Addiction to Prescription Drugs: An Interpretative Phenomenological Analysis and Constructionist Study

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ADDICTION TO PRESCRIPTION DRUGS:
AN INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS
AND CONSTRUCTIONIST STUDY

A Dissertation
Submitted to the McAnulty College and Graduate School of Liberal Arts

Duquesne University

In partial fulfillment of the requirements for
the degree of Doctor of Philosophy

By
Thomas M. Hallinan

May 2014
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AND CONSTRUCTIONIST STUDY

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ABSTRACT

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By

Thomas M. Hallinan

May 2014

Dissertation supervised by Marco Gemignani, Ph.D.

This study presents an interpretative phenomenological analysis of the experience of becoming addicted to prescription medications. In addition, a constructionist analysis of the cultural, sociopolitical, and historical aspects of addiction are examined. The modern concept of addiction did not begin to come into being until the late nineteenth century. The twentieth century saw the beginning of government regulation and restrictions on the prescription, possession, and use of pharmaceuticals. The latter half of the twentieth century saw not only the boom of the pharmaceutical industry, but the explosion of addictive disorder and the rise of the Twelve Step program for addiction. Addiction, as a culturally constructed phenomenon, is still a hotly contested issue, with extreme views on opposite ends of the spectrum, even among treating professionals. Prescription medication addiction, in particular, has been on the rise for several decades.
Toward the exploration and understanding of prescription pill addiction, six male participants were recruited and interviewed for the research data and an interpretative phenomenological analysis was applied to this data. The following superordinate themes emerged and were explored: early experiences with drugs, a perception of prescription drugs as safer than street drugs, a movement away from an ideal self, denial and avoidance, and a sense of powerlessness. In addition, cultural factors impacting the experience of the participants’ addictions were investigated.
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TABLE OF CONTENTS

Abstract ........................................................................................................................................ iv
Acknowledgment ......................................................................................................................... vi
Chapter 1: Introduction ............................................................................................................... 1
   Introduction to the Study ......................................................................................................... 1
   The Method ............................................................................................................................... 2
   A Brief History of Addiction in the United States ................................................................. 2
   The Case of Minor Tranquilizers in the United States ............................................................ 12
      Selling Tranquilizers to the Physicians ............................................................................ 14
      Changing the Perception of Prescription Drugs ............................................................... 15
      Questions about Safety Arise ............................................................................................ 17
      Culture Shifts, Perception Shifts ....................................................................................... 18
      The Problem Continues ..................................................................................................... 20
Chapter 2: Review of the Literature on Addiction and of Social Constructionist Theories of Addiction .................................................................................................................. 22
   Culture and Addiction: Postmodernity, Nihilism, and Addiction ....................................... 22
   Dunnington’s Work .................................................................................................................. 25
   Cushman’s Work ..................................................................................................................... 30
   Disease versus Will .................................................................................................................. 33
   Heyman’s Critique ................................................................................................................... 38
   Agency and Will ....................................................................................................................... 44
   Overview of Qualitative Research on Addiction ................................................................. 47
      The Emergence of Qualitative Research since the 1990s ................................................. 49
      Research on Identity .......................................................................................................... 51
      Anderson’s Work ................................................................................................................. 53
Chapter 3: Method ....................................................................................................................... 55
   Methodology ............................................................................................................................ 55
   Summary of Philosophical Background of IPA ................................................................. 57
   Theoretical Background ......................................................................................................... 60
   Participants .............................................................................................................................. 65
      Introduction to the Participants ......................................................................................... 66
      Participant Recruitment .................................................................................................... 68
# Table of Contents

Data Collection .................................................................................................................. 69

Method ................................................................................................................................. 72

Reflexivity ............................................................................................................................. 75

Researcher Data ................................................................................................................... 77

Chapter 4: Data Analysis ..................................................................................................... 79

Reintroduction to the Participants ....................................................................................... 79

Analysis ................................................................................................................................. 79

Early Experiences of Substance Use ..................................................................................... 81

Cultural Aspects of Early Experiences ................................................................................ 86

Prescription Medications as Safer Than Street Drugs ......................................................... 90

Cultural Aspects of Prescription Medications as Safer Than Street Drugs ..................... 96

Moving Away from an Ideal Self ......................................................................................... 98

Cultural Aspects of Moving Away from the Ideal Identity ............................................... 106

Addicted Identity: Marked By Denial and Avoidance ....................................................... 108

Addiction as Powerlessness .............................................................................................. 116

Cultural Aspects of Addiction as Powerlessness ............................................................... 118

Hierarchy of Addiction and Resistance to the Twelve Steps ......................................... 120

Differences and Similarities across Participants ............................................................... 125

Similarities across Participants ......................................................................................... 126

Alternative Voices ............................................................................................................. 128

Chapter 5: Discussion .......................................................................................................... 130

Conclusions ......................................................................................................................... 133

Implications for Clinical Practice ..................................................................................... 137

Implications for Further Research .................................................................................... 139

Closing Remarks ................................................................................................................ 141

References ......................................................................................................................... 144

Appendix 1 .......................................................................................................................... 155
Chapter 1: Introduction

Introduction to the Study

Drug overdose deaths have more than tripled in the United States since 1990 (Jones, Mack, & Paulozzi, 2013, p. 657). Of those deaths, nearly half were listed on death certificates as unintentional. Over half of those deaths were listed as due to the use of prescription medications (p. 658). The United States makes up only 5 percent of the world’s population and yet consumes 80 percent of its opioids (Manchikanti, Boswell, & Hirsch, 2013). Put lightly, Americans have a problematic relationship with pharmaceutical drugs.

The twentieth century introduced many new technologies that impacted American culture, economics, and politics. These technologies promised better, easier living through technological progress. The pharmaceutical industry promised better living through chemistry. The many lives that have ended due to prescription drugs are a glimpse of the shadow side of such a promise.

The present study evolved from my interest in how people who self-identified as addicted to prescription medications understood their becoming addicted. The above numbers reveal, in part, the seriousness of our communal consumption of drugs and prescription drugs in particular. Those lives ended with the pharmaceuticals that, at some point, people started to take to improve their health. The lives of the participants interviewed for this project did not. But their life stories will always be marked by their relationship with prescription drugs. Not only did the present study evolve from an interest in how addicted persons understand themselves as addicted, but also grew from an interest in the cultural configuration that allowed addiction to emerge as the
phenomenon we see today. An examination of the intersection between the cultural and
the personal in prescription drug use and abuse is also at the core of this project.

The Method.

Six men volunteered to participate in the current study. Their interviews were
transcribed and analyzed using interpretative phenomenological analysis (IPA). As
Jonathan Smith, one of the founders of IPA, writes, “the aim of IPA is to explore in detail
individual personal and lived experience and to examine how participants are making
sense of their personal and social worlds” (Smith & Eatough, 2007, p. 35-36). The
method and methodology are further detailed in Chapter Three. Cultural and social
factors that influenced the emergence of the phenomenon of addiction in the twentieth
century are examined in Chapter Two and through the brief history of addiction in the
United States below. Emergent themes were described and similarities and differences
across participants were highlighted. These themes were examined at both individual and
cultural level. Though the distinction may be artificial, the separation served to examine
how cultural understandings surrounding addiction and pharmaceuticals informed the
individuals’ experiences of their addiction. The analysis of the data is in Chapter Four.

A Brief History of Addiction in the United States

The problem of substance use and abuse in the United States is not new.
The very word addiction comes from the Latin root addicere, which means to
adore or to surrender oneself to a master. It became common in the professional
literature in the mid-1890s (White, 1998), but substances had been widely used
and abused since the colonial founding of the USA. Alcohol, the most commonly
used substance since the very beginnings of our country, was used pervasively
during colonial times. “What is striking about early colonial history is the utter pervasiveness of alcohol. It was consumed throughout the day by men, women, and children and integrated into nearly every ritual of social and political discourse” (White, 1998, p. 1). Drinking itself was not considered a problem during the colonial period and the only laws that served to restrict alcohol revolved around public intoxication. The concept of addiction started to become understood as a disease rather than a moral failing largely through the work of Benjamin Rush (p. 1), though the term “addiction” was not used during this period. Rush was one of the first and most prominent medical professionals to label drunkenness as a clinical condition. Further, Rush suggested that the condition ought to be treated medically. As the nineteenth century rolled on, drinking tastes and habits shifted. The country saw a massive shift away from the consumption of beer and wine toward distilled spirits. Distilleries and breweries opened across the country. From a social viewpoint, the nineteenth century saw the emergence of a new kind of drinker and a new drinking institution:

New immigrants, industrialization, and the movement into the Western frontier had all served to create a class of American men who organized their work life and leisure time around drinking. These men were virtually alone, unencumbered by duty to family or enduring community ties. America’s changing drinking rituals were also reflected in the evolution from the tavern to the saloon. The tavern had been the center of village life, but the saloon – associated with violence, crime, vice, and political corruption – now emerged as a threat to community life. (p. 4)

In response to the increase in drinking and drunkenness, several organizations arose throughout the country to combat the perceived ills of substance abuse. The Washingtonian Society, officially formed in 1840, was one of the first organized groups, by and for drinkers, to preach total abstinence (Conley & Sorensen, 1971). Although the
Washingtonians were one of the first, the next sixty years saw the rise and fall of many such organizations, which primarily saw drinking and drunkenness as a problem of self-control and moral failing rather than as a disease. The 19th century also saw the development and growth of public and private asylums for inebriates, although the practice itself has origins in both Egyptian and Greek societies (Crothers, 1893).

The nineteenth century also saw the rise of the narcotics’ abuse. Cocaine was advocated as a form of treatment for morphine addiction in the later decades of the nineteenth century. In 1880, Dr. W.H. Bentley argued for the use of cocaine preparations for the treatment of several of his patients who were addicted to morphine or alcohol (Bentley, 1880). Dr. J. T. Whittaker, among other American physicians, prescribed a mixture of cocaine and opium for opiate addiction in the mid-1880s (Whittaker, 1885). One of the most cited and most interesting cases of iatrogenic addiction comes from the medical advice given by Sigmund Freud to Dr. Ernst von Fleischl. Freud published a paper entitled “Ueber Coca” (On Coca) in the St. Louis Medical and Surgical Journal which recommended the use of cocaine as a stimulant, aphrodisiac, anesthetic, and treatment for nervous disorders, digestive problems, syphilis, and asthma (Freud, 1884). He recommended cocaine as a treatment for Fleischl’s morphine addiction. Freud’s recommendation worked, to some extent, as Fleischl’s morphine addiction was replaced by an addiction to intravenously injected cocaine. At the height of his addiction, Fleischl was injecting a gram of cocaine a day. Wracked by disease and handicapped by addiction, which culminated in a cocaine-induced psychosis, he died in 1891. Freud was heavily criticized for his initial endorsement of cocaine as a treatment for morphine addiction (Erlenmeyer, 1889). In 1887, he published a piece titled “Remarks on the
Craving for and Fear of Cocaine” in which he responded to his critics by admitting that cocaine had a high potential for abuse and addiction when prescribed for the treatment of morphine addiction, though he suggested that the use of cocaine for other ailments was not habit-forming (White, 1998, p. 110).

The end of the nineteenth century saw the rise of the iatrogenic addict as opium and opiates were regularly prescribed as treatments for a variety of ailments. While the typical opiate addict during this period was a woman who used opiate-laced medicines (White, 1998, p. 110), the popular imagination seemed centered on the use of opium as a recreational drug in the Chinese opium dens. A dichotomy that would appear again and again as a pattern in the social construction of addiction also began to emerge: the patient addicted to medicine was seen as suffering from a disease, while the Chinese opium addict was seen as a degenerate: “While Chinese opium users were subjected to considerable persecution, affluent White opium and morphine users were embraced in a growing medical conceptualization of their disorder” (White, 1998, p. 110).

In the eighteenth and early nineteenth centuries, narcotic use had not yet received the kind of attention in the West as had alcohol use and abuse. Thomas De Quincey published *Confessions of an English Opium-Eater* in 1822, but it would take many decades before the issue of narcotic use and addiction became a national, public-health issue in the U.S. Medical knowledge and use of narcotics had grown through the nineteenth century and was helped along by the invention of the hypodermic syringe. In addition, as Hickman (2004) writes, “though the popular belief that Civil War battlefield medicine was the chief cause of subsequent narcotic use has been disproven, a general increase in the prescription of narcotics during the Civil War era created a taste for them”
(p. 1270). The end of the nineteenth century also saw the use of narcotics shifting slowly from upper- and middle-class White women to lower-class urban men on the fringes of society. This demographic shift has been argued to be part of the reason behind the subsequent public attention to narcotics use and abuse as a public health issue toward the end of the nineteenth century in America (Courtwright, 2001).

Women during this period were frequently prescribed morphine, or laudanum, for “female complaints, such as menstrual pain and hysteria” (Aurin, 2000, p. 418). Hysteria, a markedly feminine condition during this period, was one of many ailments that was treated with opiates in the late nineteenth century. As we will see with the case of tranquilizers in the twentieth century, women were prescribed narcotics as treatments for psychological issues. Whereas in this period men drifted to the saloon to ease their suffering, women were largely excluded from such public places: “Like the medical school or the plumbing trade, bars have served to keep women from the marketplace, at home with the babies, and divorced from the decision making” (Lupton, 1979, p. 572). So while the saloon gave men a socially acceptable way to ease psychological tensions, women turned to their physicians or, alternatively, sought help at the local pharmacy or apothecary. During this period, the consumption of opiates for “female complaints” was not only socially acceptable, it was the preferred treatment for a host of symptoms (Courtwright, 2001).

The early twentieth century saw the public concern with narcotics rise to the point that political action was deemed necessary by those in power. Passed in 1914, the Harrison Anti-Narcotic Act used registration and taxation to restrict the use of opiates and cocaine to legitimate medical purposes. “America went from uncontrolled access –
under federal law – to access regulated by physicians” (White, 1998, p. 112). Although
the Harrison Act stated specifically that the prohibition of the distribution of opiates and
cocaine did not apply to the dispensing or distribution of said substances by a physician
(many addicts believed correctly that they could receive opiates or cocaine legally from
their physicians), the Harrison Act came to be interpreted differently over the next few
years. In 1915 the Treasury Department issued Decision 2200 which required physicians
prescribing opiates to addicts to progressively decrease the dosages they prescribed and
went so far as to specify how these doses would be decreased. Notably these political
decision were issued without the advice or consultation of any professional medical
organization. The Treasury Department continued to reinterpret the Harrison Act until the
law of the land, which was upheld under various Supreme Court decisions, made the
prescription of any opiate or cocaine to an addict a violation of the Harrison Act. The
Treasury Department began intimidating and even arresting physicians who continued to
treat their addicted patients (Kinder, 1991). The medical logic at the time was that
ambulatory treatment, or trying to wean a patient off the substance over time, was the
most humane method as it minimized withdrawal symptoms. However, the Treasury
Department saw physicians continuing to prescribe medications as a violation of the law.

In 1922, the Supreme Court ruled in U.S. v. Behrman that it was a violation of the
Harrison Act for a physician to prescribe drugs to an addict, regardless of the purpose.
This ruling effectively shut off all legal access to drugs for addicted persons and
“redefined the addict’s status from that of patient to that of criminal” (White, 1998, p. 113). In 1925, the Supreme Court’s reversed its position in the Behrman case. The Court
ruled in Linder v. U.S. that addicts were “diseased and proper subjects for treatment” and
that it was not illegal for a physician, acting in good faith, to prescribe narcotics for the
treatment of addiction and the alleviation of withdrawal symptoms (p. 113). Despite the
ruling, public policy was not altered because the Treasury Department continued to
intimidate physicians with the threat of criminal persecution (McNamara, 1973). Between
1914 and 1938, more than 25,000 physicians were indicted under the Harrison Act with the vast majority paying substantial fees rather than being incarcerated (White, 1998).

Most physicians remained silent about the new laws and their enforcement, as it was culturally understood that many physicians were implicated in their patients’ addictions due to careless over-prescribing of narcotic substances. They also had a vested interest in both increasing their professional credibility by cooperating with the federal authorities and securing their own powers of prescription. Despite the federal mandate against the prescription of narcotics to addicted persons, most narcotic addicts continued to receive the majority of their drugs via their physicians. Many addicts began the practice what is now known as “doctor shopping” by visiting various physicians and attempting to receive prescriptions from each. Some went to extreme lengths to convince their doctors they were indeed in pain and needed pain-relieving medications, for instance producing self-inflicted wounds that would leave blood in the urine in order to convince the physician they did indeed have kidney stones (Mosley, 1959).

Various attempts were made by the Federal Government to treat addicts during this period, leading up to the 1950s: none was particularly successful (Maddux, 1978; Lowry, 1956; Knight & Prout, 1951). The second half of the 20th century saw the rise of Alcoholics Anonymous, a self-help and mutual support group started by Bill Wilson and Dr. Bob Smith. Concurrent with the success of self-help groups for alcoholics, the
Federal Government continued to interpret the Harrison Act in such a way as to criminalize narcotic addicts and drive them toward black markets rather than their physicians. As self-help groups became more popular, the idea of addiction as a problem of morals supplanted the burgeoning idea of addiction as a disease. In 1951, Congress passed the Boggs Act legislation that dramatically increased penalties for drug violations, included guidelines for minimum sentencing, and increased punishments for repeat offenders. The Narcotic Control Act of 1956 continued this trend towards increased punishment for drug violations: for the first time in U.S. history the law allowed for life imprisonment and even the death penalty for drug violations (White, 1998, p. 114).

Though programs such as methadone maintenance and detoxification existed during this period, they were well outside of established and mainstream medical practice. Some of the more common treatment methods during the 1950s and 1960s in the U.S. included insulin treatments, electroshock therapy, aversion therapy, psychosurgery, and serum therapy – which involved creating blisters on the addicted person’s skin, withdrawing the fluid in the blisters with a hypodermic needle, then reinjecting the fluids into the patient’s arm (White, 1998, p. 234).

Narcotics Anonymous, modeled after AA, began to take shape between 1947 and 1953. AA refused to accept people addicted to narcotics into its ranks as it believed that this would muddle their stated purpose to help people struggling with alcoholism (AA Grapevine, 1965). Narcotics Anonymous, as it exists today, began on the West coast in 1953 (Stone, 1997, 21-22). The rise of NA coincided with the popularity of methadone maintenance programs, which became more prevalent in the 1960s as Dr. Marie Nyswander and Dr. Vincent Dole began a professional collaboration that pioneered
narcotics maintenance through methadone treatments. These doctors, among others, pushed the disease model of addiction and argued that the best treatment involved biological rather than psychological approaches to treating the addiction (Dole, 1988). Methadone clinics began to spread rapidly through the 1970s.

The 1980s saw an interesting backlash against addiction treatment and the very idea of addiction as a scientifically based diagnostic category. In the climate of the Reagan-era “War on Drugs”, books like Herbert Fingarette’s *Heavy Drinking: The Myth of Alcoholism as a Disease* (1989) and Stanton Peele’s *The Diseasing of America* (1989) argued against the science behind addiction treatment. The debate rose to the public level and the media began reporting on ethical abuses in treatment centers (Lewis, 1982). The rise of managed care systems and health management organizations made access to treatment increasingly difficult during the late 1980s and early 1990s (Miller & Hester, 1986). Programs gradually developed outpatient services and tried to take advantage of federal money coming from the War on Drugs campaign, but as the criteria for “successful” treatments shifted, many programs were dismantled. Through the 1990s and 2000s, the treatment of addiction increasingly became a profit-making enterprise, with several large corporations swallowing up smaller, community-based facilities (White, 1998, p. 286).

Concurrent with changes in addiction treatment, a change in the preferred substances of abuse also began in the late 1990s. National surveys suggest that approximately 15 million Americans, 12 and older, used a psycho-therapeutic drug for a condition other than medical use (Substance Abuse and Mental Health Administration, 2004). These drugs include opioid analgesics, sedatives/tranquilizers, and stimulants.
Another recent survey suggested that prescription drug misuse was second, after marijuana, in terms of prevalence of use amongst twelfth graders (Johnston et al., 2005). Most surveys also conclude that prescription medication abuse has increased exponentially in the past decade or so. The incidence of analgesic abuse increased from 628,000 initiates in 1990 to 2.4 million initiates in 2001 (Substance Abuse and Mental Health Administration, 2004). When dealing with prescription medications, the dangers of addiction and abuse are somewhat different, especially for those not seeking to actively abuse the substance. As Compton & Volkow (2006) write,

The increases in marketing of medications through media (especially television) … [and] the fact that these drugs are considered ‘medication’ and are endorsed by physicians may give a false sense of safety. It should also be noted that a key difference of the prescription drugs from other drugs of abuse is the explicit or implicit medical context of administration. (p. 6)

In addition, the Internet has allowed unparalleled access to prescription medications, without the necessary evaluation and supervision of a physician, despite the legal grey area in which online pharmacies exist (Forman, 2003).

Although the effects of prescription medications are strikingly similar to those of illegal drugs, users, doctors, legal agencies, and society in general perceive the former in radically different ways. The different social construction of prescription medications influences their use and abuse too. Joshua Lyon (2009), a journalist who writes about his own addicted experiences in his book Pill Head, well-captures this phenomenon:

Regardless of how or where someone gets their first taste of prescription painkillers (through a friend, a surgical procedure, a parent’s medicine cabinet, or, say, a journalism assignment), the one common factor that can be contributed to continued, abusive intake is that there’s a presumed element of safety to prescription painkillers that doesn’t exist with any other kind of drug out there, except maybe benzodiazepines like Valium or Xanax. Even for the bravest thirteen-year-old, smoking your first joint is going to be a little bit terrifying, but that’s part of the initiation, part of the
excitement. … But with pills, you know that somewhere down the line, it came from a doctor. A safe, kindly doctor who knew just what you needed and would never distribute something that could potentially hurt you. (p. 6).

The following section will elaborate on the history of prescription medications in the United States by examining the particular case of the rise of prescription tranquilizers and the problems associated with their overuse. This specific case is important for the present study because it traces the genealogy of the phenomenon of addiction in relation to prescription drugs. In order to understand how addiction emerges in the early 21st century, the history of the pharmaceutical industry and the ways in which it changes through the 20th century, will be examined. Given that a methodological and theoretical assumption of the present study is that individual experiences of addiction are shaped by this phenomenon’s cultural configurations, a genealogy of pharmaceuticals in the United States will be useful to understand the participants’ experiences of their own addiction.

**The Case of Minor Tranquilizers in the United States**

In 2011 Americans paid more than $340 billion for prescription pills (IMS Market Prognosis, 2012). Individually, Americans consume more prescription drugs than citizens of any other country in the world (Tone & Watkins, 2007, p. 4). In order to better understand the relationships between economics, politics, and medicine in the evolution of the pharmaceutical industry in the twentieth century, a case study of one particular class of drugs will be explored hereafter.

Despite its impressive market success in the late 1950s, the initial development of meprobamate, a minor tranquilizer, was highly uncertain. Created by Dr. Frank Berger for Carter Products, small-scale studies for meprobamate suggested its effectiveness in minimizing the experience of anxiety and tension. Nonetheless, the president of the
company, rather than rushing the new drug to market, refused to fund any large scale clinical trials. In the 1940s and 1950s, the future of the pharmaceutical industry was uncertain. In particular, at the time there was no established market for tranquilizers. The Durham-Humphrey Amendment\(^1\) had just been passed and meprobamate fell under the category of prescription-only drugs. Lastly, psychoanalysis was the preferred treatment for anxiety amongst psychiatrists and Carter executives were uncertain that physicians would be willing to prescribe medication for its relief rather than analysis. In short, “Carter Products was not sure that a tranquilizer for outpatient anxiety was even worth bringing to the market” (Tones, 2004, p. 159).

Despite the hesitation of Carter executives to fully finance the large-scale clinical trials necessary to receive FDA approval and bring the drug to market, Berger persevered. He developed a film showing Rhesus monkeys in their naturally agitated state, then unconscious on barbiturates, and lastly calm and awake on meprobamate. Berger showed the film in 1955, at the meeting of the Federation of American Societies for Experimental Biology. This attracted the attention of a rival pharmaceutical firm, Wyeth, who offered to help offset the cost of the clinical trials in exchange for licensing rights to meprobamate. Carter agreed and, in 1955, released a first version of meprobamate under the trade name “Miltown”.

Fourteen months following the release of Miltown (and Wyeth's version, Equanil), meprobamate was the country's largest selling pharmaceutical (Tone, 2004).

\(^1\) The link between physicians and drug companies was solidified in 1951 when the U.S. Congress passed the Durham-Humphrey Amendments to the 1938 Food, Drug, and Cosmetic Act. This law instituted the federal-prescription-only classification which mandated that consumers of pharmaceuticals must consult with and receive a prescription from a physician in order to purchase pharmaceuticals. Previous to this amendment, only narcotic sales were restricted – now a physician had to be consulted in order to purchase any pharmaceutical product. The doctors now became the gatekeepers.
Originally hailed as a miracle drug that “was flaunted as a safe and easy way to handle unproductive stress and anxiety” (Tone, 2004, p. 157), by 1957 thirty-six million prescriptions had been filled. In 1957 meprobamate was the fastest growing drug in American history. The cultural climate of the late 1950s in the United States proved to be very fertile for meprobamate:

The decade as a whole was characterized by widespread faith in the possibilities of a pharmaceutical science. Companies had recently made available a host of new prescription drugs, including antibiotics and synthetic hormones. Children who survived what a few years earlier might have been a deadly bout with bacterial pneumonia, adults with rheumatoid arthritis who were liberated from wheelchairs because of cortisone: these well-published triumphs provided tangible evidence of the wonders wrought by pharmaceutical medicine. No illness seemed beyond science's reach (Tone, 2004, p. 161).

Suddenly medicine and pharmaceutical science were flushed with the optimism that was characteristic of the era. As mentioned at the beginning of this chapter, the promise of science was better living through technology – the promise of the pharmaceutical companies was better living through chemistry. The shadow side of this promise had yet to fully reveal itself.

Selling Tranquilizers to the Physicians.

