic 2007), female-to-male transsexuals (“transmen”) (Dozier 2005), gay and “ex-gay” Christian men (Wolkomir 2006), and men in low-status jobs (Collinson 1992) engage in local identity projects in an attempt to signify creditable masculine selves. They work together to construct masculine selves, policing and supporting one another’s performances along the way. In each case, their manhood acts are understandable in context. And, in each case, although not (necessarily) the intention of the men in question, compensatory manhood acts work to uphold patriarchy and reproduce gender inequality.
For more on the gendered, raced, and classed patterns of substance use and abuse, see: Huselid and Cooper 1992; Fullilove, Lown, & Fullilove 1992; Peirce et al. 1994; Whitbeck et al. 2001; and Whitbeck et al. 2002.

All names of persons, places, and organizations are pseudonyms.
REFERENCES


IV.

“Basically, I just listen”:
Selling and resisting empathy in a therapeutic community

Identity can be a hard concept to pin down. Folk notions about identity in U.S. society construe it as a fixed personality trait, an expression of who we “really” are. For symbolic interactionists, identities are not fixed. Instead, they are social products negotiated through reflection and interaction (Blumer 1969; Strauss 1959). As David Snow and Leon Anderson (1987) argue, we have two kinds of identities: personal identities reflect the meanings we ascribe to the self (see also Goffman 1963; McCall and Simmons 1978); social identities reflect the meanings others attribute to us (see also Stone 1962).

Snow and Anderson analyzed the ways that homeless people constructed and managed their personal identity in the face of a stigmatized social identity. The incongruity between the meanings one ascribes to the self and the meanings imputed from others represents an “identity threat” (Elsbach 2003; see also Goffman 1963). In response to such a threat, people can engage in identity work—“anything people do, individually or collectively, to give meaning to themselves or others” (Schwalbe & Mason-Schrock 1996:115).

Identity threats occur in many social settings. In my study (2009) of a collegiate women’s rugby team, I found that the players challenged conventional notions of passive femininity through tough and aggressive play. However, in doing so, they encountered
sexist and homophobic stigma from outsiders. The players were invested in accomplishing an identity as both conventionally feminine and as serious athletes. Succeeding by either standard was a potential threat to the other. In response, the players distanced themselves from non-athletic women ("weak" women), women who did not play rugby (women who weren’t “tough” enough), and other female rugby players (women who were too “tough,” or too “butch”). They carved out a social space for themselves as “unique.” In doing so, the players relied on defensive othering—accepting the legitimacy of a devalued identity (imposed by others) but claiming status as an exception (see Schwalbe et al. 2000).

Identity threats have been found in a variety of social settings. For example, John Hepburn (1975) found that when (sub)cultural norms valorize or normalize physical aggression, identity threat often plays a role in leading up to instances of interpersonal violence. Professors who identify more with professional than religious ideologies have experienced identity threats teaching in Catholic colleges and universities (Henlein & Blackburn 1975). When faculty or other members of a group struggle with an identity threat in relation to their institutional identity it can have an impact on the structure of those institutions: “[T]o the extent that the disagreements concern the reason for the existence of Catholic colleges, then it seems clear that the very survival of these colleges as Catholic is open to question” (221-224). Students, too, can experience identity threat. Carrie Yang Costello (2005) found that students whose personal identities—related to race, class, gender, politics, or religion—are in conflict with the professional norms of graduate and professional schools struggle to negotiate the contradictions. One law student, a young woman of color, commented on the difficulty of feeling that she didn’t
belong: “Even in my first semester here at law school, it was like, What am I doing here? I was fighting a lot of, ‘I’m not like these people, I don’t want to do that’”(7). Feeling out of place, or experiencing a challenge to an identity we claim as central to our sense of self, can inspire resistance to the (perceived) threat.

In this chapter, I analyze the ways that staff in a therapeutic community (TC) called SATH (Substance Abuse Treatment Headquarters) responded to a threat to their professional and personal identity. TCs—residential programs for the treatment of drug use problems—have historically drawn staff members from the ranks of former residents (De Leon 2000). SATH was no exception. However, when state agencies put pressure on the organization to become licensed, the door was opened to bringing in staff with professional degrees. The new staff attempted to implement an alternative treatment approach to the traditional TC approach that the “old guard” had experienced as residents, still considered effective, and replicated as staff.

The new methods, which I call the “empathic approach,” represented an identity threat to the “addict” staff members on a number of dimensions. It (1) challenged their claim to personalized authority in the organization (as “recovering addicts” who had “been there”) by framing authority in professionalized terms, (2) threatened staff’s sense of competence and made them uncomfortable (outcomes of staff-resident interventions were less controllable with the new methods), and (3) altered the methods that they believed had “worked” for them as residents (staff defined “addict” as an essential identity, so changing the methods that staff believed helped them to recover was threatening). In response to the “addict” staff members’ resistance, key staff members supportive of the empathic approach made use of (a) appeals to professionalization
(offering alternative routes to semi-professional authority), (b) appeals to biology and empowerment (reframing addiction as beyond the resident’s control and repositioning staff’s role as empowering the resident to make their own decisions), and (c) appeals to effectiveness (arguing that the new methods were more effective than the old methods in achieving desired results). The TC approach remained dominant throughout my study, and no “addict” staff members gave up the TC methods entirely; but, all of the “people-staff” (those staff members who dealt with residents outside of SATH’s businesses) came to use the empathic methods at least some of the time. This research aids our understanding of the processes of personal and professional identity threat, in addition to analyzing treatment practices in TCs.

THE EMPATHIC APPROACH

The empathic approach to treatment at SATH emerged primarily through the introduction of an alternative method of staff-resident interaction known as the “Motivational Interview” (MI). In contrast to the aggressive and confrontational approach and practices of the therapeutic community (see Chapters II and III), the MI was based on empathic and reflective listening. It is designed to elicit the desire to change (“motivational”) in clients through a non-confrontational interaction based on listening and clarifying questions (“interview”). Psychologists William R. Miller and Stephen Rollnick (2002) developed the method in their therapeutic work with “problem drinkers.” They define the MI as “a client-centered, directive approach to enhance intrinsic motivation for behavior change by working with and resolving ambivalence” (25). The ambivalence in question is whether or not the client resists or indulges in the continued
use of a substance. Psychiatrist Janet Treasure (2004) outlines four directives of the method:

1. Express empathy by using reflective listening to convey understanding of the patient’s point of view and underlying drives

2. Develop the discrepancy between the patient’s most deeply held values and their current behaviour [sic] (i.e., tease out ways in which current unhealthy behaviours conflict with the wish to ‘be good’—or to be viewed to be good)

3. Sidestep resistance by responding with empathy and understanding rather than confrontation

4. Support self-effectiveness by building the patient’s confidence that change is possible (331).

In the TC approach staff members yell at residents, tell them to change, or threaten them with punishment. In theory, the drive to alter behavior in this approach comes from without. In contrast, the MI involves staff or other residents talking with the resident in question about their struggles making decisions related to drug use. By appealing to the resident’s values and desires, rather than imposing organizational values on her or him, the MI is designed to elicit motivation to change from within.

At SATH, I first heard about the MI from Maria, a recent graduate of the program working in the In-Take Department. Maria was being trained in the MI through classes she was taking to become a certified Peer Support Specialist (PSS). Working with her in the In-Take Department one morning, I asked how her classes were going. She replied, “I’m learning a lot about approaches to substance abuse treatment, and it’s different than what we do here.” I asked her what was different and she paused before saying:
The way we approach people. Here we’re pretty strict with people, and we can be pretty tough. But, in my classes we’re learning about MI, Motivational Interviews, as a way to approach people. The tough [TC] approach wouldn’t work for everyone. And a lot of people don’t make it through. A lot of people leave SATH because they can’t take it.

The MI then, offered a departure from the “tough” approach (what other staff and residents called “shaming and blaming”) that Maria had encountered as a resident.

