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A Discursive Analysis of Addicted Users' Accounts of Opiate Addiction

A research report submitted to the Faculty of Humanities, University of the Witwatersrand, Johannesburg, in partial fulfilment of the requirements for the Degree of Master of Arts (Clinical Psychology) 2005

Declaration

I declare that this research report is my own work. It is being submitted for the Degree of Master of Arts (Clinical Psychology) at the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at any other university.

_____

Vincenzo Sinisi

_____ day of _____ 2005

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Abstract

This research report undertook an original exploration into the workings of addiction. The theoretical insights of discursive psychology were applied to the study of opiate addiction and were used to analyse the manner in which using and non-using informants were able to constitute addiction through discourse. By comparing the discursive accounts of self-defined recovered, recovering and currently addicted users, the report highlighted how ways of speaking about substances and their use may be implicated in the maintenance and cessation of addiction.

The transcripts of four focus groups, consisting of a total number of 15 informants, were qualitatively analysed using a thematic method that focused on the informants' strategic use of discourse. The analysis revealed important differences between using and non-using informants in terms of the self employed discursive practices that they used in constructing their experience of addiction. Differences included variations in the attribution of agency to either the opiate or the informant and the degree to which opiate use was presented as cause for concern or not. These and other differences were explored in detail together with their potential implications, functions and apparent effects on the users' capacity to maintain abstinence as opposed to continuing to use.

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Chapter 1 - Introduction and Rationale

1.1 Introduction

This research report is exploratory in nature. It applies the theoretical insights of discursive psychology (Edwards & Potter, 1992) to the study of addiction. This allows a novel exploration into the workings of addiction and the manner in which individuals are able to constitute it, and its characteristic behaviours through discourse. Attention is paid to the discursive strategies used by the informants to portray their experiences of addiction as legitimate and an emphasis is placed on the implications of these strategies. The personalities of the informants and how or why they arrived at the position they have in life, do not form the focus of the study. Instead the interest lies squarely on the informants' language as the fundamental site for studying addiction as an action.

The work begins with the assumption that discursive attributions construct substance use for both the listener *and* the addicted speaker, and that this construction may impact on an addicted individual's relationship with a substance. This issue is explored by analysing and comparing the transcripts of four focus groups. Each group consisted of individuals at a particular stage of substance use and/or recovery. The intention was to compare the manner in which informants at different stages of recovery construct their substance use and to consider if any differences noted could help explain, or even facilitate the informants' recovery or lack thereof.

1.2 Rationale

The motivation for carrying out this research stems from two independent sources. The first is theoretical and includes the limited scope of available research and the inability of dominant theoretical models of addiction to account for choice, agency and free will (Davies, 1992). The second is both more practical and more pressing and involves the need to clinically comprehend the mounting relevance of opiate addiction in the Southern African region. This situation is compounded by the increasing availability of heroin, the spread of HIV and AIDS (South African Community Epidemiology Network on Drug Use (SACENDU), 2004), the limited number of treatment facilities and the poor efficacy of existing treatment models. The study aims to better understand the language of addiction and recovery with a view to informing therapeutic practices and thus interventions. Both of these motivations are elaborated.

1.2.1 Limitations of current research perspectives

Substance abuse and its related conditions receive considerable international attention and a wealth of rapidly progressing research exists within the field. However, as extensive and valuable as this research may be, it is subject to certain limitations.

The vast majority of existing research is biomedical in nature and studies addiction as a physiological condition. This approach to addiction places its emphasis on identifying and explaining its underlying and causative structures in the hope of developing an effective medical treatment (Schaffer, 1991). This approach has proved fruitful and boasts several pharmacological developments (such as Subatex, Methadone and Naltraxone[1]) and advances in neurology (Volkow, Fowler, & Wang, 2003). However, prioritising 'underlying' structures provides a skewed account of addiction that portrays its lived experience as a secondary and uninteresting phenomenon. Apart from providing prescriptions of what it means to be addicted, addiction is extracted from its social and political context (Heim, Davies, Cheyne, & Smallwood, 2001) and the addict's subjective realm of reference is ignored despite being a potential source of enlightening information.

Understanding the addict's own frame of reference and role in addiction is important if we are to develop a holistic understanding of the individual's experience, particularly when one considers that it is generally outside of the clinic, hospital and university that those afflicted make sense of their addictions. Yet, as Quintero & Nichter (1996) point out, it appears that it is also outside of the clinic where the least research into addiction is carried out. This is significant as it is the generally more personal or commonsense understandings that professionals must engage with when treating afflicted individuals.

While the lack of emphasis on the addict's experience is particularly evident in biomedical work, Hanninen and Koski-Jannes (1999) argue that it is not unique to these approaches. They note that the majority of research into addiction is based on paradigmatic thinking and aims to explore techniques of change and ways to influence behaviours. Indeed very little research attempts to shed light on the experience of addiction and even less research pays attention to any discursive elements that may be involved.

Davies (1992 & 1997) argues that while there are studies that attempt to uncover the experiences of addicts, most fail to take into account the attributive qualities of the addict's narratives. That is, these studies often ignore the activities and intentions of the speech and its reflection of the motives, intentions and affiliations of the person interviewed. For example, the reasons an addict gives for their relapse may have no bearing on the true cause. They may reflect his/her understanding, they may be an attempt to serve some other intention, or they may be both (Davies, 1992). Unfortunately

[1] Subatex, Methadone and Natrlaxone are agonist and antagonist therapies which are used in the treatment of opiate dependence.

most methods of analysis (e.g. content analysis) are unable to account for this (Potter, 2000). Statements are seen to represent some truth and so are often taken out of context (Heim et al. 2001). Reasons are taken as causes and very little attention is paid to the constructive capacity of the reason, why it was presented, how it might function and what implications it may have (Davies, 1992; Heim et al. 2001).

One of the consequences of the above is that current research and addiction theory has difficulty in accounting for the will or capacity of the addict as an active agent. Concepts such as compulsions, loss of control, need, cravings and biological dependence, portray the addict as a helpless victim (Davies, 1992). Addiction is in many respects defined in opposition to willed behaviour and the idea of the individual as an independent agent actively engaged in a set of behaviours arising from decisions that s/he has taken and is capable of making is lost (Davies, 1992).

It is the researcher's intention that this project's focus on the individuals' subjective positions, along with the conceptualisation of addiction as an action for which the addict is ultimately responsible, will begin to address some of the above failings.

Rather than approaching the subject from within deterministic explanations of abuse, the narratives of substance users are compared and scrutinised in order to explore the implications of the language and metaphors used by them. Addiction is addressed as an action or activity and is not viewed as an automatic reaction to some objective, underlying neurological circumstance. The contribution of factors such as neurobiology are recognised as important in understanding addiction, but they are not prioritised over the discursive practices through which addiction is constituted and portrayed.

Within the research project addiction is addressed as an action and the assumption that the verbal accounts of the informants are accurate representations of some fixed or relatively stable separate "thing" is avoided. The accounts are viewed as representing an active process through which something is being constructed, and which achieves a particular end. Addiction is approached as something that the addict *does* rather than something s/he is, has, or is subjected to. Not only is this approach relevant from a psychotherapeutic point of view, in that it holds what the individual does as central, it also reclaims the individual's agency by highlighting his/her own role in addiction. S/he is thus reintroduced as a responsible actor without applying moral judgment or ignoring the great difficulty and complexity that may be associated with his/her circumstances.

1.2.2 Relevance of the topic

Substance abuse and addiction are enormous and pressing international social problems which devastate millions of lives. An estimated 13 million people are thought to be opiate dependent in terms of recent prevalence rates, and of these, 9 million use heroin (European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 2000). In the Southern African region heroin use has steadily increased at a disproportionate rate to that of other drugs and the age of onset of use has seen a simultaneous decline (SACENDU, 2004). This is problematic as the age of onset is inversely proportional to the probability of developing a substance related disorder (American Psychiatric Association, 2000).

Approximately 40 kg of heroin was seized in the Southern African region in the first half of 2003, and in Mauritius over 50% of the patients seen in the tiny island's 8 specialised treatment facilities listed heroin as their primary substance of abuse (SACENDU, 2004). South Africa, in particular, has seen a 400% increase in the use of heroin since 1997 with the average age of users dropping from 23 to 21 years (SACENDU, 2004). The problem appears to be growing with drug related crimes increasing by 14% between 2003 – 2004 (South African Police Services (SAPS), 2004).

There is little question that the cost of opiate addiction is staggering and that it impacts heavily on already over-burdened healthcare, treatment and law enforcement facilities. Social problems are aggravated by substance abuse and addiction which are both associated with increases in violence, spousal abuse, teenage pregnancy, school failure, low worker productivity, homelessness, crime, poverty, mental illness and the spread of HIV and AIDS (Nargolis & Zweben, 1998). For example, more than a quarter (27%) of intravenous users tested HIV positive in Mauritius in 2003, with intravenous use indicated as the sole mode of transmission in these cases. This is an increase from 7% in 2001 and 14% in 2002 (SACENDU, 2004).

South Africa faces unique difficulties which leave it particularly vulnerable to the problems associated with substance abuse. Its favourable geographic positioning, open borders and quality infrastructure make it an attractive location for international drug syndicates, particularly since the political changes of 1994 (Shaw, 1998). Increasing amounts of illicit substances are currently trafficked through South Africa and have resulted in increasing availability (United Nations Information Service (UNIS), 2002).

South Africa, like its neighbours, is pressed for resources and sufficient specialised treatment facilities are simply not available (Daneels, 2004). This is especially true for individuals who do not have access to private medical aid schemes or finance. Health problems associated with HIV and AIDS have led to government medical facilities becoming over-burdened, with mental health clinics equally stretched. Difficult decisions are made regarding who will and who will not receive

treatment. Addicts are often viewed as noncompliant and troublesome and this leads to many being turned away from psychiatric clinics and hospitals that prefer to reserve their beds for more 'critical' or compliant patients. Those who do access treatment frequently relapse as success rates are low, with relapse rates estimated to be between 60% - 90% internationally (Harrison & Hoffman in Selekman, 1991; Peele in Selekman, 1991). Some argue that there is little evidence to support the use of formal treatment at all and suggest that addicted individuals do equally well relying on their own devices and support networks (Cunningham, 1999; Klingemann, 1994; McIntosh & McKeganey, 2000; Stall & Biernacki, 1986; Truan, 1993).

The above factors highlight the need for, and relevance of research attempting to develop new and creative ways of understanding and approaching addiction. It is hoped that research such as this may augment existing prevention and treatment modalities and aid in the development of innovative and potentially more effective interventions. This study aims to contribute towards this pressing need.

1.3 Structure of Report

This research report is divided into six chapters, including the preceding introduction and rationale. The focus of each of the remaining chapters is outlined briefly.

Chapter two reviews the literature surrounding addiction and is divided into three parts. The first part presents a brief history of the category of addiction and highlights its socially constructed nature. The second part outlines the four dominant contemporary approaches to addiction and the final part provides a critique of these approaches and concludes with a discussion of the advantages of the approach undertaken by this study.

Chapter three expands on the theoretical frame or epistemological assumptions of this research. It begins by briefly explaining some aspects of poststructural theory and then moves on to provide an outline of some relevant tenets of discursive psychology specifically.