Tone (2004) also points out that at the time there was no reason to doubt the efficacy and safety of psychotropic drugs. Period publications insisted that meprobamate was neither habit forming nor dangerous in high doses. Prominent physicians endorsed the drug as safe and effective. Antipsychotic drugs were being studied and hailed as nearly miraculous cures. In addition, two large-scale clinical trials were published in 1955 by Dr. Edward Schlesinger and Dr. Lowell S. Selling in the widely read Journal of the American Medical Association. The studies reported that “78 to 80 percent of patients
suffering from tension or anxiety states improved or recovered after using meprobamate” (Selling, 1955). Other studies as well contributed to the positive public and professional opinion toward the new psychotropics (Borrus, 1955; Moskowitz, 1960). To appeal to psychiatrists, still enamored with psychoanalysis, drug manufactures released educational promotions on the possible use of meprobamate to support traditional psychoanalytic therapy. While the drug companies worked to gain acceptance from psychiatry, the public demand for prescriptions for meprobamate increased. At the time, many patients were taking barbiturates for anxiety disorders, and meprobamate was positioned as a safer and non-addictive alternative (Tone, 2004, p. 164). Increasingly, as the cultural climate shifted, a greater acceptance of psychotropic pharmaceuticals spread through the country, contributing to more and more potential patients and consumers of meprobamate.

Another interesting phenomenon emerged during this period: non-psychiatrists prescribing psychotropic medications. Americans who had either read or heard about the success of tranquilizers sought out medical professionals who were not trained in psychiatry, such as general practitioners. By 1975, only 25 percent of prescriptions for minor tranquilizers were actually written by psychiatrists (Tone, 2004, p. 164).

Demand was such that the supply of the meprobamate became an issue. Carter was producing tablets as quickly as it could. A black market developed in larger cities: for instance, in New York in 1956, the street value of a dose of meprobamate was nearly four times the prescription cost.

Changing the Perception of Prescription Drugs.

The introduction of tranquilizers revolutionized the way in which Americans looked at prescription medications, as “it encouraged Americans to decided that it was
'okay' to see doctors for drugs not to cure a disease but to make them feel better about living in the world” (Tone (2004, p. 166). This cultural revolution about the construction of “lifestyle drugs” represented a goldmine for pharmaceutical companies. The successful story of meprobamate suggested them that, “if people would line up to buy drugs for anxiety, they might buy pills for other problems too: depression, difficulties concentrating, a weak libido. Prozac. Ritalin. Viagra.” (Tone (2004, p. 166). It is also interesting to notice the ironic effects on culture the introduction of tranquilizers into American society had: Tranquilizers seemed able to “smooth over cultural fissures that, left unattended, had the potential to become something more serious” (p. 166).

Minor tranquilizers were both medically innovative and culturally conservative. They were medically innovative in that medicine had not yet been positioned to be able to offer chemical solutions to ostensibly psychological problems. They were culturally conservative in that by offering a chemical solution for psychological problems, patients did not question the ways in which their internal struggles may be intertwined with cultural issues. They helped to obfuscate the idea that individual psychological problems might be rooted in the sociopolitical or cultural realm, rather than being located within the individual and solved through medicating the individual.

The massive success of meprobamate laid the foundation for the success of the next class of anti-anxiety medications called benzodiazepines, of which Librium and Valium are two examples. Synthesized in 1955, Librium was less sedating and yet more powerful by weight than meprobamate. It entered the market place with a nearly two million dollar advertising campaign behind it. Librium was also marketed as being suitable for patients with more severe anxiety. Whereas meprobamate was prescribed for
cases of mild anxiety, anything more severe was treated at the time with antipsychotics. Librium provided an alternative medication, one that was suitable for both mild and moderate cases. Within three months of Librium’s approval by the FDA, it had become the most prescribed tranquilizer in the nation.

Questions about Safety Arise.

However, it was not long before Librium was challenged as a safe alternative to meprobamate. Leo Hollister, an employee of the Veteran's Administration, worried about the potential for abuse and dependence of Librium and created a study to test out his concerns. He administered massive doses of Librium to thirty-six individuals hospitalized with psychotic disorders. Of those thirty-six, Hollister placed eleven into the withdrawal group and discontinued their medication. He found that all reacted with withdrawal symptoms, including insomnia, agitation, lack of appetite, and nausea – two patients experienced seizures. Hollister concluded that Librium was physically addictive (Hollister, Elkins, Hiler, and St. Pierre, 1957).

When he published his findings, the psychiatric community was the only one that took it seriously or consider its implications, whereas the rest of the medical community largely ignored it (Tone, 2004). In line with the above observation about the link between tranquilizer prescription and social conservationism, Tone suggests that many physicians believed that the risk of dependency and abuse was outweighed by the potential for reducing social conflict. The mainstream media also ignored the possibilities related to tranquilizers’ addictive potential. The culture at large generally had the same excitement about the potential of pharmaceuticals as they did earlier in the decade.
Hoffman-La Roche – the pharmaceutical company that produced Librium – released Valium (diazepam) in 1963, which was approximately ten times more potent than Librium. Hundreds of millions were poured into its marketing campaign. This represented a substantial shift in the pharmaceutical industry toward massive expenditures on marketing and advertising. Even “more revealing was how the sales income was used. Only 2 percent financed manufacture and distribution. The rest – fully 98 percent – went to profit and promotion” (Tone, 2004, p. 169). Part of the new marketing approach advertised Valium as incredibly versatile, meaning it might be prescribed for nearly anything. In 1978 alone, 2.3 billion tablets were sold.

Culture Shifts, Perception Shifts.

The rise of the counterculture movement by young people in the late 1960s and early 1970s questioned the traditional values of the older generations and was largely skeptical of authority. Drugs such as LSD had been researched as potentially fruitful therapeutic drugs prior to its popularity amongst the counterculture - thanks, in part, to Timothy Leary, the ex-Harvard professor of psychology who promoted the use of psychedelics as consciousness expanding substances (Greenfield, 2006) – and were branded as agents of the counter-culture.

The counterculture's overt use of drugs helped reveal their widespread but secret use in mainstream America. Although the counterculture used mostly illegal substances while the mainstream culture preferred legal drugs, the open use of drugs was part of the overall theme of inverting traditional values. For instance, a 1971 report in the *Ladies Home Journal* (Tone, 2004, p. 172), titled “Women and Drugs: A Startling Journal Study,” suggested that the typical drug-using woman was not on the fringes of society but
was rather the “average” stay-at-home mother. The popular image of the drug user as rock star, prostitute, or hippie was inverted – it was the average homemaker who was using. Whereas the counterculture’s embrace of drugs revolved around recreation (and ostensibly ideological commitments), mainstream culture was using prescription drugs as lifestyle solutions: “women as a group consumed twice as many minor tranquilizers as men, but studies showed it was non-wage-earning women aged 35 and over who consumed the most” (p. 172). Addiction was revealed to be a problem not just of young people or the lower class, but had infiltrated the middle class on the backs of medical endorsement and powerful marketing campaigns. While the line between normal and abnormal had been somewhat blurred during the late 1950s and early 1960s, allowing ostensibly “normal” people to maintain their normality while consuming psychotropic medications, suddenly the counterculture's embrace of the abnormal shook up American culture.

Feminist insights into the demographics of tranquilizer users questioned why female homemakers were by far consuming most of the drugs. They questioned the circumstances under which stay-at-home mothers would be more likely to use and abuse drugs that supposedly induced tranquil states of mind. Data showed that wage-earning women were significantly less likely to take tranquilizers (Tone, 2004, p. 172) and theorists hypothesized that employment had positive effects on a woman's mental health and well-being. Unfortunately, speculation and critical examination of this phenomenon was largely left to academics and feminists in particular. The mainstream culture focused not on cultural antecedents to explain why women were so much more likely to use tranquilizers and instead focused on the role of doctors and drug companies as drug
“pushers”. Lawsuits began to be filed against both physicians and drug makers, with plaintiffs suggesting that they knowingly addicted patients in order to create passive but loyal customers. The cultural backlash from the mainstream flipped the idea that “lifestyle problems” could be solved pharmacologically and criticized the industry for helping to construct widespread acceptance that drugs could be used to solve common everyday problems of living.

However justified it may have been to blame physicians and pharmaceutical companies for pushing tranquilizers, Tone proposes that this unfortunately covered over the other factors involved in the explosion of the industry in the 1950s and 1960s. She (2004) writes:

Companies had medicalized something that could not be fixed with a pill. These explanations resonated with Americans because, in part, they were true. Doctors had prescribed tranquilizers carelessly; companies had promoted them excessively. At the same time, media reports erased the nuances of a complicated history of drug development and use. They did not, for instance, […] mention that evidence of the drug's dependence liability had been well documented since 1961. Nor did they try to sort out the difficult question of what made Americans anxious in the first place (pp. 173-174).

The cultural problems underlying the possibility of addiction were overlooked. Though feminists were pointing out that wage-earning women were not using tranquilizers in the same degree as homemaking women were, the media did not seem to take this up and make a question out of it.

The Problem Continues.

The public blame placed on the shoulders of physicians and pharmaceutical companies led to policy changes. In 1970, the Controlled Substances Act placed Valium and Librium under the category of Schedule IV drugs (the second to lowest of five
categories suggesting that the drug has both medicinal use and addictive potential). In 1975, the Justice Department established guidelines in an effort to mitigate against medical over-prescription of tranquilizers. It also placed limits on the number of refills a patient could get and set a six-month expiration date on refills for all tranquilizer prescriptions. In 1980, the FDA required that prescription bottles and boxes of tranquilizers had a label stating that, “Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anti-anxiety drug.” The justice system began prosecuting and punishing Americans caught with illegal prescription drugs.

Despite this shift in the public’s perception of the pharmaceutical industry, our cultural obsession with medication continued through the next decades. Tone (2004, p. 175) writes:

Taking drugs to relieve anxiety proved a hard habit to break. Although sales of Valium and Librium began to decline in the 1970s, sales of new-and-improved tranquilizers, such as the short-acting Xanax, introduced in 1981 for the newly created diagnosis of 'panic disorder' soared. At the same time, pharmaceutical firms capitalized on the commercial vacuum created by the benzodiazepine backlash to launch Prozac and other SSRI antidepressants. By the late 1990s, these drugs were being repositioned as anti-anxiety agents too.

The advent of postmodernity in the twentieth century coincided with economic and political shifts that shaped the way the phenomenon of addiction appears in the early twenty-first century. The following chapter examines the social and cultural aspects of American culture that set the stage for addiction to appear as it does nowadays. The chapter, in part, serves to create a framework to understand how culture is implicated in our understanding of the phenomenon of addiction. This framework will also help to examine some of the main cultural aspects of the participants’ experiences of addiction.
Chapter 2: Review of the Literature on Addiction and of Social Constructionist Theories of Addiction

Culture and Addiction: Postmodernity, Nihilism, and Addiction

One of the difficulties for any project on addiction is defining this term. As revealed in the brief history of addiction in the U.S., this phenomenon is at least partially socially constructed. A social constructionist perspective assumes that human beings do not have a fundamental, unchanging nature. Rather, the (or a) “human nature” is integrated in and related to specific cultural matrixes that involve “language, symbols, moral understandings, rituals, rules, institutional arrangements of power and privilege, origin myths and explanatory stories, ritual songs, and costumes” (Cushman, 1995, p. 17). Individuals and their experiences are always part of one or more cultures and contexts which need to be understood in order to interpret and understand experiences. From this perspective, all phenomena, addiction included, need to be understood in their cultural context.

As noted above, “addiction” literally means to adore or surrender oneself to a master. This term is contemporarily applied to a wide range of consumables and human activities: from sex to chocolate to Internet-based forms of addiction, the term has shifted in meaning in the last few decades. Still, it seems that in many ways it has returned closer to the Latin root meaning of the word. For instance, the Diagnostic and Statistical Manual of Mental Disorders 5 (2013) does not use the term addiction, but replaces it with two categories: substance abuse and substance dependence. Perhaps this points toward some of the difficulties in operationally defining addiction and also reflects on the meaningful difference between abusing a substance and becoming dependent on it.
By the end of the nineteenth century, most of the medical literature as well as the public opinion on the addiction began to regard inebriation, alcoholism and, by extension, drug addiction as primarily medical conditions (May, 2001, p. 385). Previously, alcoholism and addiction were considered to be problems of the will, or more generally, moral problems in the individual. The inability to resist the temptation of intoxication was considered to be a moral failing in the individual person rather than a medical or biological condition in which the individual had little or no control over his or her cravings and subsequent use of substances to alleviate them. May (2001) suggests that this shift in the medical community’s understanding of the phenomenon of addiction corresponds with a general movement of medical expertise and opinion into all areas of social life which were previously understood as moral domains. The medicalization of addiction links the phenomenon to some hypothesized pathological mechanism, which controls or influences “personal agency (and thus the possibility of individual control)” (May, 2001, p. 385). Yet, as May (2001) writes, the attempt to reduce addiction to a medical disease is seriously hindered by “the absence of a casual mechanism that can be understood in terms of objective pathology (susceptibility), rather than through subjective and experiential factors (culpability)” (p. 385).

In line with this medical view, addictions is often defined by both professionals and the lay public as an uncontrollable, incurable, inherited disease, whose treatment is likely to be never ending (Peele, 1986; Peele, 1989). What is interesting here, in addition to the social construction of addiction as an ongoing medical disease, is the relationship between the professional and the addict. If treatment of addiction holds the possibility of incurability and never ending treatment, there is obviously the possibility for a very
lucrative relationship between the treatment of addiction and this particular construction of the issue. Again, as discussed below, the entanglement of medical or mental health practices and institutions, money, pharmaceutical companies, social class, and the addicted person is particularly extensive in the field of addiction. For our purposes, even more interesting is the phenomenon of iatrogenic addiction that begins with medical treatment, is labeled as addiction by medical or mental health professionals, and then is treated by medical or mental health professionals.

Various researchers have suggested that cultural and social factors play a role in the formation and continuation of addiction and related behaviors. For instance, Steele and Josephs (1990) conclude that environmental interactions “have the most powerful influence on the development of alcoholism” (p. 929) and “effective treatment of alcoholism would entail treatment of one’s troubles as much as one’s drinking” (p. 931). These observations can likely be extended into the treatment and understanding of addiction to prescription medications. For example, Truan (1993) suggests a possible link between the failure of psychology and the addiction treatment industry to successfully treat addiction and the fact that addiction is often socially constructed as a problem of the underclass. Often, social and medical interventions target addiction in the poor, the persons of color, and the disenfranchised, while “ignoring fundamental social issues” (p. 494). By neglecting or ruling out sociohistorical causes of psychological and, to some degree, medical problems, sociopolitical solutions are discounted and the only solutions generally presented and accepted focuses on individual treatment and intrapsychic healing techniques (Cushman, 1991). In contrast to the more biological view of addiction as disease, which typically ignores or obscures sociohistorical, political and cultural
aspects of addiction, a minority view lays at the other end of the spectrum between the biological and the social. This perspective “seems to be moving towards regarding addiction as a discursive device, through which individuals are able to explain their loss of volition and independence, but which has no pathological existence that is independent of these explanations (May, 2001, p. 394). The professionals who adhere to this perspective (Davies, 1992, 1997; Eiser et al., 1985) see addiction as “an expression of attributes that legitimize particular kinds of behavior… the effect [of which] is to reinstate personal volition and agency: addicts are not helpless in the face of particular behavioral possibilities, but are able to modify and control their behavior according to circumstances” (May, 2001, p. 394). The following section will continue to explore the tension between these conflicting ways of understanding addiction through the work of Dunnington, a theologian who explores addiction from a philosophical perspective.

**Dunnington’s Work**

In his 2011 book, *Addiction and Virtue*, Kent Dunnington, professor of philosophy at Greenville College, in Greenville, Illinois, argues against what he sees as a false dichotomy between the medical and moral models of addiction. Dunnington (2011) makes the argument that the rise and ubiquity of addiction in contemporary culture is a direct result of cultural changes in the nineteenth and twentieth centuries, which took place particularly in the United States. Addiction, as we understand it, can be contrasted with intemperance in that the former is concerned with intellectual and moral goods, whereas the second is concerned with sensory pleasure. Dunnington builds on this differentiation and suggests that “addiction is ubiquitous in contemporary life, both as a type of behavior and as a way of conceptualizing behavior, because addiction makes
accessible certain kinds of moral and intellectual goods, which the developments of modernity have made otherwise difficult to attain” (p. 101). I will elaborate on this argument later on, but, for the moment, I think it is important to understand Dunnington’s claim that contemporary American culture offers myriad possibilities of being and living but, in contrast to previous sociohistorical eras, it does not offer any kind of guide to which kinds of being or which styles of living are preferable in terms of living toward a moral and social good.

From this perspective, the unprecedented kind of freedom in contemporary culture comes at the cost of agreed upon direction. The responsibility of choosing falls solidly on the individual. Addiction relieves this burden because it supplies partial answers to the question of what the good life is and how one attains it. In this sense, addiction can be seen as a functional response to the postmodern world. Dunnington argues that “modern moral thought is characterized by a lack of any analogous shared context for envisioning the good life for human persons” (p. 101) and, consequently, modern civilization lacks a “common consensus about the telos of human action” (p. 104). What is interesting and useful, in part, about Dunnington’s work is that he sees addiction as adaptive in a way that the biological and moral models do not. For instance, Dunnington suggests we might understand the high rates of addiction found on Native American reservations as functional responses to the loss of traditional ways of explaining and making sense of the world. The myriad possible ways of ordering the moral life that are offered by the mainstream culture are strongly different from traditional Native American belief systems.
Since there is no general consensus (other than the consensus on the lack of consensus) across modern American culture in regard to how one ought to live, individuals feel the burden of selecting the best mode of life while simultaneously experiencing distress in the face of countless options. In previous sociohistorical eras, culture doled out roles for individuals that were largely agreed upon by the community. For example, in Aristotle's Athens, (Dunnington, 2011):

Given a person's age, social class, educational background and such, there was widespread and collective agreement on the social role that a person should be pursuing or fulfilling... The citizens could recognize failure or success both at the level of political arrangement and at the level of individual endeavor because they shared a substantive conception of what sorts of practices and relationships were necessarily constitutive of a life of flourishing (p. 104).

Dreyfus and Rubin (1994) largely agree with Dunnington's propositions about the effects of modern culture on the individual. Their work focuses on the Twelve Step model of addiction and recovery which assumes and asserts that an addict is powerless in relation to her substance of choice. As mentioned in the previous chapter, while Alcoholics Anonymous is the original Twelve Step program, Narcotics Anonymous applies the same method of recovery and takes up the same philosophical approach toward helping people achieve sobriety. In trying to understand the surge in popularity of the Twelve Step model, Dreyfus and Rubin suggest that it cannot be explained by the increase in both awareness and incidence of physical addictions. Rather, they argue, modern nihilism can help explain this phenomenon through the work of Soren Kierkegaard, the 19th century Danish philosopher. Kierkegaard's articulation of nihilism in the modern age opens up the possibility that addiction seems to be a valid way of being in response to a nihilistic culture that does not offer guidance as to which paths in life
lead toward the good: “For Kierkegaard, the difference between a nihilistic culture and a non-nihilistic culture is that in a nihilistic culture there are no distinctions between what is important and what is unimportant but in a non-nihilistic culture there are” (Dreyfus & Rubin, 1994, p. 6). For an individual living in a nihilistic culture defined in this way, her life becomes meaningless if nothing makes any difference to her.

Dreyfus and Rubin propose the idea that addiction is a response to the meaninglessness inherent in a nihilistic culture, as substance abuse “may well be an attempt to obtain the meaning once, but no longer, provided by the authentic commitments made possible by a traditional culture” (p. 7). They also point out, however, that identifying as an addict actually furthers nihilism rather than combating it. They (Dreyfus & Rubin, 1994) ask what role addiction may have in constituting a self:

One way of understanding the nature of addictions is to see that they are world-defining activities. As such, they give addicts a distinction between what is important and what is unimportant in their lives. For a drug addict, the important activities in life are the ones that revolve around addiction. (p. 7)

They further suggest that Twelve Step programs strongly resemble the kind of commitment that addict have toward their drug use. In place of the good of drug use, Twelve Step programs offer abstinence as the defining commitment around which the recovering addict structures her life and her world. “Abstinence replaces both the addictive behavior and the activities and people which support it with behavior designed to promote recovery and people who support recover rather than addiction” (p. 7). Both addiction and recovery, then, become world-defining commitments for the Twelve Step member who struggles with substance abuse.
One of the ways in which identifying as an addict is different than identifying as, say, a teacher, a psychologist, or a lawyer, is that entailed in “the very nature of addiction is that […] the individual does not choose” it (p. 8). Dreyfus and Rubin state that while a nihilistic society ostensibly offers an unparalleled freedom to make choices about one’s life, it simultaneously makes it difficult, if not nearly impossible, to actually make and live these choices. They provocatively ask: “If, as in Kierkegaard's description of the modern family and the modern educational system, modern individuals stand at a critical distance from and take an open-minded stance toward all possible commitments, how could any commitment ever come to have a claim on us?” (p. 8). In this sense, identification as an addict gets around this problem because it implies “to accept an identity that is not a product of one's choice” (p. 9). So, the addict identifies with the idea that, by their nature, she or he could not be anything else. Although one did not choose to become an addict, her or his choice was not arbitrary but an “incontrovertible given” (p. 9). From this viewpoint, while other identities seem to be fleeting in modern life, the identity of the addict is permanent, and therefore avoids the problem of sustaining a meaningful identity in the face of a nihilistic culture that posits that the choice of identity is so arbitrary that it becomes meaningless. From this perspective, one does not “choose” to become an addict – one either is or is not an addict: “an addiction gives a person a kind of stability that is hard to come by in modern life” (p. 9).

The authors do point out, however, that while identifying as an addict has some appeal for the reasons listed above, it is obvious that addiction is not the best way to have “meaning, identity, and stability in one's life” (p. 9). Addiction comes at a high cost: it robs one of her freedom. Addiction is not understood to be a choice but as a compulsion.
In other words, there is no room for agency or responsibility in a commitment to addiction: “To accept the addiction model is to accept the idea that an individual has no freedom...in relation to that which defines her most decisively” (p. 12). When a person enters a Twelve Step program, she or he makes a different kind of commitment, which aims at sobriety and replaces addiction as the absolute commitment in one's life. Yet, while this is an improvement over a life structured by addiction, the Twelve Steps present their own problems. Namely, “making the commitment to recovery unconditionally makes every other commitment conditional” (p. 15). Since the commitment to sobriety supersedes all other conditional commitments (e.g., family, job, recreation, etc.), it actually contracts one's ability to choose, and helps to foster nihilism.

In summary, Dunnington, Dreyfus and Rubin argue that addiction to a substance is an active, functional response to the culture of the 20th century. This perspective differs greatly from medical understandings of addiction in many ways. For one, it allows for an understanding of how sociocultural factors influence the way in which addiction appears in modern society. The medical model takes addiction out of its embedded context. In addition, the medical model sees addiction as a pathology, rather than as an adaptive response to particular social and cultural configuration. In doing so, being pathologized robs the addicted individual of her agency and uniqueness.

**Cushman’s Work**

Philip Cushman has also studied the effects of culture on individual and communal life. Cushman (1990) defines the self as “the concept of the individual as articulated by the indigenous psychology of a particular cultural group, the shared understandings within a culture of 'what it is to be human’” (p. 599). The self of the
modern era is individualistically subjective and “deeper”, in the sense that the modern individual tends to experience a depth or an interiority of the self. This is a communally isolated kind of self; one which is masterful and bounded, but isolated. In addition to the loss of community, the self that manifested in the late twentieth century in the United States is “empty” as a consequence of the new economy, among various other cultural changes that took place during the twentieth century. This “empty” self internally experiences the absence of community, tradition, and communal meaning as a lack of conviction and worth, which leads to a kind of “undifferentiated emotional hunger” (p. 600). Cushman (1990) describes the ways in which the late 20th century American self sought to ease the experience of emptiness:

Inner emptiness may be expressed in many ways, such as low self-esteem (the absence of a sense of personal worth), values confusion (the absence of a sense of personal conviction), eating disorders (the compulsion to fill the emptiness with food, or to embody the emptiness by refusing food), drug abuse (the compulsion to fill the emptiness with chemically induced emotional experiences), and chronic consumerism (the compulsion to fill the emptiness with consumer items and the experience of 'receiving' something from the work). It may also take the form of an absence of personal meaning. This can manifest as a hunger for spiritual guidance, which sometimes takes the form of a wish to be filled up by the spirit of God, by religious 'truth', or the power and personality of a leader or guru [italics added]. (p. 604)

Here Cushman points towards the ways in which the empty self attempts to fill the experience of emptiness. He understands drug abuse as a method by which the empty self chemically induces feelings to ward off the pain of emptiness.

Cushman, in a later piece, argues that the self we see emerging at the beginning of the twenty-first century is less empty and more marked by multiplicity, “by a propensity to gather about itself a number of identities that are located around the outside of the self,
external to but identified with the individual, although this identification takes on a
different, less essential or intense or perhaps personalized, valence than identifications
within a deep self” (Cushman, 1999, p. 16). In contrast to the empty self, the multiple self
possesses a shallow sense of interiority, a need for many different exteriors to present to
the world according to the occasion, a self that is both multiple and decentered, and a self
whose understanding of the good life revolves around consumption as a means to feed
itself (p. 17-18).

Cushman (1999) also describes some of the conflicts that the multiple self
experiences in contemporary culture:

[The multiple selves] are confronted by complex and confusing moral
dilemmas; cut off from the guidance and comfort of historical traditions,
community experience, and family support; and deprived of meaningful
work and an opportunity to be meaningfully involved in a public
commons. It is little wonder that the current way of being is becoming
marked by confusion, hopelessness, and thus the flight from a stationary,
unitary self toward an elusive, multiple self. (p. 67)

Cushman’s quote here reflects some of Dunnington’s arguments about how contemporary
culture has left individuals with the burden of having to create their own meaning and
direction in their lives. Cushman also sees the breakdown of community as implicated in
the problems faced by the modern person.

Dunnington (2011) suggests that because modern culture offers the individual
myriad possibilities of being “a self,” or it offers multiple exteriors with which to adorn
the self, an individual is placed into a situation in which she has little to no guidance as to
which possibilities are morally superior or lead to the good. In this kind of situation,
addiction appears as a viable option. The intersection of the opposing values of modern
culture – on the one hand the “deep ambiguity about the possibility of justified
commitment” and on the other “the ideologies of opportunity, self-realization and self-control” (p. 111) – is the place from which modern addiction emerges. Dunnington (2011) writes: “The collision of an ethos of self-realization with an account of human action that divorces freedom from teleology is the wreck called modern addiction” (p. 111). He begins to open up the problem of modern freedom in relation to addiction, which is further addressed below.

