January 2015

Looking at Levels of Medicalization in the Institutional Narrative of Substance Use Disorders in the Military

Chase Landes Mccain
University of South Florida, clmccain@mail.usf.edu

Looking at Levels of Medicalization in the

Institutional Narrative of Substance Use Disorders in the Military

by

Chase L. McCain

A thesis submitted in partial fulfillment
of the requirements for the degree of
Master of Arts
Department of Sociology
College of Arts and Sciences
University of South Florida

Major Professor: Sara Green, Ph.D.
Maralee Mayberry, Ph.D.
Khary Rigg, Ph.D.

Date of Approval:
June 5, 2015

DEDICATION

I dedicate this thesis to my family for nursing me with love and support as well as their dedicated partnership for success in my life. I would also like to dedicate this work to the men and women who so nobly risk their lives and put the welfare of others before their own for the continued safety of our country.

ACKNOWLEDGMENTS

I would like to express my gratitude to my committee; Dr. Sara Green, Dr. Maralee Mayberry and Dr. Khary Rigg for their guidance, patience, and tireless support throughout this project.

TABLE OF CONTENTS

LIST OF FIGURES

ABSTRACT

The purpose of this research is to examine the institutional narrative of substance use

disorders (SUDs) in the U.S. military and the extent to which it reflects the

medicalization process. Three general research questions guided my analysis of the

narrative surrounding SUDs in the military: (1) How does the military characterize the

problems and resolutions of SUDs? (2) How and to what extent does this narrative

reflect medicalization? (3) What are the limitations inherent in the institutional narrative

of SUDs in the military? In order to address these questions, I draw on three conceptual

lenses: (1) The work of Loseke (2007) and others on the powers of institutional

narratives; (2) The work of Conrad and Schneider (1980) in which they propose that

medicalization can be understood in multiple ways and on at least three distinct levels

(the conceptual, the institutional, and the interactive); and (3) The work of disability

scholars on the limitations of the medical model and the importance of adopting a social

model of the causes and consequences of disability (Oliver and Barnes 2012;

Shakespeare 2014; Berger 2012).

In this study, I use these lenses to conduct a textual analysis of the *VA/DoD

Clinical Practice Guideline for Management of Substance Use Disorders.* This manual

was developed under the auspices of the Veterans Health Administration (VHA) and the

Department of Defense (DoD) pursuant to directives from the Department of Veteran

Affairs (VA). The document was designed to provide recommendations for the

performance or exclusion of specific procedures or services related to identification and response to substance use among active duty personnel and veterans in all branches of the US military. The information and recommendations presented in the document were then disseminated throughout all branches of the military for implementation. This document is, therefore, a powerful codification of the institutional narrative of substance use in the military. Using Conrad and Schneider's model as a template (1980), I examined the document in order to see how the military has framed the discussion surrounding SUDs.

My analysis began with a close reading of the manual several times without much reflection in order to get a general feeling for the story being constructed by the text. However, as I continued with the close reading, I began making comments about the practices and overall impressions the manual puts forth. After several readings and thorough note taking, it became clear that there was a significant amount of medicalization occurring throughout the military manual, and evidence for medicalization could be seen on all three of the levels suggested by Conrad and Schneider. Words and phrases of text were eventually coded and categorized into the three levels of medicalization.

The narrative within the document depicts a specific story of how the military addresses matters involving SUDs through a system of screening, assessment and treatment. First, the document's language relating to diagnostic assessments, laboratory biomarkers and other screening devices used to categorize and measure one's substance use can all be considered evidence for medicalization at the conceptual level. Multiple segments of text have been identified and categorized on a conceptual level. Second,

clear indications of medicalization on the institutional level can be seen with references to specialty treatment, "specialty care" and "other clinics." Again, multiple text segments have been identified as being representative of medicalization at the institutional level. Finally, evidence for interactive medicalization can be seen through the use of medical referrals, pharmacological treatments and the ongoing monitoring of medical consequences of substance use.

The findings suggest that the military has adopted what many now consider a medical model approach toward understanding substance use and evidence can be found at all three levels of medicalization proposed by Conrad and Schneider. Strengths and weaknesses of exclusive reliance on a medicalized narrative of the causes of substance use among military personnel and veterans are discussed in light of the lessons learned from the social model of disability and other critiques of medicalization. I conclude that the success of a medicalized response to substance use may be hampered by the tension between the two widely circulating cultural narratives that intersect in the case of substance use among military personnel.

CHAPTER ONE:

INTRODUCTION

The purpose of this project is to examine the institutional narrative of substance use disorders within the military. Drawing on Donileen Loseke's work on the intersecting nature of formula stories at the macro, meso and micro level (2007), I argue that substance use in the military stands at the intersection of two powerful cultural narratives: a hyper-masculinized, heroic conception of military service, and a medicalized conception of human behavior and social problems. Through content analysis of a major military document, I show that the institutional narrative of substance use in the military is highly medicalized and conclude that the success of a medicalized response to substance use may be hampered by the tension between the two widely circulating cultural narratives that intersect in the case of substance use among military personnel.

Since the introduction and implementation of zero tolerance policies in the military in 1982 (Bray & Guess, 1989), the prevalence of drug use has substantially declined (Kao, Schneider & Hoffman, 2000). However, contrary to this decline in overall use of illegal drugs, recent evidence indicates that consistent with national trends, there has been a substantial increase in the abuse of prescription medications within the military (Bray & Hourani, 2007; Bray et al., 2010). According to researchers Bray, Kroutil & Marsden, in 1980, 36.5% of military men had reported using illegal drugs in the past 12 months. This number is considerably higher than current rates of illicit drug use in the military and is

presumably due to the lack of zero tolerance policies and drug testing at the time. A brief history on the rates of military drug abuse shows that from 1980 to 1992, illicit drug use in the military sharply declined from 36.5% to 6.7% (Bray et al, 1995). This decrease continued over the course of the next decade up until 2002 where it reached a low point of 3.4% (Bray et al, 2010). Something interesting happens from 2002 to 2008, however, which consequently resulted in an increase to 12% of military members participating in illegal drug consumption within the past 30 days. Exhaustive research has been done to understand this recent increase of drug use in the military, and the jarring shift has largely been attributed to the nonmedical use of prescription opioid medications (Executive Office, 2010; Murphy & Clark, 2012; Bray, Pemberton, Lane & Hourani, 2010). Thus, the increase in the prevalence of what is now called "substance use disorders" (SUDs) – especially prescription drug abuse – continues to be a grave concern for those involved throughout the military.

Substance use disorders, as defined by the DSM-IV-TR and the military, includes a "maladaptive pattern of substance use, leading to clinically significant impairments or distress, as manifested by one (or more) of the following occurring at any time in the same 12-month period:" 1) recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home; 2) recurrent substance use in situations in which it is physically hazardous; 3) recurrent substance-related legal problems; 4) continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (American Psychiatric Association 2000). SUDs continue to be an area where social science researchers should be

vigorously investigating. The dominant military culture, structural organization of medical services, personal consequences of exposure to life threatening and traumatic experiences, and the military response to SUDs are all areas that deserve attention when attempting to understand why the military has recently experienced an increase in SUDs.

While the increase of SUDs in the military has been well documented (Bray & Hourani, 2007; Bray et al. 2010; CDCP 2011; Institute of Medicine 2012; Larance, Degenhardt, Lintzeris, Winstock & Mattick 2011; Manchikanti, 2007; Manchikanti & Singh 2008; ONDCP 2011), very little attention has been given to the types of messages about SUDs that are produced and communicated to military personnel. In an attempt uncover and better understand the messages produced about SUDs in the armed forces, I examined the manual: *VA/DoD Clinical Practice Guideline For Management of Substance Use Disorders*. The manual was jointly constructed by two of the largest producers of information for service members: Department of Defense (DoD); and Veterans Affairs (VA). Both serve to disseminate information throughout all branches of the military. The manual provides a detailed story about the way in which SUDs are (or are supposed to be) handled and managed in the armed forces. As such, it codifies the "official story" of SUDs for the military.

Three general research questions guided my analysis of the institutional narrative of SUDs in the military as portrayed in the *VA/DoD Clinical Practice Guideline For Management of Substance Use Disorders*: (1) How does the military characterize the problems and resolutions of SUDs? (2) How and to what extent does this narrative reflect medicalization? (3) What are the limitations inherent in the institutional narrative

3

of SUDs in the military? In the following section, I give an overview of the various types of narratives found throughout society and how they serve to influence one another.

Formula Stories: Cultural, Institutional/Organizational and Personal Narratives

While this study focuses primarily on the military's institutional narrative of SUDs in the armed forces, institutional narratives are not mutually exclusive from other types of narratives found throughout society. In this project, I use the term *formula story* (Berger, 1997) to refer to narratives of typical actors engaging in typical behaviors within typical plots leading to expectable moral evaluations (Loseke, 2007). These stories go by many other names, throughout various academic disciplines, including: public narratives, (Somers, 1994), cultural narratives (Singer, 2004), cultural stories (Richardson, 1990), master narratives (Mishler, 1995), or schematas (D'Andrade, 1995; DiMaggio, 1997).

For the purpose of this project, following work by Donileen Loseke (2007), I distinguish among four interrelated levels of formula stories: macro level cultural narratives, meso level institutional and organizational narratives, and micro level personal narratives. In the following sections, I give a brief explanation of each type of narrative as described by Loseke and finish with a discussion about how these stories might influence one another in the specific case of SUDs in the military.

Macro Level Cultural Narratives

Cultural narratives provide a social classification for others (Lamont and Fournier, 1992; DiMaggio, 1997), or a collective representation of disembodied types of actors that serve to shape our understanding of the social world (Loseke, 2007). Cultural narratives – *formula stories* – are stories involving a collective representation of specific information

4

that helps shape one's worldview. Throughout society we have developed many different stories through which we share information with one another about other individuals who posses specific qualities. Through these cultural stories we develop certain expectations and evaluations about particular individuals and how they should be treated and valued. Cultural narratives describing particular categories of people or human experiences are socially constructed and continuously repeated by our media, politicians, activists, and social institutions. Formula stories circulating throughout society are thus disseminated by our most powerful individuals and organizations and can lead to us ignore other important stories from those with less power. More specifically, in the United States, considerable attention and weight is given to the stories created by our political leaders and medical experts and are often thought of as very credible and thus worthy of our attention. For example, if congress members were working toward criminal justice reform, lawmakers and politicians would promote and share stories that focus on the shortcomings of our criminal justice system rather than the positive aspects – potentially leading to a new formula story, which may ultimately suggest that our criminal justice system is in need of repair. Similarly, if we begin to see a sharp increase in the number of doctors who are against vaccinations for young children emphasizing their harmful effects, a new formula story about the safety of vaccinations may begin to circulate. Parents may also begin to adopt this same ideology and as a result choose to forgo vaccinations for their children. The narratives told by those with power and influence has a significant affect on altering and shaping our worldviews.

Both examples demonstrate how our most influential and powerful people can

construct cultural narratives, which are subject to change over the course of time and throughout various social contexts. However, those outside the political sphere and medical institution are not completely helpless. Individuals may push back against cultural and institutional narratives through resistance narratives that may, over time, also aid in the creation of new cultural narratives. Although this task is much more difficult for those who have less access to political power and influence. The media and our politicians provide a wealth of formula stories and as a result we see their narratives taking precedence over others with less power in society. In the sections that follow, I consider two widely circulating cultural narratives that are related to SUDs in the military: the Hero Narrative of Military Service; and the Medical Model.

The Hero Narrative of Military Service

The cultural narrative involving our nation's military is one that reflects toughness, strength, and overcoming life's obstacle, and this can be seen when viewing any number of military recruiting commercials on television as well as information presented throughout their recruiting brochures. These advertisements serve as a tool to shape and mold our ideas about the military and what we believe to be true about armed forces and its members. Shortly after the United States became involved overseas in both Iraq and Afghanistan, we began to see a plethora of military recruiting commercials that, at times, seem to resemble movie trailers for upcoming blockbusters hits or other action packed films. Many of these advertisements show service members toting guns in war torn areas, parachuting from airplanes, as well as participating in other physical feats that few individuals would be capable of carrying out. This narrative lays the groundwork for a

hyper-masculine environment, which places some military members at a disadvantage when compared to their counterparts and also shapes our expectations of our military personnel. In one particular recruiting commercial, we see the Army conveying messages that their soldiers are unlike any others in the world and possess a strength that is unmatched by any other military. Messages such as "nothing on Earth is stronger than a US army solider" and "It's a strength like no other. It's a physical strength. It's a emotional strength. It's strength of character. And it's a strength of purpose" all begin to shape the story of the American soldier and what it takes to be a part of the United States armed forces. Of course these types of recruitment tactics are not limited to the Army alone. Other branches of the military (i.e., Navy, Marines, Coast Guard, etc.) seem to produce recruiting devices that are quite similar in nature. When we hear messages like "army strong," "army of one" or "be all you can be" what we are really hearing are the specific messages about what it means to be a military service member and the strength one must possess to be an upstanding soldier.

Similar to the formula found within a variety of movies, novels, and plays, the recruiting devices used by these various institutions contain specific plots, morals, heroes, villains, and victims that can be found within these advertisements as well as the prevailing hero narrative communicated within the military. However, it is important to note that the specific components listed (i.e., plots, morals, heroes, etc.,) are not necessarily considered to be true rather they serve as part of the dominant story presented to the public about what it means to conduct oneself as a member of the armed forces. A sharp eye will begin to notice the reoccurring plot within this dominant story involving

the military hero, which implies the United States is under attack by outside forces and other existential threats that seek to thwart our democratic values and strip us of the freedoms we have established in our country. In addition, the narrative's plot tells a story about service members who are brave, responsible, endure hardships without complaints, and are willing put their lives on the line to remove threats involving our national security. Many of these individuals are thought to put the welfare of others before their own and in the process grow and develop into "the best they can be," which is considered emblematic of a service member.

There are many messages that can be taken away from these types of military recruiting devices. The main take-away, or the moral of these stories, is that in order to be considered a solider one must possess a physical, emotional, and mental strength that is unmatched and one that a select few individuals can actually obtain. In addition to this notion of admirable strength, these formula stories make claims that those who serve in the armed forces are also selfless who have the utmost respect for authority and make sacrifices so civilians do not have to experience the burden on warfare. Essentially, it is these qualities that serve to separate military members from ordinary citizens and thus makes our selective service so respected. Service members possessing these elite qualities and characteristics are seen as admirable and honorable by their country, unit peers, and commanding officers. Those who live up to these expectations will be considered both respectable and reliable as well as increase their chances of moving up in the ranks and receiving promotions. In addition, it is believed that possessing and demonstrating these qualities while serving will help aid in their ability for upward social mobility once

exiting the military. However, consequently, those who fail to meet this criterion are ostracized and seen as unfit or less desirable soldiers.