Chapter four outlines the method that the researcher followed during this study. The chapter covers the aims of the study, the selection and recruitment of the informants, the design of the research, the data collection, the method of analysis and the ethical considerations that were taken into account.

Chapter five presents the findings of the analysis. Since the findings and discussion are integrally linked, they are covered under a single detailed chapter. This is followed by sixth and final chapter which consists of a synopsis of the research findings, a brief discussion on reflexivity, implications for treatment and finally, an outline of some of the limitations of the study and recommended avenues for further research.

Chapter 2 - Literature Review

The literature review is presented in three parts. The first part presents a brief history of addiction. The section highlights that our understandings of addiction are tied to our social circumstances and reflect both political motivation and objective reality; i.e. addiction is shown to be a socially produced category dependent on other related categories, such as medicine, drugs and the conventions of being 'proper' (Truan, 1993). Shifts in theoretical and social understandings of addiction suggest that 'addiction' is fluid and dynamic construct, rather than a static and inflexible entity which exists in an unchanging vacuum.

The aim of including this section is to draw readers' attention to the socially constructed nature of addiction as a category. Doing so enables one to appreciate that the way we see and approach addiction is fundamentally linked to the systems of meaning or knowledge available to us. The same is presumably true for the addict whose relationship with his/her substances is as likely to be affected by what s/he 'knows' about it, irrespective of the validity of these ideas. The section also helps to orientate the reader to the nature of the analysis carried out by this work and intends to provide the reader with an understanding of how contemporary understandings of addiction have been reached.

The second section of the literature review outlines the four dominant contemporary models of addiction, i.e., the moral, social, psychological and disease/biomedical models. Each of these models is elaborated. A critique and discussion of the psychological and disease models is provided in the third and final part of the literature review and the advantages of the approach employed by this research project are put forward with reference to the critique of other models.

Part 1: A Brief History of Addiction

1.1 Early Understandings

Since the beginning of history members of the majority of societies have altered their consciousness through the use of psychoactive substances. Yet the meanings surrounding these practices and the institutions that have come to regulate and describe them vary considerably between social and historical milieus (Brecher, 1972; Levine, 1979; Peele, 1987; Pittman & Snyder, 1962).

Prior to the 19th century, many now taboo substances, including opium, were freely available in Europe and the USA. Opium was sold in a variety of medicinal preparations (e.g. paregoric, laudanum etc.) which were easily obtainable, unrestricted and commonly used. At one time opium preparations were even recommended to help parents calm their crying children (Musto, 1997; Willis, 1970). What is interesting in respect of this research is that even though opiates had already been in use for centuries, the social attitudes towards them were very different from ours today. While opiates and other some drugs were considered to be potentially dangerous, the concerns referred to possible toxic effects rather than addictive potentials (Steinberg, 1969). Such substances were subject to destructive habitual use but prior to the late 18th century this type of use was understood in terms of character flaws of the individual and not properties of the actual substances (Levine, 1978; Room, 1983). The will of the individual, his/her moral standards and his/her strength of character accounted for excessive use as a morbid vice or exaggerated appetite; an understanding which reflected similar moral connotations to those associated with greediness (National Institute of Health (NIH), 1997; Peele, 1990; Steinberg, 1969).

It was only towards the beginning of the 19th century that physicians began reporting addiction in terms of overwhelming and irresistible desires caused by the substance (Levine, 1979). Medical projects of the time, under the influence of the temperance movement, then began explaining addiction as a natural consequence of even moderate alcohol consumption (Levine, 1979). Hence the idea that substances can be inherently addictive was first systematically developed in relation to alcohol and only later extended to other substances, so that alcohol was thought to be addictive long before the opiates (Levine, 1979).

Early medical explanations of addiction centred on explaining the observed physical symptoms of addiction (e.g. tolerance, withdrawal etc.). Immunochemical theory was one such explanation and proposed that the excessive ingestion of a substance would stimulate the body's formation of

particular antibodies or antitoxins to neutralise that substance (Musto, 1997). Over a period of time the production of those antibodies would become constant, requiring the then addicted individual to continue to ingest a certain amount of the substance in order to maintain a physiological balance with the antibodies or antitoxins produced (Musto, 1997). Immunochemical theory could then explain the symptoms of withdrawal as indicative of the vast amount of un-neutralised antibodies turning against the body in the absence of their target substance (Musto, 1997).

While these early disease models of addiction represented attempts to advance science they also served to further the political interests of medicine. Addiction was explained through reference to physiological pathology and bodily processes and as such it came to resemble a disease. Addiction became an object over which medical science could exercise certain privileges and it was included in medicine's repertoire of treatable diseases. Although the proponents of the temperance movement advocated abstinence as the only treatment (Levine, 1979) the 'disease' was generally treated by maintaining addicts on gradually decreasing doses of alcohol, much like the methadone programs of today (Musto, 1997). Unfortunately for early addiction medicine, the political climate in America was changing and these privileges were not enjoyed for long. The late 19th and early 20th centuries were times of serious social instability, and crime and immorality were increasingly blamed on narcotic and alcohol use (Musto, 1997; Peele, 1990). Addict maintenance programs were now treated with scepticism and in the end were regarded as unsuccessful in their attempts to locate the antibodies and antitoxins said to cause addiction (Musto, 1997). Together these factors saw the respectability of physiological explanations diminish in favour of a return to more punitive or moralistic models (Peele, 1990).

The increased moralising of addiction resulted in the passing of the anti-maintenance bills in 1919 in America. These bills saw to it that any doctor found attempting to treat a patient's addiction would run the risk of imprisonment, and addiction was, along with its class of patient, thus forcibly excluded from medical assessment, care and treatment (Musto, 1997). Substances were now portrayed as a societal threat and the problem of addiction was replaced with the "drug problem". During this period of the early 19th and 20th centaury both opium and alcohol were defined as producing inevitable social and moral decline in those who used them. Interestingly, while alcohol soon broke free from the clutches of this moralising depiction, narcotics became increasingly socially unacceptable (Peele, 1985).

1.2 The 1920's to 1960's

The dominant definitions of addiction arising during the twenties and enduring up until the sixties continued to reflect a struggle between an emphasis on morality or physiology. Physiological explanations gradually gained ascendance and so individual characteristics came to be viewed as less important than the characteristics of the substance in defining and addressing addiction. For example in 1929 an addict was defined by a USA interdepartmental committee on morphine and heroin addiction as a person who does not require the use of a drug for the relief of some organic disease, but has acquired its need as a result of its repeated administration, producing an overpowering desire for its continuance, and its withdrawal leading to definite symptoms of distress or disorder (Steinberg, 1969). In this definition it is still the person and not the condition that is described in outlining addiction but attention is primarily directed to the effect of the substance. The individual *becomes* an addict and becoming an addict is the result of repeated exposure to substances. Moral overtones are also apparent in the definition's highlighting that the individual did not require the substance but chose to use it nonetheless.

Later in 1935 addiction was defined by the same committee as a state of bondage to a drug, usually, but not always, of the narcotic class, and as manifested by craving, tolerance, withdrawal, and the tendency to relapse (Steinberg, 1969). Here addiction becomes increasingly defined in terms of medical descriptions of physiological effects (tolerance, withdrawal) framed in relation to the class of the substance. Addiction becomes a term applied in differing degrees to different drugs (e.g. "usually of the narcotic class"), specifically implicating the properties of those drugs as causing addiction. Substances were now officially accountable for addiction and the characteristics of the individuals using them became less important (Orford, 1992).

In 1952 the World Health Organisation requested that the terms 'addiction' and 'addict' be exclusively reserved to refer to the relationship between a user and their *illegal* substance of choice. Addiction was distinguished from habituation where the former referred to the inevitable consequence of repeatedly using a chemical defined as a priori addictive (e.g. Opiates):

"There are some drugs, notably morphine… whose pharmacological action, under individual conditions of time and dose, will always produce compulsive cravings, dependence and addiction in any individual. Sooner or later there must come a time when the use of the drug cannot be interrupted without significant disturbance, always psychic and sometimes physical. Such drugs must be rigidly controlled." (Steinberg, 1969, p.7)

The habitual use of substances not defined as addictive was also outlined:

"There are other drugs which never produce compulsive cravings, yet their pharmacological action is found desirable to some individuals to the point that they readily form a habit, [these drugs] do not need rigid control. Thus, habituation is defined by some degree of psychological addiction to the effects of the drug, but an absence of an abstinence syndrome" (Steinberg, 1969, p.7).

With the cause of addiction now almost entirely explained in terms of substances' properties, rather than the immorality or conscious will of the abuser, drug-addiction came to represent a unique condition distinct from other compulsive behaviours, for example, gambling or sex. This position was made clear during 1964 when the World Heath Organisation's Expert Committee on Addiction Producing Drugs decided that the addiction/habituation distinction was no longer workable. The decision was taken partly because addiction had become a blanket term applied to several unrelated compulsions (e.g. sex addiction). A new term was deemed necessary; something more 'scientific' that would apply solely to drug use, and would be able to distinguish between the different compulsions induced by different substances while providing a rational explanation of such conditions (Anthenelli & Schuckit, 1997; Orford, 1992). Drug-dependence, distinguished as either psychological[2] or physical[3], was put forward as an alternative and was divided into 5 further subtypes, i.e. morphine, barbiturate, cocaine, amphetamine and cannabis type. Each type reflected the characteristic syndrome now accepted as being induced by each substance (Steinberg, 1969; Willis, 1970). This system still closely resembles that outlined in the DSM IV-TR today (American Psychiatric Association, 2000) (Appendix A).

The presentation of shifts in understanding of addiction over the last 100 years or so illustrates how the concept of addiction is shaped by the society and historical period in which it exists. This understanding of the cultural and historical relativity of 'drug addiction' is consistent with a discursive or social constructionist perspective, which contends that the meaning of behaviour is contingent on historical and social forces and that, consequently, it is vital to consider the cultural and social contexts which impinge on the construction of our understanding of behaviours.

[2] Psychological Dependence: an overwhelming psychological commitment to a particular drug, resulting from its repeated use and identified by the afflicted individual's persistent thoughts of compulsive use, and inability to remain abstinent from that substance (Doweiko, 1993; Kaplan & Sadock 1997; Orford, 1992).

[3] Physical Dependence: a condition reflecting the biochemical/pathophysiological metabolic changes of the body in response to the particular pharmacological effects of the drug. A state of physical dependence is reached once the presence of that drug becomes mandatory in maintaining homoeostasis and is indicated by the development of tolerance and a characteristic withdrawal syndrome upon the cessation of that substance (Doweiko, 1993; Kaplan & Sadock 1997; Orford, 1992).

Part 2: Dominant Contemporary Explanations of Addiction

Since the World Health Organisation's redefinition of drug addiction as a form of chemical dependence a variety of positions attempting to explain the condition have been generated. Although the psychological/physical dependence distinction still remains, categories of addiction now encompass a highly complex heterogeneous group of debilitating disorders with multifactoral origins (Anthenelli & Schuckit, 1997). Presently there are five dominant models of addiction. These are the moral, social, psychological, disease/biomedical and most recently,+ the biopsychosocial, models. Not a distinct theory in itself, the biopsychosocial model combines three of the preceding models and is noted to highlight an awareness in the field of the inadequacy of the more narrowly focused attempts to explain the condition.

