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QUEERING ADDICTION

by

TARAROSE MACUCH

A master's thesis submitted to the Graduate Faculty in Liberal Studies in partial fulfillment of  
the requirements for the degree of Master of Arts,

The City University of New York

2017

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Queering Addiction:  
by  
Tara Rose Macuch

This manuscript has been read and accepted for the Graduate Faculty in Liberal Studies in satisfaction of the thesis requirement for the degree of Master of Arts.

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Date

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Patricia Clough  
Thesis Advisor

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Date

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Elizabeth Macaulay-Lewis  
Acting Executive Officer

THE CITY UNIVERSITY OF NEW YORK

## ABSTRACT

### Queering Addiction

by

TaraRose Macuch

Advisor: Patricia Clough

Much has been written about the subject of addiction, but very little has been written from a queer feminist standpoint. Most of the work available concerning addiction is aimed primarily at a clinical audience, those interested in treating people with addictions. Most non-clinical work is aimed predominantly at people who are either suffering from addiction themselves or close to someone dealing with addiction. In pursuing this thesis project, I want to add the queer feminist discourse as well as a disability discourse to the larger public dialogue on the addict's embodied identity. I am proposing that the addict's perspective is a valuable resource that can give voice to the often unmentionable.

Addicts often negotiate with norms. It is here that we witness their attempts to create a sense of an embodied normative self-identity. These sought-after self-identities come with bodily limitations and histories through which the addict has been medicalized and pathologized. In this sense, addicts challenge universalizing norms even while they repeatedly experience extreme levels of discrimination, violence, and intolerance. In looking at the continuity between life-making and the wearing down of an addict's embodied identities through engagement with sites

of administration, discipline, and measure, the addict's self-identity remains tangled in a complicated web of assumptions about a healthy life, as well as about moral ability to generate self-capacity. Unraveling the addict perspective on self-identity can offer us an understanding of selfhood that is about learning to live with a limited self and body. Thus, the addict's identity making is a matter of queering the body as well as engaging a disability perspective.

Along with making use of queer theory and disability discourse, I will take my own embodied self-identity as an example of an addict in order to render the knowledge that regulates, controls, and manages marginalized bodies, both ideologically and materially. I will further reflect on the multi-layered manifestations of power and emotion, or affect, that comprise the experience of the addict's embodiment. Weaving together a personal narrative of addiction and recovery with academic discourses—contemporary queer, feminist, and disability discourse—I will situate the addicts' perspective alongside these other prominent theoretical perspectives.

## ACKNOWLEDGEMENT

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I would also like to acknowledge my profound gratitude to my life partner Eliza for providing me with unfailing support, continuous reassurance and a full stomach throughout my years of study and through the process of writing this thesis. I couldn't have done it without you; you're my sounding board and always my person, I love you.

And finally, I would like to take a moment to acknowledge that there is no pain greater than to be helpless in the face of a loved one's suffering. This thesis is dedicated to the addict in recovery and the addict still suffering.

Thank you,

TaraRose Macuch

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## INTRODUCTION

The fact that we are here and that I speak these words is an attempt to break that silence and bridge some of those differences between us, for it is not the difference which immobilizes us, but silence. And there are so many silences to be broken (Audre Lorde, *Sister Outsider*).

In this thesis paper I will argue for treating addiction in terms of a queer/disability. This terminology ideally will function as opposition and powerful resistance to the more usual representation of the addict as deviant, sick or immoral. However, I will not rely on a fixed meaning of disability or a disabled person but consider that the term disability like queer is always open for discussion. Additionally I will add a recovery perspective, drawing on my own recovery, which demonstrates that the addict body in recovery is not a separate identity: my body—recovering and addicted.

## ADDICTION AS QUEER DISABILITY

From the onset the drug addict has been viewed as a deviant figure linked to a multitude of negative connotations. The addict holds a number of meanings and evokes affective responses that are materially different than what come from other maligned identities such as those linked to race, class, gender, sexuality, and ability. Of course, the addict also is marked by these differences as well. For this reason, it is important to examine the potentialities and implications of responses to the addict and to question the meaning and affect addict's produce.

Queer and disability movements by and large have a politic of questioning the body. Historically they have focused on claiming identities, problematizing the oppositions of public and private, the social and biological, difference, deviance, and stigmatization. These identities have often come with corporeal limitations and histories that have been medicalized and

pathologized, both challenge universalizing norms that marginalize those that don't conform. And both engage with the lives of people who experience extreme levels of discrimination, violence, and intolerance. The addict body is located in a web of paradoxes, full of affective potentials that can never fully be contained. As Liz Grosz demonstrates, "memory directs [her] to the past and to duration, then it is linked not only to [her] body and its experiences but also to the broad web of connections in which [her] body has been located" (97).

In recognizing how I will speak about the disjuncture, the breakdown, the distress that addict bodies have navigated, I strive to explore how a body can be a multiple body. This requires a rethinking of the knowledge that has regulated, controlled and managed bodies both ideologically and materially. It requires the recognition of identities that are shaped by multi-layered manifestations of power and meaning. It also requires giving considerable regard to emotions that are tied to human lives and used as an economy because these emotions are attached to bodies that join some people together, while separating others. In queering the addict body we can begin to think about the political implication of emotions and we can also begin to extricate the magnitude of affect attached to the addict body.

Sara Ahmed has argued that the alignment of hated bodies "works as a narrative of defense: the nation/nation subject must defend itself against, invasion by other." Drawing from Ahmed we can begin to understand why the addict is such a hated body. Hated bodies are situated on a spectrum of sorts and our cultural norms determine if their lives are grievable. For Judith Butler in *Frames of War*, life is not an evolutionary conception with its own internal development that is independent of the external framework with which it is bound and reliant upon. In other words, life is a conditional process that relies upon a social framework (and

therefore an economic, ideological, and institutional framework) more than it is an internally existing quality of humanity.

Putting bodies into a sociopolitical context allows us to discuss what Butler calls the “precarity of life” In this sense precariousness is the natural condition of life that at any moment can end. We could walk across the street and be hit by a bus. That is precariousness. Precarity is our relation to, for example, “the system” as it constitutes our life. More specifically, precarity is our relation to the degree of failure that the system has imparted to us. Precarity is increased or decreased depending on how accessible resources are for a life. Thus, a homeless man with a drug addiction would be a precarious life because he is connected to a failing system of social and economic support networks. Butler’s concept of grievability is also quite relevant to frame the life of an addict. Grievability is the quality a life has, whether or not it can be grieved. “Precisely because a living being may die, it is necessary to care for that being so that it may live. Only under conditions in which the loss would matter does value of life appear. Thus, grievability is a presupposition for the life that matters” (Butler, 141). Grievability is the idea of a life that has the quality to at some point be a life that will have been lived. These lives—addict lives are despite being human and deserving of grievability in the moral sense, are considered less than human and therefore ungrievable. So the question remains why are addicts lives ungrievable? Or how are they griveable or why should they be grievable? And the answer I would propose is that throughout history addicts have been subjected to dehumanization; they are a hated group

It is here as I worry about grievability that I am reminded of the question that Eve Sedgwick asks, “What is my narrative [and] what enables me to be here? <sup>1</sup>*And from this question*

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<sup>1</sup> Eve Sedgwick, *A Dialogue on Love*. Boston, Beacon Press, 1999.