According to the narrative, the heroes found in this story are our brave military service personnel who display the aforementioned list of characteristics (i.e., strength, courage, etc.). These men and women are revered as heroes who make great sacrifices and fight on our behalf against the villains of the world while helping to preserve our country and national identity. In this story, the villains are considered to be those who threaten to harm our country in a myriad of ways. In addition, the villains may also be the service members who fail to live up the military's expectations and fall short of the strength and determination required of those who fight for our country. These individuals are seen as risking the lives of other service members as well as those back at home by failing to live up to the characteristics required of elite military service members. That is, they are unfit for duty.

Finally, the victims found within these stories are the American people who are threatened by outside forces who wish to cause them harm. According to the narrative, the average American is not capable of enduring both the physical and mental aspects of military life and that is why we have service members to protect us from experiencing the affects of warfare. The story goes on to suggests that without the help of our nation's service members our lives would be radically different and it is the strength and determination of our armed forces that should be credited for preserving and protecting the lives of the American people.

The last and final piece worth discussing involves the implicit narrative surrounding

masculinity in the military. This is naturally woven through each of the components listed above. The military represents a bastion of masculinity, not only because the majority of service members are men, but also because it serves as an agent of shaping the images and perceptions of masculinity in larger society. From a social constructionist perspective, gender can be seen as an organizing principle, a human invention like language that can serve to influence our social relationships and patterns of expectations. Human beings actively accomplish this or "do gender" (West and Zimmerman 1987) over and over and can manifest itself through the way we dress, talk, or even shake hands. Therefore the concept of masculinity is not something that is biological or innate rather it is the result of larger social practices. More specifically, the term "hegemonic masculinity" refers to a particular idealized and stereotypical image of masculinity and can be characterized as one who is independent, risk-taking, aggressive, heterosexual, and rational (Connell 1995). In Frank Barrett's article (1996), The Organizational Construction of Hegemonic Masculinities: The Case of the Navy, 58 life-history interviews were conducted with male naval officers from a variety of communities and uncovered risk-taking, discipline, tolerance of degradation, stoic endurance of hardship, tenacity and perseverance in the face of difficult physical trials as all being representative of masculinity in the military. That is, the military is both a gendered and gendering institution. It is a gendered institution in structure, practice, rituals, values, however, it is gendering due to its ability to shape and create pervasive gender identities. The military represents the pinnacle of idealized masculine qualities.

Unfortunately, you do not have to look far to see how this pervasive masculine

culture unfolds in very rudimentary aspects of military life. The cultural narrative of toughness and strength found throughout the military can be seen when researchers ask military personnel about their attitudes toward receiving help for mental health issues (Kim et al 2011). Service members who had been deployed to either Iraq or Afghanistan often stated it would be "too embarrassing" or they "would be seen as weak" by commanding officers as well as others in their unit if they were to seek out treatment for their mental health issues and or alcohol/drug abuse (Kim et al 2011). Furthermore, concerns about repercussions from military leadership regarding the use of mental health care facilities are frequent and often prevent soldiers in need of mental health services from receiving the care they so desperately need (Hoge et al 2004).

In their work on understanding the dynamics of stigma toward alcohol and mental health treatment among army soldiers, Gibbs et al (2011) report findings that suggest that this heavily masculinized, heroic narrative of military service may contribute to substance use in the military. Researchers completed focus groups with over 270 army soldiers and found that the most commonly cited belief behind the military's high level of alcohol was attributed to drinking being an "integral part of military culture and tradition" and some even saying "the Army drinks, period" (Gibbs et al. 2011). In other words, heavy drinking is often described as being emblematic of the military work hard/play hard ethos. Some service members described an implicit linkage between the consumption of alcohol and status in which, "the more you drink, the bigger man you are" (Gibbs et al. 2011). However, in addition to the pro-social function of heavy drinking in the military and equating drinking with masculinity, soldiers also reported using alcohol as a means to

cope with the traumatic experiences during deployment. Alcohol seems to be a much more socially acceptable way to cope with the stresses of deployment rather than seeking out mental health professionals or substance abuse counselors.

The Medical Model Narrative and Medicalization

The medical model is a widely known circulating narrative of human behavior and social problems that explains a wide variety of phenomena as individual pathology. The term *medical model* was coined by famous psychiatrist, R. D. Laing, in his work, The Politics of the Family and Other Essays, for the set of procedures in which all doctors are trained (Liang 1971). This set of procedures would include aspects such as a detailed medical history, physical examinations, tests (if needed), diagnosis, treatment, and prognosis. The medical model suggests that human behavior and bodily characteristics that are different from what is currently considered to be normal are faulty and needs repair.

As we begin to flesh out and understand the stories wrapped up within the medical model's cultural narrative we can once again begin to identify the plot, morals, heroes, villains and victims found within the circulating formula story. In the medical model narrative, the plot is quite clear and involves a story that suggests individuals get sick and possess specific problems in the form of illnesses, diseases, syndromes, and disorders. These medical conditions can be overcome and one can get better by admitting there is an unaddressed health condition, seeking treatment for their ailment, and following doctors' orders. However, those who do not follow the doctor's orders, or those who fail to seek treatment altogether, are seen as malingering and thus socially

deviant. In addition to adopting what is now known as the "sick role" (discussed in more detail below), the plot involves a narrative that many of our medical issues are viewed as individual problems requiring individual solutions. Rather than looking for underlying social causes which may help necessitate a wide variety of illnesses, many medical professionals simply seek to remove an individual's suffering and symptoms as they are presented. As a result, the focus of recovery is placed on the individual.

The moral of the medical model story is that while you may be "sick," "faulty," or in need of "repair" there is still hope and light at the end of the tunnel because you can be fixed through rigorous medical treatments aimed at alleviating your individual medical condition. In fact, according to the narrative, one must try and attempt to restore oneself to back to what is socially desirable, or "normal." In other words, you must adopt the sick role to avoid the repercussions of being labeled socially deviant (Parsons 1951). The sick role suggests that in order to avoid the stigma and unwanted labels suggesting social deviance, one must actively seek treatment and attempt to get better by following the directives from medical professionals (Parsons 1951).

The villains found within this narrative include the illnesses, diseases, syndromes, and disorders that are given to the individual through doctors' diagnoses. However, the villains may take shape in another form as well. Those who ignore the medical directives and advice given to them by doctors and medical professionals may also be considered villains. Individuals who go against doctors' orders or show no sign of fulfilling the requests given to them are considered villains by remaining complicit in their continuing

13

illness. In other words, if one does not work toward recovery and chooses to remain in the sick role they are seen as socially deviant and thus vilified.

Following this logic, those thought to be the heroes in the narrative are the doctors, nurses, and other medical professionals who help stave off and treat those diagnosed with various medical conditions. These heroes are the ones who usher individuals out of the sick role in back into "normal" society. They are the "soldiers" in the battle against disease and illness. Finally, the victims found within the medical model narrative would be those who are directly affected by illness and other medical conditions. However, these particular individuals are different from the villains in that they choose to work toward eradicating their illness and attempt to become productive members of society whereas the villains take little to no action at improving their condition and choose to remain in their deviant condition.

Over time, the influence of the medical profession and the medical model has expanded its narrative to encompass many problems that originally were not defined as medical conditions (Conrad & Schneider, 2010). This expanding phenomenon is commonly referred to as medicalization. For example, pregnancy, childbirth, and developmental and behavioral norms have all been subjected to the medicalization process (Barker, 1998). Conrad (1992) broadly conceptualized medicalization as:

> "Defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using medical intervention to 'treat' it. This is a sociocultural process that may or may not involve the medical profession, lead to medical social control or treatment, or be the

result of intentional expansion by the medical profession" (Conrad 1992, pg. 211).

Throughout the twentieth century, many behaviors previously considered criminal or immoral have now become defined as medical problems. This process, by which a negatively-viewed behavior previously interpreted in religious, legal or moral terms becomes re-defined and treated as primarily a medical problem has been called the *medicalization of deviance* (Conrad & Schneider 1980). That is, when *treatment* rather than *punishment* becomes the preferred sanction for deviance, it represents the transition toward medicalization and thus deviance becomes (re)conceptualized in a medical framework as illness. As societies continue to develop from simple to complex, formal sanctions for deviance change from repressive to restitutive, or from punishment to treatment (Durkheim, 1893). And while the conceptions of deviant behavior change, the agencies mandated to control deviance also change. Over the past few centuries there have been great transformations in the definition of what constitutes deviance and how it should be addressed throughout society. As previously mentioned, the medical field has increasingly taken over and influenced facets of human life and behavior that had never been considered in the realm of biomedicine. Despite widespread medicalization, the medical model is just one approach to understanding health and illness. It can be contrasted, for example, with the social model of the disability movement as well as the biopsychosocial and recovery models of mental disorders. These alternative models focus less on biological explanations for illness and disability and thus focus on eliminating social barriers and taking a more holistic, social approach to understanding

illness.

Beginning with Parsons' functionalist sociological work in the 1950s, it became apparent that the process of being labeled ill was much more complex than initially understood (Veatch 1973). Talcott Parsons wrote extensively about medicine as an institution of social control for deviance and – according to Parsons –having an illness can be considered a form of deviance throughout society. Parsons argues that being sick requires one to enter a role of sanctioned deviance, and thus those diagnosed as sick are not productive members of society. What the medical community defines as disease, then, is always a reflection of what is considered undesirable in society (Armstrong 1987 & Conrad and Schneider 1980). In this respect, the medical profession is an institution for social control since it can legitimate the deviant label inherently attached to illness through the application of the "sick role" (Parsons 1951).

However, it is important to note that medicalization is not always a top-down process where the medical profession imposes its new medical label of a behavior on the general population. For example, many Vietnam Veterans actively tried to persuade psychologists to diagnose them with post-traumatic stress disorder (PTSD) or other conditions to help legitimize their experiences post deployment (Scott 1990; Aronowitz 1992; Mechanic 1995). That is, some individuals may desire a medical label to help make sense of their suffering and legitimize their "sick role" status. This would represent a bottom-up approach.

Medicalization, then, can have both positive and negative consequences. While it is widely viewed as a humanitarian way of dealing with a problem, medicalization

incorporates the idea that the source of many social problems lies within the individual, and consequently serves to depoliticize the larger structural forces or inequalities that may exist (Zola, 1972; Conrad and Schneider, 1980; Fox, 1989). Just as treating deviant behaviors as sinful or criminal locates the problem at the individual level, medicalization has increasingly contributed to the neglect of social, economic, political, or environmental issues that may be related to and necessitate deviant behaviors. In the case with SUDs, we have continued to look at the issues of drug and alcohol abuse in a strictly individualized approach where all of the treatment is placed on the individual to make himself/herself better, not society. While this is may be considered a step in the right direction, and certainly better than doing nothing or keeping previous explanations such as sin or character weakness, we may be much better off examining some of the underlying social conditions that can contribute to the likelihood of abusing drugs and alcohol and thus seek to eliminate the social conditions rather than fixing each person individually (Oliver and Barnes 2012; Shakespeare 2014; Berger 2012).

Labeling someone "sick" immediately changes his/her role in society (Parsons 1951). One of the consequences of medicalization has been the extension of the sick role to more people and to a broader range of behaviors than in the past (Fox, 1989). Under this medical framework, an individual is considered to be suffering from a SUD if he or she has voluntarily reported excessive substance use or if they have been screened as "at-risk" from an authorized assessment instrument. However, once identified as someone who suffers from a medical condition, it may produce an unwanted stigma and negative reactions from others throughout society (Goffman 1963). Unfortunately, the

consequences of being labeled as someone with disease may in turn lower the amount of effort put forth to control their usage (Bennet 2008). The notion that SUDs are some type of physical inevitability for some with faulty brain wiring serves to create a state of learned helplessness in those who believe they are sick (diseased) and provides little to no room for the teaching of techniques on how to avoid substance dependence altogether. Our medicalized narratives have convinced some substance users, both recreational and addicted, that they may be helpless when confronted by the overpowering physiological powers of the drug. Thus whatever sense of personal control the "controlled user" had is ultimately destroyed by the deterministic message that SUDs are diseases and medical conditions. If we live in a society that pushes the narrative that addicts cannot help themselves, are sick or have a disease, and are not responsible for excessive substance use, then we should not hold them responsible or punish the individual who commits crimes as a result of his or her substance use (Fingarette 1975). This would be a radically different approach than we currently see in the United States. In other words, instead of punishing individuals who display and show signs of excessive drug and alcohol use, society would work together to alleviate the conditions that allow for such possibilities to occur in the first place.

SUDs in the Military: A Phenomenon at the Intersection of Competing Cultural Narratives

In summary, SUDs in the military stand at the intersection of two powerful, but conflicting, cultural narratives: the Hero Narrative of Military Service and the Medical Model Narrative. Tension exists between the plots, morals, victims, villains and heroes of

these two narrative in a variety of ways which may have real consequences when seeking treatment for medical conditions as well as reconciling the differences between the two narratives disseminated upon them. When considering the plots, the tension that exists between the hero narrative and the story of medical model is one that requires the soldier, who has been institutionalized to be tough and espouse strength, to admit individual weakness and ask for help from others. This may prove to be difficult for soldiers because they have been conditioned to be strong, courageous as well as remain in top physical condition, so by admitting any shortcomings or asking for help it serves to place that part of their identity at risk. This is typically met with hesitancy. In addition to part of their identity being at risk, it also undercuts the idea that service members are supposed to put the welfare of others before themselves. That is, if they do not believe they are unable to perform their duties as a result of their illness or if they know that seeking medical attention may negatively affect their unit, some may avoid seeking help for a variety of conditions because of the cost it will place on fellow service members. Furthermore, the medical model narrative suggests that health conditions are individual problems needing to be fixed and many service members do not want to be seen as in need of repair, inferior or deviant in the eyes of their unit or commanding officers. This brings us to the tensions between the morals of both cultural narratives.

Again, the moral of the hero story suggests that soldiers must require strength, courage, endurance as well as other characteristics mentioned above. However, this is in direct opposition to the medical model narrative, which suggests that you are broken (lack of strength) and can be fixed by the help of others (medical professionals). Many

service members express hostility to the idea they are broken and in need of repair for multiple reasons but mostly due to the treatment and unwanted scrutiny they will receive from fellow service members. The tensions that exist between these two narratives are easy to see and may contribute to the lack of treatment seeking we see in military populations concerning mental health conditions and substance abuse. In other words, service members may forgo treatment, or be less likely to seek treatment altogether, due to the stigma and unwanted attention that will be placed on them from their comrades.

Next, when you consider the differences between the two narratives regarding the heroes in each story additional tensions are illuminated. In the case of the military narrative, the heroes are the soldiers who save the day and protect those who considered weaker and in need of help. Although in the case of the medical model, doctors, nurses, and other medical professionals are deemed the heroes due to their ability to save lives and treat those who suffer from medical conditions. Here we can begin to see the pressures placed on service members to, in one moment, think of themselves as heroes possessing unmatched strength, courage and infallibility, and in the next, suggest that military personnel should be willing to admit to personal weakness or ask for help from others if experiencing mental of physical pain. This can produce an enormous amount of anxiety for service members who feel they are in need of help but feel they cannot ask for it for fear they might be risking their heroic identity.

