

The Social Construction of Addiction and Sexual Deviancy:
A Comparative Analysis of the Experts in Policy Debate

Hailie Rose O'Brien

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Department of Criminology
Faculty of Social Sciences
University of Ottawa

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Abstract

Sexual deviancy and addiction are two concepts that have undergone considerable development in the way in which they are constructed. Since the 1800s both concepts have come to the attention of the medical field, psychological field and the criminal justice system which have made numerous attempts to regulate and treat them within these realms. By using the lens of social construction and Spector and Kitsuse's theory of social problems, this project explores how experts describe sexual deviancy and addiction. Important considerations involving the significance of victims and a victim status emerge from the analysis, as the differentiating factors between demands for treatment for addiction, while sexual deviancy experiences an increasingly punitive regime.

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Introduction

My interest in sexual offenders began during my undergraduate studies in a criminology class titled Psychological Explanations of Criminal and Deviant Behaviour. The assignment for this course was to write a research paper based on one of the videos we watched in class. I chose to write my paper on sexual offenders and gained more knowledge of the topic including the different explanations of the causes and how it is treated (Terry, 2006). My curiosity grew when I realized that we did not know much about sexual offending from the point of view of the offenders. Therefore, my original idea for a project was to interview sexual offenders about their views of themselves and what they felt would be the best way to help them. However, due to the obstacles I would face as a student, in the form of gaining access to participants and getting ethics approval, it was advised to not pursue this type of project at this level. It was suggested to me that it would be easier to have access to the therapeutic professionals who work with those with sexual deviancies, which provided the inspiration for this project.

During my final year in my undergraduate degree, I was placed in a practicum, which led to employment, working with male inmates who were participating in an intensive addiction program within the prison. While I was facilitating treatment groups, using the cycle of addiction and relapse prevention method which was developed for the treatment for addiction, but has since been implanted for sexual deviancy treatment (Polaschek, 2003), I started to draw connections to the similarities between addiction and sexual deviancy concerning how they were treated. These similarities included the use of cognitive behavioural therapy aimed at addressing the risk of relapsing into destructive behaviours (Polaschek, 2003). Many of the residents in the program would describe their triggers, or high-risk situations, to be feelings of stress or depression, being around people who were bad

influences, or feeling isolated. These were all high-risk situations associated with sexual offenders as well.

When I began to consider the similarities, I also started to notice some significant differences, particularly in the way addiction and sexual deviancy is regulated. I started to consider, why are they regulated so differently if they are treated with the same intervention? For instance, despite those with addiction often becoming habitual offenders (Pratt, 1997), there is no demand by the public for stricter punishments for them such as those found in the dangerous offender legislation used for sexual offenders (Petrunik, 2002). The harm reduction model aimed to reduce the societal and personal harms caused by addiction is not extended to address sexual deviancy.

The discrepancy between treatment and regulation for these two concepts made me wonder if their treatment providers had any opinions as to the effectiveness of both treatment and regulation of sexual deviancy and addiction. This project was initiated in order to explore how therapeutic experts discuss addiction and sexual deviancy in regards to treatment and regulation and throughout the process, it was developed further to encompass all experts and more topics such as consequences and harms.

Originally this project was aimed at only exploring the view of therapeutic experts; however, it was expanded due to constraints with data collection and to add depth to the analysis and comparison. The goal of the project was to explore the descriptions and perspectives of experts from various backgrounds as they discuss sexual deviancy and addiction. The main assumption guiding this project is that the way in which people (the public, political officials, and experts) discuss the concepts will have an influence on the way they are regulated. This project is conducted through the lens of social construction and

answers the following question: How do therapeutic professionals (as experts) describe the concepts of addiction and sexual deviancy when submitting evidence to parliament for policy changes, and how do these descriptions compare to each other, and other experts who submitted testimony?

To situate the project contextually, the historical background of each concept is exposed to demonstrate the changing views and explanations of both sexual deviancy and addiction throughout time. In this first chapter, sexual deviancy and addiction are explored as concepts from their introduction as a problem to their current understanding. This chapter examines how context and societal values can change and influence the way in which social problems are described and regulated.

The second chapter explores the theory of social construction and the social construction of social problems, which is the theoretical framework that guided this entire project. Spector and Kitsuse (2001) discuss the idea that social problems are in fact part of a process in which there are many key players. These key roles include claim-makers, the audience, and experts. The claim-makers are a group of individuals who have identified what they believe to be a problem and they begin to campaign to bring awareness to this issue (Spector and Kitsuse, 2001). These claims-makers are trying to convince their audience, which could be the public or the government agency they believe should provide a solution to the problem. The experts are professionals and scientists who the claims-makers mobilize to legitimize their claim. These experts provide their opinion and support the claims-makers in their campaign (Spector and Kitsuse, 2001). These experts are the focus of this project.

To answer the question above, it was more effective to take an approach that allowed the participants to give their own meanings to the concepts being explored and a

constructivist framework enabled that to be possible. By focusing on how the witnesses define the concepts in their own words through their testimony, it allows for a much deeper understanding of their views. In the social construction of social problems theory, the experts have a great deal of power. They essentially add credibility to the claim that the claim-makers are trying to make and are seemingly believed above anyone else. This makes it very important to consider the opinions of experts and explore the differences and similarities in their views compared to other experts, both in and outside of their field. This project aims to explore and compare expert opinions using two controversial concepts: addiction and sexual deviancy.

The third chapter explains that the method chosen for this project is a qualitative content analysis which focuses on the themes that emerged from the literature review as well as themes that became evident during the analysis, demonstrating both a deductive and inductive approach. The data was collected from transcripts of parliamentary and senate committee meetings that were publicly available online and focused on policies pertaining to addiction and sexual deviancy. This was followed by a detailed analysis, which is organized and presented in its own chapter.

The research question above is broken down into three parts and discussed and answered in detail in chapter five. These three parts are: 1) how treatment providers discuss sexual deviancy and addiction, 2) how these descriptions by treatment providers compare to one another and 3) how other experts describe sexual deviancy and addiction. This provides a foundation for work to be carried out in future research as well as presents new questions to be explored. The limitations of this study and the implications for future research are discussed in the conclusion of this project.

Chapter 1
Literature Review

1.1 INTRODUCTION

This chapter begins the exploration of addiction and sexual deviancy from the perspective of social construction and introduces this as a specific lens to explore these topics. To begin, there is a brief overview of social construction and how it applies to this project as a framework. The chapter then delves into the historical development and background of addiction and sexual deviancy to provide context as well as to demonstrate the evolution of the concepts.

1.2 SOCIAL CONSTRUCTION

Social construction is a theory under the broad umbrella of relativism, which states that there is not one truth but that truth is based on culture and context (Faulkner, 2004). Relativism is about understanding a concept or phenomenon not necessarily about the explanation of the concept. More specifically to this project, social construction refers to the idea that “knowledge arises from processes more related to ideology, interests, or power” rather than objectivity (Alvesson & Skoldberg, 2009, p.25). This is contrary to the positivist claims that knowledge is developed from objective observation of data (Alvesson & Skoldberg, 2009).

The main premise of social construction is that people understand their world within the context of their society and that knowledge is ideological, political and laden with values. Therefore the individual’s constructed meanings are based on the dominant values in their society, or their own personal values (Denzin& Lincoln, 2000). This relates to Burr’s (2003) view of social construction which challenges the belief that we have an unbiased view of the world. Therefore, in order to take a social construction point of view, one must

be able to challenge not only the accepted knowledge of the field they are studying but also their own socially constructed understandings.

Spector and Kitsuse (2001) discuss social construction to describe how social problems arise in society. This involves what they call a “claims-maker” who begins bringing attention to an issue they consider to be a problem. Through media and lobbying this issue is constructed as a problem that must be addressed in a given society and therefore becomes a ‘social problem’ (Spector & Kitsuse, 2001). These claim makers can be concerned citizens, religious groups, professionals in the field, the media itself, or anyone else the problem affects. Following extensive lobbying and attention, individuals within the society become aware of the issue if they were not aware before. Soon members of the society or the government agencies begin to believe that this is an important issue to address and thus they become involved with the lobbying or begin to provide strategies to fix the problem. Spector and Kitsuse (2001) state that at some point the ideas dominant in our society become so ingrained in the people who live in it, that many people will suggest the same list when asked what the social problems of today are.

Social constructionism allows one to challenge the knowledge on a particular topic and question the beliefs and assumptions that are dominant in a society. Social construction is not meant to explain the origins of phenomena, but simply to understand or explore the meanings phenomena. This chapter continues by examining the historical development of addiction and sexual deviancy which demonstrates the constantly changing definitions and understanding of these concepts. It becomes clear that the dominating experts on these concepts come from the clinical and therapeutic perspectives; this includes both researchers and practitioners. As two concepts that are defined by the criminal justice system and the

public health system, there are comparable conflicts on how best to deal with those who display these undesirable behaviours.

1.3 WHAT IS ADDICTION?

There are a plethora of definitions of addiction available, but for operational reasons, only the main elements of most definitions (loss of control and consequences) are discussed in this section. There is a blurry distinction between when a person is no longer considered a recreational user, but someone with an addiction to a particular substance. Addiction is a more pathological condition in which the person is viewed to have lost control over their behaviours (Peele, 1985; Valverde, 1998). In fact, loss of control is close to universal in all explanations of addiction (Peele, 1985; Valverde, 1998; Denzin, 1993; Vaillant, 1995). Addiction also causes adverse consequences such as contact with the criminal justice system, problems with relationships, problems at work (or school) and a preoccupation with obtaining more of the substance (Peele, 1985).

Peele (1985) goes on to explain that those who have an addiction are also expected to display the cycle of addiction, which includes cravings and withdrawal. On the contrary, someone who displays simple drug use would be able to function well without any of the substance in his/her body. For instance, a drug user would go to parties on weekends and only use their drug of choice (alcohol, heroin, cocaine, marijuana etc.) on Friday and Saturday nights, while maintaining healthy relationships, performing well at school and/or work, and appearing to be a healthy functioning individual in society. Those who are addicts would use at every opportunity and when they felt deprived would display withdrawal symptoms, which could include tremors, sweats, and irritability. In addition, they would

sacrifice healthy relationships and good work and school performance in order to maintain their addiction (Peele, 1985). The use of perceived consequences as definitional criteria of addiction is one factor that may explain why addiction has been deemed a social problem; this is particularly true in the case of criminal activity as a consequence as it affects others in society.

For the purpose of this project, addiction is only focused on psychoactive substances, particularly drugs and alcohol, and does not include food, sex, gambling etc. The concept of addiction in terms of this project is understood using the Cycle of Addiction which is currently the most widely accepted model among professionals (Peele, 1985).

1.4 HISTORICAL BACKGROUND OF THE CONCEPT OF ADDICTION

1.4.1 *Nineteenth Century-Post World War I*

The term addiction is typically considered to have emerged in the early 1900s post-World War I (Peele, 1985). However, there is evidence that although the term addiction was not used until about 1920, the study, diagnosis, and treatment of substance-related behaviours can be traced back to the early 19th century. This is particularly clear in the historical examination of alcoholism (Peele, 1985; Valverde, 1998; London, 2005).

During the 19th century, asylums housed individuals with three main diagnoses: mania, melancholy, and dementia. Researchers in Paris were particularly interested in the grey area between sanity and insanity, which was termed monomania; this is how the present day alcoholic would have been defined. Monomania was considered a partial insanity and was divided into three different categories: monomania of the intellect, monomania of the emotions and monomania of the will; alcoholism would fall into the latter category

(Valverde, 1998, p.45). Although the term was not the same, French researchers tried to explain alcoholism in much the same way as researchers do now. Esquirol, a French psychiatrist, stated that some drinkers have a pre-existing condition that makes them drink uncontrollably, which is both physical and moral (Valverde, 1998, p.46; Kielhorn, 1996, p.122).

While the term “drink monomania” (Valverde, 1998, p.48) was used in France, English speaking individuals used the term dipsomania, which was coined in 1819 by a German physician (Valverde, 1998, p.48). At this time, the medical profession was attempting to validate itself and set itself apart from the medieval treatments in favour of more scientific methods. The best way in which to do this at the time was to create the idea of diseases that could be treated using scientific methods (Foxcroft, 2007, p.80; London, 2005, p.98). However, treating alcoholics as if they were insane in the 19th century under the term dipsomania failed due to the fact that the men displaying these behaviours were from the upper-class (Foxcroft, 2007). Often these men were in a higher class than the treating physicians, therefore treatment would have been considered inappropriate or improper (Valverde, 1998, p.49).

The term inebriety was used by the British starting near the end of the 19th century and this term encompassed many substances such as opium, alcohol, and morphine. Due to the focus on excessive drinking as a problem, tobacco and morphine use were being problematized in the 1880s as a comparison (Foxcroft, 2007; Valverde, 1998, p.50). The use of the term inebriate was short-lived in research as the term alcoholism, describing a pre-existing condition, came to replace it. By the end of the 19th century, the term inebriate was only used as a polite way to describe a drunkard, rather than a scientific term to be studied;

this did not, however, stop the term inebriate from appearing in the legislation of this time (Valverde, 1998).

The British Habitual Inebriates Act of 1879 and 1898 were created in order to help control those with addiction problems. These acts and the committees used to create them equated those with addiction with the insane and claimed that, like the insane, the addicts needed to be committed to places where they could be treated (Foxcroft, 2007, p.123). Neither of these acts required medical testimony in order to have someone committed under the act (Valverde, 1998, p78). The act of 1879 only dealt with the middle and upper-class members of society who were not truly committed as it was completely voluntary (London, 2005, p.101). They were also kept in privately owned “retreats” for varying amounts of time; however, the ability to go to the centres was restricted by the ability of one to pay (London, 2005, p.101). These people were usually convinced to go by their families (Valverde, 1998, p.78), and the treatment was largely based on teaching the individual “acceptable social values and behaviours” (London, 2005, p.101).

In 1898 the new act extended to target two new groups of people. The first was the recidivists of drunken related offences who were considered the new barbarians of the time (Valverde, 1998). These people were viewed to be a menace and therefore deserved no right under due process. If they were charged with drunkenness offences four times in one year, they were sentenced to three years in an inebriate reformatory instead of the short jail sentence they would have normally received for their crime (London, 2005, p.101; Valverde, 1998, p.85).

The second group that the act of 1898 introduced were those charged with an indictable offence. These people could have been committed to an inebriate reformatory

either in addition or instead of a jail sentence (London, 2005, p.101; Valverde, 1998, p.85). The habitual drunkard stipulation required no medical testimony for either of these groups, but simply a statement that the person was a habitual drunkard and to convince the jury of such. The majority of these individuals were mothers convicted of child neglect. In 1906, which was the peak of the enforcement of the particular act, 80 percent of the 364 people who had been committed under section 1 (the latter group discussed) were mothers charged with neglect (London, 2005, p.101; Valverde, 1998).

The initial part of the act contradicted the definition that habitual drunkards were incapable of managing themselves as it required the person to go before two Justices of the Peace to voluntarily commit themselves to a retreat; an act that someone who is incapable of managing themselves would not be able to do. This not only implied that alcoholism can only be treated if the person wants to be treated, but it also went against the idea that it was a disease as the act implied that a Justice of the Peace (or jury in the later act) was able to diagnose habitual drunkenness (Valverde, 1998). This demonstrates a disconnect between research and the resulting legislation; however, sometimes when legislation follows research, no matter how unbiased, it can have detrimental consequences as seen in the example of Charles Darwin and evolution.

In the 1880s the influence of Charles Darwin and his ideas about evolution led to the degeneration research movement claiming that evolution was not guaranteed and that there was a possibility for evolutionary throwbacks. This new movement led to research on the heritability of alcoholism in Britain. The majority of researchers in the early 20th century focused on both the male and female contribution to alcoholism in offspring (Valverde, 1998, p.53; Kielhorn, 1996, p.126). This was not the case in Britain as they tended to focus

on and blame the mothers (Foxcroft, 2007, p.136; Valverde, 1998, p.53). The focus on women as responsible for maintaining a healthy human race due to their ability to bear children was likely the cause for this emphasis on only the female in studies examining the genetics of alcoholism (Foxcroft, 2007). Doctor Mary Gordon was a physician in Britain in the early 20th century who followed in the footsteps of her mentor Dr. Braithwaite and began to suggest that alcoholism in women was not due to bad choices but rather due to feeble-mindedness. This research resulted in women being committed to asylums under the Mental Deficiency Act of 1913 rather than the Inebriate Act (Valverde, 1998, p.58). Women at this time were not given the same rights of free-will as their male counterparts and were often described as hysterical, even by their husbands who were also abusing alcohol or opium (Foxcroft, 2007, p.136).

Not all researchers followed the belief that alcoholism was inherited, as there was heated debate about the genetic component of alcoholism in the *British Journal of Inebriety* from 1903-1905. In addition, a book written by Dr. William Sullivan questioned whether alcoholism was a real phenomenon and considered that the excessive drinking among the lower class was actually due to outside factors (Valverde, 1998). Despite this debate, by the end of the First World War, the term alcoholism completely replaced inebriety in both research and legislation (Valverde, 1998), and the medical community took over the governance of addiction under the idea that it was a disease, influenced by genetic factors (Peele, 1985, p.5).

1.4.2 Post World War I

Following the First World War, research and theories attempting to explain and treat addiction began to develop under four main categories: (1) biological-genetic, (2) moral and spiritual, (3) psychological, and (4) cultural and sociological (Denzin, 1993).

1.4.2.1 Biological-genetic Model

As discussed above, the biological-genetic model was started in the 19th century as it applied to alcohol when alcoholism was first considered an inherited disease (Foxcroft, 2007; Valverde, 1998; Peele, 1985). Although research in genetics and addiction still exists, it is difficult to decipher whether it is the genetics or the environment that cause addiction to run in families. Denzin (1993, p.21) discusses that genetics may have a small role in addiction, but that it is part of a broader context that includes family, religious beliefs, work environment, and other situational factors.

The majority of research on addiction from a biological standpoint now typically assesses the patterns of brain activity associated with addiction and the impact of certain drugs on this activity (Lee & Dong, 2011; Rothwell, Kourrich, & Thomas, 2011; Sidhpura & Parsons, 2011; Marks et al., 2010; Wedekind et al., 2010). The dopamine reward system in the brain is the main function discussed when researching addiction. For the most part, it is believed that the dopamine reward system is the function that creates addiction regardless of the addictive behaviour (Hyman, 2007; Kuhn et al., 2010; Lane et al., 2010). The need to feed the dopamine reward system is suggested as the cause leading one to seek out drugs that could potentially cause harm in other ways. The feeling of euphoria outweighs the potential negative consequences of the drug that is ingested, smoked, inhaled or injected.

Another prominent theory that is found under the medical model is the disease model. Beginning in the late 19th century, opiates were removed from the lists that allowed them to be used for medical purposes, and then the use of opium was labelled as a social problem and finally blamed for producing a syndrome. By the beginning of the 20th century the term addiction no longer referred to a habit or vice, but rather a disease (Peele, 1985, p.5).

Vaillant (1995, p.178) argues that alcoholism is a disease because it has a natural history. A natural history “implies a biological condition with a tendency, once established, toward an inexorable progression of symptoms” and that “environmental factors and an individual’s characteristics only determine the pace of the progression” (Vaillant, 1995, p.178). Using the example of hypertension, Vaillant (1995, p.19) argues that many widely accepted diseases are influenced by societal factors. Hypertension is becoming more prominent in young urban black males. Hypertension is also on a continuum and can vary depending on the measurements being taken. Many arguments against alcoholism being a disease include the notion that alcoholism is affected by outside factors like psychological and situational; the alcoholism is merely a by-product of something else. The same could be argued for hypertension; when one changes their salt and caloric intake, thus exerting willpower, their hypertension will disappear (Vaillant, 1995, p.19). Vaillant (1995) states that “there is no other so-called disease in which etiology and cure are more profoundly dependent upon social, economic, and cultural variables” (p.17) than alcoholism, but this does not discount it as being a disease. He simply states that “alcoholism is a construct of higher order of complexity than, say, pregnancy or the measles” (Vaillant, 1995, p.376).

Those who are against the disease model believe that accepting alcoholism and other substance addictions as a disease creates numerous problems, such as not addressing the underlying causes including poverty and mental illness that contribute to addiction (Vaillant, 1995, p.17). In addition, it could cause stigma for the individual labelled as an addict and relieves the responsibility of the individual. However, Vaillant (1995) argues that being labelled with a disease brings hope and morale instead of being told they are weak or wicked; this allows for an increased ability to change. Vaillant (1995) states “there is a difference between diagnosis and name-calling” (p.21). Therefore, Vaillant (1995, p.21) suggests that considering alcoholism as a disease may be practically useful for those who need access to the healthcare system; however, scientifically it is more appropriate to consider it a behaviour disorder, implying a distinction between the two.

Medically speaking, the Diagnostic Statistical Manual does not provide a clear definition of addiction as it lists non-medical criteria such as legal problems, relationship problems etc. (Valverde, 1998, p.27). There is no internal mechanism, either absent or damaged, that distinguishes alcoholics from non-alcoholics (Peele, 1985, p.18), which makes a medical distinction between the normal and problematic drinkers completely subjective (Valverde, 1998, p.27). Treatment from the medical field is basically limited to the use of disulfiram, also referred to as Antabuse, which causes negative effects if alcohol is ingested (Vaillant, 1995, p.10). Although research in the 1960s emerged that suggested that abstinence (the primary goal of medical treatment of addiction) was not necessarily the only treatment goal, as some alcoholics could return to controlled and asymptomatic use, not all alcoholics could reach this point. Vaillant (1995) suggests that although it may be possible theoretically, practically it may be more effective to make abstinence the goal.

Vaillant (1995) states that “if we can combine the best placebo effects of acupuncture, Lourdes, or Christian Science with the best attitude change inherent in the evangelical conversion experience, we may be on our way to an effective alcoholism program” (p.354). Alternatively, the medical field, or psy discourse and treatment, has little effect on the treatment of alcoholism and other addictions as treatment studies do not show significantly different results from the natural history. However, the important factors that lead to recovery are relief from symptoms and empowering the individual to believe they can heal by changing their belief system to break their habit (Vaillant, 1995, p.354). Although foreign to the medical treatment model this treatment method has been put into use in the moral and spiritual model.

1.4.2.2 Moral/Spiritual Model

The most prominent model under the spiritual and moral explanations is that used by the popular group Alcoholics Anonymous (AA) that was developed by a group of religious alcoholics looking for a way to help one another become sober (Valverde, 1998; Kurtz, 1979). First developed for alcoholics only, AA has expanded to include addiction to many different substances and created related groups such as Narcotics Anonymous (NA), Marijuana Anonymous (MA) and Cocaine Anonymous (CA).

AA involves people who self-identify as alcoholics to gather together in meetings to discuss their problems and provide support to one another in an environment that provides relative confidentiality (Peele, 1985, p.41; Kurtz, 1979). These meetings are based on the Protestant revival meetings in which “the sinner seeks salvation through personal testimony, public contrition, and submission to a higher power” (Peele, 1985, p.31). AA groups promote abstinence and despite evidence to the contrary, members believe that drinking (or

using) again could affect their ability to control themselves; this belief is rooted in the emotional ties to religion and being a sinner (Peele, 1985, p.31).

The AA model describes alcoholism (and other addictions to substances) as a disease; however, it is not the same as how the biological model uses the term (Kurtz, 1979, p.123). AA's use of the term 'disease' focuses on the whole person and not just the physical. For example "AA defines the alcoholic as a sick person, suffering from obsession, a fatal malady, a progressive illness that is physical, mental, spiritual, emotional and self-destructive" (Denzin, 1993, p.53). AA promotes the idea that one does not have will on their own over their behaviours (London, 2005, p.100). In fact, the first step is to admit one is powerless over alcohol, cocaine, narcotics, etc. (Valverde, 1998). Therefore, the use of the term disease allows the members to understand that they need to follow the rest of the steps and accept AA's principles if they are going to be able to maintain their sobriety.

The second step of AA is to "believe that a Higher Power greater than ourselves could restore us to sanity" (Valverde, 1998, p.206). This higher power can exist in many forms depending on the individual and is often referred to as 'God as I understand him' or as 'my Higher Power' by individuals in AA meetings. Depending on prayer for knowledge and strength to this Higher Power, AA members work towards the twelfth step that involves a spiritual awakening and a will to spread this knowledge and help other alcoholics that are in need (Valverde, 1998, p.133).

For the most part, the onus is on the addict to do the work for their treatment as treatment among AA members, and those in treatment facilities that follow the AA program, consists of participating in groups and working on their 12 steps (Terry, 1998; Denzin, 1993; Kurtz, 1979). Although science has challenged many of AA's causation theories, such as

that the real alcoholic has an allergy to alcohol, the practical theory and treatment provided by the AA model remains one of the most effective ways to help someone with alcohol addiction (Denzin, 1993, p.61). However, Valverde (1998, p.133) discusses that this effectiveness for treatment is only found in those who are considered believers and will not work for those unable to accept the faith aspect of AA and submit to a higher power. For these individuals, it may be necessary to seek treatment in a different form, such as being assisted by a psychologist or a therapist.

1.4.2.3 Psychological Model

Psychological explanations of addiction aim to explain one's susceptibility or reasoning for abusing a substance through their personality traits. The two main paradigms in the psychological field that help explain addiction are behaviourism and psychoanalysis.

Theories to emerge under the behaviourist paradigm include the tension reduction theory and learning theory (Denzin, 1993). Tension reduction theory or anxiety reduction theory describes the use of alcohol or drugs as a reaction to anxious feelings, caused by job stress, loss in the family, etc. (Peele, 1985, p.99; Denzin, 1993, p.23). Alcohol or drugs become a conditioned response for dealing with stress that exists in the person's life. Peele (1985) finds this theory straightforward in explaining the use of pain relievers such as heroin, oxycodone, and morphine as they help to relax an anxious person by suppressing the nervous system. However, when it comes to alcohol or stimulant drugs, this theory demonstrates the power that the mind can have over how an individual feels, as they do not have the physiological effects of depressing the central nervous system. Although the physiological effects are stimulating the nervous system, the user perceives the effects to be a relaxing one that relieves their tension and anxiety (Peele, 1985, p.99). In this case, the

perceived effect is contradictory to what is happening inside the body biologically, however, the psychological feelings of relaxation outweigh the actual nature of the substance.

Learning theory describes alcoholism and addiction as a learned behaviour revolving around positive and negative effects. When one derives pleasure from consuming a substance they will continue to consume the substance to reach the desired effect (Denzin, 1993). In using this theory, Individualized Behaviour Therapy was applied to reduce the drinking of alcoholics by administering electric shocks. The goal was to get their drinking down to a controlled level without the experience of withdrawal. Although considered a success, the study participants were still drinking at a higher level than would be advisable even though they had reduced their intake to their intended goal (Denzin, 1993, p.25).

Psychoanalytic theories are theories that focus on childhood experiences to explain adult behaviour (Denzin, 1993, p.40). In addition, psychoanalytical theories also include a degree of sexuality-related themes that shape an individual. Psychoanalytic theories focus on the motivation of behaviour which is considered to be based on the personality of an individual (Denzin, 1993, p.40). One example of a psychoanalytic theory used by Denzin (1993, p.40) is the power theory which is concentrated on the males who abuse substances. The power theory states that males who need personal power drink alcohol, which helps them express aggression, thrill seeking and antisocial activities (Denzin, 1993, p.41). Drinking is a way in which these men feel stronger and therefore fulfills their desire for personal dominance over others.

Overall, psychological theories focus on the individual person and how they become addicted to a substance rather than focus on what the substance has that makes it addictive. Whether addiction is a way to cope with one's feelings of loneliness, anxiety, a need to exert

power and control or a way to cope with stress, the treatment for addiction in the psychological model is for the individual to overcome the factors that contribute to their drinking. This treatment could include psychotherapy for their anxiety or relaxation techniques to help cope with stress more effectively.

1.4.2.4 *Sociological*

Peele (1985, p.104-106) describes three main categories that sociologists would be concerned with when explaining addiction. These include: (1) social class, (2) peer and parental influence, and (3) culture and ethnicity. All of the sociological factors that are considered to contribute to addiction are originally external to the individual but can become internalized, thus leading to addiction.

Lower social economic status is a consistent predictor of higher levels of addiction, as well as other health problems such as obesity (Peele, 1985, p.104). However, lower social economic status is also a predictor of abstinence from alcohol, so both extremes are found in the lower social economic status. Even Vaillant (1995, p.131), while denying the social factors of alcoholism and focusing on the disease argument, admitted that those in his lower social economic status category were three times more likely to be alcoholics than the compared college sample (Peele, 1985). Social economic status does not help explain the initiation to alcohol and drugs, but merely shows trends in patterns of use.

The context in which drinking takes place was found to be a better predictor of drinking problems than one's social economic status, mainly referring to parents and peers as models. Peers were found to have a profound impact on the initiation of marijuana use in adolescents, but very little influence on drinking and other drug use (Peele, 1985). Peele (1985) states the latter was most influenced by the closeness of parent-child relationships but

he was not clear if a close relationship would reduce or increase chances of abusing other illicit drugs. The attitudes and values of parents and peers are considered a very important factor in shaping how an individual uses alcohol and other drugs (Peele, 1985).

Cultural attitudes towards drinking and drug use have a significant effect on how an individual understands alcohol and drug use in their own life. Cultures that demonstrate comfort and social regulation with alcohol experience decreased frequency of addiction when the appropriate time and place for alcohol consumption is clear (Peele, 1985).

However, societies in which alcohol is viewed as a mood alternating substance and as a danger that is hard to control, abuse rates are much higher. Differences in ethnic groups are attributed to the cultural values the society holds; for example, low rates of Chinese and Japanese people abusing alcohol is attributed to the value put on achievement, which conflicts with excessive intoxication (Peele, 1985).

Denzin (1993, P.42) discusses a specific theory called the Time-out theory that describes how one's culture can influence the relationship an individual has with alcohol and experiences of drunkenness. The theory describes the behaviour exhibited while intoxicated as a learned behaviour based on societal expectations. This means that individuals from different cultures will exhibit different behaviours while under the influence of alcohol (Denzin, 1993). Although this theory is not an explanation of alcoholism and addiction in itself, it does present a foundation for understanding why alcoholism is manifested differently between cultures or ethnic groups.

The historical development of the concept of addiction illustrated above demonstrates how addiction can be understood in many different ways and from many different points of view. The way in which addiction is understood has implications for the

way it is treated as well. For example, those who understand it from a medical point of view will also treat it from a medical point of view. This makes it important to understand how different experts explain and understand concepts as it has an influence on treatment and regulation. This project is aimed to explore the descriptions of addiction by experts and compare that to the concept of sexual deviancy. Sexual deviancy is explored in the next section, in which the relationship between explanation and treatment and regulation becomes even clearer.