**Disease versus Will**

Many scholars and professionals (Truan, 1993; Cushman, 1990; Gergen, 1991; May, 1991; Graham et al, 2008) have suggested that the medical/scientific understanding of addiction as a disease is flawed in various ways. In this study, I am mostly interested in critiques that challenge medical views of addiction as an objective disease while neglecting the socially constructed nature of addiction as well as the cultural and social forces that contribute to addictive behaviors. While there continues to be a debate about the disease model of addiction and its implications for treatment, the current study is interested in the addicted person’s experience of addiction, their understanding of identity changes in the process of becoming addicted, and how the social construction of addiction influences an individual’s experience of addiction. I will further explore this topic in the section devoted to research on addiction, as most of the literature is focused on recovery rather than on the process of becoming addicted.

As the disease model of addiction is the most prevalent and ubiquitous framework in both professional and lay circles, it can be assumed that this cultural understanding of addiction will influence the self-understanding of addicted persons. Cushman (1990) writes:
Culture “completes” humans by explaining and interpreting the world, helping them to focus their attention on or ignore certain aspects of their environment, and instructing and forbidding them to think and act in certain ways (Heidegger, 1962/1977). Culture is not indigenous clothing that covers the universal human; it infuses individuals, fundamentally shaping and forming them and how they conceive of themselves and the world, how they see others, how they engage in structures of mutual obligation, and how they make choices in the everyday world [italics added]. (p. 601)

We can therefore assume that many addicted persons will have incorporated this sense of being diseased with addiction into their personal narratives about themselves. Saying that addiction is socially constructed does not mean to discount the painful and tragic reality lived by many addicted persons, but it helps understand the experience of these individuals as culturally framed within specific dominant discourses and orders of interpretation (Foucault, 1966).

One of the central problems involved in any discussion of addiction is the tension between the understanding of addiction as a moral problem of intemperance and the disease model (Dunnington, 2011). In the former (see, for instance, Pop, 2010), we find that addiction is generally understood as a problem of the will of the addicted person. In the latter, we find that addiction is understood as distinct from will and, like any chronic disease (e.g., diabetes), it cannot be controlled or managed without intervention from a medical professional. Currently, the scarce research on the spontaneous remission of addiction to drugs seems to support a moral model.

The medical model rests on the idea that addiction is a disease of the brain and is always accompanied by neurological changes - namely, tolerance and withdrawal. Tolerance is defined as the biological process through which repeated doses of a drug over time have less effect. Addicted persons often find that they
must take increasing dosages to experience the same high they felt when first experimenting with the substance in question. Withdrawal is defined as the subjective experience of dysphoria and bodily discomfort resulting from cessation or the curbing of the use of the substance (Institute of Medicine, 1997, p. 13).

The kind of thinking that constitutes the medical model posits that all behaviors, thoughts, and emotions are controlled by chemical and electrical interactions in the brain. Further, this interpretation of addiction suggests that genes are essentially responsible for the ways in which these chemicals and electrical signals organize themselves in the brain. Therefore, if the gene for addiction could be discovered, then it would be a simple matter to understand how it affects the interaction of chemicals and electrical signals in the brain.

Dunnington (2011) suggests that “if the neurological phenomena of tolerance and withdraw are to ground the definition of addiction as a brain disease, two entailments must hold. First, it must be the case that the existence of an addiction entails the presence of tolerance and withdrawal. Second, it must be the case that the presence of tolerance and withdrawal entails the existence of an addiction” (p. 19). His first objection to this understanding of addiction as a disease of the brain is that many patients who are treated with painkillers during surgery do indeed develop tolerance and withdrawal symptoms from their use of the medication to treat the pain. Despite the experience of withdrawal symptoms, the vast majority of surgery patients are able to stop using painkilling medications when their prescription runs out. Culturally and medically, these people would not be labeled addicts despite their experience of both tolerance and withdrawal. For instance, many U.S. troops stationed in Vietnam during the Vietnam War reported
being addicted to heroin during their tours of duty. However, the vast majority stopped using heroin upon returning to the U.S. This suggests that while tolerance and withdrawal are significant features of addiction they are not its essence.

Stated differently, the medical model of addiction presents a dilemma: On the one hand, the “organic or psychogenic pathology is assumed to be the prime mover in addictive states” (May, 2001, p. 387). On the other, this pathology is only found in the accounts of the sufferer. In other words, it is in the addicted individual’s personal or social identification as an addict (e.g., through her admission that she feels powerless to stop using or through social constructions of her as an addict) that makes her an addict. Many of the structural brain changes that we can see through imagining technologies are largely the result of overuse of a substance – literally damage caused by repeated use of the substance. The dilemma of the medical model is its insistence that addiction is a brain disease that can only be diagnosed through the sufferer's admission or interpretation that she is addicted, with no physiologically based way to find objective evidence for the diagnosis of addiction. This dilemma is also reflected in addiction treatment: “Although addiction might arise out of inheritance, organic disease or psychological stress, it could only be 'cured' by attempts to motivate the patient” (May, 2001, p. 388).

Though the DSM-V (2013) does not use substance addiction as a diagnosis, substance dependence seems to be nearly synonymous. Heyman (2009) points out that, in DSM language, substance dependence is “the most extreme form of self-destructive drug use” (p. 28), whereas in everyday language
addiction is understood to be the most extreme. He also points out that the
diagnostic criteria for substance dependence reflect the cultural and medical
understanding of addiction – mainly, that both are marked by “tolerance,
withdrawal, relapse, and a shift in priorities in favor of the drug” (p. 28). Both
also refer to the compulsive nature of drug taking involved.

Proponents of the disease model of addiction assume that addicted
individuals have brains which have been structurally changed due to drug use and
that these structural changes lead inexorably to involuntary behaviors that allow
for the continuation of the addiction. What is key here is the idea that the
behaviors associated with neurological changes in both structure and function are
understood as involuntary and outside the range of a person's control. However,
there is evidence that musicians experience structural brain changes as they
become more experienced playing their instrument of choice - but we would
never assume that musicians ceased playing their instruments involuntarily (Gaser
and Schlaug, 2003). The medical model of addiction, nevertheless, does posit that
the addicted person’s drug taking and seeking behaviors are involuntary actions
that are best treated medically. The disease model of addiction “maintains, first,
that addiction is a chronic physiological disorder, and second, that it therefore can
be most adequately treated through medical treatment” (p. 24). The idea that
addiction is a physiological disorder leads naturally to the idea that once a person
is an addict, he or she is always an addict because the structural changes in the
brain cannot be undone.
Alcoholics Anonymous holds this position and, accordingly, maintains that admitting that one is an addict and will always be an addict is paramount to successfully quitting the addiction. Pop (2010) suggests that the popularity of Alcoholics Anonymous has drastically influenced public and professional assumptions about addiction. Pop ties the National Council on Alcoholism and Drug Dependence to Alcoholics Anonymous, stating that:

Since its inception, NCADD has, by and large, acted as the public face of Alcoholics Anonymous, though it claims to have no formal ties to AA. The NCADD has tirelessly promoted the disease concept of alcoholism and the belief that abstinence is the only legitimate treatment goal; it has also attempted to suppress studies on controlled drinking, and has virulently attacked those who publicly disagree with its positions on abstinence and the disease concept (p. 60).

According to Pop, the NCADD has been focused on promoting the disease model of addiction that was originally conceived of by AA. Thanks to NCADD’s influence, alternative ways of understanding addiction were actively suppressed, partially leading to a popular understanding of addiction as a disease as well as continuing to promote the disease model within professional circles. For instance, Pop suggests that public relations campaigns and diligent promotion of the AA concept of addiction influenced the American Medical Association's endorsement of the disease model in 1956. An official declaration by the AMA stated that addiction was to be understood as a medical disease and treated as such, rather than a disease of society or culture.

Heyman’s Critique

Heyman (2009) takes a very critical stance toward the ways in which research has constructed the modern understanding of addiction. He points that leading researchers
in the field of addiction insist that it should be understood as a chronic disease because the hopes for long term remission are dim. Charles P. O’Brien and A. Thomas McLellan, two highly regarded addiction researchers working at the University of Pennsylvania, suggest the idea of a cure is highly unlikely and that addictive disorders ought to be grouped with other chronic disease that require long-term lifetime treatment (O’Brien and McLellan, 1996). The traditional Alcoholics Anonymous community refers to remission from addiction as “recovering” rather than “recovered”, suggesting that abstaining from alcohol (or narcotics in the case of Narcotics Anonymous) is a constant battle that will never be fully won, the desire for the drug never fully conquered. McLellan, Lewis, O’Brien, and Kleber (2000), in a separate paper, contend that relapse, rather than sustained remission, is the expected outcome of addiction treatment. Heyman points toward the massive body of medical, psychological, and sociological research that supports the idea that many addicts will relapse after they receive treatment (p. 66).

Heyman, however, critically evaluates research in the field of addiction. He points out that, while most empirical research in this field involves participants who are currently receiving treatment for their addiction, most addicted persons who would meet the criteria for substance dependence do not seek treatment (p. 67). The Epidemiological Catchment Study, a national survey of psychiatric health and treatment, found that just 30 percent of individuals who met the criteria for substance dependence or abuse had sought treatment for their condition (Anthony & Helzer, 1991). Heyman argues that the sample from which conclusions are drawn about addiction as a disease is not representative of the larger addicted population – the disease model of addiction is based on research studying addicts in treatment. If the majority of addicts are not in treatment, asks
Heyman, is it logical or fair to generalize findings from the treated population on the majority? Heyman suggests that the “Berkson's bias” (Berkson, 1946), which refers to “the fact that patients who are in treatment for a particular disorder are more likely to suffer from additional disorders that are independent of the disease in question” (Heyman, 2009, p. 68), very likely has an effect on the relapse rates of addicts in treatment. The possible effect of the Berkson’s bias on addiction research is that the samples on which investigations are based are not representative of the population. Yet, the findings and conclusions are generalized to the population. In fact, addicted people who present for treatment are much more likely to have co-morbid psychiatric diagnoses that likely impact their substance use. As Heyman (2009) writes, “if addicts with additional disorders are the ones who end up in the clinic, and if these disorders increase the likelihood of relapse, addicts in clinics will be the least likely to stop using” (p. 68). As consequence, research on these addicts tends to suggest that relapse is inevitable, but this research may not be generalizable to the population of non-treatment seeking addicted individuals.

Heyman goes on to examine three major national studies that attempted to recruit representative samples of the addicted population. Despite the fact that not only were these studies large, statistically significant, conducted by recognized leaders in the field of addiction, and funded by various national health institutions, according to Heyman these studies have not found their way into the mainstream medical literature or have not become a staple of texts on addiction or addiction treatment (p. 69). The three studies he examines are (1) the Epidemiological Catchment Area Study (1980-1984), (2) The
National Comorbidity Survey (1990-1992), and (3) a replication of the National Comorbidity Study (2001-2002).

The Epidemiological Catchment Area study (ECA survey) showed that “by about age 37, approximately 75 percent of those who ever met the criteria for dependence [at age 18 to 27] were no longer reporting any symptoms” (Heyman, 2009, p. 70). It addition, it provided evidence on the fact that most of those who quit did it outside of a treatment program. The National Comorbidity Study (conducted in 1990-1992 and replicated in 2001-2002, NCS survey) sought to provide an unbiased account of the key characteristics of psychiatric disorder, substance dependence amongst them, and emphasized the relationships between different disorders. This is important in that it accounts for the effects of co-morbid psychiatric disorders on the rates of remission in addiction. The 1990-1992 NCS survey showed that 74 percent of lifetime addicts were in remission (the ECA study showed a 59 percent remission rate for lifetime addicts). The 2001-2002 replication showed a 63 percent remission rate.

Heyman suggests that, in face of these large studies, we cannot continue to ascribe unavoidable relapse as part of our concept of addiction. Yet, this position persists doggedly in both medical and lay communities. Heyman, preemptively responding to criticism, suggests that another way to look at addiction might be to see short periods of heavy use followed by long periods of abstinence as chronic use. A person in remission at the time of the survey may be in one of the abstinent periods but may very well have gone back to a period of heavy use and therefore still might be considered a chronic abuser. He organized the ECA and NCS data in such a way as to be able to examine the reliability of the findings. He hypothesized that if addiction was chronic but cyclical, if
we were to graph the data with age on the horizontal axis and the percentage of currently active cases of addiction as the vertical axis, we would expect to see that data points remain more or less level as a function of age. However, when this data is graphed, we see “the age trend is sharply decreasing, suggesting that when those who met the criteria for lifetime drug dependence quit, they usually quit for good” (p. 77). He also points out that the greatest decrease is seen between 20 and 30, suggesting that many addicts “grow out” of addictive behaviors.

If the discrepancy between mainstream medical research on addiction and the studies (amongst others) cited above lies in the population being studied (addicts in treatment vs. addicts in the general population), Heyman (2009) suggest two hypotheses:

First, it is reasonable to suppose that differences in pharmacological history distinguish the two groups. Second, it is just as plausible that individual differences distinguish the two groups. These are not mutually exclusive explanations and both promise to increase our understanding of the determinants of drug use in addicts. (p. 80)

In response to the first hypothesis, Heyman suggests that perhaps addicts seeking treatment are addicted to “more addictive drugs” - he points out that while a number of clinics treat heroin addiction, clinics that specifically treat marijuana addiction are very rare. However, data from the ECA survey shows fairly similar rates of remission when classified by type of drug used. He writes: “The implication is that the higher remission rates for clinic addicts is not a function of using drugs that are more addictive” (p. 80). He wonders if we might interpret this to mean that the factors associated with the origins of the addiction are separate and different from factors that might influence the persistence of addiction. Heyman rejects the hypothesis that these differences can be explained by type of drug abused.
In response to the second hypothesis, he asks if the clinic population of addicts might have started using at earlier ages or used more heavily once they became addicted. He refers to two studies conducted by Yale Medical School researchers (Rounsaville & Kleber, 1985; Carroll & Rounsaville, 1992), one concerned with opiates and the other with cocaine, which showed marked consistency across addicts in treatment and addicts in the community in terms of ages at which the addiction started and amounts of the drug used after becoming addicted. Interestingly, both studies found that addicts in treatment tended to use other drugs (beside their drug of choice, i.e. the drug that they sought treatment to stop using) far less than addicts in the community.

After rejecting the idea that pharmacological explanations are adequate to explain the relapse rate differences between addicts in treatment and addicts in the community, Heyman examines the high correlation between co-morbidity and addicts in treatment. Addicts in treatment, Heyman states, following evidence from the ECA study, are twice as likely to be suffering from additional psychiatric disorders as addicts in the community. Explanations for the difference go from suggesting that addiction is a self-medicating process to Heyman's (2009) own suggestion that individuals with co-morbid psychiatric diagnoses are possibly “less mature” (p. 81) than those without. By this he means that perhaps co-morbid addicts struggling with depression or anxiety are unable to actively participate in activities that might compete with drug use. However, he offers no empirical evidence to support this explanation.

So while Heyman reveals holes in the medical model’s conception of addiction as a chronic disease, Dunnington (2011) suggests that the tension that lies between the concept of addiction as a disease and the concept of addiction as a choice is a result of a
false dichotomy. Dunnington writes: “The false dichotomy arises from a failure or an inability to conceive of a genuine space between compulsion and choice, between, in philosophical terms, determinism and voluntarism.” (p. 31). And herein lies one of the central problems with the concept of addiction: the philosophical tension between determinism and agency.

**Agency and Will**

For Dunnington, the central paradox of the disease model of addiction lies in its suggestion that (a) one is powerless to resist the substance in question and (b) admission of one's powerlessness over the substance is the starting point from which one can gain the power to resist using the substance. “The paradox of alcoholism is that alcoholics acknowledge the futility of their own willpower to resist alcohol, yet in a nonmedicalized program of recovery they find access to a power sufficient to reinvigorate the once-impotent will” (Dunnington, 2011, p. 32). From this perspective, an addicted person is understood to be a person whose will is overpowered in such a way that they do not act voluntarily when they use a substance but are in fact compelled to use the substance. The source of the addict's inability to resist the temptation of the substance is understood to be outside of the will. In regard to the substance, the disease model suggests that the addicted person's will is powerless and her decision to use is not made freely. She cannot stop for the very reason that her will (at least in regard to using) is diseased.

Something else that is interesting about the disease model of addiction is the way in which it came to be endorsed by the medical community. Selden Bacon (1967), a distinguished alcoholism researcher at Yale University in the 1960s, wrote: “the ‘disease’ notion was an alien view to the [medical profession]. It was 'inserted' or 'foisted upon' or
'sold to' the medical profession chiefly by outsiders” (p. 10). Basing her arguments on Bacon’s reflections, Valverde suggests these outsiders consisted of the scientific temperance activists of the early twentieth century and later Alcoholics Anonymous, who sought not to put the treatment of addiction into the hands of the medical community, but rather sought a medical endorsement in order to “de-stigmatize the population they sought to reach and reform” (p. 44). Interestingly enough, the groups that pushed for policies reflective of addiction as a disease were also vehemently against medical leadership of their movements. Later I will show that medical investigation into addictive behaviors has not followed the larger narrative of medical progress – though more and more scientifically minded proponents of the disease model point toward their research as proof of the disease model, fundamental philosophical problems exist within it that are largely ignored by the medical and scientific communities.

The choice model of addiction responds to the paradox (i.e. that one must admit one’s powerlessness over a substance in order to gain the power to resist the substance) by first pointing toward individuals who were able to recover from their addictions without medical intervention, and by Heyman’s count this is the majority of people who could have, at one time, be classified as addicts. The idea is that the individual voluntarily chose to stop the addictive behavior, yet they were in the midst of their addiction when this voluntary choice was made. Therefore they must have voluntarily decided to use the substance and continue addictive behaviors prior to the decision to voluntarily cease the addictive behaviors. From this perspective, the problem lies not in one's impotent will in the face of the substance, but is rather a moral problem: the addicted individual chooses to become an addict and those who do not recover from addiction are simply those that
choose not to recover. Perhaps they do not have the moral fortitude to successfully stop using, but it is certainly within their power to stop if they chose to.

However, one of the main problems with the choice model of addiction, or the moral model, is that it must deny addiction if it is to allow recovery to be an option. If one can simply stop using an “addictive” substance at any point, then what is addiction? If addiction is not a powerlessness in relation to the substance, how can we separate an addicted person from a person who merely continues to make the decision to use in spite of the consequences? It reduces addiction to a weakness of the will and does not fully acknowledge the tremendous psychological and physiological effects that addictive substances can produce in their users. If addiction is completely reduced to a weakness of the will, then an “addiction” to cake, pornography, or exercise is understood as fundamentally the same weakness of will that is involved in addiction to drugs. Taken to the extreme, this model “characterizes attributions of 'addiction' as a perverse psychological form of rationalization and excuse” (Dunnington, 2011, p. 35) and implies that categorizing addiction as a disease really only excuses the continued addictive behaviors of addicted persons.

In the next pages, I will review some of the most relevant texts in the massive literature that has recorded and analyzed the subjective experiences of addicts (De Quincey, 1822; Preble & Casey, 1969; Capone, 1986; Banonis, 1989; Sterk, 1999; Zakrzewski & Hector, 2004; Pnina & Smith, 2009; Lyons, 2009). Overall, the consensus in this literature is that there are very significant differences between addiction to drugs or alcohol and an addiction to other substances or practices, such as cake or jogging. Accounts from addicted individuals have repeatedly demonstrated that the urge to use a
particular substance is qualitatively different than any other urge (instinctual or otherwise) they had experienced. This is perhaps why so many people struggling with addictive behaviors find solace in the disease model – it seems to fit their experience. Dunnington (2011) writes: “This is, functionally, why the disease model of addiction has been helpful to many persons with addictions. It resonates with the addicted person’s experience as something phenomenologically other than everyday struggles of the will, thus removing the moral stigma that accompanies the choice concept of addiction, according to which addiction is simply willful misconduct” (p. 35). Addicted people find solace in the medical model in that it provides them with an account of addiction that is congruent with their own struggles with their substance of choice.

Overview of Qualitative Research on Addiction

One of the first modern qualitative research projects on addiction can be found in De Quincey’s (1822) *Confessions of an English Opium Eater.* Using an autoethnographic method (Feldman and Aldrich, 1990), De Quincy described his relationship with opium over the course of years, as well as commenting on and observing the use of opium amongst the urban poor in London. This study was the first of its kind and revealed how opium, typically understood as medicinal at this time, could be severely abused. It was also groundbreaking in its sympathetic portrayal of the use of opium among the underclass as a way to escape the struggles of their daily lives.

In America, one of the first qualitative projects focused on addiction came from the University of Chicago’s sociology program. Dai (1937) used an ethnographic approach to study drug use and criminality in 1930s Chicago. Performed in the 40s and 50s, this qualitative research on drug addiction made significant contributions both to
methodology for studying ‘hidden’ populations and to theorizing on ‘deviance’ and ‘normality’ (Rhodes & Moore, 2001). One of the more interesting aspects of this period in qualitative drug research was the effort to conceptualize the addicted person as differing from popular conceptions, which tended to see the drug user as deviant and passive in his or her addiction. This research also tended to counter prevailing popular beliefs about drug addiction by portraying the addicted person’s lifestyle as purposeful and active (p. 281). We also see a shift toward understanding drug addiction not as an escape from life, but as revealing the drug users who “actively engage in meaningful activities and relationships seven days a week” (Preble & Casey, 1969, p. 2). There was an active movement toward portraying the addicted person in his or her social environment and a respect shown toward the culture of drug addiction that revealed the community aspects of being a street addict.

The post-WWII era also saw a movement in qualitative research toward asking the question of how people were using drugs rather than why they used drugs (Singer, 1999). There was a corresponding grounding of the understanding of living drug addiction in terms of the user’s lived experience rather than through the lens of medical and psychiatric understandings of the mechanisms of addiction. “A central feature of these studies is that the life or behavior under study ‘becomes meaningful, reasonable, and normal once you get close to it’” (Rhodes & Moore, 2001, p. 282).

An interesting early qualitative study was conducted by Lindesmith and published as Opiate Addiction (Lindesmith, 1947). Lindesmith discovered that the experience of opiate addiction for the addicted person had a very social rather than physiological basis, running contrary to much of the medical literature of the day. “However, [his research]
led Lindesmith to reformulate his hypothesis to one that related addiction not to withdrawal distress per se but to the purposive use of the drug after withdrawal had occurred to alleviate perceived distress” (Rhodes & Moore, 2001, p. 289). Lindesmith further concluded that the addicted person’s craving for drugs originated in his or her experience of relief of withdrawal (e.g., aches and pains associated with lack of recent ingestion of the drug, irritability, changes in appetite and sleep, etc.). He also offers us a good working definition of physical addiction based on his conclusions, being one of the first definitions that recognized that the perception of physical withdrawal symptoms as withdrawal from the drug was paramount to the formation of a drug addiction:

Addiction rests fundamentally upon the effects which follow when the drug is removed, rather than on the positive effects which its presence in the body produces… If the individual fails to conceive of his distress as withdrawal distress brought about by the absence of opiates, he cannot become addicted (Lindesmith, 1947, p. 165).

The Emergence of Qualitative Research since the 1990s.

The 1990s saw a great expansion in the use of qualitative methods in drug research following the AIDS crisis in the United States. Although the dominant form of research on addiction was, and still is, quantitative, the threat of HIV epidemics among injection drug users encouraged public health policies that were more receptive to qualitative methodologies, in terms of financing and overall goals of research as explanatory (p. 282). This shift represented an understanding of the limitations of quantitative research paradigms to be able to capture and speak to the social, political, and economic arenas in which disease, action, and people interact. The 1990s also saw an increasing interest in drug use amongst populations marginalized from the dominant culture on the basis of gender, race/ethnicity or social class (Bourgois, 1995; Maher,
in larger concerns with social justice and the implications of social stigma on the mental health and development of addicted persons coming from already marginalized populations – concerns that are best explored and understood through the use of qualitative methodologies. In addition, qualitative research was better suited to contribute to social advocacy for the oppressed or the marginalized. As one of the goals of qualitative research has been to give voice to the participants, it served to fill a gap in the literature and take up a social justice role about which quantitative methodologies were in general less interested. “Because of their inductive approach to data collection … qualitative methods are ideally suited to describing the ‘lived experience’ of drug use from participant perspectives” (Rhodes and Moore, 2001, p. 288). Qualitative methods can also often better serve to critique or question accepted conceptions about drug use and addiction in the field.

Rhodes and Moore (2001) provide another interesting example of qualitative research that challenges existing drug paradigms. They discuss the work of Gusfield (1981), who published *The Culture of Public Problems: Drinking-Driving and the Symbolic Order*. Gusfield’s project was not so much about the phenomenon of drunk-driving, but was actually more concerned with drunk-driving research. He considered the ways in which researchers constructed and maintained both commonsense and scientific understandings of their individual research projects as well as addressed the drunk-drivers as subjects of study. Rhodes and Moore (2001) write:

[Gusfield] argues that the problem of drinking-driving in the United States is constructed as a ‘drama of individualism’ centering on the ‘killer drunk’[…]. In Gusfield’s view, there is nothing ‘obvious’ or ‘natural’ about locating the ‘problem’ in the individual driver; this is a product of a
cultural view in which individual agency explains action. The culture of drinking-driving research emphasized alcohol as the problem and located the source of motor-vehicle accidents in the moral failings of the individual motorist rather than in the social institutions in which the motorist was enmeshed or the physical environment through which the motorists drove. (p. 290)

What is interesting about Gusfield’s study is its examination of both the object of study (ostensibly drunk-driving), the cultural understandings of the object, and the research paradigms used to research and explain the phenomenon. Qualitative research seems especially suited to these tasks in that it suggests that “the ‘real world’ is not just ‘out there’ but is constantly being constructed by scientific discourses that claim a position external to culture” (p. 291) – one example of which is the medical understanding of addiction.

Inebriating substances are not culture-free – they are constructed and understood by and through culture: “[A] substance has no reality external to perceptions of it, or to the context of its use... The substance is always the cultural values invested in it, and this applies whether the values be those of the police, the pharmacologist, or the user” (McDonald, 1994, p. 18). The medical conception of addiction seems to neglect the important interpretations that the user makes to understand her relationship to her substance of choice. The next section will focus on research on identity in substance abusing and dependent populations – a topic that is often left out in research that subscribes to the medical model of addiction.

Research on Identity.

Much of the work that is relevant to the understanding of identity changes in drug addiction comes from the sociological tradition. Walters (1996) provides a working
definition of identity as characterized by perception and social interaction. Identities are “situated action” locating an individual within a given social context (Stone, 1962) and may be role-pivotal or trans-situational. In other words, “identities are given meaning through a discourse (vocabulary of motives) that actors use for both themselves and others” (Anderson, 1994, p. 160). These understandings of identity will be useful to interpret the research participants’ shifting views of their own identities.