<sup>2</sup> Judith Herman, *Trauma and Recovery: From Domestic Abuse to Political Terror*

*I visualize my personal testimony as a performative entanglement that is voiced before you my audience to give you insight into the methods that I use to negotiate identity and the meaning of my personhood. It is here in this telling, in this site of what feels like a potential crisis of being ungrievable that I gain strength and give voice to the what often remains unmentionable.* Disability activist Eli Clare in *Exile and Pride* probes how to explain the “distance, the tension, the disjunction between politics and loneliness” (19). *In absorbing this tension about which Clare speaks, I understand that a crucial aspect of the addict’s struggle is a disentangling of a severely damaged felt sense of self from the isolation and shame that is intimately connected to the addict body.*

Addiction narratives promise an intimate engagement with and potential knowledge about the addicted subject, as well as the hope that recovery is possible. This addiction narrative aims to unpack the many layers that contribute to the addict’s embodied identity. Addiction can be understood as a sort of metaphysical crisis in which a person is forced to negotiate the contamination of themselves under continuously traumatic circumstances. The affective impact of shame, self-degradation, loss of control and isolation are intricately woven into the stories of suffering and survival of countless addicts. *In my own experience as an addict in recovery, I enter into a process of healing when I effectively impart to others, fragments of my narrative. This imparting helps me to avoid the repetition of my painful past and helps to facilitate in moving through the bodily trauma of my experience. Giving voice to the often unmentionable is traumatic it is an ongoing process that is continually being negotiated.* As trauma expert Judith Herman puts it, “remembering and telling the truth about terrible events are prerequisites both

for the restoration of the social order and for the healing of individual victims.”<sup>2</sup> *I believe it is here, in this restoration that we witness addicts attempting to create a sense of a normative self, a sense of a grievable self.*

*My narrative does not merely reflect my addiction experience but rather it contributes to the transformation of it. Giving you my testimony requires me to re-experience the trauma of my addiction, but it also provides me with liberation from it. In disclosing my narrative, I am born together with my truth. It’s not an act of giving you myself in the telling, but it’s allowing you to acquire the history of me, by way of my story. This disclosure constructs a very real story that is central to the shame and isolation I have felt as a queer addict. To narrate my story, to speak publically about addiction is to expose myself to the stigma of addiction. With this fear I am reminded of Audre Lorde in *Sister Outsider* who said that she too was “afraid because the transformation of silence into language and action was an act of self-revelation, and always seemed fraught with danger” (42).*

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<sup>2</sup> Judith Herman, *Trauma and Recovery: From Domestic Abuse to Political Terror* (London: Pandora, rev.edn 2001 [orig.1992]).

## AFFECT OF FEAR

The intensity of fear, the intensity of hate, this is the affect I want to discuss. We can feel it, its speculative it has potentiality and is hard to measure because it increases with the circulation of information. It doesn't rest. I use affect here to refer to the gut level response that one has upon exposure to something else. Ahmed in *Affective Economies* illuminates this concept by telling us that, "...emotions *do things*, and they align individuals with communities — or bodily space with social space —through the very intensity of their attachments" (Ahmed, 119). Ahmed's focus here is on the circulation of emotion between people, as well as between images and objects. These emotions are cultural practices, not psychological states. Bodies are given value through emotion, thus bodies as well as individuals become aligned with popular ideology and from this we can deduce that there are destructive perceptions of *us vs. them*, that create boundaries of human positioning, which obstruct mobility and produce marginalization. This type of affective circulation tolerates the production of a binary system that justifies a narrative of hate and perpetuates fear of anybody or body deemed different from the collective. *As an active addict my body was different than the collective it existed in, it endured violence, discrimination and intolerance. Even before others got to know me, they seemed to have a perception of how I lived my life, who I was and what I could or couldn't possibly be.*

There is a long history of discrimination of the addict that contributes to the stickiness of the image of the drug user. Visibility is a vital component of a lived affective economy for drug users. Addicts can and do "pass" for non-drug users. This alone heightens fear since the not knowing if one is a drug addict means the drug user cannot be contained and then the drug user passes by uncontained. Ahmed writes, "The fear is intensified by the impossibility of

containment. If others who are feared ‘pass by,’ then the others might pass their way into the community, and could be anywhere and everywhere” (Ahmed, 124). This fear from the public then justifies intrusions by the state in order to distinguish just who is and who is not a drug user. Passing and passing by, are different things. Passing involves identity formation and recognition while passing by implies physical movement. Ahmed states that, “the double possibility of passing commands the nation’s right and will to keep looking for signs of difference and justifies violent forms of intrusion into the bodies of others”(Ahmed, 122). Drug testing is an example of an intrusion put in place by state sanctioned institutions that seek to eliminate the possibility of passing as a non-drug user. Jasbir Puar in *Terrorist Assemblages* states, “the real danger [is] that he will pass by, the imminent attack unknown in terms of when, where, how, or if. Passing or passing by, raises the possibility that the difference is imperceptible: the injury is endlessly deferred to the future” (Puar, 184-85). In the case of the drug addict the fear is less about a physical attack, and more about an infestation of drug use contagiously pulling others into a collectivity of bodies defined by affective responses. The drug addict isn’t literally convincing people to use drugs, but rather they are contaminating society and corroding social norms.

In further considering affective economies and how particular emotions circulate and become attached to particular bodies, Ahmed points us to assumptions of virtue as reinforcing the emotion of fear. If drug-free bodies are those supposed to be pure, they can only exist if instances of impure bodies actually exist. Hence, the imagery of the drug user is recycled to solidify virtue, by provoking fear of the perceived violence that surrounds drug use and the drug user. To create an alleged community of drug-free people society must decide what constitutes pure and what does not. The fear induced by bodies that do not conform to normativity is not a fear that can be located within the body of the non-conformer, but rather it is a fear that is

already circulating and becomes stuck to bodies that diverge from normativity. This fear stretches into circulation through images of virtue that frankly do not align with lived realities and the drug addict is undoubtedly blamed as a source of decline and feared for having potentiality.

The marginalization of addicts can be viewed through Puar's theories of capacity. If addicts do not appear to have the capacity for restoration, then in *biopolitical* terms they are in need of discipline in order to restore their capacity. Taken from Foucauldian concepts of *biopolitics* Puar theorizes about governmental concern for the dissemination of life. In *Society Must Be Defended*, Foucault writes of biopolitics that are, "...a matter of taking control of life and the biological processes of man-as-species and of ensuring that they are not disciplined, but regularized" (Foucault, 246-7). This *biopolitical* concern refers to an anxiety that the government has for the propagation of life. It is a tactic of power that concerns itself with ratios of births to deaths, rates of reproduction and the overall fertility of a population. My understanding of capacity in these terms speaks to the inferring of a capacity or the lack thereof. It speaks to the rehabilitative potential of a population, and in this case drug addicts. Puar explains that "the notion of capacity, in other words the ability to thrive within and propagate the *biopolitics* of life by projecting potential as futurity, one indication of which is performed through the very submission to these technologies of surveillance that generates these data" (Puar, 200). Puar is suggesting a willingness to submit to surveillance and the ability of a population to thrive and this thriving ultimately implies that humans flourish despite or because we are under surveillance.

Theories of capacity rely on the perception that addiction and achievement contradict each other and that when a person overcomes this contradiction, they are seen as heroic. This narrative is relative to the disability narrative; that overcomes physical obstacles in life or the

trans body post-operative that is somehow seen in the after as a more “whole” or “real” person. These narratives are speculative and just feel wrong. *This perception has always made me uncomfortable.* However brave it may seem, it implies that the addict or disabled body is malformed, and, therefore, must strive to attain normativity for social acceptance. This harmful notion relies on perpetuating normativity and the able body classifying humanity. Rosemarie Garland Thompson asserts, that the “physically disabled figure is culturally and historically a social construction, that we encode individual bodies as “deviant” or “defective.” Thereby reassuring culture of its own “corporeal normalcy” and superiority,” which in turn is traumatic and destructive to the addict body.

*In Touching Feeling,* Eve Sedgwick introduces the concept of the “beside.” Beside is such a strange word, such an affective word. To be beside something feels like a departure from two worlds, like looking at the past from a different angle, inverted or upside down. My “beside,” is my active addict self, merged together with my new recovering self. *I am in a sense not myself, but I am always myself, and strangely I am just a little bit beside myself. Here in this concept of the “beside” I ask myself how can revealing my own disease contribute to the formation of my identity? What is the right distance between me the writer and my subject? Is it relevant that I have never attempted to distance myself from my disease? Do you the reader need to know that I have fought, resented and finally embraced the disease of addiction? Is digging deep into the dark threatening places that construct a story of resilience and self-transformation central to you seeing me? Do the resistance and composition I find in stories of the disabled and queer body matter?* Eli Clare in *Stolen Bodies, Reclaimed Bodies* said that “some bodies are taken for good; other bodies live on, numb, abandoned, full of self-hate. Both have been stolen” (363). *It is here in this numbness and resistance that that I am instinctively determined to advocate for the active*

*addict and the addict in recovery, that the disease of addiction is a disability.* My attempt to queer addiction through a disability lens is an attempt to engage and unravel this fractured identity. When we queer something it can be a powerful tool for expanding, transcending and transforming boundaries and definitions. To queer something and in this case addiction we can begin to build a different world around us.