Malcolm was another resident who graduated and went on to become a staff member during my research. Like Maria, he was exposed to the MI and other methods that constitute the empathic approach in external trainings following his graduation. His response to the methods was similar to Maria’s. In an interview, I asked him what he was learning. He said:

[How to] communicate better. Learn how to listen and not put on a lab coat and try to fix other people’s problems. Try to help guide them through their situations by being supportive and by giving ’em hope and motivation, and not, you know, demanding—it’s a little different from some of the ways I was taught in here.

[Interviewer: So, different from how you were approached as a resident?] A lot of the stuff I’m learning doesn’t really coincide with the therapeutic community. I’m not saying that either one is right or wrong, but it’s different.

In the MI, the resident is a part of the process of the therapeutic intervention and not solely the recipient of a staff member’s judgment or sanction. Ricky, the head of the Men’s Program, was initially resistant to incorporating the MI. With more exposure to the technique, he came to embrace it as a supplement to, though not a replacement for,
the TC approach. In an interview, he noted that the MI could be used effectively in day-to-day interactions between residents and staff:

[I]n general conversations with people, when people are just really going through their day—you know, because a lot of time they're just going through their day because so many residents have so many things going through them on a daily basis. Then it's just simply a daily, a daily check-in, when you're just sitting down there talking to them about their day, how their day went, their programmatic goals. I mean, that's when the Motivational Interview comes into play much more, because you can't use a traditional TC approach to that, you know, you don't wanna alienate 'em. And, you don't want to, as Allan [a professional counselor who worked part-time at SATH as a consultant] would say, get in the way [of a resident’s personal growth by screaming at them], you know what I'm saying? So, that's when the Motivational Interview can be much more successful, sitting there talking to a resident about their day, their life, what's going on with them today and tomorrow.

As I discussed in Chapters II and III, the TC approach dominated at SATH and was prevalent during disciplinary interventions and at group-based accountability sessions (“games”). SATH did not have the resources to provide residents with individual counseling, but the MI offered a potentially more empathic and individualized approach to day-to-day interaction with the residents, even for staff members who did not want to give up the traditional approach entirely.

INTRODUCING THE EMPATHIC APPROACH AT SATH

As I will describe in more detail below, the MI was threatening to the staff who had graduated from SATH or another TC. How did the methods come to be introduced at SATH? Central to the process was the influence of Allan, a professional counselor at a university-based center for substance abuse treatment and research who worked with
SATH as a clinical consultant. It wasn’t easy for Allan to become influential because James Carter, the founder and president of SATH, maintained strict control over all facets of the program. Every request I made to a staff person or resident for an interview, and all requests for the release of programmatic details or information, had to be approved by him. Staff told me that Carter was initially reluctant to create a Board of Directors for SATH because he did not want to lose any control over the direction of the program. However, as the organization grew he realized, according to one staff member, that he needed a Board for legitimacy with community leaders. Allan joined the Board at this time. Carter brought Allan more and more into the program, to the point that Allan left the Board to become a part-time staff member in the role of Clinical Consultant. As Mary, a staff person working in the Medical Clinic, told me, “it took a long time for [James] to trust Allan. Once he trusts you, you’re his friend and he’s more likely to take your suggestions. But, it took a long time to build up that relationship.” When it came to the empathic approach, this proved to be an important relationship.

Allan, as a professional counselor and academic, pushed for the adoption of “best practices”—the methods and techniques in the fields of counseling and social work that are identified by practitioners as most efficient to produce desired outcomes—at SATH. There was little uptake of these practices, though, until SATH gained licensure from the state. There is wide variation in how therapeutic communities are organized. Some are licensed, some are not. SATH did not have a license, but administrators initially looked into gaining licensure because it would open up opportunities for state and federal funding. Carter was ambivalent because licensure would also open up the agency to
oversight by the state. As Allan reported to me in an interview, administrators ultimately began the licensure process because of pressure from state regulatory agencies:

They [SATH administrators] were exploring [licensure] anyway, for all the reasons you just mentioned—it opened up opportunities, it legitimates the program, it reassures funders that this is, you know, legitimate and monitored, and so on. But, the bottom-line was that if they didn’t do it, they had a letter saying that they couldn’t operate [because the state would shut them down].

Representatives of the Department of Health and Human Services had increased their oversight of substance abuse treatment facilities in the state. They demanded that SATH become licensed and accredited in order to remain open and, according to Allan, threatened to fine the organization several thousand dollars a day for every day that it lacked a license. Becoming licensed brought with it the pressure to bring on more staff members with professional degrees.

None of the new staff members who joined the organization at this time had personal histories of addiction. In the parlance of the organization, they were “straight.” “Straight” staff were vastly outnumbered by “addict” staff, but held positions in the Medical Clinic, the Finance Department, and other administrative roles. The majority of residents’ interaction with staff occurred with those who oversaw SATH’s businesses and with staff working as house managers. But, along with Allan, two staff members, Mary and Kim, played a crucial role in pushing the empathic approach. Both “straight” clinical social workers, they joined SATH’s Medical Clinic and worked with Allan on the clinical direction of the program. Only with the threat of closure and the addition of staff with professional degrees did the empathic approach gain some traction.
SATH was in the middle of this process when I began my study. By the time I finished the project, twenty-nine months later, the TC approach was still dominant, but more staff were using the MI situationally. Resistance to the MI remained. James Carter supposedly trusted Allan, supported the introduction of the new methods, and, in his words, was invested in the “evolution” of the program. But he was not particularly happy about it. As a total institution, strict rules and a clear system of rewards and punishments imposed by staff, consistent with the TC approach, were an integral part of the operation of SATH. But Carter bristled under the “new rules” for staff:

Allan’s talking about boundaries [focusing on the resident and not bringing your personal story into the intervention] and all this crap, and I didn’t go to any meetings [about the new methods] because I didn’t want to be polluted [confused or turned off of a track that worked for him], because sometimes you get polluted and you just can’t think—no disrespect, but—and people thought that I just didn’t want to go for other reasons, but that was the real deal. It’s not that I don’t like knowledge, and I probably should have gone, but I wanted to keep perspective, you know, and, uh, I don’t want to get bogged down with rules. Rules are—you know, I’m very rigid, so, I understand what’s right and wrong. But, now we’re getting all these rules and I have to look at it as positive, you know, have to like everything, it has to be positive. It’s not about me or the dinosaurs.

Carter’s comments exemplify the struggles of many staff who attributed their recovery and sobriety to the TC model. Even if they saw the importance or inevitability of changing the model (“I have to look at it as positive”), the transition was difficult and did not necessarily make sense to them as a good or effective treatment.

Just as James Carter resisted going to meetings concerning the empathic approach (“I didn’t want to be polluted”), under his leadership the trainings in the MI were not consistently offered or supported across the organization. Mary, one of the clinical social
workers, told me in an interview about the differences in training for the “people-staff” (those who worked with residents outside the residents’ vocational training and work) and “business-staff” (those who worked on coordinating the various businesses that SATH ran):

It’s mainly the people-staff, the people who are house managers, who are folks who run some of the departments over here at S-West [the main campus], that really have been included in those meetings with our clinical services person and our consultants, who have really learned those Motivational Interviewing strategies, and learned to—trying to get rid of what they call old-school therapeutic community tactics. But, you know, folks in moving and construction, who are more the business-people, they haven’t gotten any of that training. And so, you have this, like, really some split ideas about how we discipline residents. And what I would think is that we would hopefully get the business-folks more in line with what the people-folks are doing. But, a lot of the folks who spent twelve and fifteen years in Recovery Place [another TC, from which James Carter and several other staff members graduated] many years ago think that this is just the most outrageous thing that we would not just blast somebody out and give them a huge contract [period of disciplinary probation].... They think that certain people are being too soft and they can’t see how it works. But, we’re trying to do more and more of what the best practices of substance abuse treatment would tell you to do.

In a separate interaction, Mary and I talked again about some staff members’ resistance to the MI. She reiterated her frustration: “It makes it hard to really implement change. It seems like if this is a direction we want to go, we would be providing training system-wide.”