The sociologist Erving Goffman's (1963) work on identity and stigma suggested that social stigma is internalized by individuals. The stigmatized individual is stereotypically classified by others as rejected and undesirable, and is labeled as deviant. Though an addicted person may be able to conceal his or her addiction from others (thereby avoiding overt social stigma against them), research suggests that internalizing a deviant identity can lead to psychological distress, viewing the self with contempt, and decreased levels of self-esteem and academic or vocational achievement (Heatherton, Kleck, Hebl, and Hull, 2000). Some research has also suggested that the acceptance of the label “addict” or identifying as an addict is often implicated in increased use of addictive substances and involvement in “deviant” activities (Kaplan & Johnson, 1992) – meaning that being labeled as addict often has the effect of creating a self-fulfilling prophecy that encourages increased use of a substance and the complications that result from this. However, we do see that programs like Alcoholics Anonymous encourage self-labeling as an addict and the admission of one's powerlessness over alcohol as part of the recovery process, though research into AA is unclear as to whether this identification is directly part of the effectiveness of AA or if it is a part of a complicated web of non-specific factors that lead to recovery within AA (Emrick, 1989).
Anderson’s Work.

Anderson (1994, 1998) identified several factors that are important catalysts to the identity transformation that often accompanies the move into drug addiction. In her research, a common factor that was present across her participants before the drug addiction was “ego identity discomfort”, which she defined as a kind of dissatisfaction with oneself (e.g., wanting to be someone else, wanting to improve things about themselves they did not like, describing themselves in terms of who they were not rather than in terms of who they were, not fitting into socially defined categories). Anderson (1994) found that this discomfort was a “product of the respondents' perceived possession of stigmatized 'social identities' that primarily resulted from certain 'status passages', which altered their social positions, marginalized them, and made them feel different from other people” (p. 165). Other research (Sadava & Forsyth, 1977; Ray, 1968) supported some of Anderson's conclusions that the passage from non-drug user to drug user was influenced by negative feelings about oneself. Anderson (1994) also found that the experience of being marginalized not only resulted in ego identity discomfort in her participants but also a sense of losing control in defining an identity (p. 166). Her findings suggested that both ego identity discomfort and the sense of losing control in defining an identity motivated the participants’ identity transformation. The mechanisms for change became the use of a drug, a shift toward a social network of drug using friends, and a “drug lifestyle” - which led toward a more positively regarded and socially approved identity, at least among their drug using social network.

It should be noted that Anderson's work was with people who used illegal drugs. Much of her work centered on the relationship between the individual addict and the
social world of drugs and the associated deviant culture. In a later paper, Anderson 
(1998) suggested that the identification with a drug sub-culture provided the “opportunity 
for identity change (drugs, drug-related friends, and a drug lifestyle) within a non-
normative social context” (p. 301). From this perspective, we see how drug use becomes 
for the individual a way to incorporate a new identity within the context of her or his drug 
use. As Dunnington discussed above, Anderson also sees how deciding to become a drug 
user helps alleviate the burden of having to choose an identity without communal 
agreement about which identity an individual ought to choose.

In the case of addiction to prescription medication, there is not the same clearly 
defined drug sub-culture that we might find among users of illegal drugs. This suggests 
the possibility that the identity transformation in individuals who become addicted to 
prescription drugs may have much less to do with finding a more “functional identity” in 
a drug subculture than has been found in individuals addicted to illegal drugs. Although 
there is not much literature on identity and addiction to prescription medications, there 
are a few mentions in more biographical works (Stein, 2009; Lyons, 2009) about the 
development of an addiction to prescription medications and the transformation in 
identity that occurs with it. In his 2009 book *Pillhead*, Lyons writes at length about his 
experience of becoming addicted to prescription painkillers. Stein, in his 2009 book *The 
Addict*, writes about his experience as a psychiatrist treating a young woman who is 
addicted to prescription opiates, and he contrasts this with his experiences treating users 
of illegal drugs.
Chapter 3: Method

Methodology

In this study, I use interpretative phenomenological analysis (Smith, 1999) to explore the participants’ experiences of becoming addicted to prescription medication. For ease of reading, the acronym “IPA” will be used to designate interpretative phenomenological analysis. By focusing on experiences of becoming addicted, this study contributes to the other main areas of the existing literature on addiction, namely the biochemistry of addictive substances and their interaction with the neurochemistry of the addicted person, sociological studies which connect the micro and macro levels of addiction (Anderson, 1994), and research focused on persons in recovery (Banonis, 1989; McIntosh & McKeeganey, 2000; Larkin & Griffiths, 2002; Kellog, 1993). While previous phenomenological investigations (e.g., Shinebourne & Smith, 2009; Zakreski & Hector, 2004; Capone, 1986) have focused on the experience of becoming addicted to illegal drugs or alcohol, the current study is interested exclusively in prescription drug addiction. Rather than focusing on specific types of addictive prescription drugs (e.g. opiates, tranquilizers, anti-anxiety), I explore prescription drugs as a general category. Though most of the participants used opioids as their drug of choice, the experience of becoming addicted to prescription medications, instead of the effects of a particular prescription drugs, is at the core of this phenomenological inquiry. Yet, as I will discuss in this dissertation’s conclusions, this may well be a limitation of the study as addiction to non-opioid prescription medications may differ from addiction to opioid prescription drugs.

My goal is to gain access to the experiential world of prescription addicts and to gain a nuanced understanding of their lived experience of becoming addicted. Although a
number of case studies (Chapter Two, The Emergence of Qualitative Research since the 1990s) have explored addiction and the experience of becoming addicted, mostly to illegal drugs, the adoption of an IPA approach is innovative in allowing for a rigorous comparison of participant descriptions and the delineation of themes that constitute such experience. More specifically, I am interested in the participants’ perceived transformation of the self in relation to their personal and social identification as addicts. Said another way, the research question that informs this study is: How does the addicted person’s self-perception and understanding change as a consequence of becoming addicted to prescription medications? Addiction is embedded in the contexts of life and experience, and part of this research will aim to explore and analyze the varying contexts into which participants found themselves becoming addicted. The lifeworld of the participants (the world in which we find ourselves living, with its open horizon of objects, values, and relations) is key to a project such as this as well the participants’ narration of the meanings they make about their lives. IPA is phenomenological in that “it involves a detailed examination of the participant’s lived experience” (Smith & Osborn, 2008, p. 53). Webster’s Dictionary (2011) defines experience as: “(1) direct observation of or participant in events as a basis of knowledge; (2) the fact or state of having been affected by or gained knowledge through direct observation or participation.” Being that experience is an expansive term, IPA is interested in experience which “is of particular moment or significance to the person” (Smith, Flowers, & Larkin, 2009, p. 33). That is, IPA investigates experiences that are special and momentous in an individual’s life. I also aim to explore the ways in which the contemporary and typical
constructions of addiction have influenced participant’s understandings of their own experience and their sense of self.

**Summary of Philosophical Background of IPA**

Several reasons make IPA well suited to the task of exploring the lived experience of becoming addicted to prescription medications as articulated by the research participants. First, in contrast to some more naturalistic orientations in phenomenology, such as the Husserl’s later works, IPA denies that phenomena have essential structures that can be accessed via participants’ accounts of said phenomena. This methodology therefore allows for constructionist arguments about the ways in which the experience of addiction varies across time and culture.

Addiction as we know it today appears, in many ways, significantly different from how it was portrayed in first-hand accounts and the medical literature of the late nineteenth century, for instance. Since this project is interested in how personal and social constructions of the phenomenon of addiction in contemporary American culture shape the understanding of personal addiction by the research participants, IPA is better suited for these goals than a descriptive phenomenological method would have been. Whereas descriptive phenomenology focuses on the “essential and general structures of a phenomenon” (Finlay, 2009, p. 9), an interpretative approach favors an idiographic understanding of the data. Though there are philosophical differences between the approaches, IPA owes a great debt to the work of the descriptive phenomenologists, like Giorgi (1985, 2009), who pioneered the rigorous application of phenomenology to human experience for research purposes.
IPA aims at detailed explorations of how research participants make sense of their personal and social worlds and “the main currency for an IPA study is the meanings particular experiences, events, [and] states hold for participants” (Smith & Osborn, 2008, p. 53). IPA denies that experiences have an essence and instead assumes that human beings are embedded in a cultural matrix that informs how they construct and describe their experience. For the current project, IPA allows for a critical space in which to examine how cultural understandings of addiction play a role in individual’s conception of their experience of becoming addicted.

At the same time in which IPA acknowledges the constructionist aspect of an individual’s meaning making, it does not deny the truth-value of the participant’s individual experience of a given phenomenon. In regard to the current study, the participants may have largely understood their addiction through Twelve Step language and ideology (Martin, 2011). While the participants themselves varied in their ability to make a critical appraisal of how their experience of addiction may have been influenced by their participation in Twelve Step program, their accounts were not doubted or questioned. Although part of the analysis of the data involved the researcher’s own critical stance toward Twelve Step ideology and its possible influence on the participant’s understanding of their experience of addiction – a preconception that was partially accounted for and monitored through the process of reflexivity, as I will later on explain – this in no way denied the validity of the participant’s personal accounts.

IPA accepts that the researcher may see things in the data that the participant may not, but does not suggest that the researcher’s analysis is in any way more “real” or “truthful” than the participant’s. It merely suggests that the researcher may be able to add
an additional layer of meaning, or find meanings that the participant himself did not explicitly attend to in the interviews. “The interpretative analyst is able to offer a perspective on the text which the author [or participant] is not” (Smith, Flowers, & Larkin, 2009, p. 23). IPA allows the researcher to assume a critical stance toward the data. Having said that, some participants were more critical of Twelve Step ideology than others, which added additional richness to the whole of the interviews.

While concerned with an individual’s unique and personal experience of an object or an event, IPA also “emphasizes that the research exercise is a dynamic process with an active role for the researcher in that process” (p. 53). The researcher is seen as co-constructing the interview, the data to be analyzed, with the research participant, and thereby recognizing the powerful and active role of the researcher in the process of inquiry. For instance, in the present study, my comportment, particular questions to each participants, dress and speech style, and uniqueness as a researcher had an inevitable impact in the construction of the interview questions and research data (e.g., the answers) that the participants made available to me. While the participants’ experience was the object of discussion, the conversation was a dance between the two of us. In other words, the information that was provided to me cannot be separated from the dialogical context that made the research possible and in which the “data” was constructed (Gemignani, 2014). The acknowledgement of the data as co-constructed differs from quantitative methodologies which tend to assume, typically implicitly, that the researcher is neutral and removed from the creation of the research data. Larkin, Watts, and Clifton (2006) see this theoretical divide between IPA and quantitative methods as particularly important for psychology: “Perhaps the most immediately pressing issue for psychology is the
recognition that it is not actually possible – even if it is desirable – to remove ourselves, our thoughts and meaning systems from the world, in order to find out how things ‘really are’ in some definitive sense” (p. 106). As Ken Gergen (2009) argues, it is this shift to a relational ontology that provides the strongest ground for the qualitative movement in psychology.

Despite epistemological and ontological differences between IPA and quantitative methodology, IPA also shares certain concerns in common with “mainstream” psychology. Stone and Osborn (2008) write:

IPA’s emphasis on sense-making by both participant and researcher means that it can be described as having cognition as a central analytic concern, and this suggests an interesting theoretical alliance with the cognitive paradigm that is dominant in contemporary psychology. [...] IPA and mainstream psychology converge in being interested in examining how people think about what is happening to them but diverge in deciding how that thinking can best be studied. (p. 54)

**Theoretical Background**

IPA owes a large debt to the phenomenological traditions of Martin Heidegger and Edmund Husserl. Phenomenology, the “philosophical approach to the study of experience” (Smith, Flowers, & Larkin, 2009, p. 11), is particularly valuable to psychology and psychological research in that it provides an approach to the examination and understanding of lived human experience. From a phenomenological perspective, the human being is inseparable from her world and culture. Therefore, in order to study the experiences of a person, the researcher must also study the world of the individual in question. As stated above, while it might be tempting to study the person in isolation, it can’t be done without losing the contextual meanings that infuse the person’s lived
experience. For example, for the participants in this current study their unique early experiences with substances informed their latter experiences of addiction. The cultures from which the participants came informed their experience of addiction. From an IPA perspective, the question of the objective reality of an object is unimportant insofar as the object has no meaning outside of the human being and context that ascribe meaning to it. In other words, the reality of an experience can only be understood through the research participants’ meaning-making.

IPA also gives credence to the researcher’s active role in the creation of research rather than seeing him or her as an impartial and objective observer. For instance, participation in this project required that that the subjects understood themselves as currently or previously addicted to a prescription drug, rather than needing an official diagnostic code given by a professional (which would have contributed to make their addiction objectively “real” in some sense – e.g., in the eyes of an insurance company, inpatient treatment program, quantitative research project, etc.). Of interest in this study, in contrast to quantitative methods, is the way in which the participants understand themselves as addicted, and it is assumed that the understanding of themselves is what is important rather than meeting particular diagnostic criteria. Each participant may have a slightly different understanding of what addiction means. From an IPA perspective this is not a hindrance but rather a boon – each participant may shed a different kind of insight into the experience of addiction if their understandings of addiction differ. The researcher created a context of inquiry which both controlled access for the participants and allowed for an initial opening of a hermeneutic horizon in which the participants interpreted and told their experiences with addition.
To a degree, IPA fully acknowledges that the knowledge gained from research is through the dyadic relationship between the researcher and the research participant. As Larkin, Watts, and Clifton (2006) write:

Any discoveries that we make must necessarily be a function of the relationship that pertains between the researcher and the subject-matter (person and world, subject and object, etc.) […] This function is precisely what we would expect given that we must identify the researcher as an inclusive part of what they’re describing. (p. 115)

In the below section on reflexivity and in the data analysis, I will discuss the ways in which I, as a researcher, approached this project with particular prejudices, namely a dissatisfaction with the medical and Twelve Step models of addiction. Though I met my participants through Twelve Step programs, the fact of my critical stance toward the underlying ideology of this way of understanding addiction could not be fully bracketed. Though I was reflective regarding my prejudices, they were there in the room with each research participant. Therefore, I was inextricably connected with my preconceptions and this invariably was part of the construction of the interviews. This came out in certain questions I posed to the research participants, certain statements that I inquired more deeply about, and the ways in which I was pleased to hear certain participants question Twelve Step ideology for themselves.

Quantitative methods do not, generally, explicitly acknowledge the dyadic relationship between researcher and research participant. For example, in a quantitative outcome study examining the differences in Beck Depression Inventory (BDI) scores pre- and post-treatment across an experimental and a control condition, even without postulating other variables, we know that the
researcher’s decision to use the BDI to measure the construct of depression has already shaped the “knowledge” that will be constructed from the research. This becomes increasingly complex when the researcher is collecting interview data, but this simple example serves to illustrate, in a very basic way, the co-constructed nature of knowledge creation in research. Even if the researcher should wish to remove herself from the data, in a very fundamental way she cannot. IPA fully acknowledges this and therefore does not need to make claims of neutral objectivity in order to make knowledge claims about the fruit of research gained through an IPA study.

Of paramount importance to qualitative research is the question of how the interview (or any other source of information) serves to capture the experience of a research participant. On this, Larkin, Watts, and Clifton (2006) write: “[Heidegger] lays out an argument which suggests that ‘the subject’ (as a ‘person-in-context’) is always accessible to analysis as a reflection of its current intentionality and directedness…In an IPA context, this means we must inevitably accept a third-person view of a ‘first person account’” (p. 110). The critical step is taking the step back from the participants’ account and seeing it through the eyes of the researcher, the third-person viewing the first-person account.

Phenomenology, at its heart, is interested in allowing phenomenon to reveal itself, to appear as what it is, and IPA does this through the interview with the research subject. Even if not questioned for their authenticity and reality, the data still needs to be interpreted, both for their implicit and explicit meanings. Heidegger suggested that appearance has a dual quality in that “things have certain visible meanings, but they also
have concealed or hidden meanings” (Smith, Flowers, & Larkin, 2009, p. 24). This is not to suggest that the hidden meaning that may be concealed within a research participant’s account is somehow truer than what they describe manifestly. The IPA researcher, who performs the analysis on the participant’s account, doesn’t try to make the claim that her analysis is more “true” than the account given by the participant, but instead suggests that the analysis “might offer meaningful insights which exceed and subsume the explicit claims of our participants” (Smith, Flowers, & Larkin, 2009, p. 22). The researcher/analyst is seen as offering a unique perspective across multiple accounts of a particular phenomenon but the truth value of the researcher’s perceptive is not understood to trump the “truth” of the participant’s accounts of their own experience. The researcher’s perspective suffuses, permeates, and saturates the researcher’s analysis of the research data and can shed light on how the phenomenon reveals itself through the interview process and the generation of data. The data of the interview cannot help but be seen through the eyes and experiences of the researcher (Gemignani, 2011). Hence, the secondary data (e.g., notes taken after the interviews, thoughts and reflections on the nature of addiction) is useful in explicating the content and form of the researcher’s perspective on the phenomenon being examined.

It is important, however, to emphasize the interview data rather than the researcher’s preconceptions (hence the use of the title “secondary data”). Smith, Flowers, and Larkin (2009) write:

Priority should be given to the new object, rather than to one’s preconceptions… While the existence of the fore-structures may precede our encounters with new things, understanding may actually work the other way, from the thing to the fore-structure. (p. 25)
When first encountering a text, I may not yet fully be aware of my preconceptions, my fore-structure. It is through an encounter with the text that this becomes clearly and my preconceptions may reveal themselves. Yet, IPA does assume that preconceptions may be informed by the research data and the researcher’s perspective on addiction may shift in meaning through engagement with the data. This researcher’s shifting conception of addiction will be further addressed in the later chapters on data analysis.

Participants

Participants for this study met the following criteria: first, their drug of choice was a prescription medication. Some participants were abusers of other substances, congruent with the rise in poly-drug abuse and addiction, but for the purposes of the proposed study the participants primarily used or abused prescription medications. Second, the participants identified themselves as currently or previously addicted. Rather than attempting to use objective diagnostic criteria to label participants as dependent on prescription drugs, this study is interested in participants’ experience of becoming addicted. If a participant believes he had become or is addicted to prescription medications, a medical or psychological diagnosis of drug dependence is unnecessary. For the purposes of this study, given its methodology, what is paramount is that the participants believed themselves to be addicted. Whether they met diagnostic criteria is not as important as the participants’ beliefs that they were addicted, as the study is interested in their personal experience and perspective, not that of a treatment provider. Still, many participants received a diagnosis of drug dependence and they were in treatment or had sought treatment in their past. Different participants had different
perspectives on whether current use of a substance was a prerequisite for identifying as addicted. For example, several participants who took up the Twelve Step model saw themselves as addicts even though they were not currently using any substances. These differences, and their possible influence on how the participants may have told their stories is addressed in the data analysis and discussion sections. Secondly, the participants were all male. Although restricting gender will be a limitation of the study, this restriction enabled me to better focus on the experience of addiction itself rather than a gendered experience of addiction. Third, all of the participants had to be available for in-person interviews.

Introduction to the Participants.

Below is a brief introduction to each of the research participants, which are identified through pseudonyms.

Bobby is a 44 year old, Caucasian male. He was born and raised in a small town in southeastern Texas. Bobby presented during the interview as an affable, “country”-style gentleman. He wore jeans, a western style button-down shirt, cowboy hat, and boots to the interview. Bobby is married with two children. He has been abstinent from prescription opiates for five years. He started abusing prescription painkillers following a back injury, but he started smoking marijuana and drinking alcohol as a teenager. He denied experiencing problematic effects from his previous substance use but came to understand his prescription pill use as problematic after several years of abuse. He comes from a working class background and worked in construction before his back injury, which was incurred lifting a refrigerator. He was unemployed at the time of the interview.
and, in addition to his wife’s income, he was receiving social security disability payments.

Travis is a 35 year old, African American male. He identifies as gay and is currently in a several year’s long, committed relationship. Travis was born and raised in a medium sized western Louisiana city. He moved to Houston in his twenties. He started using alcohol and marijuana as a teenager. In his later teens, Travis was involved in the “rave scene” and began using MDMA (ecstasy) on a regular basis. After moving to Houston with a friend, he started using prescription painkillers. He has been abstinent from prescription medications for three years. He still smokes marijuana and consumes alcohol on a regular basis, but denied any problematic effects from such use. Travis has been employed as a hair stylist for over a decade. He was friendly, energetic in the way he discussed his drug use, and open to questions. He seemed genuinely eager to share his experience.

Freddie is a 32 year old, Caucasian male. He was born and raised in a small town in southeastern Louisiana. He is unmarried and has no children. He has been abstinent from all substances for approximately six months. He is currently living with his parents and most of his income comes from disability payments from the Veterans Administration and social security. He is an Iraq war veteran and served as an infantrymen in two combat deployments. He started struggling with prescription pill addiction following his discharge from the army. He has a light southern Louisiana accent and dressed in Louisiana State University apparel for our interview. He wore a camouflaged baseball cap that has the emblem of his favorite fishing gear supply company. He is an avid fisherman.
John is a 29 year old, Caucasian male. He was born in California, but moved at an early age and was raised in an upper middle class suburb of Houston, Texas. He has been abstinent from his drug of choice, prescription amphetamines, for four years. He is college educated, comes across as intelligent and thoughtful, and arrived at the interview wearing a black t-shirt and jeans. He continues to use alcohol and occasionally marijuana, but denies any problematic effects from using these substances. He currently works in the technology industry.

Norman is a 48 year old, African American male. He was born and raised in large city in Florida, and moved to southeastern Louisiana following a medical retirement from the Army. He is married and has two adult children, both of who have good relationships with him. He has been abstinent from all substances for one year. He started using painkillers in his late thirties when injuries incurred while he was in the army became exacerbated in an accident. His main income comes from disability payments.

Hugh is a 33 year old Caucasian male, who was born and raised outside of a large Louisiana city within an extended, working class family. Hugh started experimenting with heroin in his twenties and began using opiate medications in an effort to stop using heroin. He has now been sober for over one year. Hugh has a six year old son whom he sees regularly. The son lives with his mother, who is Hugh’s ex-girlfriend. Hugh works part time as an administrative assistant and has moved back in with his parents to save money. He presented at the interview in jeans and a white polo shirt.

Participant Recruitment.

I contacted organizers and staff of Narcotics Anonymous meetings to request permission to recruit participants and to attend Narcotics Anonymous meetings in the
Houston, Texas, and New Orleans, Louisiana, metropolitan areas. I briefly described my interests and goals in regard to the project, the requirements for the participants in terms of time and effort, and participation criteria as described above. I conducted brief screening interviews on the phone with interested participants in order to ascertain their appropriateness for the study. Participants who met the criteria for inclusion in the study were scheduled for in-person interviews, generally at the facility where the Narcotics Anonymous meetings were conducted. The specific location was agreed upon during the initial phone interview.

Data Collection.

Each interview began with reviewing the participant consent form, which had been approved by the Duquesne University’s Institution Review Board (Appendix 1). This form described the purpose of the research, estimated duration of the interview, plans for confidentiality of their identity, and possible risks and benefits of participating in the research. After the participants gave their signed consent, I began audiotaping the interview. Both locations were small rooms housed within churches that also hosted Twelve Step Program meetings. These sites were selected for their smaller size, which provided a sense of privacy (e.g. away from busier parts of the facility, able to close the door, would be undisturbed), and because both the participants and myself were generally familiar with them.

I met most participants while recruiting them. I had contacted organizers of local Twelve Step Programs (mostly Narcotics Anonymous) and requested permission to briefly discuss my work and recruit participants. I attended many meetings over the course of several months. I would generally be allowed to speak for approximately five
minutes during which time I would discuss my project and my education and ask that any person interested to participate to the study contact me via email or, if it was an open meeting, speak with me in person after the meeting. I would then distribute flyers with the title of the project and my contact information. Three participants discussed their interest in the project with me following a meeting, whereas two contacted me via email. A sixth participant was introduced to me via another participant.

In the initial conversation, I asked the participant if they would be available and willing to meet again in person for the interview. I also clarified whether prescription medications were what the participant understood as their “drug of choice” or the drug they felt they were or had been addicted to. These conversations gave me an overall sense of the personality and history of the participants.

On the day of the interview, I typically met the participants in front of the respective church and we then walked together to the interviewing room. During this time, I would ease into ice-breaking conversation, build some foundational rapport with the participants, and get a sense of their interpersonal style. Though some participants were more talkative than others, all of them were open to conversation and were friendly and pleasant. Although this may have been due to a selection bias (i.e. all participants volunteered to be part of the current study), it was helpful that all participants were easy to engage and open about discussing fairly intimate details about their lives. Some individuals explicitly stated that they wanted to participate to help other people struggling with addiction. Innocuous conversation would continue during the two to three minutes it took to reach the interview room.
Following the signing of the consent form, I started the audio recorder and began the interview with a few questions regarding the participants’ history of using alcohol and drugs. Participants were asked additional questions to get a sense of how they experienced drug use earlier in their lives and to try to differentiate between problematic use earlier in their histories versus their prescription pill addiction. As noted in the data analysis, all participants described previous experiences with alcohol and drugs.

I then asked each participant the following question: “Please describe for me your experience of becoming addicted to prescription medication. Take as much time as you need. Describe how your drug use began, what happened when you started experiencing yourself as addicted, and what happened after you began to identify yourself as addicted. Please include as much detail as possible, including thoughts and feelings, events happening in your life, how your relationships and sense of self changed, and anything else that comes to mind. Basically, I’d like you to tell me your story about becoming addicted and how the addiction has affected you.”

During the participant’s initial response, I limited my questions to clarifications and prompts to elicit responses to all parts of the question, as necessary. I kept notes of words or statements that seemed unclear or worthy of exploration. While conducting the interviews, what was determined to be unclear or worthy of exploration seemed to be much more motivated by intuitions and emotional reactions than by an overt cognitive process of determining that which seemed to be best to follow up on. Said another way, I realized I was listening to the participants much like I as a clinician might attend to a psychotherapy client during an intake interview, which typically focuses on presenting problems and their history. These intuitions seemed to also come from the place of being
a clinician, a felt sense that something was important that was different than a purely
cognitive process. I felt motivated to collect information relevant to their drug use and
their sense of becoming addicted, and this process was different with each participant. I
did not think to myself “this seems unclear,” but rather responded to certain phrases or
thoughts that seemed charged in some way. Again, this sense seemed more felt, more
emotional, than cognitive. When the participant was finished with his initial response,
and responded to all parts of the question, I began asking a series of unstructured
interview questions in order to further deepen or clarify statements that seemed unclear.

