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Science, Religion and the Challenges of Substance Abuse Treatment

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Social science approaches to knowledge and belief systems suggest that natural science, as we know it today, emerged out of the religious and magical traditions of the pre-enlightenment era (Yates, 1966; Thomas, 1971). Nonetheless many—perhaps most—scientists assume that science and religion are fundamentally at odds.¹ An anthropologically self-reflective and culturally relative perspective on both science and religion allows one to disengage from this zero-sum, competitive binary framework and to explore avenues for pragmatic rapprochement.

The field of biomedical substance abuse treatment is dominated by molecular neurobiology, one of the higher prestige, well-remunerated fields in both science and medicine. In the 1960s, to diminish the influence of morally and religiously based censure identifying substance abuse as an individual sin and a personal moral failure, scientists in the subdiscipline of substance use treatment redefined addiction as a “brain disease” (Dole and Nyswander 1967). This conceptualization was crucial to destigmatizing the field and to legitimizing the creation of methadone maintenance clinics for opiate addicts. It currently drives the bulk of ongoing private and public funding for laboratory-based research: that research is oriented toward magic bullet pharmacological interventions for the types of psychoactive substances most conducive to destructive patterns of consumption.²

Psychiatrists for the most part dominate the administration of treatment at clinical sites as well as research venues, medical education and training institutions. They adhere to the standard, liberal medical discourse known as the “bio-psycho-social model of disease” that predominates in public health and clinical therapeutics. In practice, however, model pays only lip service to sociocultural and economic contexts. Because of their theoretical and methodological training (and their material interests), psychiatrists tend to cast a psychologically individualizing and behavioral or neurobiological lens onto understanding the reasons for risky practices and for positive or negative health outcomes. They seek to maximize individual behavior change. This individualizing approach, of course, has been

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¹The awarding of the 1.5 million dollar Templeton prize to natural scientists such as physicist Charles Townes for devising ways in which to “resolve” the tensions between science and religion demonstrate how this conflict is routinely framed.

²See anthropological critiques by Agar (1977) and Bourgois (2000).

the subject of theoretical critiques from the social sciences and philosophy over the past several decades (see, especially Foucault, 1981). The interdisciplinary “science studies” field spanning the social sciences and humanities devotes itself to deconstructing the ways facts, truth, and, even to a certain extent what is popularly called “reality,” emerge out of social networks and webs of meaning-making (Latour, 1987). Influenced by the philosopher/historian Michel Foucault, many science studies scholars argue that the emergence of scientific disciplines represents a form of disciplinary power/knowledge that becomes the basis for shaping “subjectivities.” These are the socially structured senses of self that are popularly construed as expressions of individual willpower, agency, and force of personality. They manifest themselves at the level of individual action as choices, desires, values, and embodied self-presentation, but they are culturally and socially specific and follow broad, identifiable patterns and discursive logics that change across historical eras (Foucault, 1981).

The biomedical treatment field faces an internal credibility challenge to its claim to expertise and dominance over field of substance abuse treatment: evidence-based statistics document that most people fail treatment most of the time. Treatment advocates have responded relatively successfully by redefining relapse as a normal part of recovery and by requantifying every of sobriety as an objective measure of a successful outcome. Nevertheless, public funding for treatment is limited and the dominant political and law enforcement establishments remain skeptical of medicalized interventions to the problem of substance abuse. The hegemony of the biomedical approach is, in fact, very uneven. In practice, the biomedical clinical therapeutic approach remains inconsistent. Repression, moral sanction, and stigma predominate in many—treatment programs including some that are administered by devoted and effective clinical practitioners.

The biomedical approach, in its efforts to remove social stigma and to promote a brain disease model of addiction, imposes a lifelong, chronic illness on all its patients—even those who are fully adherent and who successfully stay away from drug use. In contrast, religion-based treatment ministries offer an instantaneous and complete cure. They also claim higher success rates and point to their large congregations of former addicts as proof. Through the concept of conversion and salvation, addicts can metamorphose from being sinners and victims of the devil to being the chosen children of God destined to lead their brethren to redemption. Most importantly, evangelical churches offer addicts an immediately welcoming community that promises to rebuild their sense of meaning and self-worth. They substitute a new formal structure of personal discipline for the formerly precarious and often chaotic lifestyle of survival on the streets through petty crime and interpersonal hustling. It is not surprising, consequently, that so many vulnerable street addicts prefer evangelical, religious-based treatment services to the ones offered by biomedicine.

Faith-based treatment initiatives also generally resonate with deeply held, class-based, and culturally consistent systems of meaning and righteousness that predate addiction. Good examples in the United States are the prison-based ministries of the Nation of Islam (which recruits primarily African Americans) and Victory Outreach (which recruits primarily Chicanos and other Latinos) (cf. Rodriguez in press). Similarly, the white, middle-class phenomenon of recovering from addiction through Narcotics Anonymous by “surrendering

to a higher power” has deep historical roots in US Protestant revivalism and Great Awakenings.

It is easy and unfair to throw stones at the biomedical treatment model of chronic brain disease and individualized psychological therapeutics. In fact, the field is faced with an impossible job. Historians and epidemiologists have demonstrated that there are large-scale, long-term patterns to substance abuse across history and that these are relatively clearly shaped by class inequalities and politically structured ways of imposing suffering on individuals (Golub et al., 1999; Courtwright, 2001; Agar, 2003; Bourgois, 2003; Bourgois and Schonberg, 2009). Arguably, ever since late 19th-century germ theory overthrew the “miasma theories” that had spawned state investments in sewage and drainage systems, the intervention paradigms of public health have shifted toward individual behavior change rather than infrastructural transformation of the risk environment (Tesh, 1988).