The remainder of this section will turn to the above mentioned models and provide a brief outline of each of their frameworks. A critique or commentary is provided where relevant, and an attempt is made to highlight each model's significance with regard to this research endeavour.

2.1 Moral Theories

The moral theories are largely informal in the sense that they fall outside the professional or 'scientific' domain. They understand addiction from one of a variety of moral or religious positions and tend to adopt one of two key perspectives that will be outlined further.

The first perspective describes the addict in a manner similar to some of the early understandings of addiction outlined previously. The addict is viewed as an individual of questionable moral status and as self-indulgent. Hence s/he uses substances in the manner that s/he does because s/he willingly prioritises their use over more constructive and socially desirable responsibilities. Addiction is not viewed as a disease, illness or expression of some other underlying concern, such as poor impulse control or genetic vulnerability. It simply reflects a destructive, illegal and morally reprehensible set of choices and behaviours which the individual could and should correct by adopting a more desirable set of moral or religious beliefs and associated behaviours.

The second perspective also understands addiction in terms of moral degradation, but places its emphasis on the moral fabric of society. The proliferation of substance use and addiction are explained to be the result of a breakdown in broad social values. The collapse of the nuclear family, secularisation of society and increasing moral and social decay are thought to promote substance use as increasingly acceptable and hence lead to its increasing prevalence.

These kinds of moral positions on addiction are by no means outdated, uncommon, or absent from the minds of people in the helping professions. They represent a view of substance abuse which is very much alive and expressed formally within various religiously orientated rehabilitation centres, and colour the personal attitudes of some health workers.

2.2 Sociological Theories

The sociological theories of substance abuse, like the second moral position, account for addiction by referring to factors external to the individual, i.e. the situations, social relations and social structures of the abuser's context (Cohen, 1990). These models may look to peer-groups, subcultures, socio-economic standards, cultural milieu and political circumstances for answers as to why individuals become addicted (Johnson & Muffler, 1997). For example the apartheid system of South African might be understood to have contributed to the way in which Mandrax use came to be a problem predominantly affecting particular race groups.

Another interesting, although marginal example, would be the political economy model of addiction. This model holds that addiction is the product of bourgeois medicine, alienation (in the Marxist sense), poverty, global markets, and labour forces (Singer, Valentine, Baer, & Jia, 1992). Drugs are portrayed as villains in the media and it is argued that they ironically distract the attention of society away from the conditions in our environment which render drug use a functional form of coping. Drug use is comprehensible in a capitalist world where instant gratification is promoted and lauded. For Singer et al (1992) substance use and abuse is inextricably linked to bourgeois patterns of consumption and particular ideological and structural features of capitalism.

Although sociological models are able to help us understand why it is that an individual or social group may come to use a substance (e.g., high exposure due to socio-economic status etc.), they generally offer little to explain why individuals sometimes continue to use despite the emergence of significant negative consequences. Sociological explanations of addiction are unable to offer significant insight into how to help addicted individuals, short of restructuring their social circumstances. As such, these theories tend to be viewed as extensions of the psychological and biomedical theories of dependence presented below (Peele, 1976).

2.3 Psychological Theories

In contrast to sociological theories, psychological approaches generally locate their understanding of addiction as occurring within the 'mindset' of the individual (McMurran, 1994). Psychological approaches can be loosely divided into three categories: cognitive behavioural models; psychoanalytic models; and family systems theory models (Nargolis & Zweben, 1998). Each is briefly reviewed in turn.

2.3.1 Cognitive-behavioural models

The cognitive-behavioural models originate from a variety of conceptual bases including cognitive, classical/operant conditioning, social learning and modelling theory. These theoretical frameworks assert that human behaviour is learned rather than genetically determined and that behaviour is driven by the tendency to seek rewards and minimise negative consequences (Nargolis & Zweben, 1998).

The abuse of drugs is seen to begin and to continue because it offers some form of reinforcement, such as euphoria, social reward, peer acceptance, esteem, or relief from pain, anger, anxiety or depression (Jaffe, 1992; Shaffer, 1992). However, what begins as a pleasure-seeking activity or the masking of a problem, often ends in a trap of pain avoidance with the now consumed individual committed to that substance in order to cope with the added, induced psychological pain, i.e. chemically induced depression/anxiety, and to prevent the negative consequences of withdrawal (Jaffe, 1992).

An addictive cycle is often entrenched as the addict attempts to reduce the negative consequences of their drug related behaviour and to avoid facing the pain of their new circumstances by employing a number of irrational defence mechanisms. For example, individuals deny experiencing difficulties with the substance, negative consequence are minimised or attributed to other causes, and very careful attention is taken to rationalise inappropriate behaviour (Haidiman, 1998).

From the cognitive-behavioural is perspective, addiction is viewed as a habit similar to compulsive eating or gambling. It is felt to be amenable to behavioural analysis and modifiable through the application of the same principles of learning that led to its development (Hadiman, 1998). Irrational thought processes are modified, problematic consequences are highlighted, negative behaviours are discouraged and positive ones are reinforced. In essence the addict, while recognised as in need of

help, is portrayed as able to alter addictive patterns and as personally responsible for such change. The discursive analysis undertaken by this study shares some similarities with the cognitive model however; a discursive analysis extends beyond perceiving an account or way of thinking as 'irrational'.

2.3.2 Psychoanalytic models

Psychoanalytic models approach addiction with an eye for deficits and possible predisposing factors within the personality of the abuser. While psychodynamic theory recognises substance abuse as a problem, the abuse is not understood as the root of the problem. Instead it is viewed as either symptomatic of, or an indirect consequence of some other underlying psychopathology (Nargolis & Zweben, 1998).

Although the search for the addictive personality has for the most part been abandoned (Haidiman, 1998), some common characteristics have been identified amongst addicts which link addiction to underlying emotional difficulties. Faced with impairments in self-regulation, affect tolerance, poor self-development, low self-esteem, and a limited ability to maintain relationships, substance abuse becomes something of an adaptive mechanism (Brehm & Khantzian, 1997). Practically, it offers the abuser a way of achieving social status, while simultaneously providing a psychological retreat from the realities of separation, neglect and/or emotional distress (Steiner, 1990).

Psychoanalytic theories of addiction are broadly based on either early or contemporary analytic theory. Early psychoanalytic theory emphasized a fixation in the oral phase of psychosexual development, latent homosexuality and/or other internal conflicts, as underpinning addiction. Substance use was seen to follow the pleasure principle in that it enhanced pleasure and aided in the alleviation of pain (Rado, 1926). The addict was portrayed as craving a return to a presupposed original state of idealised bliss and substances offered an available substitute for this state. Substance use was viewed as a means through which intolerable anxiety, rage and shame could be warded off and unconsciously expressed through the destructiveness of the habit (Glover, 1932).

Contemporary psychoanalytic formulations rely less on theory relating to early fixations and are now typically based in the ego or object relations schools (Nargolis & Zweben, 1998). These schools highlight the substance's capacity to manage or mask unpleasant or otherwise intolerable emotional states. Substance use is viewed as an adaptive response to deep-seated or unmet unconscious needs and disordered personality structures and development (Keller, 1992). Addiction is explained in terms of an individual's progressive attempts to manage the needs and deficits arising from early

infantile deprivation and maladaptive parent-child relationships (Nargolis & Zweben, 1998). Substance use is viewed as an attempt to self-medicate underlying emotional disturbances with the substance selected for its ability to function as though it were an emotional 'prosthesis' (Khantzian, 1985; Wurmser, 1974, 1984).

Kernberg (1975) describes addiction as a symptom of a borderline personality organization. Substance use provides a means through which an early sense of wholeness can be revived and the anxieties of separation and fragmentation are avoided. The induced euphoria strengthens the ego's ability to tolerate underlying feelings of dysphoria and protects it against low moods (Khantzian, 1974, 1985). A similar formulation is offered by Krystal and Raskin (1970) who explain addiction as the expressed desire to eliminate un-symbolised emotions. These undifferentiated emotional states cause unbearable physical anxiety that can result in a compulsive urge towards relief. Substances offer an efficient means to achieve this.

The psychoanalytic view of addiction differs from other psychological formulations in that the addict is viewed as acting out destructively or as using substances in an attempt to achieve a defensive end[4]. This end may not be conscious but the substance comes to form a part of the individual's complex system of defences and hence becomes incorporated into their sense of identity. Giving up substances is portrayed as extremely difficult and painful because it involves giving up one's defensive pattern and hence facing profound anxiety.

2.3.3 Family systems models

The final psychological model to be explored is the family systems model. Unlike the previously mentioned models, the family system model does not focus primarily on the individual and instead considers the family unit or system as its point of focus. Family units are seen as systems governed by sets of rules which, although not necessarily explicit, serve to maintain a particular equilibrium. This principle of balance or homeostasis is one of the fundamental tenets of systems theory and is commonly drawn upon in explaining why change can be so difficult to implement and how pathology develops and remains resistant to alteration (Nargolis & Zweben, 1998).

Family systems theory understands that families will attempt to defend the balance within their system, as any behavioural change by an individual in the family has the potential of affecting all the others and hence could become a destabilising force. From this perspective even destructive

[4] This is the reverse of cognitive theory which understands that the addict uses defensive means in order to justify continued use of the substance.

behaviours, such as addiction, can serve to maintain a particular balance with the prospect of sobriety appearing as threatening to the family system (McCrady & Epstein, 1996).

For example, drugging teenagers may serve to distract parents from facing their own growing marital problems and in so doing may maintain family cohesion. Changing the teenager's behaviour threatens the family system and so is avoided, and the addictive behaviour is covertly (or overtly) maintained.

Family systems theory looks at the roles which people have come to play in their families (e.g. scapegoat, hero etc.) and tries to understand how theses roles might be enabling the substance abuse, or functioning to maintain homeostasis (Thombs, 1994).

2.4 Biomedical Theories

Since its inception, the disease model of addiction has gradually gained professional and public support and, since the 1970's, has been the dominant influence in many treatment approaches, including the approaches of groups such as Alcoholics and Narcotics Anonymous (AA & NA) (Nargolis & Zweben, 1998). The AA and NA models of addiction are not strictly biological as they draw on a combination of moral, psychological and medical perspectives (Freeman, 1992). Furthermore, their understandings of addiction are not intended to act as a coherent *scientific* model and rather provide a body of resources from which members draw to manage their disease, e.g. the twelve steps (Appendix B) (George, 1990).

2.4.1 Addiction as a disease

Addiction is approached as a disease from two perspectives. The first approach is utilitarian, in that while this approach understands that addiction is not necessarily an actual disease in the traditional sense, it recognises that naming it in these terms is functional (Schaffer 1991; Schneider 1978). It is therapeutically useful because it provides a framework through which addicts can understand and manage their behaviour (Kissin, 1983) and it offers a stigma-free understanding of addiction that legitimises access to treatment (Truan, 1993). Hence, although addiction may not be viewed as a disease in the same sense as malaria, thinking in these terms is practical and offers certain advantages.