**Method**

The research question that guided the analysis was: How did the research
participants experience their addiction to prescription drugs? The secondary question
was: How did culture appear to inform the participants’ experiences of addiction?

The basic process of the Interpretative Phenomenological Analyses went as
follows (Smith and Osborn, 2008, p. 53-80):

1. The transcript was read a number of times. The left-hand margin was used
to annotate, parts of the participant’s speech that were interesting or
significant in terms of the phenomenon being studied. Familiarity with the
transcript came with multiple readings. This was important to get an
overall feel for the transcript and the participants.
2. Beginning comments often came from summarizations or paraphrasing,
associations or connections, or early interpretations. The entire transcript
is considered to be data – particular passages or selections are not yet
separated from the whole.
3. I identified the themes that seemed relevant to the research question. They were then listed on a sheet of paper and I looked for connections between them. Aspects of the themes that were individual were described as so. Aspects of the themes that seemed better understood as culturally based, defined for my purposes through Cushman’s definition discussed in the preceding chapter (“language, symbols, moral understandings, rituals, rules, institutional arrangements of power and privilege, origin myths and explanatory stories, ritual songs, and costumes” [Cushman, 1995, p. 17]), were coded separately. Concretely, different colors were used to code these different aspects on the transcripts themselves. In the initial list, the emergent themes were listed chronologically. The second list was more analytic, more interpretative than descriptive, and was based on connections between or among themes.

4. Connections between or among themes were checked to make sure that they actually corresponded with the primary source material. That is, I checked my own sense-making against what the participant actually said during the interview. This was achieved by going back to the context of the interview and its transcription to make sure that I was not forcing my own perspective onto the participants. Concretely, while examining particular extracts I would go back to the transcript to make sure that the context of the extract actually fit with the theme it was used to illustrate.

5. The next stage was to produce a table of the interview themes in a coherent order according to their ability to answer, inform, or complicate
the research question. I labeled the clusters, which represented the superordinate themes. The table listed the themes that compose each superordinate theme.

6. When moving on to subsequent transcripts, I used themes from the first transcript to help orient the search for themes in the subsequent analyses. At the same time, themes that were unique of this interview were added to the table. I paid attention to both divergences and convergences across the transcripts.

7. After coding and identify the themes of each transcript, I constructed a final table of superordinate themes. Themes were not selected purely based on their prevalence in the data but also in terms of their richness and how they illuminated other parts of the accounts.

8. The final section was concerned with moving from the final themes to a write up. This took the form of a final statement which outlined the meanings inherent in the various participants’ experience.

9. The themes were translated into a narrative account in the final write up. Themes are explained, illustrated through reference to the original data, and made more nuanced by exploring unique and contrasting instances, experiences, constructions, and interpretations. Care was taken to clearly distinguish what the respondent said and the analyst’s interpretation of it. To mitigate against the creation of universal categories of meaning and interpretation, the narrative was made relevant to the specific context in which the participants lived and told their stories. For example, different
extracts from different participants are put into their unique contexts within the overall themes that are discussed. Both the similarities and differences between participants are part of the analysis.

**Reflexivity**

IPA takes the stance that it is neither possible, nor perhaps not even desirable, to attempt to bracket the researcher’s experience and understandings (Finlay, 2009, p. 12). Instead, the researcher’s preconceptions are pulled to the foreground, so that they can be separated from the knowledge that belongs to the research participants.

My reflexive awareness about my perceptions of addiction developed significantly in the very process of writing the first chapters of the dissertation. I held my own understanding of addiction in my mind as I reviewed the transcripts. This reflexive strategy helped me to become and remain aware of my own positions and values and the ways in which they may have influenced my analysis of the data. These understandings are presented in this dissertation’s conclusions (Chapter Five).

Reflexivity became an ongoing dialogue and dance between my own, theoretical understanding of addiction and what was actually told by the participants. Part of this involved examining the researcher data, as described below, to note shifting thoughts about addiction as I worked with the transcripts themselves. Chapter Five also discusses how my interaction with the research participants changed my own thoughts about addiction.

As for any researcher in a process of inquiry, I entered this study with my own biases toward addiction. For instance, I had largely rejected the medical interpretation of addiction as a disease. I saw addiction as a rejection of freedom and responsibility, while
simultaneously seeing it as an answer to the questions posed by postmodernism, the breakdowns in community, and the massive cultural changes of the 20th century.

While being aware of these prejudices helped to control them, it was still a challenge at times to keep an open mind, especially at the beginning of the data analysis. I struggled, for example, to avoid forcing the participants’ experience into my preconceived model of addiction. As part of the reflexivity process as well as a way to increase the validity of the analysis, I returned to the data after delineating the final themes to re-examine the context in which they were embedded. I also revisited the whole data set to evaluate whether the themes were actually grounded in the data. Through this process of returning to the data and its contexts, I could be more critical and nuanced in considering whether various data excerpts properly described the participants’ experiences, instead of choosing them for their ability to prove my ideas or theories on addiction. I actively looked for parts of the transcripts that countered my original positions against addiction and I found many that did not fit neatly into my preconceived notion of addiction. For example, many of the participants found solace and wisdom in the Twelve Steps. While they actively saw themselves as addicts in recovery, their identity was not fully captured in this self-definition. In other words, they understood themselves also as fathers, brothers, friends, partners, workers, and men. Their identity as addicts in recovery did not supersede these other identities. Their commitment to sobriety did not eclipse other roles and subjectivities in their lives, as did their previous commitment to their substances of choice. They did not really understand their addictions as a solution to the postmodern problem of finding their own answers about how and what to be. They only realized how far they had fallen when, often in moments of critical
clarity, they recognized that their lives had drastically moved away from their ideals. They did not experience their addictions as functional, but as a true sense of powerlessness.

Through this process, my own understandings and beliefs around addiction shifted. Several themes, such as addiction as apathy and addiction as functional response, were abandoned following this process. Other themes were clustered together to form more comprehensive descriptions, while others emerged anew from the critical and analytic strategy of looking for points and counter-points. I found that, in many ways, the data was not panning out what I had expected to see. For example, my expectation that participants would clearly see their addiction as a response to a nihilistic, post-modern culture that forced them to take up the burden of choosing their own path toward “the good life,” was not supported by the data.

Researcher Data.

Data in this study also included the researcher’s own reactions to and reflections about the process of inquiry (Gemignani, 2011). This secondary data was in part used to critically examine the ways in which the research data are analyzed and interpreted. This data consisted of the following:

1. Notes taken following each interview and distinct from the transcriptions were recorded within a few hours of the actual interview. These notes consisted of reflections on the interview, general impressions about the meeting, and aspects of the interview that raised further questions or seemed confusing, uncertain, or particularly interesting. Insights and further ideas about the research were also recorded here.
2. A reflection on my perspective of the phenomenon of addiction – including exploration of my own personal expectations, assumptions, and motivations in regard to the research project. This was used to help separate my own preconceptions about addiction from what the participants were actually saying in their interviews with me. This is discussed in Chapter Five.

3. Notes taken during the course of transcribing the interviews. These will consist of affective responses to the data (e.g., shifts in mood while transcribing, feelings about what I am reading) and/or further insights, questions, or confusions that arise during the transcription process.
Chapter 4: Data Analysis

Reintroduction to the Participants

Before the data analysis, I would like to briefly reintroduce the participants at this point to help reorient readers to their backgrounds. Bobby is a 44-year-old Caucasian male, married, with two children. He has been abstinent from drugs for five years. Travis is a 35 year old, African American, gay male. He has not used prescription medications for three years but continues to occasionally consume marijuana and alcohol. Freddie is a 32 year old, Caucasian unmarried male. He has been completely sober for six months. The fourth participant is John: he is a 29 year old, single, Caucasian male. Unlike the other participants, who used prescription opiates, John’s drug of abuse was prescription amphetamines. He occasionally uses alcohol and, rarely, marijuana, but has not used amphetamines for over four years. Norman is a 44 year old, married, African American male. He has two children. He has been sober for approximately one year. The sixth and last participant is Hugh, who is a 33 year old, unmarried, Caucasian male. He has one son. He has been sober for over one year.

Analysis

Several superordinate themes were common across the participants during the data analysis. These themes were identified in sections of the transcripts that were directly related to the participants’ discussion of their sense of becoming or identifying as addicted, as well as sections of the transcripts that were related to their thoughts and perceptions related to prescription drugs. While the majority of the superordinate themes were similar to themes that commonly appear in research studies on illegal streets drugs, the participants in this research perceived prescription drugs as safer and intrinsically
different from other drugs, at least in the earlier stages of use. Given the purposes of this study, this is a central observation because the fact that prescription drugs were perceived as different from street drugs suggests that their use may have been experienced differently. In addition, this observation raises the question of whether the participants saw their addiction as different from addiction to street drugs.

It was clear that, at least at the beginning of their use, all of the participants saw the use of prescription medications as somehow more innocuous than street drugs. Of note, another emergent theme that was common across all participants was the early use of substances. Some participants were raised in families in which parents, siblings, and/or other relatives abused substances. All of the participants described using their first drugs, which was usually alcohol or marijuana, in adolescence.

Most participants began to recognize their substance use as problematic when, in the eyes of the participants, it became obviously avoidant of thoughts, feelings as well as relationships (e.g., avoiding friends and family). All of them recognized periods of heavy denial preceding the point in which they identified as addicted, but this denial moved from being concerned with their use as problematic to denying reality, in a kind of absolute avoidance. For example, John stated: “So, and I know this is true for addicts, I love it because I could just escape from everything. I just didn't think about anything and I loved that, right? Because I didn't think about being lonely or sad or frustrated or whatever.” Bobby said: “I didn't think about much of anything. [I had] no pain in my back, and I just kind of floated through my days. Didn't give a shit about much of anything.” This denial is examined in further detail below. Four of the six participants began to identify as addicted at this point of recognizing the denial of their use, whereas
for others the addicted identity became central in their lives when they sought help or saw themselves as “in need.” Nearly all of the participants recognized that they had lost control or had become powerless over their use of a substance. For them, this realization became part of their identification as addicted.

Early Experiences of Substance Use.

*When you’re younger, I think, when you’re younger you look around and say, “If everyone is doing this than it can’t be a problem!”*

- Hugh

The participants in this study discussed early (e.g., adolescence and early adulthood) and generally positive experiences using substances. This theme appears to have drastically influenced how the participants later experienced drugs: they often seemed primed to see substance use as normal and even ubiquitous. At the time of their early uses, none of the participants questioned that using drugs and alcohol as teenagers was abnormal or detrimental in some way. As I further discuss below, for many participants it was not only members of their social circles who were using drugs and alcohol, but it was often members of their immediate family and other adults in their neighborhoods. So, to use drugs and alcohol, as a teenager or as an adult, was taken for granted: it was as a sort of truism in the participants’ lives.

Bobby: Yeah. I probably wouldn't have said that back then, but I know it now: that I was drinking too much, probably. But we was young, that's just how it goes. Me and my roommate would probably kill a case a night, after work. Maybe have a few beers with lunch. Nobody really cared much.

Travis: We was drinking whenever we could get that shit, you know, drinking at my house, drinking at friends’ houses. Nobody's parents gave a shit, it's just like that, you know what I'm saying? So, I probably was drinking every weekend when I was a teenager… Shit, well, I guess I
started smoking some pot when I was 12 or 13 or something, you know, friends be coming over with that shit, I tried it, I liked it. It was just how it was in our neighbor and at school, you know what I'm saying, we was always trying to get fucked up.

In both of the participants’ extracts, it is clear that using substances was seen as unproblematic at a previous point in their lives, even during the day at work. The first participant indicates that this was a normal and culturally accepted part of an American, southern, young adulthood and early adolescence. Perhaps, in their views, it was even developmentally appropriate. Yet, both of the participants see their early drug and alcohol use as unproblematic, as part of their social world. For instance, they discussed how heavy drinking was typical in the home when they were young children. Travis describes how substance-using behaviors were not only normal in his family of origin, but throughout his neighborhood and amongst his schoolmates. Bobby shows insight gained in hindsight: he was likely drinking too much, but is clear that during this period of his life he felt that this behavior could be excused. Drinking heavily, even during work, was somewhat normal and therefore not something to be questioned as problematic. When Bobby discusses his early adult experiences with alcohol, he communicates a sort of “boys will be boys” attitude in life. Similarly, Travis as well hints that nowadays, in hindsight, he sees the use of substance as problematic. For this participant, his family and neighbors were complacent about his drinking behaviors: drinking alcohol and using marijuana were culturally acceptable and appropriate. Substance use was clearly ubiquitous in his world.

Other participants too felt that part of their social world as young people involved using marijuana and alcohol. Differently from Travis and Bobby, however, some expressed reservations about using harder drugs at this stage in their lives.
Freddie: It really started with smoking pot and drinking in high school. I probably had my first joint when I was like 13 or 14 and first beer around then too. I didn’t do anything harder than that in high school.

TH: Nothing harder?

Freddie: Yeah, like, heroin or cocaine or meth. It just wasn’t around where I grew up. You might have seen it on TV or in a movie or something. Maybe kids were doing it, I don’t know, but my friends weren’t. I don’t know that I would have even touched it during high school.

TH: Why’s that?

Freddie: I don’t know, then, I probably thought it was too hardcore for me. I was OK being a stoner kid but I don’t think I was ready for the hard shit.

For Freddie, drugs such as heroin, cocaine, and methamphetamine weren’t accessible. The “harder” drugs were somewhat mythical and seen only in media. They existed for this participant apart from his day to day reality. He also hints that he thought about his substance use as “softcore” versus “hardcore” as a teenager. Part of his reluctance to even search out such drugs seems to be tied to his acceptance of his identity as a stoner but a reluctance to go beyond this “milder” label. For Freddie, identifying as a “stoner kid” is more acceptable and benevolent: he distances himself from alternative identities in a way that explains, in part, his choice not to use anything beyond marijuana. Although we will soon see that his relationship with substances becomes far more problematic for him, it is important for Freddie to identity as a stoner when explaining his story on how he started using drugs. Even more significant for his identity is the fact that, when looking at his adolescent-self in hindsight, he was “just a stoner kid.” There is almost an innocence communicated in describing himself as a “stoner kid” rather than “stoner adult” or just “stoner.” His view changes and becomes less innocent, however, when he starts experimenting with different substances following his military experience. He reveals a
sort of foreshadowing when he states that he didn’t think he was ready to use harder
drugs (which instead he begins to use as an adult).

Hugh’s narration develops along a plot that is similar to Freddie’s. Both of them
began to use drugs “innocently” or “naively”:

TH: Do you think you were addicted then?
Hugh: No man, no. It wasn’t like that. We were just Louisiana boys, that’s
just what we did. Everyone was drinking and going to parties and smoking
weed, except maybe the nerdy kids. Everyone I knew was doing it. It was
like not a problem for me then.

TH: Uh huh. It was normal?
Hugh: Yeah, it was normal. We’d joke, you know, like say, hey John is an
alcoholic man, did you see how many beers that fool drank? He couldn’t
even walk! Stuff like that. But we’d just be laughing about it, we didn’t
really know what an alcoholic was. I didn’t know what an alcoholic was.

Hugh discusses how he and his social circle would not have thought of problematic
drinking as indicative of alcoholism. Even if the behavior of certain friends was
recognized as excessive, it was not seen as addiction. He even states that the concept was
foreign to him at this point. He also clearly felt that drinking alcohol and smoking
marijuana was normal and socially acceptable for his culture.

John: Well, I didn't get high the first time I smoked, right? A lot of people
seem to say that too. (laughs) I don't know if there's a chemical reason
behind that, like the body has to get used to it or something, I don't know,
but I probably didn't get high until the third or fourth time. K and I
smoked in the backyard at his parent's house and then went to Jack-in-the-
Box. I remember it because I was so stoned I couldn't stop laughing at
everyone at the restaurant, well, at the Jack-in-the-Box. (laughs)
Everything just seemed so funny, like the Mexican day workers drinking
their beers in the grass. For whatever reason I just thought that was
fucking hilarious, right? I couldn't stop laughing the whole time. I have a
pretty positive memory of that day, right? Sometimes, like later in my life,
I wondered if I had had some bad experiences first maybe I wouldn't have
liked it as much.
TH: What do you mean?

John: Well, I guess if I hadn't like smoking pot, right, I wouldn't have gotten into other stuff. When I was younger I always thought it was bullshit that people said that pot was a fucking gateway drug.

John clearly sees a link between early, positive drug experiences and later, more problematic drug use. There are three main components here of John’s early experiences with drugs: he did not perceive his drug use as problematic; his drug use was a social activity done with friends; and lastly, it was a source of fun and entertainment in contrast to a life that he described as being often dull and boring. Despite his compassionate understanding of his own beginning with drug use, John seems to blame these early experiences for the negative experiences he had with drugs later on, as a teenager. He even wonders if his earlier experiences with substances made it inevitable that he would later have problems with prescription drugs:

John: Right, so you probably remember that crap too. I just thought it was bullshit, right? Like, ok, I'm going to go from pot to heroin because I like pot. They made it seem, like inevitable, right?

TH: uh huh.

John: Maybe it was though, I guess that's what I'm trying to say. Maybe, like, maybe it was inevitable for me to move on to harder stuff.

TH: Uh huh. Inevitable?

John: Well, like, what I mean is that if I hadn't liked smoking pot in high school I'd probably, like later in life, I'd probably be way way less likely to try anything else.

Here, John is speaking about the Drug Abuse Resistance Education (D.A.R.E.) he participated in during elementary school and the concept of marijuana as a “gateway drug.” He wonders if his use of pot is directly implicated in his later drug use. It is interesting that, while he initially felt that the concept of a gateway drug was untenable, he then wonders about this idea in light of his own struggles with addiction later in life.
The reason why John felt that connection between his early and late drug use was inevitable is somewhat unclear. Although his enjoyment of marijuana does not guarantee problems later in life, he creates this deterministic explanation. In hindsight, John sees his story as part of an inevitable destiny. John seems to adopt a kind of fatalism in this extract. Perhaps he has used this narrative as a way of lowering his sense of responsibility for “choosing” to use and therefore evade feeling guilty for the negative consequences he experiences later. Given that this is John’s reflection on the beginnings of his drug use, perhaps this indicates, in addition to guilt, a sense of anger toward himself. It is likely that John and other participants are deflecting their guilt and anger by assuming that they were destined to become drug-users.

Cultural Aspects of Early Experiences.

Several participants discussed the ways in which culture, particularly movies and music, may have played a role in the ways in which they perceived drugs, particularly alcohol and marijuana, while growing up. Above, John has already mentioned how D.A.R.E. shaped some of his thinking about drugs and their use. Several participants discussed how the families in which they grew up used alcohol in ways that led them to believe their own use was normative. The research participants found a sense of safety in this normativity, particularly during their early experiences with substances. However, these perceptions seemed largely reinforced by cultural configurations that romanticize or idealize the use of particular substances. For instance, several participants discussed how certain movies influenced their constructions of drugs and alcohol:

Freddie: Do you remember the movie *Half-Baked*? I loved that movie when I was a kid.

TH: What did you like about it?
Freddie: It was hilarious man (laughs), you know?! They were just having a good old time, just a bunch of stoner buddies, laying back and having a good old time. All the stupid shit they got into, that stuff was hilarious. They were always stoned but they were always having a party. My buddies back then picked out the guy we thought we were. It was a lot like that, our posse in high school. Always fucking around and getting drunk and high.

Freddie even goes as far as pointing out that he and his friends identified with different characters in a movie about marijuana-smoking friends. He seems to romanticize this particular film and his teenage years. He felt that the movie was similar to the experiences they had as adolescents, but no doubt his adolescence was also marked by painful experiences. Like his own experiences, possibly romanticized in hindsight, they were a “bunch of stoner buddies” that were “always stoned” and “always having a party.” He seems to remember those times fondly, in the same way he remembers the movie. Perhaps in this extract he recalls not just missing the physical pleasures of the drug, but the social components of his use, the fact that, during adolescence, using drugs played a role in creating a common ground for a shared experience with his friends. Similarly, during the interview, Freddie laughs as he recalls a shared memory in which he and his friends were the movie stars: the stoner kids who were always partying and having a good time.

Hugh also has fond memories of the *Cheech and Chong* films, in which the protagonists were two marijuana-smoking friends who systematically got into difficult, and sometimes bizarre, situations.

Hugh: I just thought they were fucking funny as hell, man, those two. I think I saw one of those movies when I was pretty young, like way before I started doing anything, like any drugs or drinking or whatever. And I
remember, like, I remember when I was a kid thinking, shit, those guys are having a blast. What the hell are these teachers and shit telling me about smoking weed? That shit is bad? You know, it seemed like they were having a great time. They always were getting into some stupid shit but it always turned out alright and some funny shit always happened, like, they were just always having a good time.

TH: Do you, well, it sounds like you had a certain way of thinking, umm, about marijuana, after seeing those movies, but really, really you hadn’t even used anything yet.

Hugh: Well, no man, I saw those movies way before I tried anything. But it didn’t seem to be a bad thing, like our teachers were saying, like, you know, like the cops were telling us. I guess I thought it looked pretty fucking cool. And it was, you know, when I started smoking and drinking, it was cool when I was a kid. I didn’t have any real problems then.

In this extract, Hugh sees a clear connection between watching the *Cheech and Chong* films as a young adolescent and his perception of marijuana as innocent and fun. He seems to see the experiences of the characters (“They were always having a great time,” “…pretty fucking cool”) as perhaps a way of “feeling like a movie star” himself. The characters even seemed to be more “real” to him in their portrayal of marijuana use than what he was hearing from his school teachers. The film portrayal of drug abuse seems to be more convincing to him than what he is being told by people in authority.

Remembering his adolescence, it seems that his experience was congruent with his expectations, gleaned from watching these kinds of movies portray marijuana use. It was not until later in his life that he really started to experience problems with substances.

In addition to film portrayals of substance use, Freddie also recalls popular music from the 1990s romanticizing drug and alcohol use:

Freddie: Dude, yes, I remember cruising around listening to that… shit I can’t remember the album but it was Snoop Dogg and Dr. Dre, “Sippin’ on Gin and Juice.” We were always playing that shit in the car, at parties, wherever. Do you remember that one?
TH: Yeah, I do.

 Freddie: That one was like the best back then. It was funny, kinda, because we were all a little racist back in high school. It was just a Louisiana thing, you know, I didn’t know any blacks until I was in the Army. But I loved that Snoop Dogg shit because they were all about just getting fucked up, smoking endo and drinking gin. We thought it was awesome. We were doing the same thing as these black dudes from the ghetto, driving around to parties on a Saturday getting blasted.

Freddie clearly identifies with how the rappers are portraying themselves through their lyrics. This identification may be interpreted as a way to, again, connect both with that “movie/music star feeling.” It also seems to bring Freddie back to his past, when being was lightly connected to “just getting fucked up” and this practice did not have the negative consequences he later experienced in his life. He even recognizes that, though he is coming from a very different place, he glorifies his substance use in the same way it’s glorified in the music. He acknowledges that despite some racist tendencies when he was younger, he could identify with people of color, because of the way in which they rapped about their drug use. So, to an extent, the drug use created a common ground that, in Freddie’s view, extended beyond race and geographical locations.

For Freddie, the attraction to the stoner/partier identity was partially linked to how the lifestyle was portrayed in the music and film of his adolescence. The consumption of substances was fun, carefree, and non-problematic. Although it is questionable that the reality portrayed by these famous rappers corresponded to that of “black dudes from the ghetto,” for Freddie these rappers represented a model to which he felt close (they were “dudes”, just as he was) and that pointed toward the desirable drug and party escapes of his Saturday nights. For both Freddie and Hugh, these media models seem to have filled a gap of sorts for them. Perhaps this gap could have been filled with a sports star or an
action hero, but both of these participants mention with a fondness these pieces of media from their adolescence. They were attracted to the fantasies portrayed here and both link this adolescent search for models to their substance use problems as adults.

**Prescription Medications as Safer Than Street Drugs.**

*I got a prescription [for painkillers] from a pharmacy ... and I got a plastic sandwich bag filled with weed from a dude on the corner.*

- Norman

All of the participants perceived prescription medications as safer than street drugs. The fact that these drugs were legally-prescribed situated their use in a medical context of healing or pain management (palliative care). In other words, in the eyes of the participants, these drugs were part of their health care. They did not have to be hidden, in the way that illegal drugs like marijuana must be; the participants did not need to hide their use, feel bad, or feel judged for it. As these drugs were sanctioned by the medical establishment, it took time, sometimes years, for these patients to realize they had become addicted.

Norman: Well, my life wasn’t destroyed by it, you know? It wasn’t destroyed by it like some other guys. But, umm, well, you know? I was never on the hard stuff. I was taking medicine for my pain. That’s how I thought about it. For years I thought about it as medicine. Maybe I just had a doctor that was okay giving me more and more, but it was still coming from a doctor. It was different than smoking weed. I got a prescription from a pharmacy when I got my painkillers and I got a plastic sandwich bag filled with weed from a dude on the corner. I was using them both to help with my pain, but one was medicine and one wasn’t. I knew there was a difference. I felt bad sometimes about smoking weed, I didn’t want my kids to know that, but I didn’t care about the pills. There was nothing to feel bad about. You know, daddy is in pain and needs his medicine.

Norman’s life was not “destroyed” in the way it was for some of the other drug users whom he met at the Twelve Step gatherings. He creates a distinction between himself, as
a person addicted to prescription opioids, and those who used “the hard stuff,” though it is not clear what Norman means by this. In addition, in contrast to marijuana, he sees prescription medications as medicine. They came from a doctor, rather than “some dude on the corner”: to him, this is meaningful as he is clearly concerned about safety. While the pharmacy is a safe place where his doctor sends his medications, illegal drugs and the street corner are dangerous. Another point of difference between street and prescription drugs is that consuming the former is a source of shame, whereas he does not feel bad for his prescription drug use because a doctor prescribed it. Norman’s shame is linked to his identity as a father and his fears about his illegal drug use being discovered by his children. Though he clearly was using both drugs to control his pain, they are fundamentally different because of the source and the ways in which Norman constructs them as being “shameful” in relation to his identity as a good, law-abiding, role-model of a father.

