Rethinking the Medicalization of Violence: The Risks of a Behavioral Addiction Model

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In "A Behavioral Addiction Model of Revenge, Violence, and Gun Abuse,"[1] Kimmel and Rowe medicalize retaliatory violence, suggesting that an addiction model will empower communities plagued by gun violence to heal from victimization and oppression. However, promoting a medical model of violence may overly individuate a phenomenon better described by social problems, creating a bias for clinical intervention and *against* redressing structural failures that drive violent behavior. A medical model of violence risks pathologizing behavior rooted in social injustice.

This response aims to criticize Kimmel and Rowe's *model*, not to dismiss effective medical or other individual-level interventions. Efforts to prevent individual retaliatory behavior — through cognitive behavioral therapy, the Nonjustice System, peer support services, etc. — have a legitimate role in violence prevention. But reframing violence as an addiction is not necessary to support individualized approaches, and we should resist a model that may further marginalize poor urban communities of color and potentially subvert the impetus for structural change.

Medicalization and the Behavioral Addiction Model

"Medicalization" is a sociological term critiquing the process by which medical models produce an epistemological shift in the way we view human behavior, typically by pathologizing it. Using biomedical etiologies to reconceptualize behaviors that are largely socially determined tends to decontextualize and depoliticize social problems. By focusing causation on individual-level pathology, medicalization obscures community-level and structural solutions.[2] "A behavioral addiction model of revenge-seeking and violence" fits squarely within this frame. It redefines violent behavior in terms of neurobiological causation, thereby abstracting it from social context.

The scientific validity and clinical utility of "behavioral addiction" models are controversial among experts.[3] Only one so-called "behavioral addiction" (gambling) is classified as such in the *Diagnostic and Statistical Manual of Mental Disorders*.[4] Some well-respected experts, including professional associations, adamantly reject addiction models of behavior as empirically unsupported and unduly pathologizing.[5] Critiquing the empirical conclusions underlying Kimmel and Rowe's model is beyond the scope of this commentary, which instead scrutinizes their model's *societal implications*. But the considerable scientific skepticism about "behavioral addictions" nevertheless accentuates doubts about the value of modeling violence this way.

Oppressive History of Medicalization

Because low-income, predominately-minority urban communities have the highest rates of gun violence[6] — and are therefore disproportionately implicated by Kimmel and Rowe's model — we must consider how medicalization has historically oppressed poor people of color in the United States. During the Civil War era, fleeing enslavement was hypothesized as a mental illness, called "drapetomania."[7] Early-twentieth-century eugenicists medicalized poverty and criminality as

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rooted in heredity, leading to involuntary sterilization of poor women of color.[8] During the civil rights movement, psychiatrists medicalized civil unrest by reconceptualizing schizophrenia as a "Black disease" and institutionalizing Black protesters.[9] Medicalizing substance use has followed similar patterns. A 1985 medical report on prenatal cocaine exposure spawned the now-discredited, racist notion of "crack babies." The ensuing moral panic motivated an onslaught of fetal protection laws, which are still used to prosecute predominantly poor women of color for using drugs during pregnancy.[10]

well-intentioned police and prosecutors making more arrests and filings to get people into court-ordered treatment.[13]

The addiction model has also motivated jail expansion. While jail populations are declining in our largest cities, they are increasing throughout most of the country due to a boom in jail construction, driven in part by jail officials' desire to build specialized substance abuse treatment facilities. County jail systems have received state funding to expand existing facilities to increase treatment capacity and build new "therapeutic" detention centers. They have also diverted existing funds from social services to jail construction.[14]

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Addiction Model and Carceral Investment

A behavioral addiction model of revenge-seeking and violence may appeal to reformers who believe the "brain disease model of addiction" subverted the War on Drugs and expect that Kimmel and Rowe's model could have similar decarcerating effects for violent crime. However, while treatment for substance abuse is essential, the addiction model has failed to elevate medical over carceral responses. In fact, it has fueled *new investment* in the criminal legal system. The carceral system has become America's primary infrastructure for managing substance abuse since deinstitutionalization began in the 1960s,[11] and the addiction model follows this trend.