The lack of widespread training in the methods of the empathic approach amounted to a form of institutional resistance. Even when the trainings did occur, staff were not always supported in their efforts to use the new methods. In an interview, Malcolm, who took many counseling classes outside SATH after graduating from the
program, clarified this point when I asked him about tension among the staff: “Well, like the Motivational Interviewing class I took, that was—it didn’t have nothing to do with SATH, that was on my own.” He continued, noting that his development as a “substance abuse counselor” would require him to leave SATH:

[Interviewer: Do you feel like there’s support for you to bring these skills in and do this?]

Um [pause], not necessarily to bring it into here. I do all this for me. It’s, anything I can do to help other people, I’m glad to do it.

[Interviewer: So, it’s like, it’s in your toolkit, but you might not get to use it?]

Right. The way things, like, how I view becoming a staff member, and where I see it now and from what I really want, I see myself stepping out of here [SATH]. Uh, I’m really grateful for this place, and I never, I never want to burn any bridges. And, I’ll probably stay a couple of more years. But, from what my goals are heading toward now, that’s not [trails off].

[Interviewer: That’s not your last step?]

Right.

Similarly, John, another former resident who became a staff member, left the organization midway through my study to work as a substance abuse counselor at another organization that was using methods like the MI. He caught up with me following a meeting to tell me the news: “I’m walking on air! This is so exciting. I’m just thrilled that I’m actually going to get to start applying the things that I’m learning in these trainings.” James Carter opened the door to the empathic approach, but not widely.
SELLING AND RESISTING THE EMPATHIC APPROACH

Despite institutional-level resistance to adopting the empathic approach, Allan, along with Mary and Kim, continued to offer support for and trainings on the new methods to the “people-staff.” The empathic approach was threatening to the “addict” staff members in a number of ways: it challenged their claim to personalized authority in the organization; it led them to feel incompetent, frustrated, and uncomfortable; and it scared them to give up on the methods that had “worked” for them as residents. In response, Allan, with support from Mary and Kim, made use of (a) appeals to professionalization, (b) appeals to biology and empowerment, and (c) appeals to effectiveness to convince the rest of the staff of the worthiness of the empathic approach. The TC approach remained dominant throughout my study, and no “addict” staff members gave up the TC methods entirely; but, all of the people-staff came to use the empathic methods at least some of the time.

Appeals to professionalization

In Chapter II, I discussed the ways that the “addict” staff members justified the use of the traditional TC methods through personalized authority claims. They had “been there” and “got clean,” in their account; therefore, they knew what they were talking about and should be listened to. Having “walked the walk,” they demanded—and expected—respect and compliance from residents. The “straight” staff who used the empathic approach did not have personal histories of drug use and addiction. Instead, they had professional degrees.
Just as the new staff members represented the formal institution of education, the empathic methods were endorsed by the medical and professional establishment as *best practices*—“a practice that, upon rigorous evaluation, demonstrates success, has had an impact, and can be replicated” (INFO 2007: para 1). Consider the comment from Mary, quoted above, in which she discussed her frustration with staff members’ resistance to the MI: “They think that certain people are being too soft and they can’t see how it works. But, we’re trying to do more and more of what the best practices of substance abuse treatment would tell you to do.” Allan made a similar comment to me when discussing the uptake of the empathic approach in some areas of the organization: “The program really is moving to embrace more of the best practice orientation.” The empathic methods, then, were backed up by research, as opposed to the personal experiences of the staff members.

Basing a claim to authority in a professional degree and “best practices” was threatening to many of the staff members. Although they had street smarts and survival skills from hard living, qualities that garnered respect from the resident population, these were not skills that translated into conventional success outside SATH. Few of the staff members had graduated from high school, let alone going on to attain undergraduate and graduate degrees. Moreover, because the majority of the residents at SATH (and the majority of the staff members who transitioned from the resident population) had felony convictions, their ability to secure a good job with support and benefits after graduation was limited. Staying on to work at SATH became attractive. Being a staff member provided them: continued affiliation with the highly regimented organization that helped them to “get clean;” a good benefits package and extras (low-cost housing and
transportation) that enabled a relatively middle-class lifestyle; an opportunity to help others who also struggled with drug use; and, authority and respect as staff members who had “gotten clean.” If securing a position at SATH were to require a professional degree, no residents would be hired.

It is not surprising, then, that many “addict” staff members resisted the addition of “straight” staff and the implementation of the empathic methods. James Carter reluctantly opened the door to straight staff, and only because of pressure from the state to become licensed. Recall that he refused to attend meetings or trainings on the empathic approach because he did not want to be “polluted” by the ideas; and, he resented the “new rules” that he was coming up against. In addition, he found working with straight staff challenging:

I’m not saying the straight staff aren’t soldiers [dedicated] because they are soldiers. Most of the straight staff are fantastic. It’s just, it takes time for some of them to “get it” because they come from a business background. The folks in murderers’ row² here [motions back to the administrative offices, filled with “straight” staff almost exclusively] are really fantastic, you know; they get it [believe in the mission of the organization], Bob is going to get it, Charlotte is going to have a harder time, a very difficult time. Marian gets it, you know, [the staff in the] Medical [Clinic] get it. They wouldn’t be here if they didn’t get it, or pieces of it. And I’m a driver [demanding boss], man, you know? And, like, working with straight people—fuck, they get their feelings hurt so easily! I mean, everybody gets their feelings hurt! Just get over it, man! It’s the mission, it’s not your feelings!

Resistance to the addition of “straight” staff extended beyond the belief that they had a difficult time adjusting to the emotional culture of the organization (“Just get over it, man!”). Even those who ultimately embraced the addition of “straight” staff believed
that their personal histories of addiction and recovery made a positive difference in their ability to connect with residents. Colleen, the head of the Women’s Program, said:

Well, I think it makes it easier for you if you have [a history of addiction] because [pause] you’re not fooled as easily, um, because some people [addicts] just naturally do that. So, you have a little more insight that way, and, um, and then, you pretty much know what people are feeling a lot of times when they’re describing it.

Street smarts, in this view, trumped book smarts. In addition to representing a change in the basis of authority, the empathic approach represented a change in the tone of staff-resident interactions. Instead of approaching residents with distrust and anger, the empathic approach was based on listening and a medicalized model of affective neutrality (Parsons 1951), acting in a “personable, but not personal” way (Mills and Kleinman 1988:1022). The focus of an intervention in this model is the resident’s motivation and feelings, not the behavioral transgression or the personal experiences (“I’ve been there”) of the staff member. According to the MI, focusing on the personal stories of the practitioner is a distraction from the goal of the intervention. Allan referred to this as “getting in the way” of a resident’s recovery. During one of the Clinical Meetings, a bi-weekly meeting for the “people-staff,” Allan, Mary, and Kim pushed for the adoption of the empathic approach. Allan said:

Our job [as treatment providers] is really to facilitate a process in which the residents can gain self-discovery. The Motivational Interview helps with this in two ways: One, it puts the focus on them and facilitates self-discovery by eliciting internal motivation; and two, it trains staff to get out of the way of that
process. The old [TC] ways get in the way of the process. The Motivational Interview, then, is in many ways the art of getting out of the way.

In this view, the emphasis should be on the resident. This, too, undercut the traditional TC claim to authority through personal biography, and was, not surprisingly, met with resistance. In an interview, James Carter commented on the changes in staff members’ approach to residents:

I can’t even say good morning to somebody without I’m crossin’ boundaries, you know what I mean? And part of this thing [treatment in a TC] is sharing with other people, and now you’re not supposed to share because that’s boundaries. You’re not supposed to tell ‘em about your story because that’s crossing boundaries or some bullshit. I mean, I can’t keep up with all the names and the rules. And like, there’s a fine line when you start [trails off]. And, I think [sharing is] good, I think it takes it to another level of interaction with staff. For us dinosaurs [staff who graduated from a TC], we’re used to living by example and, you know, being able to verbalize, you know, “I was a jerk, I did this.”