With “respect for histories of oppression that are not mine,” (McCruer, 9) *I ask myself if I have the audacity to turn the word addict into a source of pride as other marginalized bodies have turned their defamation? Am I within my rights to claim disability? Can I do this? Will my non-visible disability be recognized as disabled? Should drug addiction be considered a disability and if so why and what thresholds does it have to exceed to be considered one? As I ask these questions and contemplate this claim I sense that familiar friend in shame creeping up on me, it’s like an imposter, guarded and cautious.*

Mindful of my visually able body and the privilege that comes with it, I recognize that there is an uncontested undeniable privilege that exists for people with non-visible disabilities because of their ability to assimilate. To focus our attention away from the tangibility of the visual is a relatively new method of exploring disability. Much of the preceding and foundational work in the field of disabilities has focused on the gaze, but what about the internal and hidden manifestations of disability? How might invisible disabilities reveal the interrelations between the disabled and the nondisabled? I believe that from a queer and disability standpoint, we need a greater understanding of which kind of bodies need access, and how these bodies can participate fully. My use of disability in this project attempts to recognize the complex interactions between sociopolitical structures, specific bodies, minds, and senses that produce disability.

To come out as disabled is not a static singular event it involves making decisions about revealing oneself on a daily basis, in personal, professional and political contexts. Not all coming out processes are straightforward requiring a construction of specific narratives to explain the body, to an often skeptical, ignorant, and somewhat hostile audience. Within both a queer and disabled discourse, to pass as normative is often seen as evidence of a deeper internalized oppression. There is a perception that non- visibly disabled people prefer to pass and that passing is a sign and product of assimilationist longings. Thus to “pass” would mean to reject public recognition as disabled or queer. For bodies that visibly do not have disability written all over them there exists limited options for publically performing and claiming their disability. For the addict body in recovery, this concept is a daily material reality.

## QUEERING DISABILITY

In *My Body, My Closet: Invisible Disability and the Limits of Coming Out*, Ellen Samuels examine the analogies between the experiences of non-visibly disabled bodies and queer bodies. While considering the material realities that these two groups share (such as their relationship to the discourse around “passing” and “coming out”), Samuels main objective in this piece is to put emphasis on the ways in which analogies of identity and oppression can distort complicated differences between analogized groups. Samuels’s aims to expose the idea that accepting informal analogies can lead to making all experiences appear equivalent. She gives the example of the sex/race analogy that many white feminists used to parallel their own oppression to the oppression of black civil rights activists. The using of previous identity struggles to legitimize current struggles diminishes the fact that identities can be variant they are not just one or the other. Samuels considers this type of analogizing to be problematic, because it is a restrictive view of gender and race, and equates gay with disabled and gender with race. As a reparative turn, Samuels argues for a more in-depth investigation into analogies that would provide a more nuanced interpretation of marginal identities.

While it is common to use the language of “coming out” to discuss both the queer and invisibly disabled experience Samuels establishes that this “coming out,” differs in considerable ways. Within the two frameworks “coming out” often, means two very different things. In one structure “coming out” as disabled can mean claiming a positive self-identity, and rejecting internalized ablest beliefs about disabled people and in the second structure “coming out” for those with invisible disabilities can mean revealing or proving oneself to be disabled. “Coming

out as disabled appears to have more in common with racial discourse of coming out or passing than with queer discourse, since the contingent (non) visibility of queer identity has produced a variety of nonverbal and/or spoken means to signal identity, while the assumed visibility of race and disability has produced an absence of nonverbal signs and a distrust of spoken claims to those identities” (Kafer, 322).

History has shown us that there is a blatant defiance in accepting responsibility for queer, disabled and addict bodies. Historically, queer and disabled bodies have been “soaked in shame, dressed in silence and rooted in isolation” (Clare, 44). The medical model of disability frames these atypical bodies as deviant, defective and pathological and tries to cure these bodies with treatment, isolating the person with a condition rather than treating the social processes and policies that constrict these marginalized bodies. This is medical model is unacceptable for the addict because to frame addiction vis-à-vis a cure is to accept the medicalization of the addict body and reveals more about able-bodied culture than it does about the body being interrogated. It implies that the able-body is what we all strive for. *As an addict in recovery, with an incurable disease, I cannot accept this because this position implies that there is a cure for addiction. To accept this would be disingenuous because addiction is a disease to which there is no known cure, tomorrow is tomorrow; there is no way of knowing if this disease will resurface. The disease of addiction is progressive it is always lying dormant just waiting for the addict body to pick up and use. As an addict in recovery, I need no specific medical care, medication, or treatment for my disease; the adaptive tools I use to navigate life are generated from within and from the help of others. Addicts in recovery must remain one step ahead of their disease diligent and aware of the shadows that it hides in.* Many people with non-visible disabilities are not visibly impaired and have to frequently remind people of their needs and limitations, this in itself

can be a source of alienation from other people with disabilities, because it requires repeatedly calling attention to impairments. Disability activist Liz Crow has written a powerful critique of our silence about impairment. She says:

Impairment is safer not mentioned at all. This silence prevents us from dealing effectively with the difficult aspects of impairment. Many of us remain frustrated and disheartened by pain, fatigue, depression, and chronic illness, including the way they prevent us from realizing our potential or railing fully against disability (our experience of exclusion and discrimination); many of us fear for our futures with progressive or additional impairments; we mourn past activities that are no longer possible for us; we are afraid we may die early or that suicide may seem our only option...yet our silence about impairment has made many of these things taboo and created a whole new series of constraints on our self-expression (Crow, 209-10).

This notion of impairment rests upon medical diagnosis. If addiction is not a diagnosed disease should it then be permitted into a disability category? The Americans with Disabilities Act (ADA), heralded as the most important civil rights legislation since the 1964 Civil Rights Act, boldly set forth the goals of assuring “equality of opportunity, full participation, independent living, and economic self-sufficiency” for people with disabilities. The ADA defines disability in three parts; a physical or mental impairment that substantially limits one or more major life activities, a record of such impairment and being regarded as having such an impairment.” The origin and intention of the ADA were put in place to eliminate pervasive discrimination. However, the ADA made explicit moves to exclude addiction during its conception in 1990.

There are three central arguments circulating for why addiction should be permitted and recognized as a disability by the ADA. First, to recognize addiction, as a disability would reflect the lived realities of some people with dependence, whether actually disabled or perceived to be disabled, who may then impose limitations or restrictions, Second, to recognize addiction as a disability is to challenge the stigma and basic logic of drug prohibition because it challenges the fundamental notion of demonizing, stigmatizing and excluding people who use drugs from the body politic. And thirdly, it opens doors to an entitlement to certain benefits under public and private insurance schemes that may be recognized as having a disability.

Those protected under the ADA should not be required to demonstrate that they are “disabled enough” but rather prove unjust discrimination based on their actual or perceived impairment and or lived realities. Currently it appears that the overarching fear that is being expressed by the courts is that anything could be considered a disability, and therefore necessitates accommodations—the protected class is too big, the cost to employers and society at large are too high, etc. This fear is based on a scarcity model that hinges on a belief that rights are limited and any new granting of “special rights” threatens the pre-existing “normal” individual rights (the same model deployed against same-sex marriage). The purpose of broad civil rights claims are not to require that individuals prove they are oppressed enough to receive special rights but that, taking historical discrimination into account, rights are spread out among everyone. Whether we adopt a narrower medical model or a broader social, political/relational model of disability, addiction does fit into the concept of the disease model and therefore I further argue should be recognized by the ADA as a disability.

Let us use the example of HIV/AIDS. Historically people with HIV/AIDS had to overcome social ignorance and aggression. They had to fight for access to decent, affordable

healthcare, against stigma and hollow moralizing that promoted lies that they “got what they deserved” and that they caused this disease through their own bad and immoral behavior. This historical example with HIV/AIDS is arguably similar to the predominant view that people have with the disease of addiction. If culturally we could begin to draw comparisons between our experiences with HIV/AIDS and to figure out our position as addict bodies relative to power, then we may be able to facilitate change.

If as a culture we remain confined to a medical model, drug addiction and all that it entails remains vilified because the actions and assertions of enacting this model maintain that people are problems. When in reality the problem exists when marginalized bodies face encounters with a broader society that repeatedly demonstrates the unwillingness to accept difference and make a change as a result of that difference. The more or less automatic labeling and problematizing of a person derives from socially constructed ideas of this difference. If we were to implement a social model or perhaps a political/relational model to addiction it would allow us to see ostracized identities as products of their environment. In the long run, implementing a political/relational model would help us to view addiction as a disease and as a mental health problem rather than as moral failure to generate capacity.