1.5 WHAT IS SEXUAL DEVIANCY?

The terms ‘sexual deviancy’ and ‘sexual offending’ are not interchangeable, however, they have some overlap. Feelgood and Hoyer (2008) discuss this issue using the example of ‘child molester’ and ‘pedophile’ and describe the difference between a sociolegal definition and a psychopathological definition which will be used to guide an explanation of the differences between ‘sexual offending’ and ‘sexual deviancy.’

The terms ‘sexual offending’ and ‘child molester’ are sociolegal definitions, which means the understanding of these definitions come from legal sources and change across time and place (Feelgood and Hoyer, 2008). The acceptability of the act and specific definitions such as what constitutes a child, and what constitutes consent are derived from the law. For example, in Canada until 1983 it was not considered ‘rape’ when a husband forced himself on his wife (Johnson & Dawson, 2011). The legal definition of ‘rape’ at the time did not include the forced sexual act on a married woman by her husband because it did not violate the term of consent at the time.

‘Sexual deviancy’ and ‘pedophile’ are both psychopathological definitions, which means they refer to an individual’s sexual preference or interest regardless of the legality or whether the person has acted on these urges (Feelgood and Hoyer, 2008). A psychopathological label is a diagnosis that implies a degree of dysfunction in the individual. In order to obtain a diagnosis, one must display certain symptoms that fit into a criterion for the diagnosis. These symptoms distinguish the mentally disordered individual from those who are not mentally disordered (Feelgood and Hoyer, 2008).

‘Sexual deviancy’ and ‘sexual offending’ or psychopathological and sociolegal definitions can overlap. This means that someone who falls under the ‘sexual deviancy’ label with diagnosed pedophilia by a mental health professional may also have acted on his urges and therefore also is classified as a ‘sexual offender’ under the sociolegal definition. However, although it is possible to have both labels, it is also possible to only have one or the other. For example, someone who participates in sexual activity with a child, which defined under Canadian law is under the age of 16 years old, may not have a sexual preference for children but simply saw a vulnerable individual and took advantage; these individuals are considered opportunistic offenders and although they are sexual offenders they do not satisfy the criteria for a psychopathological diagnosis and therefore are not considered sexual deviants. The opposite can also be present in the case of an individual who has a sexual preference for children, but has not acted on these urges; they would be considered a ‘pedophile’ or ‘sexual deviant’, but not a ‘sexual offender.’

To further explain the distinction, consider a ‘sexual deviancy’ that is not illegal under the legal definitions in Canada. For example, partialism, or having a sexual interest in and being sexually aroused by a specific part of the body such as feet, is a diagnosis in the

DSM-IV-R so it would classify as a 'sexual deviancy.' However, the act of using a person's feet as a source of sexual arousal (as long as they are consenting adults) does not qualify one to be a sexual offender as it is not illegal under the Criminal Code of Canada. In essence, to be considered a 'sexual offender' one must only commit an illegal act. However, to be considered a 'sexual deviant' one must have a specific thought pattern or psychological makeup that fit certain criteria in order to be diagnosed with a mental disorder. The focus of the current project is on the latter: those who would be of concern to mental health professionals.

Sexual deviancy for the purposes of this project and through the lens of social construction includes behaviours which at a particular moment in time or in certain cultures have been considered deviant. Due to the fluidity of concepts when studied through social constructionism, this definition includes different behaviours as it encompasses many cultures. The historical background in the following section demonstrates the changing construction of sexual deviancy and how it is constructed through the dominant values in a society.

1.6 HISTORICAL BACKGROUND OF SEXUAL DEVIANCY

1.6.1 Archaic Period- Beginning of the Nineteenth Century

The understanding of what is considered sexually deviant has changed over time and across cultures, this is evident in the example of homosexuality¹. In Ancient Greek times, same-sex relations were very common especially between young boys and adult males. In

¹Although I do not consider homosexuality to be sexually deviant, historically, and even in some current cultures, homosexuality was considered not only illegal but a mental disorder; therefore, it was included in this chapter to illustrate the changing perceptions about deviancy across cultures and time.

fact, this behaviour was not only considered acceptable but was also considered beautiful and was depicted in art, plays, and stories of this time (Terry, 2006, p.20). Roman culture also encouraged sexual relationships with young males, claiming it would aid in the mental development of the children; due to this, the presence of boy brothels was very common. However, while Greeks portrayed relationships with young boys to be beautiful, the Romans often portrayed young males in violent sexual situations (Terry, 2006, p.21). Ancient Egyptians encouraged sex between adults and children in order to prepare them for sexual activity in adulthood. Sexual intercourse was considered taboo, but oral sex on young males was encouraged (Terry, 2006, p.21).

During the Medieval Ages, when the church gained significant influence over citizens, homosexuality became a crime and sex for any other purpose than procreation was a sin (Terry, 2006, p.22; Karras, 2011). Sodomy was a term in the Medieval Ages that referred to acts that were considered unnatural, which included anal intercourse, fellatio, masturbation, bestiality, and intercourse between heterosexual couples that was not in the missionary position; all of these crimes could be punished by death (Terry, 2006, p.22; Freedman, 1982). During the 16th and 17th century it was very common for parents to fondle their prepubertal children until the child reached adolescence at which time it was no longer considered acceptable. In the late Middle Ages, there were offences similar to rape that would have been brought forward to the church courts; these were referred to as knowing a woman carnally or deflowering her against her will (Karras, 2011).

In the 18th century, serious sexual offences were considered to be homosexuality, bestiality, and sexual intercourse with prepubescent children; these offences were brought forth to a criminal court. Masturbation was considered a moral offence and was therefore

brought to the court of the church (Terry, 2006, p.22). Hebrews at this time also considered masturbation to be abhorrent and equated it with premarital sex if done by an unmarried man and adultery if it was done by a married man. Men were encouraged not to touch their penis while urinating as this was thought to lead to masturbation (Terry, 2006, p.22). Although not as prominent or obvious, religion continued to play a key role in certain aspects of what sexual acts were considered appropriate.

1.6.2 *Nineteenth Century- 1930*

During the nineteenth century, Progressive Era researchers began to concentrate on what were considered serious offenders, who were now classified as insane and a medical problem. During the Progressive Era, people had an increased belief in the ability to rehabilitate and cure individuals, which gave the professionals in the psychiatric field a great deal of legitimacy (LaFond & Durham, 1992). In the 1880s researchers like Richard von Krafft-Ebing and Sigmund Freud began to describe sexual deviants as pathological, requiring treatment, and threats to social hygiene (Terry, 2006). Despite this medicalization of sexual deviancy, religious groups, particularly The Women's Christian Temperance Union (WCTU), participated in campaigns to change laws and policies regarding sexual crimes.

In 1889, the WCTU campaigned to have the age of consent law changed from ten years old to 18 years old (Terry, 2006, p.24; Freedman, 1982, p. 209). Women at this time were beginning to leave their home and neighbourhood as more women entered the workforce. The WCTU encouraged new laws to protect women from being seduced or taken advantage of by men (Terry, 2006, p.26). By 1920 they had succeeded in getting some laws changed and in nearly every state the age of consent law was either 16 or 18 years old. Also

during this time, the awareness of child prostitution of boys and girls was at the forefront especially with the spread of the venereal diseases such as syphilis and gonorrhoea (Terry, 2006, p.27).

During the Progressive Era, most of the regulations were focused on rehabilitation and good intentions. People had a strong belief that their government was there to help them and so the use of indeterminate sentences and lack of review boards for the treatment of prisoners was based on this belief in treatment (La Fond & Durham, 1992, p.5). The first time retribution was used to justify incarceration of sex offenders in the United States was between 1910 and 1915 (Terry, 2006, p.27). There were a great number of sex-related child homicides during this time. The police increased control over those who offended in public such as homosexuals but ignored incest offenders. The panic was at its peak in 1937 when sexual psychopath laws began to emerge. However, the panic was momentarily interrupted by World War II (Cole, 2000).

1.6.3 Post World War II- Present

Following World War II, many more models and theories began to emerge to explain sexual deviancy in addition to the already existing models. In addition to explaining sexual deviancy, these models each also provided their own unique treatment options for sexual deviancy.

1.6.3.1 Psychological Model

During the time that psychological theories were dominating the knowledge on sexual deviancy in the 1930s, there were also a few high-profile cases such as Albert Fish, a notorious child rapist, murderer and sexual deviant, giving the public an impression that habitual offenders were on the rise (Terry, 2006, p.28; Cole, 2000, p. 293). In actuality, the

majority of arrests were for consensual acts such as homosexuality and the habitual sexual predator was comparatively rare. Despite this fact, the term “sexual psychopath” was developed in 1937 and many States began to pass their own sexual psychopath legislation (Terry, 2006; Cole, 2000, p.293; Zonana et al, 2003, p.12; Pratt, 1998, p.27). Psychological theories for sexual deviancies use pathologies in the individual to explain their sexual deviancy and include: psychodynamic theories, behavioural theories, cognitive-behavioural theories and developmental theories.

The original psychodynamic theory, which stems from the original psychoanalytic theory developed by Freud, suggested sexual perversions are caused by childhood deprivation, developmental fixation or a regression to earlier stages of sexual development (Terry, 2006, p.38; Pratt, 1998, p.28). He also claimed that as children, boys assume that girls are boys who have been castrated and if they do not overcome this phase they will be pathologically afraid of women. Psychodynamic theories prescribed lengthy psychotherapy as the only way to treat sexual deviancy. Freud claimed this process was very long because the deviant desires were deeply rooted in the individual’s personality (Terry, 2006, p.38).

Behavioural theories claimed that sexual deviancy is a product of a long-term process involving positive rewards that both initiate and perpetuate deviant behaviours (Chan, 2015, p.68; Ward, Laws, & Hudson, 2003). The individual is rewarded with a certain response to a stimulus and therefore continues the behaviour (Terry, 2006, p.45). Behaviourists in the 1950s treated sex offenders by attempting to recondition them so they would no longer respond to deviant sexual stimuli; this included therapies such as aversion therapy, orgasmic reconditioning and shaping (Terry, 2006, p.141).

Soon the thoughts of the individual as well as the behaviour were taken into consideration and thus emerged - cognitive behavioural theories (Petrunik, 2003). The specific cognitions that are of concern in sexual deviancy are the cognitive distortions offenders use to rationalize and legitimize their behaviour and the behaviour of others (Ciardha, 2011, p.495 Ward et al, 2003; Zonana et al, 1999, p.70). These include claiming the victim was seducing them, the victim was not harmed in the act or that they were teaching the child (Terry, 2006, p.141; Ciardha, 2011, p.495; Ward et al, 2003, p.137). The treatment used to address the cognitions aims to change the fantasies and thoughts of the offender in order to treat the cognitive distortions. The limitation with cognitive distortions as an explanation of sexual deviancy is that the theory fails to explain how the cognitions developed in the first place (Ciardha, 2011, p.498).

A developmental approach to explain sexually deviant behaviour is based on attachment and relationships developed in childhood and adolescence. The main premise of attachment theories is that humans have a natural need to form attachments to other humans (particularly primary caregivers) and that the attachments in infancy have an effect on the attachments made in adulthood (Terry, 2006, p.42; Ward et al, 2003, p.248; Chan, 2015). For the purpose of explaining sexual behaviour, the period of adolescence is critical for adult behaviour. By adolescence, an individual should understand how to have healthy attachments to others and the parents should be instilling values about healthy relationships (Chan, 2015, p.66). In addition, by adolescence individuals should know how to control their aggression and sexual urges (Terry, 2006, p.42). If there is an interruption in any of this development it is assumed to be the explanation of sexual deviancies in adulthood as it causes maladaptive attachments or social bonds (Ward et al, 2003; Ciardha, 2011; Chan,

2015). Particularly in those who offend against children, it is thought that sex offenders have problems forming attachments to those of the same age and therefore seek attachments and intimacy with those younger than themselves (Ward et al, 2003, p.248). There is an increasing frustration from not being able to make healthy attachments with age appropriate partners that cause men to turn to children (Terry, 2006, p.43; Ciardha, 2011, p.497).

The rise of the psychological and medical fields, which had a belief that an individual could be cured with treatment, started to change the approach to sentencing of high-risk offenders, with courts increasingly using alternatives to incarceration such as mental institutions, treatment centres and probation (Fox, 1999). The designations of “sexual psychopath” in the 1930s led to the clinical approach to sexual deviance; this was the dominant treatment method from the 1930s to 1950s, specifically targeting these individuals (Cole, 2000, p.294; Pratt, 1998, p.27). This form of control included an involuntary commitment to mental institutions until the psychopath was cured, even though the criteria to have someone committed was subjective and varied from state to state (Terry, 2006, p.28; Petrunik, 2002). Although this was a dominant belief, Cole (2000) states that not all psychiatrists believed that sexual psychopath was a true designation, and it was never added to the Diagnostic Statistical Manual of Mental Disorders. Soon new research on normal and deviant sexual acts, in addition to the Liberal Era, caused a significant shift in beliefs about what is normal and the rights of individuals.

Alfred Kinsey conducted a thorough study of sexual behaviour in order to discover what was normal and what was deviant; he concentrated primarily on homosexuality and masturbation as there seemed to be a consensus that these were deviant behaviours at the time. Kinsey discovered that a high percentage of his participants had engaged in this

behaviour and that maybe they were not deviant after all (Terry, 2006, p.31; Pratt, 1998, p.39). The Liberal Era in the 1960s and 1970s saw a drastic change in what was considered normal sexual behaviour with the women's movement, legalization of abortion and the gay rights movement. This time period also saw a decreased use of the sexual psychopath legislation developed in the 1930s to the point that this legislation became obsolete (Terry, 2006, p.32). During the Liberal Era social scientists also began to question the ability of mental health professionals to diagnose and predict risk in sex offenders. This led to the development of the Justice Model approach to treating sexual deviants (Petrunik, 2002; Cole, 2000).

The term 'sexual psychopath' was considered by social scientists as more of a moral judgement than a diagnosis and research showed limited effectiveness of treatment programs (Petrunik, 2002; Zonana et al, 1999). These treatments consisted of lobotomies, hormone injections and sterilization with very little individual or group therapy (Cole, 2000, p.300). The justice model was based on the premise that offenders are rational and will weigh the costs and benefits of each act; it also relied on least restrictive sanctions, due process, equality, and took very little consideration of the offender's circumstances, but simply looked at the offence (Petrunik, 2003). This model also introduced the increased use of determinate sentences for offenders (Petrunik, 2002). By 1977, changes to legislation allowed for both indeterminate and determinate sentences as the feminist movement and sociological theories brought more focus on the victims.

1.6.3.2 *Sociological Model*

The feminist movement and the influence of Kinsey's research about what is normal and what is not, led to theories that looked outside the individual and considered the effect

that the environment had on the development of sexual deviancy. Sociological theories address cultural, familial, and societal factors that could lead to sexual deviancy. These theories include both feminist theories and psychosocial theories (Terry, 2006).

The feminist movement during the Liberal Era led to a new focus on female victims and victims of sexual abuse. This focus changed the way people thought about victims as they were no longer considered at fault for their abuse (Cole, 2000, p.301). In fact, feminist theories explain rape and sexual aggression as part of the general male oppression over women, which place the blame completely on the perpetrators and the culture of machismo (Terry, 2006, p.41; Purvis & Ward, 2006, p.301). In addition, they claim that rape is not about sexual gratification but is about domination and control over women. According to feminist theorists, sexual aggression is a societal problem that stems from values and beliefs of society about male-female relationships and roles (Purvis & Ward, 2006). An example of this is the portrayal of women in pornography as submissive, which feminist theorists claim affects how males expect women to act in real relationships, thus leading to dominating behaviour (Terry, 2006, p.42).

Psychosocial theories incorporate both psychological and sociological factors to explain sexual deviancy. A common claim within this model is that many sex offenders do not have the ability to form healthy relationships with others. For example, rapists may view force as the only way to achieve sexual gratification and child molesters may use children as someone they can attach to and get sexual gratification from (Terry, 2006, p.45). Another possible trait is the inability for sex offenders to interpret social cues by both individuals (usually the victim) and society (Terry, 2006, p.45). This would mean that the offender would misinterpret a child's behaviour as seductive when it is not. Pornography is also

discussed by psychosocial theorists who claim that pornography only impacts already deviant individuals by reinforcing what they believe to be normal sexual experiences. However, psychosocial theorists claim there is very little evidence that someone can have their views changed by watching pornography, thus suggesting how the psychological traits and sociological traits must both be present to create a situation for sexual deviancy (Terry, 2006, p.46). A popular claim in psychosocial theories is the cycle of abuse theory that claims children who are abused will often grow up to be abusers themselves (Ward et al, 2003, p.120). However, there are a few inconsistencies in this theory, such as the fact that the majority of child abuse victims are female, but the majority of offenders are male. Also, about one third of offenders were never abused as children. Researchers conclude that past abuse could be one of many factors that contribute to later offending behaviour, but it does not explain sexual deviancy in itself (Terry, 2006, p.46).

The combination of feminist theories, women's movements, and a few high profile cases once again contributed to a change in how people viewed sexual crimes which led to a new control policy called the Risk-Management and Community Protection approach (Terry, 2006, p.33; Petrunik, 2002). Lobby groups questioned the research that claimed risk could not be predicted and that treatment was unsuccessful, which was the basis of the justice model. The premise of these challenges was that the methodology in these studies was flawed, as they only reported repeat behaviours measured by police reports and conviction rates, which did not account for unreported acts (Petrunik, 2002). At the same time, victimization surveys were coming out demonstrating that both women and children were victimized at much higher rates than the police and conviction reports were showing.

A very clear demonstration of how sexual deviancy treatment and regulation was affected by the Liberal Era and feminist movement is that of New Jersey's Adult Diagnostic and Treatment Center (ADTC) (Cole, 2000). According to Cole (2000), the ADTC was originally created to provide a hospital-like experience while also serving as a correctional facility. The intention was that sex offenders would be diagnosed, treated, and incarcerated within one facility. However, victim advocacy groups began to emerge and attitudes began to change towards sex offenders, calling for more punitive measures over treatment. As a result, "by the time it was ready for occupancy, the ADTC, the first freestanding prison in the U.S. built exclusively for housing sex offenders, actually marked the shift from a medical to a punitive model for 'treating' sex offenders" (Cole, 2000, p.302). Instead of being administered through both the mental health department and the corrections department like its predecessor, the ADTC was opened under the exclusive control of the Division of Corrections and Parole (Cole, 2000, p.302).

During the 1980s a new group of victims began to emerge, composed of adults coming out with repressed memories of past sexual abuse. Although the validity of these memories was questioned by some experts claiming that the therapists were planting these memories, the panic in the public was high (Terry, 2006, p.32). In addition to the repressed memories of the 1980s, there also emerged the satanic ritual abuse claims from children. These children were repeatedly asked questions about what they witnessed until they finally stated that they had witnessed satanic rituals. Despite the outrageousness of these claims and the fact that all charges were dropped due to lack of physical evidence, the public panicked (Terry, 2006, p.33). In the late 1980s two highly publicized cases of child molesters in Washington State emerged: Wesley Alan Dodd, who tortured and murdered three boys and

stated he would do it again if released, and Earl Shriver who, while in prison for raping and torturing a boy, claimed he thought of doing it again and also had a record of reoffending in the past (Hannem & Petrunik, 2007; Terry, 2006, p.35; Purvis & Ward, 2006; Cole, 2000, p.309; Zonana et al., 1999). Victims' rights movements used these highly publicized cases to cause waves of moral panic about sexual offenders (Petrunik, 2002).

Victim advocacy groups for women and children claimed punishments used for sex offenders were not proportionate to the crime as the effects of sexual assault were much more serious than previously thought and included problems with eating, sleeping, and disruptions in creating and maintaining intimate relationships (Petrunik, 2002). These claims, combined with feminist theories and the moral panic caused by high profile cases, lead to new legislation targeting sexually violent predators who were likely to be released from prison (Terry, 2006, p.35; Zonana et al., 1999).

The risk management and community protection approach was driven by victims' families and public outcry for protection (Cole, 2000; Zonana et al., 1999). This approach involves community notification laws, chemical castration and special statutes for sex offenders creating indeterminate sentences (Petrunik, 2002). These laws were similar to the sexual psychopath laws but instead of being committed to a mental institution in place of prison, the new legislation allowed individuals to be released into a mental institution (indefinitely) after their prison sentence was completed, where they could be further rehabilitated (Terry, 2006, p.35; Cole, 2000, p.308; Zonana et al., 1999). Despite the claim that these laws provide more rehabilitation upon release from prison, this change was based on a retributive agenda as opposed to a rehabilitative one (Zonana et al., 1999). Similar to the old sexual psychopath legislation, the new sexually violent predator legislation targets

only a small population and increases costs to the public (Terry, 2006, p.35). The use of notification laws is perpetuated by the belief that sex offenders, even if not violent, are to be considered very dangerous (Petrunik, 2003). Cole (2000) claims this recent panic over sexual offenders—particularly those who offend against children— to be the “longest-lasting sex crime panic” (p.303) in the United States, for which there does not seem to be an end in sight.

1.6.3.3 *Biological Model*

The biological model had very little effect on the evolution of understanding and treating sexual deviancy, despite having contributed some of the treatments currently used. Following the work of Cesare Lombroso that were popular in the late 1800s, biological theories existed in the shadows of the dominant psychological theories. The majority of modern biological theories concentrate on the levels of hormones, particularly testosterone, in offenders compared with non-offenders (Sullivan & Mullen, 2012; Terry, 2006, p.39). Researchers claim that testosterone is responsible for aggression in males and that those who demonstrate higher levels of aggression have higher levels of testosterone in their blood (Sullivan & Mullen, 2012; Ward et al, 2003). Although some research has supported this claim, using violent offenders compared to non-violent offenders, researchers suggest that outside factors must influence the individual as hormone levels alone do not explain sexually violent acts (Terry, 2006, p.39). Sullivan and Mullen (2012) suggest that one factor outside of hormones that could influence offending behaviour is impulsivity.

The biological and medical theories lead to the use of hormone treatments (used as chemical castration) and tranquilizers in order to treat individuals displaying deviant sexual behaviours (Terry, 2006, p.153; Ward et al, 2003, p.266; Zonana et al., 1999, p. 103;

McAlinden, 1998, p.258). These treatments were found to be reasonably effective. However, they are not commonly used due to the side effects they produce, such as the feminization of males consuming estrogens. Surgical castration, which is rarely used due to ethical considerations, also was not as successful as was originally thought (Terry, 2006, p.153).

1.7 CONCLUSION

The historical background of both addiction and sexual deviancy clearly demonstrates the fluidity of definitions; as beliefs and ideologies changed, so did the way practitioners and researchers viewed these concepts. In turn, this evolving understanding led to new ways to treat these individuals, dictated by the definition available to the practitioners. Therefore, understanding addiction and sexual deviancy from a social constructionist point of view is important as these constructions and concepts affect the lives of individuals who are considered abnormal.

This thesis is an examination and comparison of the expert opinions on sexual deviancy and addiction. It is guided by social construction theory and Spector and Kitsuse's theory of the social construction of social problems. Testimonies and briefs submitted to parliamentary and senate committees constitute the data source, which is analyzed using a content analysis method. This thesis aims to answer the following question: How do therapeutic professionals (as experts) describe the concepts of addiction and sexual deviancy when submitting evidence to parliament for policy changes and how do these descriptions compare to each other and other experts who submitted testimony?

By using social construction as a framework to study the concepts of addiction and sexual deviancy, one is able to see the consequences that arise from ideologies and science coming

together to create a socio-legal reality. The following chapter discusses more specifically what social construction is and how it guides this research, exploring the beliefs and assumptions of the practitioners who work with individuals diagnosed with addiction and sexual deviancy as well as other experts.

Chapter 2
Theoretical Framework

2.1 INTRODUCTION

This chapter explores the use of social construction as a theoretical framework for the analysis of social problems. Several important objectives will be discussed throughout this chapter that will demonstrate the importance of using social construction as a means of analysis for sexual deviancy and addiction. The first objective will be to examine the theory of social construction, emphasizing the importance of how humans create concepts and meanings through daily interactions. Social construction does not take knowledge for granted and this challenges where the ideas came from and how they are reified throughout society.

Secondly, this chapter will discuss the shortcomings of functionalism and value-conflict theories in their attempt to analyze social problems. Despite the best efforts of the researchers both of these theories fail to effectively analyze social problems. This leads to the third objective, which is to discuss the method of analysis presented by Spector and Kitsuse (2001) in which social problems are considered an activity. Spector and Kitsuse (2001) present the construction of social problems as a process which develops through stages. The first stage includes claim-makers conceptualizing a phenomenon as a problem and appealing to a governmental agency for a remedy. In the second stage, the government agency makes recommendations for a solution to the proposed problem.

The fourth objective of the chapter is to discuss how the conceptualization of a problem influences how the solution (in stage 2) to the problem is constructed. The temperance movement in the early 19th century led to the concept of heavy drinking being reframed as a moral issue, with the presumption that through religion a person could sober up. At this time the “norm of abstinence and sobriety” (Gusfield, 1996, p. 172) had replaced

the previous norms which accepted heavy drinking. This formed what Gusfield (1996) refers to as the repentant deviant, “someone to be brought back into fold by moral persuasion and the techniques of religious revivalism” (p.178). Although the aspect of religion is no longer used (with the exception of Alcoholics Anonymous) in most therapy provided now, the solution to the problem of sexual deviancy and addiction is to bring the individual back in line with the norms and values of society by means of psychological therapy.

The fifth and will be to discuss the dual role that is held by treatment providers whom also conduct research. There are several main roles in social problems work and in the case of sexual deviancy and addiction, there is a potential overlap between Spector and Kitsuse’s *expert* and Gusfield’s (1996) and Loseke’s (2003) *helping professional*. The expert is the voice of authority on a particular issue; they conduct research and state facts that have great influence in persuading government agencies and the general public to pay attention to the social problem presented. The helping professionals are those who are employed to treat individuals who are either affected by the problem or causing the problem (usually through some type of therapy). However, in the case where the helping professionals are doing research on their own profession and then producing the results as experts, there is a potential for a self-validating cycle to emerge.

Finally, the chapter ends with a discussion on the significance of social construction as it applies to this project. Since social construction emphasizes the importance of social interactions at many social levels, the vital role that professional training and subculture play is used to explore the testimony of these witnesses. Police subculture has been studied since the 1950s and consists of a set of norms and beliefs that dictate how police officers operate in their professional field (Herbert, 1998). The police subculture model that was developed

in the 1950s changed over time as broader social values influenced the way in which police interpret the world illustrating the way in which the macro social circles have an impact on the micro-social circles. Another example of how the broader social context influences individuals is the way in which childhood and victims are constructed within society and that shapes the way in which individuals understand sexual deviancy.

2.2 SOCIAL CONSTRUCTION

Social construction is not about the physical world, but about how we understand the world at large. Social construction assumes that humans understand and react to objects based on the meanings that are assigned to the object. For example, a pet cat is not considered food in our daily lives because that is not the category in which they have been placed; it would contradict our meanings (Loseke, 2003). Social constructionists do not take words for granted; they examine and study the meaning these words have and thus the reaction humans have to the words. These typifications and images are essential to our understanding of the world as it would be impossible to physically experience everything ourselves (Loseke, 2003). We all know what an elephant is even without actually seeing one in person; therefore, our knowledge of elephants is not based on our experience of elephants but is based on our image of an elephant.

Social construction is focused on the interpretations of people in a given society as “meanings do not come attached to people, conditions, or experiences. Humans give the world meanings” (Loseke, 2003, p.18). Gusfield (1996) claims that “it is valuable to conceive social realities as products of the interaction between observers or actors on the one hand and an objective world on the other” (p.5); from this perspective, the objective world

and understandings of the objective world are separate. Friedmann (1980) claims social construction is a critical theory as it questions the status quo in our current society; it does not take what we consider knowledge for granted (p.2).

Social construction applies to social problems because “there is nothing in the world whose meaning resides in the object [or phenomenon] itself” (Loseke, 2003, p.18) and nothing has meaning until the recipients give it meaning, and this meaning cannot be determined by the speaker beforehand (Gergen, 2001, p.119). This means someone needs to first construct a certain condition as a social problem, and then society needs to accept it as a social problem. Social constructionists are not concerned with objective phenomena; therefore, a social problem does not exist until it is said to exist, despite the objective conditions that are present. For example, child abuse did not exist as a social problem in the United States until the 1960s despite the fact that the behaviour (or objective condition) of hitting children had existed for centuries (Loseke, 2003). In addition, Gusfield (1996) claims that social problems can change throughout time without any relation to the objective condition, meaning that a social problem can be constructed in different ways throughout time.

Social construction allows for social scientists to understand the phenomenon of social problems beyond statistics and reports. By using the lens of social construction, social scientists can see the process by which conditions (even those that have existed for ages) can be constructed in a way that makes it a problem in society. In the next section, the definitions of a social problem will be discussed, as well as the problems that arise in defining them in certain ways. Then the lens that this thesis will be using will be introduced, which is a branch of social construction.

2.3 SOCIAL PROBLEM ANALYSIS

2.3.1 *Functional and Value-conflict Analysis of Social Problems*

There have been many attempts to define and study social problems and like many social phenomena, there is debate about how this should be done. Depending on the researcher's epistemological standpoint, the definition of social problem can change. Furthermore, due to the obvious flaws in the positivist perspective discussed below, many definitions of social problems are either functional or are considered value-conflict (Spector & Kitsuse, 2001). These definitions influence how researchers are able to study social problems.

Positivist views focus on quantifiable and qualitative data and claim that social problems are factual phenomena that can be studied through objective scientific methods (Spector and Kitsuse, 2001). For example, reports and statistics show that the crime rate is high, crime causes harm and, therefore, it is a social problem. There is no discussion about how high the rate has to be in order for it to be considered a social problem and there is no consistent measurement of harm. For example, street crime is committed at a much higher rate than corporate crime. However, corporate crime costs its victims much more in damages. In this case, how do we know which category of crime represents a social problem and why? Is street crime a social problem based on the high rate of occurrence and corporate crime according to its high damages?

In the case of value-conflict analysis, there is a sociological aspect to the definition that draws away from this positivist view. For example, Heiner (2002) defines a social problem as "a phenomenon regarded as bad or undesirable by a significant number of people, or a number of significant people who mobilize to eliminate it" (p.3). Heiner (2002)

claims that in this definition, either the group has to be significant in size or significant because of the members within the group. In this case, it is understood that a social problem is not a social problem until it is labelled as such by a significant group. However, by using words like 'significant' and 'number', it is still unclear at what point something is a social problem or just a group making a statement.