In addition to chafing under the erosion of personalized authority claims, Carter suggested the professional model of affective neutrality was overly impersonal and, thus, inauthentic. Comments from a resident support this view. In Chapter III, I discussed the interaction I had with a young male resident named Truck. Truck broke down in a “game” (an aggressive and confrontational group accountability session) one night under intense and angry grilling from other residents. A few weeks after this event, Truck and I talked privately while we worked at a SATH Christmas Tree Lot. I mostly listened, but I also answered questions that Truck asked of me. He disclosed a history of sexual and
emotional abuse from childhood, for which he had seen counselors in the Department of Social Services. Their emotional distance, he noted, frustrated him:

I’ve even tried asking them things, not even overly personal things, just like how they’re doing, and they’ll say, “Oh, we’re here to talk about you.” That’s why it’s so nice to talk to you. You’re a really great listener, but you’re not shutting me out either.

Although I was not using the TC approach with Truck, his comments, along with Carter’s comments above, frame the more middle-class “professional” model of impersonal listening and affective neutrality as suspect, inauthentic, and phony. In contrast, the TC approach, a more working-class model based on directives and raised voices, could be experienced as “real” (see Sattel 1976).

The professionalized authority of the empathic approach was threatening to the traditional staff members, but Allan, Mary, and Kim used an appeal to professionalization in response to staff resistance. Specifically, they encouraged the staff members to go through external trainings in the new methods. These trainings did not offer a professional degree, but the successful completion of them bestowed a certificate on the staff member that offered occupational capital in the field of substance abuse counseling. With a Master’s degree in Social Work, a counselor can become a Licensed Clinical Addictions Specialist (LCAS). But the staff at SATH, who did not have a degree but who did have experience in the field, could become Certified Peer Support Specialists (CPSS) through the completion of the trainings. This certificate, along with training in the “best practices” of the medical establishment, offered reflected status and an alternative route to semi-professionalized authority to “addict” staff members. Allan praised the staff
members who had completed certificate programs during Clinical Meetings: “Does everyone know that Colleen passed her written exam for certification?!”

Staff members who completed the trainings expressed pride in doing so. In an interview, Malcolm told me excitedly that he had just passed his test to become a CPSS. I offered him congratulations, and he said, “Thank you, that was a major accomplishment. I worked really hard for that.” And during a group meeting for graduates of the program who were transitioning to become staff members, a resident noted that his training in the empathic methods had made him feel that he had a contribution to make to SATH, even though he was “uneducated generally.” The certificates, in addition to offering the staff members access to an authority claim based on professionalization, could also translate into occupational capital at other organizations. Ironically, as a comment from Malcolm (quoted above) points out, the institutional resistance to the empathic approach at SATH may have upped the chances that staff who learned the new methods would leave:

Uh, I’m really grateful for this place, and I never, I never want to burn any bridges. And, I’ll probably stay a couple of more years. But, from what my goals are heading toward now, that’s not [trails off].

[Interviewer: That’s not your last step.]

Right.

The professionalized appeal, then, had potential payoffs beyond the walls of the organization.
Appeals to biology and empowerment

As I discussed in Chapter II, the traditional TC focus on “personal responsibility” led staff members to enforce the rules of the organization through aggressive tactics. In this staff role, it is hard to fail. The staff member enforces the pre-established rules, and residents either comply or they do not. If they do not, the TC frame puts the blame on the resident for making poor choices as an addict. Staff members get frustrated and angry at residents in this approach, and they may be disappointed in residents’ choices, but if a resident fails to comply or leaves the organization it is not the staff members’ fault. As Henry, a graduate of the program and a staff member, said to me in an interview:

I could have a hundred percent compassion for you and love for you, but if you leave the program I’ve forgotten you in two weeks. I’ve forgotten you that day, because your choice was not to be with your family [SATH]. Your choice was to leave, so I’m just going to let you go out, and feel that wrath [of the world outside of SATH] again.

The empathic approach calls for the practitioner to become involved in unscripted and uncertain interaction with the resident as opposed to simply enforcing rules that the resident was forbidden to challenge. The explicit focus of the interaction moves from controlling the resident to facilitating a process, as Allan discussed it, of “self-discovery.” The outcome of this new kind of intervention is complicated, unpredictable, and puts more responsibility on the staff member. As Kenneth H. Kolb (2008) found in his study of domestic violence and sexual assault advocates, treatment/advocacy that relies on empathy and sympathy for clients can heighten the provider’s feelings of responsibility for the outcome of the intervention.
In response to these points of resistance from staff, Allan, Mary, and Kim made an appeal to biology and empowerment. In short, they framed addiction as a disease instead of a matter of personal irresponsibility and framed the goal of the intervention as empowering residents to make changes themselves. For example, during a Clinical Meeting for the “people-staff,” the discussion turned to “re-starts” (residents who graduate, use drugs again, and return to the program). Colleen, the head of the Women’s Program, said that staff should focus on what these residents “missed” the first time they came through the program and on what had happened to them since they left the first time. Kim listened, then replied:

I agree. We need to focus more on what happened since they left the first time and try to help them talk about how they feel different, but I don’t usually ask them what they missed the first time or ask what went wrong. Relapse is really part of the disease. It’s part of the process of recovery, so it’s not necessarily that they missed something or did anything wrong. It’s just that that is part of the process (emphasis added).

This appeal to biology through disease-talk worked in three ways: it fostered empathy for the residents by framing their drug use as something for which they weren’t responsible; it undercut the traditional TC frame of addicts as manipulative liars who made bad personal decisions (see Chapter II for more on the traditional TC approach); and, it alleviated potential feelings of staff responsibility for resident outcomes. If “relapse is just part of the disease,” then continued drug use is not a result of staff’s inability to “fix” the residents. It is, instead, simply “part of the process.”

Related to the framing of addiction as a disease, Allan discussed the “science of addiction” and the impact of drug use on the brain. In a Clinical Meeting, he explained
that drug use, particularly when an individual begins taking drugs at an early age, has an impact on “the brain’s ability to control impulses.” In an interview, he developed this idea further:

[W]e have different parts of our brain, and the thinking part of our brain is not the only part that controls what we do. The part of our brain that really controls what we do is the limbic system, the parasympathetic nervous system, which is the part of our brain that is certainly affected by drug use. So, part of what happens is that drugs create these powerful emotion memories and change the brain chemistry such that we believe we need that in order to feel okay. So, that’s kind of the neurobiology of addiction.

Again, by framing (continued) drug use as a “disease” or the result of a change in brain chemistry, neither the resident nor the treatment provider is a failure in the face of “relapse.”

Further distancing the staff members from responsibility for the outcome of an intervention, staff in support of the empathic approach reframed the residents as the “experts” of what they needed. If the resident is the expert, then the staff person does not have to have all the answers. It is not the staff member’s role, then, to “fix” the resident. Instead, the resident must fix themselves, and it is the role of staff to empower them to do so. For example, Kim left the program during my research because she and her partner were relocating to another state. In her last Clinical Meeting, Sarah, another staff member, asked her, “If you had one thing to say to us as you leave, what would it be?” Kim thought for a moment, and then said, “The client knows what’s best for them.” Allan responded, “Ohhhh, I like that.” Kim continued, using the opportunity to frame the role of the treatment provider as following the lead of the “client”:
I’m continually amazed by [the clients’] wisdom. Also, in doing my termination of service with my clients here, I’ve asked for their feedback on our work together. Over and over again, they say that they appreciate how I sum things up for them. Basically, I just listen. Ask for clarifying questions, I listen, and then at the end I sum up what I heard them say. This helps them get some clarity on their thoughts, and it also provides them the space to get through some of their resistance. They may say they’re fine and happy and talk about that for thirty minutes, and then they start getting to the stuff that’s really bothering them.

The staff member’s role in this approach is to “listen,” providing the space in which residents can come to their own conclusions and discoveries. Staff are not rule-enforcers, but facilitators of recovery who help residents change themselves.

Comments from the TC-oriented staff members who took on the empathic approach suggest that this appeal was convincing. Malcolm, in a comment quoted above, noted that what he was learning to do with the MI was “listen and not put on a lab coat and try to fix other people’s problems.” Brandon expressed a similar sentiment. A resident when I began my research, Brandon stayed on to become a staff member after graduating from the program. He sought out trainings in the empathic approach and, more than any other resident transitioning to staff (who I met), tried to put the new methods to work. In an interview, he discussed these attempts, his struggles and successes:

I have to practice in here, work at it, and with people from all different walks of life, to unglue my thoughts and opinions about who they are, and where they come from, how they look, you know, and just listen to what’s going on with them, so that I can help direct them to the right place. And that’s where the Motivational Interviewing comes in here. I can ask them, “What do you think you need to do?” And that, it helps because I get a plan from them, and how to assist them in doing what they need to do, and not feel emotionally committed,
or get too overwhelmed, or just put the white coat on, because I don’t have a
degree. I don’t have any, you know, formal training or anything like that. So, it
really alleviates that pressure of telling them what they should do, how to do it,
and when to do it.