Contemporary biomedical science lacks the conceptual power to understand the relationship between individual agency and structural forces. It is not oriented toward comprehending how distinct patterns of “subjectivities” emerge during distinct historical eras. To be successful in the so-called “war on drugs,” treatment would have to be able to solve structural and historical problems for which it lacks a theoretical apparatus. Furthermore, the field has always been grossly underfunded in the United States, and its relative penury has been exacerbated by the consolidation of neoliberalism in the 1980s. Public subsidies for health have been slashed and the ideological emphasis on individual self-help and personal responsibility is hardening. Subsidized treatment on demand does not exist in the United States, for example, and the disjunction between short-term detox and long-term recovery programs has widened.

As a first step, biomedicine must recognize that addiction organizes the lives of substance abusers, enveloping them in a community of mutually dependent (even if dangerous and unstable) peers on the street who share the same priorities. Consequently, physical dependence and/or psychological cravings for a psychoactive substance, contrary to appearances, provides order and direction to lives that have often been disrupted by indigent poverty, intimate childhood violence, institutional abuse, and exploitation in the labor market. This is especially evident for homeless heroin injectors. When they wake up in the morning, they know exactly which foot to put in front of the other. Their needs and priorities are unambiguous: they must solve their most urgent physiological problem before worrying about anything else. Finding employment, acquiring food, obtaining shelter, appearing in court, applying for public assistance, or treating an abscess become inconsequential. Society’s opprobrium and personal public failure are the least of their worries. Similarly, childhood psychological wounds of abuse or abandonment have long since been subordinated to the demands of daily heroin consumption. Furthermore, most addicts cannot survive as solo operators on the street. They are constantly seeking one another out to exchange tastes of heroin, sips of fortified wine, and loans of spare change. This gift giving envelops them in a web of mutual obligations and also establishes the boundaries and interpersonal hierarchies of their community. Sharing enables their precarious survival and allows for expressions of individual generosity, even if gifts often go hand in hand with betrayals (Bourgois 1998).

To be successful, biomedicine must learn to address the vacuum left in the lives of newly detoxed patients. Doctors are able to manage the short-term detox process with remarkable success. Unfortunately, few coherent, replicable follow-up programs exist for indigent addicts who urgently need to build supportive social networks from scratch and who must immediately find remunerative employment in order to survive. Furthermore, their new lives must be fulfilling and inspiring in order to keep them away from the urge to return to destructive patterns of drug use and violence that are so familiar to them (Bourgois and Schonberg 2009).

Evangelical religions, in contrast, have no problem transcending the theoretical and practical challenges of the structure-agency divide. They organize themselves around recreating sociability, establishing a sense of meaning, and imposing a protocol of individual discipline that enables individuals to commune ecstatically and collectively with an invisible omnipotent and omniscient being. The long-standing Protestant-derived American focus on “spirituality”—individual cognitive and emotional relations of faith with/belief in a higher power as the core of religion—may lead some analysts to miss the central arguments of sociocultural anthropology concerning the power of religion. A long tradition of French, Durkheimian sociology and British Malinowskian ethnography has argued that religion is constituted by a set of social and conceptual techniques for organizing everyday life (Durkheim, 2001 [1912]; (Malinowski 1978 [1935], 1984 [1948]; Evans-Pritchard 1985 [1965]). Indicators that strong “perceived religious and spiritual support” is a predictor of abstinence during treatment (Avants et al. 2001 cited in Borrás et al., in print) may have more to do with this framework of culturally imposed discipline than it does with the “growth of conscience” or with “scales of spirituality.” Theories of a “human universal need for religion” (or for “spirituality”) miss the point that social embeddedness both produces and assuages “needs.” The “needs” of an addict are not universal: they are locally specific and historically and socially contextualized.

From a practical perspective, in the absence of a paradigm shift in public health and of a massive infusion of public funds for treatment, we must explore nonpolemically and pragmatically what forms of faith-based therapeutics work for whom and when and how we need to articulate them more productively with biomedical technologies. The current zero-sum competition between science and evangelical religion is a waste of time. At the same time, evangelical treatment cannot be embraced blindly. It is deeply steeped in ideologies of gender and sexuality which many people consider unjust, repressive, and intolerant. Furthermore, reliance on low-cost, “faith-based” treatment modalities often facilitates the retreat of state investment in desperately needed health services for street-based substance abusers (Hansen 2004; Hansen, Alegria et al., 2004; Hansen 2005). Fundamentally, the biggest problem faced by treatment is not science versus religion. It is the rising hegemony of the punitive, US-led global war on drugs. Most heroin detox treatment does not take place in clinics or under medical or faith-based supervision. It occurs in a purposefully brutal and coercive setting, on the cold concrete floors of precinct holding cells and county jails. It is generally accompanied by the jeers, kicks, and curses of guards and hostile inmates. Vulnerable populations of addicts are not evenly distributed across the social spectrum nor are spiritual or biomedical treatment protocols universal. We need to talk directly about

who, precisely is addicted, where, and when, and for what reasons, if we want to promote long-term abstinence from destructive patterns of drug use.

Biographies

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