In using this word moral failure, it leads me to wonder if all human beings experience shame? Could it be true that only some people feel the damaging impact of scrutiny? *In my own experience with active addiction, the roots of my disease were so deeply embedded in the toxicity caused by my own homophobia, that it had the power to create a narrative that isolated me and turned me into just another “addict,” and believing I was nothing more.* Robert McCruer in *Compulsory Able-Bodiedness* argues, “the most successful subject is the one whose sexuality is not compromised by disability (metamorphized as queerness)” (304). *The power of scrutiny and*

*internalized homophobia did not manifest from just one person or institution, it manifested from many interrelated, conflicting sites that circulated and took hold, thereby setting a precedence for what I understood to be acceptable in our culture's norms. Understanding power in this context has aided in the comprehension of how and why social normativity can distribute human vulnerability and security.*

*The turning point came when the alcohol and drugs didn't work anymore; I was empty, abused and spiritually ruined. Living what felt like an alternate reality, my life needed to change, I was in crisis, and I was imploding. I could no longer deny my pain or avoid my queerness. My suffering could no longer be kept hidden I needed some control in my life. Things were no longer what they seemed. I knew from the depth of my being, or maybe it was just that one last bruise disguised as a love in a partner, that something was shifting, that my life was about to change.*

## SHAME AND STIGMA

When an addict absorbs the process of stigma, they learn that the normative point of view is that drug addiction is deviant, and then they realize they are disqualified from social acceptability. How many times have you walked past someone on the street corner nodding out, shook your head in disgust and just kept it moving? To be an addict in the imagination of culture is to cease to exist. The stigma of addiction is built into the foundation of our society and into social structures that are necessary for people to rebuild their lives. What if there were no stigmas attached to addiction? Perhaps the addict role wouldn't last a lifetime. Stigma explains why many addicts in recovery hide their disease. Active addicts and addicts in recovery are faced with obstacles, especially those who have been in treatment or the criminal justice system for chemical dependency. This has an enormous impact on addict's lives every day—in the community, in the family and social networks. People who need help are often afraid to speak up. State and federal agencies feel safe in denying food stamps, or housing to a mother who has a past drug conviction because mothers who used drugs have few supporters in the political system and face massive discrimination. Instead of examining addiction as an individual problem we need to begin to examine how addiction is perpetuated by systemic factors like lack of affordable housing, poverty and social isolation. We need to unravel the limited representation of the addict body. Eli Clare insists that “building a politics that reflects all the multiplicity in our lives and the world isn't optional, but rather absolutely necessary.” Clare's analysis offers us insight into the multi-vector and contingent natures of stigma and oppression.

These notions of power and stigma bring me to think more deeply about shame. The internal fear and psychic intensity of shame can create a disqualified identity and reduce someone to just a drunk, just a junkie, just an addict and nothing more. Shame has the power to flood every inch of one's existence. Feelings of shame are often accompanied by feelings of guilt that in turn produce silence. Hence, it is this silence and absences of physical signifiers that suspicion toward addicts are created all around us. In thinking about this doubt, I can't stop thinking about how this distrust, this suspicion can create shame and how thoroughly interwoven it is in both the disabled and queer narrative. Eve Sedgwick describes the conventional way of distinguishing guilt and shame as a sharpening sense of what one was.

*This sharpening sense of what I had been defined me. Haunted by years of unresolved trauma I learned to live with profound feelings of anxiety and helplessness. Alcohol and drugs helped me with the unease of making new friends or finding sexual partners. Inebriation and skewed coping skills helped me to mediate difficult feelings around my sexual orientation and gave me the courage to have secret affairs with women. Fast forward to my early recovery and free from the grip of active addiction and I did not have my old behaviors to rely on. The potency of my newly found recovery forced me to look in that broken mirror at my fragmented self. I put my fear into perspective dug down deep and found strength to affirm my queerness.*

In her seminal essay *Queer Performativity*, Eve Sedgwick imagines shame and stigma as transformational, and having the ability to be an "experimental creative performative force" (38). *Somewhere deep down inside I found a willingness to meet my truth and confront it. I did not have to pretend to be someone else to function or to be accepted. I found freedom in authenticity. Yet the fact remains that here I am years later in recovery and I'm still rattled by the reality that I needed to get clean to recognize I had a disease and to identify my queerness. And it is*

*precisely because of this rattling that the queer and addict body are so intricately and painfully woven together for me. The isolation that I experienced not living my truth intimately mimics the years of isolation I experienced in active addiction, they are almost one in the same, “but just as the stolen body exists so does the reclaimed” (Clare, 73).*

*The feeling of being apart from—and sometimes apart from myself, often does not add up to feeling like a whole person. When I focus on what is real, I can accept myself with all my contradictions. No amount of recovery will ever make me immune to my disease or exempt from the challenges of life. The challenge isn’t in adapting or assimilating but in functioning, in learning to live with a limited body. The challenge lies in understanding our bodies, our minds, and our spirits and accepting what they can and cannot do and perhaps in recognizing that all bodies are limited. True autonomy comes from discovering who I am, and what I’m made of. Today, if I had the option of not having this disease, I wouldn’t give it away. This disease has taken a lot from me but in truth it has given me more.*

Queer theorist Heather Love makes a poignant claim for shame in *Feeling Backward* and its ability to bring together individuals into a “meaningful community.” To create space where one doesn’t have to explain, hide or justify them has been essential for the queer community. Historically the queer community has been grounded in expanding awareness and promoting pleasure. It is important to tease out the role that drugs and alcohol have played in sub-cultures, namely the queer community in promoting sexual liberation. Substances over time have become part of the way in which many queer people socialize and connect with each other. Expressions of self and culture through the use of drugs and alcohol are intimately connected to the liberation of the queer body, both politically and sexually. While many queer people use drugs and alcohol for pleasure and fun, still a great many more use them to annul pain and to get outside of

themselves. Feelings such as nostalgia, regret, shame despair and loneliness are intimately tied to the queer community and social exclusion, the “historical impossibility of same sex desire.”<sup>3</sup>

Many queer people in society and throughout the world long for a sense of caring community and connectedness, and for the ability to have a decent standard of living and pursue meaningful lives free from the threat of violence and intimidation. We seek to create a movement that addresses this longing. Many of us long for communities in which there is systemic affirmation, valuing and nurturing of difference, and in which conformity to a narrow and restricting vision is never demanded as the price of admission to caring civil society.

*I found supportive space and community to bring my shame to, in the likes of dingy church and school basements, places that still today smell like home. These rooms will always be a place of safety for me, a place to rest without stigma or judgment. When I finally got clean and sober, when I finally had suffered enough I didn't go into a treatment program as many do, I just quit fighting one day and a friend who was in recovery brought me to a 12 Step meeting. I was broken and needed to surround myself with other people who would understand my struggle, my shame, and my fear. I cried for weeks, swollen with pain, learning to rely on the strength of other female addicts who had gone before me, who like me had survived when the odds were against them. I remember distinctly the relief I felt when I realized I wasn't alone, that I did not have to grieve in silence and that there were others who understood my disease. I can't imagine my early steps into recovery without the help of these women. They were my lifelines to the world at times. In thinking retrospectively about this experience I question what would happen if we inverted our positions toward addiction and responded as a society from a care perspective as these women did for me. Living with a disability or relating to someone with a disability makes it very clear*

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<sup>3</sup> Heather, *Love Feeling Backward*, Cambridge, Harvard University Press, 2009.

*how interrelated our lives really are, how much we socially and politically absolutely need each other.*

Disability forces us to face the problem of reciprocity, the investment in a relationship by both participants. Reciprocity involves the difficulty of recognizing each other's needs, relying on each other, asking and receiving help, delegating responsibility, giving and receiving empathy, and respecting boundaries. As human beings we need to rethink the human as a site of interdependency and ask ourselves, do we or do we not live in a world where we assist each other? Do we or do we not assist each other's basic needs? And are these basic needs there to be decided on as a social issue?

*Today my sense of safety and my disease depend less on these women and more on an internal set of resources. However, I must admit that the rejection and stigma that still surrounds the addict identity keeps me guarded, keeps me isolating myself. I am out as a queer woman (double stigma) but often remain silent about being an addict in recovery (triple stigma) for fear of undermining any credibility attained in my years clean. Many queer people that I know have expressed discomfort with disclosing their disease, even within the queer community that prides itself on inclusion and acceptance. I have witnessed queer people shy away from addressing the disease of addiction, for fear perhaps that it may bring them closer again to scrutiny from the dominant culture.*

The queer community has reached greater visibility, yet a considerable number of queer people with the disease of addiction remain hidden. In the queer community, many are willing to disclose their sexual orientation or gender variance, but not their disease of addiction. There is an ongoing tension in the queer community between assimilationists and those who challenge pro

binary roles. This ongoing tension leads me to wonder if addiction also then challenges assimilation?