By framing addiction as a disease and viewing their role as empowering the residents to
make changes in their own lives, the staff members were able to manage their initial
feelings of inadequacy as well as their anxiety about feeling responsible for residents’
recovery.

*Appeals to effectiveness*

Staff members who had graduated from SATH or another TC found the empathic
approach threatening because it challenged the methods that they believed had worked
for their recovery. In the traditional TC approach, staff’s authority is anchored in their
identity as “recovering addicts.” The TC approach also cast “addict” as an essential
identity—using drugs is not something addicts do, but it is a defining feature of who they
are. On several occasions, I heard staff members remark that they would “always be an
addict,” even though they might be “clean” for the rest of their lives. Being a “recovering
addict,” then, was a central identity for the staff members. Challenging the methods that
ostensibly “worked” to get them—and keep them—“clean” felt threatening. It not only
challenged an aspect of their beliefs about their own identity, it challenged a method they
believed would work for other residents as well. In an interview, Colleen, the head of the
Women’s Program, said:
Yeah, it’s hard to give up what worked for you! And we, and we dig our feet in on a lot of that stuff, because, like, most of the management staff [staff who oversee the dormitories and work directly with residents], all of the management staff except one or two have all come through either SATH or Recovery Place [another TC in a different part of the country]. So, we all have been there and this is what worked for us. And so it’s really hard for us to not do it.

Beyond struggling with giving up the methods that “worked” for them, many staff members refused to believe that the empathic methods were effective. In a Clinical Meeting in which Allan was pushing for the increased use of the MI across the organization, Rocky, who worked in the Men’s Program, said in a dismissive tone: “Yeah, but the MI is not for everything. The TC approach is just fine.” And Sarah, who worked in the kitchens and with the Women’s Program, argued in the same meeting that some residents misused the MI:

Some folks will take advantage of the Motivational Interview, overusing it. They’ll come and talk to every staff person they can find about the same things again and again and again and again. They just stay on the surface with it, they don’t go within.

Here, in a move that reflected the traditional TC framing of the “addict” as a manipulative liar, Sarah argued that the residents could not be trusted to make appropriate use of the alternative methods.

Every “addict” staff member with whom I spoke said that the MI would not work in all situations. Specifically, they argued that it was critical to use the TC approach in disciplinary interventions (reflecting the traditional TC focus on the enforcement of rules) and with newcomers to the program. TC-oriented staff argued that new residents needed
“a lot of structure,” “a lot of guidance,” and “strict rules” because they “need to be forced
a little bit in the beginning,” and “they don’t know anything—their mind is still clouded
with drugs, it’s still in their brains.” Over and again, they told me that at the start of the
program residents were not “ready” for the MI.

In response, Allan, Kim, and Mary stressed that the empathic methods worked
and, beyond that, that they worked better than the traditional TC approach. In an
interview, Mary argued that the belief that residents were not “ready” for the MI was off
base:

Well [pause] I don’t believe that just because I’ve never seen things from that
perspective. And, I think if you asked professionals they would say, “No, you
can start with Motivational Interviewing from the beginning, and that will build
a stronger rapport.” But, I think the answer is going to be totally split based on
the audience you’re talking to.

She understood where staff’s resistance might be coming from, but she argued in an
interview that the traditional TC approach could be driving residents away:

I think that [the traditional TC approach is] what so many staff have known, and
they’re clean, so [in their minds] that must be what you need to do. Of course,
there are thousands of people who it hasn’t worked for, who aren’t there, who
aren’t in recovery, [who] it hasn’t worked for. And [the staff] don’t think, you
know, [the ones who didn’t make it] probably wanted recovery just as much as
you did, and it just didn’t fit their personalities to be yelled at.

In a different interview she offered an example of the way an interaction in the empathic
approach might go:
Like, you know, instead of saying, “Oh my god, I can’t believe you just did that, you’re so stupid”—which I’m sure has been said here many times in the past—we might look at the behavior and try to help the person understand why that was wrong, help them generate that themselves, and then tell them what needs to happen instead. And more in a way that you would want, more of an adult role model, because a lot of people here have come from families where all there was was yelling, verbal abuse, and physical abuse. So, I like the change happening because it’s them being able to see staff in emotional control, and really working toward a solution, talking to them as an adult, someone who has to be responsible for their actions, and them generating what’s wrong instead of, you know, us yelling about what’s wrong.

The key difference here, as Mary articulated it, was that the resident was “generating what’s wrong” instead of being told what was wrong. By working as a participant in this interaction, the resident would presumably become more invested in the outcome. The desire to change would be fostered internally and thus produce a deeper impact than an external imposition. In an informal discussion one day, Mary directly expressed her frustrations with the TC model: “[I]t’s not good to shame and blame people. I mean, [in] what environment is that ever good?”

For his part, Allen used a biological rhetoric (in an interview) to challenge the effectiveness of the traditional TC approach:

[“Shaming and blaming” is] what’s being stressed [at SATH]. And the other thing we know is that the number one predictor of how we activate the craving state in the brain, in an addicted brain, is stress. And so, when you’re changing chemistry based on stress that leads to the activation of the craving signal. What we’re doing is driving people into their addiction. Whereas the motivational approach is all about connection and relations.

By shaming the residents, he argued, staff members were triggering the craving impulse and exacerbating the symptoms of addiction. In another interview, he expressed his
frustrations with the traditional TC approach emphatically: “The [residents] learn better
[with the MI], versus, ‘You motherfucker, blah blah blah!’ Like they’re going to think,
‘Let me reflect on that’? No, they’re going to sit there and stew all day and be pissed off
at the guy who yelled at you.”

I did not observe Allan or Mary express their frustrations with the TC methods as
directly to “addict” staff. Yet, Allan (especially), and Mary to a lesser extent, argued hard
in Clinical Meetings for the effectiveness of the empathic approach. In one meeting Mary
took the floor and told the group about an experience she had had leading a tour of
community members through the program:

I noticed something last month while I was leading a tour through campus that
kind of bothered me, and I just wanted to check in with folks and see if this was
just something about me, or if it was something that we should address. As I
was leading these tours through, almost every resident who stood up to share
their story gave a list of their “character defects.” That expression just really
bothered me. They would say, “Hi, my name is Jane and my character defects
are x, y, and z.” And then the next person would do that, and the next. It was
weird, and the people on the tour asked about it.

Allan commented that this practice came out of other programmatic models: “That
language comes out of AA [Alcoholics Anonymous], out of 12-Step programs. It’s self-
shaming.” Although this language reflected practices of programs apart from SATH, he
used this opportunity to challenge the traditional TC focus on shaming and blaming:

It goes against what we’re trying to do here. We’re trying to build people up and
focus on their strengths, to use a strength-based perspective. Self-shaming goes
against that. What we can focus on instead are behavioral problems. That’s why
we say what we do is behavioral therapy. It’s not the person who is defective,
it’s behavior that’s problematic. We can change behavior.
During another meeting, Allan asked the staff members to report on their attempts to use the MI. The follow excerpt from my fieldnotes highlights some points of resistance:

Ricky: “The Motivational Interview isn’t appropriate in every situation, and it shouldn’t just be used across the board. It’s not going to work in the Blue Room [the room in which disciplinary interventions are handled in the men’s dormitory], so you need to go back to the SATH-way for [disciplinary] correctives.”

Rocky and Peter nodded. Rocky added: “Yeah, I find it works better with individual check-ins and reviews with small groups.”

Sarah: “For me, I find that it depends on the individual—some are ready and some are not. If I try to use it and they’re not responsive, I’ll switch over to the peer support mode, sharing more about my experience and what worked for me.”