Although Travis never received a prescription for the pharmaceuticals he uses, like Norman he also sees a fundamental difference between abusing prescription medications and using illegal street drugs:

Travis: Pills are different like that, you know, they just can't make that shit up and sell that shit, like you can with rolls or whatever shit, like with pot mixed with oregano and shit (laughs). You just can't do that with pills.

Here Travis is saying that, first, he indicates that with pills one knows what one is getting. They are different from MDMA\(^2\) (“rolls”) and marijuana because he can trust

\(^2\) MDMA (3,4-methylenedioxy-N-methylamphetamine), known popularly as ecstasy, is an illegal “empathogen” that produces particular effects in the user (e.g., perception of enhanced empathy, manic moods, euphoria, etc.) that make it a popular drug at clubs and other music venues.
they are what they appear to be. Travis sees the prescription drugs he is using as recreational and not medical, because he uses them for his leisure or fun and not to control symptoms.

Travis: They ain't coke or x or nothing. Just pills. And D was on that shit all the time and I didn't have any problems with it. I guess I looked at him and saw how he was living and thought to myself, “I’m not as bad as D, I just like getting a little high,” you know? I just felt better when I was on the pills.

Travis contrasts prescription drugs with street drugs and suggests that the latter are more dangerous. For one, as touched on in Travis’ quote above, prescription medications are quality controlled. Street drugs, by their nature, are not. As Travis points out, one is never truly guaranteed to buy what the seller is saying he is trafficking. Because a drug dealer would have to go through lots of trouble to manufacture a pill that looks exactly like, for instance, a hydrocodone or a Xanax, there is a sense of assurance with prescription medications, even when they are bought on the black market. In addition, knowing that the pill came from a physician lends some sense of safety to its use. As Joshua Lyons (2009) states, sarcastically and in retrospect, after his own struggle with addition: “But with pills, you know that somewhere down the line, it came from a doctor. A safe, kindly doctor who knew just what you needed and would never distribute something that could potentially hurt you” (p. 9). Travis suggests that his friend D, who is also using pills in addition to cocaine and MDMA, is somehow doing worse than Travis. He seems to be suggesting that while he did not have “problems” with D’s illegal drug use, he did not see his use of pills as problematic because, at this point, it was still occasional and recreational. What appears to make D’s use problematic, from Travis’ perspective, is that he is using them “all the time.” It is this constant use that Travis sees as potentially
dangerous. He contrasts his own behaviors with D’s and feels that he is not like him, perhaps that he does not have the same problems as D because he’s only using pills and only using them on occasion. Whereas D might have a problem, Travis just liked “getting a little” high because it made him feel better. Travis is afraid of becoming a “junkie”, a heroin addict, and he is seriously concerned that this may be his destiny. He seems to use the comparison between himself and D to justify that his use was moderate and therefore preserve his identity as a user but not a “junkie” or an addict.

Hugh: I started using pills, first and foremost, to get off heroin. It was bad, like, it was just getting bad and I felt, at the time, I felt that doing pills wasn’t as bad as shooting up or snorting heroin. Now (laugh) of course now I see how stupid that was, but at the time I was just in a bad place. I had just gotten busted for intent to distribute and my girlfriend was getting off heroin and I just felt like, well, I’m gonna back off, I gotta get off this shit, and I had a good pill guy. Why not? It felt like, uhh, at the time it felt like I was stepping it back a bit. It felt different. I threw out all my gear –

TH: Gear?

Hugh: Uhh, yeah my needles and tourniquets and cooking spoons and all that. I just stopped. But then I was eating the pills and (laughs) like I said, it sounds stupid, but I thought it was an improvement at the time. Even my girlfriend, she wanted me off the heroin but, well, at first, she uhh she didn’t care about the pills.

Here as well, Hugh is concerned about safety. He sees prescription pills as inherently safer and a better alternative to his continued heroin use. Hugh’s concern about his safety is linked to his hope for his future and for his future with his son. He sees switching to pills as a way to manage the risk associated with drug use toward living a long life. Hugh was unique in that his use of prescription pills began as a way to stop using heroin and eventually became more problematic than his previous heroin use. However, this extract captures some of Hugh’s logic behind the switch. He clearly felt that moving from heroin to prescription painkillers was a step back. He even goes so far as to throw out his “gear.”
It seems meaningful that his heroin use required paraphernalia or instruments whereas the prescription pills did not. It is as if there is less of a commitment to the prescription pills than there is to the heroin. Hugh states that even his girlfriend, who was concerned previously about his heroin use, was not worried about his use of prescription pills. He seeks confirmation in his girlfriend’s view that using pills is a lesser deal to somehow give himself permission to continue to use. For him, taking pills was a way to reduce harm without having to seriously consider abstinence.

Hugh: And the thing was, I was just going through my day kinda stoned. It was different than before, because, uhh, with the heroin, I was kinda past just snorting it, uhh, I had to shoot up. I felt like I was wasting it if I didn’t shoot it. But when I was taking pills, uhh, I didn’t need anything else. I just kept them in my pocket and took them whenever. Before, uhh, well when I was working, I’d have to kind of plan my day around heroin. So, uhh, I’d shoot up in the morning and then have to think: “Ok, where are the good places to shoot up at work? Can I use this bathroom or whatever? Or, or will I have go to the car?” But when I was using the pills, I could take them right in front of people. No one batted an eye. I didn’t have to, uhh, like plan my day around using. People didn’t even ask me about it, like, “Oh shit man, are you sick? What are you taking?” They didn’t even say anything.

In this extract, Hugh goes a bit further in his reasoning behind the switch to pills. While heroin demanded that he structured the day around his use, for instance by planning when, where, and how he was going to use, his pill use was much less demanding. A major advantage of using pills, for Hugh, is that he could even use in front of co-workers and customers. It is interesting to notice, however, that he seems surprised that his pill use was not questioned by his co-workers. It is almost as if his drug use became invisible in contrast to the (possible) spectacle of his heroin use.

John: I mean, nobody really – well that's not true, but most people don't think that pot is dangerous. It's like beer, right? It doesn't really hurt you if you're not drinking a case a day, right? Pills, well, for me at least, pills
were like that for me too. They weren't dangerous, like heroin is, they weren't scary like heroin is.

John articulates his past perception of the difference between prescription drugs (which he groups with alcohol and marijuana) and other drugs, like heroin. He seems to suggest that the amount of a drug used can be problematic, but he does not see pills as dangerous in the same way as heroin is. In this view, heroin is scary. His concern here is also about the safety of certain drugs and the dangerousness of others. Similar to Hugh, though for different reasons as John is not a father, he fears the potential effects certain drugs may have on his health. His concerns with his own safety are linked to wanting to have a future, a healthier future. He later gets at this in a different way. John reveals how earlier experiences as a child worked to draw a distinction for him between the “harder” and more dangerous drugs and those that, by comparison, seem harmless.

John: That's kind of the image you get as a kid – right? “You try this shit once, little kid, and you're hooked for life!” That kind of thing. It's weird that I took that shit seriously, but I never really thought of pot or pills like that.

He is speaking again about the D.A.R.E. program and how it shaped some of his thinking about substances. He is speaking about the potential to become addicted to heroin after one use and his perception that other drugs (marijuana and prescription drugs) are less dangerous. Ostensibly, examining these two extracts, what makes heroin potentially scary for John is the perception of its intrinsically addictive nature. Given that opioids, historically, were the first drugs outside of alcohol to be considered dangerously addictive, this make sense that John would also share this perception. In contrast, what makes alcohol, marijuana, and prescription pills not scary is the perception that they are not intrinsically addictive.
Cultural Aspects of Prescription Medications as Safer Than Street Drugs.

As mentioned above, several of the participants seemed to see the fact that pills came from a pharmacy or a doctor as somehow indicative of their safety. This seemed, in part, due to the cultural power of the doctor and the pharmacy, and the ways in which they differed from the black market of street drugs. I previously referred to Norman’s interpretation that medication were safer because they came from a pharmacy and therefore they were obviously safer than marijuana bought in the neighborhood. There is a social stamp of approval there for Norman that, in part, leads to the perception of the drugs as safe. Other participants discussed how advertising for prescription medications influenced their perception that they were different from street drugs.

Bobby: There’s this damn commercial that I don’t see any more on the TV, but I remember it. It’s like this little ball scooting around his, I don’t know, his damn street or something. And he’s got this frowny face and I think, I think he’s even colored blue. He’s supposed to be sad, depressed and all. And he’s scooting around, rolling around his neighborhood and the voice on the commercial is talking about some pill that makes him happy. And the little ball takes that pill and it’s all good after that, like he’s all smiles and before there’s all these clouds and shit and now it’s sunshine and pretty weather and all that. Do you remember that one? I can’t remember when it was on the TV.

TH: No, sorry, I, uh, I don’t remember that one.

Bobby: Well, anyway, it was like that for me too. That’s how I felt when I was taking those pain pills, like that little smiley ball. All smiles and sunshine. I liked that commercial.

It is likely that the commercial was advertising anti-depressants, but the imagery seems to fit into how Bobby experienced pain medications, at least when he first started to use them. The cartoonish presentation of the commercial and the simplicity of its message (pills can make you happy) seems to mask the seriousness of the problem. But it appealed to Bobby at the time. It’s unclear if the commercial fit his experience or if the
commercial was part of the construction of Bobby’s experience, but it seemed powerful enough that he still remembers it several years later. Later on in the interview, Bobby states:

I kinda think its bullshit that they can advertise that shit on the TV. They don’t tell you that shit can kill you on the TV in them commercials. It’s legal and all, I mean I get that, but still man, they don’t say nothing about these things killing people. I figured that out later and was thinking, damn, how the hell does the damned government let these people put that crap on TV and not tell you that they can kill you? That don’t seem legal to me.

And though Bobby seems to possibly confuse anti-depressants and painkillers, he makes the valid point that the way in which prescription drugs are presented on television denies their potential danger. Given that the pharmaceutical industry has an interest in marketing their drugs as best they can to derive a profit from them, the dangers of certain medications are covered over in advertising. He states that he later discovered that certain drugs can be lethal, but at the time, and with his fond memories of the commercial, it seems that the way in which the drug was advertised led him to perceive prescription drugs as relatively safe.

Alternatively, other participants discussed how popular culture influenced their views of street drugs as particularly dangerous and to be feared. John already discussed, above, how he thought of soft drugs and hard drugs growing up and also mentioned how music influenced his beliefs about certain kinds of drugs. In the extract below, John links some of his fears of what he perceives as harder drugs (e.g., heroin) to the music he listened to as an adolescent.

John: I was really into Nine Inch Nails in middle school and high school. Like really into them. And I remember a few songs that seemed like they were talking about drug addiction or whatever. I can’t really, like now, I can’t really remember if they said or they were talking about heroin, but that’s what I always thought. Like, I knew they weren’t talking about
weed. That’s part of why I was so scared of those harder drugs, I think, because it was like, well, I was listening to Nine Inch Nails and thinking, “Damn, he was really fucked up on heroin.” I thought, “I’ll never touch that stuff.”

John argues for the influence that Nine Inch Nails\(^3\) songs had on his perception of heroin, which he sees this as clearly distinct from marijuana. John does not blame Nine Inch Nails for his later substance abuse problems. In fact, he sees his experiences of listening to this music as helping him take a stance against using heroin, which he never used. He seems again to be pointing toward the ways in which his earlier experiences led him to create a dichotomy between harmful and harmless drugs. He places his later drug of choice, prescription amphetamines, into the latter category. In hindsight, he seems to blame his naivety of thinking that prescription amphetamines were safer. Perhaps he sees these earlier experiences, which led to the dichotomy, as having set him up for using prescription drugs without the kind of care that what he would have had instead if he had seen them as harder drugs.

**Moving Away from an Ideal Self.**

*I guess I started thinking, Jesus Christ, what kind of father am I going to be to my son if I keep up like this?*

- Hugh

Nearly all participants described feeling that the first signs of their movement into an addicted identity began when they started noticing a shift from what they considered to be their ideal self. For Bobby and Norman, who had older children and were married, this ideal was related to being good providers and to their ideas of masculinity.

\(^3\) Nine Inch Nails is an American industrial rock founded by Trent Reznor in 1988. Reznor struggled with addiction to alcohol and cocaine and in many Nine Inch Nails lyrics describes his emotional experience of addiction.
Bobby: I was a bum, a junkie, after a couple years of that shit. I used to think of myself as a man. A man takes care of his family. A man makes the money. But I was like one of the kids and M was taking care of all of us. That’s just fucking embarrassing man. It took me awhile to get there though, but when I finally was just staring it in the face I felt like shit. I mean, it ain’t like it came outta the blue, I’d been pretty fucked up for years at that point. But it kinda hit me all a sudden like and I just thought, “Shit, I ain’t even a man no more.”

Bobby suggests that not only was his identity as a man compromised by his addiction, but his ability to be a functional member of a family unit as well. Having to rely on his wife not only as the sole financial provider but also as the main caretaker of the family was a strong hit on his view of his gender role. Bobby saw himself as neither a man nor an adult. He was embarrassed that his wife had to assume a role that he believed was his. It seems as if his wife has had to become mother to not only of their children, but also of Bobby. Realizing how far he has fallen from his ideal self is painful for Bobby. He denigrates himself by calling himself a junkie, in the same as Travis does when he feels an incongruence between what he feels he has become and what he feels he ought to be.

Travis: I gotta stop this. I'm a fucking junkie now, you know what I’m saying, only junkies do shit like that, get so fucked up out of their minds that they'd do something like that. You know what I'm saying? I wasn't the man I wanted to be, you know what I'm saying? And I wasn't on no path to be that man.

Though “junkie” often refers to a heroin addict, Travis seems to see this word as meaning just addict, regardless of the substance. He almost seems to see the junkie as less than human, as animal. Travis had previously discussed the ways in which he felt he was different from a cocaine or heroin user, a junkie, and here we see he is confronted with the possibility that though he isn’t using heroin or cocaine he may have also become a junkie. Here he’s speaking about coming off a recent pill and alcohol binge. He is also referring to coming to grips with the fact that he has missed the funeral of a cousin to
whom he was particularly close, but with whom he did not have the opportunity to resolve some unfinished issues before his death. By saying that he deviated from the path toward becoming the man he ideally wishes to be, he painfully realizes that he had to stop using drugs if he wanted to ensure or even have a future that was acceptable, in the sense of being somewhat in line with his view of being “the man [he] wanted to be.” For Travis as well as other participants, the addiction covered over the realization of this deviation. For Travis, the recognition that his substance use has become problematic comes, in part, for his fear of taking on a “junkie” identity through his actions. Travis sees himself as person in control, whereas a junkie is clearly someone who is not in control. A junkie is a man who “get[s] so fucked up out of their minds that they'd do something like that.” This “something like that” is incongruent with Travis’ sense of identity. These values are also connected to social and cultural factors that influence what kind of man Travis thinks he should be. He is violating not only his personal values, but also those of his culture (e.g., missing a family member’s funeral). Clearly he does not wish to live a life as a “junkie” or “addict,” which would be in direct contrast with the values that he has claimed for himself.

Norman: So, well, so eventually I got service connected and I go on disability and all that. So I didn’t have to work, I would want to, if I could. I hated not working, but… uhh, you know, what could I do? What can I do now? I just… uhh, physically, I just can’t any more. And I’m only in my 40s, you know? I just never thought it would come to this. I was always really physical. And not just that, but I couldn’t even be intimate with my wife. I would either be in pain or I couldn’t get aroused if I was high and not in pain. It was embarrassing, man! Uhn… I wasn’t making any money and I couldn’t make love to my wife. And I just felt like, “damn, uhh what

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4 Service connection refers to disability payments from the Veterans Administration for an injury, mental or physical, that can be proved to have been incurred while the veteran was active duty.
has happened to me?” I really never in a million years thought this is where I’d end up. I was just noticing myself thinking that. This is just never in a million years where I thought I’d be.

Like Bobby, Norman’s inability to work started as a chronic pain issue. Soon, his pain and medications affected his sexuality, creating an important dilemma for him: he was either in pain or not able to become aroused. For Norman, being able to be financially supportive and to be sexual is connected to his identity as a man and both of these identity dimensions have been affected by his pain and substance use. The fact that he cannot be intimate with his wife is obviously distressing to Norman. Also, he reflects on the fact that he never thought he would be living his life like this. There is obvious tension between his ideal self, as a provider and a “sexually-able” man, and the reality of his situation.

Like Travis, Norman recognizes that his drug use is interfering with his ability to live a life according to particular values that he has identified as important – such as being a provider for his family and being physically intimate with his wife. It seems that partially his drug use is about assuaging the pain of recognizing he is, in truth, not the man he used to be and that he can hardly be the man he wanted to be. Following his injuries, he is simply unable to physically (and sexually) perform as he did as a young man. He understands that his drug use was in response to his intense physical pain, but only later does he realizes the ways in which his drug use is also linked to his psychological pain. This creates a kind of vicious circle. Due to his chronic pain he cannot work and he takes painkillers to cope, but this affects his identity as a financial provider and his sexual male identity. In this process, Norman experiences the psychological pain of not living up to his ideal self. He feels “useless,” depressed, and
experiences a loss of meaning in his life. He then takes more drugs to deal with this psychological pain, which further contributes to his inability to work and his impotence. His identity becomes even more incongruent, in the Rogerian sense. He consequently experiences even more frustration and anger, which eventually lead to feeling depressed and stuck, and to the increasing use of drugs to cope with the pain of his daily living and lost identities.

In addition, for Norman generating income is very important to his identity, as a way of making meaning of his role in life. When he became unemployable, he lost this path toward finding a core meaning and a project to help make his life meaningful, and he struggled to find an alternative.

Norman: I just, well, at the time I didn’t care. I’d just go do my thing with those guys at the park, taking my pills, you know? Smoking and drinking, come home early and pass out. I just wasn’t the same guy. I think, uhh, now it’s more like… I guess I realized, I was trying to just deal with that I wasn’t that same guy. I guess I’m still dealing with it.

This extract reveals how painful it was for him to come to grips with the physical limitations that his chronic pain issues placed on him. He not only wasn’t the same guy physically, but his behavior is incongruent with the physical, working man he used to be. His life now is severely limited and he sees his substance abuse as a way of coping with the shift in his identity. He contrasts his meaningful life as a working man to his meaningless life as an addict. He socializes with “those guys at the park,” the men he uses with. The way in which he speaks about them as “those guys” suggests a lack of any real, meaningful connection to them. They’re merely “those guys” who help Norman waste his day. This is his narrow world: consuming drugs and alcohol and sleeping.
John: Well, really, it was probably after I graduated. Like I said before, my grades were OK, like I was able to hang together well enough to get my shit basically taken care of. They weren't great but I wasn't failing, right? So, it wasn't a problem. But it was probably after college that I started realizing it was a problem, like, it was a serious fucking problem. I didn't look for jobs, I just kept at it at the grocery store, which sucked because, you know, here I am, with this fucking degree that I just went into massive debt for, and those debts are coming due, and I'm checking fuckers out at the fucking grocery store, right? I didn't really have friends or any kind of social life. Really, I didn't see people too often after college, like, besides work. My parents, I think, well, I think they were starting to get worried that something was going on because I'd lost all that weight and just wasn't looking healthy. I didn't call them back right away when they called. Especially if I was on a binge because I was all speedy and cranked up and thought, shit they're going to fucking know I'm high, so sometimes a few days would go by before I returned their calls.

TH: Uh huh.

John: So, and this was probably, I don't know, maybe a year after I graduated and I'm just starting to feel stuck. And I'm slowly realizing that I don't have control over what I'm doing and, like, this is a path that I don't want to be on. You know, I guess one day, really, I guess one day I looked at my life and thought, “What the fuck am I doing?” I felt sick all the time, I was wasting like, like literally weeks and weeks of my life just speeding in my apartment by myself, you know, like just fucking around with video games or surfing the web. I remember how much I liked myself during my freshman year and I just, I don't know, I don't know, I just started falling apart I guess.

This extract reveals how John arrived at a place where it seems he does not fully recognize himself any longer. He sees himself far from his ideal self: he's working at what he perceives to be a dead-end job after he achieved his degree; he has lots of debt; he is not keeping in good contact with his parents, which probably makes him wonder about being a good son, which is another important aspect of his identity. He also shares his fear of losing control over his life. He sees himself stuck in a direction that he feels he cannot change. Although he rejects much of the Twelve Step language, he rubs up against another theme that many participants experienced – a sense of powerlessness over a
substance. He recognizes now that he was “wasting” time using drugs and is not living the life he would ideally be. John’s current situation is in sharp contrast with how he saw himself as freshman year of college – a part of his identity that he contrasts to his self as a drug-abuser.

For Hugh, being a good father was part of his ideal identity and his reflection on falling from this ideal is evident in this extract:

Hugh: Well, for me I was just at this place where I’m looking at my life and all I see is shit. My dad was an asshole and when he wasn’t an asshole he just wasn’t there at all. I grew up thinking, fuck that, I’ll never be like that with my own kids. I’ll never be like that. I mean, half the reason I got off heroin was because I didn’t want to be a fuck up and I wanted to be a good father and all that shit. But here I am, more fucked up than ever, and I just looked at myself and thought, damn son, look how far you have fallen. You know? I kept trying to do right but I just kept fucking up. And I just (pauses) I couldn’t look at my son in the face because I knew that he was remembering all this shit and he knew, you know, he fucking knew that I was a fuck up. I had fucking myself into a corner because I’m an addict and I just couldn’t handle it. Not the heroin and definitely not the pills. You’ve got to be fucked up in the head a little if you think you’re being a good father to your kid by getting off heroin and onto pills. You’ve got to be fucked up if you can’t see something wrong with that.

Hugh recognized that he wanted to be a different kind of father to his son than his father was to him, but he feels he has failed in this. When he recalls speaking to himself and saying “Damn son…” one wonders if he’s speaking to his own child or hearing the voice of his father. Either way, the disappointment is obvious. It also seems that part of the reason he cannot look at his son in the face is that he feels he has failed himself in his own promise to be a better father than his own father was to him. He also recognizes that being a good father and fulfilling an ideal self is incongruent with the reasoning that led to his addiction to painkillers. Hugh feels ashamed and guilty. He is overwhelmed by it when he looks in his own son’s face. He recognizes the nonsensical and desperate stance
of trying to get off one drug by using another and, more significantly for his sense of his ideal self, he fears he may have irreparably damaged his relationship with his son. This is a very emotional moment for him.

The experience of falling down is interestingly described by John in another extract:

John: Well, (laughs) it got worse before it got better, right? I really try to look at all of that in my past as lessons, right? I needed to learn certain lessons.... I'm just the kinda guy who needs to learn the hard way, right? There are people that just start living a certain way from the get-go, right, they just – and I don't know what it is. They just learn how to live in an easy way. Not me. Definitely not me! I had to get burned, right?! I had to get burned by the sun before I knew I was flying too high. Like Icarus, I always loved that story as a kid and it makes so much sense to me now: looking back, I was just like Icarus. I wanted to see how high I could go and didn't realize, well, didn't realize back then that I was going to fall if I flew that high. I think it's a bit odd, well, now that I'm older I think it's a bit odd that I loved that Icarus story when I was a kid.

This is an interesting metaphor on multiple levels, as the story of Icarus and his fall seems to echo Hugh’s statement about having fallen from his ideal self. John suggests that he had to fall to become who he is now. Though Hugh does not use the same language, he also had to “fly high” and get burned to come back down to earth. John and Hugh see some justice in this fall, similar to the hubris of Icarus who ignores his father’s warnings about flying too high. This fall, then, is not meaningless and useless. They needed to “hit rock bottom” in order to live a sober life that was more fulfilling and congruent with what they expected of themselves. Their respective experiences of the overused cliché, “it had to get worse before it got better” were painful but realizing. We see this here with both John and Hugh who needed to “fall” in order to move forward. John also realizes that he did not expect to fall, suggesting that perhaps he did not realize
he was flying too high until it was too late. These individual stories are telling, their experiences and lives, including their drug use, are also part of larger social and cultural contexts, which are explored in the next section.

Cultural Aspects of Moving Away from the Ideal Identity.

Many of the participants discussed that part of their identification as addicted was, in part, tied to a feeling of moving away from their constructions of masculinity, which were partially related to being a breadwinner, being sexually-active, and being a model to their children. Some of the participants, particularly Bobby, Norman, and Hugh, described learning what it means to be a man from their fathers.

Bobby: My daddy was the strong, silent type, as they say. Man never complained about nothing, man never bitched about going to work, didn’t matter how hung-over he was. The man did drink, he drank a lot, but he never missed work. Men were just like that back then: I guess, it was a different time. He always made sure we had food on the table and clothes on our backs, no matter what. He wasn’t one of them touchy feeling dads, but he did all the right stuff, the important stuff. Part of doing the meetings was hard for me because, well, you know, men ain’t supposed to talk about all their feelings and that.

Bobby feels he is not living up to his conception of what it means to be a man. He is clear that his father was the model for him and, as discussed above, not living up to these standards was part of what made him begin to question his drug use. For Bobby, becoming an addict was, in part, losing some of the qualities of being a man that he saw in his father. But he also begins to discuss how perhaps part of a sober existence means to accept qualities that do not neatly fit with his conception of masculinity. He talks about how discussing his feelings, as he began doing at the Narcotics Anonymous meetings, was difficult for him at first as this did not fit in with his previously held beliefs about his masculinity. As he started to recover from his addiction, he began questioning some of
the qualities of masculinity that he had previously held dear. Given the strong link between his gender identity and his father, this re-interpretation of his masculinity entailed also a re-construction of his father, whom Bobby is able to describe in some complexity. On the one hand, the father was an alcoholic. On the other hand, he was a good provider, with a strong work ethics, and Bobby wants to identify with this side of his father.

Norman also speaks about his father and his family played a powerful role in shaping his understanding of what it means to be a man:

Norman: Now, this is just how it was then. A man worked; a woman stayed at home and took care of the kids. And my dad and my uncles, they really took pride in their work. Never missed a day, even when they were sick. He worked into his sixties. I mean, you’re younger, but that’s just how it was. That’s how I was raised. I felt like I wasn’t living up to him, you know, you know what that’s like? When I stopped working and was boozing and taking pills and all that crap, I let myself down and my dad down. Especially for a black man, you know, my dad hated to be thought of as “one of those blacks that don’t work, don’t do nothing.” So, that’s what he did, go to work every day. They were real men back then.