According to Spector and Kitsuse (2001), the value-conflict definitions were an attempt to examine social problems from a social construction point of view. However, it was not fully a social construction theory. Heiner (2002) calls his theory critical constructionist which is a blend of Marxist theory and symbolic interactionism. It allows researchers to ask why some phenomena are considered social problems, while others that cause more harm are not considered social problems (Hiener, 2002). Heiner (2002) claims this theory allows for the examination of how those who decide what is a social problem are those in power and, therefore, may only establish social problems if it benefits them, such as to further their political career (p.10).

An example of a functional definition is the one given by Gusfield (1996), which states that a social problem is considered a societal phenomenon that is negative and opposed to the well-being of that society; therefore, it is something that needs to be eradicated for optimal existence of members of the society (Gusfield, 1996, p.17). Gusfield (1996) describes a social problem as something that deviates from the "standard", which assumes a consensus about values and morals; this is a vital point in a functionalist perspective (Spector and Kitsuse, 2001). In essence, the social problem aims to affirm or reaffirm what is valued in a given society by showing what is considered abhorrent. For

example, by designating child abuse as a social problem, we can determine that society values the safety of children and expects children to be cared for without the use of violence.

Spector and Kitsuse (2001) claim that although attempts have been made to understand and define social problems as social constructions, there has not been any that are completely successful. Each definition still has some aspect of an objective condition or relies too heavily on numbers and measurements. Spector and Kitsuse (2001) stress that definitions and conditions are not related, in that the definition of an objective condition varies and this variation does not reflect actual changes to the objective condition. Consider the example of marijuana, which was defined as addictive during the 1930s, but around the 1960s the medical community no longer referred to the drug as addictive or to the users as addicts. The physiological makeup of marijuana did not change during this time, just the way it was described (Spector and Kitsuse, 2001, p.10).

Due to the disconnect between the objective world and the definitions of social problems, the only way to approach social problems research is to completely remove the objective condition from the analysis. This means embracing the idea that social problems are a creation of society and those within society; they are completely unrelated to the objective world or conditions. Spector and Kitsuse (2001) actually understand and define social problems as an activity involving many key players and a specific process with numerous stages.

2.3.2 Social Problems as an Activity/Process

Spector and Kitsuse (2001) define a social problem as a process of claims-making or “the activities of individuals or groups making assertions of grievances and claims with respect to some putative conditions” (p.75). By using the word putative, which emphasizes

that these claims are alleged, Spector and Kitsuse (2001) aim to concentrate on the claims-making activity rather than whether or not the conditions truly exist. Spector and Kitsuse (2001) say that claims are made only about things that can be remedied; people do not make claims about things that are considered natural or inherent, such as earthquakes or tornados.

According to Spector and Kitsuse (2001) “claims-making is always a form of interaction; a demand by one party to another that something be done about some putative condition” (p.78). The idea is for the group to mobilize institutions and agencies to remedy the repugnant circumstances that they perceive. As a result, values have a significant role in claims-making activities. People make claims about conditions they find offensive, “conditions that ought not to exist” (p.86) in other words, conditions that do not line up with their morals or values. It is the job of *claims-makers* to construct the meaning of something in order to gain attention for their cause (Loseke, 2003, p.25) and the *audience* “evaluate[s] the believability and importance of what claim-makers say” (Loseke, 2003, p.25). “Audiences are critical because a social problem is created only when audience members evaluate claims as believable and important” (Loseke, 2003, p.27). According to Spector and Kitsuse (2001), the construction of social problems goes through four stages: 1) claims-making stage, 2) reaction from a government agency, 3) maintenance and holding government accountable, and 4) alternatives to failing procedures from stage three.²

During the first stage, the claims-making stage, it is pertinent for the group making the claim to phrase their claim in a way which makes it controversial and arouses awareness of the public and government officials (Spector & Kitsuse, 2001, p.143). There are three

²Stage 4 will not be discussed as it is not relevant to this project. However, briefly stage 4 deals with social problems that fail at stage 2 or stage 3, in that they are not receiving the appropriate attention from the government agency. In stage 4 the claim-making group establishes their own agency to deal with a problem such as a non-profit group to offer services.

types of claims that can be made: rhetoric claims are simply verbal claims, visual images that depict things, such as a beaten child or an oil covered bird, or behavioural claims such as a protest (Loseke, 2003, p.26). The initial claims-making is difficult as “social problems work is the work of constructing images of *typical* conditions and *typical* people, it is the work of constructing simplicity out of incredible complexity” (Loseke, 2003, p.27). This means the claims have to be relatable to the audience; the audience has to believe it is a widespread problem, not just limited to a select few.

The power a claims-making group has can have a significant impact on whether or not their claim will be considered a social problem or just be ignored. This power could come from large amounts of money, good organization, political influences or other benefits that would allow them to be heard (Spector & Kitsuse, 2001, p.143-144). Often having *experts* or scientists back up the issue with ‘facts’ can have a profound impact on how well received a claim is by the audience. According to Loseke (2003), “[t]he American public in general tends to believe claims made by scientists” (p.38); therefore, having experts can be a significant contributor. In addition, sometimes it can be beneficial to gain interest from an opposing group as the public debate can gain awareness and influence the movement into the second stage (Spector and Kitsuse, 2001, p.148).

Stage two requires formal recognition from the government agency to which the claim was made, and has significant influence on transforming the claim to legitimization. If the claim is legitimized by the government agency, there would likely be some sort of recommendations put forth in order to remedy the situation. However, formal recognition is not always in favour of the claims-making group; for example, the government agency could deem the claim to not be a problem (Spector and Kitsuse, 2001, p.148-150). If the claim is

deemed not to be a legitimate problem, the claims-making group would have to either give up or proceed back to stage one and reconstruct their claim. If, however, the claim is legitimized and recommendations are made, stage three becomes paramount.

Stage three is essential as it prevents the problem from disappearing from public attention without being properly addressed. This stage no longer makes claims about the problem itself, but about how it is being regulated, governed or treated. Essentially, the claims groups in this stage are like watch dogs; they make sure the government agency is aware that they are still being watched carefully about this social problem (Spector and Kitsuse, 2001, p.150-153). This could include making claims that the recommendations, made in stage two, are not being implemented effectively or fairly. For instance, if they promised more transparency for a particular issue, but evidence arises that there is not as much transparency as expected, this would be a reason to protest or rally once again (Spector and Kitsuse, 2001, p.150-153). Alternatively, this stage might involve claims groups keeping a watchful eye on how effective the treatment or solution actually remedies the problem.

2.3.3 Providing Solutions to Social Problems

According to Gusfield (1996) “the conceptualization of situations as ‘social problems’ is embedded in the development of the welfare system” (p.19). More specifically, he states that our contemporary society expects public agencies to improve the lives of citizens and that this is a “right rather than charity” (Gusfield, 1996, p.19). This ideology regarding social institutions naturally leads to citizens feeling dissatisfied or concerned about an aspect of their lives, which they present as a problem to a public agency with the expectation that the solution will be provided.

Even though the constructivist notion of “social problems” comes from the welfare system, the way in which problems are constructed is more of a neo-liberal concept. Most social problems, especially the extreme ones, have a *villain*. The villain is constructed as the one responsible for the condition and could be social structure, social forces or a specific individual or group (Loseke, 2003). Although claims made about victims tend to be far more effective than claims made about villains, extreme cases work best with villains. These extreme cases include villains with whom the audience has strong feelings of hatred and condemnation toward, such as child molesters and terrorists (Loseke, 2003). In addition, people only tend to assign blame to those who intended to create the harm, and the harm must be committed without good reason.

This dichotomy between the welfare system and neo-liberal views creates a conflict when it comes to providing solutions to social problems. For example, crack cocaine was originally constructed as a public health issue falling closer to the welfare system explanation; however, the “war on drugs” policy introduced as a solution constructed crack as a crime problem, which was more in line with the neo-liberal perspective. This has led to a complete failure of the entire “war on drugs” policy (Loseke, 2003). Since blame and condemnation (encouraged by the neo-liberal solution) can be deflected, the most effective strategy has been the medicalization of deviance (presented as a welfare system ideology) as “the medical diagnostic frame simultaneously constructs individuals as the cause of the problem while releasing these people from responsibility and blame” (Loseke, 2003, p.86). This implies that the most effective claims-making strategy is likely aligned with the medical model or the welfare system.

How a social problem is framed has a significant impact on how it is treated and approached. For example, by demonizing the individuals who become alcoholics (i.e. blaming the individual), the establishments that sell the alcohol are not held responsible. If it was considered a problem with the substance itself, such as the case with heroin, then it is the manufacturers and distributors (i.e. drug dealers) that are the focus of regulatory attention (Gusfield, 1996, p.22). For conditions such as sexual deviancy and addiction, there is often a conflicting conceptualization of the problem from a medical point of view and a legal point of view which makes it very difficult for both to work together.

Under the legal perspective on deviance (criminalization of behaviours) the offender commits a deviant act. They are viewed as someone who has control over their actions and free will; therefore, they must be punished for their deviant acts. Once the punishment is served, the person has been redeemed; they have 'paid for their crime' and, thus, they get to re-enter society. In this sense, it is not the person who is deviant, but merely the act that they committed (Gusfield, 1996, p. 206-207). Under the medical definition of deviance (medicalization of problem behaviours), the person has an ingrained illness or disease that can only be managed through medical intervention. Without this intervention, the person would continue to commit deviant acts in an uncontrolled manner. In this sense, the person is actually the deviant as it is a flaw in their psyche that is causing their behaviour (Gusfield, 1996, p.206-207). In the legal definition the person is considered like all other law-abiding citizens, they made a mistake and were punished for it. In the medical definition, the person is different from those in the general population, they have a sickness that not everyone else has. Therefore, there is an element of isolation and stigmatization inherent in the diagnosis (Gusfield, 1996, p.206-207).

As demonstrated above, the construction of social problems is a constant process; different social problems emerge at the same time that other problems disappear or recede. As societal values change, so do those issues considered social problems, while new claims emerge. The strength of the claims-makers' plea can be significantly attributed to the experts they use in their campaign. The next section will discuss how, in the case of therapeutic professionals, there is a dual role as they act as both the expert and the solution.

2.4 CRITIQUE OF THE SEPARATION OF ROLES

The roles within the process described by Spector and Kitsuse (2001), as well as Gusfield (1996) and Loseke (2003), are discussed in a way that implies these are not just separate roles but are separate people. The *claim-makers* use the *experts* to persuade the *audience* to take a problem seriously and individuals within agencies will then provide the *solution*. However, in the case of sexual deviancy and addiction, there are individuals and groups who actually maintain multiple roles in the social problems process. The focus of this thesis is the therapeutic professionals who provide treatment to those with specific diagnoses making them part of the *solution*. However, these professionals have additional roles in the construction of sexual deviancy and addiction. They evaluate their treatment through research, which gains them credibility as research *experts*. They also disseminate the results of this research in journals and at conferences, making social scientists both *claim-makers* and *audience* members. Therefore, within their role as *experts* treatment providers with this dual role are making claims to other treatment providers in the *audience* role that their solution, in the form of treatment, is the most effective. The audience in this scenario likely

already validates treatment as the solution so it becomes a claims-making process based on claims of which treatment works rather than whether treatment in general works.

2.4.1 Therapeutic Professionals as Part of the Solution

Professionals who deal with social problems in the welfare society are those meant to help the deviants or victims in need; this includes psychologists, social workers, counsellors, etc. (Gusfield, 1996). Loseke (2003) calls this the troubled persons industry, which is made up of organizations and groups that are designed to “help, or rehabilitate, or punish the people in social problems formula stories” (p.139). In other words, “somebody’s trouble, in an open polity and a welfare economy, is somebody else’s job” (Gusfield, 1996, p. 201).

The development of the laws surrounding the sexual psychopath in the United States demonstrated the ability of the psy-discourses to encroach on the making of laws and procedures (Pratt, 1997, p.96). These laws included the indeterminate sentences given to those considered a danger to the public. In the early 1920s, the sentences were served in mental institutions, whereas now these sentences are served in prisons under provisions such as the Dangerous offender legislation. In both cases, testimony from mental health professionals used to determine the status of an individual is written into the criteria of the legislation.

2.4.2 Therapeutic Professionals as Experts and Claims-makers

Research, including social science research, is a form of persuasion; it is conducted and presented in a way to convince the readers of something. The readers, in this sense, are the audience (Gusfield, 1996, p.33). In this case, the readers could be other academics consulting a journal or the public reading about the results in a newspaper article. By examining social science research in this way, it is possible to find the dominant discourses

on any subject. This dominating discourse is also what is likely influencing policy makers (Gusfield, 1996, p. 33). The public is persuaded by newspaper articles to believe that the results of the study are truth and, thus, they would encourage their politicians to use these results in policy making.

Ideological unmasking is a process which includes examining how society is affected by the explanations and descriptions of human behaviour that are provided by experts, such as what is normal versus what is abnormal (Gergen, 2001). In other words, ideological unmasking describes how “professional accounts are disseminated within the culture, bearing the stamp of scientific authority, so do they inform people’s actions and instruct policy” (Gergen, 2001, p. 27). Paradigms in psychological research are tested against ‘facts’, but these paradigms are actually deciding what will be considered fact. Once a certain paradigm, epistemological or ontological stance become consensus, research essentially amounts to a confirmation bias throughout the entire discipline (Gergen, 2001, p.30).

2.4.3 Why is this problematic?

Social problem ownership is when one group has ownership of a diagnosis for a particular problem; this group becomes the only accepted authority and are high on the hierarchy of credibility (Loseke, 2003). In other words “they own the problem so to speak, so their claims are given more attention than are claims constructing alternative frames” (Loseke, 2003, p. 69). Social problem ownership leads to thinking that there is only one ‘truth’ and makes it difficult for other claims to be taken seriously. These accepted constructions become popular wisdom, which gives these constructions more power in future social problems debates (Loseke, 2003).

In the case of therapeutic professionals, who have multiple roles as the experts, the claims-maker, and the solution, the issue may actually even more serious than social problems ownership discussed above (Loseke, 2003). If psy-experts conclude in their research that they are the only reasonable solution to a problem, a confirmation bias may be present. Their research could always support the notion that they are the solution because that is likely how they approach the topic as it is based on their practice. This may create not just an ownership on the problem and the solution, but also on the research about a particular problem. This potential confirmation bias could lead to knowledge having been taken for granted and accepted as ‘truth’ without further challenge. Social construction allows for this challenge of the status quo.

2.5 THE IMPORTANCE OF SOCIAL CONTEXT, VALUES, AND BELIEFS

Social construction is based on the assumption that humans gain knowledge from the world based on meanings associated with concepts. These meanings are generated through social interactions, both verbal and non-verbal, which confirm or contradict knowledge (Loseke, 2003). In order to understand how these meanings are changed or influenced, it is crucial to explore the context in which these daily interactions are occurring. Social construction considers multi-levels of social circles, including the community and the family, to explain how one develops their understanding of the world (Loseke, 2003). The broad social context of time and place is just as important as smaller social circles in shaping one’s perceptions. The everyday social interactions between individuals at work, at home and in the community reify the value system of the social context in which the individual

belongs. These different levels of interactions present varying frames of understanding for the individual which all have an influence on their overall construction of the world.

One particular social circle which may have an influence on the ways in which an individual perceives the world is found within their professional field. The process to become a doctor, lawyer, police officer or academic involves a specific training, which can be viewed as a ritual through which an individual is indoctrinated into the social world of a doctor, lawyer, police officer, academic etc. This training process is an essential and ongoing social interaction during which an individual learns a new set of values and beliefs and becomes part of a subculture. Since “culture is significant in shaping people’s world views and actions” (Herbert, 1998, p.345), culture, or subcultures, becomes a key element in how a group of experts from similar professional backgrounds construct a particular problem, such as addiction and sexual deviancy.

Subculture, whether it is focused on police or another profession, attempts to explain how individuals in similar professions may be shaped by the formal and informal rules of their field. Police subculture includes a set of rules that help officers cope with the unique stress of their work and these rules are passed down from veteran officers to rookie officers, solidifying these rules throughout time (Ganapathy & Cheong, 2016). From a constructionist point of view, this culture is essential in shaping how officers understand their world. This thesis primarily focuses on one model of police subculture: normative police subculture. Traditional police subculture refers to the first subculture discussed by researchers as it pertains to the personality traits that are present in law enforcement. Following a drastic change in the demographics of police forces, with the addition of members of the LGBTQ community, females and those of racial minorities joining the force, subculture theories

needed to consider this diversity. Herbert (1998) calls his model the normative orders of police subculture which considers several normative orders –or sets of guidelines- one has while approaching a particular situation.

Traditional police culture was based on an assumption that law enforcement professionals were a homogenous and cohesive group. As this assumption began to change, authors attempted to explain the conflict and differing opinions within law enforcement, such as management versus street cops, but these models remained rigid and did not account for agency of the individual officers (Herbert, 1998). The normative police subculture model presents six normative orders, (1) law, (2) bureaucratic control, (3) adventure/machismo, (4) safety, (5) competence, and (6) morality. These normative orders according to Herbert (1998) shape the social environment in which police officers work. They encompass both formal and informal rules and may differ from one officer to another or one precinct to another. This model of police subculture presents an analysis for which all levels of social interactions are considered for the police officers with the consistency of the normative orders which are common to most law enforcement agencies but which may be defined differently throughout. For example, the normative order of law is associated with formal legislation, as well as individual and community definitions of what is considered police business. Therefore, if two neighbourhoods exist in the same city, they are governed by the same formal legislation. However, the police in the neighbourhood containing the downtown core, which has an increased drug use problem, may choose to focus on what they consider more harmful drugs. Whereas the police in the more suburban family centred area may consider all illicit drug use as a police issue and may make more arrests overall pertaining to

all drugs. Despite being governed by the same legislation, their focus changes depending on their work environment and agreements between management and street cops.

Research has existed on the subculture within law enforcement since the mid-20th century (Ganapathy & Cheong, 2016; Blumstein et al, 2012; Herbert, 1998); however, it can be assumed that a subculture may exist within most professions. Many professionals experience some type of training which aims to introduce them to their subculture that may focus on values and beliefs based within medicine, law etc. (Conrad, 1985). These unique experiences and interactions within an individual's training and profession shape the way in which they view the world and social problems. This means that addiction and sexual deviancy may be constructed differently from one group of experts or professionals to another. For this reason, social construction is a beneficial way in which to explore the topics of sexual deviancy and addiction.

Beyond the small social circles one interacts with, there is the broader social context of time and place which also has an influence on how an individual constructs their understanding of their world. The value that society places on children and the association of innocence and vulnerability of children are examples of the broader social values which influence the perception an individual has on their world (Bell, 2011). Therefore, it is essential to include the broad social context, as well as the micro- level social contexts that individuals experience on a daily basis. Together these form the values and beliefs system from which individuals construct their understanding of their world. The framework of social construction allows for this type of multi-level analysis.

2.6 CONCLUSION

Social construction is a valuable way to approach this project as it provides a new perspective on two concepts (addiction and sexual deviancy) that have become widely accepted as a problem that is either a legal problem or a psychological problem; this debate is very rarely challenged by a completely different perspective. In this case, the most important roles are the therapeutic professionals who hold multiple roles as the expert, the claim-makers and as the professionals responsible for the solution to the problem. Due to the fact that these roles are potentially self-validating, it is important to have a research perspective that challenges the knowledge produced on the subject. The following quote reflects precisely the value of approaching subjects from a social construction point of view:

“In their denaturalizing the ‘objects of research’, along with methodologies, research reports, statistics and resulting practices, critical inquiry first invites an appropriate humility. It functions to curb the presumptuous claims to unbridled generality, truth beyond culture and history, and fact without interpretation...” (Gergen, 2001, p.31).

The following chapter will outline how this research project has been conducted from a social construction point of view and which methods have been utilized. It will begin to explain how the following question will be answered: How do therapeutic professionals (as experts) describe the concepts of addiction and sexual deviancy when submitting evidence to parliament for policy changes, and how do these descriptions compare to each other, and other experts who submitted testimony?

Chapter 3
Methods

3.1 INTRODUCTION

This chapter outlines the decision making process that was used for this research project and provides justifications for each of those decisions. All decisions were made with the following research question in mind:

How do therapeutic professionals (as experts) describe the concepts of addiction and sexual deviancy when submitting evidence to parliament for policy changes, and how do these descriptions compare to each other, and other experts who provided testimony?

3.2 DATA COLLECTION

There are many strategies that could have been used to access how professionals describe sexual deviancy and addiction such as through interviews, surveys, or mailed vignettes. These methods would have required ethics approval and participant recruitment at multiple sites, which would have slowed the progress of the study. For this project, the data was collected from transcripts from Parliamentary and Senate Committees meetings. These transcripts were available to the public, which means that they were accessible without research ethics approval.³

The data collected for sexual deviancy was collected through the parliamentary website for the Parliamentary Committee for Justice and Human Rights. The witness testimonies were collected from the 40th parliament, 3rd session, meetings 44-49 covering the subject of an act to amend the criminal code (sexual offences against children). These

³Originally this project was to interview therapeutic professionals about sexual deviancy and addiction. Research ethics board approvals were obtained from both the research site and the University of Ottawa; however, some issues occurred during the recruitment process, limiting access to participants. Therefore the project was changed to use publicly accessible transcripts so as to ensure the viable completion of this thesis project.

meetings took places from January 31, 2011, to February 16, 2011. There was an additional meeting held on February 28th, 2011. But since this meeting did not have any witnesses give testimony on the subject, it was excluded from the data.

The data for addiction was collected from the parliamentary website covering the Senate Report on the legalization of cannabis. All the testimonies available online were considered for the data for this project. Some meetings and evidence were not available online or to the public due to their level of secrecy; therefore, these were not used in the data. It was not clear why certain evidence was not available and this results in incomplete data as it does not represent all meetings. These meetings were held from March 19th, 2001 until August 28th, 2002. All the transcripts from both websites were copied into a Microsoft word document and saved individually per witness.

3.3 SAMPLING

3.3.1 *Sampling Method*

This project used a convenience sample collected through Parliamentary Committee and Senate Committee witness evidence. This method was chosen as the documents were available to the public and provided details about the witnesses so that it was easy to determine in which category of expert they would fit. A convenience sample relies on the easily accessible participants available to the researcher and is inexpensive and efficient (Berg, 2009). Convenience samples are the most commonly used sampling method, but are often biased and generally create a homogeneous group (Liamputtong & Ezzy, 2005). Lack of generalization is a concern for convenience sampling. For example, some of the issues with convenience sampling are the common use of university or college students and then

the tendency to try and generalize the results to a larger population; however, university students are not representative of the general population (Liamputtong & Ezzy, 2005). The current project used documents on specific topics that were submitted by individuals to the committees and, since this was a debate type process in the federal sphere, the group was very diverse in their backgrounds and included individuals from all across the country. Therefore this group of subjects was a rather heterogeneous group.

3.3.2 *Sample Size*

The convenience sample method rendered a total of 163 different testimonies; 18 in the field of sexual deviancies and 145 in the field of addiction. The experts included, but were not limited to, psychologists, counsellors, academic researchers, police officers, victims, victim advocacy groups, and government department representatives.

Unlike quantitative research methods, qualitative sample sizes do not use an equation to calculate a proper sample size for the specific analyses that will be used (Liamputtong & Ezzy, 2005). It is up to the researcher to decide how much detail they want for their particular analysis and to decide on the breadth of analysis they will conduct. After conducting the analysis process (described in section 3.4.4), the transcribed testimonies rendered a total of 62 transcripts; 12 for sexual deviancy and 50 for addiction. A specific breakdown detailing how many transcripts were in each group of experts can be found in Figure 3.1. These remaining transcripts provided sufficient data to conduct a thorough analysis of the themes in sexual deviancy and addiction. In addition, this research is not concerned with generalizability as it is only exploratory, so a large sample size is not needed.

The disparity between the numbers of transcripts for addiction compared to sexual deviancy is due to the focus of the committees to which the testimonies were submitted. The

Senate Committee discussing the legalization of cannabis was the source for all the addiction testimonies. Many of the testimonies focused primarily on cannabis and the issue surrounding its use and legalization as well as international law and circumstances. Due to this, the initial data was reduced to focus only on those testimonies that discussed addiction in general. In addition, not all the witnesses focused on cannabis and also introduced other drugs such as alcohol, tobacco, heroin, cocaine, etc. This is the reason there are significantly fewer testimonies included in the group of data that was analyzed compared to the number of testimonies collected on addiction. In contrast, the Parliamentary Committee for Justice and Human Rights was conducting an investigation of new laws and amendments pertaining to sexual offences against children. This provided a platform for the witnesses to submit testimony on sexual offences with a focus on treatment, regulation, consequences and recommendations to the committee. This committee was much more focused on the one subject so despite having significantly less representation in the sample numerically, it provided sufficient saturation on the subject to be used as data for this project. The process through which data was determined to be acceptable for the analysis for this project is detailed in section 3.4.4.

Figure 3.1 Sample Size by Expert

Expert	Addiction	Sexual Deviancy	Total
Law enforcement	8	2	10
Lawyers	2	1	3
Victims/Victim Advocates	0	4	4
Public Officials	3	0	3
Treatment Providers	16	6	22
Academics/Researchers	20	0	20
Total	50	12	62

3.4 ANALYTICAL METHOD

3.4.1 *Qualitative Content Analysis*

Content analysis was originally developed by quantitative researchers who usually used it to count units and to measure certain phenomena within text documents and, in other communication sources (Berg, 2009). However, Morgan (1993) presents content analysis as a very effective tool for qualitative research, stating that quantitative researchers tend to reduce their data to numbers, but do not attempt to interpret these patterns further. In addition, qualitative content analysis requires more of a process in the creation of the coding scheme that is adapted depending on the data collected (Berg, 2009; Morgan, 1993; Skinner et al., 1999). This process reflects a more inductive than deductive approach, although it has elements of both (Spens & Kovacs, 2006). While the current project had categories of analysis that were created through a review of the literature (deductive approach), further categories were created after the initial analysis was conducted as new themes emerged from the data itself (inductive approach).

Morgan (1993) suggests using a qualitative content analysis when the research is comparative in nature, which is one reason this method of analysis was chosen for this project. In addition, the large amount of data was very diverse in nature and Spens and Kovacs (2006) suggest that this can be overwhelming during the analysis stage. However, with the content analysis approach, the large amount of data can be easily organized into useful categories that ease the analysis process.

3.4.2 *Units of Analysis*

The unit of analysis (i.e. what will be extracted) is what a researcher will use to begin to distinguish patterns (Berg, 2009). For this project words, phrases and remarks were taken from the testimonies. The idea was to extract the meanings of the statements made by witnesses. Essentially, the words and phrases were not important; it was what those words and phrases conveyed about the concept that was the focus of analysis. The aim of this project was not to count how many times the word “treatment” was used to describe patients, but to actually look at how the actors were conceptualizing treatment, or how this “treatment” was phrased by the witnesses. The use of conceptual units of analysis allowed for a deeper understanding of the meaning behind the words and phrases, thus giving much more insight into how the witnesses themselves viewed the concepts.

3.4.3 *Categories of Analysis*

The categories in which the data was sorted were initially derived from the literature, as they appeared as common themes historically discussed by researchers. For example, the theme of disease comes from the literature and is discussed in detail in chapter 1. The dominance of this theme within the literature provided an expectation that the idea of addiction or sexual deviancy as a disease would be discussed by witnesses, and therefore, was included in the categories. In addition, while going through the analysis, further themes and commonalities were identified and, thus, additional categories were created. Therefore, a new category was created in order to provide the opportunity to analyze data from the perspective of these individuals. The initial categories were divided into questions and then subcategories were established as to how these questions were answered. The questions asked were (1) what is sexual deviancy (addiction), (2) can sexual deviancy (addiction) be

treated, (3) what are the consequences and risks caused by sexual deviancy (addiction), and (4) how can sexual deviancy (addiction) be regulated?

3.4.3.1 What is sexual deviancy (addiction)?

This question was the most important part of the analysis. It was asked to develop an understanding of how exactly the concepts of addiction and sexual deviancy are understood and explained by various experts. The explanations given were organized into categories which were derived from both literature and the data itself.

The first category, **disease/illness**, was used for both sexual deviancy and addiction in the analysis. This category was derived from the literature as a way to explain addiction and sexual deviancy and justify its treatment by a therapeutic professional, especially in the case of addiction. Vaillant (1995) describes addiction as a disease due to its natural history, meaning it presents with certain symptoms that progress over time; the speed of this progression is based on individual and environmental factors. In the case of sexual deviancy, the disease category is based on the medicalization of sexual deviancy demonstrated in the 1930s in which sexual psychopathy became a prominent diagnosis (Terry, 2006).

The second category, **morality**, also applied to both sexual deviancy and addiction in the analysis. This category is derived from the literature discussing the AA Model which bases their understandings of addiction in religious and moral teachings (Valverde, 1998). Although this category is derived from the addiction literature, it was also considered as a possible explanation for sexual deviancy given the history of religious influences on the construction of sexual deviancy (Terry 2006; Karras, 2011).

The next category, **sexual orientation**, pertained only to the sexual deviancy analysis and emerged from the data itself as a common theme. During the analysis, it became clear that some witnesses used sexual orientation to describe sexual deviancy and this seemed an important subject to explore, so it was added to the analysis. Comparisons to homosexuality and other sexual orientations were used to identify statements that were placed in this category.

Lack of control was a category that was included in the analysis of addiction as a possible explanation of the phenomenon. Any mention of inhibitions, self-control, or compulsions was used to identify the statements that were placed under this category. This category was derived from the literature and was based on Valverde's (1998) discussion on alcoholism as disease of the will or, in other words, an issue in terms of one's ability to assert self-control and willpower.

A category that was included only for addiction was **withdrawals/cravings**, which was retrieved from the cycle of addiction model (Peele, 1985). This is a typical concept in the field of treatment to explain addiction and to design a treatment program, and it is related to the disease model. Discussions about withdrawal symptoms, and cravings were used to develop this category.

Risk-taking was a category that was derived from the analysis itself for the concept of addiction. This category was identified through the analysis to be a recurring theme, so it was included as a possible explanation of addiction. Keywords, phrases, and discussions about risk and thrill-seeking were used to develop this category.