Rocky: “I think you need to condense it. It takes too much time to do the Motivational Interview with 170 people, man. We ain’t got time for that. I just pick people, condense the process, and then move on to the next one.”

Allan seemed to be applying the techniques of the MI to the staff as he listened and then “reflected back” what he was hearing. He validated the staff member’s frustrations, but then asserted in each case of resistance how the MI could be used effectively. A sample of his comments include:

That’s true. However, the Motivational Interview can be used effectively even if all you have is fifteen minutes. It can be used to open a door to help the person evaluate what behavior is consistent with their values. What behavior will get them closer to the life they want to lead? It may not get them thinking about
changing, but it may get them to think about thinking about changing. And if you can do that, that’s great.

The Motivational Interview is for people who get stuck, and they may not even be aware that they’re stuck. It is a pragmatic way to approach people, but it’s not a guarantee. You can use it, though, to help people interpret their behavior in context.

The Motivational Interview can help people tune in to the consistency between their behavior and their values, the consistency of their behavior and the life that they want to live. They may not feel any real movement at that moment, but is being here overall helping them to get closer to the life that they want to live? The Motivational Interview gives them responsibility to change, as opposed to putting it on the program. A lot of residents expect SATH to change them, as opposed to using the resources within SATH to make changes themselves. They think there’s some magic program dust we can sprinkle on them and fix them, but there isn’t. The Motivational Interview can help them to come to that awareness, to motivate them to change themselves.

Allan and Mary’s appeal to effectiveness also relied on what they and other empathy-oriented staff members pointed to as early indications of the impact of the MI on residents. For example, during our interview, Malcolm said that he was already seeing positive results from the increased use of the new methods: “The numbers [of people staying through graduation] are increasing with this different approach. Before, they were decreasing.” Regardless of accuracy, reports from other staff concerning graduation rates confirmed Malcolm’s observation of the changing numbers. Other staff, too, said they had seen a positive impact in other aspects of the program. I asked Ricky, the head of the Men’s Program, if he had noticed a change in how the residents were responding to the newer methods:
Ahhh [pause], now that one is, is a difficult one, you know what I'm saying? Because, we have so many different residents, you know? Uh, and it's not, if we were dealing with thirty residents I could tell you more than what we're dealing with. Now, what I can say is that our [disciplinary] interventions have dropped, you know what I'm saying? That's dropped, you know, where we were actually upwards of two hundred and fifty a month, you know, but last month we did a hundred and forty. So, you know, that has definitely dropped. I can see that we do a lot of checking in, more interactions and things of that nature there.

Again, whether the change in the numbers of interventions could be attributed to the increased use of the empathic methods or not, more and more staff members began to interpret the change in that way.

Even those staff members who had been most resistant to the empathic methods to begin with started to soften. Colleen, the head of the Women’s Program who said that the staff would “dig [their] feet in” to hold onto the traditional TC approach, came to believe in the effectiveness of the empathic methods. In a Clinical Meeting one day, a staff member named Reggie dismissed the MI in a joke. Allan responded by saying, “People need to be heard. If you don’t do that, there is nothing therapeutic at all about what you’re doing.” Colleen supported Allan, saying simply, “Motivational Interviewing works.” Colleen’s public support was important. She was a graduate of the same TC that James Carter had participated in, and he brought her to SATH specifically to start the Women’s Program. Her voice, and her example in gaining a certificate as a Peer Support Specialist, carried a lot of weight with the staff. More than that, it represented a success on the part of Allan, Mary, and Kim in appealing to the rest of the people-staff.

Toward the end of my project, Allan reflected on his efforts to introduce the empathic approach at SATH:
Well, I think, I do think it’s making a difference. I think it’s shifted—I think it’s enabling a kinder, gentler, more responsive system. And, I’m not going to tell you that some of those [old] practices don’t still exist. I’m not going to tell you that; well, James [Carter], in particular, is kind of reluctant to let go of some of that. But, I think it’s more blended than it was last time we talked. It’s much more blended.

The TC approach, as noted above, remained dominant throughout my project. But, the appeals of staff members like Allan, Mary, and Kim had secured some space for the empathic methods at SATH.

RESPONDING TO THE EMPATHIC APPROACH

The traditional TC approach remained dominant, but the program became “more blended” over time. Most residents had some exposure to the empathic methods through their interaction with house-managers, if nothing else. I did not observe staff using the empathic methods directly with residents. But, conversations with residents and graduates, including staff who had graduated during my study, provide some data on how they responded to the new approach.

For the residents, the potential impact of the empathic approach was double-edged. It could help them avoid feeling like a failure if they had started using drugs after “getting clean” in the past, or if they went on to use drugs after graduation. Although not tied directly to the empathic approach, comments from a re-start named Lefty speak to the power of internalized feelings of failure. In a conversation, I mentioned the history of “relapse” among some of the staff members. He responded, “I need to remember that, you know? A lot of the staff have been exactly where I am now. I’m not a failure. I don’t need to be ashamed of myself.” The empathic approach could aid residents like Lefty in
managing a damaged self-image. However, if disease-talk was taken to the extreme it
could also make the residents feel hopeless. If relapse is “just part of the disease,” as Kim
said, then it doesn’t matter what someone does, it doesn’t matter how hard they work or
how many years they give to a treatment program. The traditional approach required an
admitted loss of control on the part of the residents. However, this was a control the
residents relinquished to staff temporarily—and later might regain—as opposed to the
loss of control to a biological process they could not resist.

The re-starts with whom I spoke, perhaps because of the sense of hope it
engendered, did try to name something that they “did wrong” following their first
graduation. If they could identify a mistake, they could correct for it in the future. Sarah,
for example, who had just moved from resident to kitchen staff member, graduated twice
from the program. After her first graduation, she got a job with benefits on the outside,
met a man, and got married. These facts could be seen as markers of personal
responsibility and conventional success. However, Sarah said that she became too
“comfortable” and was unable to handle the absence of the rigid structure of SATH:

That’s when I think I kind of went south, because, you know, I said, “I could
call in, I could take that day off, and this, that, and the other.” I think I
developed some deceptions also. I think what I was really doing was grieving
the environmental loss—the structure. ‘Cause it was a shock. I went from being
in SATH to, bam! being on my own, being married, and being responsible and
all this….I don’t know, it’s just different. And, I think I became depressed, and I
would never have admitted that before….So, um, when I graduated I started,
you know, slipping, going downwards.

Following this, Sarah took a different approach to her second time in the program:
So, this time I feel like I’ve been able to break through a lot of the, uh, concrete that was set, you know, and find out what I’m really made of. Opposed to last time, it was just, uh, get through it. Just get through it. Just get through it. You know? And, this time it’s different.

Being able to believe that her approach was different the second time around enabled Sarah to feel hopeful about her future.

Sarah was exposed to the empathic approach during her second time through the program. In her account—which reflects the appeals to professionalization and effectiveness—this made a positive difference:

I think things are getting better [at SATH], you know? And, um, with best practices and Motivational Interviewing, and all these types of things really get to the core of problems. Where, opposed to before it was just, “Okay, you need to develop a work ethic, you need to say, ‘Okay,’ you need to be quiet, you need to do this, do that, and do this.” And now it’s like, “Let’s find out why you can’t work through a day. Let’s find out why you feel tired all the time. Let’s, you know, discover things.” It’s just better now.

For Sarah, the empathic approach enabled her to do more than get through the program. She could “discover things,” make use of the program as a resource to promote self-discovery, and support her efforts to achieve and maintain sobriety.