The second version, held by groups such as NA, asserts that addiction is a disease just like any other (Alcoholics Anonymous, 1965; Alcoholics Anonymous, 1976). Addiction is portrayed as comparable to diseases such as essential hypertension, gout, or coronary heart disease, which have a

genetic component and are also impacted upon by environmental factors and the individual's chosen lifestyle (Lewis, 1991). Addiction is considered to be a chronic, progressive, and potentially fatal disease; that, like other diseases, is founded upon biological processes and characterised by unique symptoms, a predictable course, loss of control and denial (Lewis, 1991; Maltzman, 1994; Miller & Chappel, 1991). Although the afflicted individual is understood as initially able to choose whether or not to initiate use, the addiction that follows is viewed as an involuntary consequence of both innate factors and initial exposure (Morse & Flavin, 1992). From this perspective addicted individuals are understood as victims with little freedom or control over their condition. This model de-stigmatises addiction to some extent as it views addiction as largely involuntary, but it also carries some moral overtones in encouraging complete abstinence and renunciation as the only 'cure' for addiction.

An understanding of addiction as an involuntary condition to which the afflicted individual is subject and over which s/he has no control is at the heart of constructions of addiction as a disease (Miller & Chappel, 1991; Truan, 1993). This position was first popularised by a series of papers in which Jellinek (1946, 1952, & 1960) argued that alcoholics were not in control of their drinking and hence that alcoholism was disease. For Jellinek (1952) the label of 'disease' was justified not by the excess of consumption in the face of negative consequences, but rather by the aspect of "loss of control". The loss of control element of addiction remains very much a part of current definitions of addiction and can be found reflected in the DSM IV TR's references to "compulsions", "using more of the substance than intended" and "failed attempts to control substance use" (American Psychiatric Association, 2000, p. 197).

2.4.2 The biological basis of addiction

Evidence in favour of the disease model is provided by studies attempting to outline the biological basis of addiction. These theories focus predominantly on two points. Firstly, biological models understand and explain addiction by highlighting the effects that substance use has on human biology. Secondly, studies aim to demonstrate how differences in each individual's unique biological makeup help account for that specific individual's vulnerability towards addiction. Both perspectives are reviewed in turn.

2.4.2.1 Physiological Effects of Substance Use

The effects that substances exert over the body include both acute mechanisms of action and the long-term consequences of chronic exposure.

a) Acute Actions: Substances exert their effect by interacting with various neurotransmitter systems within the brain or nervous system. What distinguishes abused substances from other psychoactive

agents is that these substances have a more pronounced affect on the areas of the brain that mediate feelings of pleasure and reward, i.e. the dopamine system (Gardner, 1997; Koob, 1992). Substances are thought to stimulate this system either directly (e.g. amphetamines) or indirectly (e.g. opiates) by altering other systems which in turn affect this reward system (Gardner, 1997). This stimulation is believed to produce feelings of pleasure (including the reduction of dysphoria) which have strong reinforcing properties that then support continued use. As this is true for both addicted and non-addicted individuals and as most individuals do not become addicted, this pleasurable effect of substances cannot entirely account for addiction (Volkow et al. 2003).

b) Chronic Actions: When the neurological system is in regular contact with a substance, certain neurological changes occur. Some of these reverse within weeks after the substance has been withdrawn while others can take months or possibly years (Volkow et al. 2003). Generally speaking, the available theory presents these changes as either adaptations designed to accommodate the effects of the presence of a substance, or as consequential damage caused by the ongoing presence of the substance. The latter explains changes that do not revert rapidly once the substance has been withdrawn, while the former explains tolerance and withdrawal.

Once the neurological system adapts to the presence of a substance, its cells require that presence in order to function normally (Gardner, 1997; Koob, 1992). Abruptly withdrawing the substance upsets the cells' homeostasis, causes them to behave abnormally, and an abstinence or withdrawal syndrome follows. This syndrome tends to be reflected in a series of signs and symptoms that often appear as the opposite action of the substances' acute effects. For example, agitation is characteristic of opiate withdrawal while opiates are sedating substances (Gardner, 1997).

The need to avoid withdrawal was previously put forward to explain why users will continue to use even in the face of serious negative consequences (Alexander & Schweighofer, 1988; Brecher, 1972). However, there are substances (e.g. cocaine) which do not produce withdrawal but are subject to addictive use, while other substances (e.g. steroids and certain antidepressants) do produce withdrawal but are not necessarily used addictively (Jaffe, 1980, & 1992). In light of these observations withdrawal is no longer considered a necessary or sufficient condition for identifying addiction (Brecher, 1972; Jaffe, 1992; Kalant, 1989; Stewart, de Wit, & Eikelboom, 1984).

Volkow et al. (2003) provide a contemporary neurological model of addiction which offers an understanding that goes beyond the avoidance of withdrawal. The model draws from PET imaging studies and proposes that addiction can be explained by changes observed in the dopamine system. This system is either directly or indirectly affected by all abused substances and involves various circuits of the brain. Four circuits are identified as being most influential in addiction. These include

the reward circuit; the motivation and drive circuit; the memory and learning circuit, and the control circuit (Volkow et al. 2003).

The model understands that an individual's choices are influenced by an interaction between the reward, memory, motivation, and control circuits. The appeal in choosing a particular stimulus is influenced by its expected reward. These expectations will depend on memories which dictate whether the associations to the stimulus are either positive (pleasant) or negative (aversive). Stimuli are also judged against other available options and against their expected ability to satisfy internal needs of the individual. The more a particular stimulus is felt to be potentially rewarding, the more the motivational circuit will become activated and so the stronger the drive will be to procure it. Ultimately, the cognitive decision to act (or not) on this drive is mediated by the control circuit[5] (Volkow et al. 2003).

Volkow et al's model proposes that in the addicted subject the need for a substance and its associated cues are enhanced in the reward and motivation/drive circuits while those of other reinforcers are significantly decreased. The substance induces levels of stimulation in the reward circuits that exceed those induced by natural reinforcers. This leads to a resetting of these circuits' thresholds and consequently decreases sensitivity to the reinforcing properties offered by other ordinary activities. These changes cause an over-activation of the neuronal processes highlighting the saliency of the drug and so exaggerate the reinforcing value of substances, in turn producing a corresponding over-activation of the motivational/drive and memory circuits. Together this disequilibrium overwhelms the ability of the frontal cortex to inhibit impulsiveness and so compulsive substance use begins to take place (Volkow et al. 2003).

In Volkow et al's this view, substance addiction results from the repeated over activation of the reward circuits followed by subsequent decreases in activity and hence disruptions of the circuits that the reward circuit regulates (motivation/drive, memory/learning, and control). Addiction is portrayed as a state in which the value of the substance as a reinforcer is much greater than that of any natural reinforcer. Natural reinforcers are no longer able to compete as viable alternative choices and the enhanced value of the substance becomes fixed in the individual's neurology. The fixed nature of this value contrasts against those of natural reinforcers whose saliency is momentary and decreases with the presentation of a more appealing reinforcer. Furthermore, the motivation circuits of the addicted individual become dependent upon the presence of the substance to function and become hypoactive when the substance is withdrawn. Only the substance is able to reactivate these circuits so

[5] Although primarily biological, the model takes account of associated psychological features such as internal needs and reinforcement schedules.

that the addict feels driven to acquire the substance in its absence and, according to this theory, motivated only when under its influence (Volkow et al. 2003).

The learning and memory circuits also contribute to addiction, as is evident in the effect that any cue triggering memories of substance related experiences can have on someone trying to remain abstinent. The model suggests that in addiction, previously neutral stimuli become profoundly associated with the substance and acquire the ability to activate the motivational circuit even in the absence of the actual substance. Encounters with such cues are also thought to automatically elicit habitually learned behaviours by activating the dorsal striatum, a region associated with habit learning. What results is an automatic impulse to acquire the substance and a follow through with behaviours known to achieve this (Volkow et al. 2003).

The final aspect of the model refers to the control circuit which is thought to be depressed relative to the over activation of the motivation, drive and reward circuits. The control circuit's involvement in decision making and in impulse control is disrupted in favour of immediate gratification, and at the cost of decisions favouring long term gain (Volkow et al. 2003). This contemporary model has considerable credibility as it seems to offer a comprehensive model of addiction.

2.4.2.2 The Effects of Individual Biology

Models of addiction which focus on the idiosyncrasies of individual biology draw heavily from neurologically based views of addiction, such as the one described previously. What the study of individual biology seeks to achieve is an understanding of why some people are more likely to produce these pathological biological adaptations than others. For example, they might postulate that certain individuals are more or less vulnerable to addiction because of their biological predisposition towards decreased sensitivity of reward circuits to natural reinforcers, decreased activity of control circuits, or an increased sensitivity of memory/learning or motivation/drive circuits to substance-related stimuli (Volkow et al. 2003). Other theorists have focussed on inherited biological predispositions to the manner in which one's body responds to a substance (Anthenelli & Schuckit, 1997). For example, individuals who experience severe nausea after consuming small amounts of alcohol may be less likely to continue to use it and hence less likely to become dependent upon it.

To date, the majority of this thread of research has focused on the role that genetics plays in individual susceptibility to substance dependence (Anthenelli & Schuckit, 1997). The study of genetics brought the realization that addiction probably involves an environmentally activated genetic component in that hereditary differences may impact on one's susceptibility towards addiction but cannot determine initial exposure. Although studies suggest that this is the case, the genetic component appears to be weaker than once believed and does not appear to sufficiently account for addiction in the absence of psychosocial factors (Nargolis & Zweben, 1998).

Part 3: Critique and Discussion of Existing Models of Addiction

A critique and discussion of the psychological and disease models is provided below. The approach undertaken and outlined in this research is put forward as potentially offering certain advantages over existing models.

3.1 Critique of Psychological Models

Of the approaches outlined, this research is most aligned to aspects of psychological theory. Addiction is conceptualised as a pattern of behaviour not entirely determined by biological mechanisms and for which the addict is in part responsible or involved in, rather than being subjected to. For example, cognitive theory describes the addict as actively minimising the negative effects of his/her actions while psychoanalytic models suggest that addiction is a way that particular individuals adapt to circumstance and manage distress. Such conceptualisations share some commonality with the discursive approach taken in the current study. However, the manner in which these psychological approaches conceptualise the human mind (as formed by intra-psychic and/or cognitive structures) poses problems for empirically based research since these hypothetical structures are not directly observable and are only accessible through inferences based on what is expressed in language. This research study avoids these difficulties by re-conceptualising these notions or processes as observable actions. The implications of this are considerable as such an approach allows addiction to be observed and explored directly, as it occurs in text, rather than considering the text as evidence of some process or entity existing elsewhere or at a different level.