Additional tensions are created when you begin to take into consideration the villains identified within each narrative. The hero narrative claims that those who threaten our national security and the safety of Americans are considered villains. Additionally, those

who fail to live up the hegemonic masculine cultural norms required of soldiers may also be considered villains in the story. However, according to the medical model narrative, the villains are considered to be those who remain complicit in their illness and fail to follow medical directives. As a result of these competing narratives, this produces a lose-lose scenario for many service members and can create an enormous amount of anxiety when attempting to harmonize the two stories. On one hand, one may really have a mental health or substance abuse issue they are struggling with and may, in fact, need to seek some type of treatment. However, they may be prevented from pursing treatment and arranging an appointment with a medical profession due to the unwanted stigma and consequences of being perceived as weak. This type of behavior may be received as showcasing one's lack of conformity to masculine cultural norms found in the military and lack of mental and physical strength. In addition, you will also be considered a villain if you are aware of your medical condition but chose to malinger and refuse help. In this scenario, the solider will be considered a villain whether they seek help or not. According to the hero narrative, one will be considered a villain for seeking treatment and failing to fulfill their service duties, but will also be considered a villain by the medical model if they fail to seek removal from social deviant state of sickness. This is the tough situation that too many service members find themselves in when trying to balance the two narratives and find common ground between the two.

Finally, the last set of tensions includes those that exist between each story regarding the victims. The hero narrative makes it clear that the victims in this case would be the American people who are threatened by outside forces whereas the victims in the medical

model narrative would be those who are affected by illnesses, diseases, syndromes and disorders. These competing narratives create pressure for soldiers when they have to acknowledge that when they are sick they are considered victims and as a result may no longer be capable of fulfilling the hero/soldier role to the best of their abilities, which can be difficult after having been conditioned to always demonstrate strength and endurance. Few service members would like to consider themselves victims because they believe they are capable of demonstrating the physical and mental fortitude required for overcoming any of life's obstacles. Admitting they are the victims of circumstances, outside their own control, may be perceived by other service members as weakness or personal failure. Soldiers will continue to have a difficult time reconciling the differences between these two narratives as long as they continue to communicate vastly different messages about the appropriate course of action when experiencing a wide variety of medical conditions and illnesses.

Meso Level Formula Stories: Institutional and Organizational Narratives

Similar to our cultural narratives found at the macro level, institutional narratives can also be described as "formula stories" that involve specific types of people engaged in predictable types of behaviors with expected results (Loseke 2007). At the meso-level, both institutional and organizational narratives can lead to morals (what are praised or condemned) and to policy justifications that will have a wide range of effects throughout the institution in which they are implemented. Both narratives, then, are the imagined characteristics of the targets of policy or law (within the institution), which can serve to justify policy decisions (Schneider and Ingram 1993) and therefore legitimize social

arrangements promoting freedom or constraint (Alexander 1992). As mentioned above, there are countless stories involving drug and alcohol abuse, which are then disseminated throughout institutions involved in addressing SUDs. Many of the stories shared about substance abuse tend to view this issue an individual problem and results in personalized approaches for treatment. This begs the question: What distinguishes a good story from a bad story within a particular institution?

In many instances – as noted above – the stories told by politicians, medical professionals, and academics are often given more serious consideration than those told by individuals with less power and less access to media (Gamson and Wolsfeld 1993). The narratives told by the most powerful and influential people serve to solidify and legitimize specific worldviews throughout various institutions. Unfortunately, the narratives told by marginalized individuals or those with less power are often ignored and not taken into consideration when constructing policy. This presents enormous problems during the policymaking process because this process involves constructing causal stories, which define the problem, the cause of the problem, and the need for policy of particular types (Stone 1997; Loseke 2007).

In 1956 powerful institutions, such as the American Medical Association (AMA), began to push forward the notion that alcoholism as a disease and encouraged physicians to treat the problem as a medical one. This resulted in many recovery advocates supporting efforts for alcoholism and other chemical dependencies to receive the same levels of benefits and resources as other diseases, thereby moving toward the development of the treatment facilities (Roy & Miller, 2012). In addition to the

development of treatment facilities, the release of the Diagnostic and Statistical Manual of Mental Illness (DSM) began to outline several different diagnoses that can be given to various SUDs. Both of these efforts (AMA pushing alcoholism as disease and the DSM) ultimately served to further substantiate efforts toward medicalizing SUDs (Roy & Miller 2010 & 2012). The military uses the DSM-IV criteria for determining who possesses the qualities indicative of SUDs (Bray et al 2010). In this most recent version of the DSM, a SUD is characterized as a maladaptive pattern of substance use leading to clinically significant impairment or distress occurring within a 12-month period (APA, 2000). The widespread use of the DSM in the military has suggested, at least to some extent, that SUDs have become partially medicalized throughout the military institution.

So, how is it that the medicalized cultural narrative of human behavior and experience (medical model) has permeated so many institutions? What is the process by which various kinds of social behaviors have come under the prevue of this cultural model? In Conrad and Schneider article, *Looking at Levels of Medicalization,* they provide a provocative new model for better understanding what has been known previously as *medical imperialism* (the expansion of the medical field). The authors prefer this nuanced approach because the medical imperialism framework put forth by P.M. Strong and others has fallen short in accurately describing how the medical field has achieved to widespread expansion. Conrad and Schneider propose that medical imperialism appears to view the pervasiveness of the medical field too narrowly by focusing solely on "what doctors actually control and do" (Conrad and Schneider 1980). Medicalization is, however, a complex phenomenon, and its manifestations are by no

means limited to the doctor-patient interaction. To begin widening our understanding of the medical field and its' pervasiveness, Conrad and Schneider pose that medicalization can occur in multiple ways and on at least three distinct levels: the conceptual, the institutional, and the interactive level. In the following sections I will further describe the necessary components of each level of medicalization as described by Conrad and Schneider.

On the conceptual level, a medical vocabulary and medical terminology may be used in order to define the unique characteristics of a condition at hand. Put simply, the conceptual level of medicalization refers to the language we use in order to interpret one's condition or behavior as a medical problem. According to Conrad and Schneider, the conceptual level of medicalization can occur on the elite levels of medicine in terms of new "discoveries" published in medical journals, or it may occur even occasionally outside the medical profession altogether, such as the case when some non-medical group (social activists) adopts a particular set of medical definitions and explanations during a particular social context. Medicalization at the conceptual level can also occur through government or court-mandated definitions of human problems in an attempt to control them (i.e., drug and alcohol use) (Conrad and Schneider 1980). Furthermore, conceptualizing SUDs in a medical model narrative can be best understood through their use of authorized assessment tools, which are thought to accurately diagnose one with having a drug or alcohol problem. In other words, the assessment tools ask individuals about their consumption of drugs and alcohol and based on the results they are placed into categories of no risk, at-risk, or diagnosed. After they have been categorized, some

individuals are then faced with medical diagnoses and, in some cases, mandatory medical treatment.

At the institutional level, physicians and other medical professional serve as the gatekeepers of what is considered to be a legitimate medical condition and worthy of medical treatment. In this respect, organizations such as Alcoholics Anonymous and Narcotics Anonymous may begin to "adopt a medical definition and approach to a problem" (Conrad and Schneider 1980). Examples of institutional medicalization can be identified through the development of new specialty care programs designed to address specific behaviors that have not always fallen under the purview of the medical community. As society continues to design specialty facilities for the treatment of mental health issues, reproductive issues, etc., we can start to view this as a direct result of medicalization and the medical establishment's attempt to expand their role in determining what is considered a medical problem.

Finally, at the interactive level, "a physician defines a problem as medical (i.e. gives it a medical diagnosis) or 'treats' a 'social problem' with a medical form of treatment" (Conrad and Schneider 1980). This component of medicalization includes the specific actions taken by both physicians and the medical community regarding an individual's diagnosis. This approach taken by the medical establishment include actions that may be similar to how physicians would treat ailments such as cancer, hypertension, or a wide range of other medical conditions. For example, some physicians may prescribe medications to individuals who are suffering from high blood pressure in hopes to bring their levels back into a range widely considered normal. Similarly, individuals in need of

easing withdrawal symptoms due to abuse of opioids or alcohol may also find themselves on the receiving end of physicians prescribing medications. Conrad and Schneider's typology provides an excellent start for further understanding medicalization and how it manifests itself within particular institutions. The levels of medicalization as proposed by Conrad and Schneider continues to be a good heuristic for helping scholars to identify multiple sites and mechanisms of medicalization, and it usefully suggests that medicalization may occur unevenly across these three sites.

Medicalization can also come into conflict with other powerful institutional narratives of human behavior. For example, despite movement along the path toward medicalization, SUDs are still sanctioned and managed by the criminal justice system, resulting in a medical-legal-moral hybrid definition of these issues (Conrad, 1992). That is, in both a criminal justice setting (the court) and a medicalized setting (treatment program), the medical, legal and moral frameworks interact in various ways. There are no clear distinctions as to when the problem is a criminal one and when it is a medical one, and as a result penalties (or treatment) may be distributed unequally. Yes, the medicalization of substance abuse may have been a move toward a more sympathetic and less punitive way to deal with the problem (Akers 1992), however, medicalization can also be seen as presenting more barriers to care than necessary. For example, as treatment for SUDs becomes more medicalized, the high price for quality care and admittance into inpatient rehabilitation centers is now out of reach for some individuals and leaves many with fewer options for recovery. As a result, numerous treatment centers, both informal and formal, have popped up over the last few decades. The large

number of self-help groups, where everything from gambling to credit card debt has become viewed as "addiction," could be evidence that the "addict" label is becoming less stigmatized and allows for more individuals to receive help outside the medical profession (Valverde 1998).

While various theories of SUDs continue to exist, the director of National Institute on Drug Abuse (NIDA), Dr. Nora Volkow, has been quite successful in promoting the view that addiction and SUDs are a the result of a "brain disease" to both the medical community and wider society. Her research has used imaging technology to illustrate how drugs affect certain areas of the brain, causing damage and leading to the user's inability to control further drug use (NIDA 2003). Taken together, this information begins to indicate that SUDs have become increasingly more medicalized in our society (Roy & Miller 2010, 2012). It also becomes clear that medicalizing certain behaviors is just one of many ways to address and justify deviant actions.

In the case of the military's institutional narrative, the voices used in constructing policy justifications for individuals with SUDs come from the medical profession while simultaneously serving to minimize the concerns coming from outside the field. In other words, by only allowing the voices of the medical community to enter the conversation surrounding substance abuse in the military, we can expect for the solutions to these problems to involve a strict, medicalized approach that includes the screening for the disorder, the assessment of the severity, and finally a proposed treatment for those who are in the most need of services. Allowing the medical community to capitalize and takeover the narrative that SUDs are individual problems, few consider the possibility for

there to be any underlying social causes which may necessitate drug and alcohol use.

Micro Level Formula Stories: Personal Narratives

Finally, at the micro-level, there are personal narratives that help produce our individual identities, the self-understanding of unique, embodied selves about their selves (Loseke 2007). In other words, these personal narratives serve as vehicles for rendering ourselves intelligible and make sense of various circulating formula stories. Many scholars have mentioned that characteristics of modern industrial or postindustrial societies have made it more difficult for social actors to achieve a sense of personal identity (Loseke 2007). It becomes a difficult and mind-numbing task to begin making sense of the many narratives put forth by our culture and institutions. Although rather than mindlessly subscribing to one of the formula stories presented by either hegemonic cultural discourse or institutions throughout society, many individuals find themselves developing their own personal narrative by drawing pieces from larger hegemonic narratives (cultural and institutional) while simultaneously using their own experience to supplement any missing pieces of information. Social actors might also use their understandings of socially circulating formula stories as the yardstick with which to evaluate their own experiences (Loseke 2007). This allows many individuals to evaluate and categorize their particular experience in a way that aligns with, or diverts from, existing macro and meso narratives.

With regard to drug and alcohol abuse, many individuals that look to our dominant cultural and institutional narratives surrounding SUDs find that they fail to fully capture and explain their own specific experiences and understandings involving

SUDs and their condition. For example, the previous hegemonic narratives surrounding drug and alcohol abuse typically involved an explanation that viewed individuals suffering from addiction as either sinners or possessing some critical character flaw. However, at the same time, many people failed to see themselves as possessing either of these qualities and thus had a more difficult time making sense of their condition. More recently we have seen a push from the National Institute of Drug Abuse (NIDA) and other organizations lamenting at the notion of sin or character flaws as a viable explanation for SUDs and consequently have begun to push forward a perspective which aligns the condition as a "brain disease" or some other medical condition which can now be ameliorated through rigorous individualized treatment methods.

Personal narratives about oneself that seem too different from the culturally or institutionally sanctioned narratives might be seen as less credible and not given as much consideration. That is, service members who view the medical model's individual approach as an inefficient means of addressing their most pertinent needs may eventually become disconnected from its treatment methods and view it as an insufficient way to appropriately tackle the issues they are facing. Fortunately, for those diagnosed with SUDs, there has been a growing body of literature that suggests adopting a medical model approach may actually contribute to more stigma and less recovery when explaining behaviors through both genetic components and biological functions (Bennet 2008). This can become increasingly more problematic when service members' personal narratives about what works for their recovery treatment becomes at odds with the larger institutional narrative found in the military.

To be clear, each of these narratives play a significant role in shaping our understanding of what it means to have a SUD as well as the appropriate way for addressing the needs of those who partake in excessive use of drugs and alcohol. The prevailing formula story is one that suggests those with SUDs are to be treated individually, separated from "normal" society and placed in specialty treatment programs, and "fixed" through a series of medical interventions. While this has been hailed as a humanitarian response to the scourge of drug and alcohol abuse, it falls short in acknowledging some of the wider social aspects which may play a role in contributing to the onset of SUDs.

The process of piecing together a personal narrative from other existing stories found throughout society is quite common and can represent a period when individuals feel trapped between these competing narratives. This is certainly plausible for service members who receive two vastly different messages about how to act as well as avoid deviant labels in both the military setting and medical setting. When individuals enter the military, they are immediately socialized into the cultural norms that are thought to be emblematic of the institution. The heroic narrative of strength, courage, and the ability to overcome any of life's obstacles flies in opposition to the medical narrative which requires for the individual to acknowledge they are "broken" and in need of repair. As a result, these dual narratives present problems when reconciling the difference between the hero narrative in the military and the victim narrative in the medical model. As laid out in the section addressing the tensions between the two narratives, this may ultimately

lead to a hesitancy to disclose SUDs and accept the treatment offered by medical

professionals.