Between 1999 and 2004, as the "brain disease model of addiction" gained traction, drug treatment courts (DTCs) more than tripled in number, with over 3000 now operating in all fifty states.[12] Despite modestly reducing convictions, DTCs are an unmistakably carceral response. For example, even *successful* graduates of Santa Clara's DTC spent an average of 51 days in jail due to sanctions. Failure results in enhanced prison sentences (judges disproportionately fail poor and nonwhite participants). DTCs may even widen carceral control: drug cases in Denver nearly tripled in the two years after it established a DTC, likely due to

Similar investments have been made in policing. For example, as Congress increasingly asserts that opioid abuse is a disease, it is doubling down on funding for police: in fiscal year 2018, Congress appropriated over $300 million (an approximately 12% increase from the previous year) for law enforcement efforts to combat the opioid crisis.[15] Department of Justice-administered grants, as well as private foundation money, fund traditional drug interdiction, along with police initiatives to administer naloxone and refer people to treatment *after arresting them*.[16] While life-saving first-responder initiatives are essential, police are poorly suited to this role. However, because we have built our crisis response infrastructure around police and eviscerated social services, policies that aim to address addiction as a medical problem slot effortlessly (albeit perversely) into this extant carceral infrastructure.

These investments not only bolster a bureaucracy that devastates poor communities of color; they also detract from investment in community infrastructure that can prevent substance abuse or provide treatment that does not hinge on arrests, criminal charges, or jail stays.

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Risks of Medicalizing Violence

Applying the addiction model to violent behavior may produce similar investments in the carceral state: expanding jail systems to treat "revenge addiction," investing in treatment courts for "violent criminals," and funding police first-responder initiatives to diffuse "revenge cravings." Any further investment in carceral infrastructure, however well-intentioned, will disproportionately harm communities of color. Moreover, ill-intentioned carceral investment seems equally likely *because* those most affected by violence are poor people of color. That is, the notion of "inner-city violence addicts" seems more likely to spark fear that would exacerbate over-policing and mass incarceration than to elicit empathy that would motivate public health interventions. As history reveals, medicalizing violence could easily become a tool of oppressive social control.

Furthermore, an addiction model that motivates carceral investment would detract from funding to redress structural failures that are empirically linked to high rates of violence — including inadequate social spending, low social mobility, residential segregation, and failing public infrastructure.[17]

More broadly, when social problems are redefined in medical terms, policymakers tend to prefer medical solutions because they are "less elusive" than reforming social policy; also, because medicalization locates problems in individual pathology, it can obscure the need for such reform.[18] Thus, an addiction model of violence may reduce political accountability for structural change — either through racial bias, which will favor a naturalized explanation of inner-city violence, or through political weaponization that characterizes these populations as victims of apolitical pathology rather than systemic government neglect that warrants remediation. This may be especially likely because addiction is highly stigmatized — research shows that Americans hold significantly more negative attitudes about people with addiction than people with mental illness (an already stigmatized group), including strong opposition to social policies aimed at helping them.[19] Notwithstanding Kimmel and Rowe's assertions that their model is not a substitute for social reform, their model's normative force, as well as the cognitive effect of shifting focus from a social to a neurobiological etiology of violence, may actually subvert such reform efforts. Moreover, it is not clear why this highly pathologizing and potentially stigmatizing model is needed to support clinical interventions to reduce violent behavior, such as cognitive behavioral therapy, motivational interviewing, or Kimmel and Rowe's own Nonjustice System.

Conclusion

With the recent surge in anti-racist activism — fueled by police murders of Black citizens and racial disparities in COVID-19 — cries to dismantle the carceral state and medical racism have become too loud to ignore. The legal and medical communities are rightly being called upon to center anti-racism in every aspect of our work. Pathologizing violence, and in so doing, abstracting it from structural inequality, is a step in the wrong direction. It will undermine the divestments and investments that affected communities are demanding.[20] A behavioral addiction model risks fueling investment in the carceral bureaucracy. Furthermore, it risks undercutting structural investments that research suggests may reduce violence at the community level — such as neighborhood revitalization, residential integration initiatives, and increased spending on education and welfare.[21]

Of course, community reinvestment should include funding community-based mental health treatment and violence interruption programs, which can support individuals to break out of cycles of violence even as other structures fail them. Indeed, recent reinvestment petitions have included these demands.[22] But a behavioral addiction model does not advance this cause. It places our focus on failures of neural circuitry, not on failures of our mental healthcare infrastructure or state funding priorities. This model's potential to further marginalize poor urban communities could ironically undermine funding to expand access to individual-level violence prevention. And it risks detracting from efforts to fundamentally reshape a structural landscape in which violence, far from being pathological, is a means of survival.

Note

The author does not have any conflicts of interest to disclose.

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