Coping was another theme that was created for addiction due to themes in the analysis. Although occasionally mentioned in the literature, it was not included initially as it

is not as common of an explanation. However, since it developed as a theme throughout the analysis, it was included to make sure the analysis and project are accurate and represent the sample fairly. Words and phrases such as coping, self-medicating and numbing were used to identify statements for this category.

The final category for this question is **frequency**, which applied only to addiction. It was derived from the literature, particularly Peele (1985), who discusses the belief that addiction should be defined in regard to frequency and quantity of drug use. This belief is not common, but because it was mentioned by witnesses it was considered for the analysis as it helps create an accurate picture of the concept of addiction as viewed by experts. Keywords and phrases such as amount, volume, and frequency were used to identify this category.

3.4.3.2 Can sexual deviancy (addiction) be treated?

This question was asked to gain an understanding of how treatment was understood for each expert as well as whether they believed there was a possibility for treatment. This question acted as a focal point of the analysis as it is intertwined with beliefs and recommendations surrounding the concepts of addiction and sexual deviancy. For example, one who believes addiction is not treatable is not likely to push for a health model, but rather push for more enforcement and punishment. This question helps guide a very important aspect of the witnesses' beliefs and understanding of the concept. Initially, there were no subcategories in this section other than a simple 'yes, it is treatable', or 'no, it is not', with the justifications being compared. However, throughout the analysis, it became very clear that there was a distinction between **manageable** and **treatable**. Although they were not specific organization categories, they were important terms to consider, as some witnesses

seemed to vary their answer based on whether they were discussing how to manage addiction or sexual deviancy compared to treating addiction and sexual deviancy. These two terms were derived from the data itself and they are discussed throughout the analysis in relation to how experts consider treatment for addiction and sexual deviancy.

3.4.3.3 What are the consequences and risks of sexual deviancy (addiction)?

This question was developed from the data after the coding stage (described below) as it became clear that there was a major difference in the witnesses called to the meetings for addiction and sexual deviancy. This major difference was that sexual offending, or sexual deviancy, involves a clear third party victim. These victims, and their advocates provide a unique view in the realm of sexual deviancy, conducting and presenting research, treating victims, and proposing legislative changes. However, addiction is more complicated as it does not always involve a direct third party, seemingly innocent victim. The person who has the addiction is recognized to be suffering, but it is not inflicted by someone else; there is no third party victim that is clearly identifiable in regards to addiction. However, during the discussion of the consequences and harms of addiction, there are important points about how addiction increases crime and violence in neighbourhoods; these claims refer to third party victims. So this question was developed to examine this difference and explore the impact the difference can make on recommendations about regulation.

Initially, this project had two separate questions for this category: one for the consequences and harms and one for dangerousness and risk. However, during the analysis, it became clear that there was a great deal of overlap between these two questions, so it was combined into the one question discussed here.

3.4.3.4 How can sexual deviancy (addiction) be regulated?

This question was pre-determined before the analysis began. It was used to examine if there is a relationship between the type of expert and their recommendation on regulations. In addition, it was used to identify any patterns in the construction of the concepts and how these constructions influence the recommendations for regulations. The responses typically fit within one of the following categories: punitive, public health, harm reduction or treatment.

Figure 3.2 Table of Categories

Category	Keywords
Explanation:	
Disease/Illness	Disease, ill(ness), sick(ness), health
Morality	Moral, values, judgement
Sexual orientation	Sexual orientation, sexual preference
Lack of control	Control, will power
Withdrawals/Cravings	Withdrawal, cravings, triggers, cycle of addiction
Risk Taking	Risk taker, adventurous
Self-Medication	Coping, self-medicating, self-treating
Frequency	Frequent, amount
Treatment	Treatable, not treatable, curability, management
Consequences and Risks	Violence, crime, relationships, family
Regulation	Incarceration, punitive, rehabilitation, treatment, mandatory minimums, harm reduction, public health

3.4.4 *Coding Steps*

1) A literature review was conducted for the first chapter of this thesis and key categories were extracted from the literature to provide a basis of categories for the analysis. Questions were also developed to address important issues that the researcher wanted to explore in this project. Originally these questions were created as an interview, but when the project changed the questions were adapted into broad categories to be explored.

2) The transcripts for all witnesses were copied into a specific word document; all quotes from each individual were copied, no matter their relevance. Those individuals who did not fit any of the categories of experts, such as those who were members of the federal or provincial governments in Canada, were not selected. This resulted in a total of 163 transcripts, 18 for sexual deviancy and 145 for addiction as data for this project.

3) The transcripts were then read over to ensure that they contained relevant quotes for the current project. For example, one individual from the sexual deviancy data worked for the Canadian Centre for Child Protection, which fulfilled the criteria as an expert (according to my definition based on that of Best (2013) described in detail in section 3.5) as part of the victim advocacy group. However, this individual's testimony was only describing the program for which he works and did not contain any quotes that gave insight into his views of sexual deviancy, so this transcript was not used in the final data. Those transcripts that were eliminated at this stage were transferred to a folder called "Tossed Sexual Deviancy Data" or "Tossed Addiction Data" depending on their subject. This reduced the total transcripts to 62 transcripts, 12 for sexual deviancy and 50 for addiction. The remaining data was placed in either the folder titled "Addiction Data" or "Sexual Deviancy Data" depending on their subject.

4) Each transcript was then read over again to determine the category of expert to which the individual belonged and their title(s), professional designations or associations were identified at the top of the document with their name.

5) To begin the analysis, documents were created for each category of expert (e.g. Law Enforcement), and quotes along with the speaker's name, were copied and pasted into this new document under the category of which they represented (e.g. Regulation). For

example, a quote by an individual identified as a police officer discussing his recommendations for regulation of sexual deviancy would be copied and pasted to the law enforcement document under the heading “Regulation.”

6) Following step 5, the data was reorganized in documents according to the category of discussion and then the type of expert. For example, the quote from the police officer from the example in step 5 would then be copied and pasted into the document titled “Regulation” and placed under the subheading “Law Enforcement.” By having the data presented in these two different ways, it made it easier to see patterns between different experts on the same topic and allowed for easy detection of patterns within a group of experts, such as how their understanding of the explanation of the concept influenced their recommendations for regulation.

7) The documents created in step 5 and step 6 were then printed out. They were read over carefully and keywords and themes were used to distinguish in which category the quote fit. For example, a quote containing keywords such as illness, sickness or disease would be coded as a disease model and a “D” would be placed next to the quote. In addition, a quote that may not use those specific keywords but that implied a disease model approach would also be coded with a “D” for disease model.

8) Finally, the patterns and themes were organized and formally presented in a chapter titled “Analysis” using quotes to support the claims and reflecting on the literature and theory from chapters 1 and 2 of this thesis.

3.5 THE WITNESSES

The witnesses chosen for this project were selected due to their expert status as defined by Joel Best (2013). Best (2013) defines an expert as an individual who has special knowledge (knowledge not available to someone without the same experience or training) about a putative social problem and therefore has influence over the audience. Experts are considered claims-makers; however, they are more significant as people tend to give more value to what they have to say.

The witnesses that provided the data for this study were invited to Parliamentary committee meetings or Senate committee meetings by the members of these committees. The witnesses were divided into categories based on their expertise; this was a self-reported profession or expertise as well as the introduction provided by the committee (a full list of the witnesses and their professions can be found in Appendix A). For those who fit into more than one category, they were discussed under the category they emphasized the most. This was particularly relevant for academics who also identified themselves as treatment providers. Generally speaking, these individuals identified themselves more strongly with their clinical work and therefore were classified as treatment providers rather than academics. Unfortunately, this did result in less representation of academics in the data. The categories of experts are law enforcement, public officials, treatment providers, academics and researchers, victims and victim advocates and lawyers.

Law enforcement experts consisted of individuals who self-identified as police officers; both patrol officers and those in supervisory and management positions. This group did include some retired individuals, but they still spoke from the point of view of police officers and their work experience.

Public officials was a group of experts created once the data was collected as they provided a unique viewpoint, but were not originally considered as a group of experts. This group consisted of municipal leaders such as city councillors and mayors who could only influence policy on a small scale. These individuals were included as they have an interesting position: they are in a position of power, so their citizens expect them to intervene in issues. They do not, however, have as much control over influential policy as provincial and federal leaders.

The treatment provider group was made up of individuals who self-identified as professionals who treated individuals with addiction or sexual deviancy. This is an important distinction from those who identified as a treatment provider for victims in the case of sexual deviancy; these individuals were placed in the victims and victim advocates group as that is the category with which they most closely related. The treatment providers consisted of individuals with various backgrounds and credentials including psychiatrists, psychologists, counsellors, social workers, and therapists.

The majority of the group of academics and researchers were faculty professors at universities and colleges; however, there were some independent researchers as well. These individuals self-identified as researchers and emphasized their work in research even if they had other professions. The credentials of each witness were not always clear, so their educational backgrounds may vary greatly. Despite this potential diversity, most of these witnesses held a Ph.D.

The victims and victim advocates were an eclectic group of individuals from various backgrounds, expertise, and fields. However, they spoke from the point of view of the victim. Some were social workers who worked with victims, while others were researchers

with an emphasis on victims. In addition to these roles, some were also victims themselves. This group was entirely centred on sexual offences and sexual deviancy. Victims and victim advocates are what Best (2013) refers to as insider claims-makers who have an established connection to policy makers and are often consulted for their expertise.

The lawyers consisted of only defence lawyers. This group spoke from a legal point of view and did not advocate for any particular side, but simply used their experience to inform their opinion. This was a small group that provided an interesting perspective on the concept of addiction.

3.6 ETHICAL CONSIDERATIONS

This project did not require approval from a research ethics board as it used publicly available documents. When witnesses submitted testimony to the committees, they knew the transcripts would become public. There would have been no harm to the subjects by using this data set. Names and titles that were used in this project were all gathered from the transcripts; therefore, this information was also in public records. There is no expectation that this project violated any section of the Tri-council policy statement for ethical research.

3.7 METHODOLOGICAL LIMITATIONS

Initially, this project was aimed at conducting interviews as well, but due to issues with the accessibility of participants, the choice to use transcripts exclusively was made in order to ensure access to the descriptions by experts. However, the way in which this project was conducted involved some limitations as far as generalizability and depth of exploration. Mainly, the use of data that was not developed specifically for this research and the limited

topics covered in this data were the main limitations. This section acknowledges and discusses these limitations.

The use of transcripts from parliamentary and senate meetings limited the opportunity to ask probing questions or to focus the questions on the topics that were to be explored in the analysis. Instead, the data was limited to the questions asked by the members of parliament and the opening statements by the witnesses. As a result, not all witnesses were asked the same questions as the meetings took place over several occasions so there is a lack of consistency. In addition, there was no opportunity to ask a witness to expand on their points or explain their reasoning. This resulted in a lack of clarity across some of the data, which also affects the depth of analysis.

In addition, the use of secondary data limited to the review of cannabis and the review of laws protecting children from sexual abuse reduced the scope of the witnesses and thus limited the topic of discussion. For example, the sexual deviancy section was mainly focused on sexual acts against children and did not cover sexual acts on other adults. This did not provide a full spectrum of the sexual deviancy data. As well, the addiction data was derived from transcripts discussing cannabis. Although many witnesses also discussed other drugs and addiction in general, this did limit some of the testimonies. If the data had been derived from a general exploration of addiction, there may have been more in depth discussions on addiction itself. However, this is the only data I was able to find and that was available to the public.

3.8 CONCLUSION

Overall, the use of content analysis to explore this data set was an effective way to generate interesting findings on the subjects of addiction and sexual deviancy. The meanings that the witnesses assigned to addiction and sexual deviancy were explored using several categories and keywords and were organized into an analysis chapter which will be presented in the next section of this thesis.

Chapter 4 Analysis

In this chapter, the data has been analyzed and sorted into categories. The chapter is organized by categories of expert and will proceed to discuss the various topics beneath each expert heading. The experts included in this chapter are law enforcement, lawyers, victims and victim advocates, public officials, treatment providers, and researchers and academics. Some expert testimonies did not provide information for all of the topics; thus some sections are shorter than others. In addition, some of the sections only discuss addiction or only discuss sexual deviancy in accordance with the data that was available.

The topics that will be discussed are how the experts describe the concept, whether or not it can be treated, the consequences and risks, and finally what their recommendations are for the regulation of addiction and sexual deviancy. Examples in the form of quotes will be used to demonstrate how the experts use the terms and their meanings and the concepts and ideas from the literature review and theory chapters will be applied throughout the chapter.

4.1 LAW ENFORCEMENT

Law enforcement is an important set of experts, as they are frontline workers who arguably see the worst of the criminal justice system. They are often called as witnesses in governmental hearings as they can provide a particular insight into the consequences of crime and victimization. However, this same insight and knowledge may also produce a negative perspective on certain individuals due to the ‘revolving door ‘phenomenon. The revolving door refers to the idea that released offenders will re-offend and, thus, the police officers are exposed to the same people over and over, usually for similar offences.

This section explores the testimony of several law enforcement individuals on the various aspects of addiction and sexual deviancy. It will explore these testimonies and relate

them to the model of normative police subculture to illustrate the connection between social interactions on many levels and how professionals perceive social problems.

4.1.1 *Explanation*

The way in which law enforcement experts describe addiction demonstrates the kind of environment in which they work. The implication in the following quotes is that addiction is somehow connected to one's family.

“In many cases, the addiction is multi-generational within families and it is invariably tied to some form of criminal conduct to acquire the necessary funds to support the addiction.” (Cal Johnston)

Cal Johnston, Chief of Police in Regina, describes addiction from the point of view of someone who has contact with the public in a unique way. He likely responds to situations in homes where he would witness evidence of addiction in several family members, thus indicating to him that addiction must have something to do with the family. However, he does not offer any specific explanation for addiction. Robert G. Lesser, a police officer and chair of the Drug Abuse Committee for the Canadian Association of Chief of Police, expands on this idea that addiction afflicts many members of the same family and even suggests it could be genetic:

“Kids can be exposed to the best programs in the world, about safe driving, about smoking regular cigarettes or about doing illegal drugs, but if there is a certain environment at home or if they are genetically predisposed to addiction, the behaviour will not change inside one generation. These are multi-generational challenges that we have to face.” (Robert G. Lesser)

This description by Robert G. Lesser states that addiction is multi-generational and suggests it could be both biological and environmental, but does not comment on whether or not he believes it is a disease. Robert G. Lesser is suggesting that despite the best efforts made by policy makers for prevention, addiction cannot be resolved that easily. From a

constructionist perspective, reality and meaning are developed through the experience of individuals. Loseke (2003) discusses how social construction means that individuals create and adjust their meanings based on their interactions and experiences. This is highlighted in the case of these two officers as they have had similar experiences in which they have seen addiction present in several family members and, therefore, their construction of addiction indicates that it is a multi-generational (familial) issue.

4.1.2 *Treatment*

The way in which law enforcement in this sample seemed to describe addiction and sexual deviancy in the realm of treatment is split between whether it works and whether it does not work. In the case of examining who should be in charge of treating and rehabilitating offenders, law enforcement seemed to acknowledge the limitations their profession place on this possibility. The following examples demonstrate this observation:

“With respect to dangerous drugs, we recognize that the people who are addicted to heroin, crack, rock, cocaine derivatives and some of the amphetamine stimulants, should be looked at and treated outside of the law enforcement system. These people need help; they should be directed to agencies that have expertise to deliver the health care and so on. We should not be pushing these people through the system.”
(Kash Heed)

“I believe that if you're sexually attracted to children, that sexual attraction stays with you for life, but I also believe that through community intervention, such as circles of responsibility, that supervision and managing the sex offender can be conducted in the community, with varying degrees of success.” (Catherine Dawson)

While both witnesses indicate that intervention is desirable for both sexual deviancy and addiction, law enforcement is not the perceived means through which this can occur. Kash Heed, a police officer and member of the vice drug section in Vancouver, directly contends that addiction must be treated outside of the criminal justice system, especially in the case where dangerous drugs have been used. However, Catherine Dawson, a police trainer and

member of Society for the Policing of Cyberspace, is somewhat more subtle about stating that intervention for sexual deviancy should be conducted in the community. She uses the word “supervision” which implies a more formal corrections approach such as probation. However, she also suggests that sexual deviancy can be managed, particularly with programs such as Circles of Support and Accountability. While this does not suggest a cure for sexual deviancy, she does consider the idea that they can be controlled within the community.

Not all witnesses believed that treatment is an option for addiction and sexual deviancy. Two witnesses state that treatment is not an option or it is at least a very limited one. Julian Fantino, Chief of police for Toronto, states:

“We have tried to rehabilitate those who are beyond rehabilitation. We think that we can fix everything and fix everybody, and you just have to say that some people cannot be fixed. There are some habits that cannot be altered.” (Julian Fantino)

Similarly, when Scott Naylor, a detective specializing in child sexual exploitation cases with the Ontario Provincial Police, was asked:

“Given all of your experience in the field of law enforcement or in child advocacy or victim counselling or criminological studies, do you believe that a person who is a pedophile can be cured?”

His definitive answer was simply:

“No.” (Scott Naylor)

The definitive answer of Scott Naylor leaves no room for interpretation; he believed so strongly that sexual deviancy cannot be cured that it did not even require further explanation. Had Scott Naylor been asked if sexual deviancy could be treated rather than cured, it could have changed his answer. However, the question was not rephrased to address treatment. In contrast, Julian Fantino comments on the relative effectiveness of treatment for addiction. Julian Fantino states that some individuals cannot be helped through treatment. However,

this does imply that some can be treated. Julian Fantino's statement may reflect the reality of a police officer, the revolving door of the system, which shows the same individuals are repeatedly arrested, charged, sentenced, released and then once again arrested. Considering Scott Naylor's specialization in child exploitation cases, it is not surprising that he would have a strong view about sexual deviancy as he is continually exposed to these types of cases. Herbert (1998) refers to the bureaucratic normative order of police subculture which considers the different positions members of the police force hold and how these positions influence the way in which they perceive a particular situation. In the case of Scott Naylor, his position on the force would have him focused on child sexual abuse much more than a regular street cop who may or may not come in contact with sexual offences regularly. These interactions with victims and families could influence Scott Naylor and explain his strong opposition to the effectiveness of treatment for sexual deviancy.

4.1.3 *Consequences and Risk*

The law enforcement group of witnesses was clearly concerned about the consequences and risks of both sexual deviancy and addiction, in reference to a victim. However, the way in which the victim is constructed is rather different in the case of addiction compared to sexual deviancy.

The victim in the case of sexual deviancy consists of an individual with a very direct role, particularly from the point of view of law enforcement. Law enforcement professionals only approach sexual deviancy from a legal perspective, so in that case, there must always be an inherent victim. Since their experience does not involve diagnosis and treatment, their reality of sexual deviancy is constructed in part from reports by victims. Therefore, it is not surprising that these individuals construct the consequences of sexual deviancy based on the

harm reported by the victims, indicated by the following quote by Catherine Dawson, a police trainer.

“Health Canada has identified over a dozen observable effects of child abuse, including unusually high levels of anger and aggression. These effects have long-ranging implications for the children, their families, and their communities.” (Catherine Dawson)

This quote by Catherine Dawson emphasizes the consequences for the victim and indirectly the community. Catherine Dawson, mentions that the consequences to the victim (in this case anger and aggression) expand beyond the children themselves and reach their families and communities. This implies that the victim will grow up to cause harm to others. The view by Catherine Dawson that victims become a risk to society is consistent with Terry (2006) who discusses the cycle of abuse theory, which claims that children who are abused are likely to grow up to be abusers themselves, as a factor in explaining sexual deviancy.

On the side of addiction, Michael Boyd, the Deputy Chief of the Toronto Police Service, also focuses on the harms to a victim. However, in his case, there is a little more ambiguity on whether or not the victim is always a third party victim or rather the addict himself.

“Victims of violent crime are often physically hurt and psychologically scarred. This results from drug-addicted users committing crimes to get money to feed their habit. Often, addicts will frequent an area where a supply of drugs can be purchased. Sometimes these are areas of high crime and high victimization, where the supply meets the demand.” (Michael Boyd)

Michael Boyd’s comment is interesting as at first, he seems to be talking about addicts committing crimes on seemingly innocent victims, much like Catherine Dawson’s comment on sexual deviancy. However, the last sentence of his comment seems to equate

victimization with the supply and demand chain, implying that perhaps addicts are both the offender and the victim, and are therefore a danger or risk to themselves as well as to others.

The major difference between these statements is how victimization is discussed in sexual deviancy compared to addiction. Sexual deviancy is constructed to have a clear victim who needs protecting (usually focusing on children, but potentially victims of any sexual offence). In regards to claims-making, this is an important distinction; having an explicit victim to protect would help rally a community and gain momentum for a cause (Spector & Kitsuse, 2001). However, the focus on the victims rather than the offender could lend itself to a construction that legitimizes the use of harsher punishments, especially if sexual offenders are constructed as the villains and the causes of this harm. Loseke (2003) has suggested that claims made about victims and claims made about villains are both effective. Therefore, in the case of addiction and sexual deviancy, claims-makers could use either method and be successful. The construction of victimization and addiction is present, however, is not presented the same way as it is in sexual deviancy and perhaps is more subtle, this distinction arises throughout this chapter and will be discussed further in later sections and chapters.

4.1.4 *Regulation*

Members of law enforcement commented substantially on the possible regulation strategies for addiction and one of the most common themes to emerge was that of ‘awareness’. Although awareness is never clearly defined, it is raised several times by different witnesses.

“We are not saying that we want more money for policing and arresting people. We agree with the current balance. We think that not only crime prevention, but also drug awareness is a vital tool in making a difference.” (Barry King)

“We believe, first, that there is a role for police in prevention and awareness as well as in enforcement. We have excellent partnerships with teachers, parents and community groups. Community policing has really started to come together in the last 10 years.” (Barry King)

“We think public opinion is important. That is why we are also advocating a strategy that increases public awareness, focusses [sic] on education and prevention and addresses not only the issue of supply but also the issue of demand.” (David Griffin)

“Integration has brought the community to recognize that the drug problem is not just a police problem; it is a community problem. As a result, we need to take an integrated approach to dealing with the drug problem. Enforcement of drug laws is just part of the solution. We must integrate our approach with treatment, rehabilitation, prevention, education, awareness, and enforcement.” (Ward Clapham)

Awareness could be a goal of such strategies as education and prevention, such as the D.A.R.E program that is organized and facilitated by law enforcement agencies, as demonstrated within the previous quotes. According to Herbert (1998), the willingness of law enforcement officers to work with the public is indicative of the changing values that are present in police subculture. The traditional police subculture conveyed the ‘us vs them’ mentality that was present in law enforcement, which leads to a distrusting relationship between citizens and law enforcement. The demographic changes in the police force over time has led to a drastic change in beliefs of law enforcement which has created an environment in which community policing, as mentioned by Barry King, the Chief of the Brockville Police Service, has become a very common strategy within law enforcement (Herbert, 1998).

Another theme that emerged from the law enforcement witnesses on addiction was that of maintaining the status quo on regulation through maintaining prohibition; in other

words, not changing the laws or police involvement. Michael Boyd's statement is by far the most clear on this idea stating: "...we believe that the drug laws are fine as they currently are..." indicating no change to enforcement should be made. Julian Fantino is also very straightforward about his views on the legalization of drug use:

"I stand with the Canadian Association of Chiefs of Police in firm opposition to any type of legalization of any and all current illicit drugs in Canada, including the possession of small amounts of marijuana or other cannabis derivatives." (Julian Fantino)

These clear-cut statements leave little room for interpretation and analysis. It is obvious these individuals believe in the role that enforcement has and that this role should not be changed. The normative order of law is what guides a police officer in their understanding of the role law enforcement has for certain behaviours (Herbert, 1998). The legislative guidelines, such as the criminal code, outline whether or not a particular behaviour is within the realm of law enforcement by determining its legal status. In the case of Michael Boyd and Julian Fantino, there is a belief that drugs should be illegal and are therefore police business. According to Herbert (1998) to remove drug offences from the Criminal Code would remove the legitimacy of law enforcement in regulating these behaviours. In addition, they mention no integrated approach with other aspects of drug control such as prevention, education, etc.; they simply rely on the enforcement approach. David Griffin similarly does not offer new solutions and simply reaffirms the current approach to addiction in Canada. However, his statement is more subtle in its affirmation of enforcement and also includes other aspects of drug control policy:

"That [the dangerousness of drugs] is the basis for the public policy decisions on what is the best way to reduce demand, reduce the supply, educate and inform the

public about the consequences, and provide treatment and rehabilitation to those who develop dependencies.” (David Griffin)

This above statement by David Griffin addresses many aspects of addiction including reducing the supply of drugs, which is a responsibility of the police. Only one witness in the law enforcement group acknowledged any limitations of enforcement in the regulation of addiction. Kash Heed states “[t]otal prohibition has resulted in costly enforcement, alienation of groups of people, discriminatory enforcement, little deterrence in supply, and minimal deterrence of use.” This is a direct criticism of the role of enforcement in drug control and although he does not make any new suggestions as to how to regulate addiction, it is clear that he does not approve of the prohibition strategy. Kash Heed is also appealing to the normative order of law by implying that prohibition creates problems and that possibly the police do not perform an effective role in the regulation of drug use. The views of how to regulate addiction from the point of view of law enforcement seem to cover almost all approaches from punitive and prohibition, to prevention, education and harm reduction.

For the topic of sexual deviancy, the general consensus in this set of witnesses seems to favour a punitive approach, advocating for longer sentences to deter crime. This is illustrated in the following quote from Scott Naylor:

“Strong deterrents are necessary as a first step to deter perpetrators from preying on our children, particularly those who are in a parental role or are responsible for children through kinship.” (Scott Naylor)

The use of the verb “prey” is a common theme when describing sexual deviancy, as it implies the innocence of the victim, the helpless prey, and the monstrosity of the offender, dark and dangerous; in other words, it promotes the villain construct discussed by Loseke (2003) which is considered a very effective claims-making tactic. In addition, Scott Naylor’s

emphasis on “strong deterrents” implies an increased perception of dangerousness and risk of sexual deviancy. Regular deterrents are not sufficient; they need the extra strength to maintain and control this risk. His mention of parental and kinship roles also implies that he views these particular offenders as the most dangerous and that the caregiving context creates a particular vulnerability. Scott Naylor’s comments are also illustrative of the normative order of morality presented by Herbert (1998), which refers to the strong sense of right and wrong, good and evil, exhibited by police officers. Scott Naylor clearly views his role as a police officer, especially one on a special task force, to be one who protects innocent children from perpetrators. His use of the phrase “our children” depicts a sense that he feels responsible for these victims; he takes ownership over their safety and thus embraces a role as a hero for the public, which is consistent with the writings of Herbert (1998) who describes police officers as valiant defenders of the innocent with a strong sense of right and wrong.

Catherine Dawson also emphasizes the importance of the victim when considering sentences and policy for sexual deviancy.

“Minimum sentencing, as it stands today in Canada, does not achieve this goal. I would argue it does not consider the real and often lifelong impact that offences have on the victims.” (Catherine Dawson)

“Victim recognition and respect are enhanced by longer sentences and greater penalties.” (Catherine Dawson)

In this case, emphasis on the victim is used to justify more punishment in the form of longer sentences for the offender. This reflects the notion that sexual offenders are villains and in need of strong punishments in order to protect the innocent victims of society.

Overall, the influence of police subculture seems to be present in this group of witnesses and is illustrative of how one's social interactions have an effect on the way in which they view the world. Traditional police subculture having been a dominant model around the 1950s is not as prevalent within law enforcement today. Changing values in the broader social context has led to a drastic change in the demographics of police forces, which now include a more diverse group of individuals and thus highly varying values and beliefs. Viewing police subculture as a group of normative orders which influence the individual officers differently based on other layers of social interaction such as family and community not only accounts for these changing values in the broad social context, but also provide more agency to the individual officers and illustrates the diversity found within law enforcement today.

4.2 LAWYERS

Lawyers provide an interesting perspective on issues relating to criminal law because even amongst themselves they inherently provide two sides to the issue: defence lawyers and Crown Prosecutors. Defence lawyers have more contact with the accused and also may have more details as far as the background of the accused and facts of the case as some disclosure would be privileged information between client and counsel. Prosecutors would have more contact with the victim (if there is one) and the family of the victim and would be working more closely with law enforcement. The very nature of their work and whom that brings them in contact with could have an impact on how they describe the concepts of addiction and sexual deviancy. Unfortunately, the witnesses in this group of experts are all defence lawyers and therefore there could be no comparison between the two groups. This section focused on the views of defence lawyers as they pertain to sexual deviancy and addiction.

4.2.1 *Explanation*

John W. Conroy and Alan Young, defence lawyers, take a stance against our current response to addiction and denounce the criminalization of addiction and drug use. They come to this conclusion in two different ways. John Conroy approaches it from a moral point of view, and Alan Young approaches it from a psychological perspective.

“What is the moral value? It is telling people what they can or cannot do with their bodies. It is the imposition of your views on others when what they do does not affect you in any way and should be none of your business. This moral value thing is nonsense.” (John W. Conroy)

“I believe this has to do more with psychology and certain reckless types of personalities. Certain people will try anything once. Certain people will bungee-jump from the Grand Canyon; I will not. People who are not risk-averse will go on to try something that has nothing to do with the pharmacological properties of the drug; it has to do with personality. We cannot control that by law.” (Alan Young)

Mr. Conroy implies that the understanding of addiction is purely moral, that the current system simply aims to impose views on others and sway them to believe that drugs are harmful and therefore should not be taken. John Conroy’s view is in contrast to the view that was popular during the temperance movement, which led to the prohibition of alcohol (Peele, 1985). Although to less of an extreme, the moral view for which John Conroy is referring to is the basis for the AA movement which is still a widely accepted and used form of treatment (Peel, 1985). Alan Young states that addiction cannot be controlled by law, in other words, addiction will continue no matter what the law dictates. This is a critique of the regulation of addiction through the criminal justice system, which candidly states that criminalization is ineffective and begins to imply that drug use and addiction are a lifestyle choice.

4.2.2 *Consequences and Risk*

John W. Conroy illustrates a point of view that is blaming all the problems associated with addiction on the fact that it is a prohibited act. He blames the prohibition of drugs for the harms caused, stating that:

“[t]he problems we have from all illicit drugs combined are primarily caused as a result of prohibition itself and economic issues that surround them.” (John W. Conroy)

John Conroy provides a critique of criminalization, and once again he is questioning its effectiveness. Without further elaboration, which was not given, it is not possible to know the types of economic issues to which John Conroy was referring.