CHAPTER TWO:

METHODS

The use of text as data is common in many academic disciplines. Both anthropologists and sociologists have explored the way in which society's texts provide a glimpse into that society's composition (Barker 1998; Oliver & Barnes 2012). Not only is there considerable precedence for the use of texts in a social scientific analysis, but textual explorations have also become a widely used technique among scholars exploring the constructed nature of biomedical knowledge (Foucault 1966 & 1975; Oakley 1984; Martin 1987; Eyer 1992 & Rodin 1992). This study conducted a textual analysis of the *VA/DoD Clinical Practice Guideline For Management of Substance Use Disorders* - published in 2010. Given the date of its release, it is likely this document captures the most current policies directed toward SUDs throughout the military. Furthermore, it will depict the military's most current discussion surrounding SUDs.

Data

The *VA/DoD Clinical Practice Guideline For Management of Substance Use Disorders* was developed under the auspices of the Veterans Health Administration (VHA) and the Department of Defense (DoD) pursuant to directives from the Department of Veteran Affairs (VA). This 150-page manual can be found online at the DoD's government web address as well as other online sources (http://www.healthquality.va.gov/guidelines/MH/sud/sud_full_601f.pdf). The document

was designed to provide recommendations for the performance or exclusion of specific procedures or services which were derived through a rigorous methodological approach that includes: (1) Determination of appropriate criteria such as effectiveness, efficacy, population benefit, or patient satisfaction and (2) a literature review to determine the strength of the evidence in relation to these criteria. The information and recommendations for managing SUDs are then disseminated throughout all branches of the military for future implementation toward military personnel. Although this guideline represents the state-of-the-art practice at the time of its publication, medical practice is constantly evolving and this evolution will require continuous updating of published information. New technology and more research will improve patient care within the military in the future.

Analysis

The document's narrative tells a specific story of how the military addresses matters involving SUDs throughout all branches of the armed forces. The study's examination began by using a narrative analysis (Loseke 2012) to uncover the plot and practices inherent in this specific story, as well the behaviors various characters are expected to follow while managing SUDs in the armed forces. To help aid in the process of understanding the document, and to provide a template for understanding and organizing the manual as it is presented, I borrowed from Conrad and Schneider's piece *Looking at Levels of Medicalization* (1980) to provide a foundation for interpretation. It provided the lens through which I examined the document as well as gave me three different levels

in which to view the manifestation of medicalization; conceptual, institutional and interactive.

To this end, I went through the document and categorized sections of the manual that were representative of medicalization and color-coded each section of text. I used primary colors (red, blue and yellow) to categorize pieces of text that were specific to each level (red = conceptual; blue = institutional; yellow = interactive). However, there were also sections that showed more than one level of medicalization and colors were then mixed. For example, pieces of text that were representative of both conceptual (red) and institutional (blue) medicalization were then identified with the color purple. This process allowed me to identify each section of text throughout the manual and helped aid in the coding process.

The document is divided into five separate sections: Introduction, Guideline Update Working Group, Definitions, Algorithms and Annotations, and Appendices. The majority of information and coded text segments come from the section titled Algorithms and Annotations due to its specific focus on the screening, assessing and treating process of SUDs in the military. While the other sections include important information in respect to defining SUDs as well as various assessment tools used to measure substance use, they include broad definitions and widely used assessment tools that are not specific to the military. If the manual had used unique definitions and assessment tools for SUDS that were specific to the military, then, a narrative analysis of those sections would have been crucial.

The Algorithm and Annotations section lays out five modules that address the screening, assessment and treatment of military personnel with SUDs. This section provided the most insight into the inner workings of how the organizations manage SUDs. The five modules included; Module A: Screening and Initial Assessment for Substance Use; Module B: Management of SUD in Specialty SUD Care; Module C: Management of SUD in (Primary) General Healthcare; Module P: Addiction-Focused Pharmacotherapy, and Module S: Stabilization and Withdrawal Management. The section dedicated to the Annotations and Algorithms specifically address the screening, assessment, and treatment of military personnel and carry the bulk of the manual's information on procedural processes.

The analysis began by doing a close reading of the Annotations and Algorithms several times in order to get a feel for the story being told. As I continued with my close reading, specific characteristics germane to the military's practices of screening, assessment and treatment became well known. Afterwards, I reflected on these discoveries while re-reading and re-thinking its content as information continued to emerge. This process allowed me to piece together the characteristics of the narrative while simultaneously identifying the practices and characteristics of the military's narrative which fall into Conrad and Schneider's piece Looking at Levels of Medicalization (1980). This initial stage of the analysis helped me describe how, and to what extent, the military's institutional narrative reflects the medicalization process and biomedical language. As such, it was the first step in addressing my research questions: (1) How does the military characterize the problems and resolutions of SUDs? (2) How

and to what extent does this narrative reflect medicalization? (3) What are the limitations inherent in the institutional narrative of SUDs in the military?

In the next step, document data (words and phrases of text) were analyzed through a strict system of color-coding. To this end, I furthered my use of Conrad and Schneider's Levels of Medicalization as a template and began structuring categorized data into appropriate sections for coding. This specific coding system was developed to help identify both manifest and latent functions of the manual. Manifest coding involves the process of identifying the visible, surface content in a text whereas latent coding refers to the underlying, implicit meaning that can be identified (Neuman 2006). To uncover the manifest functions of the document, the coding system incorporated words and phrases found within the document that appear to fall within each of Conrad and Schneider's distinct levels of medicalization. That is, words and phrases coded as conceptual, institutional, and interactive levels of medicalization were then carefully considered and formally categorized by color after determining which level of medicalization they represented. The articles of text that did not fit into the framework as laid out by Conrad and Schneider were then separated into its own category for an additional analysis of counter narratives, which may be indicative of latent functions. The counter narrative within the document focuses less on medical explanations and instead turns to some of the larger social arrangements, which may necessitate the onset of SUDs.

After coding all available information, I began to analyze its content more closely and developed specific findings regarding the characteristics of the data. This helped uncover the characteristics of the narrative, as well as aid in determining whether or not it reflects

the medicalization process. At each stage of the analysis process, I constantly compared

my coding categories and themes with the general plot and characters identified in the

first stage of the analysis.

CHAPTER THREE

FINDINGS

The *VA/DoD Clinical Practice Guideline For Management of Substance Use Disorders* depicts a specific story of how the military addresses matters involving SUDs through a system of screening, assessment, and treatment. The manual showed significant evidence for the medicalization of SUDs occurring on the conceptual, institutional and interactive levels. The following sections include a detailed explanation of the goals found within the document, overview of each module and the steps they take to address SUDs, and finally a series of subsections that demonstrates each level of medicalization as well the counter narrative found within the document.

Goals of Guidelines

The clinical practice guidelines laid out in this document were discussed through a series of modules that addressed the appropriate mechanisms for diagnosing SUDs, the processes of managing those diagnosed, and the guidelines around the use of administering pharmaceutical drugs for both opioid and alcohol withdrawal. More specifically, the manual consists of three specific goals: (1) identifying patients with substance use conditions, including at-risk use, substance use problems, and substance use disorders, (2) promoting early engagement through brief interventions and increasing patient retention of those who can benefit from treatment, (3) improving outcomes for patients with substance use conditions (cessation or reduction of substance use, reduction

in occurrence and severity of relapse, improved psychological and social functioning and quality of life, improved co-occurring medical and health conditions and reduction in mortality) which may be achieved through pharmacotherapy. Each module, then, consists of an algorithm that describes the step-by-step process of the clinical decision-making and intervention process that should occur with the specified group of patients examined (each module's algorithm is located in the appendices).

The following sections discuss each module in more detail and provide examples of medicalization as described by Conrad and Schneider in *Looking at Levels of Medicalization*. As luck would have it, the manual seems to follow in the steps of Conrad and Schneider's framework and is arranged in a manner where the first module investigates the conceptualization of SUDs. This is achieved through a variety of ways including biological testing, physiological markers, medical consensus etc. (Module A: Screening and Initial Assessment for Substance Use). The next two modules (Module B: Management of SUD in Specialty Care; Module C: Management of SUD in Primary General Healthcare) examine the institutional and interactive levels of medicalization in the forms of specialty facilities designed for treatment and how medical professionals facilitate recovery for patients. Finally, the last two modules (Module P: Addiction-Focused Pharmacotherapy & Module S: Stabilization and Withdrawal Management) discuss situations where physicians begin to prescribe medications for soldiers and determine the appropriate regimens to alleviate withdrawal symptoms involved with SUDs.

Module A: Screening and Initial Assessment for Substance Use

Module A lays out the complex processes of screening individuals, defining SUDs, providing interventions for those diagnosed and – if necessary – make specialty referral considerations for military members with significant SUDs. The algorithm for Module A involves 15 potential stages as laid out in the document (Appendix A). The algorithm displays the appropriate steps (laid out in a numbered sequence) to be taken by physicians when first making contact with patient during their annual screening of drug and alcohol abuse or their initial intake to the armed forces. During this phase of the screening process basic medical history information is collected as well as information involving past and present drug and alcohol consumption. This is collected by doctors through various methods and used later used for specific diagnostic purposes.

According to the document, the process for diagnosing and treating SUDs involved screening, which is "similar to that of hypertension, colorectal cancer, or vision in older adults" in that it encompasses an individualized approach and can use various biomedical biomarkers as a means of determining severity. In this section, considerable information is presented which represents medicalization occurring on the conceptual level. At the conceptual level, this section – and screening process – demonstrates three distinct examples of how physicians define and diagnose SUDs. Positive screenings for risky substance use and other SUDs can be determined through a series of assessments including 1) lab results (i.e. blood and urine) 2) physiological measures (i.e. weight, blood pressure, and heart rate) 3) questionnaires and short surveys (self-report data). This information is then taken by physicians – analyzed – and then used to determine the

appropriate course of action and whether or not to classify an individual with a SUD.

In addition to traditional dialogistic approaches to understanding health and illness (lab results and physiological measures), physicians also rely heavily on social screening tools in the form of questionnaires and surveys. These instruments are used to identify patients along a continuum for risky and hazardous substance use and measure their overall use of drugs and alcohol. In addition to placing people on a continuum, the self-report data gives clinicians information that allows them to compare an individual's drinking behaviors and habits to that of others. Individuals screened for high consumption are flagged and recommended for brief interventions, motivational support, or medical treatment. The instruments used for this screening process include the Alcohol Use Disorder Identification Test Consumption (AUDIT-C), the Single-Item Alcohol Screening Questionnaire (SASQ), and the CAGE questionnaire. Following a positive diagnosis, one's treatment course could involve further diagnostic assessments, referrals for counseling or, in some cases, immediate medical treatment requiring medication.

After looking at some of these assessment tools a little more closely, stark differences were found regarding the recommended limits imposed on men and women. According to the document, for men – no more than 14 standardized drinks a week and no more than 4 standardized drinks on any day. However, the amount of drinks per week that is considered appropriate, and not at risk for being labeled problematic, is considerably different when compared to women. For women – no more than 7 standardized-sized drinks a week and no more than 3 standardized drinks on any day.

42

While these set measurements represent what it means to have "risky" or "hazardous" alcohol use, the guidelines are not the result of biological testing and empirical science rather they are socially constructed and imposed by health professionals and medical organizations throughout the world of medicine.

While this module focused much more on the conceptualizing and defining what it is to have a SUD, evidence for medicalization at the institutional was also found in this section in the form of clinicians referring patients to "specialty addictions treatment" and counseling sessions. Moreover, several pieces of data were identified as representative of medicalization at the interactive level as well. This took place in the form physicians recommending brief intervention to those who have been identified for unhealthy alcohol consumption or other substance use. In summary, Module A discusses the process by which the military identifies, defines, and construct SUDs during their initial screening process in the United States armed forces. These classifications are based on what many would consider well-accepted medical knowledge about the physical body, which has been presented throughout the professional community. Overall, this module showed considerable evidence for medicalization on the conceptual level and the information was discussed throughout the following sections:

A. All Patients Seen in VA or DoD General Medical and Mental health Care Settings
B. Screen Annually for Unhealthy Alcohol Use Using Validated Tool
C. Does the Person Screen Positive or Drink Despite Consequences
D. Assess Current Alcohol Consumption
E. Does the Person Drink Above Recommended Limits or Despite Contradictions?
F. Provide Brief Intervention
G. Is Referral for Alcohol Use Disorder Indicated or Requested

H. Does Patient Agree to the Referral or is the Referral Mandated?
I. Continue to Provide Brief Interventions During Future Visits
J. Provide Positive Feedback Regarding Changes
K. Advise to Stay Below Recommended Limits
L. Screen Annually for Unhealthy Alcohol Use

The following modules look more closely at managing the individual once diagnosed and those who have been identified and categorized on the institutional and interactive level.

Module B: Management of SUD in Specialty SUD Care

In this module, the focus shifts away from the diagnostic process involved in screening and moves toward managing the SUD by placing the individual in the appropriate care facility, completing further biopsychosocial assessments, initiating pharmacotherapy (if needed), managing co-occurring conditions, and assessing their response to treatment. Broadly speaking, this stage allows for further assessment (to determine severity) and motivational enhancement for those who are seeking remission.

Many individuals diagnosed with SUDs in the military typically undergo a comprehensive biopsychosocial assessment. This comprehensive and multidimensional assessment procedure evaluates a person's strength, needs, abilities, and preferences as well as determines their priorities to help aid in the process of establishing an initial action by the treatment team. This tool is used at the beginning of the therapeutic process and covers questions that address the individual's physical, emotional, cognitive, behavioral, and environmental domains. The assessment includes all of the following area of interest:

- Family history
    - Family alcohol and drug us history, including past treatments

- o Family social history, including profiles of parents (guardians or other caretakers), home atmosphere, economic status, religious affiliation, cultural influences, leisure activities, monitoring and supervision, and relocations
  - o Family medical and psychiatric history
- Developmental History, including pregnancy and delivery, developmental milestones and temperament
- Comprehensive substance use history, including onset and pattern of progression, past sequelae and past treatment episodes (include all substances, e.g., alcohol, illicit drugs, tobacco, caffeine, over-the-counter medications, prescription medications, inhalants)
- Tobacco Use
- Recent pattern of substance use based on self-report and urine drug screening
- Personal/social history (including housing issues, religious/spiritual affiliation, cultural influences)
- School history
- Military history
- Marital history
- Peer relationships and friendships
- Leisure activities
- Sexual Activity
- Physical or sexual abuse
- Legal/non judicial history, including past behaviors and their relation to substance use, arrests, adjudications and details of current status
- Psychiatric history, including symptoms and their relation to substance use, current and past diagnoses, treatments and providers
- Medical history, including pertinent medical problems and treatment, surgeries, head injuries, present medication and allergies
- Review of systems, including present and past medical and psychological symptoms

Specific examples of medicalization at the institutional level can be found when the document says "patients may be referred to a specialist for more extensive evaluation of risks related to substance use" or "when unavailable through the primary treatment team, patients may need referral to other clinics in order to access the needed services, such as primary medical care or psychiatric evaluation." These quotes represent the expansion of the medical paradigm. It is also indicative of how fewer diagnoses can be appropriately treated by general physicians and thus more patients are being referred to specialists and specialty facilities outside the primary care setting. Module B: Management of SUD in Specialty Care contains 13 sections discussing the recommendations and considerations for physicians such as referrals for further bio-psychosocial assessments, review of the individual's motivational levels for improvement, and in some cases – opioid and alcohol dependence – administering the use of pharmaceuticals for help aiding withdrawal.