Sarah’s comments also highlight the traditional TC focus on following the rules. As I argued in Chapter II, the TC methods conditioned the residents to follow orders and defer to authority. In Sarah’s words, they learned to say “Okay” (follow staff members’ directives) and to “be quiet” (avoid challenging the rules). Similarly, staff justified the “games,” described in Chapter III, as a means to condition the residents to “keep their head,” to suppress emotional responses of anger with authority figures and to channel it
laterally. The empathic approach offered a similar message of “keeping your head,” but through a different method and with different potential consequences. Instead of demanding obedience and the suppression of anger, staff coached the residents in emotion management strategies that focused on “choosing” how to respond to a given situation. Brandon, a resident when I began my research and the staff member in charge of Aftercare Programs when I left, had fully embraced the new methods. He commented on how he attempted to work with residents:

There are things that I practice, and so I try to give it to them. And I told them, “I know that this is a lot, but if you can look at your perception, and then become nonjudgmental, first, and unglue your thoughts and opinions about it before you react to it, then it will help you make a better decision about what you need to do. Or it could help, you know, make a better decision.” Because they ask me, “What are you doing?” I say, “Everything [those things that bother me] is still there. Nothing has gone away. It hasn’t disappeared into some great sky, like, poof!” It’s like, “I deal with everything like you deal with it. It’s just how I choose to respond to it.”

He continued, offering the following example:

You know, one way we practice this is by, you know, somebody is walking in the room, and they kind of wrinkle their face. It doesn’t mean that they’re wrinkling it at me. It’s that they are wrinkling, you know, because their nose itched. Or it could be a hundred reasons that a person walks in the room, and they just happen to look at me and then think of their nose, and it’s not because they wanted to get back at me, and they’re talking about me, and oh God, they hate me, and blah blah blah, you know?

Here, in a more explicit manner than that offered in the traditional approach, the MI teaches the residents how to “keep their head” through a process of intentional emotion
Instead of suppressing anger and saying, “Okay,” the MI involved residents in changing their perceptions and feelings.

Brandon took his first class in the empathic methods before he graduated from the program. He told me in an interview that he sought it out after a less than positive experience in the games:

I was, like, “Wow, I don’t want a gang member just out of prison coming up to me to confront my behavior.” I didn’t want to deal with it. And then cussing you out about [pause] anything. So, you have, you know, it, it can be overwhelming.

He was offered the opportunity to take a class that focused on empathic methods and he took it:

I knew that I was looking for something more, the next step. So I jumped into it and I saw this is good. It works. It was like one of those light-bulb moments. For me, it just changed. It was like another level [pause] of just recognizing internally who I was, or how I was working, how I could manage myself.

The comments of the residents, staff-in-training, and staff members with whom I spoke suggest that at least some of the residents responded positively to the empathic approach. And, Brandon’s comments suggest that the empathic methods may gain more traction in the organization in the future as more residents are exposed to the methods, go on to graduate, and become staff members themselves.
CONCLUSION

Key staff members at SATH attempted to challenge the traditional TC approach to treatment. In contrast to “shaming and blaming,” they introduced the empathic approach, a method marked by “reflective listening” and probing questions. This represented a personal and professional identity threat to the traditional TC-oriented staff members. As would be expected, the traditional TC-oriented staff resisted the implementation of the new methods. The “straight,” professional staff members responded by appealing to professionalization, biology and empowerment, and effectiveness. They had some success, but the TC methods remained dominant.

In Chapter II, I argued that the traditional TC approach constrained the residents’ moral agency. If the residents have to follow rules without question and are prohibited from confronting staff members openly, they are left with the simplistic moral “choice” of following pre-established rules or receiving punishment. The empathic approach, in part, offers a corrective. By bringing the resident, in a more active way, into interventions, and by asking questions to learn “how to assist [the residents] in doing what they need to do,” the empathic approach provides space for the residents to weigh options and make choices—even if those options are constrained. And at the very least, basing the staff-resident intervention on empathic questioning is arguably a more humane approach than the yelling and degradation that typify the traditional methods (see Eliason 2006; Wahab 2005).

Empathic methods are not beyond critique, and staff who make use of them do not always give over control of the intervention to the resident/client. Kolb (2008) found that advocates for victims of domestic violence and sexual assault sometimes “subtly
steered clients toward options that staff believed would have fewer negative consequences,” yet still felt that “their clients had made their own decisions” (42-43). For example, advocates steered their clients in specific directions by asking leading questions, encouraging clients to imagine an alternative future, or framing their advice as an opinion. In one case, an advocate provided a client with numerous reasons why a judge would not sign a Domestic Violence Protective Order, even though the client wanted one and pushed the matter with the advocate. When the client gave up pursuing the order, the advocate framed the client as having been “empowered” to make her own decision. The advocate’s intentions were good—she doubted the judge would sign the order and was trying to save the client from having to deal with the rejection. The point, however, is that she used the rhetoric of “empowerment” to justify pushing her client toward one decision over another.

The use of empathic methods to promote social control is clear in the field of probation, where the goal is explicitly to control “probationers.” Social worker Michael D. Clark (2005) suggests that the MI is a more efficient means of social control: “Motivational Interviewing contends that objectives of control and motivation can exist side-by-side” (24). As Allan did at SATH, Clark argues that a purely confrontational approach can increase resident/probationer resistance, making the goal of obedience less likely: “the more one is directive and presses, the more the other person backs away” (25). By using the MI, Clark argues, the resident/probationer becomes more amenable to following orders. It is a way to “ensure compliance and foster hoped-for behavior change” (25). In this sense, the empathic approach may well be a “kinder, gentler, more responsive system,” as Allan suggested, but it is still a system focused on control.
Like the traditional TC approach, the empathic model neglects structural conditions of inequality that enable broader patterns of substance use and incarceration. Drug use does not “just happen.” It occurs within specific social contexts and is informed by the systems of privilege and oppression that provide shape to those contexts. For the overwhelmingly poor and black residents of SATH, to neglect structural conditions in the implementation of their treatment is to deny the reality of those conditions in their drug use. As Philippe Bourgois (2008) argues, “drugs are not the root of the problem…they are the epiphenomenal expression of deeper, structural dilemmas. Self-destructive addiction is merely the medium for desperate people to internalize their frustration, resistance, and powerlessness” (319). If the conditions of racism, sexism, and class inequality are left unexamined, the residents may have a harder time making “better” choices after graduation from the program because they will re-enter the same materially harsh reality. Further, individualist treatment—at best—leads to individual solutions. Treatment may be personally empowering, but it will not provide liberation to “addicts” as a class. It is beyond the ability of SATH to dismantle systematic oppression. SATH would need to be involved in a much wider campaign of multi-issue collective organizing to approach such a goal. However, staff could include analysis of structural inequality in their treatment work with residents, giving them the tools to critically examine their structural location and personal experiences. By placing their lives into a socio-historic and political context, they would have more resources at their disposal to make informed, if structurally constrained, choices, or to work collectively for broader solutions.
All names of people, places, and organizations are pseudonyms.

Carter fondly used the expression “murderers’ row” in this instance. A sportswriter originally coined the term to refer to the New York Yankee’s starting lineup in 1918. The team was seen as exceptionally good and tough to beat, and sports fans and writers have continued to use the expression to refer to high quality teams (Popik 2005). In this instance, Carter begins his quote by referring to the “straight” staff as “fantastic.” His use of the expression “murderers’ row” is an extension of that sentiment.
REFERENCES


V.
CONCLUSION

When I tell people that I’ve been studying a “residential substance abuse
treatment center,” responses vary. Some pass it off simply: “That’s interesting.” Some
want to know what I’ve found. In an echo of the traditional TC frame of addicts, a
massage therapist said, “Wow, that must be really emotionally difficult dealing with
people who are so manipulative.” Many people, though, get interested and want to know
more. In talking with them, they would sometimes disclose that their brother, their
daughter, their neighbor, or the man who cuts their grass is an “addict,” “struggling with
an addiction,” “in a program out in Utah,” or “in a bad way with drugs.” One woman said
the hardest thing about watching her sister battle addiction was giving up hope that her
sister would get better.

The purpose of this study was not to find a cure for “addiction.” Nor was it to
evaluate the success of the various methods used at SATH in getting and keeping
residents sober. However, I understand the sense of frustration and despair expressed by
the people with whom I’ve spoken about my study. I formed close relationships with
some of the residents over the twenty-nine months that I was involved with SATH. Many
of them went on to graduate, and I’m still in touch with some ex-residents. Others
dropped out of the program. One man, Jeremy, left the program the day before his
graduation ceremony. I have no idea what happened to him or where he is. I still find
myself worrying about him from time to time. Another man, Kyle, graduated and moved back to his home community to try and rebuild his life. He lost touch with the organization, but staff told me that he died in a car accident a few months later. They suspected that drugs were involved. And then there were residents like Truck, of whom I wrote in Chapter III. I did not get to know Truck well because we only had one long conversation. However, his story has stayed with me.