Paying attention to the constructive capacities of language also addresses several other shortfalls of addiction theory. Davies (1992) argues that the majority of addiction theory is based on interview data and not informant observation and hence typically reflects addicts' descriptions of addiction. While this is not problematic in principle, what he suggests is that much of this research ignores the implications of the larger process of attribution. It does not ask what people are doing when they describe their behaviour and often takes these descriptions as though they represent the direct transmission of objective facts about addiction. A growing body of evidence suggests that this is not the case and that it may be important to pay attention to the dynamics which influence the manner in which accounts of addiction are structured (White & Davies, 1998). For example, the mode in which the interview is carried out and the relative status of the interviewer are known to influence the manner in which substance users report on their use. Face to face reports tend to uncover greater estimates of consumption and more favourable appraisals of substance use than reports collected by telephonic interviews (Aquilino, 1994; Best & Mortimer & MacMillan & Davies, 1995). High status interviewers with a clear institutional affiliation (e.g. a suit wearing university researcher) receive

reports of greater use (Johnson & Parsons, 1994) and greater dependence (Davies & Baker, 1987) than interviewers of less status or interviewers known to be using substances themselves. It appears that other forces come in to play during an interview and that verbal reports cannot be taken as simple declarations of facts (O'Connor, Davies, Heffernan, & Van Eijk, 2003) and hence must be viewed within the social and political context that they are reported (Heim, Davies, Cheyne, & Smallwood, 2001).

Furthermore, a recent study (Davies, Ross, Heim, & Wallace, 2004) suggests that non-addicted individuals who have had no exposure to addiction are able to produce descriptions of addiction which are statistically indistinguishable from those provided by actual addicted individuals. This is significant because it points to the existence of a widely distributed and popularly accessible social script or discourse of addiction (Davies, et al. 2004). The existence of such a script highlights the possibility that the reports generated by substance using individuals could reflect such scripts rather than memories of their own experience.

Bearing the above in mind, one may challenge the idea that the commonalities noted amongst addicts' accounts represent truths about addiction. While the expression of truths may be one possibility, they could also point to commonalities in function or convention (Davies, 1992). For example, many addicts describe their use by drawing on notions of compulsions and loss of control. Considering that illicit substance use is subject to certain legal and moral judgments one could argue that describing use in these terms fulfils a function for the addict (Davies, 2003). They represent a set of socially accepted explanations for using substances in socially unacceptable ways. Drawing on these modes of explanation enables the speaker to portray their use in a manner that allows them access to treatment as opposed to imprisonment and avoids a sense of personal responsibility and guilt (Davies, 2003).

This brief critical discussion is intended to sharpen focus on the importance of asking what it is that addicts are actually doing when they provide an account of their addiction. Failing to ask this is a significant flaw, because apart from assuming that the addict unquestionably knows the reasons for their behaviour (Davies, 1992), it ignores how their descriptions are influenced by their intentions, understandings, misunderstandings, beliefs and biases (Edwards & Potter, 1992). People configure their explanations so as to serve their particular purposes (e.g. to communicate or create an impression about something) and so these explanations shed as much light on the needs and beliefs of the speaker, and perhaps his/her assessment of the listener (Edwards & Potter, 1995), as they do on the phenomenon of addiction. This perspective is central as it implies that while theory developed

from interview material might give us insight into what sense addicts make of, and how they construct their behaviour, it does not necessarily *explain* their behaviour (Davies, 1992). It is exactly this point that this research attempts to address by explicitly asking what it is that the informants are doing when they describe addiction and what implications this may have for their addiction.

It should be made clear, however, that this work does not suggest or imply that the descriptions produced by addicted individuals are dishonest. While there is little doubt that individuals may at times actively structure reports in ways which aim to deceive the listener, this is not what is explored in this research. The interest lies in uncovering how addiction is constructed in the accounts provided by the informants. The work does not assume that the informants know the cause of, or truth about, their addiction, but rather understands that their depictions of addiction produce a version of reality (rather than depicting an actual reality). Whether that version corresponds to the individual's actual attitude or belief is irrelevant.

3.2 Critique of Disease Model

The disease model of addiction is as valuable as it is widespread. It has allowed for the development of several valuable treatment options (e.g. methadone and naltrexone) and forms the philosophical foundation of many successful treatment centres and support groups. However, the model is also the subject of criticism. Based primarily on observations of biological phenomena the model presents addiction in linear cause and effect terms, adds little to our understanding of addict thought or experience, and cannot explain how addiction functions socially.

The mechanistic depiction of human behaviour by the disease model is also subject to considerable weaknesses. Purly mechanistic models are unable to account for recovery or for levels of influence such as consciousness, reasoning and decision making, that result in an environment being interpreted and acted upon in a particular manner (Davies, 1992). Human behaviour is rarely mechanistic and people's responses are tempered by their social circumstances and their appraisals of the implications and consequences of the context in relation to their desires, wishes, expectations, aspirations and attitudes (Edwards & Potter, 1992).

Davies (1992) cites research into identical twins as an example of the limitations of purely biological perspectives. Even though such twins share identical neurological structures their personalities and the choices they make differ significantly. Non-common events take place despite their commonalities in neurology. In the light of this, Davies (1992) argues that an explanation at the level of neurology does not translate into an explanation at the level of human behaviour, or commission or non-commission of specific action. All behaviour has an underlying mechanism or mechanisms,

yet identifying a biological mechanism does not imply that the behaviour or mechanism is a disease, nor does it prove that the behaviour facilitated by this mechanism is beyond our control (Davies, 1992).

Biological mechanisms may explain the parameters and limitations of possible actions, the likelihood of their occurrence and perhaps the factors that facilitate particular outcomes. However, they cannot account for the decision to use, or continue to use a drug, apart from explaining how pharmacology may facilitate an environment in which choosing to use might become increasingly likely (Davies, 1992).

Loss of control in addiction is a point of contention raised by many authors (Fingarette, 1988; Lewis, 1991; Maltzman, 1994; Miller & Chappel, 1991; Peele, 1987) who point to several weaknesses in theorisation of loss of control, including observations that addicts are able to modify their consumption patterns. They also argue that suggesting that addicts are unable to control their use implies that individuals who recover were never addicted in the first place. The manner in which this research project constructs addiction engages with this difficulty by casting the addict as an active informant of his/her behaviour.

A further critique of the disease model is that it portrays addiction as though it refers to a distinct pathological set of behaviours only seen in substance use. However, there are many instances where non-substance using individuals find it equally difficult to change potentially devastating behaviours. Many individuals fail to reduce their calorie or salt intake despite being aware of potentially fatal side effects. Partners in abusive relationships are often unable to leave these relationships even in the face of extreme risks and despite voicing the desire to be free of them. Individuals have described irresistible urges to harm or damage themselves, bite their nails, gamble, have promiscuous sex, pull out their hair or binge on foods, despite expressing conscious wishes not to partake in these activities. Indeed changing any of a number of behaviours can be extremely difficult, particularly those behaviours which allow us to manage our anxieties.

Despite these examples of self destructive, obsessive, compulsive and impulse related disorders which resemble, but do not result from substance abuse, biomedical addiction theory implies that addictive behaviours evolve specifically out of substance use. While depicting addiction in this manner is valuable in that it allows one to structure medical interventions to address the particular withdrawal pattern presented by each substance, it risks simplifying the behaviours noted to understand them purely to be the result of consuming that substance. Such understanding ignores the host of functions which that consumption may fulfil and so encourages an overly simplistic focus on

the biological properties of the substance rather than on the meanings of the actions of individuals using them. Reducing addictive behaviour to its biological mechanisms further minimises the role that the individual must play in changing their behaviour by supporting the notion that they have become the victim of a condition beyond their control and hence have little hope of recovery. Adopting a discursive attitude towards addiction addresses these concerns by portraying addiction as less distinct from other behaviours and also as within the individual's own sphere of influence.

It is, however, noted that many addicted individuals find it helpful to adopt the disease model offered by groups such as AA or NA in order to combat addictions, but this disease model differs from the purly biomedical models. Rather than focusing on how the organism reaches a stage where it becomes unable to function in the absence of a substance, these groups (similarly to Jellinek, 1946, 1952, & 1960), describe the individual as loosing his/her capacity to moderate substance use. The NA model thus provides a functional view of addiction that is both in line with the addicts' experience and encourages complete abstinence as the only means of regaining control (Alcoholics Anonymous, 1965 & 1976). This is of particular interest to this research as it appears to imply that the way addiction is constructed can have real implications for behaviour, despite a lack of objective evidence (Davies, 1992).

In summary, this literature review has illustrated that addiction can be understood as a socially constructed category and that approaches to addiction are inextricably linked with the theories that define it. Four dominant models of addiction were then outlined and this was followed by a brief critique of two of these models. Psychological models were argued to be based on research that often fails to take the constructive nature of language into account, while medical theories were argued to be mechanistic and unable to account for human agency. The approach undertaken in this research hopes to avoid both of these limitations.

The report will now move to a discussion of the epistemological assumptions and theoretical orientation employed by the researcher.

Chapter 3 - Epistemological Assumptions

The research study is located in two closely connected theoretical traditions and epistemologies. The first is the epistemology of discursive psychology. The principles informing discursive psychology enable the conceptualisation of addiction in discursive terms and so allow the texts generated out of the focus groups to be analysed as though they are social practices reflecting the construction of an event. This kind of discursive analysis rests on the tenets of poststructural theory, which provides the second intimately related epistemological base for the analysis. Poststructural theory emphasises the context, framing and available resources from which an individual can draw when constructing an event. Broadly speaking, while discursive psychology enables an analysis of the individual's strategic construction of reality, poststructural theory accounts for the available and socially sanctioned knowledge and meanings which shape and limit that construction.

The paragraphs below offer an outline of some key elements of poststructural theory informing the study, exploring some of the ideas originating in the work of Foucault and Derrida[6] before moving to some of the theorisation offered more specifically by discursive psychology. The intention is to briefly clarify the theoretical frame of this research endeavour.

1.1 Poststructuralism

Historically our certainties originated in the existence of gods, common sense, empiricism, and our phenomenological experience of reality. Today, the recognition that our theories influence and shape the objects that they describe brings such certainties into question. Language is no longer accepted as being a neutral reflection of the reality that it describes. Rather language has been shown to be inseparably tied to, and trapped within the confines of its particular discursive forms, paralysed beyond the boundaries of its own terms (Weedon, 1991). "Addiction", "dependence", and "abuse" are after all words belonging to a system of thought and so are only meaningful within the conceptual matrices in which they reside.

Highlighted in the writings of Foucault (1982) is the notion of discourse. A discourse in this sense can be understood as a collection of related statements that together provide the rules through which knowledge is produced and legitimacy judged. These collections of statements form particular manners of speaking about a particular subject (Parker, 1992), e.g. psychological as opposed to psychiatric. Together they describe, and in the process of describing, form that subject in a particular

[6] Derrida and Foucault are regularly categorised as poststructural theorists, however, it is acknowledged that both of these theorists resisted this title.

way (e.g. the product of psychological vs. neural process). Being linked to social practices, discourses are inclined to reflect the power relations and moral codes inherent within the social setting in which any practice takes place. All knowledge produced by discourse mirrors social relations and produces the subjects they describe accordingly (Parker,1992).