A. Patient with Presumptive or Possible Substance Use Disorder
B. Ensure Behavioral or psychological Stabilization if necessary
C. Obtain a Comprehensive Biopsychosocial Assessment
D. Determine Diagnosis of SUD; Develop Integrated Summary and Initial Treatment Plan
E. Initiate Addiction-Focused Pharmacology (If indicated)
F. Initiate Addiction-Focused Psychosocial Interventions
G. Address Psychosocial functioning and Recovery environment
H. Manage general medical and psychiatric co-occurring conditions
I. Assess response to treatment/Monitor biological indicators
J. Reinforce and follow up
K. Are treatment goals achieved?
L. Discontinue specialty SUD treatment; Develop Aftercare/Recovery Plan
M. Reevaluate Treatment Plan Regarding Setting and Strategies

Module C: Management of SUD in (Primary) General Healthcare

Module C focuses on the management of SUDs in general healthcare and emphasizes earlier interventions for less severe SUDs. However, for service members unwilling or unable to engage in specialty care treatment, chronic disease management techniques are used. Clinicians in both primary and mental health care settings are likely to encounter patients with presumptive or possible substance use who are either referred, self-referred, or otherwise seek help related to substance use. In these instances physicians assess co-occurring conditions (psychiatric illness, medical conditions, legal or psychosocial conditions) to determine the appropriate course of treatment. Co-occurring conditions can complicate the treatment for SUDs for many individuals and many variables must be taken into consideration. Co-occurring disorders (CODs) are common with SUDs and must be identified and addressed as part of a comprehensive care system. CODs, also termed co-morbid disorders, are defined as sub-clinical or diagnosed medical and/or behavioral health conditions that occur and influence the SUD condition. That is, CODs threaten the health of patients and may complicate the treatment of SUDs. According to the document, SUDs are "highly correlated with posttraumatic stress disorder and other psychological disorders that may occurs after stressful and traumatic events, such as those associated with war." Module C gives a review of guidelines and recommendations through 14 sections that help explain the process for managing SUDs in a primary general healthcare setting.

      A. Patient with presumptive or possible substance use
      B. Ensure behavioral of physiological stabilization, if necessary
      C. Complete assessment and diagnostic evaluation

D. Assess co-occurring conditions) psychiatric illness, medical conditions, legal or psychosocial conditions)
E. Summarize the Patients Problem(s), Discuss Treatment Options, and Arrive at Shared Decision Regarding the Treatment Plan
F. Referral to Specialty SUD care
G. Treatment: Consider Addiction-Focused Pharmacotherapy
H. Treatment: Medical Management and Monitoring
I. Treatment: Psychosocial Support and recovery (I LIKE THIS SECTION)
J. Management of medical and psychiatric co-occurring conditions
K. Assess response to treatment/monitor biological indicators
L. Follow-ups
M. Educate about substance use, associated problems, and prevention of relapse
N. Reevaluate treatment plan regarding setting and strategies

Module P: Addiction-Focused Pharmacotherapy

Module P moves forward and illuminates the appropriate protocol for addiction-focused pharmacotherapy while also addressing the use of medication approved by the Food and Drug Administration for the treatment of alcohol and opioid dependence. Throughout this section evidence for medicalization on the interactive level can be seen on multiple occasions. For example, when medical professionals begin to prescribe various types of medications to help aid in the ongoing efforts to eradicate the individual of their SUD this can be understood as medicalization on the interactive level. Module P lays out the process for prescribing medications for the treatment of SUD in 10 sections focusing on determining whether or not medications for both opioid and alcohol withdrawal should be implemented.

A. Patient with Substance Use Disorder (SUD)
B. Does the patient meet DSM-IV criteria for opioid dependence?

C. Is opioid agonist treatment (OAT) medication appropriate for, and acceptable to, the patient?
D. Is treatment in a specialized opioid agonist treatment program (OATP)
E. Initiate opioid agonist treatment in opioid agonist treatment program or office-based opioid treatment (OBOT)
F. Is naltrexone appropriate for and acceptable to the patient?
G. Assure patient is withdrawn from opioids and opioid free before continuing
H. Initiate naltrexone for opioid dependence with patient education and monitoring
I. Is the patient alcohol dependent?
J. Initiate pharmacotherapy for alcohol dependence

Module S: Stabilization and Withdrawal Management

In Module S addiction focused pharmacotherapy is discussed further and provides recommendations for the stabilization and withdrawal management of those with SUDs as well as those who may be experiences sever psychiatric crises. The appropriate protocol for providing medications is advanced further and addresses withdrawal management including pharmacological management of withdrawal symptoms.

A. Substance-using patient who may require physiological stabilization
B. Obtain history, physical examination, mental status examination, medication including over-the-counter, and lab tests indicated
C. Is the Patient in any immediate medical or psychiatric crisis or intoxicated?
D. Provide appropriate care to stabilize; or, follow policies for DoD active duty members: Keep commanding officer informed
E. Assess level of physiological dependence and indications for stabilization including risk of withdrawal
F. Is the patient in need of withdrawal management
G. Does Patient require inpatient medically supervised withdrawal?
H. Admit to inpatient withdrawal management or initiate ambulatory withdrawal management
I. Was withdrawal management successful?

J.   Is care management indicated?

After moving through the 4 modules, Conrad and Schneider's framework proved to be an excellent model through which I was able to easily point out and identify various items related to medicalization. Ultimately their template allowed me to uncover a considerable amount of medicalization occurring within the armed forces at very specific levels.

Conceptual

Evidence for medicalization at the conceptual level can be seen in various forms throughout the manual. According to Conrad and Schneider (1980), on the conceptual level, a medical vocabulary (or model) is used to categorize and define a specific behaviors or human conditions. This process may occur at the "elite levels of medicine in terms of new discoveries published in medical journals" or in some instances "outside the medical profession altogether, such as when some non-medical groups adopt a particular set of medical definitions and explanations" (Conrad and Schneider 1980). The document's language relating to "diagnostic assessments," "laboratory biomarkers," and other screening devices are all used to categorize and measure one's substance use and can be considered evidence for medication at the conceptual level. Lab results, physiological measurements, and social assessments are used to carefully conceptualize the severity of one's substance use and then place them on appropriate paths for treatment. Further confirmation of medicalization on the conceptual level can be seen when the document likens the screening of SUDs to other medical conditions such as hypertension, high cholesterol and cervical cancer. For example the manual states,

> "Unhealthy alcohol use screening and counseling is similar to screening for hypertension, colorectal cancer, or vision in older adults, and a higher priority than breast and cervical cancer screening, as well as cholesterol screening."

Thus, treating SUDs in the same way that physicians treat other conditions such as hypertension and cancer serves to help give an individual a framework on how to understand their condition through an individualized, medical process. In addition to witnessing evidence for medicalization on the conceptual level, this passage also depicts how some forms of illness are considered to be more deserving of our attention. According to the manual, the attention given to SUDs should rival or be similar to that of other medical conditions such as hypertension and colorectal cancer, however, each of these conditions is viewed in the eyes of the VA and DoD as more deserving of our attention and care than conditions such as breast and cervical cancer. Another example of medicalization on the conceptual level can be found in Module A:

> "Multiple validation studies—both inside and outside the VA have shown that screening cut-points of 3 or more in women and 4 or more in men balance sensitivity and specificity for identification of risky drinking and alcohol use disorders."

That is, not only are these medical professionals likening SUDs to that of hypertension, diabetes, cancer, etc., but they are also determining – medically – what qualifies for "risky drinking" based on the consensus of medical elites, not through empirical evidence produced by rigorous biological testing. This suggests that the medical information used to determine what qualifies as "risky drinking" has been

usurped by our medical establishment and is culturally constructed through those occupying medical professions. After a strict coding regimen was in place I was able to categorize similar pieces of text into segments that were indicative of medicalization occurring on the conceptual level. Numerous segments of text were identified and categorized as medicalization on a conceptual level and more examples are discussed within the module descriptions.

Institutional

The second level of Conrad and Schneider's framework appearing in the document involves institutional medicalization. On the institutional level, "perhaps only one or two medical professionals, usually physicians, are necessary to legitimate the medicalization of whatever program or problem in which the organization specializes" (Conrad and Schneider 1980). Institutional medicalization occurs when specific facilities are created to help address and treat human conditions that have not always been described and treated as a medical condition. In recent years we have seen many new facilities developed to help individuals confront one's problems involving SUDs, and as of lately this has taken on a more nuanced medical approach involving extensive biopsychosocial assessments. This is also true within the armed forces. Clear indication of medicalization on the institutional level can be seen with references to specialty treatment, "specialty care" and "other clinics" which are to be used when confronting much more severe levels of substance use. An example of institutional medicalization in the document comes from Module B:

> "Treatment of chronic relapsing patients is difficult. For
> those willing to accept referral, treatment should be
> undertaken by addiction professionals in specialty
> treatment settings that employ a multi-faceted approach."

This is indicative of institutional medicalization. After the physicians have diagnosed patients with SUDs, they are then sent to counseling services or other medical facilities designed to specifically deal with the severity of SUD appropriately. Another example of this type of medicalization includes the quote,

> "Patients who are diagnosed with SUD or who are
> seeking to help with problem drinking or drug use,
> should be offered treatment and/or a referral to specialty
> addiction treatment, and monitored for unstable medical
> or psychiatric conditions."

Both of these examples show that the armed forces have begun creating special facilities carefully designed for the treatment of SUDs. Implicit within this statement is the idea that SUDs cannot be treated effectively within the confines of general health care settings and service members should be sent to care settings that have the appropriate medical professionals and tools necessary to adequately address their pressing concerns. Moreover, it is indicative to the expansion of the medical field at the institutional level.

Interactive

The last level involved in the framework, includes medicalization on the interactive level. This final level of medicalization occurs when medical professionals begin to interact and treat the human condition in question as a specific medical problem. After combing through the document, this is clearly true of SUDs in the military. Evidence for

interactive medicalization can be seen through the use of pharmacological treatments for

withdrawal, and the ongoing monitoring of medical consequences for substance use. The

following is an example of interactive medicalization that can be found in Module

> "While non-pharmacological treatment has been the
> mainstay of treatment for SUD, recent scientific
> advances have encouraged the use of pharmacological
> treatments. Pharmacological treatments can serve as an
> effective adjunct to non-pharmacological treatments to
> help patients reduce of eliminate alcohol consumption."

In this quote, we can see the manual endorsing the use of medications as a viable means

of treatment and suggests that physicians should begin treating service members with

pharmaceutical drugs. Another example of this type of medicalization involves doctor

and patient interactions regarding the management of:

> "Provision of care at OATPS is highly regulated,
> with provider and patient-level requirements
> including limited take home medications provided,
> mandated laboratory studies and clinical
> assessments, appropriate psychological intervention,
> and formal agreements for provision of OAT."

Both of these examples are indicative of interactive medicalization. In each of the

quotes listed above, clinicians have begun to interact with patients and determined the

appropriate facilities for handling their particular SUD. That is, in some cases outside

services are arranged with psychiatrists, medications are distributed while medical

surveillance continues takes place.

Counter Narrative: Latent Functions

As suggested throughout the findings of this thesis, the bulk of the manual includes a very specific set of instructions on how to change the individual through a series of specialized treatment methods that are to be administered through various facets of the medical community. This strict, narrow, and medicalized approach to understanding SUDs in the military has resulted in the majority of efforts placed toward eradicating drug and alcohol abuse from the individual, while rarely giving any attention to the structural and social causes which could lead to this type of behavior. However, there are a few places in the manual that begin to suggest that SUDs can be more complicated than the physiological and biological explanations we typically subscribe to and may actually be the result of the environmental stressors and conditions in which many military members find themselves in after deploying overseas to fight in war.

The first sign of this counter narrative was made evident in Module C: Management of SUDs in (Primary) General Healthcare in the section titled: Asses Co-Occurring Condition (Psychiatric Illness, Medical Conditions, Legal or Psychosocial Conditions). This section begins by explaining the importance of treating any and all co-occurring disorders (CODs) that an individual with a SUD may possess and includes, but is not limited to, bipolar disorder, schizophrenia, PTSD, and anxiety. CODs are common with SUDs and must be appropriately identified and addressed as part of the comprehensive care program used throughout the military. According to the manual, "CODs, also termed co-morbid disorders, are defined as sub-clinical or diagnosed

medical and/or behavioral health conditions that occur with and influence the SUD

condition. CODs threaten the health of patients and may complicate the treatment of

SUDs." The manual goes on to state:

> "SUD is highly correlated with posttraumatic stress
> disorder (PTSD) and other psychological disorders that
> may occur after stressful and traumatic events, such as
> those associated with war."

This quote represents one of the few instances where the manual begins to stray

away from the biomedical explanation of SUDs and puts forth the idea that the

environment and social situations many service members find themselves in while

serving our country in combat can play a significant role in the development of SUDs.

The manual goes on to suggest some recommendations for appropriately assessing

individuals with SUDs include assessing significant, unmet psychological needs or

situational stressors. The criteria includes:

A. Inadequate or no housing
B. Financial difficulties, especially if unable to meet basic needs
C. Problematic family relationships or situations (including caregiving burden or domestic violence)
D. Poor Social Support
E. Religious or spiritual problems
F. Occupational problems
G. Difficulties with activities of daily living or instrumental activities of daily living
H. Any other acute of chronic situational stressor

This criterion is where we begin to see the military taking into consideration various

social conditions that may influence and contribute to the onset of drug and alcohol

abuse. Individuals, who experience difficulties such as finding housing, having problems

56

with family members, difficulties maintaining a job, or trouble with financial security may be more likely to experience problems with drug and alcohol abuse. While most will agree that this criteria provides a good jumping off point where we can begin to examine the social contexts in which SUDs can flourish, however, what is particularly interesting is that the list does not specifically mention military history, military culture, or combat exposure as any of the situational stressors worth investigating and contributing to CODs or SUDs. While mentioning the role that military life, war and the consequences of combat may play in SUDs, these factors do not play a major role in the text of this manual – suggesting that they are not major players in the institutional narrative of SUDs in the military. Moreover, the pressures placed on military personnel by commanding officers and the military lifestyle are also ignored. Making modest statements, such as the quote mentioned above, serves to downplay pertinent factors, which need to be addressed to understand the increasing rates of SUDs more holistically. A latent function of the manual, then, is to suggest that while non-individual level factors may play a small part, SUDs are primarily the result of individual illnesses and weaknesses that need to be "treated" and "overcome" through medical intervention. However, as more and more research about military members and SUDs becomes known, we are beginning to find out that the costs of war may extend well past one's deployment overseas and tenure in the military and consequently continue to affect soldiers' lives for quite some time. One particular piece of text stands out in the discussion section of Module C, which shows that researchers such as Jacobson et al. have pointed out recent data collected on a cohort of recent veterans and states:

"an analysis of the Millennium Cohort Study data found
that combat deployment in support of the wars in Iraq and
Afghanistan was significantly associated with new-onset
heavy weekly drinking, binge drinking, and other alcohol-
related problems…"

This line of thinking would suggest that service members deployed overseas may experience intense and stressful combat situations as the result of their military duties and may be more likely to fall victim to drug and alcohol abuse upon returning. That is, it is not the individual who possesses some character flaw or weakness (as we have previously thought) rather it is the environmental conditions in which they find themselves that can contribute to soldiers turning to drug and alcohol as a means to mask their feelings and cope with the difficulties of combat. This sentiment was echoed once more in Module C in the section titled Treatment: Psychosocial Support for Recovery.