There is no magic bullet for dealing with “addiction,” as SATH staff members knew well. And although the purpose of this project was not to evaluate the effectiveness of the methods used in the agency to promote sobriety, it is my hope that it will broadly aid our understanding of the processes and patterns of interaction that take place in treatment programs like SATH. Doing so may help us understand the social construction of addiction and recovery.

SUPPORTING MORAL CHOICES

In her study of a holistic health center, Sherryl Kleinman (1996) analyzed the ways that staff members constructed a “moral identity”—“an identity that people invest with moral significance; our belief in ourselves as good people depends on whether we think our actions and reactions are consistent with that identity” (5). Although Kleinman used “moral identity” to indicate a virtuous identity, it is possible to invest moral identities with stigmatized or negative meaning. At SATH, staff members constructed “addict” as a negative moral identity, an identity that discredits an individual’s claim to being a good person. “Addict,” in this conception, is a stigma, a sign of a discredited self (Goffman 1963).
The construction of the residents as manipulative liars justified the use of the traditional TC approach. If the residents were liars, they could not be trusted. If they could not be trusted, they must be controlled. Enforcing rules became the central role of the staff members. And, as I argued in Chapter II, the demand that residents follow the rules without question, coupled with organizational rules that forbade challenging staff members openly, constrained the residents’ moral agency. It is ironic, given the rhetorical focus on “personal responsibility,” that the residents were not allowed to exercise moral choices. Instead, they were given the “choice” of following pre-established rules or being punished. And, completing the tautological reasoning behind the TC methods, if the residents resisted total control—which is to be expected in a total institution (Goffman 1961)—that was taken as evidence of their manipulative, untrustworthy nature.

Although the purpose of this study was not to evaluate the success of the treatment methods, these findings do raise questions about the TC methods in regards to residents’ lives outside the program. If they are not encouraged to develop and exercise their moral agency, how will they navigate the structural conditions that enabled their patterns of drug use prior to coming to SATH? What will happen to them when they leave the all-encompassing structure of the total institution and have to make tough choices from constrained options, none of which may be particularly attractive? Further, how do the residents manage their identities as “addicts”? If they internalize the staff members’ imposed negative moral identity, how does that impact their views of themselves, their recovery, and their future? On what resources can they draw to maintain an affirmed sense of self?
CRITIQUING PATRIARCHY

In Chapter III, I analyzed one resource on which the male residents drew to promote an affirmed sense of self: patriarchal masculinity. At the games, the male residents enacted a masculine self that was based on aggressive confrontation of others and the subordination of women and non-conventional men. In response to their lack of control within the organization, the men reframed sobriety and following the rules as masculine acts. The games, and the identity performances that took place in them, were structured and scripted by the organization. Staff justified the games as providing residents a “forum to safely vent,” but the games served as social control in the organization. Instead of having room to challenge staff members’ belittling and degrading treatment of them, residents were encouraged to take out their frustrations only on one another. In this sense, the games served as an organizational safety valve, ensuring a compliant and docile work force.

I argued in Chapter III that the games conditioned the men to accept abusive and exploitative working conditions without challenge. This could prove particularly consequential for this group of men as they had little in the way of marketable job skills; in addition, most of the men had felony convictions. The cards were stacked against them. In response to frustrations beyond their control, the organization encouraged them to engage in compensatory manhood acts. In practice, the men drew on misogyny, (verbal) violence, and homophobia as a means of doing so.

Paul Willis (1981) studied a group of white, working class boys in a British secondary school. The “ear’oles” conformed to school expectations and aspired to middle class occupations, while the “lads” rejected the achievement ideology and took an
oppositional stance to the school culture. They realized that schooling would not provide them the means to go much farther than their current position in society. Seeing through the myth of the meritocracy, the “lads” could have achieved a sense of class solidarity. But the oppositional potential of their brief insight into the reproduction of the class structure was stunted by sexism. Framing mental labor and middle-class jobs as feminine, and the manual labor of their brothers and fathers as masculine, they sought out work alongside their brothers and cut short their ability to view their class position as an example of class domination (see, also, MacLeod 1995). In a related way, the potential for SATH to resist the revolving door of the prison industrial complex and to shed light on the structural conditions of oppression that enable patterns of substance use more broadly was stunted by the reproduction of patriarchal ideology during the games. Organizational policies framed already marginalized and exploited men’s deference to authority as “being men” and fashioned the confrontation of peers as an indicator of masculinity, thus reproducing the class system. And as I argued in Chapter III, the equation of risk-taking behavior (like drug use) with patriarchal masculinity renders “being men” a part of the problem. It is unlikely to be part of the solution. As Robert Jensen (2007) writes:

> If my options as a man are being part of a mob that is on the edge of violence or being cut off from myself and others, I desperately want to choose something else.

> I choose to renounce being a man.

> I choose to struggle to be a human being (185).
Critiquing patriarchy—and white supremacy and capitalism—as enabling conditions for substance use may offer deeper insights and alternative strategies of resistance to the oppressive conditions of the residents’ lives.

**ADDICTION BEYOND THE INDIVIDUAL**

The need to critique broader patterns of structural inequality at SATH extends beyond the games. Both the TC and empathic approaches to treatment frame addiction and recovery in individualistic terms. The material conditions of residents’ lives and the larger systems of privilege and oppression that enabled patterns of substance use and rates of arrest and incarceration were never part of the discussion at SATH. In the TC approach, invoking a resident’s life and circumstances was the equivalent of offering “excuses” rather than legitimate explanations. Whatever was going on for residents at the time of their drug use did not matter. In a reductionist and victim-blaming move, all that mattered was the drug use and the “bad decisions” the residents had made. The empathic approach provided more space for the residents to discuss their lives in the context of therapeutic interventions, but it also neglected the impact of structural inequality and the material conditions of the residents’ lives. Either approach may promote a sense of personal empowerment for the individual resident, but neither will promote the liberation of the resident population as a class.

None of us make decisions in a vacuum, including “addicts.” And to consider the socio-historic context of individual action is not to deny individual agency or considerations of “personal responsibility.” As Philippe Bourgois (2008) argues:
[T]he self-destructive daily life of those who are surviving on the street needs to be contextualized in the particular history of the hostile race relations and structural economic dislocation they have faced. [Doing so places the analysis] within the context of the theoretical debate over structure versus agency, that is, the relationship between individual responsibility and social structural constraints. The insights from cultural production theory—specifically, the notion that street culture’s resistance to social marginalization is the contradictory key to its destructive impetus—is useful to avoid reductionist structuralist interpretations. Through cultural practices of opposition, individuals shape the oppression that larger forces impose on them (17).

Even if it isn’t revolutionary, and even if it is “self-destructive,” using drugs can be an act of resistance in the face multiple systems of oppression (see also Friedman & Alicea 1995).

If we are serious about addressing the problems of “addiction,” it will require more than the efforts of staff members in therapeutic communities. Yet, it will take a “community” effort. It will require TCs working in collaboration with organizations like Critical Resistance, the national grassroots organizing effort to oppose the expansion of the prison industrial complex. It will require legal activism to dismantle three-strikes and mandatory sentencing policies, if not organized efforts to decriminalize drugs—“the single cheapest and simplest way to wipe out the material basis for the most violent and criminal dimensions of street culture is to destroy the profitability of narcotic trafficking by decriminalizing drugs” (Bourgois 2008:321). Alongside these efforts, dismantling the problems of “addiction” will require legal and adequate means of making a dignified living. Policy reforms such as a living wage, comprehensive healthcare, and comprehensive childcare would move us closer to that reality. And because “addiction” is a symptom of the larger problems of race, class, and gender inequality, this effort will
require local, national, and global anti-racist and anti-sexist campaigns to erode the foundations of white supremacy, class domination, and patriarchy. “Addiction” demands an intersectional and multi-pronged analysis and solution(s).
END NOTES

1 http://www.criticalresistance.org/
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