## MULTIPLE IDENTITIES

Addiction and isolation go hand and hand. The reality is that most addicts know the hazard of isolation and where it can lead, but the tendency is so ingrained that the natural inclination is to withdraw without even realizing it. For most addicts, it is the isolation that triggers the addiction and then the addiction that drives the isolation. Black-and-white thinking is a hallmark of addiction. It narrows everything down to some extreme. Something either is or isn't, there really are no gray areas in between. Unfortunately, most things in life have quite a bit of gray in them. This grayness often makes addicts fairly ill equipped to deal with the realities of everyday life. Isolation provides a much more conducive environment for narrow thinking to flourish. When we feel isolated, feelings of insignificance and loneliness can easily seep in. This discomfort can start a chain reaction, provoking other emotional triggers. Without social support, the weight of emotional pain can begin to feel like everything around you is caving in. Thus, I argue that it's not about curing the queer, disabled or addict body but just the opposite, it is about making human connections to these bodies and not conceding to too many gray spaces.

In reflecting abstractly about queerness, disability and how addiction intersects with these multiple identities I am reminded of a passage called the *Plural Body* by Roland Barthes. Here Barthes does the work of reminding us that we have many bodies, digestive, sensual, depressed, intimidated, shamed, socialized etc. A 'plural body' creates a sense of otherness, of two dimensions. In thinking about what a 'plural body' may look like I envision a before and after, a cause and effect, a trauma and a recovery. A 'plural body' challenges us to understand the plural as that which lies not only in the representation of texts but also to understand the plural as that which takes place in the reading of something. Hence, meaning and identity are continually being negotiated. In this framework disability could be seen less as an objective fact of the body

or mind and more as a product of social relations. Multiple bodies and plural identities demand an understanding of life that seeks to destroy meaning and create something entirely different, leaving room for new identities. Barthes shows us that the contradictions placed on the body and gender as a modality limit us rather than free us. Healthy plural frameworks, embrace the idea that they can have multiple true selves, with no self more valid than the other. Plural frameworks contain the formation of multiple selves, sometimes with a self or selves.

Alison Kafer does the work of creating plural frameworks in *Feminist Queer Crip*. Kafer crafts a hybrid model of disability and makes room for activist responses, collective reimagining and multiple identities. In Kafer's political/relational model the problem of disability no longer resides in the minds or bodies of individuals but in the built environments and social patterns that exclude or stigmatize particular kinds of bodies, minds and ways of being. Thus the political/relational framework recognizes the difficulty in determining who is included in the term "disabled." It sees disability as a site of questions rather than firm definitions, as plural bodies and realities.

In thinking about this plural framework it has become apparent to me that when a young person is not allowed or encouraged to address their authentic self, they develop multiple identities that are often defined by those around them. *As an unknowing queer child, I relied on filtering my perceptions of reality for sake of acceptance and validation from others. Looking back on my childhood I can pinpoint these foundational sites. The self-monitoring and the urgency to please others took a disastrous toll on my developing a healthy autonomous self.* Sedgwick affirms that it is that childhood sense of shame that acts as a "nexus of production." I believe it is in relationship to this production that many queer and unknowingly queer people use alcohol and drugs to invalidate their pain and to intimately connect with others. Hence, the queer

and addict body materialize and are interwoven in a somewhat paradoxical way, by which the addict identity appears to be masking the queer identity. *My “nexus of production” would be in the absence that was produced or the un-doing of whatever was happening.*

## DISCOURSE

There are keywords that are standing out for me as I convey my narrative; pain, shame, other and, of course, normal. The point being is that these words resonate with many central philosophies in disability and queer theory that are relational to the mind and body. This brings me to the construction of language. Language lives just under the skin and is an important vehicle through which stigma is perpetuated and reproduced. Stigma represents a view of life; a set of personal and social constructs: a set of social relations and social relationships; a form of social reality.<sup>4</sup> One of the ways that stigma is preserved and carried out into our communities is through the use of language, which in turn is internalized by those stigmatized, and the cycle continues. Discourse is a medium through which power flows, Foucault theorized that dominant discourse is firmly established within our culture and that discourse carries fixed meanings, familiar metaphors, and common human applications. He argued that there is no “binary division to be made between what one says and what one does not say; [that] we must try to determine the different ways of not saying such things, how those who can and those who cannot speak of them are distributed, which type of discourse is authorized, or which form of discretion is required in either case” (425). Discourse is relational to the production of knowledge through language. It defines and produces the objects of our knowledge and governs the way that a topic can be meaningfully talked and reasoned. It influences how our ideas are put into practice and regulates conduct. The notion of discourse is not about whether things exist but about where meaning comes from. Foucault’s examination of discourse helps us to see the emphasis on the productive rather than just the oppressive dimensions of power relations.

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<sup>4</sup> Lerita Coleman Brown, “Stigma: An Enigma Demystified,” in *The Disability Studies Reader*, 2<sup>nd</sup> ed., Lennard Davis (New York: Routledge, 2006), 148.

The reclaiming of pejorative words began in oppressed communities that have had an intimate experience with ridicule and hate. Reclamation can be understood as an act of personal, social or political empowerment. In the last half-century, we have seen the reclaiming of words like crippled, dyke, and queer. Reclaiming a word does not change the word's meaning rather it borrows' its power from the vagueness and force of the word. If marginalized addicts felt empowered to reclaim derogatory words, we might be able to create a powerful counter-discourse, like other distressed communities. *I want to reclaim the words that have caused gut-wrenching shame. Junkie, whore, cokehead, fiend drunk*, these words “mark the jagged edge between self-hatred and pride, the chasm between how the dominant culture views marginalized peoples and how we view ourselves” (Clare, 33). Whatever we name ourselves, however, we end up shattering our self-hatred, shame and silence the goal is the same: to end our daily material oppression. Addicts spend a lifetime trying to silence the inner critic that repeats *I'm not good or worthy enough*, many suffer from a core belief that they do not deserve anything but the misery they have known in their active addiction; repeatedly accepting the discourse and stigmatization that has been infused in our culture. It is critical as addicts that we continue to cultivate healthy supportive language that is unstigmatized, dynamic and productive.

## HISTORICAL PERSPECTIVE

History plays a large part in how affect can become aligned with identities, such as that of the addict. Kathleen Stewart in *Ordinary Affects* believes that affects are “ordinary public feelings that begin and end in broad circulation, but they’re also the stuff that seemingly intimate lives are made up of” (5) that create the subject as a capacity to affect and be affected. Ordinary affect Stewart insists is registered in its particularities and connects people and creates common experiences that shape public feeling. Whatever emotion the addict might provoke, it most likely is not a new reaction; you’ve most likely felt it before. Ahmed calls this reacting a “sliding” or a “rippling effect” of emotions; “the movement between signs does not have its origin in the psyche, but is a trace of how histories remain alive in the present” (Ahmed, 126).

In the 1960’s America witnessed a huge increase in illicit drug use. The increase was shocking because for the first time it was highly publicized. For the first time white, middle-class youth represented American drug users and future addicts. The profile of the drug user changed while simultaneously massive political transformations were happening in American culture. The 60’s were characterized by an enormous growth in the United States. Funds were available to wage war in Vietnam and they were also available to fight the war on poverty at home in the states. With the rise of the counterculture and illicit drug use, the Nixon administration coined the term the *War on Drugs* promising to defeat “public enemy number one.” Evaluating the social climate during the Nixon administration is instructive to illustrate how affect slides. As a direct result of the *War on Drugs* some of the most influential cultural narratives of addiction came to be. The powerfully stigmatizing rhetoric of the *War on Drugs* left us with a narrative that said, drugs take away our agency; they hook us, beckon and seduce their users. Heroin addicted Vietnam veterans and cocaine addicted young, urban white professionals offered

unsettling pictures of addiction. Addiction, as seen through the eyes of the dominant culture challenged prevailing narratives of illicit drug use as a problem not only restricted to ethnic minorities, the poor and the otherwise deviant. The non-conforming drug addict was blamed as the source of degeneration, and feared for potentially possessing the power to destroy lives. The drug user and addict then became the site of conflict and struggle.

There is very little evidence that radical feminist groups of this era were speaking out against drug cultures that overlapped with, informed and in some cases seemed to power the counterculture during the 70's. The women's liberation movement existed at the same time as the onset of the *War on Drugs*; participants in it were also radicals in other movements and shared many of the same anti-capitalist, anti-imperialist frames of reference. While Nixon and the DEA instituted moral panic around drug culture and consumption, the women's movement was fighting for abortion rights, The Equal Rights Amendment, access to credit and equal pay. The slogan, "the personal is political" would seem appropriate for the motivations and consequences of drug and drug addiction and especially in the action orientated philosophies of liberation movements that were rooted in struggles for public space, voice, and power. It seems logical that the women's liberation movement would have been as concerned as its contemporaries about the toll exacted on women by alcohol and drug use, but it was not.