"Negative life events and stressful situations may
contribute to the onset or relapse of a substance use
disorder. They may also influence treatment adherence and
outcome."

We once again see the military making claims that stressful environments and specific social conditions may actually contribute to the onset of SUDs rather than turning to biomedical explanations for a complete understanding. However, nowhere in the manual is there information on how the military plans to address these findings or what their plan is to avoid similar situations in the future. This suggests more attention should be directed toward alleviating the psychological pain and suffering many soldiers experience once their tour has ended.

In summary, the manifest functions clearly indicate that the institutional narrative of SUDs in the military is highly medicalized and can be seen at all three levels put forth by Conrad and Schneider (1980). First, more than 70 pieces of text were identified as being representative of medicalization at the conceptual level. Next, 57 phrases were identified as institutional medicalization. Finally, more than 100 items were coded as medicalization at the interactive level. However, Conrad and Schneider's model is not a perfect fit for all the text included in the manual and thus a counter narrative section was created.

While I was able to find dozens of examples of conceptual, institutional, and interactive levels of medicalization in the document, there were only a few places where the manual gives attention to the environmental conditions and social stressors that may contribute to the onset of SUDs. These latent functions were placed into the counter narrative section and only 3 pieces of text were identified and fell outside the medical narrative. In other words, only 1.3% of all text identified and coded in the manual fell outside the prevailing medial narrative. This suggests the latent functions (social underpinnings) play a minor role in the military's understanding of SUDs and thus less attention should be given to their contributions toward SUDs. In the next chapter I will explore the implications of these findings as well as the consequences that may result from focusing attention predominately on the individual and downplaying the social environment.

CHAPTER FOUR:

CONCLUSION

In this study, I set out to answer three questions involving the medicalization of SUDs and how the military responds to these conditions: (1) How does the military characterize the problems and resolutions of SUDs? (2) How and to what extent does this narrative reflect medicalization? (3) What are the limitations inherent in the institutional narrative of SUDs in the military? In addition to answering these questions, I was also able to uncover some of the tensions that exist between pre-existing cultural norms found in the military and the prevailing medicalized methods for treating SUDs. In order to address these questions and identify the underlying tensions, I drew on three conceptual lenses: (1) The work of Loseke (2007) on the power of institutional narratives; (2) The work of Conrad and Schneider (1980) in which they propose that medicalization can be understood in multiple ways and on at least three distinct levels (the conceptual, the institutional, and the interactive); and (3) The work of disability scholars on the limitations of the medical model and the importance of adopting a social model of the causes and consequences of disability (Oliver & Barnes 2012; Shakespeare 2014; Berger 2012). Answering each of these questions will help facilitate our understanding of the dominant narrative told by the military and the response to SUDs that is sanctioned within the institution of the armed forces.

To answer my first question (how does the military characterize the problems and resolutions of SUDs?), we must refer back to Loseke's (2007) work on intersecting narratives in the form of the macro, meso, and micro stories told throughout the social world. After taking her work on interrelated stories into consideration, we can determine the military has produced two competing narratives surrounding the characterization and resolutions of SUDs. The first narrative – the medicalized narrative – characterizes the problems and resolutions of SUDs as an individual issue, which is to be overcome through rigorous treatment methods and carried out by established medical professionals within specialty treatment centers. In doing so, SUDs are handled in ways that are quite similar to other medical conditions. The second narrative – the hero narrative – suggests that soldiers possessing SUDs are considered weak as well as lacking the strength required of service members to overcome adversity. Thus, SUDs should be overcome through self-discipline and strength, not through medical interventions. These competing narratives and characterizations of SUDs serve to create tensions for soldiers when attempting to reconcile the differences between them as well as the decision to seek treatment for medical issues.

This medical narrative characterizes service members as sick individuals who are, for the moment, broken and in need of repair. To many within the medical community, sickness represents a state of social deviance because it falls outside what is considered "normal" and acceptable by current medical standards. The narrative suggests that in order to rid individuals from the deviant label, they must admit to physical or mental shortcomings and seek help from the others in the medical community. In some cases, in

order to resolve the SUD, service members may be segregated from their unit and placed in specialty services aimed at "fixing" and restoring them back into working order. The document characterizes the problems and resolutions for SUDs in a way that is strikingly similar to that of the sick role. However, this story of recovery serves to create problems for service members once you take into consideration the hegemonic narrative surrounding masculinity and what it means to be a strong service member.

While not a manifest function of the manual analyzed here, the heroic, masculine narrative found throughout military advertisements, recruiting devices, and cultural norms runs counter to the medicalized narrative and provides little space for service members to admit to sickness thus making the treatment of SUD much more difficult. The hero soldier narrative characterizes the problem of SUDs as a weakness or personal failure as well as something about which to be embarrassed by if thought to possess. In other words, a soldier no longer represents the qualities required of service members by possessing SUDs or other medical conditions that demonstrate weakness and should be avoided at all costs. Service members should be strong, endure intense hardships without complaint, and possess the ability to overcome their weakness through self-discipline, not medical interventions. Consequently, if a service member requests treatment for their SUD, many may feel they are falling short of military standards and cultural norms. That is, they will no longer be seen as strong, self-sacrificing, or capable of enduring hardship, which are emblematic qualities of service members. Rampant through the military's culture is the idea of pulling oneself up by the bootstraps and overcoming any of life's obstacles. As a result, service members are revered for their mental and physical

fortitude, however, by adopting the sick role it places their identity of a heroic soldier in jeopardy and is usually met with hesitancy.

While the medical model's approach toward addressing illness (i.e., acknowledge there is a problem and seek help for it) seems to work well for the majority of the population, it consequently fails to provide service members with a narrative that acknowledges and respects their sensitivity toward admitting weakness and personal shortcomings. The idea that military members diagnosed with medical conditions are somehow broken and in need of repair can be very difficult for some service members to acknowledge and accept due to their strict socialization and cultural norms. As a result, it may be easier for non-military members to admit they have a medical condition or weakness worth treating and thus easier for them to accept the prevailing medicalized narrative and sick role.

The second question (how and to what extent does this reflect medicalization?) can be answered by harkening back to Conrad and Schneider's work *Looking at Levels of Medicalization* (1980). In their work they suggest three levels for which medicalization can be identified (conceptual, institutional, and interactive). Once implementing their work as a means to understand how the narrative might reflect medicalization, it became clear that evidence for each level was found throughout the military manual. On the conceptual level, self-report data, laboratory biomarkers, and other assessment tools are used to define and categorize various SUDs. In addition, comparing and contrasting SUDs to other medical such as hypertension and cancer furthers the idea that SUD have been conceptualized in a medicalized framework. On the institutional level, the

widespread use of referrals and the use of specialty facilities for treating those with SUDs reflect the expansion of the medical model into domains that have not always fallen under the purview of the medical community. For example, now, when service members are seen by general physicians and diagnosed with a SUD they may be sent to specialists at other facilities that are better equipped at addressing their needs. Finally, at the interactive level, individuals who have been diagnosed with a SUD, depending on their severity, may be given prescription medications in order to help alleviate withdrawal symptoms stemming from both opioid and alcohol use. In other words, medical professionals work through a network of clinicians as well as the patient to determine the appropriate method of treatment.

The final and perhaps most important question this study set out to answer (what are the limitations inherent in the institutional narrative of SUDs in the military?) can be illuminated through the work of disability scholars and the social model of disability. While SUDs may not be considered a disability per se, the lens through which these scholars view disability can be extended to examine SUDs as well as how we come to understand the experiences of these conditions in military. According to scholars such as Oliver, Barnes, Shakespeare, and Berger, as well as others, disability can be constructed as either 1) personal tragedy or 2) social oppression (Oliver and Barnes 2012; Shakespeare 2014; Berger 2012). The former is prevalent within the medical model narrative whereas the latter is found within the social model of disability. When disability is viewed as a tragedy, we tend to view people with disabilities as if they are the victim of some awful circumstance and thus provide solutions aimed at the helping the individual

(Oliver and Barnes 2012; Shakespeare 2014; Berger 2012). Alternatively, when disability is viewed as social oppression, people with disabilities can be seen as the collective victim of an uncaring or unknowing society and leads policymakers to look beyond the individual and more toward the social conditions that serve to disable the individual throughout society (Oliver and Barnes 2012; Shakespeare 2014; Berger 2012). In this respect, the first limitation found within the intuitional narrative involves the military constructing SUDs as a personal tragedy with solutions aimed at the individual. This approach underemphasizes some of the wider social conditions at play, which may affect the experience of SUDs in the armed forces.

As a result of focusing primarily on the individual and individual medical solutions for SUDs, the military has ignored the cultural norms and rituals cultivated through an intense masculine environment – praising strength and toughness – that have consequently led to an atmosphere that is hostile to those who seek treatment. Furthermore, the failure to acknowledge the adversarial social conditions that prevent service members from participating in treatment can be characterized as a form of social oppression and the result of an unknowing society.

In addition to the shortcomings of the military adopting a personal tragedy perspective, additional limitations can be found when the medical model's narrative calls for individuals to adopt the sick role in order to overcome their illness. Fulfilling the obligations of the sick role can be a difficult task for soldiers due to their socialization toward masculine cultural norms regarding strength and endurance. According to the hero narrative found in the military, many of these individuals have become accustomed

to thinking of themselves as those who protect others from danger thus the process of adopting the sick role may be extremely uncomfortable for many service members due to experiencing such a severe role reversal. By adopting the sick role, soldiers must abandon their familiar role as the hero and accept the position as a victim of circumstances outside their control. This goes in direct opposition to many military norms and can create mounting anxiety for service members who possess SUDs. They find themselves trapped between their duty as a solider and the role as a victim. That is, seeking treatment for various medical conditions, specifically SUDs, risks embarrassment from peers as well as exposing the service member as failing to possess the qualities required of military personnel. More importantly, though, the advocacy for adopting the sick role found within the medical narrative fails to taken into consideration the sensitive nature surrounding service members and their unwillingness to admit weakness and physical limitations. In turn, this also stifles their ability to seek out treatment.

The military could potentially become more aware of the conditions that might encourage SUDs if they were to adopt a social model perspective toward medical conditions and SUDs. The military, then, could eventually bring attention to and identify its own role in necessitating and exacerbating SUDs as a result of its hyper masculine environment and oppressive attitude toward treatment seeking. Adopting a social understanding toward excessive drug and alcohol use could also serve to shift the blame and responsibility of possessing a SUD away from the individual service member by placing it onto the social structure and the social conditions found in the military. This heightened awareness and attention to underlying social explanations may eventually

66

soften the stigmatization of SUDs in the military as well as facilitate recovery. Finally, this shift in ideology may result in fewer soldiers viewing SUDs as an individual problem in which they are broken or sick and thus be more likely to participate in and seek treatment.

While this research set out to examine the institutional narrative of substance use disorders within the military and the ways in which it reflects medicalization, additional concerns and limitations involving the competing medical model and hero narratives began to make themselves known and tell a story about an environment that is both hyper masculine and dismissive to individuals with SUDs. As a result of characterizing the problems and resolutions of SUDs in a strict, medicalized framework we can assume that fewer service members will accept and participate in substance abuse treatment due to their socialization as a hero who possesses strength. However, this can be overcome by reconfiguring the current narratives toward SUDs and other medical conditions by replacing the current medical model understanding of illness with that of a social model that pays close attention to social explanations and remains sensitive to the unique needs of service members and their prevailing cultural norms. If the military were to reframe treatment for medical conditions as a means of maintaining their strength, and not as a sign of losing it, the military may be better at ensuring those with medical conditions receive treatment.

Future Directions

There are three directions I could take this study in the future. First, I could consider other narratives involving substance abuse in the military. This could be achieved by

67

looking at memoirs written by soldiers who have returned home, or by interviewing student veterans to better understand their personal narratives. The personal narratives of service members may provide insight into other dimensions that have been missed in this study and may also provide data on how military members overcome the tensions between the two widely circulating hero and medical narratives. I could also analyze newspaper stories, news broadcasts, and films to get a closer look at the cultural narratives in the military, which could help aid in identifying additional cultural narratives as well as substantiate the narratives already known.

Second, I could adopt different methods for addressing substance use concerns. I could use interviews with clinicians at the VA to better understand how these protocols are implemented. In addition to interviews, I could also make use of focus groups with service members who have received treatment for SUDs while serving. Both of these methods would allow for me to gain additional insight to how the process unfolds.

Finally, I could extend this methodology to other areas outside the military. This methodology could be extended to the criminal justice system in at attempt to identify the institutional narrative of addressing and treating mental health concerns in our prison and jail systems. I could identify the protocols on treating offenders with pressing mental health issues and determine how these organizations characterize these conditions. For example, I could ask how does an individual, medical approach provide limitations to care, or how do cultural stories about offenders serve to influence they type and quality of care they receive? Many offenders are thought to deserve prison and jail sentences and we typically marginalize these individuals and show little concern for their well-being.

How can this translate into the type of care they receive while incarcerated? This is just one of many questions that can be answered by extending this methodology to areas outside the military.