When discussing the risks posed by addiction and sexual deviancy, this group of defence lawyers discussed the most extreme case on the non-risky end of the spectrum. Alan Young, a defence lawyer, used marijuana as an example to demonstrate that people in society are not afraid of all drug users; it depends on their drug of choice. In this case, he is stating that those dangers are not seen in marijuana users.

“According to a 1993 Statistics Canada victimization survey, published in *Juristat*, 27 per cent of Canadians are afraid to walk their neighbourhoods at night and it is not because of pot smokers or pot dealers.” (Alan Young)

Michael Spratt, a criminal defence lawyer, demonstrates a similar theme in his discussion on sexual deviancy. Mentioning that the expression “at risk of reoffence” is often found in medical reports, he uses an outlying case to illustrate that not all sexual offenders are risky.

“I received a report rather recently where the risk of reoffence for an individual, as diagnosed by the doctor, was zero. He had ongoing treatment with the hospital, and that was the doctor's professional opinion. I don't see it very often, but that was his report.” (Michael Spratt)

Alan Young used a statistic to demonstrate that Canadians are afraid and perceive danger, but he dissociates marijuana and related offences from this danger, displacing the blame to other groups of offenders. Michael Spratt, however, uses an example of an assessment done by a practitioner who deemed the individual not to be a risk to society. Both of these statements use a perceived notion of risk—one from society and one from assessing practitioners—to discuss a risk potential, yet neither of the witnesses definitively says whether or not they themselves believe the group poses a threat. Their use of extremes seems to be a way to captivate the audience and make them listen to the rest of their arguments and claims.

Up to this point, the main theme from these lawyers, in particular, Alan Young and John W. Conroy, is an opposition and critique of the criminalization as a way to regulate addiction and drug use. Throughout this opposition, there was very little discussion of using a medicalization approach to addiction, although some medicalized terms were used.

4.2.3 *Regulation*

As the following quotations illustrate, Alan Young, once again emphasizes his opposition to the criminalization of addiction and introduces an illustration of vindication. Vindication is the process through which a particular behaviour is no longer constructed as deviant and therefore is also no longer criminalized or medicalized.

“Medical issues, or the promotion of good health and well-being are not criminal justice issues.” (Alan Young)

“That is when, senators, you will see people start talking about civil liberties. I deal in the area of civil liberties; I say it is a liberty issue to choose your intoxicant as long as it does not hurt other people, and the courts do not agree. You take away the right to consume alcohol; people will understand it as a civil liberties issue.” (Alan Young)

Alan Young's first statement is very clear, he believes that the criminal justice system has no business governing people's health and he presents addiction as a health problem. His second statement is a unique perspective on the governance of one's choices in their own health; he considers it a civil liberties or human rights issue. Alan Young begins his statement in the third person stating 'people start talking...' but changes to the first in the next sentence stating 'I say...' indicating these are his beliefs. His overall testimony made it clear that he viewed addiction as a civil liberties issue as well as he speaks in the first person throughout. Alan Young's phrase "choose your intoxicant as long as it does not hurt other people" is reflective of Conrad and Schneider's (1992) discussion on the vindication of deviance in which they explore how homosexuality cycled through medicalization, criminalization and finally to vindication. Conrad and Schneider (1992) state that in current society, deviant behaviour is either considered medicalized, criminalized or a hybrid of both; the only way to break this cycle is for behaviour to no longer be considered deviant at all but to be vindicated. They use the example of homosexuality and described how activists declared homosexual acts to be a lifestyle choice which led to a movement towards tolerance and acceptance (Conrad & Schneider, 1992). Alan Young reflects this idea of homosexuality as a lifestyle by stating that people have the right to choose their intoxicant. Alan Young's statement is reflective of the framework through which addiction is constructed from the point of view of vindication, rather than medicalization or criminalization.

The perspective presented by Michael Spratt is focused on how the criminal justice system has lost its connection with rehabilitation. Michael Spratt focuses his discussion on the sentencing principles found in section 718 of the Criminal Code of Canada.

"...mandatory minimum sentences can interfere with rehabilitation, which is a paramount principle of our sentencing principles. They essentially abandon

rehabilitation or devalue rehabilitation, and put an offender sometimes in a worse position” (Michael Spratt)

Michael Spratt’s comment states that our use of retribution in the form of mandatory sentences interferes with the principle of rehabilitation. He states that not only is rehabilitation important but that focus on retribution through mandatory minimum sentences actually “abandons” or “devalues” rehabilitation which he emphasizes could cause more issues for the offender. Michael Spratt’s comments are actually a critique of the justice model, as Petrunik (2003) claims this model focuses on the offence and does not consider the unique circumstances of the offender. In essence, Michael Spratt is claiming that rather than considering all offenders as homogenous individuals who deserve the same punishment, they should be treated as individuals with specific needs in regard to rehabilitation. This comment provides a good illustration of the inflexibility of the justice model and its associated policies.

Overall, these defence lawyers seem to consider both sexual deviancy and addiction as two concepts that go beyond the realm of the criminal justice system. In the case of addiction, there is a clear demand for complete removal of the prohibition of drug use and to instead focus funds and resources towards a public health approach for those whom would like to seek treatment. Their approach towards sexual deviancy is not quite as extreme as removing the prohibition, but there is a clear understanding among this group of experts that the punitive measures are not more important than the treatment measures. They do not imply that we should remove the criminal justice system from the regulation of sexual deviancy, but they recognize its limitations. Interestingly, for the most part, there is minimal discussion about the victims of sexual deviancy by the defence lawyers, which could contribute to the emphasis on treatment over punishment. All three lawyers are defence

lawyers; therefore, most of their experience would be with the accused, rather than the victims and law enforcement. Their understanding of addiction and sexual deviancy is based on this experience with offenders. It would be interesting to explore if Crown Prosecutors, who spend more time with victims and law enforcement would perhaps have a different construction of sexual deviancy and addiction which aligns with the victim and law enforcement groups. This would not only possibly provide a different perspective from lawyers but it would also allow for the ability to generalize about lawyers as a group.

4.3 VICTIM/VICTIM ADVOCATES

Victims and their advocates have a unique perspective as they are directly affected by sexual deviancy. Victims and their advocates present claims from a point of view that no one else has access to which makes them an expert in their own way. The lack of representation of victims in the addiction discussion is likely due to the fact that it is hard to identify who is the victim in the case of addiction, especially when compared to sexual deviancy when there is often a very clear victim. This distinction between addiction and sexual deviancy is accentuated by the way in which the typical victim is portrayed in society, often with connotations such as “weakness or lack of agency” (Dunn, 2008, p 1608) or “passivity and helplessness” (Dunn, 2008, p 1608). The next section of the analysis will focus on how victims are constructed in society and more particularly on how the constructions of childhood and children are illustrated in the construction of sexual deviancy.

4.3.1 *Explanation*

Karyn Kennedy, a victim advocate, provides her perspective on sexual deviancy and raises the question of whether it should be understood as a mental disorder and as a manifestation of control over the victims.

“If I could just respond, I respectfully would disagree with my colleague [who claimed pedophilia was a mental disorder]. I believe that for some individuals it may be a mental disorder; for others, really, it's not and it's an issue of power and control.”
(Karyn Kennedy)

The use of power and control as a description of sexual deviancy is not uncommon in the literature and was expected to emerge more frequently than it has in this set of data; it was not a dominant theme in any other group of witnesses. Karyn Kennedy does not have an absolute position in either direction but rather points out that it can be a mental disorder in some and a power and control issue in another.

The explanation of sexual deviancy as a power and control struggle is reflective of psychodynamic theories in that individuals have not learned to meet their own needs and, thus, have abnormal behaviours in order to cope (Terry, 2006). Even more relevant, power and control are closely related to feminist theories that describe sexual aggression as a function of the values and beliefs that are dominant for members of a (patriarchal) society. In addition, the portrayals of women in pornography, as explained by feminist theory, change the sexual expectations of men and, therefore, lead to an expectation of dominance (Terry, 2006, p.42). It is significant that the witnesses representing victims would explain sexual deviancy in a way that reflects feminist theories, as it was both the rise of feminism and the emergence of campaigns bringing attention to victims that helped influence the development of the risk-management model that is dominant in the regulation of sexual deviancy (Terry, 2006; Petrunik, 2002).

4.3.2 *Treatment*

Overall victims and victim advocates have a bleak outlook on the possibility of sexual deviancy being treated. Given their position in the claims-making debate, this is not a surprising view of treatment outcomes; generally, they are advocating for punishment, not treatment.

Brian Rushfeldt, a social worker and president of Canada Family Action, and Ellen Campbell, the founder of the Canadian Centre for Abuse Awareness and a victim of abuse, demonstrate a lack of belief in the use of treatment for sexual deviancy in their responses to the following question:

“Given all of your experience in the field of law enforcement or in child advocacy or victim counselling or criminological studies, do you believe that a person who is a pedophile can be cured?”

“I would say probably not, from my experience as a social worker and also from the research I've read, but I think we do owe every one of those individuals at least an opportunity, while they're incarcerated, to hopefully get their life together.” (Brian Rushfeldt)

“I don't think so at all. I think there are what they call crimes of opportunity, which I still think are pedophilia. Once somebody offends.... Given all my experience, all my knowledge, I know of one instance, really quickly, in which there was a support group and the offenders had to be accountable. They came in every week for eight weeks, but as soon as the support group was over, they all went and reoffended. So no, I don't.” (Ellen Campbell)

Later on in her testimony, Ellen Campbell also added:

“I understand, and I think most people do, that pedophilia is not curable—I don't believe—so we need to protect children.” (Ellen Campbell)

The witnesses were asked if pedophilia is curable and both of them gave a definitive answer that it was not curable. Even though Brian Rushfeldt highlighted a belief that pedophilia is not curable, he stated that they should at least be given a chance. However, this response could be a result of the terminology that was used in the question. The use of the word

“curable” makes this a difficult question, as many witnesses in other groups of experts would agree that it is not curable, but is treatable or manageable. However, since the question posed used the term curable instead of treatable, it is not clear if these witnesses would have changed their answers if they were asked about treatability instead.

In addition, Ellen Campbell is reporting the widely shared belief that children are in need of protection, a notion that did not emerge until the early 20th century (Bell, 2011; Conrad & Schneider, 1992). Prior to this, children were considered small adults and thus by the age of seven often had jobs and contributed to the family. The perception that childhood is “a natural and essential category marked by characteristics such as innocence, vulnerability, and passivity...” (Pascura et al, 2012, p 202) was a result of the belief that children who were neglected would become delinquent and thus a burden to society. The broad context of capitalism viewed children as future workers and therefore any potential problems with their status as a worker would be a threat to society itself. Although the focus on protecting children is no longer justified through a capitalist framework, statements like Ellen Campbell’s, which emphasize a need to protect children, are common and are highlighted throughout this section.

Another relevant point that is raised by Ellen Campbell is her example of the offenders who participated in a support group for eight weeks but once the support group was gone, they all reoffended. She uses this example as a way to demonstrate her point that treatment does not work, as she implies the offenders simply re-offend when they leave treatment. However, if this example was given by a treatment provider, it would have been easy to assume that they would use it as an example of how treatment does work, and that the only reason these people re-offended is because the treatment and support were removed.

This seems like an ideal way for someone to propagate an agenda for more support for offenders, but it was instead used against them to demonstrate they cannot change. It is very important, especially from a social constructionist point of view, to consider how one fact can be interpreted to support arguments on both sides of the same issue. This illustrates that apparent objective facts, in this case, rate of reoffending after leaving treatment, is not crucial in the social world and that it is the meaning attributed to the 'evidence' and 'facts' by members of a social circle that guide understanding.

Karyn Kennedy discusses the aspect of treating sexual deviancy and brings up two very interesting points:

“I don't currently work with sex offenders, but I have in my career. The ones who are able to benefit from treatment are the ones who are also willing to admit and take responsibility, and in my experience that's not the majority of sex offenders. I believe that for many, prison is necessary in order to have some leverage to get them into treatment. And there are many good institutional treatment programs that can be initiated while somebody is in custody and they can continue treatment in the community. But for many sex offenders, taking part in treatment is not necessarily something they agree to very easily.” (Karyn Kennedy)

The first point that Karyn Kennedy discusses is the voluntariness of treatment and how that affects the outcome and results of treatment. She states that those who take responsibility and admit fault will gain the most benefit from their participation in treatment, but she also claims that this is not the majority of sex offenders in her experience. However, instead of taking a position that reaches out to these individuals and encourages treatment, her second point states that incarceration would be effective in pushing them into treatment or, in her own words, used as “leverage”. On one hand she is saying they need to volunteer for treatment or it will not work, but on the other hand, she is also advocating for incarceration in order to get them into treatment, which is not voluntary. In this case, it seems as though she is advocating for a punitive measure under the guise of getting the

offenders treatment despite a belief that that treatment will not work. It could be that the incarceration serves as a motivator for the offender to want to get treatment; not as a threat or coercive measure, but more as an epiphany that treatment is needed. This is similar to the idea of addicts refusing help until they have reached what is considered “rock bottom” or an ultimate low in life.

4.3.3 *Consequences and Risks*

Surprisingly, this section is quite short for this group of witnesses considering their main focus was the victims and how sexual deviancy harms the victims and poses a risk to them. Since most of their testimonies throughout the other categories focused on the underlying theme of victims, which also included the consequences and harms to the victims, statements that were solely focused on these consequences or other more general consequences were lacking.

Brian Rushfeldt, for example, focuses on the victim in sexual deviancy and discusses the feeling of insecurity and paranoia associated with being a victim.

“... I hear that the crime doesn't stop when the guy is caught. Those images, as we just heard, are out there circulating for years. In fact there are some quotes in this report from the ombudsman in Canada: 19-year-olds who were victims at six saying they're still victims because they can't walk down the street without thinking, ‘Did this man see my pictures?’ ‘Because they're still out on the Internet.’” (Brian Rushfeldt)

Brian Rushfeldt's statement emphasizes that the victims' suffering extends beyond just having the offender caught, but also includes the psychological distress they continue to feel. This consequence, of lifelong struggles for the victim, is a common justification for lengthier sentences for sexual offenders, claiming the punishment should fit the crime and the consequences of the crime (Petrunik, 2002). The risk-management and community

protection approach to sexual deviancy was significantly influenced by victim advocates (Cole, 2000; Zonana et al., 1999); this is also illustrated in the testimony from Brian Rushfeldt.

4.3.4 *Regulation*

Regarding regulation, there is a clear theme to the statements made by these witnesses and that theme is more punishment for the sake of the protection of the innocent victims, illustrating the societal beliefs around children and childhood. Brian Rushfeldt first uses the idea of justice for victims to explain his support for mandatory minimums when he states:

“It's known that when perpetrators are brought to justice, if justice is applied, it can often bring healing to the victims.” (Brian Rushfeldt)

He then adds in protection as an important factor and says that:

“Clearly, there must be changes made to Bill C-54 to accomplish meaningful protection and true justice for these defenceless children.” (Brian Rushfeldt)

Subsequently, Brian Rushfeldt uses both of these principles, protection of victims and justice for victims, to support the notion that incarceration and mandatory minimum sentences are the best methods for regulating sexual deviancy. He states:

“We believe that incarceration is critical. I know there are people--possibly in this room--who don't agree with mandatory sentences. But in all the discussions I've had with people across Canada, no one has suggested any better method than incarceration for people who commit these crimes. We simply cannot protect children as long as these people are out wandering the streets in our communities.” (Brian Rushfeldt)

The relevant aspect of this statement above is when he says “no one has suggested anything better” even though many people in this study have mentioned that treatment is the more cost effective solution. However, when looked at from the framework that Brian Rushfeldt developed above, emphasizing protection and justice for victims, this statement makes much

more sense. He believes that incarceration is the only way to approach the protection and justice for victims, and does not engage in a discussion about how incarceration affects offender's outcomes. The risk-management approach that Brian Rushfeldt's comments reflect was never meant to be rehabilitative, but rather was meant for retribution or, in this case, protection. This focus on retribution is consistent with the findings of Zonana et al. (1999) as they described the expectations victims had for the role of the criminal justice system. The main objective for the victims described by Zonana et al. (1999) was to protect potential future victims from experiencing the same fate as them. This illustrates that although on the surface, victims and their advocates appear to be vengeful in their promotion of stricter punishments, their justifications are actually based on the idea that their suffering should not be in vain but should help protect future victims by taking their perpetrator out of society.

This is where a clear and unexpected binary is formed in this issue of sexual deviancy; that of victim outcome versus offender outcome. This changes the discussion entirely as it does not matter what facts one raises about the effectiveness of treatment because someone viewing it from a victim perspective does not see how that would bring justice to the victim. On the other hand, it would not matter how the victim advocate emphasized the need for a victim to feel justice if the other person is only concerned with treatment effectiveness. Although desistance from offending could be considered a treatment outcome, and would therefore indirectly protect potential future victims, this does not give justice to the previous victim. Once again, retribution is the common theme in the risk-management approach, with very little emphasis on rehabilitation. As discussed by Petrunik (2002), the role of the victim and their insistence for justice was a major factor in the

development of the risk management model. Cole (2000) also described how there was a shift from a rehabilitative approach to a significantly more punitive approach for sexual deviancy, primarily due to victims campaigning for justice. This need for justice became more important than the rehabilitation of individuals and resulted in the risk-management model, characterized by a more punitive approach. Within this group of witnesses, there seems to be a belief that one cannot have both a rehabilitative approach to sexual deviancy and provide protection and justice for victims. This binary is evident in the following quotes as well.

“I don't know that we consider the mandatory sentencing issue from the perspective of deterrence. I'm not sure it does deter. I have no evidence to say whether it does or doesn't. You mentioned that some say it doesn't. I don't think it's a matter of deterrence as much as protection of the innocent.” (Brian Rushfeldt)

“Certainly we look to the separation between retribution and rehabilitation. I think our agency certainly supports mandatory minimums.” (Lianna McDonald)

While both of the above statements acknowledge that other perspectives exist, they clearly state that they do not approach the topic from those perspectives. In the case of Brian Rushfeldt, he acknowledges that deterrence may be a factor in mandatory minimum sentences and that he does not know if they provide deterrence. However, he then dismisses that point as irrelevant because he is solely focused on the protection of victims. Lianna McDonald, executive director of Canadian Centre for Child Protection, approaches her support for retribution differently as her dismissal is more implied. She states that retribution and rehabilitation are separate, implying you must choose one or the other, and then she states that she supports mandatory minimums. This implies she has dismissed the rehabilitation model and has accepted the retribution model instead and, therefore, urges for a more punitive approach, which is reflective of the risk-management approach (Zonana et

al., 1999). This is a stark contrast in how addiction is discussed by other witnesses who imply that to punish an addict would hinder their recovery, while sexual deviants are constructed as needing punishment and treatment, although not always entirely dismissed, is not the focus.

Lastly, Karyn Kennedy demonstrates how one does not have to always approach the topic from one side or another, and she promotes a punitive measure in order to enhance the possibility of treatment. She states that:

“The increase in some mandatory minimum sentences and the addition of others may also increase the possibility for more treatment options while in custody and provide greater opportunities to engage offenders in treatment as well as conduct treatment-related research...” (Karyn Kennedy)

This is clearly advocating for more mandatory minimum sentences, which is typically understood as a more punitive approach to crime. However, she is able to justify this measure under the intention of creating more opportunity for treatment. This relates to her above comments about having to forcibly engage offenders in treatment in a prison setting in order for them to hopefully choose to continue this treatment when they are released. The idea that incarceration is a way to reach offenders in regards to treatment is reflective of Conrad and Schneider's (1992) discussion on the role of a sick person. According to this role, one must accept that their situation (being sick) is undesirable and that they need professional help to get treatment for this illness. In the case of sexual deviancy, which has strong ties in criminalization and the criminal justice system, it is almost as if there needs to be cooperation between the criminalization and medicalization approaches in order to reach offenders. By using incarceration, in the form of mandatory minimum sentences according to Karyn Kennedy, as the criminalization aspect, offenders are shown that their actions are deviant and undesirable. When they begin to accept this idea they can then move on to the medical side and receive treatment for their condition.

Karyn Kennedy adds another contribution to this section in the form of the following quote:

“And from the perspective of victims, including mandatory minimum sentences for all child-specific sexual offences sends the message that there are no underlying values as to which sexual victimizing offences are more serious than others. From the victim's perspective, the experience is very individual. The law takes into account that all sexual offences against children must be taken seriously.” (Karyn Kennedy)

Karyn Kennedy's statement uses the view that our law is the measuring rod for the values and beliefs of society. She claims that victims gauge their understanding of how serious a crime is based on the length of punishment given to the offender. This is a very victim-centric and punitive-centric view of the criminal justice system which does not consider the needs of the offender.

Having a clearly identifiable victim is most certainly the best way to garner attention from the public and government officials in the claims-making process (Loseke, 2003). This is exacerbated when the victim in question is a child. The societal beliefs and values of children and childhood were illustrated throughout the testimonies from this group of experts. The main focus of this group was the belief that children are vulnerable and therefore in need of protection from those who may corrupt their innocence. This is a stark contrast to the way in which victimhood is constructed in addiction, as the victims of addiction are not as easily identifiable and are often thought to be voluntary participants. The witnesses throughout this section illustrate the way in which victims are constructed within sexual deviancy and how this is influenced by broader societal values.

4.4 PUBLIC OFFICIALS

Public officials were a small group in the sample, consisting of city councillors, mayors, and other non-Canadian government officials. These individuals primarily identified as public officials however as a group they likely have other functions in society and other professions. In addition, all these witnesses come from the lower mainland in BC and therefore only speak to the issues found in that area, particularly the downtown east side in Vancouver. There were no statements addressing the concept of sexual deviancy, so this section will strictly discuss addiction.

4.4.1 *Explanation*

There are two different views of what addiction is for public officials: a disease or a symptom of social problems. Philip Owen, the mayor of Vancouver at the time of his testimony, states that addiction is a disease and he pushes for a health care approach to the problem, not a criminal justice response.

“The public is now beginning to recognize that a teenage cocaine and/or heroin user is sick, not a criminal. Our people have trouble getting their minds around it, but that is now beginning to be a given. These people need assistance through the national health care system to change their lifestyle...” (Philip Owen)

During the testimonies, many witnesses discussed the problems experienced in the Downtown Eastside of Vancouver so it was not surprising to see the mayor present at the meeting. The city was implementing the safe injection site at the time, which is a health care approach to harm reduction, so the fact that this is being presented as a health problem or a disease is expected given the circumstances and context. In other words, Phillip Owen’s statement is reflective of the current situation in Vancouver at the time during which addiction was becoming a matter for the health sector through harm reduction policies.

Bill Marra, a city councillor and correctional worker, also discusses the struggles that individuals in the Downtown Eastside face, which may cause them to turn to drug and addiction. He also recognizes that these obstacles are not eliminated upon release from a prison environment. In this observation, Bill Marra states that addiction and drug use is simply a symptom of the low socioeconomic status of individuals.

“The gap exists between their discharge from our facilities and their return to the community. There are the other issues of homelessness, unemployment and disintegration of the family. The drug, as we would all agree, is symptomatic of all the other stuff. There must be investment in all those areas.” (Bill Marra)

Both Philip Owen and Bill Marra approach the subject from the point of view that those with addiction need to be helped in non-criminalized ways, in other words outside the criminal justice system. While Philip Owen describes a disease explanation of addiction, Bill Marra describes a more sociological and environmental explanation of addiction. However, both still come to the conclusion that these individuals need help, not punishment. This similarity demonstrates how claims-makers do not necessarily have to compete. Even if several claims-makers have different perspectives on the causes of a social problem, they may not disagree that it is, in fact, a social problem and that it needs a solution. Spector and Kitsuse (2001) state that claims-making is a competitive process as each claims-maker needs to receive the (exclusive) attention and affirmation from the audience in order to validate their claim as a social problem. However, as is the case with Philip Owen and Bill Marra, social problems work does not have to be all that competitive. Following from this connection found within the data, an argument could be made for a multi-agency approach to the understanding of social problems. In other words, if the different group of experts and claims-makers could agree there is a problem and that this problem requires a solution from

governmental organizations, they could work together to garner the attention of the audience, rather than spending a great deal of resources competing against one another.

4.4.2 *Consequences and Risks*

Bill Marra is the only witness to discuss the consequences and risks of addiction and, simply put, his concern is violence. He describes many forms of violence and several different people affected by this violence, which is all associated with the illicit drug trade and those involved in it.

“...of all organized criminal activities, the illicit drug trade has the strongest link to violence. Examples of violence fuelled by illicit drugs include: violence between criminals fighting over drug market share; violence against law enforcement officers; violence against the public, motivated by the need for money to purchase drugs; and random violence resulting from the disoriented state of drug users.” (Bill Marra)

This statement, however, implies that the problematic consequences of addiction are predominantly related to the way in which it is regulated. With the exception of his last point, stating that violence occurs as a result of being disoriented, all the substance-related violence is a result of having an illegal drug trade and making the drugs hard to acquire. This theme reflects his statement (discussed in the explanation section) that positions him more towards a harm reduction approach, rather than a criminalization approach. The focus on violence in Bill Marra’s statement highlights the fact that although the victim is less clearly identifiable in the case of addiction, there is certainly a concern about the harms caused by those with addiction. In this case, the addict is not constructed as a victim, but as a perpetrator of violence and mayhem.

4.4.3 *Regulation*

In regard to regulation, Linda Barnes, a city councillor in Richmond, states that the only way to approach addiction is to have many agencies and organizations working

together. She states that this is the only effective way to deal with addiction and that one agency alone does not have the ability to be “sustainable.”

“An inter-agency cooperation is the key to the success of any drug strategy. Sustainable solutions cannot be accomplished in isolation.” (Linda Barnes)

Based on Linda Barnes’ experience as a city councillor, it is not surprising that she would advocate for multi-agency approaches to addiction. Similar to the other witnesses in this section, Linda Barnes’ experience as a city official would likely include attending meetings with various agencies and organizations in order to come up with solutions to many problems. Therefore, their experience would help shape their understanding of addiction as a problem that can only be solved with a multi-agency approach.

Overall, the witnesses in the public officials group did not add much to the analysis since their number was particularly small. In addition, with the exception of Bill Marra, who was a former correctional officer, the professional background of these officials was not clearly stated. These witnesses did illustrate the idea that the solution to addiction, and perhaps other social problems, can include more than one agency or agenda. Their main concerns were in fact about the implementation of services or programs that could help to reduce the consequences of addiction in their specific locations.

4.5 TREATMENT PROVIDERS

Treatment providers make up a significant proportion of the data collected for this project and the witnesses come from a variety of backgrounds and specialties including medical doctors, counsellors, and social workers. These differences have implications for the way in which different treatment providers understand addiction and sexual deviancy as their backgrounds and training have influenced their experiences. The common thread that

connects all these witnesses is their tendency to medicalize both sexual deviancy and addiction. Their role as therapeutic professionals is pivotal to the medicalization of deviance, which will be the focus of this section.

Medicalization is understood as “the defining of deviant behaviour as a medical problem and mandating the medical profession to provide some type of treatment for it” (Conrad, 1985, p.195). This medicalization process can take place in the following ways: 1) adoption of medical vocabulary 2) adoption of medical solutions or 3) adoption of medical professional control over the individuals who display the deviant behaviour (Conrad, 1985, p.196). All three of these conditions will be discussed as it applies to the testimony of the treatment provider witnesses.

4.5.1 *Explanation*

This section is very clear as the witnesses provided statements that fit plainly in one category or another, which left very little room for ambiguity. It will begin with a discussion on sexual deviancy followed by a discussion on addiction and will end with a discussion comparing the two concepts. Due to the size of this section, subheadings will be used to provide better organization and to distinguish between sexual deviancy and addiction.

4.5.1.1 *Sexual Deviancy*

The witnesses in this group understood sexual deviancy in one of three ways: 1) as a disease or mental disorder, 2) as a coping mechanism or 3) as a sexual orientation or preference. Andrew McWhinnie, a practicing psychologist, uses the *Diagnostic Statistical Manual of Mental Disorders* to explain that sexual deviancy is a mental disorder.

“Sexual offences against children would be classified as deviant sexual arousal, clearly, but they are also included in the *Diagnostic and Statistical Manual of Mental Disorders* by the American Psychiatric Association. It is a mental disorder. It can't be

cured in any respect, but it can certainly be managed and managed well in the community, as the numbers I have just referred to you state.” (Andrew McWhinnie)

Although he does not explicitly state that sexual deviancy is a disease, he constructs the concept within a medical framework, explaining that it is an official diagnosis that does not have a cure. This is an illustrative example of how medical vocabulary is contributing to the process of medicalization. Conrad and Schneider (1992) suggest that by introducing medical language to explain a behaviour or phenomenon, individuals begin to understand the behaviour or phenomenon as a medical problem requiring a medical solution. Andrew McWhinnie uses two terms, mental disorder and cure, which imply a medical connection. The term mental disorder, used by Andrew McWhinnie, is a term that Conrad and Schneider (1992) claim is the medical word for non-biological ailments that are largely accepted to require professional intervention for treatment.

Randall Fletcher, a social worker specializing in sexual deviance, and William Marshall, the director of Rockwood Psychological services and a retired professor, both argue that sexual deviancy is not a disease, but is a way of coping with needs that are not being met.

“It needs to be understood that if someone commits a sexual offence, it's not a sickness. It's not a disease process that happens with them. They're not born with something different about them that leads to that behaviour. It's a learned behaviour. Somewhere along the way in life, they learned to try to get their emotional and psychological needs met through that type of behaviour, and they choose to do so in the absence of skills or the awareness of how to do it differently. That's what treatment focuses on.” (Randall Fletcher)

“I just think that [the medical model] [i]s an inappropriate way to look at the problem. A lot of human behaviours that are persistent are not best viewed as a disease process, but as a learned, habitual behaviour that's satisfying some kind of need. Then you look at how this person could satisfy those needs in a more appropriate way that is less destructive to himself and to others. That's a better way to think about this.” (William Marshall)

These quotes by Randall Fletcher and William Marshall both highlight the belief that sexual deviancy is a learned behaviour and that an individual uses it to fulfill certain desires and needs. This is reflective of behaviourism in which sexual deviancy is part of a process that includes positive rewards (Chan, 2015; Ward, Laws, & Hudson, 2003). Rewards reinforce a perpetuating cycle, which –as both Randall Fletcher and William Marshall mention– must be broken through treatment involving a reconditioning process (Terry, 2006).

Hubert Van Gijseghem and Vernon Quinsey, both practicing psychologists and professors, are offering a completely different explanation of sexual deviancy that was not discussed among any other group of witnesses nor within the literature. Both Hubert Van Gijseghem and Vernon Quinsey claim that sexual deviancy, particularly pedophilia, is a sexual orientation equivalent to heterosexuality or homosexuality.