From this vantage, subjects such as 'drug addiction' are not understood as naive reflections of real neutral conditions but rather as inseparably bound to the dominant values of the discourses through which they are produced. Thus, neither their described objects, nor their attributed qualities are viewed as finite things. Instead they become contextually specific, shifting descriptions or explanations, which are created, maintained and passed on through the language of the social institutions that describe them. Language is thus viewed as having the capacity to literally produce its subject as well as to provide the framework for debating the value of one way of speaking about reality over and above others (Parker, 1992.). The subject is produced in a particular manner (e.g. disease of addiction vs. immoral lifestyle), while it is simultaneously positioned within the relational power dynamics inherent to that discourse that describes it (Bury, 1996; Foucault, 1980; Petersen, & Bunton, 1997), e.g. cause for treatment vs. cause for punishment.

Jacques Derrida's deconstruction of subjectivity, while differing in its focus, is epistemologically compatible with Foucault's ideas. For Derrida it is also language that is central and not subjects. The world as we conceive it is explained as a function of language rather than a given entity mediated through it (Robins, 2000). This implies that concepts such as drug abuse, while conceived of as categorical explanations of the 'presence' of some essential phenomenon through the medium of language, are actually the discursive subjects that language constitutes as categorical in the first place (Robins, 2000). Further, according to Derrida's theory of 'differance' - all meaning is set up by a process of relational difference from what it is not (e.g. our understanding of order, depends fundamentally upon the premise that it is not disorder, chaos etc.) and by an endless deferral of definition: i.e. in defining a word such as 'order' one can only refer to other words, which in turn will refer to more and so on (Robins, 2000).

Taking the above theoretical perspectives together, objects or categories such as drugs and addiction are not attributed meaning through some positivist "Truth" but are rather produced and positioned by the discourses that speak them. This positioning occurs in relation to every other topic concerning that particular discourse, with the final position both produced through and reflecting the power inherent to those relationships: i.e. addiction as a subject will reflect its relationships to every other discourse on the topic (e.g. epistemology, morality, health etc.) and these relationships will depend

on the cultural space and time in which that discourse exists (for example, the manner in which medical doctors construct marijuana use will differ substantially from how it is portrayed by traditional healers.)

1.2 Discursive Psychology

The term 'discursive psychology' (Edwards and Potter, 1992), as it is used in this research project, does not refer to a specific formalised school of thinking. Instead it is a shorthand term for a recent branch of psychological theory[7] which attempts to incorporate the insights of writers such as Ludwig Wittgenstein (1953) and Harvey Sacks (1992). The discussion that follows does not claim to provide a comprehensive account of the theorists who have contributed to discursive psychology. Such an account would go well beyond the scope of this work. Instead this subsection of the report presents an artificially coherent depiction of this theory. The intention is to introduce the reader to the frame from which the material was analysed by the researcher and to provide a context through which the reader may understand or evaluate the findings.

Discursive psychology shares many of the epistemological assumptions of poststructural theory. It prioritises the constructive capacity of language and challenges dualist notions of truth. Meaning is seen neither to originate from within the individual (Vygotsky, 1978) nor to play a purely individual role in our lives (Dixon, 1995). In fact, one of the essential points of discursive psychology is its assertion that our personalities, conceptions of our selves, others, emotional experiences and views of the world are all explicated from phenomena whose existence is created beyond us in the realm of society (Lock, 2004). From this perspective human beings are seen to be transpersonal, with our minds and our conceptual systems viewed to reflect social discourses which have been explicated and rendered into mental form (Lock, 2004). People are seen as profoundly penetrated by cultural elements, institutional discourses and power, all of which greatly influence our habitual lines of thought and the effects and affects that we are able to accomplish (Lock, 2004). Thus discourse imparts its own qualities to the mind; with the mind then defined, shaped, mediated and infiltrated by the characteristics of that discourse. On the other hand, discursive psychologists recognise that the cultural world is itself intentional in that it is infiltrated by human desires and designs (Shi-xu, 1998). Thus, the intersection between the social and the individual is portrayed by discursive psychology as being seamless. The mind, cognition, emotion, self and consciousness are all seen as discursive in nature because they are all constructed through, presumed in, mediated by, modelled upon, and born out of discourse (Shi-xu, 1998). From this perspective, no layer can exist between human neurology

[7] See Antaki, 1994; Billig, 1996; Edwards, 1991 & 1994; Edwards and Potter, 1992 & 1993; Harré, 1995; Harré & Gillett, 1994; Parker, 1992; Potter, 1996; Potter & Wetherell, 1987 & 1995.

and conscious experience (Harré, 1999) and so the constructs typically approached as intra-psychic entities become viewed as the mental representations of accomplishments achieved through interactive discourse.

Thought cannot occur independently from context and hence discursive psychology focuses not only on our expressive functions but also on their dependence on specific cultural and functional contexts (Harré, 1999). It attempts to treat the full range of social forms and practices in terms of how they are discursively produced and understood. The result is an action orientated approach grounded in four insights concerning discourse (Harré, 1999). One is the affirmation that social realities are linguistically/discursively constructed. The second is the appreciation of the context-bound nature of discourse. The third is the idea of discourse as social action. The fourth insight is the understanding that meaning is negotiated in interaction, rather than being present in and of itself in our utterances. Together these form the basis upon which all discourse is approached as an action and not merely as representation.

Edwards (1997) for example, took the cognitive notion of scripts and demonstrated the value of portraying them in terms of accomplishments orientated in interaction as opposed to conceptualising them as existing in mental space and driving action from there. In so doing he applied Sacks' (1992) challenge to the individual/social dualism of sociology and offered a reappraisal of private psychological events in terms of accomplishments in social interaction (Edwards, 1995; Potter, 2000). This turned the notion that the underlying competence (e.g. cognitive script) should be the object of study, rather than the performance (e.g. human interaction) it is accomplished in, on its head.

Potter (2000) argued that one of the consequences of taking a discursive approach rather than a traditionally cognitive one is that it provides a theoretically grounded reason for addressing topics typically dealt with in intra-psychic terms, by focusing on action. Rather than extrapolating presumed inner entities or processes occurring within an individual from their behaviours, one can explore how these entities are mediated through action. This approach allows one to ask questions like: How is addiction maintained through interaction? How are memories, themes or facts presented and constructed to present or portray substance use as rational? How are evaluations utilised to portray ones relationship to a substance as a legitimate state of affairs?

Adopting this theoretical stance enables the researcher to focus on what people are doing when they speak and how doing this might explain their circumstance or serve their purposes by producing a

particular view of reality. This is in direct opposition to traditional cognitive theory which is inclined to view what people do as being 'caused' by some underlying competence (e.g. cognitive defence mechanism, belief, attitude) that should be identified and studied. Rather than trying to explain actions as a consequence of mental processes or entities, discursive psychologists attempt to understand how mentalist notions are constructed and used in interaction. The private and personal are brought into the same arena as the public and collective (Harré, 1999) and the mind is understood as a symbolic process which is not an accessible material thing. Beliefs, attitudes, memories and emotions are not approached as mental states or processes but are instead thought of as functional private and public negotiations. They are the result of people putting local symbolic systems to work in order to achieve any number of purposes (Harré, 1999).

Applying this philosophy to addiction hinges on the assumption that addiction is not an entirely physiological reaction, existing beyond the realm of human agency. As stated previously, the research endeavour recognises that addiction has been shown to have a physiological component. Certain changes in receptors and neurotransmitters have been associated with addictive patterns of use and these are often highlighted once the drug is withdrawn. However, addiction is not merely a physical condition and it does have a significant inherent psychological/cognitive component. For example, this may involve what the pattern of use means to/for the individual, how they make sense of themselves; their judgments around what behaviours are acceptable or appropriate under certain contexts; the function of substance use; and the extent to which it can be indulged or should be stopped (Davies, 1992).

Accepting the assertions made by discursive psychology allows this cognitive component of addiction to be re-conceptualised in discursive terms. This enables the researcher to view the communicative practices of the addicts studied as forming as significant a part of the total complex of addiction as the act of using substances or the neurobiological state of addiction. Indeed it suggests that there can be no distinction between addiction and the expression of addiction. Furthermore, approaching a seemingly individual condition such as an addicted individual, as part of a larger cultural production, automatically redefines the relationship between individual psychology and social behaviours (Potter, & Wetherell, 1995). Social reality is taken into account and an allowance is made for the fact that addiction, as it is experienced individually, and by others, is shaped by cultural influences. This is something not easily addressed using typical medical or psychological models of addiction.

Approaching addiction as a discursively mediated product is not to exclude the material conditions that interact with language in shaping addiction. It is also not to suggest that a conscious manipulation of the language used by the addict would necessarily lead to a change in their addiction. This would be too gross a neglect of the non-linguistic factors involved in addiction as well as the broader discursive context in which the individual resides and social practices are produced. However, the focus of this particular research study is on discursive constructions of addiction as manifested in the talk of individual addicts.

In summary, the chapter has introduced the reader to the theoretical orientation of this study. Relevant tenets of poststructural theory were described and particular attention was paid to the constructive capacity of language. This was followed by a broad outline of discursive psychology and the assertion that the mind is itself a discursive product. Presenting these theoretical perspectives further highlighted the relevance of this study by clarifying how our selves, actions and realities are profoundly shaped through our discursive interactions and contexts.

The report will now move to a discussion of the method undertaken to achieve the aims outlined.

Chapter 4 - Method

The following chapter covers the aims of the study, the selection and recruitment of the informants, the design of the research, its method of analysis and the ethical considerations taken into account.

1. Aims

The purpose of this study was to deepen understanding of the ways in which addiction to opiates is constructed by its addicted users. The project aimed to explore how informants described addiction, and what the implications of these portrayals might be. By comparing discursive accounts of self-defined recovered and currently addicted users, the study aimed to highlight how ways of talking about substances and their use might be implicated in the maintenance and cessation of addiction.

1.1 Research questions

The following questions were asked in order to achieve the above aims. In analysing and comparing the discursive accounts of recovered opiate addicts and currently using opiate addicts:

1. How is opiate use described by current and past users?
2. Are there notable differences in the discursive construction of the drug use between current and past users?
3. If differences are noted what do the implications of these differences appear to be for both ongoing use and abstinence?

2. Informants

Since the selection of informants reflects discursive as well as purely methodological considerations, requiring the exercise of judgment on the part of the researcher, a fairly extended discussion on the choice and exclusion of informants is provided.

2.1 Determining eligibility for the study

Several factors were considered when deciding who should be eligible to participate in this study. These included criteria such as how to define opiate addiction and abstinence; and the significance of factors such as sample size and representation.

2.2 Identifying addiction

Bearing in mind that definitions of addiction vary widely, this study did not indiscriminately include all individuals labelling themselves as addicted and only included those addicted in the clinical sense. In order to qualify to take part in the study all informants were required to have met the

criteria for substance dependence outlined in the DSM VI TR (Appendix A) or to have been accepted into a treatment facility. This approach was thought to be the most likely to elicit material from informants actively trying to make sense of addiction in the accepted clinical or psychiatric sense.

The decision to include only opiate addicts was based on the increasing prevalence and clinical severity of opiate addiction in South Africa and on the assumption that opiate addicts could be considered a distinct social group amongst the general substance abusing population. The assumption was that opiate addicts might share a similar system of meaning or use similar discursive strategies that could be meaningfully analysed. Furthermore, it is well documented that opiate use is associated with unique effects such as a particular euphoria and distinctive withdrawal symptoms. The researcher anticipated that these shared experiences would be drawn upon in describing the experience of addiction. Offering the possibility of uncovering a socially coherent construction of addiction that might be more difficult to identify in a group of mixed addicts. This is not to say that the informants were only using or even only addicted to opiates. On the contrary all of those interviewed used a variety of substances, but all of the informants identified themselves as opiate addicts.