FIGURES:

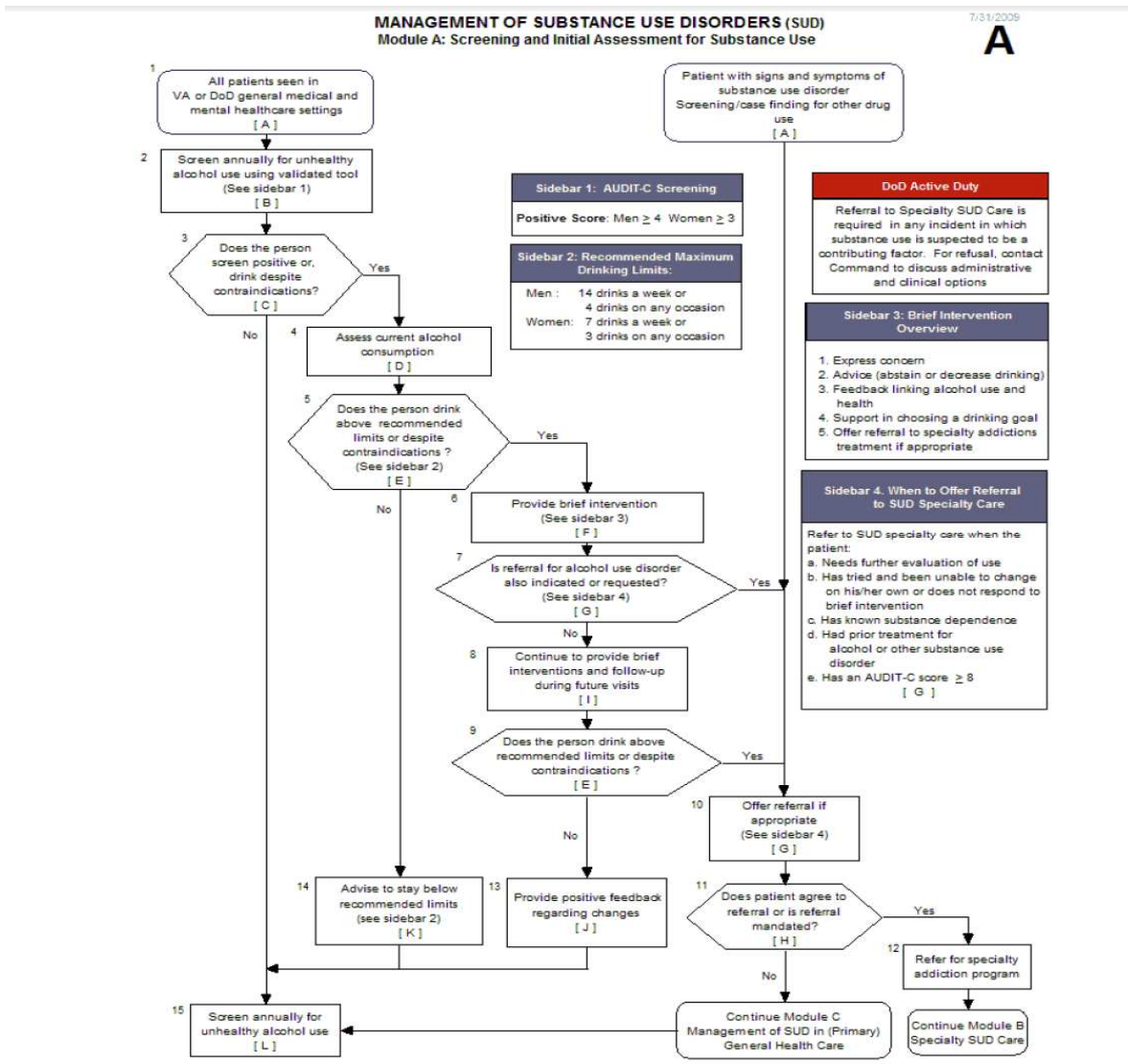

Figure A. Module A: Screening And Initial Assessment For Substance Use Disorders*

*Information provided by the U.S. Department of Veteran Affairs
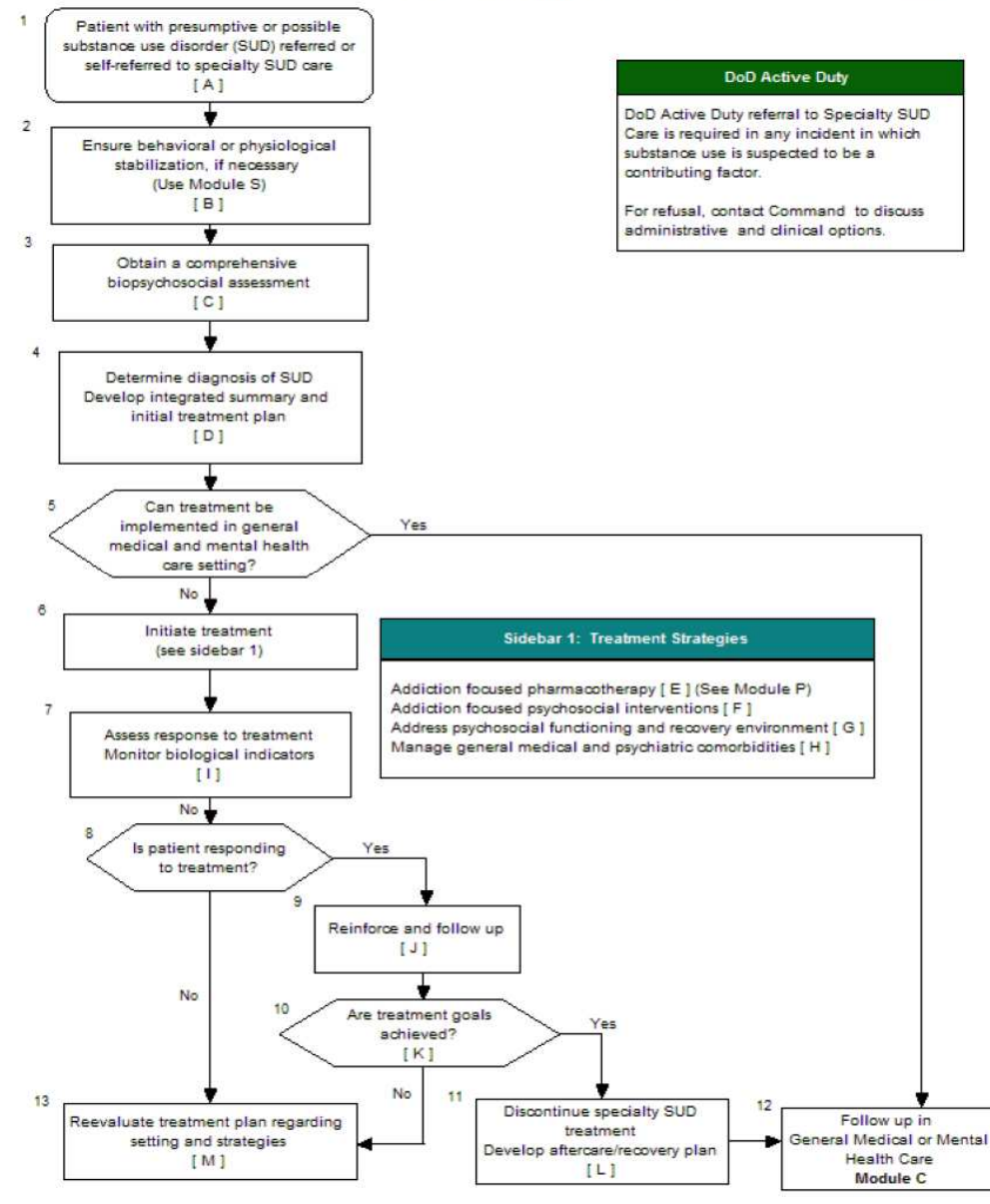
Figure 2. Module B: Management of SUD In Specialty Care*

Information provided by the U.S. Department of Veteran Affairs

Management of Substance Use Disorder
Module C: General Health Care

7/24/2009

C

1 Patient with presumptive or possible substance use disorder (SUD) [A]

2 Ensure behavioral or physiological stabilization, if necessary (Use Module S) [B]

3 Complete assessment and diagnostic evaluation [C]

4 Assess co-occurring conditions (Psychiatric illness, medical conditions, legal or psychosocial conditions) [D]

5 Summarize the patient's problem(s) Discuss treatment options and Arrive at shared decision regarding the treatment plan [E]

6 Initiate/continue treatment (see sidebar 1)

7 Assess response to treatment Monitor biological indicators [K]

8 Are treatment goals achieved?

9 Follow-up:
- Monitor substance use
- Monitor biological indicators
- Encourage continued reduction or abstinence
- Provide motivational support [L]

Educate about substance use, associated problems and prevention of relapse [M]

10 Reevaluate treatment plan regarding setting and strategies [N]

Patient may be offered referral to addiction specialty care at any time for:
- Stabilization if necessary
- Evaluation and diagnosis
- Addiction focused specialty treatment [F]

For DoD Active Duty
DoD Active Duty referral to Specialty SUD Care is required in any incident in which substance use is suspected to be a contributing factor.

For refusal, contact Command to discuss administrative and clinical options.

Sidebar 1: Optional Treatment Strategies
Consider addiction-focused pharmacotherapy [G] (See Module P)
Medical management and monitoring [H]
Psychosocial support for recovery [I]
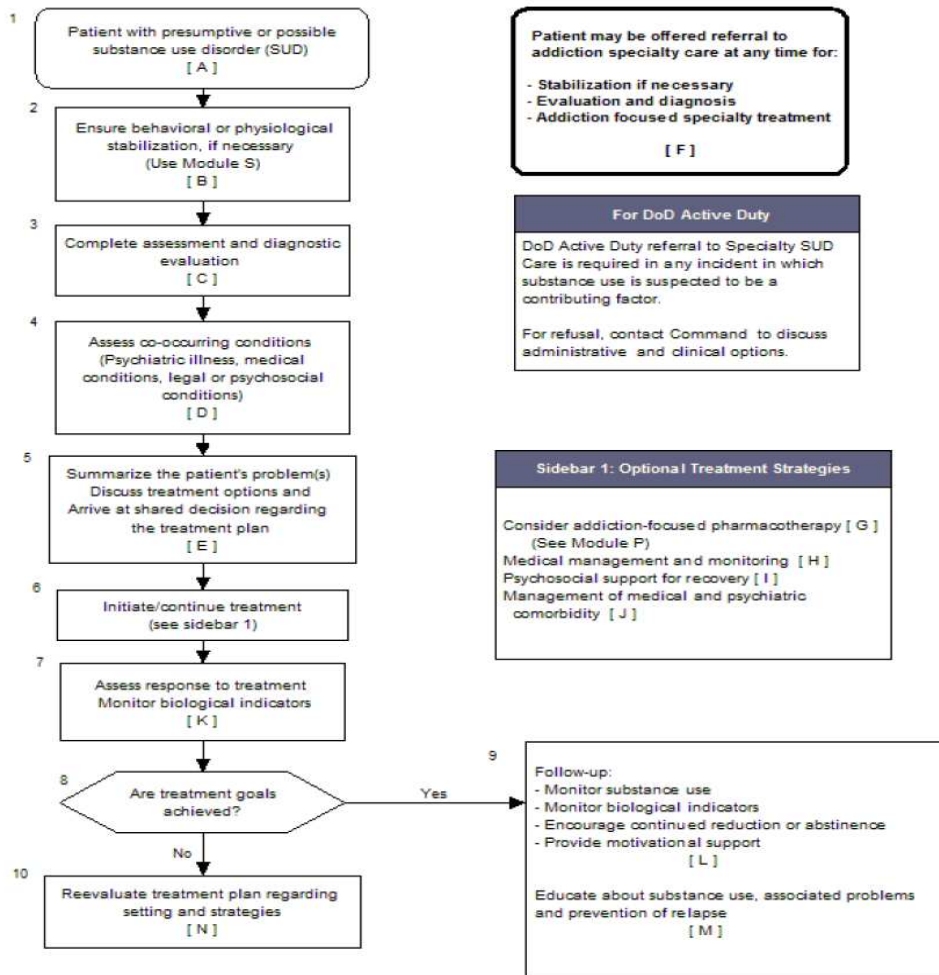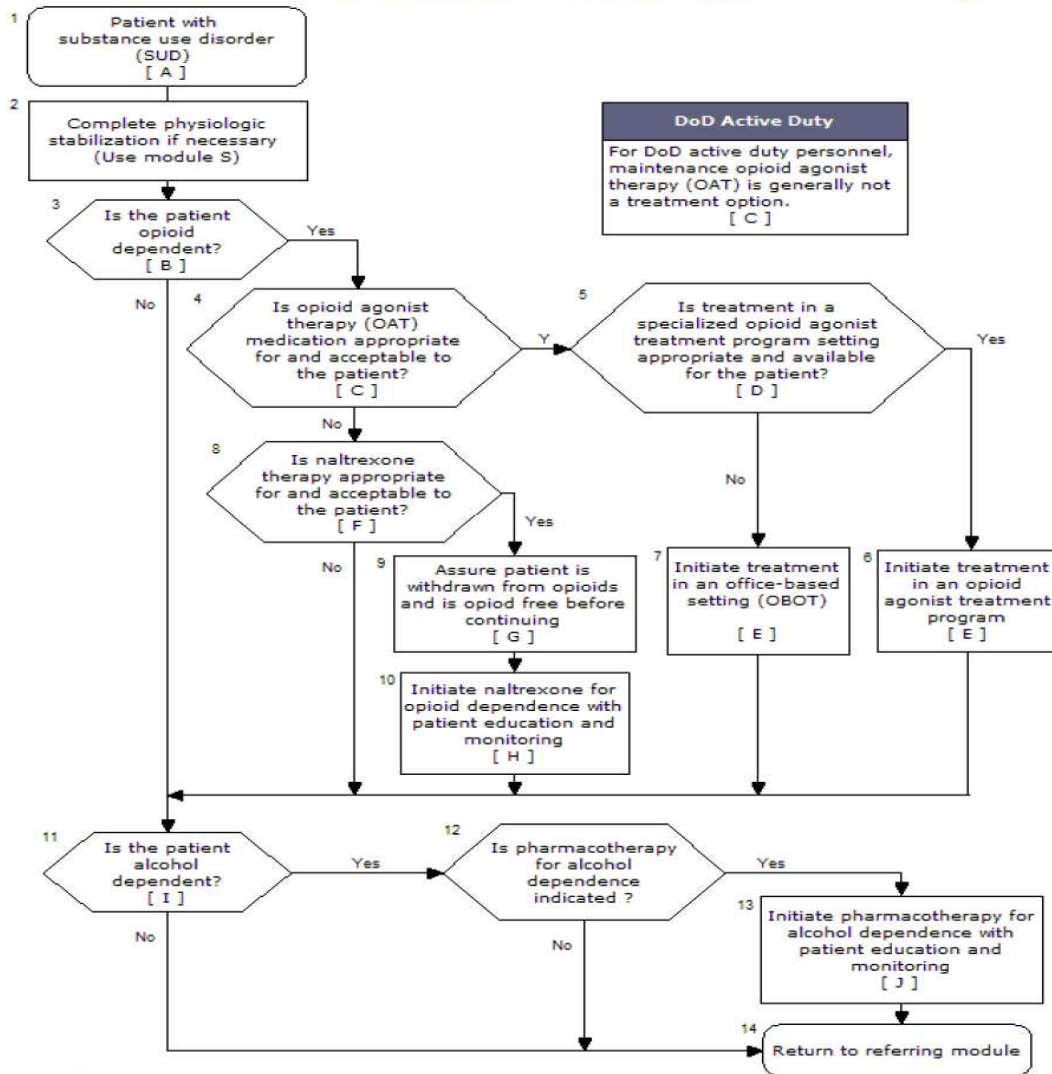Management of medical and psychiatric comorbidity [J]