“If we know that pedophiles are not simply people who commit a small offence from time to time but rather are grappling with what is equivalent to a sexual orientation just like another individual may be grappling with heterosexuality or even homosexuality, and if we agree on the fact that true pedophiles have an exclusive preference for children, which is the same as having a sexual orientation, everyone knows that there is no such thing as real therapy. You cannot change this person's sexual orientation. He may however remain abstinent.” (Hubert Van Gijseghem)

“First of all, pedophiles are people who prefer prepubescent children. They're not interested in 15-year-olds who have an adult body shape or anything like that. They're not interested in those kinds of people. They have quite a restricted area of sexual interests in terms of the kinds of body types that their victims have. There is no evidence that this sort of preference can be changed through treatment or through anything else.” (Vernon Quinsey)

The explanation that pedophilia is a sexual orientation is not used to garner sympathy, but to simply state that it has implications for treatment, as Vernon Quinsey states that sexual orientation cannot be changed. This has significant implications as homosexuality, a sexual orientation, was once considered criminal, deviant and a mental disorder (Conrad

&Schneider, 1992). Through activism, homosexuality became vindicated as in it was no longer considered deviant and was therefore demedicalized and decriminalized. Neither Hubert Van Gijseghem nor Vernon Quinsey is suggesting that sexual deviancy be vindicated; however, consistent with the research by Conrad and Schneider (1992), their statements parallel the thought process of the activists in the 1960s.

4.5.1.2 Addiction

The ways in which addiction is discussed by this group of witnesses can be divided into the following categories: 1) Disease/public health, 2) Withdrawal/cravings, or 3) Lack of control. Once again these statements left no ambiguity as the witnesses were very clear on their perspectives.

The idea that addiction is a disease was discussed in different ways within this group compared to those discussing sexual deviancy. For example, Jerry Fitzgerald, the manager of Alcohol and Drug Services in Regina, discusses addiction as a disease, but a disease which does not affect everyone to the same degree. He implies that problems related to use do not necessarily render a person dependent.

“Chemical dependency is a disease characterized by changes in behaviour, feelings and physical functioning. Some of the primary symptoms are an impaired control of the consumption of the chemical and tolerance to the chemical used. Not every individual who experiences problems related to the consumption of chemical substances is or will become dependant [sic].” (Jerry Fitzgerald)

Jerry Fitzgerald’s use of the terms ‘disease’ and ‘symptoms’ illustrates how medical terminology is mobilized in constructions of addiction. These terms are consistent with the terms described by Conrad and Schneider (1992) as attempts to medicalize deviant behaviour. By using medical terms such as disease and symptoms, images are created in the mind of the audience that reflect patients receiving treatment from a medical professional.

These images strengthen the link between addiction and medicalization. Conrad and Schneider (1992) suggest that the use of very complicated and medicalized language solidifies behaviour as a medical problem because it appears to be specialized and only understood by those trained in medicine. Jerry Fitzgerald's comment is reflective of this idea as he uses some jargon within his statement such as 'tolerance' and 'dependency' which would need to be explained to someone not trained in addiction or medicine.

Michel Landry, from the Centre Dollard-Cormier, also discusses addiction as a disease, but with a degree of responsibility placed on the individual for the development of this disease. He also compares this idea of responsibility to other illnesses, an illustrative example being that people do have a responsibility to eat well and exercise so as to not develop heart problems or diabetes. His view is similar to Valverde (1998)'s discussion about hypertension, which is classified as a medical disease despite the fact that it can be controlled or eliminated with lifestyle changes. Michel Landry states:

“In my opinion, people have some responsibility for having developed the problem, which is the case for other illnesses, by the way.” (Michel Landry)

This statement by Michel Landry is illustrative of the idea that just because someone is constructed as sick rather than bad, they are still considered in a way responsible for their actions. Conrad and Schneider (1992) describe the role of a sick person and that this role requires the individual to adopt a set of characteristics and behaviours as part of their role. The first part of this sick person role is to accept that their condition is not desirable and that they need to take the steps to rid themselves of this condition. In this way, they have a responsibility to do what is required (often treatment) to improve their situation and realign with what is “normal” in society, whether that be socially accepted levels of drug use or medically accepted blood pressure numbers (Conrad & Schneider, 1992). Michel Landry

adds to this idea of responsibility by stating that an individual has responsibility for becoming sick in the first place. This is illustrative of the way addicts are constructed as willing participants in their suffering which can have an impact on the level of stigmatization they experience.

A different way to discuss addiction as a disease is to use the disease aspect as a way to garner sympathy for the individuals with addiction. Randy Cormier, a counsellor at Brentwood Recovery Home, uses the addict's family and the suffering they experience as a result of their loved one's addiction to demonstrate how one should be sympathetic. He even discusses the substances as painkillers for the disease, eliciting a sympathetic response to the pain and suffering of the individual.

“We deal on a daily basis with the disease of alcoholism and drug abuse. Although this disease, which affects so many in our community, is a disease about self, it affects and can destroy entire families. The actual disease is not the alcohol, marijuana, legal or illegal substances we abuse or are addicted to. They are only the painkillers of the disease, not the disease itself.” (Randy Cormier)

Randy Cormier's comments are an example of how victim status is illustrated in the discussion about addiction. He describes the family who suffers negatively from the consequences of addiction, making them victims. Those who lose a family member to an overdose are victims of addiction, even though they have not been directly hurt by the individual with the addiction. Medicalization is often considered a more humanitarian approach, rather than criminalization, for the control of deviant behaviours (Conrad & Schneider, 1992). By aiming to garner sympathy for the suffering of not only the addicts but their families as well, it would seem that Randy Cormier is advocating for a more humanitarian approach and understanding of addiction as a disease.

Expanding on the harm reduction model, Henry Haddad, a medical doctor, uses this same rhetoric discussing both the suffering experienced by addicts and those with other diseases whom we do not hold responsible for their circumstances. He also adds in a statement about removing the stigma in order to better provide treatment.

“Let us be clear: Addiction is a disease and those who suffer from it need medical assistance just as those who suffer from heart disease or cancer. We are very concerned that this stigmatizing effect may be preventing individuals with addiction from seeking help.” (Henry Haddad)

Henry Haddad’s reference to other more concretely medicalized ailments seems to be an attempt to equate addiction with diseases considered not to have moral connotations and that are beyond the individual’s control, in order to reduce the stigma associated with addiction. This is consistent with Conrad and Schneider’s (1992) finding that medicalization is often used to construct individuals formally considered just ‘bad’, as ‘sick’ is an attempt to reduce the stigma associated with their behaviour. Although medicalization cannot completely eliminate stigma generally speaking there is less stigma associated with being sick compared to being criminal. Although medicalization cannot completely eliminate stigma, generally speaking, there is less stigma associated with being ill compared to being criminal. Even for medically establish diseases such as cancer which can be associated with a lifetime of smoking, there is a degree of blame and therefore associated stigma. Furthermore, individuals who have been diagnosed with a mental illness still experience stigma based on their diagnosis alone.

It is not surprising that Henry Haddad would view addiction from a medical point of view considering he is a medical doctor. His training in medicine likely helped shape his experience as a treatment professional and, therefore, contributed to his understanding of addiction. In contrast to Randy Cormier’s view of addiction, which is not shaped by medical

training but rather by his experience working with addicts in a recovery house does not reflect the same construction of a disease as the one promoted by Henry Haddad. Denzin and Lincoln (2000) explain that within a social construction framework, experience is essential to shaping one's understanding of concepts in the world. If social interactions are considered within Denzin and Lincoln's (2000) definition of experience, one must consider the training that an individual undergoes to have a vital role in shaping their understanding of the world. Herbert (1998) suggests that training is a method to initiate an individual into their profession by passing down values and beliefs. Once individuals are working within their profession, they would be surrounded by like-minded individuals who would then reify their value system and constructions. Henry Haddad's statement focuses on diagnosis and treatment, suggesting a medicalized approach, while Randy Cormier's statement reflects on the impact that addiction has on the addict and surrounding individuals, which indicates a more community and public health approach. Despite both individuals using the term 'disease' it appears that they construct addiction differently possibly reflecting their professional training and environment.

Bill Campbell, a medical doctor specializing in gastroenterology, similarly discusses the stigma felt by those with addiction and relates it moral influences that restrict access to the help needed for treatment and research.

“There are perceived negative moral and social consequences toward all addictions, and so funding for research and treatment is often the first to suffer when money is limited. However, addiction is a disease. Those with it suffer greatly and deserve to be treated like any other Canadian with a medical disease. That is the message I hope to deliver to all Canadians.” (Bill Campbell)

Anne Vogel, a medical doctor at a HIV/AIDS outreach program, expands on the disease and moral aspect by clearly stating that addiction is not a moral issue, in the sense that they are not immoral beings, but that they need medical help.

“People are beginning to understand that this is not a moral issue; it is not a criminal issue. It is about people who have a health problem that needs to be dealt with in that form.” (Anne Vogel)

Both Bill Campbell and Anne Vogel discuss addiction relative to a moral issue. However, their view is not that it is a moral issue, but rather it can be perceived as a moral issue and should not be viewed in that way. The aim of their statements appears to be to reduce the stigma associated with addiction. The tendency to appeal to medicalization as an attempt to destigmatize an individual is consistent with Conrad and Schneider (1992) who claim that medicalization does not eliminate the stigma, but changes the understanding of the individual by reducing blameworthiness.

Withdrawal was not a common theme amongst the treatment providers group. The discussion on withdrawal demonstrates two sides to an argument, one stating that withdrawal is an indicator of addiction and the other stating that withdrawal and addiction are separate issues. In both cases, withdrawal is considered a symptom (a medical term), consistent with the view of addiction as a disease.

“However, as soon as the drug leaves the body, it is crying for more, and that is the physical addiction... the withdrawal...” (Al Breau)

“Withdrawal is not a good indication of whether a drug is addictive or not. Cocaine has minimal withdrawal symptoms but is massively addicting, whereas alcohol is addicting and has withdrawal symptoms.” (Bill Campbell)

The difference between Al Breau and Bill Campbell’s comments on addiction are actually opposite as to what would have been expected. Bill Campbell comes from a medical background, so it would be more likely that he would construct addiction based on medical

terminology, whereas Al Breau comes from a counselling background, not a medical one. However, in this case, Al Breau's explanation comes from a more medical background and Bill Campbell seems to critique the medical definition. This illustrates that although one is partly shaped by their professional training and experience, it is not the only important social interaction that may have an influence on the way people are constructing situations as social problems.

Loss of control as an explanation for addiction was not as common of a theme as the literature would have suggested. Martin Petit, a treatment provider from Montreal, discusses control as a spectrum in which some individuals have more control than others. He discusses the ability for some to control their consumption, while others cannot. Diana Power-Jeans, a social worker for youth, implies that her clients have all lost that ability to control themselves, and this is why they have arrived for assessment.

“Of course, some of them have less control, but we are trying to get an overview of drugs and see who can manage their consumption and who cannot.” (Martin Petit)

“This means that the teens we assess have lost most of the choice and control over their drug use; the drugs now control them.” (Diana Power-Jeans)

The representation of addiction as a condition related to lack of control, depicted by Martin Petit and Diana Power-Jeans, is reflected in the literature on addiction. As was discussed in section 1.3, almost all authors (Peele, 1985; Valverde, 1998; Denzin, 1993; Vallaint, 1995) consulted in this thesis have reported how the idea of control was mobilized to define addiction and to draw a distinction between normal and abnormal. Conrad and Schneider (1992) discuss the tendency to use the term ‘compulsion’ to explain and medicalize deviant behaviours that do not have a clear biological marker. Based on the literature, one may assume that this would be a common way for treatment providers to discuss addiction, but

the witnesses that were selected for this research project, with exception of Martin Petit and Diana Power-Jeans, seem to contradict this assumption and instead use more overt medical terms to describe addiction.

Overall, it is clear that treatment providers have a tendency to use medical terminology to explain and understand addiction and sexual deviancy. Explaining deviant behaviour by using terms such as ‘symptoms,’ ‘disease’ and ‘illness’ satisfies the first condition, adoption of medical vocabulary, in which deviant behaviours become medicalized (Conrad, 1985, p. 196). The following section will discuss how treatment is constructed as the solution to sexual deviancy and addiction.

4.5.2 Treatment

Conrad (1985) states that the second condition through which deviance can be medicalized is by the adoption of medical solutions for the behaviour, such as prescriptions for medication and therapy. In general, mental health/treatment experts discussing both sexual deviancy and addiction concluded that they are treatable or manageable with some type of intervention. This idea was discussed by two witnesses, Michel Landry and Paul Garfinkel, who were describing the treatment of addiction. Michel Landry takes an approach that reflects a view that addiction is treatable.

“Is treatment in that case something that I would favour? Yes, for a philosophical reason, since it is better to help people resolve problems that they have developed than simply to punish them for having the problem, and for a pragmatic reason, since treatment can lead to changes.” (Michel Landry)

This statement by Michel Landry achieves two goals: it advocates for the medicalization approach to addiction by advocating for treatment and challenges the criminalization of addiction by critiquing punishment as a form of regulation.

In contrast, Paul Garfinkel, from the Centre for Addiction and Mental Health in Toronto, uses the term ‘managed’ rather than ‘treated’ to discuss the intervention used for addiction. He supports his argument with a harm reduction approach to addiction that does not require abstinence.

“Our treatment approach, regardless of the substance involved, is based on a harm reduction philosophy. This comes from a public health framework and is in keeping with good clinical practice today. By this, we mean focusing on reducing the adverse health and social consequences of substance abuse, without necessarily requiring total cessation of drug use.” (Paul E. Garfinkel)

Paul E. Garfinkel uses the terms ‘public health’ and ‘clinical practice’ which implies a medical solution to addiction, consistent with a condition of medicalization according to Conrad (1985). The treatment that Paul E. Garfinkel is discussing implies a management approach such as using treatments like methadone maintenance in which individuals are given a daily dose of a drug substitution so they can go to work or school without suffering the effects of cravings. His statement about not requiring total cessation would indicate that some type of drug use is appropriate, as long as the consequences can be diminished for both the individual and the community, thus managing the addiction rather than curing the addiction.

Similar to testimonials concerning addiction, witnesses also referred ‘management’ when discussing treatment for sexual deviancy. This notion of management does not mean that treatment is not working; it simply means that it is an on-going struggle and that their affliction cannot disappear, as the following quotes suggest.

“Sexual offences against children would be classified as deviant sexual arousal, clearly, but they are also included in the *Diagnostic and Statistical Manual of Mental Disorders* by the American Psychiatric Association. It is a mental disorder. It can't be cured in any respect, but it can certainly be managed and managed well in the community, as the numbers I have just referred to you state.” (Andrew McWhinnie)

“Treatment for those offenders shades into management, where you essentially have to teach someone to live within their sexual preference structure. They have to find other kinds of outlets. They have to avoid high-risk situations. They have to do all those sorts of things. But I think that most people would agree that this kind of sexual preference pattern—an actual preference for prepubertal children—is not alterable by any kinds of current treatments.” (Vernon Quinsey)

“So it's not necessarily that they need to change their sexual orientation; they need to learn to control themselves, with our help.” (Vernon Quinsey)

Both Andrew McWhinnie and Vernon Quinsey emphasize that sexual deviancy, in this case, pedophilia, is not curable and cannot be altered. Instead, treatment can focus on learning to control urges and finding outlets. This is a very similar discussion to the commonly used relapse prevention treatment for which addicts identify their triggers and learn to avoid them in order to maintain their abstinent lifestyle (Witkiewitz & Marlatt, 2004; Polaschek, 2003). In essence, this treatment regime is based on the notion that addiction (or sexual deviancy) is only manageable, and that it is an affliction that the person will live with forever. Both sexual deviancy and addiction are commonly treated with relapse prevention. Therefore, it is not surprising that treatment providers would view them from the perspective of relapse prevention and reflect their managerial approach. The consensus that seems to be present over the treatment of addiction and sexual deviancy illustrates the importance of challenging the status quo, instead of taking for granted the knowledge and beliefs that are widely accepted.

Overall, treatment providers advocate for the use of some type of therapeutic or medical intervention as a solution for addiction and sexual deviancy. Given their training and professional experience, it is not surprising that treatment providers would approach the solution from a medical point of view. Their everyday professional interactions are based on a medical model. Whether they work in a formal hospital, a medical clinic or a less formal

counselling office, they would still approach their work from a diagnosis and treatment perspective as would their coworkers. This focus on the medical approach to sexual deviancy and addiction further illustrates the tendency for treatment providers to medicalize deviant behaviours (Conrad, 1985).

4.5.3 *Consequences and Risk*

Overall, treatment providers generally agreed about the consequences and risk for addiction and sexual deviancy. For the topic of addiction, themes once again revolved around the idea of harm reduction, emphasizing the suffering that the addict experiences. For sexual deviancy, there is an overall theme that emphasizes the importance of understanding sexual deviants as individuals and assessing their risk on a case by case basis. These themes become important arguments for the treatment providers to use when advocating for a medical approach to addiction and sexual deviancy.

Bill Campbell sums up the hardships of addiction on the individual with the following statement:

“Even with those addictive substances that cause dramatic and often horrific consequences, the saddest result of addiction is the loss of an addicted individual's ability to achieve his or her maximum potential when actively addicted” (Bill Campbell)

This is a general statement about how addiction can affect the overall potential of a person while they are addicted. However, his use of “actively addicted” implies a possibility to overcome the addiction and gain back that lost potential. Conrad and Schneider (1992) discuss this ‘loss of potential’ as it applies to the capitalist society. Those who were mentally ill were seen as a drain on the community, as they were not productive workers and therefore were not contributing to the economy. With the implementation of asylums, the unproductive were removed from being a nuisance, jobs were created and a therapeutic

industry was established (Conrad & Schneider, 1992, p.44). Although it is not clear what specific potential Bill Campbell is describing, he could be referring to this loss of production discussed by Conrad and Schneider (1992), in the sense that addicted people cannot adequately participate in what is considered a valuable activity, such as work or school.

The specific problems experienced by an individual with addiction, which could interfere with the potential that Bill Campbell discusses, are listed by Achille Maillet, the director of Addiction Services in New Brunswick.

“...in terms of their problems with relationships, financial problems, depression and all those problems, they arrive at our door with those problems.” (Achille Maillet)

Darlene Simpson, a social worker and the Director of Program at House of Sophrosyne, expands on these listed consequences for the individual by including those felt by the individual's family.

“After a while, as with all addictions, and I think the Centre for Addiction and Mental Health will agree, you become focused on getting high and maintaining that high... When people's drug-seeking behaviour becomes their priority, they are unable to tune into their environment and be aware of the nuances of another person's experience, whether that is their partner or their children.” (Darlene Simpson)

This statement by Darlene Simpson implies that the family of the person with an addiction may experience neglect, whether that is emotionally or in other ways is not specified.

Essentially, she is claiming that the drug seeking behaviour caused by addiction becomes the priority and the way it affects family cannot be perceived by the addict. This is an important point as it highlights the less identifiable type of victims that are affected by addiction; in this case, it is the family.

The more obvious victims of addiction are those who are victims of the criminal acts committed in order to support one's habit or as a consequence of their altered state. In response to a question about criminality and cannabis use, Achille Maillet discusses the

consequences and risk of crime associated with addiction and he claims that as the addiction becomes more serious, the risk for committing crime increases.

“...the likelihood of becoming involved in crime increases as the usage or the abuse becomes more important or increases.” (Achille Maillet)

This statement implies that there is a degree of risk for crime by the addict, and Achille Maillet goes on to discuss that the youth he works with generally do commit trafficking, prostitution or shoplifting crimes to support their habit. Peele (1985) discussed the idea that a diagnosis of addiction is only indicated when there are consequences to one's actions. He states that until someone has contact with the criminal justice system, or has problems with employment, school or relationships, they would not be viewed as an addict. In this case, it is the consequences that define what addiction is and whether it is a problem.

For the topic of sexual deviancy, only two treatment providers discussed consequences and risk. Randall Fletcher discusses how the stigma associated with sexual deviancy is in itself a consequence and this causes alienation and a greater risk to reoffend.

“You also have to take a look at the increased feelings of alienation and of being singled out as less trustworthy, more likely to reoffend, and less acceptable than people who commit other forms of crime. That, in turn, can lead to social and emotional isolation, both of which are factors that seem to increase the risk for reoffending.” (Randall Fletcher)

Randall Fletcher's explanation suggests that the system alienates the individual and creates a stigma which causes social and emotional isolation and increases the risk of reoffending.

Essentially he is stating that the reaction of society and the response by the criminal justice system actually led to higher rates of offending; it is not the sexual deviants who are risky, but the lack of social (re)integration for these individuals. This is another example of a statement that aims to both advocate for the medicalization of deviance, while also critiquing the criminalization approach. Although there is no established harm reduction approach to

sexual deviancy at this time, the statements made by Randall Fletcher could be an argument supporting a movement towards a humanitarian solution which according to Conrad and Schneider (1992) can be an objective of medicalization.

Vernon Quinsey however, views the risk of sexual deviancy to be based on individual factors that vary from one person to another. He states that it is not the sexual deviancy that makes someone risky, but it is the presence of additional factors such as anti-social tendencies that increase the risk.

“Pedophiles are not usually the highest-risk offenders. Sometimes they are, but there are other characteristics in addition to sexual preference that make people extremely dangerous. One of them is their anti-social tendencies--things like psychopathy, and their propensity for risk. Those things in combination with sexual deviance make people particularly risky.” (Vernon Quinsey)

This statement essentially indicates that not all individuals can be assessed to have the same risk based on their sexual deviancy; they would need to be evaluated further to assess their risk to society. By emphasizing the individuality of those with sexual deviancy, Vernon Quinsey is implying that policies and legislation aimed at all individuals will not be effective as they need to be assessed on a case by case basis. This is consistent with Conrad and Schneider’s (1992) claim that medicalization policies tend to focus more closely on the individual, providing a more flexible approach to deviant behaviour, whereas criminalization focuses on the act rather than the person.

4.5.4 Regulation

Recommendations for the regulation of addiction and sexual deviancy by treatment providers, not surprisingly, seem to revolve around the theme of treatment (medicalization) rather than punishment (criminalization). For addiction, this means presenting addiction as a

health concern rather than a criminal concern, and for sexual deviancy, it involves encouragement towards making treatment the first priority over incarceration.

In the discussion of addiction, the witnesses made it very clear that their stance was in support of less punitive measures. This is illustrated by Tracy Butler, a medical doctor and treatment provider at the Salvation Army when she states that:

“From a treatment perspective, yes, I do not believe in punitive measures for people who relapse...” (Tracy Butler)

In addition, the witnesses made it clear that the best way to approach addiction was from a health perspective by using a harm reduction model. This is evident in the way Walter Cavalieri, a social worker in Toronto, states:

“In the interim, harm reduction is an absolute health necessity. It is a social, it is a moral necessity to help people not to die while they are getting ready to move on with their lives and hopefully make better choices.” (Walter Cavalieri)

Two witnesses even state that criminal sanctions need to be replaced by a health approach and that addiction is not a criminal issue, but a health issue.

“Therefore, the CMA [Canadian Medical Association] believes that less coercive ways to discourage illegal drug use need to be examined. When you consider all of the facts, illegal drug use is primarily a health and social issue, not a criminal problem.” (Henry Haddad)

“Relaxing those policies and treating addiction as a public health issue, as a medical issue rather than a criminal issue, I think, would change a lot of things. I think it would change the face of addiction, quite honestly.” (Thomas Fulgosi)

One witness goes as far as to claim that addicts are often blamed for societal problems and that, instead, they should be helped through treatment. Mark Tyndall, a medical doctor at the Centre for Excellence in HIV/AIDS, even introduces the idea of prevention, albeit without elaborating on his conception of it. He explains that:

“Too often, drug users are portrayed as self-indulgent, morally corrupt and generally responsible for the social and economic problems we face in urban centres. Such

scapegoating is entirely counterproductive and clouds the real issues - specifically, drug use is primarily a public health issue and should be approached through prevention and treatment.” (Mark Tyndall)

Treatment providers are part of what Loseke (2003) defines as the “troubled industry”, which consists of a network of professional and governmental agencies that are designed to rehabilitate individuals in need of care and assistance. Being part of that industry, the treatment providers, including Mark Tyndall, are advocating for the validation of their own profession. Conrad (1985) states that medicine, although a very new field of intervention is growing rapidly and more practitioners are becoming specialized. This specialization is leading to a greater number of diagnoses of particular ailments, such as addiction. From social workers (without medical degrees) to HIV specialists, these treatment providers all reflect the broader social values, which have been shifting to a medicalization of addiction.

In the case of sexual deviancy, the arguments for more treatment over punishment are not as clear as they are for addiction. The exception is one statement from Andrew McWhinnie who does clearly state treatment should have priority over punishment. He explains that:

“...the mandatory minimums called for in Bill C-54 would be far better diverted to increasing treatment for sexual offenders and equipping alternatives like circles of support and accountability.” (Andrew McWhinnie)

This message was conveyed in more implied statements as well. In particular, the witnesses do not explicitly say that less punishment is required, but rather denounce the need for mandatory minimum sentences for sexual offences. They do not view mandatory minimums as effective punishment or reintegrative measures.

“We know that mandatory minimum sentences neither act as a deterrent nor reduce crime rates. The protection of society is best served through the timely, supportive reintegration of offenders back into our communities. Mandatory minimum sentences do not facilitate that process.” (Ed McIsaac)

“Following even a minimum sentence, offenders will be returned to their community--or some other unsuspecting community--and their families as untreated, unemployed, unsupported, and despised.” (Andrew McWhinnie)

Ed McIsaac’s statement denounces the use of mandatory minimum sentences, which he believes to be ineffective. He does not, however, criticize the use of punishment; rather he simply suggests that treatment is more desirable. In contrast, Andrew McWhinnie critiques the use of mandatory minimum sentences but also uses the word “untreated”, indicating that he believes a clinical approach is necessary for the reintegration of sexual deviants which is consistent with his comment above advocating for treatment over punishment.

Randall Fletcher advocates for less punitive measures simply by stating that the individuals are better off receiving treatment outside of the correctional setting. In addition, he also implies that they would be moving away from a correctional setting into a more therapeutic or treatment setting.

“I can't emphasize enough the value of their being able to get out of that correctional setting and into a setting where they feel safe, where they feel they can be open, where they can express themselves and begin to look at their problems.” (Randall Fletcher)

The type of facility that Randall Fletcher seems to be discussing is reflective of New Jersey’s Adult Diagnostic and Treatment Center (ADTC), which was originally designed to provide a therapeutic environment for sex offenders rather than a correctional facility. However, by the time the facility had opened, the views of sex offenders had changed and it was instead completely regulated by the Division of Corrections and Parole, instead of a joint regulating body that also included representation from the mental health department. Randall Fletcher’s

statement demonstrates that even though the majority of views on sex offenders changed, there is still a belief within the treatment community that the original plan for the ADTC would be an effective solution to sexual deviancy.

William Marshall has a different view on the solution to sexual deviancy, as he does not seem to think the two methods, rehabilitation and punishment, are mutually exclusive. In fact, he lobbies for longer sentences so as to provide longer treatment.

“What we need is for them to be in a prison for three years where we can provide treatment. Three years is the minimum requirement to provide satisfactory rehabilitation.” (William Marshall)

Hubert Van Gijsegghem elaborates on this point; he states that treatment is not an alternative to punishment and that judge ordered or court order treatment is not a substitute for punishment. This implies that he believes that sexual deviancy should be treated, but should also be punished.

“This leads us to believe that therapy or an order given by a judge for a course of therapy, even though it may be seen as good news by all, cannot be perceived as an alternative to incarceration nor a substitute for punishment.” (Hubert Van Gijsegghem)

The views by William Marshall and Hubert Van Gijsegghem represent the past era when the medical and mental health professions had complete monopoly over the regulation of sexual deviants. As discussed in the literature, this resulted in the use of indeterminate sentences to hospitals and asylums for sexual deviants, following the assumption that these professionals knew best about how long an individual needed treatment (La Fond & Durham, 1992). The difference between what is being suggested by these testimonies, and what was done during the Progressive Era, is that punishment is now included in the solution to sexual deviancy. For this reason, William Marshall and Hubert Van Gijsegghem highlight that the criminal justice system can be used as a method to deliver treatment and therapy,

which illustrates hybridization between criminalization and medicalization for sexual deviancy. This is a contrast to the general consensus by treatment providers that addiction should entirely regulated as a medical problem.

Overall, treatment providers advocate for therapeutic control over addicts and sexual deviants illustrating the third and final condition toward medicalization, which is the adoption of medical professional control over the individuals who display the deviant behaviour (Conrad, 1985, p.196). However, there appears to be a difference in how this is presented and proposed for addiction compared to sexual deviancy. In the case of addiction, there seems to be a consensus that the criminal justice system should not have any part in the regulation of addiction and that this control should be entirely under the responsibility of the medical field. In contrast, there seems to be some agreement among treatment providers that the medical field and the criminal justice system can work together to regulate sexual deviancy. On the whole, it would appear that medicalization is a very dominant theme within the discourse of these treatment providers. All three conditions of medicalization (adoption of medical vocabulary, adoption of medical solutions, and adoption of medical professional control over the individuals who display the deviant behaviour) are represented in this section illustrating that these witnesses are reifying the construction of both addiction and sexual deviancy as medical problems within their testimonies. These witnesses did not provide a great deal of critique towards the medicalization of deviance which could be attributed to their working within the medical and treatment fields. The following section will continue to discuss medicalization as it applies to researchers and academics.

4.6 ACADEMICS/RESEARCHERS

This section centres on the topic of addiction, as that is the only data that was provided by this group of witnesses. Academics consist of a unique group of experts, as they view addiction from many different perspectives and backgrounds. For instance, one may come from a clinical background, a pharmacological background, or they could come from a law background; this diversity provides for an interesting discussion.

Researchers, particularly those from a social science perspective, have a pivotal role as it relates to medicalization both as challengers and as perpetrators of medical policies for deviant behaviour. More recently, academics have challenged medicalization and the associated labelling process within the research of both sexual deviancy (Terry, 2003) and addiction (Petrunik, 2003). This section will explore how academics construct addiction and how these constructions challenge or perpetuate the medicalization of addiction.

4.6.1 *Explanation*

As researchers, the witnesses in this category know the value of defining their terms, which eased the process of determining their conceptualizations. The statements made by witnesses can be placed in one of the following categories, 1) disease/illness 2) lack of control 3) coping or 4) craving/withdrawal. Each of these categories will be discussed with illustrative quotes.