Norman discusses how important work was to his father, his role model for what it was to be a man. He also mentions that his father’s racial identity was caught up with not being “one of those black that don’t work.” Norman feels that he has let his dad down because he feels that he had become one of those men who his father hated. The racial identification with the negative stereotype is a double challenge for Norman: First, it is an offense to his father’s values. Second, his drug abuse and his inability to keep up with his father’s work ethics provide a validation of the negative social constructions of black males. Although Norman does not talk about this, it is important to observe the typical self-blaming and Fundamental Attribution Error of people of color, instead of considering the role that the Stereotype Threat (Steel and Aronson, 1995), the anxiety and pressure a
person experiences when she or he has the potential to confirm a negative stereotype about her or his social group, likely played in Norman’s experience.

Interestingly, whereas Norman and Bobby did not mentioned popular culture in discussing some of their ideas about their ideal selves, the younger participants did so. For example, Hugh discusses television as playing a role in his construction of fatherhood:

Hugh: Like I already said, my dad was a piece of shit, really, I hated him. I still hate him. I don’t want to be that guy with my son. This sounds pretty fucking stupid, but I always thought I’d be like one of those TV dads to my kid (laughs), right? That’s what I thought being a good dad was, like, you know, being in a good mood, having a good job, always hanging around. That’s like totally not what my dad was like.

These very qualities of the “TV dad” that Hugh lists were absent from his life during his nearly decade long addiction. His ideal self, built upon the impossible and idealized TV father, was in complete contrast with his own father. Despite his ideal being based on fiction, it was his distance from this ideal that played a role in his identification as addicted. What made this fictionalized account of fatherhood impossible was its perfection. Likely, this was the reason why Hugh found himself attracted to the TV father, especially given the grave imperfection of his own father. The fiction-father is a fantasy: ever patient, loving, kind, almost more than human in his tolerance and wisdom. Yet, Hugh focuses on qualities of the TV dad that are not in themselves impossible, such as good mood, good job, and presence in the lives of his children. While in the midst of his addiction, Hugh felt that he was achieving none of these characteristics of the good father.

Addicted Identity: Marked By Denial and Avoidance.
If you don't think about bad shit then you don't realize that shit is bad.

- Hugh

All participants discussed using prescription medications at some point as a form of avoidance and escapism. A current of apathy also runs through the participants’ accounts when they were in the midst of their addicted experiences. However, this sense of apathy was almost a veneer under which people experienced a great deal of guilt and shame. For many participants, their drug use served not only to allow for a temporary apathy in response to the overwhelming emotions and situations of their lives, but it also helped to perpetuate this sense of apathy, creating a cycle. While many participants talked about feeling apathetic when they were using, the addiction perpetuated the apathy and the sense of dullness and meaninglessness in life, and in fact, they felt a great deal of pain underneath the haze of the drugs. The haze of drugs contributed to maintain a sense of disempowerment, lack of agency, and apathy toward life that covered over their psychological pain.

John captures this well in the following extracts:

John: Yeah, so, I loved the Adderall too because, well, because I was never bored. I was lonely sometimes, right, but I could always focus on whatever I was doing. And when I was focused like that I just didn't think about being lonely or being bored at all.

John: And I think, well I didn't think this at the time. At the time, I didn't see any problems with it. Right? But, like I said, in hindsight, it was pretty obvious that I was using to get away from my problems. Like being asocial and asexual.

John: So, and I know this is true for addicts, I love it because I could just escape from everything. I just didn't think about anything and I loved that, right? Because I didn't think about being lonely or sad or frustrated or whatever.
In the first extract, he clearly sees abusing Adderall as an avoidant strategy. The intense focus he experiences on amphetamines allows him to avoid his loneliness and boredom. The unpleasantness and distress of these emotions can be suppressed or avoided through the intense focus of the drugs. Avoidance can be seen as a way of coping with these unpleasant experiences, but the drug helps him avoid them so effectively and easily that it becomes his sole coping mechanism. It is interesting to observe the narrative sequence of his first statement: in the same sentence in which he discusses his loneliness, he also mentions his love for the drug. This seems to hint at the idea that perhaps his relationship to the drug (i.e., his love for the drug) replaced the friendships and relationships that are missing in his life at that time.

He insightfully recognizes that he was abusing drugs to get away from problems he started experiencing after he switched universities. He now recognizes for the first time that, while in college, he was deceiving himself through his drug use. While he originally perceived boredom and loneliness as the main emotions he wanted to avoid by using drugs, it is only later that he realizes that these emotions are the result of being socially disconnected and that the core of his problems was not the emotions themselves, but his lack of involvement and membership in a community. In the final extract, he recognizes the addictive character of using drugs for avoidance and escapism. He even states that he came to love the experience of being high because it allowed for such an effective avoidance of unpleasant emotions. Travis, similarly, sees his use as becoming a way of coping with boredom.

Travis: It got to the point where I was starting to spend the whole weekend drinking and eating pills and just fucking laying on the couch all day, you
know? Just fucking stoned out of my mind, sitting on the couch, doing jack shit, you know?

Travis points to the escapism that the drug abuse allowed. These are not pleasant memories. At this point, the drugs are not recreational any longer. They have become for him a way to run away from reality, spending his days on the couch doing nothing. Travis is not happy with himself at this point. It is unclear what the meaning behind “lay on the couch all day” is, but it is clear that, in hindsight, Travis sees this as a waste of his time and sees his drug use as enabling a lifestyle of complacency, “doing jack shit.” Bobby also mentions being on the couch during his drug binges, thinking of nothing. He is avoiding not just the unpleasantness of physical pain, but life itself.

Bobby: I was taking them originally so I didn't have to think about the pain, but I got myself to the point where I was taking them to not think about anything. Like I said before, it was easy to stay on the couch when I didn't give a fuck about nothing.

This extract from Bobby gets at the element of escapism as well. He is also in a state of being removed from the world, having little connection to anything, caring about nothing. He also recognizes that his drug abuse was a way to not think about his situation. He seems to suggest that part of being able to limit his existence was directly related to his drug abuse and the way in which it effectively cut him off from the world. It is easy to narrow one’s existence if one is apathetic in relation to it. The loss of possibilities is often experienced as a pain in itself, as psychological pain. The use of drugs made the participant’s able to be numb to the narrowing of their own possibilities.

Escapism is also part of Freddie’s experience. The following extract describes how drugs helped him cope with seemingly posttraumatic symptoms:
Freddie: It got really bad a few years after I got out of the Army. I just couldn’t handle the nightmares and being all fucking keyed up all the time. I was just thinking about that shit all the time, uhh, and I couldn’t get away from it. That’s when it really got bad, really bad.

TH: Really bad?

Freddie: Yeah, I was popping pills and drinking constant, like fucking constantly, like waking up and drinking and taking a bunch of pills. I couldn’t sleep if I wasn’t fucked up on pills and booze. I’d keep them next to my bed so if I woke up I’d just take a handful and chug some booze and go back to sleep. It was horrible, but I felt like I couldn’t do anything else. I didn’t have any other way to deal with it.

For Freddie, using alcohol and prescription medication was a strategy to seemingly avoid some of his symptoms while coping with others. To escape consciousness and the psychological pain associated with his traumatic memories, he tried to maintain a continual level of intoxication. Even his sleep was troubled to the point that he had to keep drugs and alcohol on his nightstand. Freddie was highly emotional during the interview: anger was the most salient and, perhaps, the most easily accessed emotion for Freddie during our time together. In particular, it seemed very difficult for him to admit that having been addicted was a sign of his emotional vulnerability and that the wounds still hurt him.

Freddie continues to discuss why he felt he was using to the degree he did:

Freddie: In AA they talk a lot about being an addictive personality and that shit. Maybe it’s true, I don’t really know, and I won’t put words in other people’s mouths. I don’t know what it’s like for them. But I know, I know if I didn’t go to war, I wouldn’t have gotten like that. Uhh, I just know I wouldn’t have gotten like that.

TH: Why not? What do you –

Freddie: Here, lemme tell you this: I saw and did some fucked up shit over there. And when I came home, it was just like nothing changed [while I was] over here, uhh, nothing changed. But I changed. You can’t do and see that shit and not change. So I was back home, trying to uhh, trying to
get back to my old life. And I just wasn’t the same guy. I didn’t know how to deal with all the shit that happened. The only thing I could do was get fucked up. I thought I’d just get so fucked up I wouldn’t remember. I just didn’t give a fuck about anything except nothing thinking about that shit. I mean, really, I didn’t give a shit about my family, my girlfriend, nothing. I just said, “Fuck everything!” Everything was fucked up.

Freddie sees a causal relationship between his war experiences and his later addiction. It is not that there was something intrinsic about his personality that led him to struggle with substances as he did. Rather, Freddie sees that he was changed by his war experiences and he turned to substance use in order to cope with the symptoms of those changes. In addition to the overseas trauma, returning “home” was not easy and required some adjustment. He feels that he did not fit in the same way back home. He was different, although things had largely remained the same. He is trying to fit a new version of himself into the mold of his previous self. But the fit is uncomfortable; the mold does not work neatly. Memories and experiences of war changed him. As he clearly states, he could not cope with his memories. Turning to drugs and alcohol was a way to deal with his symptoms, to avoid the painful memories by attempting to obliterate his consciousness and, with it, his traumatic past. Following his return, “everything was fucked up:” regardless of how hard he tried to find some congruence between the world he was experiencing outside of himself and the world he was struggling with inside his own mind, he failed. In a way, by getting “fucked up” – in the sense of becoming drunk, wasted, stoned, or high – Freddie was trying to psychologically match his sense that “everything was fucked up.” This can also be seen as a desperate search for agency: by abusing drugs, he was at least controlling his life, even if in a dysfunctional way, instead of being affected by his traumatic memories and PTSD symptoms. The psychological pain related to the trauma and the resulting change in his perception of himself was so
intense that it felt unmanageable. While escaping from his traumatic experiences and, to an extent, from himself was a strategy to cope with the pain, it led to neglecting his relationships and his own health. This is clear in other participant’s accounts as well:

Hugh: I really think I realized I was an addict when I didn’t care about anything except getting fucked up. I mean really, now I’m disgusted with myself, but that was only after. I had to walk through that shit, you know, hit the bottom, before I could really realize that. But when I was getting high, I tell you, man I didn’t give a shit about anything. Really. I didn’t even care about getting more pills until I started sobering up. That was my life for a while. Getting high, coming down, and getting high again. There wasn’t really room for anything else.

TH: Where was your son at this point?

Hugh: Fuck, he was with his mom then. It kills me now to think about that. Like I said, you know, she had left and she took him a few months before I started getting my shit together. Things will never work out with us. I mean, now, we’re friends, but I fucking burned that bridge so many times. I just pray now that [my son] was too fucking young to remember when I was really bad. I let them go and just didn’t give a shit at that point. They were getting in the way, you know, they were just like holding me back. So I pushed her until she left. And she took him with her.

Hugh saw his world as centered solely on drug use. The incredible sense of shame and guilt that he expresses regarding neglecting his relationship with his son was part of what brought him to sobriety. He seemed to have lost sight of his relationships when he was abusing drugs to the point that he neglected those closest to him. While he might have felt numbed to concerns outside of his relationship to the drug, it was the very fact that these important relationships were being neglected that seems to have shaken him out of apathy. Realizing the importance of the relationships that he had just lost led him to recognize the tragic effect of neglecting his family and of neglecting himself by abusing drugs.
In a similar fashion as John’s reference to Icarus, Hugh also talks about how he had to hit a limit of sorts. Interestingly, he uses Twelve Step language here that John has somewhat rejected. It is when Hugh finally realizes that his apathy has damaged aspects of his life that he sees as the most important, that he recognizes himself as addicted. Feeling in pain, guilty, and ashamed was the seemingly turning point for his identification as an addict.

He also discussed how no room was left in his life for anything but his drug addiction. There was no room in his life for his girlfriend and his son. He obviously regrets this part of his past, but states clearly that at the time they were obstacles in his way of continuing the cycle of intoxication. Bobby further discusses how he experienced the freedom from distress that drugs provided him.

Bobby: Heaven. It was like heaven. Before I'd be all pissed off that I couldn't work, that I was stuck inside all day with an aching back. Vicodin never really got me to a place where I didn't think about it. But Oxy did. Maybe 80 mgs and a six-pack and boy, I was in heaven. Didn't think about much of anything, no pain in my back, and I just kind of floated through my days. Didn't give a shit about much of anything.

In Bobby’s account, using Oxycontin is heavenly because it allows him to enter a place in which he does not have to think about anything. It is a heaven because he does not “give a shit about much of anything.” However, it is not that Bobby does not care about anything. In fact, he is able to avoid and cover over the anger, anxiety, and frustration he feels when he thinks he may be wasting his life. Though many participants discuss feeling apathetic, it is clear that they were not. They all seemed fearful of the awareness of wasting their lives. For those that were running away from something (trauma or something else), abusing drugs became a way to deal with the pain of a changed-self that
they do not recognize. The word “floating” gives an angelic but also ghostly quality to Bobby’s experience, which suggests he was just partially present in his life. This appears to be his way of trying to cope with a lack of meaning in his life. Without work, which for Bobby is tied to both masculinity and self-worth, his life here feels meaningless. He first started abusing substances to avoid the experience of pain but he achieves heaven when he is able to avoid experience all together.

Addiction as Powerlessness.

All participants, even those that rejected some of the central tenets of the Twelve Step model, discussed feeling that their experience of addiction was marked by powerlessness over their ability to control their drug use. For some participants, this even seemed to be the most salient and most indicative theme of their addiction. As with other themes, this one appeared to be covered over for many participants until they started to identify as addicted, at which point they found the concept of being powerless to resonate deeply with their experience. Both Hugh and Freddie speak to this:

Hugh: The first step is recognizing you’re powerless over drugs. You can’t control yourself, like, really, it’s not even a choice anymore. And, for me, but not just me though, I mean, this is what it’s about. It’s also in the first step that says, and this is important too, right: “Your life is unmanageable.” And my life was totally unmanageable. All I cared about for a long time was getting fucked up. It didn’t really matter if it was shooting up or eating pills. That’s where I fucking up, when I think back on it, that’s where I really fucked up. I thought they were different, like I said already, pills were different and I thought they were better than shooting up. But I’m an addict, that’s how we think, but it doesn’t matter what it is. I can’t control myself around them.

Freddie: I don’t know about the addictive personality shit, but I know I didn’t have any power over the pills. That part makes a lot of sense to me. I think that the Army definitely fucked me up. I don’t know if I’d be like this if I didn’t see that shit over there, but I do know that now I just can’t fucking control myself with drugs, or booze, or whatever.
Hugh states clearly that he feels powerless over his ability to resist using drugs. He accepts that he has no agency in regard to substances: he has no choice but to use. For Hugh, it does not matter whether they are pills or street drugs. His perspective had shifted. Where previously he saw these as two different kinds of substances, he now understands that his lack of power over both heroin and prescription opiates is the same. The fact that he discusses the first step as the first of the Twelve Steps points toward how well admitting that his “life is unmanageable” fits his experience. It makes sense to him that acknowledging his powerlessness over drugs would be the first step on his journey toward sobriety. Freddie rejects the idea of the addictive personality, as he has already discussed, but he takes up the idea of feeling powerless over substances, though he sees the possibility that his experiences in Iraq may have opened him up to being powerless. Freddie seems to find some solace in seeing himself as a victim, rather than as an active agent, someone who made the choice to use drugs. Regardless of the how of it, Freddie identifies as an addict. Norman also speaks to how his identification as an addict through the Twelve Steps fit for him.

Norman: It was just one of those things, I don’t know, it just made sense to me, you understand? It was like a little light bulb turning on and I knew that, hey, this is me. I’m an addict. I don’t have control over myself with drugs and alcohol, I am powerless over them. It just fit for me in a way that made so much sense when I first started. It gave me a starting point.

For Norman, the idea of being powerless over substances helped him to make sense of his own experience. In other words, he sees himself in the description of being powerless. Describing himself as feeling lost gave him a “starting point” and a direction for him to follow, whereas he was directionless while he was actively using. The image of the light bulb gives the feeling of a kind of sudden awakening, an awareness that helped Norman
to see himself in a different light. This kind of awakening was obviously a powerful experience for him.

   Though John does not see himself as powerless over all substances, he also speaks about his experience of feeling that he has little control over himself with regard to prescription amphetamines:

   John: Like I said before, I was out of control, with the pills. I was using them all for the wrong reasons at that point, you know? My life felt out of control because I think I was out of control with the pills. And “out of control” really gets at it because I didn’t have control over them. Like, like, I was out of control, like I had used it all up. I mean, it was beyond a habit, it really felt like that. I wasn’t something I was just used to doing: it felt like it was something I had to do. That part, you know, the first step part, that does make some sense to me. But it was just with Adderall, I never felt like that with anything else.

John discusses feeling out of control as if he had had a finite amount of control to begin with, at least in relation to his drug of choice. Unlike the other participants, John saw his pill use differently because of this feeling of not having control over his use. Similarly to Hugh and Norman, his recovery experience was marked by the first step of recognizing the power of addiction to make life unmanageable, in which he felt “controlled” by the drugs.

   Cultural Aspects of Addiction as Powerlessness.

   This was a theme that was clearly tied to the language of the Twelve Step model. It comes from the “Big Book” written by one of the founders of Alcoholics Anonymous, Bill Wilson. The first step reads: “We admitted we were powerless over alcohol – that our lives became unmanageable” (Wilson, 2001, p. 59). From a Twelve Step position this admission is necessary in order to recover. The participants, all of who had some exposure to Narcotics Anonymous and some of whom were active members, were all
very familiar with this step. Some even used words and expressions that were taken directly from Wilson’s book. It is not surprising that the participants who explicitly identified with the Twelve Step model thought that they should accept their powerlessness as vital to understanding themselves as addicted. Though this admission fits with the experience of many participants, it originated from the Twelve Step’s construction of addiction. For some participants, this conception of addiction seemed to fit their experience and helped them make sense of out their relationship to their substance of choice. By accepting the identity of an addict in recovery the participants were able to abstain from using prescription medications because they admitted their powerlessness over their substance of choice. Despite my own critical stance toward the Twelve Step programs and their construction of addiction and the addicted person, I was moved by how helpful these participants had found their experiences as members of the Twelve Step community. More will be said about this in the discussion section. Some felt that understanding themselves through the Twelve Step construction saved their lives.

Several other participants believed that they had to turn to a higher power in order to stop using, part of the second and third steps of the twelve. In fact, all of the four participants who used NA actively to stop their drug-use described turning back to their faith as part of their recovery. They also blamed turning away from their faith as part of their addiction.

Freddie: Man, I hadn’t been to church since I was a teenager. I even started thinking: “Maybe there is no God, maybe that’s all bullshit.” But when I was clean, I went back. God took me back, he’ll always forgive. I had to put my trust back in God to get myself together. I couldn’t do it by myself.

Hugh: I said I was Christian, even when I was using heroin and all that, but I wasn’t no Christian. Not really. You don’t just say you’re a Christian
and be a Christian. You have to accept Jesus and live your life like he told us to. I wasn’t living like a Christian for a long, long time, man, I just wasn’t. But when I started working the steps, it was like being baptized again. I didn’t just say it anymore but I’m trying to live my life like Jesus every day now. I know I’m not strong enough to fight this disease, but if I walk with Jesus, you know, he’s strong enough to fight it with me. I had to give myself up to God and Jesus before I could get clean.

Both of these participants think that part of their addiction involved turning away from their faith. Freddie even came to doubt his faith completely. They partially blame the loss of their religious faith and practices on their addiction. And, accordingly, they see that part of their recovery entails returning to their religion and regaining their faiths, as part of working the steps. Both of them see themselves as needing the help of a greater power to find the strength to resist the temptations and to significantly change their behaviors around their drug use. Part of their understanding of recovery seems greatly informed by the second and third step.

Hierarchy of Addiction and Resistance to the Twelve Steps.

Some participants discussed how they saw other people addicted to illegal drugs as different from themselves in some ways. In the following example, John mentions how he felt different from other addicts at NA meetings:

John: Well, so I said when we first met, for me Adderall was my drug of choice. Umm, which, (laughs) some people find funny. And – well – and I think that's the case for a lot of addicts that are addicted to heroin or meth or crack or whatever. They – and well, I mean to say some of them – kinda look down on pill addicts. Which (laughs) is kind of funny, you know? Like a heroin addict looking down on an Adderall addict. We're all addicts, right? But they don't think… well, it seems like they don't think that you can get addicted to pills like you can to street drugs.

John has come to see prescription pills as dangerous and addictive, but he is met with what he perceives as derision from other NA members at the meetings. When other AA
members did not recognize his struggle because of the substance he used, this felt unjust and hypocritical to John. John points to a kind of hierarchy amongst the addicted community in which the users of “harder” drugs like heroin, methamphetamine, and cocaine looked down on other drug users. He feels that he was placed beneath them somehow. John was turned off to NA when he experienced this sense of a hierarchy, which placed him at the bottom. This was important to John because he believed that his personal experience was invalidated by the way the other NA members perceived him. He saw his struggle as very real and wanted that experience to be validated by others. Those who were addicted to the “harder” drugs seemed to feel that their addiction was somehow more “real” or authentic, that their recovery was more difficult, and therefore their victory over the drug all the more laudable. John questions that the substance of choice holds any kind of true meaning. Rather, he suggests that addiction is addiction, regardless of which substance is involved – and he feels alienated by a group that seems to claim that his experience is somehow less valid than theirs.

In contrast to John’s feeling that he is placed by other addicted persons at a lower spot in the hierarchy, Travis seemed to see himself above people addicted to illegal drugs.

Travis: I started eating those pills in the morning before work just to keep my shit straight, you know, but I always showed up, I never called in sick or anything (pauses) okay, maybe a few times, but not like some of those fucking junkies, you know, that just drop everything. I never got that bad.

And:

Travis: I mean, some motherfuckers, they know they is a junkie and they just don't give a fuck. But that wasn't me, you know. I always prided myself on being able to handle my shit, you know what I'm saying. I wasn't a sloppy fuck up like that, you know what I'm saying?

As well as:
Travis: You know, a lot of motherfuckers can't do that shit, you know, they just can't do that shit. They try but they always go back, they always go back. Crack heads is like that, you know, dope fiends is like that.

In the last extract, Travis sees himself as fundamentally different from cocaine and heroin addicts. He is discussing how he stopped using prescription pills and how he feels that, because he was able to stop using on his own, he is different from other addicted people who continually go back to their substance of choice. The fact that he talks about “crack heads” and “dope fiends,” but doesn’t mention users of prescription medications suggests that he thinks that part of the difference between himself and other addicts is their choice of drugs. He also sees himself as different from what he calls a junkie and was very adamant about how he feels different from them. Travis’ desire to see himself as opposite to the junkie reveals his fear that perhaps he was a junkie. His need to other the junkie may stem from his self-hatred for behaving as one. By claiming that he is different from a junkie he is able to disown that part of himself that was junkie-like.

For Travis, it appears that rejecting the Twelve Step construction of addiction is, in part, for him a way of reclaiming his agency. While the Twelve Steps insist that he is powerless, Travis claims that he is powerful. He makes the choice to stop using rather than accepting his powerlessness over the substance. He does not seem himself as bound to his addiction in the same way as the Twelve Step programs would have him believe. For Travis, he made a choice to stop using opiates and that was simply the end of his “addiction.” Travis seems to have created this narrative out of a need to claim he has control over his own life, in contrast to the junkie who is ruled by his drug addiction. This interpretation and his telling of it during the interview serves to support the construction that he needs to make of himself. In a typical narrative circle (Ricoeur, 1990), the telling
tries to create a self-fulfilling story. In Travis’ telling of the story, it is not the story that
tells what happened, but it is the story telling that made the (construction of his) past
happen. His addiction could be seen as a set of problematic choices over several years,
rather than as the absence of a choice in relation to the drug. Travis never suggests that he
had lost complete control. It seems that it took several events for him to recognize the
extent to which his drug use was impacting his functioning and getting in the way of
living according to his values.

During the interview, Travis seemed to desire that I recognized that he was
different from the junkie. In other words, he sought my approval to further validate his
narrative. In contrast to most of the other participants, Travis did not see himself in the
Narcotics Anonymous image of an addict (Martin, 2010):

Travis: Nah, it wasn't like that for me. That's why I don't go to the
meetings, it just wasn't like that for me. I was done, you know what I'm
saying? When I say I'm done, I'm fucking done. I mean, I guess I'm an ex-
addict, you know, but I don't say: “Hey, look at me, you know, I'm in
fucking recovery.” I just do my best to stay away from motherfuckers that
are into that shit, you know? And just, well, it just kinda took care of
itself. I just pulled myself up, you know? Looked in the fucking mirror,
and that was that!!

Particularly, Travis does not see himself as an addict in recovery. It is unclear if, in his
view, this is because of a unique quality Travis believes he possesses (and that others in
NA do not) or if this is because Travis was addicted to prescription drugs. Still, Travis
takes pride over having worked through his addiction himself. He rejects the idea that
people who are addicted should always think of themselves as addicts, which is a
dominant theme in the Twelve Step Programs’ construction of addiction. John also seems
to hold this view:
John: Umm, well, honestly, I don't really like using a label like that. And I'll tell you why: I was an addict when I was using. Some people, like, well, a lot of people in NA and AA, they'll tell you that you're an addict for life. I just can't accept that, right? I mean, I think I was an addict during a particular time in my life, but I don't think I am any more.

John does not accept the assumption of powerlessness over the drug that is central to the AA ideology. For John, like Travis, he was able to stop using his drug of choice without having to come to understand himself as powerless over the drugs. In fact, in both of these participants’ cases, it was the opposite stance toward their behavior that led them to be able to stop their drug use, at least in the way that they narrate in their stories. Both of them accepted that they did indeed have power over the drug and, through this acknowledgement, chose to stop using them. They feel uncomfortable with the label “addict” or “addict in recovery,” because they no longer see themselves as addicted. Even if addict-in-recovery implies a different kind of addict, it is an addict nonetheless. One’s recovery is a never-ending process. One does not become “recovered,” but is perpetually in a state of recovery. By claiming power over the substance, they have rejected this possible view of themselves: they refuse to tie their identity to the drug and their recovery from it. By claiming power over the substance, they have also rejected the view of themselves as wounded, broken, or damaged. They may have been at a time, but no longer are. Their narrative about claiming their agency over the substance points toward the paradox in Twelve Step ideology discussed in Chapter Two, that in order to have power over a substance one must admit powerlessness over it.
Interestingly, both Travis and John identified as atheists, in contrast to the other participants. They did not directly discuss how their religious identification informed or impacted their relationship with the Twelve Step ideology, but nevertheless it is interesting and meaningful that all the other participants, who had used the Twelve Steps and largely accepted that particular construction of addiction identified as Christian, found that returning to or relying on their faith was instrumental to be able to recover from their addictions.