The *Feminist Memoir Project* written in 1998 is a collection of twenty-eight essays edited by Rachel Blau du Plessis and Ann Snitow. In this collection women involved in the movement, reflect on what brought them into the movement and on what sometimes took them out of it. Feminist authors chronicled their lives in the late 60's and early 70's and occasionally spoke about drugs and alcohol but only when speaking about men. It is surprising that there are very few references to women's own drug and alcohol use. If there are references they are heavily

veiled. Seattle peace activist Barbara Winslow notes that she “learned about sex, drugs, and rock ‘n’ roll” in her alternative high school (227); Vivian Rothstein of Chicago Women’s Liberation acknowledges that life with a raised consciousness was sometimes hard, and “we all experimented with different ways to either avoid or integrate our consciousness into our daily lives” (47). And deep into the ‘70s, poet, anti-racist, and lesbian-feminist activist Minnie Bruce Pratt—finally admits to something more than social drinking (412). Performance artist Eve Ensler, writing about that same time, characterizes herself as “a depressed alcoholic” (413), and black feminist Michelle Wallace acknowledges that her provocative classic *Black Macho and the Myth of the Superwoman*, 1978, appeared and was perhaps written while she was “drinking and smoking heavily, even doing the occasional illicit drug” (440). Absent, however, is any systematic analysis of the role of alcohol and drugs—within individual lives or, more importantly, the women’s movement. Unlike the Black Panthers and the Young Lords, who critiqued the political economy of ghetto drug culture as a colonialist project, radical feminism, and the women’s liberation movement seemed to have been uninterested in, or unable or unwilling to theorize alcohol and drug use, dependence or addiction.

In the late 80’s the “crack mother” and the “crack whore” emerged from the so-called “crack epidemic” amid poor, inner city, people of color, which garnered them the position as an object of hostility. Simultaneously addiction was being re-conceptualized in medical circles as a disease in which genetically inherited biochemical irregularities in the brain and liver caused compulsive cravings and out of control behavior. Using the example of the “crack whore/mother” relative to the concept of regeneration we can deduce that any new lives created by the female “crack mother,” would not have the capacity for life. Thus, it is easy to see how the “crack

epidemic” and drug use enforced a distinction between potentiality for living and perceived incapability for regeneration.

Paradoxically the creation of the disease model of addiction helped to explain drug use and abuse without fully demonizing the addict, but this model didn’t accommodate everyone. It accommodated white, middle-class addicts by offering them the possibility of recovery. Thus, a mixed message emerged addiction was a disease, but not a respectable one; an addict might be sick but they still carried the stigma of addiction and access to recovery was only for the dominant culture. In her most recent work, *Creating the American Junkie: Addiction Research in the Classic Era of Narcotic Control*, Caroline Acker identifies a systemic prejudice in the treatment of drug addicts. She argues that addiction is simultaneously a disease and a crime. Noticing the operation of cultural and social biases, Acker has posited that this schizophrenic approach has contributed to the inconsistent treatment of addicts under current drug control paradigms:

We now have in the United States a two-tier system of response to drug dependence: treatment for the middle to upper classes and incarceration of most others, including the poor, the uninsured, ethnic minorities, and immigrants. Employment status, race, gender and class all influence which response an individual encounters (Acker, 41).

By 1986 The ‘Just Say No’ crusade against drug abuse was launched by President Ronald Reagan and First Lady Nancy Reagan. That same year President Reagan signed the Anti-Drug Abuse Act, creating mandatory minimum sentences for drug crimes which lead to a massive increase in the number of people incarcerated in Federal prisons for drug related crimes. American politicians responded to the “crack epidemic” by passing draconian drug laws.

Reasoning with no evidence that crack cocaine was 100 times more addictive than powder cocaine. Given that crack cocaine was more popular among people of color and powder among white drug users, the result of the draconian legislation resulted in a massive racial disparity in the punishment given out to users of the same drug. In 1989 alone, 46% of all arrests made in New York City were for the possession or distribution of crack cocaine.

In unraveling the symbolic meaning of drug addicts as they are rooted within society, what is arising is a vision of the human body gripped within a nonhumanizing addiction. When we take chemical substances and particularly illegal ones, the addict enters into a place of otherness. Through state surveillance and the collection of statistics, using populations to obtain bodies of data further stigmatizes the addict as a deviant body. Since data is typically stored in machines, I am thinking of Jasbir Puar's machine like assemblages to describe the joining of body and data for measurement and control. The image of the gaunt nodding out human form becomes a specimen in this assemblage and joined with statistics obtained through state surveillance becomes a body of data. Addicts then become assemblages of data to be recorded, analyzed and measured.

## WOMEN AND ADDICTION

*I remember it pretty clearly I was nine years old. My baby sister had just recently been born. I had a new last name and was adjusting to calling my stepfather Dad. I was an active child my time was strategically planned by my mother, between babysitters, dance classes, softball, brownies and YMCA camps on school vacations, my time was never my own. My mother kept me busy and in line, like a fine tuned little soldier, I always had some duty to report to. She kept me occupied she said, "to keep me out of trouble" and because she had gone back to work, back to the men's prison she was a staff psychologist at. Her caseload was mostly comprised of men who were incarcerated and serving life sentences for various drug related felonies. She often came home wielding horror stories of fathers and sons, mothers and daughters whose lives had been destroyed by drugs and addiction. I remember wondering why the word addict was such a bad word? Not only did she use it to talk about these inmates who were in prison but also, she used it to talk about and describe my biological father, who I only saw maybe once or twice a year. This made me sad and curious about addicts, just as I was sad and curious about my biological father. A full understanding of this word and the potency that it generated wouldn't come to me for many years later, when I myself would be that bad word.*

*I recall one night sitting on the living room floor watching television the President Ronald Reagan and his wife Nancy were delivering an address to the nation. They sat perched on a small living room couch, holding hands. The address came "from our family to yours, from our home to yours." What followed was a speech about the nation's drug problem. The Reagan's called on families, churches, schools, entertainment outlets, and athletic organizations to 'Just Say No.' My mother being employed by the state and working in the prison system had hopped on the moral panic band wagon and was given permission to have police officers come into my*

*semi-rural elementary school to deliver an anti-drug message, they re-played a video clip of Nancy Reagan's three-word mantra, 'Just Say No'; distributed posters of a drug-sniffing K-9 police dog; and shared their experiences of scrapping with drug users and dealers characterized as a crude assortment of losers and bums. 'Just Say No' was a powerful tool; it aligned drugs with a dangerous and roughly defined "other," and presented them as the consequence of collective personal failure in effected communities rather than a public health crisis for millions of Americans. Overall, the officers' message was simplistic and vague, grouping everything from alcohol to heroin into one toxic cloud that loomed over our society. The demonization of such substances and "those" people in their orbit was a piece with the national public service announcements of the day, which told us that drugs either made you fly or fried your brain like an egg. Much like abstinence-based sex education, Dare and "Just Say No" spread fear and ignorance instead of information, placing all responsibility on the individual while denying them the tools they needed to make key decisions. It's a shame the anti-drug programs of the period failed to show the same ingenuity when it came to teaching children about the very real dangers of substance abuse. The end result was that, in the minds of impressionable students like my classmates and myself drugs were a defect rather than a symptom, a moral rather than societal failure.*

*Contrary to popular belief, Nancy Reagan's anti-drug activism was not just silly or ineffectual. It was fundamentally misguided, openly intolerant, and unabashedly repressive. It reinforced misconceptions about drug use that shaped public policy for decades, leading to millions of unjustified arrests and prison sentences. While I have no doubt that Nancy Reagan was genuinely moved by the plight of drug addicts and sincerely motivated by a desire to help children avoid that fate, the policies she supported hurt a lot of innocent people. Whether she*

*saved lives is doubtful, but she certainly helped ruin many through her influence on the general public. It is tempting to think that any attention paid to the drug epidemic is a blessing, even if it is just a wrong-headed cliché and a seized vehicle. But unless we radically change course and acknowledge the lived realities of American drug users and the underlying socioeconomic factors, millions of 'Just Say No' kids like me will continue to grow up and 'Just Say Yes.'*

Contradictions of the early twentieth-century surrounding the drug addict and the cultural ambivalence of the time gets played again and again in the female addicts' negotiation with addiction. The addict is either a victim of the disease or stigmatized as individually responsible for it. Furthermore constructs of femininity continue to complicate this binary as women are still regarded as biologically and psychologically vulnerable to illness, which locates the blame for their "disease" in their individual, conscious behavior. With the ever-present visibility of the female drug addict and decades of marked social and political change, the refrain has sadly remained the same, *pull yourself together and act like a lady*.