The use of the disease model was not very prevalent in this group of witnesses. Reflecting this, William A. McKim, a professor of psychology, states that addiction is not a disease, but a process that is natural within the body:

“The mechanism involves the brain mechanism [referring to the dopamine reward system]. The reason we use drugs is because it is a natural system. It is not a disease, for example. It is a natural system.” (William A. McKim)

William A. McKim continues on to explain that some people do end up using drugs compulsively and that this is likely due to environmental factors, but he does not specify any particular factors. Interestingly, Conrad and Schneider (1992) state that it is very common for therapeutic professionals to use the term ‘compulsion’ to explain behaviour that does not have a clear biological cause, particularly in the field of mental illness. This does not seem to be the case with William McKim, as he has referenced a brain mechanism, the dopamine reward system, which is a biological entity. Although William McKim states that addiction is not a disease, it is consistent with the way in which Conrad and Schneider (1992) discuss medicalization as a compulsion.

Andy Hathaway, a sociologist, mentions that using the mental disorder diagnosis from the DSM is a good guideline for defining addiction.

“A more standard set of dependency criteria...derived from the Diagnostic and Statistical Manual of Mental Disorders, or DSM-IV...” (Andy Hathaway)

The use of the DSM as a reference is an example of using medical terminology to describe a deviant behaviour. However, it is not clear if this is how he defines addiction or his use of the term ‘standard’ is to introduce a definition with which everyone is familiar.

Richard Mathias, a professor of health and epidemiology, is the only witness who claims that addiction is, in fact, a disease:

“Since dependency is a chronic relapsing brain disease, and I will stay with the medical model to define this...” (Richard Mathias)

It is not clear whether or not Richard Mathias is a medical doctor or a Ph.D. However, his focus is on health care and medical research, so this could be the reason he uses a medical model to explain addiction. He continues to discuss that since addiction is a “chronic relapsing brain disease”, it must be treated. He follows the assumption that people will

relapse as part of the healing process and should not be punished for this relapse. He states this while encouraging a public health approach to the solution of addiction, which reflects a medicalization approach to addiction.

A more common explanation of addiction for this group of witnesses was that of lack of control. The distinction between those who can control themselves and those who cannot is used by witnesses to determine what constitutes addiction.

“A reasonable definition of addiction is that addiction occurs when a person is overwhelmingly involved with something to the degree that even if it produces harmful effects the involvement persists.” (Bruce Alexander)

“...the compulsive use of a drug, which we would call addiction.” (William A. McKim)

Once again, this refers to the compulsion aspect of addiction, a non-physical ailment that only plagues certain people. Bruce Alexander’s statement is essentially a definition of a compulsion, and William McKim directly uses the term compulsion. In both testimonies, the same belief is conveyed: that addiction could be recognized as a compulsory habit. This is consistent with the medicalization of addiction according to Conrad and Schneider (1992).

A common theme amongst the witnesses who discuss the lack of control as a measurement of addiction is that of causing harm to oneself. They claim that the lack of control over their use of drugs is so bad that they will actually cause harm to themselves or others. This is evident in the following quote:

“When a person becomes a drug addict, taking drugs becomes the centre of their lives and these people are more greatly exposed to the repercussions of their habit.” (Celine Mercier)

The statements by Bruce Alexander and Celine Mercier are reflective of Peele’s (1985) definition of addiction, which states that addiction is persistence use in spite of harmful consequences to one’s self. Peele (1985) recognizes this as a common way to define

addiction, as that is when individuals become visible to organizations and agencies, such as the criminal justice system and treatment providers. He explains that due to these negative consequences, this type of addictive behaviour becomes more obvious and, therefore, influences how individuals construct their understanding of addiction. For example, someone who is repeatedly being arrested for petty crimes in order to provide for their habit is much more visible than a wealthy doctor who steals his drugs from the hospital for which he works (Peele, 1985). The high visibility of the first individual shapes the understanding of addiction for many people; therefore, those with little consequences in their lives, such as the doctor, remain excluded from the definition of addiction. One could go on to argue that at the level of societal values, the latter of the addicts is still a productive member of society within a capitalist regime, while the highly visible addict is not and that is when they become a problem.

Expanding on the concept of control, Patricia Erickson, a professor of sociology in Toronto, explains why individuals with addictions lack the control to stop, while most people can control their consumption. She claims that their lack of control is because of past harm, such as abuse.

“We do not understand why most people can control use, while there is a group who gets into trouble. We know that it is associated generally with deprivation, with early childhood physical and sexual abuse and with serious mental conditions.” (Patricia Erickson)

Art Steinmann, the executive director of Alcohol-Drug Education Service, expands on this idea, stating that addiction is a matter of coping with unwanted feelings such as depression caused by abuse and neglect. In essence, addiction is a form of self-medication in order to cope with problems. This is very similar to the behaviourist explanation of sexual deviancy in which an individual is reinforced through positive rewards and thus their behaviour

continues in a cycle (Chan, 2015; Ward, Laws, & Hudson, 2003). In the case of sexual deviancy, the reward is the feelings associated with the sexual behaviour (e.g. sexual gratification), whereas, in the case of addiction, the reward would be the positive feelings caused by the substance. The behaviourist model is illustrated in the following quote by Art Steinmann.

“Finally, in our years of work and prevention we have come to understand that the real problem is not so much a drug problem as a people problem. That is, all people - especially kids who have suffered abuse, neglect, trauma, and addiction in the home - seek ways to deal with their feelings of anger, despair, hopelessness or powerlessness. Some may have feelings of boredom, curiosity or a desire to belong. Marijuana and other drugs can seem to solve or at least soothe these emotions.” (Art Steinmann)

The final category in which witnesses discussed addiction was through withdrawals and cravings, also known as the Cycle of Addiction. Mohamed Ben Amar, a professor of pharmacology and toxicology, discusses both concepts as follows:

“There are two types of dependency: psychological dependency, where, when the drug is no longer present, the individual's psychological functioning is disturbed and he or she will have psychological behaviour problems known as "craving." In the case of physical dependency, when the individual is no longer using the drug, his or her brain will be disturbed and there will be physical symptoms known as the withdrawal syndrome.” (Mohamed Ben Amar)

Mohamed Ben Amar is describing craving as a psychological dependency and Andy

Hathaway expands on this, stating that craving is a subjective experience.

“dependence may be indicated by the prevalence of a strong, subjective desire or craving for the substance” (Andy Hathaway)

Mohamed Ben Amar has a medical background and studies how substances work within the body, which is evident in his explanation of addiction as it is reflective of the medical model; using the term syndrome implies there is a set criteria of symptoms that everyone would experience. In contrast, Andy Hathaway studies the concept of addiction from a sociological

point of view and, therefore, views withdrawal in a much different way, implying that the experience is subjective and therefore differs from person to person. Their experiences and training have shaped the way in which they view addiction, and could also shape how they conduct their research.

Bruce Alexander and William McKim state that documenting the presence of withdrawal is not an effective way to determine if an individual has an addiction. Bruce Alexander points out that not all individuals experience withdrawal, but this does not mean that they do not have an addiction, as they suffer other consequences such as incarceration.

“The presence and absence of physical withdrawal symptoms is not really that important.” (William A. McKim)

“For example, there are a number of heroin addicts who do not have withdrawal symptom[s] - most do, of course, but some do not. We could say that these people are not addicted, but that would be foolish because we are talking about people who spend most of their lives in jail and, in one way or another, are being seriously harmed by heroin addiction.” (Bruce Alexander)

This statement by Bruce Alexander reveals a paradox that defining addiction presents: due to the many definitions of addiction, if one definition is agreed to be the “true” definition (in this case the experience of withdrawal), it could exclude many individuals who are still negatively affected by their drug use. Conrad and Schneider (1992) discuss the ‘sick role’ taken on by individuals who are deemed to have a medical ailment, which connotes an undesirable condition, for which they must now seek treatment by a professional. However, if withdrawal, an expectation of addiction, is not present in an individual, it might be difficult for them to receive treatment, as they would not satisfy the criteria as a sick (addicted) person. Bruce Alexander seems to be arguing that whether or not someone presents with an accepted criteria for addiction they should be offered help when they seek it

out. From a therapeutic sense, this would mean less focus on diagnostic criteria and more focus on the problem that an individual is presenting with.

It would appear that medicalization is dominant within this group of experts in the way they explain and define addiction. Although these definitions are presented in different ways, the underlying tone of this group is that addiction is a medical condition, whether it is derived from biological markers or environmental factors.

4.6.2 Treatment

The main theme for the treatment section for this group of witnesses is the notion that harm reduction is the best form of treatment. Both Ambros Uchtenhagen, a retired professor, and Brian Grant, the director of Addictions Research Centre of Correctional Services Canada, state that abstinence is not necessarily an ideal option for treating addiction, and that it can be managed simply by teaching individuals self-control.

“Treatment-resistant heroin addicts can be reached and sufficiently retained in this type of treatment. Use of illegal and non-prescribed substances can be significantly reduced. Safe and stable dosages are feasible. I did not show you the figures on that, but one of the anxieties was that once you prescribe heroin people will need more and more, which is not the case. On the contrary, the average dosage slows down during participation in the program.” (Ambros Uchtenhagen)

“On the other hand, if you tell them that the program is designed to teach them to control their substance abuse problem, which is a more positive point of view, people who are severely dependent often recognize when they get to the end of the treatment program that they cannot continue to use, and that becomes their choice. We are much better off if they make that choice through the program rather than trying to force them to abstain.” (Brian Grant)

Brian Grant does also add a caveat that not all individuals with addiction should be treated with a management approach, and that some will need to reach abstinence. This highlights the belief that addiction should be assessed on a case by case basis, and that perhaps treatment and policies cannot be generalized to the entire population. This idea again is

consistent with Conrad and Schneider's (1992) statement that medicalization offers more flexibility, which is not necessarily available with criminalization that tends to focus more on the act rather than individual circumstances.

“However, abstinence may be the only solution for severely addicted people. For other people who are, for example, abusing alcohol, reducing the quantity to a safe level may be an acceptable option.” (Brian Grant)

Overall, the witnesses in this group maintain a harm reduction approach for the treatment of addiction. They believe that individuals can be treated, but that the typical goal of abstinence is not necessarily what they need to live a full life. This kind of treatment would include methadone maintenance, heroin prescription and, more generally, teaching the use of control. These types of solutions to addiction demonstrate the idea that addiction is something that is manageable, not something that can be cured.

4.6.3 *Consequences and Risks*

The statements presented in this section show a critique of the current policies surrounding addiction and challenge the preconceived beliefs that many have around the consequences of addiction. To begin, Michel Perron, executive director of the Canadian Centre on Substance Abuse, first identifies the harms experienced by society:

“There is no doubt therefore that alcohol and drug abuse is costly to Canadian society. The price to pay is not entirely or solely in dollars, but also — and I would say this is equally important — in physical and psychological suffering.” (Michel Perron)

In his statement, Michel Perron focuses on the societal harms, which illustrates the subtle way that communities are constructed as victims in the case of addiction. In this quote, Michel Perron is discussing the harms such as HIV and HEP C contraction, as well as criminal behaviour. Further in his testimony, Michel Perron discusses that these harms are casual, meaning that without the drug use, the consequence would never have happened. The

way in which Michel Perron has presented these harms in relation to Canadian society illustrates that the community can be constructed as a victim, even if it is not as easily identifiable as those discussed in sexual deviancy.

In addition, he discusses the stigma associated with addiction:

“We call it "Narcotics Anonymous" for a reason. These are anonymous constituencies. Therefore, we have a huge stigma issue.” (Michel Perron)

According to Conrad and Schneider (1992), medicalization is often an avenue used to reduce the stigma identified by Michel Perron, by applying a new label to the individual: from badness to sickness. Although being considered sick certainly carries its own stigma, especially in the case of mental illness, it also tends to reduce the blameworthiness of the individual. In other words, “[d]eviance considered *willful* tends to be defined as crime; when it seems *unwillful* it tends to be defined as illness” (Conrad and Schneider, 1992, p.32).

Ethan Nadelmann, the executive director of the Lindesmith Center-Drug Policy Foundation, critiques the criminalization of addiction by stating that the only reason an individual experiences adverse harms, is due to the inaccessibility of the substances they seek.

“If people have easy and ready access to the substance everyday [sic], and were not deprived of it, they would never experience any withdrawal symptoms. It is only when the substances become unavailable - imagine what would happen in our countries if coffee were unavailable - that people try to find substitutes.” (Ethan Nadelmann)

This is an example of the way in which academics are challenging the status quo, pointing out the flaws in the current system and making recommendations as to how to address these flaws. In addition, Ethan Nadelmann uses a very strong technique for claims-making, by making his statement about addiction relatable to a larger audience. Many people have not experienced addiction to heroin, but it is more likely they, or someone they know, drink

coffee every day in an addiction-like way. By making the statement relatable to the everyday person Ethan Nadelmann prevents the audience from considering addiction as irrelevant to them. It also discourages an “othering” process, in which addicts are marginalized, which reduces stigma.

Michel Kokoreff, a professor from France, also acknowledges the struggle that addicts have in accessing their substance of choice. However, he discusses an important factor in that individuals, from different classes or socio-economic statuses, will have very different experiences with law enforcement, treatment providers and society in general regarding their addiction.

“All of that to say this: Part of the population is more less marginalized but treatment workers and enforcement officials are becoming more familiar with them because of their drug use habits; and there is part of the population that is much more invisible and that will eventually deal with their substance abuse problems within the cosy confines of a psychiatrist's office, which does not exactly have the same social ramifications as an ongoing treatment in a detox centre. It is a real public health problem.” (Michel Kokoreff)

Michel Kokoreff implies that someone who is marginalized, and not privileged enough to have access to high-end health care in order to detoxify, will be further stigmatized by the police and treatment providers. In addition, he implies that those individuals who are better off would be given much more privacy as they can pay the fees for an expensive psychiatrist or rehabilitation centre. This description relates to the sociological discussions of addiction; although it does not explain addiction itself, it does discuss the difference that one experiences based on their socio-economic status. Michel Kokoreff's discussion echoes Peele (1985) and Vaillant's (1995) reporting of a higher level of addiction in lower socio-economic individuals. The way in which they collected their data or where they did could

have had an influence on their findings. Publicly funded treatment centres would likely have a greater amount of lower socioeconomic individuals, compared to a private facility.

Richard Mathias explains how individuals with easy access to a substance, or their ability to afford it, also separates individuals of different socio-economic statuses. Due to the easy ability to afford a drug, those who are well off do not suffer the additional consequences that those from the lower socioeconomic positions would experience. He explains that those who are not well off and suffer a great deal of consequences are more visible to the public and are generally what we consider to be the picture of an addict.

"It was pointed out to me, when I first presented this, that the definition of 'dependent' is inadequate because there are two kinds of dependent individuals. The first are those who are compensated for their dependency- the drug is available, they can afford it, and it does not interfere with their personal, social and, in general, financial position. In particular, I believe that users of tobacco, as it is currently available in this country, meet the definition of a 'compensated dependent.' The decompensated dependent is an individual who can no longer afford the drug, or who is affected by the drug's actions, such as it causes the person to fail at normal tasks, such as employment. It is that person, the decompensated dependent, whom we normally think of when we use the term 'addict.'" (Richard Mathias)

Richard Mathias' claim bears similarity to the contention advanced by Peele (1985) who explained that our understanding and definition of addiction was developed through observations of addicts in public hospitals. These individuals would not have had access to their drugs regularly, so they would be forced to commit crimes and would enter the mental health system. By contrast, Valverde (1998) claims that those who had more means would be sent to private retreats; these retreats were expensive and therefore only accessible by the wealthy and were much more comfortable than asylums and hospitals. Often, these retreats were utilized by ashamed family members who would pay for their relatives to get treated

out of the public view, and therefore they would be invisible to those developing an understanding of addiction. As emphasized by Richard Mathias, this distinction in the visibility of those who have an addiction has shaped the understanding and construction of addiction for many individuals, both academics, and laypersons. By focusing on the more visible individuals, those who are often on the streets and committing crimes, it creates an image that all addicts commit crime and take to living on the street. This marginalization could lead to further stigma of addicts.

Finally, John Morgan, a professor of pharmacology, discusses that a consequence of addiction is the creation of addiction treatment providers. He discusses this relationship as a self-fulfilling prophecy; there are more individuals being diagnosed with addiction because there are more professionals who are practicing addiction rehabilitation. In other words, there are more people available to give the diagnosis, which results in more diagnoses being documented; this does not necessarily indicate more prevalence of addiction. As discussed in the theory chapter, the troubled-person industry is created and maintained by the troubled people; without people to treat, many people would be out of work (Loseke, 2003). This is demonstrated by the quote from John Morgan.

“I signal a warning for you that cannabis dependence is an increasing illness in the United States because the number of physicians practising addiction medicine is an increasing phenomenon in the United States.” (John Morgan)

Conrad and Schneider (1992) would agree with John Morgan in that the medical field has become more specialized including addiction specialists who are now available to make a diagnosis. In addition, there has been a net-widening of the medical field which now means that therapists, social workers, counsellors and psychologists, all of whom do not have medical degrees, can make the diagnosis of addiction (Conrad & Schneider, 1992). This

increase in medical and non-medical diagnoses leads to a perception that addiction is a growing problem.

When speaking about how criminal activity relates to addiction, Dirk J. Korf, a professor of criminology, presents a different view. He indicates that crime is not caused by addiction itself. He states that individuals were on the path towards crime before the addiction, even started because they had problems with their family and in school growing up. This could have potential in providing more targeted prevention programs for those with risk factors for addiction.

“It is a rather general assumption that crimes committed by heroin addicts are consequences of their addiction. I do not believe that is true. Problem drug users are not like any random selection of drug users. At an early stage there are differences. In general, problem drug users come from problem families and have problems at school before beginning to use drugs. In many cases, the tendency towards crime existed before the drug use.” (Dirk J. Korf)

In contrast, both Patricia Begin and Serge Brochu, professors of criminology, view crime as a means to feed the addiction or pay for the drugs; thus, the criminal acts are a consequence of the addiction. Patricia Begin emphasizes that an individual uses crime to finance their habit and that this impacts how safe the community feels.

“We also know from the research that drug addicts, particularly those involved with street drugs such as cocaine and heroin, are likely to be involved in income-generating crime and heavily involved in the criminal justice and health systems. As such, they are seen to threaten community safety, heighten public fear of crime and disorder, and place considerable demands on both the criminal justice and the health care systems.” (Patricia Begin)

Serge Brochu, however, views the risk of addiction to be somewhere in the middle of the extremes presented by Dirk J. Korf and Patricia Begin. Where Dirk J. Korf believes addiction to not be the cause of crime at all and Patricia Begin believes it is entirely what motivates the criminal lifestyle, Serge Brochu’s perspective meets them halfway. Serge

Brochu states that the background of the individual, before the addiction started, dictates what kinds of crimes he/she will commit.

“We find that those people who get into criminal activity and who were not criminals before they became addicted will commit minor crimes, such as shoplifting, petty trafficking, or in the case of women, prostitution. Prostitution is less and less common among women however. They now prefer fraud or peddling. Those people who are already involved in criminal activity will tend to turn to armed robbery and more serious crimes.” (Serge Brochu)

In essence, Serge Brochu bridges the gap between the statements made by Dirk J. Korf and Patricia Begin, as he recognizes that those from a criminal background will naturally progress to a more dangerous form of income-generating crime, thus creating more risk. However, he does not discount that those without a criminal past will also need to generate income but considers them less of a threat to the public. This is a very important claim for the implementation of policies around substance use and abuse, as Serge Brochu’s comments illustrate a belief that risk needs to be assessed on a case by case basis and should not be generalized to all individuals. This necessary consideration would cause problems in the creation of policies, as it is very difficult to target many individuals with distinct needs.

Generally speaking, the testimonies by academics and researchers in regard to consequences favour a harm reduction approach. The focus of these witnesses was the harm for both the individual and the community, including consequences to health, psychological suffering, monetary loss, and crime. This understanding of the consequences logically leads one to advocate for a harm reduction approach which is one of the regulatory avenues that will be explored in the following section.

4.6.4 Regulation

In this section, the recommendations and discussion around how addiction should be regulated fit into one of three categories: 1) non-punitive, 2) prevention, or 3) judgement and

moral convictions. This section discusses each of these categories and how they relate to medicalization and harm reduction, using examples from the data.

The discussion of the non-punitive approach starts with a statement by Dirk Korf, who states that the current punitive approach (criminalization) to drugs is not effective and, therefore, he suggests that decriminalization should be the first step.

“Yes, I would agree. To reduce harm, it would be logical to decriminalize the possession of the other drugs as well. My personal opinion is that the legal control of drugs has done more harm than good.” (Dirk J. Korf)

Similar to the testimonies in the consequences and risk section, Dirk Korf states that the status quo, in this case, criminalization, is having more a negative impact and is not having the desired effect on addiction.

Michel Germain, the director of the Standing Committee on Campaign against Drug Addiction, suggests that not only should addiction be regulated by less punitive means, but treatment should be given the priority. In other words, he claims that sentences should be focused on providing treatment, not punishment.

“In answer to your question, what we meant was that in the case of a drug addict, the sentence would tend to involve treatment or some type of compulsory help; for others, there could be a fine.” (Michel Germain)

Michel Germain’s comment implies that those who are addicted should be treated differently than those who are not addicted. Compulsory treatment could include drug courts, which divert addicts from the traditional criminal justice system in favour of more therapeutic approaches. Even for those who are not deemed addicted, he advocates for a less punitive response, such as using fines. This distinction is an illustration of the status that is given to sick individuals over those who are not deemed sick. Those who are considered sick, in this case addicted, are given treatment and help, while those not considered sick are punished

with fines. The belief that wilful deviance should be criminalized and that unwilful deviance should be medicalized is obvious within Michel Germain's quote and is consistent with the suggestions made by Conrad and Schneider (1992).

Andy Hathaway expands on the idea that punitive measures should not take priority over treatment. He emphasizes that punitive measures are not having the desired effect and that we should be taking a health approach instead.

“We must begin to approach our drug policy with the idea of humanization and address this issue in an evolutionary, non-punitive manner. Our research has led us to believe that these sanctions are not having the intended effect. In fact, they have had the opposite effect in many cases. They are, in fact, exacerbating harm.

Let us step back and take a public health educational approach. This approach provides accurate information for drug users and treatment for those who feel they need it. We must forget about this coercive means of trying to purge our society of these evil, immoral beings. That is where policies come from, and I believe it is time for a change.” (Andy Hathaway)

Medicalization is generally considered to be a humanitarian approach to a problem. It demonstrates a shift from the view that an individual is evil or bad to someone who is sick and does not necessarily have control over their condition (Conrad and Schneider, 1992). This humanitarian idea can be illustrated in the justifications for harm reduction. A vast majority of the witnesses, including Andy Hathaway, proposed or advocated for a harm reduction approach to regulating the drug problem. It is significant that Andy Hathaway goes on to equate criminalization with the purging of evil and immoral beings, which is reflective of religious approaches to deviance that were prevalent prior to the medicalization process. Before the increase of legitimacy of the medical field, citizens put all their trust in religious leaders to regulate deviant individuals. Since religious explanations are less relevant within

the social context of Western society, this could have been an attempt by Andy Hathaway to make criminalization appear just as irrelevant.

Another theme that arose in the discussion of regulation was prevention. Both witnesses emphasize the importance of using prevention and education as a means to regulate addiction.

“...we say before any major change is made to drug laws, let us first put in place a comprehensive prevention and treatment approach offering many new evidence-based sustained prevention initiatives and treatment options. Let us get this up and running to prepare people and educate the public, if the time does come to change the laws.” (Art Steinmann)

“Prevention is probably the most misunderstood and often neglected and inconsistent area, but I think you would agree it is the most vitally important facet of any drug response.” (Colin Mangham)

The suggestion of prevention as a solution for addiction was only mentioned by two groups of witnesses: law enforcement and the academics/researchers. Colin Mangham stipulates that he is aware of this gap, claiming that prevention is often the ‘neglected’ area. In the case of academics, prevention was overshadowed by the emphasis on medicalization and harm reduction approaches to addiction. Even within his advocacy for prevention, Art Steinmann discusses the need for treatment.

A few witnesses also raised the issue of moral judgement within regulatory practices. In essence, by treating or punishing individuals with addictions, society is implying that there is something inherently wrong with drug use. Andy Hathaway discusses this issue from a clinical perspective, and Patricia Erickson discusses this from the criminal justice perspective.

“If we assume from a strictly clinical treatment perspective that we know better in terms of intervening, I think that is a little backward. We have to allow for a more subjective interpretation of what dependence is all about and, indeed, what place we have to intervene, if at all.” (Andy Hathaway)

“The issue is this. Do we really want the law to tell us about our own health behaviours? What line do we draw? We do not draw the line for alcohol and tobacco. However we do draw the line for cannabis. The law is there in a moral sense. There is a suggestion that the behaviour is wrong.” (Patricia Erickson)

The statement by Andy Hathaway is a critique of the medicalization of addiction. He is stating that establishing a clinical diagnosis implies a political statement because it is deeming a particular behaviour as undesirable. This is consistent with Conrad and Schneider (1992) who also claimed that medicalization is a political process in which medical professionals are staking a claim, similar to the claims-makers of Spector and Kitsuse (2011), on a particular problem. Andy Hathaway’s statement is illustrative of a de-medicalization of deviance in which, according to Conrad and Schneider (1992), challenges not just the effectiveness of the medical model for a particular behaviour, but also questions whether it is morally right to intervene at all.

Peter Cohen, a professor and the director of Centre for Drug Research, includes a discussion about research regarding regulation of addiction. He states that research on addiction perpetuates a moral conviction that drug use is wrong; this implies that even with evidence-based research guiding regulation, there is still a moral judgement at work.

“In the western world, many quasi-scientific problems exist around the legalization or even the decriminalization of drugs. It is the guise taken for what is actually a moral conviction that any drug use is wrong. In order to amplify that conviction, you can take a few observations and hold them as the general truth about drug use. They are illustrations of a basic moral conviction. One cannot discuss moral convictions on the basis of statistics. A moral conviction is a moral conviction.” (Peter Cohen)

Peter Cohen’s discussion of the moral convictions in research is very important as it highlights that academics and researchers are claims-makers as well as experts. Academics conduct their research through a lens that reflects their understanding of a concept. For example, Colin Mangham, mentioned above, would approach his research from a prevention

perspective, as that is the mandate of his organization. Similarly, an individual doing research through Corrections Canada would likely have a perspective reflecting a corrections model. From a social construction perspective, it is important to consider this point, especially when individuals are recommending an evidence-based or research-based solution to a problem. It is critical to understand that those researchers have shaped their understanding of the concept through their own experiences and previous research and, therefore, they must also be considered claims-makers, vying for validation from the audience.

Overall, medicalization was a common theme amongst academics and researchers as it applied to addiction. However, more than any other group of witnesses, this medicalization seemed to be in reference to harm reduction rather than a strict clinical approach. One theme that remained constant throughout this group was the critique of the criminalization of addiction, as there was a great deal of support for decriminalization of drug-related offences and legalization of drug use. This challenge of criminalization highlights the role that academics and researchers have in contesting widely held beliefs on deviant behaviour, which historically has been the basis for social policy changes.

According to Loseke (2003), academics are in a position with a unique source of power when it comes to producing their research, as they can choose how to frame their research, how to define their terms, and which direction their research will take. Loseke (2003) also claims that research is never completely objective and, thus, a researcher's approach can shape their research and their outcomes. Therefore, it is vitally important to understand how an academic constructs addiction and sexual deviancy, as it may influence the results and studies that they choose to conduct and disseminate. The quotes from these

academics seem to be consistent with Loseke's (2003) suggestion as their underlying goal of harm reduction was implied whether they were discussing definitions, treatment, consequences or regulation. This trend was common amongst other groups of witnesses as well but those witnesses do not produce research at the same volume and rate as researchers.

4.7 CONCLUSION

Throughout this chapter, several sociological concepts were explored as they relate to the social construction of sexual deviancy and addiction, such as police subculture, construction of childhood, and medicalization. These concepts helped to understand how social problems are constructed and how perceptions of social problems are influenced by everyday interactions between individuals on many levels such as family, community, profession, and the larger social context. The discussion about police subculture highlighted how this unique set of values and beliefs might influence the way in which law enforcement professionals understand addiction and sexual deviancy. Testimonies from victims and their advocates illustrated how societal values and beliefs surrounding children and childhood influence the way in which they perceive sexual deviancy and its harms. Finally, medicalization was discussed as an example of a broader social process that is based on values and beliefs relating to the legitimacy of the medical field within Western Society.

The witnesses in this project were all experts invited by the committee members to speak for the purpose of supporting or opposing changes to legislation. Experts have a special role within the process of claims-making, as they are considered to have certain legitimacy in regards to those specialized issues. Therefore, it is important to consider that these individuals do not exist outside the broader social context. They are influenced by the

social values within their society, just like everyone else. The perceptions of experts are shaped by their professional experience, including training and interactions with coworkers and clients. In essence, experts are also claims-makers, vying for the attention of the audience and making their views known and accepted over the views of other experts.

Finally, throughout this chapter, significant differences between the discourses on sexual deviancy compared to the discourse on addiction were discussed. In the case of sexual deviancy, it is difficult to forget the role played by the victims in the way this issue is delimited, as it is constantly recalled by the experts who are dedicated to representing these victims. In regard to the construction of addiction, the role of the victim is quite different, since no direct victim is clearly identified. Even if the addiction discourse did not mobilize the image of a distinctive victim, many references were made about the collective consequences of addiction. Experts discussed not only how addiction-related crime creates victims, but also how the addict themselves is a victim and how addiction has negative consequences for the family of the addict. These differences in focus lead to a distinction in the way in which experts advocated for regulation of addiction and sexual deviancy. Addiction was almost entirely based in harm reduction and the medicalization of deviance, while sexual deviancy was discussed in relation to both criminalization and medicalization with policy recommendations often representing a hybridization of both. The following chapter will discuss these findings in more detail and in relation to the research question for this project.

Chapter 5

Discussion

5.1 INTRODUCTION

In the area of claims-making, the role of the expert is to legitimize the claims made by the claims-makers (Spector & Kitsuse, 2001). The claims-makers will appeal to the expert's knowledge as a way to support their claims and make their argument stronger. In addition, experts are claims-makers themselves and are also competing for validation from the audience (Loseke, 2003). For this reason, it is important to understand that these experts all have personal and professional experiences that have guided their work and contribute to their understanding of concepts. With this idea in mind, this chapter explores how experts describe two concepts: addiction and sexual deviancy.