2.3 Identifying abstinence

Abstinence is a category that can signify a variety of states. In its most extreme form it refers to refraining from consuming any psychoactive substance, including nicotine and caffeine. At the other extreme abstinence refers to abstaining from a particular substance deemed problematic, while continuing with the recreational use of other substances. The same variation in meaning surrounds recovery. For some, recovery implies complete abstinence, while for others it refers to regaining the capacity to continue using a previously problematic substance in a more manageable manner.

Since this study was not undertaken to specifically understand the experiences of individuals no longer using any substances, and following the suit of similar studies (Hanninen & Koski-Jannes, 1999; Mcintosh & McKeganey, 2000; Polkinghorne, 1996), it was deemed appropriate to allow the informants to define their own status. If an informant said that they had been abstinent for one month this is how they were identified in terms of inclusion in a particular focus group. More objective measures such as urine testing or collateral interviews were deemed unnecessary and possibly even inappropriate given the discursive nature of this study. While it could be argued that an abstinent group should only be identified on the basis of absolute abstinence, for the purposes of this particular study this stance was viewed as too constraining.

This study was interested in exploring individuals' subjective accounts of addiction. Allowing such accounts to structure the group composition and discussion enabled meanings to come to life through their enactment. If an individual used substances on weekends but said they were abstinent this was taken as valuable information about the how patterns of addiction could be variably constructed. The question was not "had they actually given up?", but rather, "how do their accounts function?" and "do they function differently amongst those who view themselves as current, as opposed to past or recovering, addicts?"

2.4 Sample size and representation

A total of 15 informants were interviewed in four focus groups. Three groups included four informants and one had three. This relatively small sample was deemed adequate because of the in-depth nature of the analysis and the type of questions posed. The analysis does not attempt or claim to produce a representative model of how *all* addicts explain addiction, and so is able to provide insight into how a specific set of texts function in this sample of 15 informants. It is the convention of many discursively orientated studies to utilise small samples because, as Potter and Wetherell (1987) point out, while large samples increase the labour of analysis they rarely add incrementally to the findings.

2.5 Recruitment of informants

The research followed the example of similar studies and utilised 'snowballing' techniques to recruit informants (Davies, 1997; Hanninen & Koski-Jannes, 1999; Mcintosh & McKeganey, 2000; Polkinghorne, 1996). This method was selected because of its demonstrated efficacy in accessing socially marginalised populations and because the research did not require a large number of informants or a probability sample.

Prospective informants were identified by speaking to individuals already known to the researcher and by contacting therapists and rehabilitation centres working with opiate addicts. Potential informants were provided with the details of the study and an outline of its central purpose, namely that it was an exploration of the manner in which people who are addicted to, or have been addicted to opiate drugs, speak about their addiction, their experiences and their understandings of these. The researcher emphasised that it was the manner in which the transcribed texts would be able to convey meaning that was to be studied and not the informants themselves. Hence all were informed that they would be under no obligation to disclose any sensitive personal information.

Those who replied were asked if they knew of others who might be interested in participating. If they thought that they might, they were asked to contact them and ask if they would be willing to be contacted by the researcher. In the end, all of the individuals who were approached expressed interest in participating in the study, although some were concerned about issues of anonymity. Unfortunately not all interested parties were interviewed as it was difficult to establish dates that would be suitable to everyone.

2.6 Informed consent

Informed consent was ensured by explaining the features of the research to each of the potential informants (including its terms of confidentiality, voluntary nature and the process of audio recording) before they choose to take part in the study. The informants were also provided with written documentation concerning each of these features once they expressed an interest to continue. Three forms were distributed in duplicate and the informants were asked to read and sign them if they agreed to their terms. These included a letter outlining the terms of confidentiality, a letter of consent regarding the audio recording of the sessions and an information sheet outlining the requirements of the study (Appendix C). All of the informants agreed to the terms of the research and signed and returned one copy of the documentation, retaining the other. No pressure to participate was placed on any of the potential informants and none were included in the study without their informed consent. Participation in the study was voluntary and no remuneration was provided.

2.7 Demographic profile of informants

Recognising that it is the discrepancies between individual accounts that often highlight the relative or constructed nature of these accounts, it was decided that informants would be selected in order to encourage historical and contextual diversity. Consequentially the ages of the informants ranged between 22 and 47. All of the informants identified heroin as being their drug of choice and between them their experience with the substance ranged from two to 20 years. Seven females and eight males were included and the abstinent informants claimed to have given up for periods of anything from one month to 10 years. Economic and class factors varied substantially between the informants and on the whole tended to reflect the informant's degree of current involvement with heroin. Those who had not used heroin for long periods tended to occupy professional positions while some of those currently using were unemployed and financially destitute. All of the informants spoke English although two had Afrikaans backgrounds and one also spoke Portuguese as a first language. All but one of the informants were white South Africans, with the other being black and from Mozambique.

3. Design

The research followed a qualitative, exploratory and non experimental design. This design was selected over quantitative approaches because it allows for the exploration of avenues not necessarily considered at the onset, and hence offers a flexibility that can add value to exploratory studies such as this.

The group of informants was divided into four focus groups. Each of the four groups was composed in terms of the informants' clean time, stage of recovery and/or on the basis of whether the informants were actively using. The researcher anticipated that grouping the informants in this way might elicit common themes and discursive strategies in the groups while simultaneously allowing for differences between these groups, if they appeared, to be more easily identified. An additional reason for grouping informants in this manner was ethical concerns, in that exposure to actively using informants could have had a detrimental effect on those trying to abstain.

The first group consisted of four people, two females and two males, and each identified themselves as having been abstinent for between four to 10 years at the time of the interview. The second group was also attended by four informants, one female and three males, who identified themselves as having been abstinent for between one month and one year. The third group consisted of four informants, three males and one female. These informants were all currently resident in a rehabilitation facility. The final group was made up of three informants, all of whom were female and actively using heroin.

4. Data Collection

4.1 Focus groups

Each of the groups was interviewed by way of a loosely structured focus group. Focus-groups provide a true life sample of conversation and hence were thought to be more inclined to produce an authentic text for analysis. Focus groups also allow a greater number of people to be interviewed in a reduced amount of time. The assumption was that if a particular theme was noted across a larger sample it would present stronger evidence than if it was noted in one individual interview. Furthermore, more people would provide a greater diversity of opinion and so would add to the richness of the text.

Although the convention within discursive studies seems to be a shift towards the collection of naturally occurring data (Potter, 2003), the researcher felt that focus groups were more appropriate and feasible for the purposes of this particular research project. They allowed the interviewer to

concentrate the conversation around specific topics thought to be of importance, whereas natural data (e.g. recorded therapy sessions) may have provided less relevant information and would have introduced ethical difficulties.

Perhaps the most compelling reason to utilise focus groups in this study was that they provided an actual sample of what the research was interested in exploring, i.e. a live description of addiction. While the context of a focus group may not be "natural", the conversation taking place in it is an example of genuine social practice, complete with group dynamics, alternative views, challenges and responses.

4.2 Location

Each group was conducted in a prearranged place which had been selected by the members as convenient. The first interview took place at the researcher's home, the second and third at different rehabilitation centres and the final interview was carried out at the home of one of the informants.

4.3 Interview style and process

Each group began with the researcher introducing himself, reiterating the aims of the research and answering any outstanding questions. Once this process was completed the microphone was turned on and the discussion was initiated building onto something that one of the informants had already said.

The groups were conducted over approximately 90 minutes and were loosely directed by a topic schedule. The topic schedule was based on a set of questions prepared at the outset of the study (Appendix D). The topic schedule was intended to aid the researcher in maintaining the focus of the group, but the group discussion was generally allowed to proceed openly and naturally so long as addiction remained at the heart of the discussion. The interviewing style was relatively informal. This style was appropriate in this context because the research was less concerned with uncovering the informant's actual, unaltered point of view than with how conversations take place.

5. Data Analysis

Bearing the aims of the research in mind the transcripts (Appendix E) had to be analysed using a method that was sensitive to their content, their capacity to actively construct addiction and also a method that allowed for some clinical analysis of the implications of the portrayal. A combination of elements of a discursive analysis and thematic content analysis was selected as the most appropriate means to achieve this. Here, a discursive analysis is distinguished from a discourse analysis. Unlike a

discourse analysis which typically seeks to identify the available 'discourses' that are promoted by institutions and present in the informants talk, what is implied in the approach of this study is a discursively sensitive thematic content analysis that enabled an analysis of the construction of a particular version of events and its implications. While the analysis is thematic in that it identifies recurring portrayals as themes, these are understood as discursive acts which carry implications that go beyond the descriptive.

5.1 Carrying out a discursive analysis

At its simplest, discursive analysis is an attempt to analyse how, and to what end a piece of text operates. This is achieved by reading and rereading a text while viewing it as an entity actively portraying the thing it speaks of, in a particular manner, while achieving a particular, not necessarily intended, end. Patterns used to arrive at this portrayal are noted, along with their possible consequences, constructive influence and hypothesised functions. This process involves a careful detailed exploration of the implications of the actual words, phrases, sentences and rhetorical devices used by the speaker/s.

Although this process cannot be easily broken into sequential steps, phases can be identified and described. The term phase is used because phases of analysis are less definite than stages and sometimes overlap or even run simultaneously. Some of the phases commonly anticipated and employed in a discursive analysis are outlined as follows, in order to provide a clearer sense of the actual process of analysis.

A discursive analysis is an ongoing process. It begins at the moment a project is undertaken as the analyst starts to recall relevant texts encountered in the past and how those texts portrayed their informant/s (Potter, 2003). This type of thinking continues thorough the interviewing and transcription process and it is with these initial impressions that the formal analysis begins.

Once the transcripts are complete they are read repeatedly, first as a whole with the objective of the study in mind and taking note of general impressions; and second, in order to highlight sections that seem relevant and to omit those that are obviously not.

The next phase involves a thematic coding of the documents in order to make the data more manageable. Sections are marked in ways that indicate what the informants are talking about at different times (e.g. becoming inebriated). These marks serve to distinguish parts of the text that refer to the objects and areas of interest already identified (e.g. addiction, heroin etc.). The

highlighted sections are then grouped together under relevant categories and pertinent observations are noted (Appendix F).

Once the text has been organised it is approached as if it were an object in its own right. That is, it is understood as an action rather than a channel to information (e.g. to the informants thoughts about their addictions). This action is what is studied rather than the speaker per se.

While analysing the text, all meaning is considered to be constructed through the discursive activity of the text. Connotations, allusions and implications are explored through a free association of ideas, usually with the help of a co-analyst. This also involves considering what is not said. For example, an informant may explain that opiates offer a sense of emotional warmth but may omit that they also induce feelings of agitation. The reader must also try to be critical of his/her own presuppositions and assumptions. S/he must question why s/he is inclined to read the text, fill in gaps or make sense out of unclear passages in a particular way. Noting the features of the passages that lend themselves to particular readings can provide strong evidence of what the text is attempting to achieve.