Figure 3. Module C: Management Of SUD In (Primary) General Healthcare*

Information provided by the U.S. Department of Veteran Affairs

MANAGEMENT OF SUBSTANCE USE DISORDERS
Module P: Addiction-Focused Pharmacotherapy

P

Figure 4. Module P: Addiction-Focused Pharmacotherapy*

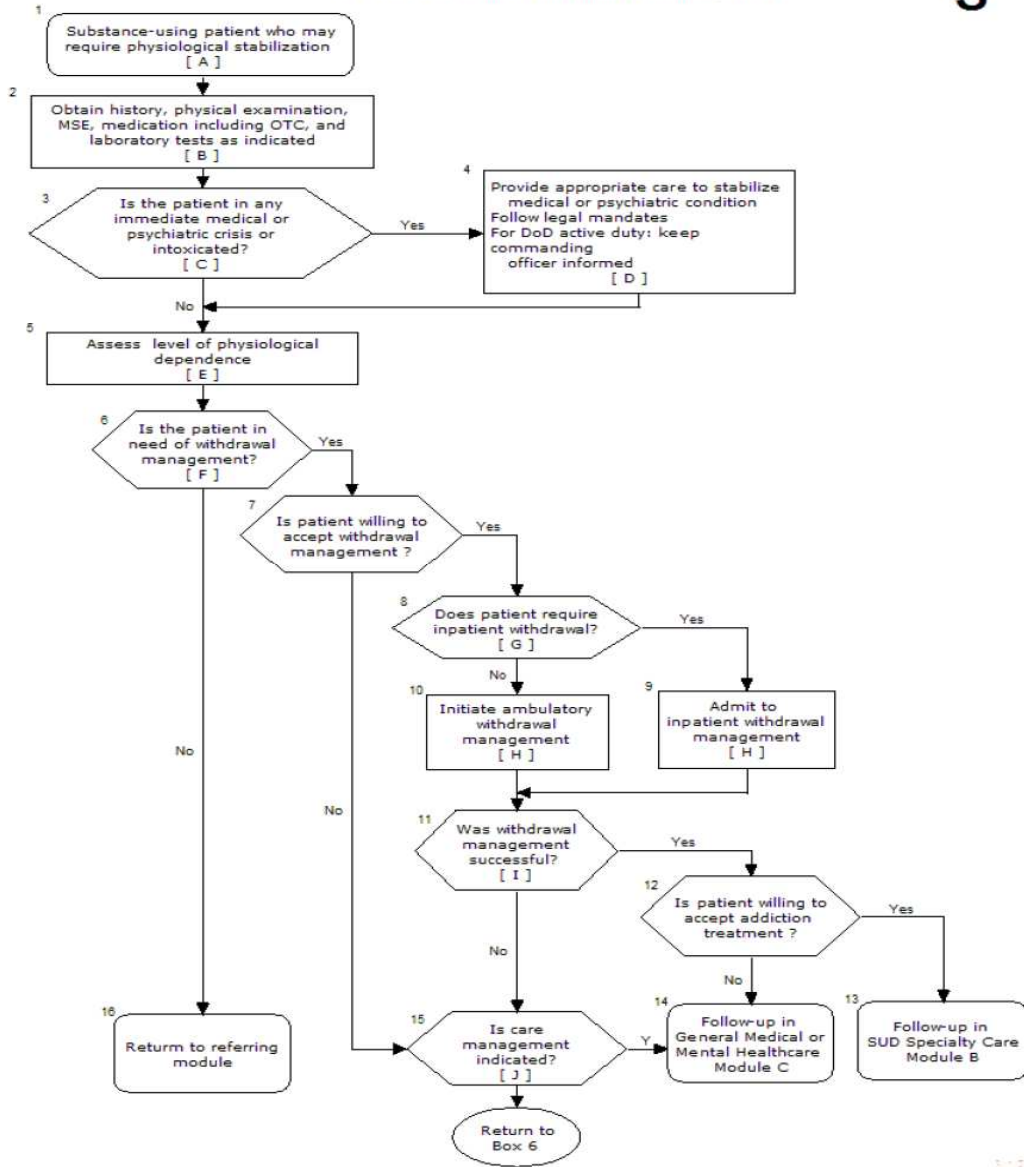*Information provided by the U.S. Department of Veteran Affairs*

Figure 5. Module S: Stabilization And Withdrawal Management*

Information provided by the U.S. Department of Veteran Affairs

REFERENCES

Akers, R. 1992. Drugs, Alcohol, and Society: Social Structure, Process, and Policy. Belmont, CA: Wadsworth Publishing.

Alexander, Jeffrey C. 1992. "Citizen and Enemy as Symbolic Classification: On the Polarizing Discourse of Civil Society." Pp. 289-308 in Cultivating Differences: Symbolic Boundaries and the Making of Inequality, edited by Michele Lamont and Marcel Fournier. Chicago, IL: University of Chicago Press.

American Psychiatric Association. (2000). Diagnostic and Statistical Manual of Mental Disorders (4th ed).

Armstrong, D. 1987 "Theoretical tensions in biopsychosocial medicine." *Social Science and Medicine* 25: 1213-1218.

Aronowitz, R. 1992. From Myalgic Encephalitis to Yuppie Flu: A History of Chronic Fatigue Syndromes. In Framing Disease: Studies in Cultural History, ed. Charles Rosenberg and Janet Golden. New Brunswick, NJ: Rutgers University Press.

Barker, K. 1998. "A ship upon a stormy sea: the medicalization of pregnancy." *Social Science Medicine. 47(8) 1067-176.*

Barrett, F. 1996. "The organizational construction of hegemonic masculinities: the case of the navy." *Gender, Work, and Organization 3 (3) 129- 142*

Bennet, A. & Bennet, D. (2008). The decision-making process in a complex situation. In *Handbook on Decision Support Systems 1* (pp. 3-20). Springer Berlin Heidelberg.

Berger, A. 1997. *Narratives in Popular Culture, Media, and Everyday Life.* Thousand

    Oaks, CA: Sage.

Berger, R. (2013). *Introducing Disability Studies*. Boulder, CO: Lynne Rienner.

Bray, R. M. & Guess, L. L. 1989. "Prevalence, trends, and correlates of alcohol use,

    non-medical drug use, and tobacco use among U.S. military personnel.

    Military Medicine." 154 1-11

Bray, R. M., Kroutil, L. A., & Marsden, M. E. (1995). Trends in alcohol, illicit drug, and

    cigarette use among US military personnel: 1980-1992. *Armed Forces & Society*,

    21(2), 271-293.

Bray, R. M., & Hourani, L. L. 2007. "Substance use trends among active duty military

    personnel: findings from the united states department of defense health

    related behavior surveys, 1980–2005." *Addiction*, 102(7), 1092–1101.

Bray, R. M., Pemberton, M. R., Lane, M. E., & Hourani, L. L. (2010). "Substance use

    and mental health trends among U.S. military active duty personnel: key findings

    from the 2008 DoD health behavior survey." *Military Medicine*, *175*, 390-399.

Connell, R. W., & Connell, R. 1995. *Masculinities*. Univ of California Press.

Conrad, P. & Schneider, J. 1980. Deviance and Medicalization: From Badness to

    Sickness. Philadelphia: Temple University Press.

Conrad, P. & Schneider, J. 1980. "Looking at Levels of Medicalization: A Comment on

    Strong's Critique of Medical Imperialism." *Social Science and Medicine 14(1):*

    75-79

Conrad, P. 1992. "Medicalization and social control." *Annual Review of Sociology* 18: 209-232.

Conrad, P. Schneider, J. 2010. Deviance and Medicalization, From Badness to Sickness. Philadelphia: Temple University Press

CDCP. 2011. Prescription painkiller overdoses in the US: Vital signs.

D'Andrade, R. 1995. *The Development of Cognitive Anthropology.* New York: Cambridge, University Press.

DiMaggio, P. 1997. "Culture and Cognition." *Annual Review of Sociology* 23:263-87.

Durkheim, Emile. 1893. *The Division of Labor in Society.* Trans. W. D. Halls, intro. Lewis A. Coser. New York: Free Press, 1997, pp. 39, 60, 108.

Executive Office of the President. 2010. Newsletter of the office of national drug control policy, 1(2)

Eyer, D. E. 1982. Mother-Infant Bonding: A Scientific Fiction. Yale University Press, New Haven and London.

Fingarette, H. 1975. Addiction and criminal responsibility. *Yale Law Journal*, 413-444.

Foucault, M. 1966. *Madness and Civilization*. Mentor, New York.

Foucault, M. 1975. The Birth of the Clinic: An Archaeology of Medical Perception. Vintage, New York.

Fox, R. 1989. The Sociology of Medicine: A Participant Observer's View. Englewood Cliffs, NJ: Prentice Hall Inc.

Gamson, William A. and Gadi Wolsfeld. 1993. "Movements and Media as Interacting

    Systems." The Annals of the American Academy of Political and Social Science

    528:1 14-26.

Gibbs, D., Rae Olmsted, K., Brown, J., Clinton-Sherrod, A. 2011. "Dynamics of stigma

    for alcohol and mental health treatment among army soldiers." *Military*

    Psychology, 23: (1), 36-51.

Goffman, E. 1963. Stigma: Notes On The Management Of Spoiled Identity. New York,

    Simon & Schuster, Inc

Hoge, C., Castro, C., Messer, S., McGurk, D., Cotting, D., & Koffman, R. 2004.

    "Combat duty in Iraq and Afghanistan, mental health problems, and barriers to

    care." *New England Journal of Medicine*, 351: 13-22

Institute of Medicine. 2012. Substance Use Disorders in the U.S. Armed Forces.

    Washington, DC: The National Academies Press

Kim, P., Britt, T., Klocko, R., Riviere, L., & Adler, A. 2011. "Beyond Stigma: Negative

    Attitudes About Treatment and utilization of mental health care among soldiers."

    Military Psychology, 23: 112-23

Koa, T., Schneider, S., and Hoffman, K. 2000. "Co-occurrence of alcohol, smokeless

    tobacco, cigarette, and illicit drug use by lower tanking military personnel.

    Addictive Behaviors." 25(2) 253-262

Larance, B.,Degenhardt, L., Lintzeris,N.,Winstock,A.,&Mattick, R. 2011. "Definitions
related to the use of pharmaceutical opioids: Extra medical use, diversion, non-
adherence and aberrant medication-related behaviors." *Drug and Alcohol Review,*
30(3), 236–245.

Lamont, M. & Fournier, M. 1992. "Introduction." Pp 1-17 in *Cultivating Differences:
Symbolic Boundaries and the Making of Inequality*, edited by Michele Lamont
and Marcel Fournier. Chicago, IL: University of Chicago Press

Laing, R. 1971. *The Politics of the Family and Other Essays*. Routledge.

Loseke, D. 2007. "The study of identity as cultural, institutional, organizational, and
personal narratives: theoretical and empirical integrations." *The Sociological
Quarterly.* 48 661- 688.

Loseke, D. 2012. "The empirical analysis of formula stories." Pps. 251-71 in *Varieties
of Narrative Analysis* edited by James A. Holstein and Jaber F. Gubrium.   Los
Angeles, CA: Sage Publications.

Manchikanti, L. 2007. "National drug control policy and prescription drug abuse:
Facts and fallacies." *Pain Physician*, 10(3), 399–424.

Manchikanti, L., & Singh, A. 2008. Therapeutic opioids: A ten-year perspective on
the complexities and complications of the escalating use, abuse, and nonmedical
use of opioids. *Pain Physician*, 11(2 Suppl), S63–S88.

Martin, E. 1987. The Women in the Body: A Cultural Analysis of Reproduction.
Beacon Press, Boston.

Mechanic, D. 1995. "Sociological dimensions of illness behavior." *Social Science and Medicine* 41: 1207-1216.

Mishler, E. 1995. "Models of Narrative Analysis: A Typology." *Journal of Narrative and Life History* 5:87-123.

Murphy, J. & Clark, M. 2012. "Prescription opioid abuse in the military." *Clinical Theory, Research, and Practice 4 (269-274)*

National Institute of Drug Abuse. 2000. The Science of Drug Addiction. http://www.drugabuse.gov/about-nida/directors-page

Neuman, W., L. 2006. Social Science Research: Qualitative and Qualitative Approaches. Pearson Education. Boston.

Oakely, A. 1984. The Captured Womb: A History of the Medical Care of Pregnant Women. Basil, Blackwell Inc., New York.

Oliver, M. & Barnes, C. 2012. *The new politics of disablement.* London: Macmillan Education.

ONDCP. 2011. Epidemic: Responding to America's Prescription Drug Abuse Crisis.

Parsons, Talcott. 1951. The Social System. New York: Free Press.

Richardson, L. 1990. "Narrative and Sociology." *Journal of Contemporary Ethnography* 19:116-35

Rodin, M. 1992. "The social construction of premenstrual syndrome. *Social Science and Medicine."* 35(1), 49-56.

Roy, A. & Miller, M. 2010. "Parity and the medicalization of addiction treatment. *Journal of Psychoactive Drugs."* 42 (2): 115-20

Roy, A. & Miller, M. 2012. "The medicalization of addiction treatment professionals. *Journal of Psychoactive Drugs*." 44(2) 107-118

Schneider, A. & Ingram, H. 1993. "Social construction of target populations: implications for politics and policy." *The American Political Science Review.* 87(2) 334-347

Scott, W. 1990. "PTSD in DSM-III: A case in the politics of diagnosis and disease. *Social Problems."* 37: 294-310.

Shakespeare, T. (2014). *Disability rights and wrongs revisited* (Second ed.). New York, New York: Routledge.

Singer, J. 2004. "Narrative Identity and Meaning Making across the Adult Lifespan: An Introduction." *Journal of Personality* 72:437-60

Somers, M. 1994. "The Narrative Constitution of Identity: A Relational and Network Approach." *Theory & Society* 23:605-49

Stone, Deborah. 1997. Policy Paradox: The Art of Political Decision Making. New York: W.W. Norton.

Valverde, M. 1998. Diseases of the Will: Alcohol and the Dilemmas of Freedom. Cambridge, England: Cambridge University Press.

Veatch, R. M. 1973. The medical model: Its nature & problems. *Hastings Center Studies*, 59-76.

West, C., & Zimmerman, D. H. 1987. Doing gender. *Gender & society*, *1*(2), 125-151.

Zola, Irving. 1972. "Medicine as an institution of social control." *Sociological Review* 20: 487-504.