Using the data and findings discussed in the previous chapter, this chapter addresses the question: How do therapeutic professionals (as experts) describe the concepts of addiction and sexual deviancy when submitting evidence to parliament for policy changes, and how do these descriptions compare to each other, and other experts who submitted testimony? The chapter will be divided into three parts so as to break down the question. The first section will address how these treatment providers discuss sexual deviancy and addiction, while the second section will address how the descriptions by treatment providers compare to one another, and the third section will discuss how other experts describe sexual deviancy and addiction.

5.2 DESCRIPTIONS OF SEXUAL DEVIANCY AND ADDICTION BY THERAPEUTIC PROFESSIONALS

The treatment providers consisted of a large group of individuals who work directly with sexual deviants and drug addicts. These treatment providers have varying backgrounds

and credentials such as medical doctors, counsellors, psychologists and social workers. The first part of this section will discuss how treatment providers defined sexual deviancy and the second part will discuss how treatment providers are defined addiction.

5.2.1 *Sexual deviancy*

In the case of sexual deviancy, there is very little discussion of the disease model as an explanation. Instead, sexual deviancy, from the point of view of treatment providers, is essentially discussed as a learned behaviour, something that the individual learned to do in order to meet certain needs. It is also described as a socially inappropriate way to meet those universal needs, which is reflective of the behaviour theories (Chan, 2015; Ward, Laws and Hudson, 2003). This explanation of sexual deviancy leads to a treatment based on the idea that the individual can be taught the socially appropriate ways to meet their needs (Terry, 2006). It is implied that if a behaviour is learned, then it can, therefore, be unlearned and a new behaviour could take its place. In other words, they can be taught a new way to meet their needs as part of their treatment.

Treatment providers, in general, acknowledged the risk associated with sexual deviancy (in the form of sexual offending), recognizing that there is a possibility for recidivism. However, they did not frame this risk as something that needed to be feared. Instead, they acknowledged the risk as something that could be managed through proper treatment and programs. They proposed that this risk could be managed by avoiding isolation upon release, providing support in the community through programs such as COSA and, in serious cases, the use of indefinite sentences to confine high-risk individuals. This outlook implies the need to reduce stigma involved for sexual deviancy and that individuals should be supported rather than segregated. It was suggested that maintaining this attitude

would foster an environment in which the offenders feel safe and, as a result, reduce the risk of reoffending and subsequently keep the community safe as well.

5.2.2 Addiction

Treatment providers who discussed addiction from the disease point of view were more likely to be medical doctors and, as a result, they promoted a health response to addiction. On the other hand, most other treatment providers were more likely to discuss the idea of lack of control or compulsions as an explanation for addiction. Although these seem different at first, the use of the compulsion explanation is common when experts are attempting to medicalize a behaviour that does not have a clear biological marker (Conrad and Schneider, 1992). While appearing to be constructed differently, both sets of treatment providers (medical and non-medical) have presented explanations of addiction in line with a medicalization of deviance. Medicalization of deviance can decrease the stigma associated with a particular behaviour by reducing the blameworthiness placed on the individual. When someone is deemed sick rather than bad or evil, there is a sense that their behaviour is not considered to be wilful. An extreme example of this would be the designation “Not Criminally Responsible on Account of a Mental Disorder” (NCRMD) in which an individual is deemed to be mentally ill will not be held responsible for his/her actions, which otherwise would have been considered criminal.

Kelly (2010) discusses the importance of using language to reduce the stigma associated with addiction. He states that this can be done by using the term “substance use disorder” rather than “abuser” which reduces the blameworthiness for the individual. The term “substance use disorder” is much more related to the medical model and, therefore, this is consistent with the idea that treatment providers use the medical model in order to reduce

the stigma. However, the treatment providers who used the lack of control explanation are more in line with the “abuser” terminology that Kelly (2010) discusses. According to Kelly (2010), the abuser terminology can increase the stigma associated with addiction, as it implies that addiction is a choice, and this can decrease the chance that individuals will seek out treatment. However, in this group of witnesses, it did not appear that either group believed that individuals should be stigmatized for their addiction and, whether they used the medical model or the lack of control theory, all the witnesses in the treatment providers group believed in a harm reduction model.

The discussion surrounding the consequences of addiction was centered on the individual with the addiction and in some cases their family. This emphasis on their suffering leads to a level of sympathy, which supports the idea of a harm reduction approach to addiction. This is because harm reduction has a humanistic component that provides support for the individual without moral judgement and accepts their drug use as a way of life (Riley & O’Hare, 2000, p.5). Whether or not the treatment provider used the disease model or the control model, their statement promotes a harm reduction approach. Since treatment providers emphasized the harms the individual is suffering, it is not surprising that the harm reduction approach was favoured over punitive measures when providing a solution to addiction. Harm reduction is based on the idea that a person should be assisted in a way that prevents their drug use from doing harm to themselves or others (Riley & O’Hare, 2003, p.5). The consensus was that the approach to treatment should be non-coercive and should be healing, not punishing. This suggests that despite the differing terms used in their explanations and claims about addiction, these two groups could actually reach a consensus about how to solve the problem of addiction. This means that despite Spector and Kitsuse’s

(2001) assertion that claims-making is a competitive process, with claims-makers competing for the audience to validate their claims, claims-makers can, in fact, have different claims and yet promote similar solutions to the problem. In this way, it is not competitive in all stages. While in stage 1, claims-makers are trying to gain the attention of the audience in order to validate their claim about a particular problem. In this stage different groups could work in collaboration to gain the attention and validation from the audience and then in stage 2, compromises could be made for the solution to the problem.

Treatment providers have constant and direct contact with sexual deviants and addicts and, therefore, this could influence and shape their construction of their clientele. Due to the fact that they would develop relationships with these individuals, but have less contact with the victims or people they have harmed, it could lead to a construction that does not include the experience of the victim.

5.3 COMPARISON OF SEXUAL DEVIANCY AND ADDICTION

These descriptions of sexual deviancy and addiction by treatment providers have obvious overlaps and some very visible differences. The next section will discuss a comparison of the way therapeutic professionals are describing these two concepts. In the realm of treatment, there is considerable similarity between sexual deviancy and addiction as they are discussed by treatment providers. In both cases, there is a wide consensus about the idea that these conditions can be managed rather than cured, which indicates that both are a life long struggle. The goal of treatment seems to be learning to gain control over behavioural impulses, whether they are sexual in nature or driven by a substance. This is evident in the cognitive behaviour therapy that is used for both sexual

deviancy and addiction, especially in the form of relapse prevention programs (Witkiewitz & Marlatt, 2004).

Relapse prevention is a method used to treat many forms of problematic behaviours in the psychological field. Originally developed for the treatment of addiction, it is now common practice to use relapse prevention for sexual offenders (Witkiewitz & Marlatt, 2004; Polaschek, 2003). The basic theory guiding relapse prevention is that changing behaviour is a process which involves an awareness of what leads to the undesirable behaviour and learning to avoid these high-risk situations in order to maintain the desired behaviour. The triggers would vary from person to person. For addiction, this could mean avoiding parties where drugs and alcohol are present; for sexual deviancy, it could include avoiding parks where children play. If one allows him/herself to succumb to the high-risk situation, it could lead to what is referred to as a lapse or pre-offending behaviour. These lapses can include having one drink at the party or, in the case of sexual deviancy, starting to fantasize about inappropriate behaviour (Polaschek, 2003). If one was to give into the need for instant gratification, this could lead to a full relapse into addiction or committing another sexual offence (Polaschek, 2003).

Treatment providers discussed addiction and sexual deviancy in regards to regulation somewhat differently. Witnesses constructed addiction from a completely medicalized framework. Not only was addiction explained using medical terms such as disease and illness, but there was also proposals that the medical and clinical treatment was the best solution for addiction, and that the criminal justice system should not have any responsibility over addiction (Conrad & Schneider, 1992). In contrast, although sexual deviancy was constructed primarily as a medical problem using for example language from the DSM-IV

and supporting the need for treatment, there was still recognition of the legitimacy of the criminal justice system as a regulatory authority. Policy recommendations for sexual deviancy indicated that the health system and the criminal justice system should be working together to provide treatment. In fact, the justification for incarceration was generally based on providing treatment in a controlled environment rather than for punishment.

5.4 DESCRIPTIONS OF SEXUAL DEVIANCY AND ADDICTION BY OTHER EXPERTS

The other experts who gave testimonies in front of the committees came from different backgrounds and, therefore, had a different set of experiences and perspectives than the treatment providers. This section explores how the various personal and professional experiences of experts could have an influence on how they shape their understanding of sexual deviancy and addiction.

5.4.1 Law Enforcement

Law enforcement presents a unique perspective on both sexual deviancy and addiction, and throughout their testimonies illustrations of police subculture became apparent. Law enforcement officers in this project were resoundingly in favour of a public health approach to addiction, as some of them were even reporting limitations to the prohibition model. In contrast, the views of the police officers who commented on sexual deviancy proposed an entirely punitive approach to sexual deviancy and did not recognize that treatment as a valuable avenue. Due to the fact there were no regular street cops presenting testimonies, only those on a special sex offences task force, it was not possible to

determine if there would be a difference based on job specialization in regards to sexual deviancy.

Herbert (1998) presented a model, normative police subculture, which was used throughout the analysis to explore how law enforcement individuals construct sexual deviancy and addiction. This model illustrated the social context in which police officers develop and understand their beliefs and values. The normative order approach to police subculture aimed to account for individuality within law enforcement while also providing a solid structure that is consistent across culture and time (Herbert, 1998). Throughout the analysis, the witnesses illustrated how these normative orders and organizational beliefs may have an influence on the way in which law enforcement professionals view sexual deviancy and addiction. While the basic normative orders seemed to be present, there were also illustrations of how police officers had different opinions surrounding the same issue. This suggests that although there does appear to be a police subculture that each individual is influenced by many social levels and interactions.

5.4.2 Victims and Victim Advocates

Victims and victim advocates, discussing sexual deviancy, obviously concentrate more on the victims than on the offenders, as this is what their experience represents. Victims and their advocates viewed sexual deviancy as a predatory act in which the offender is expressing power and control. They encouraged longer, harsher punishments and did not view treatment as more effective than punishment for reducing offending. This perspective reflects a punitive approach to sexual deviancy. The construction of children and childhood appeared to have a significant role in the way sexual deviancy was constructed by these witnesses. According to Pascura et al. (2012), children and childhood are socially

constructed concepts, which developed late in the 19th century and led to the belief that children are different from adults with “...characteristics such as innocence, vulnerability, and passivity...” (p.202). The witnesses in this group framed children as innocent and vulnerable beings, consistent with the findings of Pascura et al. (2012). Sexual deviants were then viewed to be a risk of corrupting this innocence. This risk is considered extremely high because of the role of children as the victims. Due to this potential threat to the innocence of children, the witnesses advocated for the punitive approach to sexual deviancy to protect the children. Victims play an important role in claims-making, as they provide a strong foundation to garner attention from the audience. In fact, using victims is one of the most effective approaches to claims-making and therefore this group of witnesses was an important group to explore (Loseke, 2003).

5.4.3 Treatment Providers

Treatment providers within this project presented a unique problem. Due to the source of data from which the transcripts were collected, parliamentary and senate committees, the categories of treatment providers and academics and researchers may have merged, particularly in the case of sexual deviancy. Many of the practitioners that accepted the offer to testify in front of the committees were also part of academia; however, this is not necessarily the case for most treatment providers. That being said, this provided an opportunity to examine that dual role that these particular individuals represent within the claims-making process. More than likely the reason these experts were invited to the committee meetings was due to the fact that they benefit from the practical experience as a treatment provider, as well as the distinction as an academic. These designations give these experts a great deal of legitimacy, a key aspect to gaining validation from the audience (Best,

2013; Spector & Kitsuse, 2001). Although this dual role does not represent the typical experience of a treatment provider or academic, it is possible that it represents a trend in the experts considered for this type of evaluation by government agencies. Therefore it is important to consider the idea that they are given a public avenue to lobby for their job as they promote treatment over punishment for addiction and sexual deviancy. In this sense, they are aiming to validate their own work. More exploration of this idea using different sets of data would be significant in the study of claims-making and social construction.

5.4.4 Lawyers

Overall, the group of lawyers, consisting of only defence lawyers, seemed to have a negative view toward the role of the criminal justice system as a regulation policy for sexual deviancy and especially for addiction. Due to the fact that they were all defence lawyers, there is no way to compare these findings to prosecutors and to find any differences that may be present. Interestingly, this group was the only group to provide examples of vindication, the process in which a deviant behaviour is constructed as 'right' or 'acceptable'. Conrad and Schneider (1992) discuss the vindication process of homosexuality by explaining that while considered deviant, homosexuality was caught in a cycle that changed its status as either criminal or medical, but always deviant. However, through activism, homosexuality was constructed as a lifestyle and therefore any condemnation of this lifestyle was a violation of human rights. Consistent with this finding, defence lawyer Alan Young constructed addiction as a lifestyle choice and claimed that laws preventing individuals from making this choice would be a violation of civil liberties. This was perhaps a glimpse of how addiction could be constructed in the future.

5.4.5 Academics and Researchers

Academics and researchers come from various backgrounds, creating an eclectic group of individuals with varying experiences and views. However, a few dominant trends were discovered throughout this particular sample. The disease model was not frequently used by academics to describe addiction. Instead, addiction was understood as a compulsion or as the result of a lack of control. Conrad and Schneider (1992) state that the use of the term compulsion is still, in fact, a form of medicalization, but is often used to describe ailments that do not have a physical marker. The witnesses' testimonies seemed consistent with this idea, as they explained addiction as a compulsion, but also advocated for a health approach to addiction, including harm reduction policies. Consistent with their counterparts with similarly critical orientations from earlier decades, social scientists demonstrated a strong opposition to the criminalization of addiction, but very little towards medicalization. The focus seemed to be advocating for what they considered a more humane approach to addiction, which Conrad and Schneider (1992) would agree is a primary goal of medicalization, as it is often seen as a more humanistic approach to deviance over criminalization.

5.5 CONCLUSION

Overall, there seems to be a greater acceptance amongst all experts surrounding the idea of removing addiction from the criminal justice system and moving towards a health care approach. The overarching sense is that those who have an addiction are suffering in some way and need the help and guidance of a treatment professional in order to learn to manage their addiction. This belief leads to an endorsement for harm reduction and public

health strategies and an attempt to reduce stigma. Views on sexual deviancy, however, have not evolved to this perspective, as the involvement of an innocent victim seems to overshadow the rehabilitative approach proposed by treatment providers. Although there is some support for the needs of those with sexual deviancy, and the understanding that they require help, there is still an advocacy for the punitive aspect of regulation. The encouragement of law enforcement and the victims to increase punishment for these individuals seems to be driven by the desire to seek justice for victims. The next chapter will discuss how these findings can be applied to future research and what we can learn from the processes of social construction that the discourse of sexual deviancy and the discourse of addiction have undergone.

Conclusion

The focus of this project was to explore the concepts of addiction and sexual deviancy through the views of the therapeutic professionals who treat these individuals. Even though the main focus was on the therapeutic professionals, many other expert opinions were explored as well. This project examined the way in which experts describe sexual deviancy and addiction and what recommendations they make as to treatment and regulation of sexual deviancy, and addiction. The two concepts were compared to one another to identify similarities and differences in how they are discussed.

This project was conducted with a theoretical framework derived from Spector and Kitsuse's theory of social problems as social constructions. This theory provides an understanding of social problems as constructions created by a process of claims-making and campaigning. Within this process, there are important roles, including the claims-makers, audience, government agencies, and (the focus of this project) the experts (Spector & Kitsuse, 2001). By using a social constructionist framework as the lens through which to explore the data, this project examined the meanings of the concepts created by the experts, which allowed for an in-depth analysis of their perspective. Social constructionist theories do not require prior categories and definitions, which in the case of this project allowed the data to guide the analysis and categories. This project did, in fact, combine an inductive approach and a deductive approach.

SUMMARY OF MAJOR FINDINGS

The major focal point of this project was the importance of social interactions and how they can shape and influence the way in which an individual constructs their understanding of addiction and sexual deviancy. The varying professional and personal

backgrounds across these groups of witnesses, and even within groups of witnesses, may raise the question about the impact of social interactions have on the way these experts understand the world. From that view, particular groups (such as law enforcement and victims) described sexual deviancy in a way that reflected their experience with victims, and the harm to victims that sexual deviancy presents. This led to discussions by these groups about increasing punishment to provide justice for the victims, which allowed for very little support for treatment and rehabilitative measures. In contrast, treatment providers –who spend most of their professional lives with sexual deviants and have very little contact with victims– promoted a rehabilitative approach to sexual deviancy and favoured treatment over punishment. The most common way to justify these recommendations was to use the perceived consequences as evidence.

There was a considerable difference in how such consequences were constructed and then utilized for addiction compared to sexual deviancy. In the case of addiction, most of the experts discussed the consequences experienced by the addict themselves, including poor relationships and being caught in criminal activity. The consequences and harms for the family and community were less of a focus for these witnesses, however, many implied these less identifiable victims exist. In contrast, the consequences for sexual deviancy were often claimed to affect only someone else. In particular, victims and victim advocates discussed the long-lasting trauma to victims, while recidivism rates were discussed by all groups of experts. Treatment providers were the only group of witnesses that primarily focused on the sexual deviant in their discussion of consequences, often stating that isolation and punishment would increase the likelihood of re-offending.

The difference in the presentation of consequences resulted in contrasting recommendations and justifications in regard to the regulation of addiction and sexual deviancy. Due to the suggestion by most experts that much of the harm caused by addiction is experienced by the addict himself, there was a general consensus that the harm reduction approach and health model presented the best response to addiction. This emphasis on harm reduction was the focus, even when experts were discussing the harms of crime and violence experienced by other members of society. It was often suggested that individuals resorted to crime due to a lack of means to obtain their drug of choice, either because of the legislation prohibiting the use of the drug or due to one's ability to afford the drug according to their socio-economic status.

For sexual deviancy, the focus on the consequences to the victims resulted in an emphasis on giving those victims justice through a retributive and punitive approach. These were the main points put forth by both law enforcement and the victims and their advocates. However, treatment providers presented consequences of sexual deviancy that also included the stigma and the feelings of isolation the offender experiences; both of these were claimed to be factors in recidivism rates. Therefore, treatment providers concluded that sexual deviancy required treatment more than punishment and that social support would reduce the risk of reoffending and subsequently keep the community safer.

The impact of promoting the image of an innocent, identifiable victim was particularly evident according to the findings of this study. Using this kind of image is clearly supporting more punitive measures to protect future victims and give justice to past victims. As discussed by Loseke (2003), creating a claim around a victim is a very effective method for claims-makers. However, Loseke (2003) states that using villains as part of a

claim is also an effective strategy. In the case of sexual deviancy, the claims made incorporate both of these strategies; they stressed the victim and the harm they experience, while also discussing the villain and his predatory nature. This would provide a very strong base for the claims-makers to encourage policy makers to increase sentences for sexual offenders.

Throughout their testimony, the witnesses presented a general consensus that addiction is not something that can be regulated within the criminal justice system but would be better dealt with in the health care system. Many witnesses constructed the addict as an individual in need of help, insisting on the fact that punishing them might hinder their recovery. The addict, in essence, is constructed as a 'troubled person' who should then be taken over by the troubled person industry (Loseke, 2003; Gusfield, 1996). To reiterate this idea, the troubled person industry refers to the social function of professions such as psychologists, social workers, and counsellors, whose mandate is based on the idea that society includes individuals who require intervention in order to realign them with conventional societal behaviours and values. These constructions, which were consistent across all groups, led to a largely medicalized approach to addiction mainly emphasizing their need for treatment.

There was far less consensus on how to regulate sexual deviancy, which seems to be caught between criminalization and medicalization. As mentioned above, sexual deviants are widely constructed by victims and law, enforcement, as villains in need of punishment, reflecting a criminalization approach. However, within the treatment fields, there appears to be more of a concentration on the intervention these individuals need in the form of treatment and community support, such as with the program COSA. COSA, which stands for

Circles of Support and Accountability, is a program that was developed in Canada and aims to provide a support network for high-risk sexual offenders (Hannem & Petrunik, 2007). This is achieved by creating a group of volunteers who all meet with the offender (called the “core member”) once a week, as well as one-on-one throughout the week. They are there, implicitly, to provide support in the offender’s life, particularly with obstacles he may experience or even to celebrate successes he has. In other words, they become similar to a group of friends (Hannem & Petrunik, 2007). This is a step in creating a construction of sexual deviancy as a problem requiring treatment, similar to that of addiction. To further this point, sexual deviancy and addiction are treated with the same type of cognitive behavioural therapy/relapse prevention (Witkiewitz & Marlatt, 2004). In other words, the treatment of addiction and sexual deviancy are believed to involve the same process in which individuals must become aware of their behaviours, what leads to their behaviours, and learn to avoid these situations in the future.

Another significant finding that emerged from this project was the important distinction between management and cure when discussing the treatability of addiction and sexual deviancy. Many experts from all groups of witnesses adamantly denounced the idea that sexual deviancy and addiction could be cured; the consensus was that both involve a lifelong struggle, which means that the urge cannot be entirely eradicated. This is evident in the relapse prevention approach to treatment, which is not aimed at providing a cure for the individual but rather is focused on educating that individual about how they can learn to control their behaviour. In addition, sexual deviancy is considered a manageable risk by treatment providers because they referred to the use of incarceration for those who need it as part of the management aspect of treatment. This means that although they believe treatment

is most effective, they recognize that some individuals would be best managed within the criminal justice system. In essence, the term ‘management’ seems to encompass more than simply treatment or punishment, but rather cooperation between the two so as to provide the least risk possible to members of society.

LIMITATIONS

Generalizability is a major limitation within this project as it was focused on a small sample of secondary data. The witnesses were mostly experts invited to speak at committee meetings by members of parliament or senators; they do not necessarily represent the entire field from which they came. Although there is a representation of individuals from across Canada, there is not much representation from international sources. These individuals were chosen specifically by the members of parliament so they do not represent the views of all Canadians both within their field of study as well as those untrained in these professions. Finally, certain experts were not as well represented, particularly the lawyers and public officials, so there is less generalizability for those groups compared to those with much more representation, such as treatment providers. In addition, the topic of sexual deviancy was not represented in the academics group as there were many witnesses who were both treatment providers and researchers, but these individuals all spoke more from a treatment provider perspective and were, therefore, categorized in that way. Overall, the use of secondary data involved limitations to this study which affects the generalizability of the findings and results. Despite these limitations, the project still resulted in interesting discoveries about the topics of addiction and sexual deviancy.

CONTRIBUTIONS TO THE LITERATURE AND CRIMINOLOGY

The contribution of this project to criminological knowledge on addiction and sexual deviancy is two-fold: 1) It has illustrated that the concepts of addiction and sexual deviancy are not concrete; and 2) it has highlighted the importance of social science research that challenges the status quo. The ways in which sexual deviancy and addiction are constructed have consequences on the individuals who are deemed deviant, as regulatory policies, including criminal justice practices. Therefore, it is crucial to explore the beliefs and assumptions that may have an influence on how a phenomenon is constructed and how one's social interactions reinforce these meanings.

Concepts such as addiction and sexual deviancy are used to regulate and control groups and individuals who deviate from the norms of society. Being identified as a sexual deviant, or being diagnosed as a drug addict, might have a major impact on the life of a person, might it be positive or not. It might help the person to access the support services required for recovery; but it might also create stigmatization and lead that person to prison. It is, therefore, important to understand that these concepts are constructed within a particular social context and therefore are not concrete. The ontological status of addiction and sexual deviancy is dependent on the time, place, and even according to the group of professionals to which one belongs. A profession is an additional social context, which contains values and beliefs that inform an individual's perceptions of social problems.

In addition, this project also highlights the role that social science research has in challenging the status quo of the regulation of deviancy. In recent history, social science research, within critical frameworks, has become the leading voice to challenge policies such as medicalization. These have led to new ways to construct, regulate and control different

types of deviancy. The critique of the status quo prevents groups from taking knowledge for granted and allows for innovative approaches to the understanding of deviance.

FUTURE RESEARCH

The findings and results could be explored more thoroughly in numerous different ways in order to provide a better understanding of the topics. First and foremost, the limitations of this project discussed in both chapter 3 and this concluding chapter were based on the use of secondary data. Future research in this area could be conducted using primary data, consisting of interviews with different experts. This would provide more thorough and direct answers, which would result in a more in-depth analysis. In addition, interview questions can be made more consistent and would be created with the project in mind, which would produce less irrelevant information for the researcher to handle. The use of focused questions and interviews would greatly increase the depth of exploration on this topic.

Future research could also explore how the victim-like status of addicts can help create a policy that helps them rather than punishes them, such as with harm reduction. In addition, further research in how language and terminology affect the stigma surrounding a topic would be an important project. This could include conducting interviews with experts about why they choose certain terms and how they believe it influences stigma. It would also be beneficial to interview addicts and sexual deviants about what the terms used mean for them and how this affects their perception of stigma.

Despite this project having some limitations due to the data that was collected, the findings are nonetheless important in building a foundation of knowledge about social problems as social constructions. This project provided a base to begin to understand the

different ways in which experts describe addiction and sexual deviancy and explored a comparison between these concepts and across experts. By examining two different concepts from their historical origins to their current conceptions, it is clear that past ideas remain for both sexual deviancy and addiction.

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Appendix A- Names and Titles of Witnesses

Law Enforcement Witnesses

Michael Boyd Deputy Chief of Toronto Police Service, Chair of Drug abuse committee
Ward Clapham Superintendent RCMP, Richmond BC detachment
Catherine Dawson Police Trainer, Canadian Police Sector Council, Society for the Policing of Cyberspace
Julian Fantino Chief, Toronto Police Service
David Griffin, Former Police officer, Executive Officer, Canadian Police Association
Kash Heed, Officer, Vice Drug Section, Vancouver Police Service
Cal Johnston Chief of Police, Regina Police Service
Barry King Former Chair of the Drug Abuse Committee and Chief of the Brockville Police Service, Member of Canadian Association of Police Chiefs
Robert G. Lesser, Police officer, Vice Chair, Drug Abuse Committee Canadian Association of Chief of Police
Scott Naylor Detective Inspector, Child Sexual Exploitation Investigations, Ontario Provincial Police

Lawyer Witnesses

John W. Conroy Criminal Defence Lawyer
Michael Spratt Criminal Defence Lawyer, Director, Criminal Lawyers' Association
Alan Young Defence Lawyer, Associate Professor, Osgoode Hall Law School

Victim and Victim Advocate Witnesses

Ellen Campbell President, Chief Executive Officer and Founder, Canadian Centre for Abuse Awareness, victim of sexual abuse
Karyn Kennedy Executive Director, BOOST Child Abuse Prevention and Intervention
Lianna McDonald Executive Director, Canadian Centre for Child Protection
Brian Rushfeldt Social Worker, Canada Family Action Coalition

Public Officials

Linda Barnes- City Councillor for Richmond, BC
Bill Marra- City Councillor of Windsor and Youth Correctional Officer
Philip Owen- Mayor of Vancouver, BC

Treatment Providers

Al Breau Coordinator for the alcohol and drug program, Addiction Services, Village of Salisbury
Tracy Butler M.D. Program Director, Salvation Army Harbour Light Addiction and Rehabilitation Treatment Centre
Bill Campbell, M.D., Gastro-entorologist, President of Canadian Society of Addiction Medicine
Walter Cavalieri Social Worker, Toronto Harm Reduction Task Force, Canadian Harm Reduction Network
Randy Cormier Counsellor/Group Leader at Brentwood Recovery Home
Jerry Fitzgerald Manager, Alcohol and Drug Services, Regina Health District
Randall Fletcher Social worker, Sexual Deviance Specialist, Office of the Attorney General of Prince Edward Island

Thomas Fulgosi Addiction counsellor, Seaton House
Paul Garfinkel Centre for Addiction and Mental Health Toronto
Henry Haddad, M.D., Chair, Canadian Medical Association
Michel Landry Director, Professional Services and Research, Centre Dollard-Cormier
Achille Maillet Director of Addiction Services in south eastern New Brunswick
William Marshall Ph.D., Retired Professor from Queen's University, Director, Rockwood Psychological Services
Ed McIsaac Interim Director, Policy, John Howard Society of Canada
Andrew McWhinnie MA Practicing Psychologist
Martin Petit Treatment provider, Representative of CACTUS Montreal QC
Diana Power-Jeans Social Worker, Janeway Community Mental Health Division, Health Care Corporation, St. John's
Vernon Quinsey, Psychologist, Professor Emeritus of Psychology, Queen's University
Darlene Simpson Social Worker, Director of Programs, House of Sophrosyne
Mark Tyndall M.D. B.C. Centre for Excellence in HIV/AIDS
Hubert Van Gijseghem Ph.D., practicing Psychologist, Professor at University of Montreal
Anne Vogel M.D Manager, Gilwest Clinic

Academics and Researchers

Bruce Alexander Professor, Department of Psychology, Simon Fraser University
Mohamed Ben Amar Professor of Pharmacology and Toxicology, University of Montreal
Patricia Begin, Director, Research and Evaluation, National Crime Prevention Centre
Serge Brochu, Ph.D., Director, International Centre for Comparative Criminology, University of Montreal
Peter Cohen Director, Centre for Drug Research, Professor University of Amsterdam
Patricia Erickson, Ph.D., Professor at University of Toronto, Centre for Addiction and Mental Health
Michel Germain Director General, Comité permanent de lutte a la toxicomanie (Standing committee on campaign against Drug addiction)
Brian Grant Director, Addictions Research Centre of Correctional Service Canada
Andy Hathaway Ph.D., Sociologist, Researcher at the Centre for Addiction and Mental Health
Michel Kokoreff, Professor at the Université de Lille
Dirk J. Korf Ph.D., Professor, Department of Criminology, University of Amsterdam
Colin Mangham, Unclear if Ph.D. or M.D., Director, Prevention Source B.C
Richard Mathias Unclear if Ph.D. or M.D., Professor Health care and Epidemiology at UBC
William A McKim Ph.D., Professor, Department of Psychology, University of Newfoundland
Celine Mercier Associate Professor, Department of Psychiatry, McGill University
John Morgan Professor of Pharmacology, University of New York Medical School
Ethan Nadelmann, Ph.D. Executive Director, Lindesmith Center-Drug Policy Foundation
Michel Perron Executive Director, Canadian Centre on Substance Abuse
Art Steinmann Executive Director, Alcohol-Drug Education Service
Ambros Uchtenhagen Retired Professor, Addiction Research Institute