Psychological weakness, the disease concept, and normalized pathology each function as tropes through which addicted women not only make sense of their addictions but of themselves as drug addicts. These tropes are specific not only to the historical and cultural moment of each woman's story but also, to the popular and medical discourse of drug addiction. Sociologist Elizabeth Ettore points out in her book *Women and Substance Use*, that drug use historically has been seen as a "man's disease" or a "male problem." Arguing for a feminist perspective on women's drug use, Ettore reveals the "masculine bias" within the field of addiction, she states, "the centrality of the notions...that men are socially dominant and active participants in the drug-using culture and women are socially subordinate and relatively passive participants has meant that the situations and needs of women have been largely unacknowledged and unrecognized

within both treatment and the research world” (17). The responsibility for biological and social reproduction, the conflation of gender and biological difference in the discourse of women’s addiction has resulted in the thorough stigmatization of women drug users.

If women are seen to “abuse” in any way their already abused bodies, they are seen to be worse than their male counterparts. This is because these women are seen to defile and indeed to desecrate the sacred symbol of their sexual essence: their bodies, which house their wombs or reproductive power. While the female body is the embodiment of women’s reproductive nature, substance abuse is seen as an attack on women’s nature. A substance-abusing woman is the quintessence of a wicked woman defiling her body with harmful substances (Ettore, 10).

Hence the female drug addict is the embodiment of a woman who rejects her femininity. Put simply, drug use itself is seen as essentially unfeminine, especially as it renders women morally shameful mothers and irresponsible wives, it violates normative femininity.

In examining women’s addiction from a feminist standpoint, I am thinking about its inherent connection to structural inequality and whether or not connecting women’s addiction to power and the institutions that produce this power are a gain for women in practical terms or if it is a loss? And in thinking this through I believe the answer very much depends on which population of women we are talking about. Perhaps the most disadvantaged and disenfranchised women are low-income women and welfare mothers. One of the most powerful tools in the arsenal of welfare reformers was the image of a welfare mother addicted to drugs and paying for her habit with public distributions. The imagery came to its logical conclusion in welfare reform’s Gramm Amendment that ended all aid even food stamps for the families of female drug

felons on a lifetime basis. By 1990, 65% of women were working outside the home. A large portion of women were paying for services to assist in domestic labor, however somewhere along the way, as a culture we seemed to forget that poor women don't have the same wherewithal to purchase the services of daycare, housekeeping, food preparation, etc. Where did this leave the welfare mother? Essentially, looking like a failure—and society questioning why she couldn't make ends meet like the rest of the women? And sadly the common political discourse to this was, *maybe it's because she's too busy getting high*. From a feminist perspective we have wound up with two cultural scripts about women and substance use. There's the accepted "wet feminist" script that applies to women of means and power. These women, it seems, have earned the right to a three-martini lunch and then some. And then there are the different standards for women who have not experienced the economic mobility promised by feminist standards that are more prohibitive, more punitive, and stricter than ever before.

These cultural conditions, norms and "diminished" subjectivities are particularly evident in contemporary narratives. In his book *The Transformation of Intimacy: Sexuality, Love, and Eroticism in Modern Societies*, Anthony Giddens describes "the addictive experience as the giving up of self, a temporary abandonment of that reflexive concern with the protection of self-identity generic to most circumstances of day-to-day life" (72). "The loss of self, therefore, is a characteristic of addiction" (73). *I would agree with that many addiction narratives, including my own invariably lament the loss of self as one of the overarching consequences of addiction and that many recovery narratives are often expressed as a restoration or a discovery of the self*. It seems relative that to understand addiction as avoidance of pain one can further recognize the connections between emotional pain and social conditions. This loss of self-occurs not just as an

inherent characteristic of addiction, many addiction narratives that women tell invariably recount experiences of victimization and trauma, which also upset concepts of self and identity.

Traumatic events destroy the sustaining bonds between individual and community. Those who have survived learn that their sense of self, of worth, of humanity, depends upon a feeling of connection with others. The solidarity of a group provides the strongest protection against terror and despair, and the strongest antidote to traumatic experience. Trauma isolates; the group re-creates a sense of belonging. Trauma shames and stigmatizes; the group bears witness and affirms. Trauma degrades the victim; the group exalts her. Trauma dehumanizes the victim; the group restores her humanity. (Judith Herman, *Trauma and Recovery*)

### TRAUMA AND THE FEMALE SUBJECT

*In my early recovery, I didn't understand the significance that the trauma of my addiction had played in my life.* Herman asserts that “being a witness to trauma makes it real, valid and allows for us to move forward.”<sup>5</sup> Trauma manifests both overtly and subtly. Trauma presents itself in its effects such as isolation and disconnection concealed by a profound sense of otherness. *Today my relationship with my trauma looks very different than when my disease was active, but it is still there. This lasting impairment is disguised and lives in my body like a ghost limb; I can still feel it.*

In addition, it is important to understand that the experience of victimization, trauma, and the loss of self—are distinctly gendered; they are more commonly seen as women’s experiences than men’s. *Many women like myself tell their stories to politicize their emotional and psychic pain; our stories echo the attitude of second wave feminism: the personal is indeed political.* Drawing from consciousness-raising efforts helps to illustrate important connections between feelings of shame, helplessness, abuse and sexism. Women’s narratives of addiction describe periods of depression, loneliness, and a governing sense of isolation that directly relates to their addiction. They often entail childhood incidents of abuse and catalog psychological trauma and

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<sup>5</sup> Judith, Herman. *Trauma and Recovery: The Aftermath of Violence-From Domestic Abuse to Political Terror*, New York, Basic Books, 1992.

suffering. The recognition of psychological trauma is an overwhelmingly common etiological factor of female drug addiction. Most women who are addicts are aware of their emotional and psychological methods and states as they relate to their addictions. However, rarely do women make explicit links between their socio economic conditions, the roles that these conditions dictate and the painful feelings that influence addictive behaviors.

Like the disease model, the trauma model includes a broad range of experiences and symptoms under a single, medicalized rubric, and provides a unifying basis for group identity. Trauma and the disease concept constitute a similar lens of pathology that raises questions about individual and social responsibility. What happens, then, when women use the concept of psychological trauma to explain their drug addictions? Indeed many women's stories of drug addiction begin with the recollection of childhood traumas, such as sexual, physical or emotional abuse. Furthermore women's repeated narratives of drugs' emotionally numbing effects demonstrate that women often see their drug use as response to the overwhelming emotional and psychic pain they correlate with traumatic events or circumstances.

A 2004 study published found that almost 95% of those who were in treatment programs for substance abuse reported a history of trauma.<sup>6</sup> However, these findings neglected to locate this analysis within a broader sociopolitical context. Although psychiatry recognizes the close relation between traumatic experiences and drug addiction, it treats drug dependence as a distinct and individual pathology, a "disorder" whose cure is entirely separate from systemic relations. In other words it rarely resonates with a broader cultural and political context. This is where feminism can intervene by moving "the analysis of the problem beyond an individual perspective to a larger sociopolitical, systemic framework" (Root, 238). Viewing addiction within a feminist

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<sup>6</sup> JP Reade, PJ Browne, CW Kahler. *Psychology of Addictive Behaviors*, 18 (1) 19, 2004.

framework of trauma is then not pathological but a common, adaptive response to trauma and various facets of oppression socio-politically. Given that drug addiction and PTSD are properly understood as enduring often life-long conditions that have compelling biological explanations and are said to dictate the sufferer's behavior and definitively shape their identity, the question remains whether or not women who are addicted are helpless and long-suffering victims of both trauma and drugs?