Differences and Similarities across Participants.

While the participants discussed coming to a point of apathy in their addictions, it appears that they were actually caught in a cycle that led to cover their feelings through using, to fall further from their ideal selves, and to cover over their guilt and anger about moving away from their ideals by using more. As mentioned above, several interviewees described hitting a limit at which time they felt like they could not continue as they were. For some, this was a reflection in the eyes of another. For others, it was the recognition that they had lost control. John illustrated the latter point by stating that he knew he needed help when he felt he could no longer control his use of Adderall. Travis also reached this point of feeling out of control when he missed his cousin’s funeral because of his drug use. For Bobby and Norman, it was the concern of family that finally reached them and they found that, after seeking treatment for their problems, they began to understand themselves as addicted. Hugh and Freddie reached this point after run-ins with the legal system forced them to face their choices and to realize the bottom point they had reached. All of the participants narrated reaching a place in which their avoidance and apathy were so high that it was impossible for them not to admit to
themselves that they were addicted. For many of the participants, this coincided with an acknowledgment of feeling powerless over substances. Many participants described this acknowledgement as a powerful turning point and as fitting cleanly with their own experience. They discussed the feelings of shame, guilt, anger, and disappointment related to having become something far from their ideal selves. They had reached a point where they felt they had lost their paths, given up their ambitions and dreams of their ideal selves.

Similarities across Participants.

A common experience that all of the participants discussed was that, while they experienced apathy and meaninglessness, their addiction actually served, at least temporarily, to meaningfully structure and organize their lives. As Hugh described above, his life was literally structured by a cycle regulated by consuming and acquiring pills. We see this also with other participants, like Bobby, who actively sought out sources to acquire the drug. Though they thought of themselves as addicts and saw their addicted existence as meaningless, clearly their behavior was meaningfully organized around their drugs of choice. Obviously, for all the participants, the cost of using drugs to organize and structure their existence was high. Nonetheless, their internal experience of apathy does not mirror their dedication to the drug that is observed in their narratives regarding their actual behaviors. Said another way, while they discussed feeling apathetic to everything, in their addiction they were far from apathetic in relation to their substance of choice. For all of the participants, the problem surfaced when they realized that drugs gave meaning to the lives they were living. These were not the kind of lives they valued. It seemed that for all of the participants, as very clearly stated in Travis’ account, the
turning point came when they realized they had strayed far from their ideal sense of self and their set of values. All of the participants realized as well that, during their periods of addiction, they neglected their meaningful relationships. It seemed that for many participants, reconnecting with these relationships and structuring their lives through the significant people they neglected were two key processes that helped them stop using their drugs of choice, or in the case of some participants, start living a sober lifestyle.

It was also clear that all of the research participants were, at some point, using drugs to escape their own experiences. For some, this was partially the experience of physical pain (Bobby and Norman) in addition to psychological pain. We saw clearly that apathy and avoidance of both internal and external experiences became part of the participants’ worlds while they struggled with their addictions. It seems that this period of apathy, a lack of concern with anything, obviously did not apply to the participants’ drugs of choice, but it did seem to suffuse much of their worlds outside of their relationships to the drugs. In hindsight, this realization that they were giving up on themselves and their lives was a major challenge and turning point for the participants, as they did not identify any longer with the person they had become. Each participant, for instance, discussed the painful experience of coming to grips with the ways in which they manipulated or distanced themselves from important people in their lives. For many, like Bobby, the acknowledgment of the destructiveness of apathy in important relationships seemingly served as the fulcrum to make changes in regard to their addictive behaviors. Hugh also discusses how he had become neglectful of other important relationships, outside of his relation to the drug. It was this awareness that led him to stop using, as if he had lost sight...
of what was important to him. When he glimpsed it again, it was terrifying for him to realize the price of putting the drug above his relationship with his son.

Despite the fact that participants described a kind of apathetic stance toward their worlds and relationships, it begs the question of the utility of escapism. It was, for many, the power of their relationships that helped to bring them out of their addictions. They were, as Hugh’s extract captures well, intensely guilty and ashamed, in many cases, about the ways in which their drug use had impacted these relationships, or led to the neglect of these relationships. So while they all expressed experiencing a period of not caring, it was the realization that this stance toward their significant relationships was damaging them that led them to consider themselves as addicted. In other words, the acknowledgement of the experience of wanting to escape, the need to get away from their world, due to shame or other painful emotions, led them to realize that they were addicted. In comparison to their love of the drug, they may have indeed felt indifferent to anything else. For several participants, their recognition that this apathy was destructive was instrumental in their identifications as addicted.

Alternative Voices.

One of the interesting and salient differences among participants came from John’s and Travis’s accounts. Both of these participants rejected the Twelve Step ideology and in particular the label of “addict in recovery.” Whereas other participants seemed to greatly benefit from thinking of themselves as addicts, Travis and John felt that this labeling did not capture their experience. While both John and Travis felt that they were indeed addicted when they were using heavily and compulsively, they both felt that since they had stopped engaging in drug using behaviors, they felt that the label of
“addict” no longer applied to them, Interestingly, both admitted to occasionally using marijuana and alcohol, but somehow, for them, these substances did not count as drugs in the same way that prescription pills did. Still, Travis and John rejected the lack of agency in relation to their drugs of choice – a lack that 12-Step ideology sees as foundational. Travis and John saw themselves as people who used to be addicted, but they did not identify as addicts in recovery in the same way as the other participants in the study did.

I will continue to elaborate on these superordinate themes in the Discussion chapter, which will connect the findings from the present study to the larger body of addiction research.
Chapter 5: Discussion

As detailed in the introductory chapter, addiction is not a new problem in the United States. The twentieth century, however, saw the emergence of the pharmaceutical industry and the general booming of a culture of pharmaceutical drug consumption. Initially fueled by the optimism of the post-World War II era, breakthroughs in the sciences led to exponential growth in the medical field. This growth led to new markets and industries, together with massive financial investments and overall golden profits. In just two decades, the adolescent pharmaceutical industry was forever changed and, by the end of the twentieth century, it became one of the biggest industrial sectors in the world. As a result of the changing social constructions of pharmaceuticals, drugs were for the first time directly marketed to consumers as solutions not only to physiological and psychological pathologies, but also as enhancers of normal, everyday life.

The questions in the study revolved around how people who became addicted to prescription medications understood their addiction, and further, how these understandings differed between people addicted to prescription medications and those addicted to illegal street drugs. The introduction served to illustrate not only the United States government’s response to narcotics in the twentieth century, but also the rise of the pharmaceutical industry through a case study of the tranquilizer class of drugs.

In Chapter Two, the phenomenon of addiction was explored from a historical perspective which concentrated particularly on the tension between perceiving addiction as a medical problem versus perceiving addiction as a problem of individual will: the disease model and the moral model. While these two interpretative frameworks simultaneously inform experiences of addiction, neither one of them was independently
able to fully capture the participants’ experiences of addiction. For instance, the Twelve Step approach underscores that addiction is first and foremost a medical pathology; a person’s self-recognizing that he or she is sick is the first step toward recovery. While all of the participants involved in the study had exposure to Twelve Step programs at some point, some of the interviewees took up the Twelve Step ideology as a way to both understand their addiction and make sense out of their recoveries, whereas other participants rejected some of the foundational concepts in Twelve Step ideology and therefore came to understand their experiences of addiction somewhat outside of the Twelve Step framework. So, while the Twelve Step programs endorse a pathological model, some of the participants rejected the assumption that the person has no agency and is practically helpless and powerless in relation to the pathology.

Chapter Two also explored the ways in which the biological and moral models of addiction tend to obscure the culturally and historically constructed nature of addiction. These aspects of addiction were examined with the goal of making them more visible. In some ways, the entire project was an attempt to serve as a corrective to mainstream psychological research into addiction, to add an alternative voice to the research on addiction by not only emphasizing individuals’ unique experiences but also questioning the dominant ways of constructing the concept and experience of addiction. Chapter Two opens up the question of why addiction appears as it does in contemporary culture. Partially, this was understood as a way of coping with or answering postmodernity’s challenges to traditional culture, starting from the loss or weakening of referents and master narratives. The data analysis, in part, examined the ways in which participants used prescription drugs as a way to cope with the demands of a postmodern culture on the
self, in which identity is more fluid and less tied to strong referents than in the past (Cushman, 1996; Dunnington, 2011). From this perspective, addiction can be seen as an active, adaptive response to the lack of a clear, communal consensus on how to live the good life. However, as described below, this “adaptive” response brought with it a heavy price in the lives of the research participants. In addition, many of the participants’ account did not seem to clearly tie back to the demands of postmodernism, therefore challenging this theory.

The literature on addiction has been seemingly receptive to qualitative methodologies. One of the most salient reasons for this is the subjectivity of addiction, which also justified the choice of a qualitative research methodology for this particular area of study. In addition, the need to rely on patient self-reports in order to make a diagnosis of substance abuse or dependence also requires the researcher to reflexively consider relational (i.e., social, cultural, and political) processes, which are more easily understood from a qualitative viewpoint. Post-World War II research into addiction began to consider the contexts within which people with addictions lived. While the first explorations were mostly quantitative, it soon became clear that the mere analysis of variables could not make justice to the complexity of personal interpretations and social constructions. It was not enough, for instance, to study the effect of poverty or race without understanding social economic status and racial dynamics were understood by drug users and the contexts in which drug-use took place. Research that examined the subjective experiences of addicted individuals became recognized in the field.

Despite the amount of research on addiction, its translation to social and public-health policies and interventions was slow. The rise of prescription pill abuse and
dependence that began at the end of the twentieth century has steadily continued to climb in the twenty-first and has not been as well studied as addiction to illegal or street drugs. Therefore, this project also contributed to partially fill this gap, while at the same time trying to give an alternative perspective on addiction based in both theory and participants’ experiences.

Conclusions

Most of the work that led into my own thoughts about addiction consisted of writing the first chapters of the dissertation. Through researching and considering the history of addiction, the rise of the medical model and the Twelve Step programs, and the explosion of the pharmaceutical industry in the twentieth century, I found myself becoming critical of the medical model of addiction. During my time in graduate school, I participated in the Scaife Fellowship in Alcohol and Drug Dependence. It was a fascinating experience, even more so because of the apparent disagreements across various treatment programs and individuals regarding the nature of addiction. Some seemed dedicated to the idea that addiction was a disease and that the individuals afflicted with addiction were not fully responsible for their behaviors. Other seemed to see their patients as having significant moral flaws and saw their behaviors as obviously tied to their inability to resist their own desires. The latter camp tended to hold a very suspicious view of the addicted person. They did not express much compassion toward their patients and they seemed rather firm in their views and beliefs about this population. Admittedly, the more I fleshed out my own understanding, the more suspicious I found myself becoming toward addiction and the addicted. Having had little contact with addiction or addicted people prior to this fellowship, it seemed odd to me that there was
so little agreement, even amongst treating professionals, about what addiction was. The
question of how addiction appeared, now, in our contemporary culture seemed more and
more ambiguous to me.

Borrowing from Dunnington’s conception of addiction and Heyman’s scathing
critique of the medical model of addiction, the conclusions I reached were a mixture of
the moral model and a rewriting of the choice model. Dunnington’s link between the loss
of referents and drug use made sense to me. It seemed the addiction was a choice, an
answer to the questions that the postmodern era posed to people living in it. The ubiquity
of the Twelve Step model increased my suspicions. Further, the revelation of AA’s
lobbying power and involvement in the medical field led me to believe that the Twelve
Step’s philosophy was one of many theories competing to describe a phenomenon as
compelling, complex, and polemical as addiction. I progressively came to see it as a
theory and position that had bullied its way into prominence and become dominant not
through the power of its argument, but through the power of its connections. It seemed to
me that it was less the power of the arguments that made this theory so powerful, but the
power of those who espoused the theory that made it so. I began to question who really
benefitted from a construction of addiction like this. However, when I started the
interviews and listened to the stories of the participants my thoughts on addiction became
more complex. I had imagined that the addiction phenomenon to prescription-pills would
be different in some substantial way from the abuse of illegal street-drugs. The most
prominent way in which it appear differently was in the perception of its relative safety.
In most other respects, it seemed to be very similar to other reports of addicted persons’
experiences.
Culturally, the Twelve Step model shaped, for better or worse, the way in which the participants understood and experienced their addictions. Even the two participants rejected this model’s constructions of addiction and recovery, still understood their own experiences in relation to the Twelve Step model. They primarily resisted the construction of the “addict-in-recovery” concept (i.e., “I was and ever will be an addict and therefore must be ever vigilant in order to resist its temptations”), but not necessarily the idea that they were addicts at a particular time of their lives.

Only one participant, John, explicitly saw his drug use as a way of coping with a loss of community and the identity that was associated with being a member of that community. He clearly saw his abuse as way of dealing with the boredom and social isolation he experienced after leaving the college community with which he very much identified as a source of meaning and direction. He was the only one who saw his drug use, even if only in a very particular moment of his life, to be an answer to the questions raised when he was unsure of who he was and where he stood in life. The other participant, Travis, who rejected the Twelve Step idea of the addict-in-recovery, saw his “addiction” as a series of bad decisions that resulted in a habitual, chronic, and problematic use of substances. He did not see his use as negative in itself, but rather the functional impairments that came with his heavy use. Really, Travis saw his use as problematic because it had reached the point in which it was not tempered by moderation.

It seems difficult to fit the other participants’ accounts neatly into a category that explains their use as adaptive or functional, in contrast to Dreyfus and Rubin’s (1994) work. Three of the participants that found solace and meaning in the Twelve Step model found their use peaking during periods in their lives when their identities was most in
transition. Freddie was using to cope with possible PTSD symptoms and with his adjustment to a civilian life. Both Norman and Bobby were adjusting to living with chronic pain and the ways in which their pain had closed off their possibilities of working. For both Norman and Bobby, not working meant that they could not identify themselves as breadwinners in their respective families. This left them struggling to find an identity outside of this prescribed gender role. While all of these participants identified with the addict-in-recovery, they did not understand it as a way to find a new identity, as Emrick (1989) suggests.

At the time of the interview, Bobby and Norman were still trying to figure out what they were or they could be, if they were not working men. Freddie continued to adjust to a post-war, post-military life. Hugh was still trying to be a better father than his own. If anything, their identification with the Twelve Steps made these questions more salient than before, as this model seemed to fit with their experiences. Rather than answering these identity questions and developing a functional sense of purpose and meaning in their lives, these participants seemed to see their use as a way of obscuring the need to find an answer. In other words, rather than helping them to answer the questions, their experiences with addiction seem to be an attempt to delay the answers or delay the need to find answers to the questions. It was a way of putting things off.

All of the participants reported early, positive experiences with drug use, which fits with a Twelve Step conception of the addict, who is always an addict rather than a person who develops a taste or, in recovery, a distaste for drugs. All of them felt hopeful after meeting other people who had previously struggled with addiction and found community amongst these people. They did not report experiencing their addictions as
adaptive or functional, but clearly saw their roles in Twelve Step programs as giving them a sense of direction, hope, and support. As stated above, their memberships in these communities did not answer or even fully address questions around their identities. They were still left trying to figure out who they were and how they fit into their worlds. While the participants took on the identity of the addict in recovery, found a community of people struggling with similar problems, and worked the steps as part of their recovery, each still was left with the same questions about who they were and who they wanted to become.

Implications for Clinical Practice.

One of the important implications of this research is that it supports the seemingly obvious psychotherapy maxim that the therapist must meet the patient where she or he is. While four of the six participants used the Twelve Step model heavily in their recovery, two of the participants were turned off by the dogma of Narcotics Anonymous and did not find the community to be helpful toward their personal recoveries from addiction. Both of them were able to decrease or eliminate their use on their own, but this raises the question of how many addicted persons, turned off by the Twelves Steps, have difficulty finding help outside of AA or NA? The Twelve Steps are ubiquitous in every U.S. major city and in most minor cities for a number of reasons: they are free for members; they are anonymous and will keep personal information outside of healthcare networks; there are no real alternatives to AA or NA on the scale of these programs for those who choose not to work them. Two of the six participants were able to make significant behaviors changes on their own, but this points toward the need for treatments for addiction that understand addiction outside of the medical or disease model. In meeting these patients
where they are, instead of imposing a predefined ideology, other addiction and recovery models may help the many who are not suited, for whatever reason, to successfully engage in a Twelve Step-oriented substance abuse program.

While I personally entered this research highly critical of the Twelve Step model, I was positively challenged to recognize that this program was clearly useful for many of the participants. While bracketing one’s own thoughts about addiction seems common sense from a theoretical perspective, it is much more difficult process to achieve in practice. Addiction is a polemical topic and there are extreme views of how it should be treated. Different patients are going to see different benefits from various treatments, but perhaps a thorough evaluation of the patients’ view and perspective of addictions would be a helpful addition to a treatment planning session that focuses on substance use as the presenting problem. It seems that too often the forgone conclusion is that a certain program will work regardless of the patient, for instance in court-ordered attendance at AA or NA. This project clearly shows that this cannot be assumed to be always the case. For example, for a patient such as John, who clearly sees his drug-use linked to existential questions about his own identity and experience, psychotherapy would be more helpful than sending him to attend NA meetings. There is a certain relation here the concept of external vs. internal locus of control. The Twelve Step model proposes that one’s freedom in relation to the drug is forever limited. Addicts will always want to use and will always use irresponsibly when they do. Therefore the addict must abstain, if he is to remain in control of his life and possibilities outside of using the substance. This sounds like the drug has the control and the addict has none – that the control is external to the addicted person. Perhaps an evaluation related to the patient’s sense of whether
their locus of control is primarily external or internal may be a fruitful avenue for research into whether a patient would benefit from a Twelve Step program or from an alternative approach. More research is needed in this area to better flesh out how individual differences might impact clinical practice.

Implications for Further Research.

The present study examined the ways in which the research participants understood themselves as becoming addicted to prescription drugs. One of its most interesting findings concerned the ways in which all of the participants saw the use of prescription drugs as less dangerous than the use of illegal street drugs. All of the participants suggested that their perception of prescription drugs as safer was part of why they began abusing them. For example, one participant started using prescription opiates in order to stop using heroin, as he felt that pills were clearly safer. Two participants struggling with chronic pain originally saw their use of prescription drugs as completely justified because a medical professional, an authority, had prescribed them. It was only later, when they began using doses higher than those prescribed, that they started to question their physician’s understandings of their pain. Still, more research is needed in order to better explicate how the perception of prescription drugs as safe may affect the ways in which people become addicted to them. Given the sharp increase in the abuse of prescription medication discussed in the first chapters, this will continue to be a pressing concern not only for researchers, but also for treating professionals, medication prescribers, regulating officials, public health professionals, and pharmaceutical companies. There is obviously a need for a large-scale public health campaign and for greater training for prescribers related to discussing the implications of taking potentially
dangerous medicines. Research into the efficacy of such campaigns or training would be helpful in order to establish how to best educate the consumers as well as prescribers of these medications. These drugs work well under certain conditions and their use is likely to increase in the future.

A second interesting finding that warrants further research is related to the counter-narratives of the two participants who rejected the Twelve Step ideology and were nonetheless able to successfully stop their compulsive use of drugs, as already discussed in the implications for clinical practice. Given that Twelve Step programs have contributed heavily not only to the public perception of addiction but to its treatment too, it is clear that alternative voices outside of the Twelve Step tradition might often be silenced by the dominant narratives about addiction. In their telling, these two participants pointed out the importance of feeling that they were active agents who could control their drug use. Unlike the call in Alcoholics Anonymous or Narcotics Anonymous to admit that one is powerless over a substance, these two participants were able to claim agency over their drug use and, consequently, break the compulsive cycle of use. It would be interesting and useful for future research to explore the outcomes and experiences of people who did not embrace a Twelve Step framework to stop engaging in drug using behaviors. This research may offer useful clinical and theoretical implications into the conception and treatment of addiction. The recruitment of such participants might be more difficult, as the Twelve Step community seems open to discussing their own stories and thoughts about addiction, and are easily located by a simple Internet search. To find those who do not agree with this model might be more difficult. There is not an alternative that even mildly competes with Twelve Step programs and therefore
actually engaging with people who stopped their use without the aid of the Twelve Steps may be difficult to identify and recruit. Nevertheless, more research into the views of this population might shed greater light on how to design and implement alternative programs that may be better suited to treat individuals who, for whatever reason, do not fit with the Twelve Step ideology, model, or program.

Lastly, the current project was necessarily limited, given its purpose of exploring participants’ experiences of becoming addicted to prescription medications. All of the participants were male. It would have been interesting to see the ways in which female accounts of becoming addicted to prescription medications differed from or coincided with the male accounts. Also, in terms of participant recruitment, most of the recruiting took place at NA meetings and this clearly affected the participant pool, as most of the participants were sympathetic to the basic idea of Twelve Step programs and therefore understood their experience of addiction through this lens. Further study with participants recruited from alternative programs or who have not entered a recovery program yet would enrich the data and give room for perspectives outside of the mainstream. However, engaging with these individuals may also prove to be more difficult due to the ubiquity of Twelve Step programs across the nation.

Closing Remarks

The following themes emerged from the data within the context of the research question: early experiences with drugs, a perception of prescription drugs as safer than street drugs, a movement away from an ideal self, denial and avoidance, and a sense of powerlessness. Despite my own hypotheses and theoretical conceptions around the idea of addiction, few of the research participants saw their own experiences of addiction as
resulting from a lack of meaning in their lives or as an adaptive response to the lack of communal structure and purpose in our postmodern culture. Those that preferred a Twelve Step model seemed to see themselves as inherently addicts and were clearly happy that they were able to rely on a community of the like-minded to steer themselves through the initially rough waters of abstinence. Though they took on the identity of addicts in recovery, this identification did not seem to blot out other important pieces of their identity, such as being fathers, sons, and members of a community outside of and bigger than NA. While I was initially somewhat surprised by this, and even possibly disappointed that these participants did not share my critical stance toward the Twelve Steps, I was also pleased to see that this program seemed to have worked for them and had not subsumed them in the way that I thought likely when one engages in the Twelve Steps. I suppose I had assumed that Twelve Step followers would be as “addicted” to abstinence and the way in which it guided their identity, as they may have previously been to drugs. This did not seem to be the case when I met with these individuals, who embraced a view of themselves that was much more than addicts-in-recovery. In regard to prescription drugs, the theme of safety was the only one that set this study’s participants apart from those addicted to illegal substances or alcohol. Although some participants seemed to see NA as hierarchical, with those addicted to prescription medications at the bottom, most did not. However, given the initial perception of safety around the use of pharmaceuticals, obviously more must be done at both national and patient-prescriber level to help better educate patients who may be prescribed medications with potential for abuse or addiction. It is unclear how the course of events around the participants’ experiences of addiction could have been different, if these
individuals had been thoroughly informed about the risks of their drug use. Many participants said that they abused substance they knew to be dangerous prior to using pharmaceuticals. Yet, consumers of these medications deserve to be fully informed. In addition, since other participants, namely Travis and John, did not identify with the Twelve Step model, further research on and development of alternative programs might better serve substance users who reject or are not good fit with the Twelve Steps. Travis and John were able to stop their compulsive use of their drugs of choice without subscribing to the Twelve Steps.

In closing, I would like to thank my participants. Each and every one had the courage to make serious, painful, changes in their lives and to work toward something better for themselves. And they were willing to talk to me, a stranger, about their hopes and fears, their shame and their guilt, because all of them wanted to help other people who may be struggling with addiction.
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Appendix 1

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CONSENT TO PARTICIPATE IN A RESEARCH STUDY

TITLE: Addiction to Prescription Drugs: An Interpretative Phenomenological Analysis and Constructionist Study

INVESTIGATOR: Thomas M. Hallinan, M.A.
2809 Westgate St.
Houston, TX 77098
412-XXXXXXX

ADVISOR: Dr. Marco Gemignani
Department of Psychology
412-XXXXXXX

SOURCE OF SUPPORT: This study is being performed as partial fulfillment of the requirements for the doctoral degree in clinical psychology at Duquesne University.

PURPOSE: You are being asked to participate in a research project that seeks to investigate the experience of becoming addicted to prescription drugs. I am interested how this experience has affected how you understand yourself, your relationships with other people and your world. I will be interviewing you about your experience and will audiotape and transcribe our conversations. In addition, I will contact you after our interview to discuss how your experiences may be similar or different from the experiences of other people who had become addicted to prescription drugs. We will meet at a private and secure location that we will both discuss before on the phone before our in person meeting. Likely, this location will be at a treatment facility office or a room in a Narcotics Anonymous meeting place. These are the only requests that will be made of you.

RISKS AND BENEFITS: During our conversations I will be asking you to tell me the story about your experience of becoming addicted. I may ask questions about your childhood and family life in addition to questions about your current and past relationships with significant people. You may experience distress while discussing how your experience of addiction has affected your life. You may also find that discussing your experience leads to a deeper understanding of what you have gone through. Your participation in this

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study may potentially help contribute toward improvements in the treatment of addiction. I will have a list of options, including the contact information for counseling centers, should you experience distress during the course of our interviews.

**COMPENSATION:** You will not be compensated for your participation in this study. However, participation in the project will require no monetary cost to you.

**CONFIDENTIALITY:** Your name will not appear in any of the transcriptions of our interviews or in the analysis of your interview. I will place a coded name on the interview data and keep a list of names and codes in a locked cabinet. The audiotapes of the interviews will be destroyed after I have transcribed them and will be stored in a locked cabinet until they are destroyed. Identifying materials, such as references to jobs or locations that could be used to identify you, will also be removed from the transcriptions of our interviews. In addition, the names of and identifying material related to other people you might mention will be removed. All written materials and consent forms will be stored in a locked file in the researcher's office. Portions of your transcribed interview will appear throughout my dissertation as well as in an appendix. The list of coded names and actual names will be destroyed at the end of the project.

**RIGHT TO WITHDRAW:** You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time. You have the right to request that your interview data be removed from the study at any time.

**SUMMARY OF RESULTS:** A summary of the results of this research will be supplied to you, at no cost, upon request.

**VOLUNTARY CONSENT:** I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project.

I understand that should I have any further questions about my participation in this study, I may call Thomas M. Hallinan, M.A. (412-303-8837), Dr. Marco Gemignani, Dissertation Committee Chair (412-396-1376) and/or Dr. Joseph Kush, Chair of the Duquesne University Institutional Review Board (412-396-6326).

Participant's Signature Date

______________________________

Researcher's Signature Date

______________________________

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