*In my addiction narrative the traumatic effect of sexism was most evident in my negotiation with femininity and heteronormativity. The roles that were offered to me by my mother were oppressive and psychologically damaging. She maintained that the roles expected of me as a girl and as a woman were that I was powerless and unimportant and that I needed a man to make me whole. I pursued alcohol and drugs as an experience to transcend the real, one forbidden and rebellious. I needed to protest; I needed to escape from the chaos, loneliness and shame that resided in me. Angry and confused I thought alcohol and drugs could save me from my queerness and myself. Throughout the process of growing up, I learned quickly that I was a pretty little girl and that I was expected to act as such. My mother projected unattainable standards of femininity on me that I didn't understand and that I didn't want to be a part of. No matter how liberal she professed to be, men raised her, she worked with only men and carried her life out in a deeply misogynistic manner. She was powerful, manipulative and frightening. I absorbed her vicious words and learned early on that they hurt more than bruises ever would. My mother's venom paired with her insatiable need to be the center of attention are deeply embedded in my body. Her voice is the voice that I hear when my disease wants to be in control, when I want to act out or pick up. The messages that I received were that I would act proper, be seen and unheard. I learned from my mother that a woman's worth was determined by her*

*attractiveness, that no matter how smart you were what mattered most was your appearance. And doing drugs did not add up to preserving proper feminine normativity. I interpreted myself as an innate depravity, a biological flaw that liked other little girls. My safety in the world felt thoroughly dismantled I had no sense of myself. Struggling through all my childhood and well into my adult life to be heard, understood and seen, I prayed for the yelling to stop. As a child I just wanted to be left alone, to hide in the tall grasses with the caterpillars that would whisper stories of triumph. I wanted to ride my red BMX bicycle shouting, "look at me, I'm here, whoever you are, I'm worthy of your love!" I wanted the noise to stop. There was a volatile ingraining in my mother that was deeper than any maternal nature that she may have possessed. I remember picking up on this at a very young age, of course not having a name for it but certainly feeling sad for my mother, that her self worth, her value, her mode of thinking was only accessed through the eyes of men. My mother's ability to get what she wanted and needed in life was executed in a very confusing and contradictory manner. The unequal balance of power in my home made it impossible for me to model my mother. The contradictions that I witnessed as a child created enormous internal conflict for me growing up as a young girl grappling with sexual identity. With adulthood, I learned to push the feelings of queerness and loving other pretty little girl's way down deep. The intense shame, self-hatred, and isolation I felt from this otherness was brutishly masked and I turned it into indifference, rage and aggression. I secretly went looking for trouble while trying to play by the rules that society and my mother had emphasized for pretty little girls like me. Using alcohol and drugs helped me to keep the lid over the hole that was my growing queerness. The substances helped me to numb the pain that throbbed underneath and gave me the energy to keep the lid sealed tightly. Self-harm in the form of alcohol and drugs relieved the unbearable pain of my emotions and my shortcomings; they*

*were my self-preservation. I was in and out of active addiction and in and out of abusive relationships with all the wrong people for the majority of my young adult life. My body had been given and taken by countless men; my worth had been abandoned. I moved around allot making new friends and new homes. I moved on a whim to Mexico and stayed for five years. The beast, my disease was stronger than I was. I couldn't stop running, running away from myself. I took unnecessary risks, exposed myself to very dangerous people and acquired extremely skewed coping skills. I was out of my mind and in so much pain. It physically hurts to think of how deeply rooted my self-loathing was and can be. Even today as a socially conscious queer woman, educated and somewhat evolved I still find myself shrinking when it comes time to assert myself, apply my point of view and my place of relevance. By rejecting my mother's values, which I couldn't help but internalize, I went to war not only on society but also, with my self. I was engaging with drugs and its culture as a way to disassociate and hide from my true self, from my queerness. This learned otherness fostered and reinforced my feelings of inadequacy and isolation, which eventually added to and fueled my predisposition to addiction. And it is for this reason that my drug use and addiction represent a very real negotiation with my queer identity. This conflict I had with identity and the regulating of my childhood are a direct result of the gendered violence that I experienced.*

Reading my drug addiction as a response to my trauma leaves me with a different but parallel paradox: while women's drug addiction may be an adaptive response that foregrounds the impact of abuse and insidious trauma, and therefore potentially recasts addiction as a social and political issue, as a "symptom" it still operates with the conventional medicalized model of addiction, and more broadly psychopathology. In this configuration, the validation of drug addiction as a response to or manifestation of women's psychological pain threatens to become

another therapeutic avenue by which the old idea of inherent female vulnerability is reinforced. *Arguably we need to look critically at the contemporary cultural acceptance of trauma, which currently circulates without a distinct political movement, by revealing how women like myself have the capacity to assert meaningful agency in their lives.*

## EXPANDING CONVENTIONAL NOTIONS OF TRAUMA

In the late twentieth century, the feminist movement in North America brought into public consciousness the psychological trauma of sexual and domestic violence. Judith Herman in *Trauma and Recovery* states, “Not until the women’s movement of the 1970’s was it recognized that the most common post-traumatic disorders are not those of men in war but of women in civilian life” (Herman, 28). A hallmark of second wave feminism, consciousness-raising groups sought to break the silence that surrounded the conditions of women’s lives and to expose the violence hidden in the sphere of the personal. Women spoke freely about their personal lives, including experiences of sexual assault and abuse, and they included experiences and interactions within public and political life. The feminist movement helped reduce the effectiveness of silencing techniques by creating forums where women could tell their stories of abuse. The feminist understanding of sexual assault fostered within and by consciousness-raising groups “empowered victims to breach barriers of privacy, to support one another, and to take collective action” (Herman, 29). The feminist movement not only documented pervasive sexual violence for the first time; it also offered “a new language for understanding the impact of sexual assault” (Herman, 30). The feminist understanding of women’s private, personal and everyday experiences of violence as traumatic nonetheless challenged the concept of trauma as a discrete public event.

Bringing the discussion to the present a more contemporary and intersectional feminist analysis of trauma asks us to understand how the constant presence and threat of trauma in the lives of girls and women of color, queer people, people in poverty, and people with disabilities has shaped our society therapist Maria Root in *Traumatic Failures: The Role of Sexual Victimization in Women’s Addictive Behavior* developed the concept of “insidious trauma,” and,

more specifically, the notion of sexism as an insidious trauma. The concept of insidious trauma refers to and is usually “associated with the social status of an individual being devalued because a characteristic intrinsic to their identity is different from what is valued by those in power, for example, gender, color, sexual orientation, physical ability” (Root, 240). Insidious trauma is often present throughout a lifetime and may start at birth. And while direct trauma, including such diverse experiences as combat and sexual abuse, shatter assumptions about the world; insidious trauma shapes a worldview. As a rule insidious trauma’s effects are cumulative and directed toward a community of people. Consequently, they encompass some very normative yet nevertheless traumatic experiences for groups of people.

Insidious trauma sustained by minority groups usually starts early in life before one grasps the full psychological meaning of the maliciousness of the wounds, for example, a child is told he or she is not the right kind of person to play with—too poor, the wrong color, too effeminate etc. They do not typically include physical violence yet leave a distinct threat to psychological safety, security or survival. Overtime Root argues, insidious trauma “may result in a picture of symptomatology similar to that of direct...trauma, particularly involving anxiety, depression, paranoia, and substance abuse” (Root, 240). The formulation of insidious trauma to describe women’s everyday experiences of systemic sexism has been one of feminism’s most significant contributions to the study of trauma. Whether or not women have a history of abuse, many commonly describe a governing sense of alienation, inherent badness, and helplessness, which according to Judith Herman and psychiatry typically characterize the traumatized person.

These contradictions of the early twentieth-century surrounding the drug addict and the cultural ambivalence of the time get played again and again in the addicts’ negotiation with addiction. The addict is either a victim of the disease or stigmatized as individually responsible

for it. Furthermore constructs of femininity continue to complicate this binary as women are still regarded as biologically and psychologically vulnerable to illness, which locates the blame for their “disease” in their individual, conscious behavior. With the ever-present visibility of the female drug addict and decades of marked social and political change, the refrain has sadly remained the same, *pull yourself together and act like a lady*. The intensity of fear, the intensity of hate, perceived psychological weakness, the disease concept, and normalized pathology each function as tropes through which addicted women not only make sense of their addictions but of their addict bodies. These tropes are specific not only to the historical and cultural moments of each woman’s story but also, to the contemporary discourse of drug addiction. The responsibility for biological and social reproduction, the conflation of gender and biological difference in the discourse of women’s addiction has resulted in the thorough stigmatization of female addicts.

In looking at the continuity between life making and life building and the wearing down of subjects, through sites of administration, discipline and measure and of what constitutes a healthy life and ultimately life, I put forward that based on these examples the addict position remains tangled in a complicated web of assumptions, degeneration and the moral failure to generate capacity. I suggest instead that we consider the disease of addiction as queer/disability, as this would allow the addict body and identity the opportunity of challenging individualistic, stigmatic explanations for addiction and would further reveal the diminishing function of abelist culture.

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