Attention is paid to the fact that the text is spoken with the intention of being heard and to the fact that what the text seems to assume about the listener must also inform the analysis. For example, what does the text assume the listener is thinking; is it presented with a degree of formality or authority, what does it define as true or likely, desirable, obligatory, or important? This approach to analysis helps to answer questions about how the text might deal with objections or alternative perspectives. It also provides insight into what challenges are anticipated by the speakers and hence draws attention to norms that might otherwise go unnoticed by the analyst.

Very often, presenting an object as natural or factual can allow the text's intention to go unnoticed as it appears to have no stake in describing something in a particular way. However, if we are able to find discrepancies within the text regarding the construction of an object, the intentions and stake become clearer. One way of achieving this is to contrast ways of speaking against each other while exploring how each way constitutes the same object differently. Points where such ways of speaking overlap can then be identified, (i.e. where they constitute what looks like the 'same' objects in different ways) and exploring such differences can shed light on the intentions of the constructions.

The addition of a co-analyst is both routine and valuable within discursive studies as co-analysts are often able to complement/supplement the interpretation/ideas of the researcher by identifying perceived discursive styles and strategies that s/he may not have otherwise noted. While this may not

offer the parallel of formal inter-rater reliability, it does allow for some commonality of understanding and adds to the integrity and credibility of the overall analysis. In the case of this analysis the texts were scrutinised by the supervisor of the project.

The final phase of the analysis involves considering how each of the transcripts functions independently, as well as how they function as a whole. What patterns emerge, what are the discrepancies, what are the consequences of their style and how do all of these answer the research questions at hand? This information is then synthesised into a report that demonstrates how a particular phenomenon, in this case opiate addiction, is legitimated, constructed and construed through discourse. Illustrative examples are also provided to support arguments made during the analysis and to refine its clarity. The report then moves to a discussion of the practical implications of its findings and possible further avenues of study.

This is the broad process of analysis followed by the researcher in this study.

6. Ethical Considerations

It is acknowledged that the ethical implications of this study were both complex and sensitive. The most obvious concerns were for the informants. One such concern regarded the inclusion of informants who were currently using heroin and what form of intervention, if any, should be offered to them. After careful consideration it was agreed that while a referral to a treatment centre would be offered, no direct intervention should be carried out since these informants had undertaken to participate in the study under the express condition that no judgment, diagnosis or effort to stop their heroin use would be made. No informants made use of this offer. It was made clear that the disclosure of information that was not absolutely necessary and/or voluntarily offered was not expected. The availability of debriefing was made known, but none of the informants chose to make use of this.

A more complicated issue was that of legality. To be in possession of any one of several of the opiate drugs is prohibited by law and the abuse of these drugs is associated with other forms of criminality. This raised the possibility that sensitive and potentially incriminating information regarding a informant's dealings in other criminal activities may have come to the fore. This situation could have placed the researcher in an ethically awkward position and put the informants at potential risk of prosecution. In order to discourage such disclosure the informants were informed that the materials and information collected in the study could potentially be summoned by a court of law. As a further precaution, all identifying information was removed from the documentation produced by the study

and was marked 'Not for forensic purposes'. It was also stressed that, contrary to popular belief, psychologists and researchers were not protected by client privilege and that the informants should realise that they should be willing to undertake the study with this in mind.

The nature of the analysis carried out also brings with it its own set of ethical concerns. The most relevant to this study is the manner in which the researcher approaches the texts and the accounts provided by the informants. An ethical dilemma may arise in respect of treating the accounts of the informants in a manner that they do not and cannot expect. Their accounts are not treated at face value and are examined for unintended effects and implications. Hence the texts are analysed in such a way as to reveal information that the informants may not have anticipated or been aware that they may have disclosed. Furthermore, the very aim of the study required the researcher to adopt an interrogatory or critical analytical stance, reading the accounts with what has been referred to as a 'hermeneutic of suspicion'.

However, the decision to undertake the research was based on a number of factors. It was felt that a real need existed for this research as it was intended to add to the understanding of opiate addiction in a beneficial manner. The risk to the actual informants was deemed to be negligible great lengths have been taken to ensure that their accounts are not identifiable. The informants were informed at the outset that the research did not intend to explore them as individuals or the content of what they said, so much as what the effects of what they said might be on and/or might tell us about addiction. Thus there was no attempt to disguise the intention of the project and the researcher was open to engaging with the full range of perceived positive and negative discursive strategies.

Having provided a comprehensive description of the method followed by the researcher this report will now move to a presentation of the results of the analysis and a discussion of these.

Chapter 5 – Findings and Discussion

Since the findings and discussion are integrally linked they are covered within a single detailed chapter. Only the most dominant observations have been selected for discussion. Many other strategies and discursive representations were present, however, these could not be adequately addressed in terms of constraints of length.

The Analysis

In analysing the transcripts it became apparent that the informants described their heroin use using three distinct characterisations. The first characterisation of heroin use was as *initial* or commonplace. This characterisation presented use as similar to other everyday human activities and directly opposed pathological representations. The second characterisation of use was of *addiction*. This characterisation constructed use as having taken a destructive and negative form. It is argued that elements of this characterisation not only describe a changing pattern of use but also employ available discursive resources in a manner that actively perpetuates further use. The third characterisation was of *recovery*, a particular retrospective portrayal of use that, in opposition to addiction, is argued to discursively support abstinence.

Each of the three characterisations is explored in turn. Each subsection begins with a brief outline of the characterisation, how it appeared to function and a paragraph on how the subsection will be presented. The researcher's observations are then illustrated, substantiated and discussed. While there may be some overlap between each section and/or the subsections, each heading represents a distinct theme which has been identified as significant.

Section One – Initial Use

The first characterisation is of use as initial, commonplace or ordinary. The term 'ordinary' is used in two senses. Firstly, use is portrayed as ordinary in that it is resembles other human behaviour in its being wilful or within the informant's control, and secondly because it is presented as regular, everyday behaviour. This characterisation was achieved through emphasising that heroin use was a rational activity that added significant value to the informants' lives.

The characterisation of initial use is outlined by exploring three principle features upon which it was based, i.e. the presentation of heroin use as ordinary, rational and functional. Heroin's functionality is covered by outlining five of the functions which were attributed to heroin use, its ability to: enhance the individual; obtain acceptance from peers; substitute for relationships; self-medicate; and aid in the adoption or expression of an identity. The subsection exploring identity is divided into three further subsections dealing with how heroin use facilitated the expression of: an alternative identity; oneself as superior; and membership of, or affiliation to a desirable social group.

1. Heroin Use as Ordinary

A proportion of the transcripts presented heroin use as though it was an innocuous and ordinary behaviour. Some of the more prominent ways in which this was achieved are explored along with some of the probable functions of this portrayal.

The portrayal of heroin use as ordinary was most evident in the informants' depictions of their early use. The initiation of heroin use was almost unanimously presented as though it was then experienced as an everyday event, with little significance in informants' daily lives. This was highlighted by the informants' use of neutral language and tone, and their focus on the benefits of use. Informant's tended to present themselves as initially naïve and hence unable to appreciate or anticipate the possible consequences or dangers of heroin use.

> "From when I used chemicals when I was young it didn't occur to me really not to use them. I mean I would not do certain things before work in the morning but um, they seemed to have a perceived payoff and so I used them…" (Desmond, C163)

Substance use is presented as though it were a sensible thing to do. Desmond's account works to substantiate his responsibility by presenting him as a careful citizen who "would not do certain things before work". Like many of the informants' accounts, it portrays Desmond as a considered,

sane and innocent individual who was unaware of the dangers that lay before him. This emphasis on lack of anticipation of possible negative consequences ran through many of the informants' accounts.

> "I don't think anyone in their right mind would set out to be a drug addict, if they knew what it was about…. It's something that kind of progress, you progress into, you… I never planned to be, I thought I could control it, I thought how could this substance, I mean a powder, land up ruling my life?" (Renaldo, A868)

> "… I don't accept that it was self-inflicted. I do accept that I chose to use drugs but I didn't know when I chose to use them that I would be unable to choose to stop to use them." (Anton, C54)

The sections of text which present heroin use as ordinary describe a scenario in which there is or was no sense that using heroin should be questioned. Using substances is portrayed as a given and heroin use is described as though it were indistinguishable from other forms of substance use; e.g. alcohol consumption.

> "You know and on a bank holiday I went into the pub at ten o'clock or eleven o'clock in the morning and I stayed there until closing time… I have always been like that. In fact I liked heroin because I stopped drinking so much." (Desmond, C928)

> "I think at the time I just took any drugs but then when I first tried heroin and I really liked it, it was firstly a matter of taste…" (Renaldo, A374)

The ordinariness of heroin use was further constructed by drawing analogies between using heroin and other everyday behaviours. In the extract above, Renaldo draws on the very natural and ordinary notion of "taste"; he tries heroin and likes it in much the same way that he might try and enjoy a new dish.

> "It's like I was saying earlier you know you prefer the coke or the diet-[coke] or whatever." (Jay, A269)

Heroin is presented in a matter of fact manner that portrays a picture in which selecting to use it seems entirely appropriate.

> "Ja um basically it, was just another drug that I could try. That kind of, kind of relaxed feeling after work it was, it was like smoking a thousand joints. It was quite good." (Jack, B48)

Another important feature of the presentation of heroin use as ordinary was that certain informants actively resisted all pathological representations of use. Instead of considering use as symptomatic of some underlying pathology, the informants' accounts suggested that heroin fulfilled basic human needs and hence could conceivably form part of a 'normal' 'healthy' lifestyle.

> "A lot of people that I used heroin [with] when I first used heroin never became addicted…. and I don't think that we were going at it from a different angle…. We had the same, you know it was fun, we were getting kicks. It was cool we were having fun… It was meeting some… I don't even think that perverse a need. It was a fairly obvious and basic need… Or the need for fun and for enjoyment. The need to relax." (Anton, C193)

Presenting heroin use as specifically non-pathological enabled the informants to portray their use as though it was reasonable and formed the foundation upon which they could present such use as rational.

2. Heroin Use as Rational

Presenting heroin use as a rational behaviour was achieved by highlighting the logical sense of selecting heroin in terms of its benefits and capacity to satisfy particular ends.

> "…because you see this [using heroin] was just easier and my primary objective was just to be high." (Allen, A528)

Sections of the informants' accounts placed emphasis on the effects of and practicalities surrounding the use of heroin thus portraying their commitment to heroin as based on an array of considered and reasonable factors. These included the cost of the substance, its properties, its effects on the informants' productivity, and the substance's ability to achieve a particular end.

> "Cheaper, easier. For a while I thought I could work quite well on it as well, which was quite nice because I was starting to get to a point where I couldn't on coke." (Allen, A532)

> "It was like, I put it in a needle and I put it in my arm and like three seconds later it was like phew! It was the only drug that could like actually hit me as hard as what it did. You know it did what it was supposed to do. I mean other like drugs like uppers and stuff used to make me anxious, they didn't last as long, it was too… too expensive to use them." (Dan, B95)

Far from being viewed as the source of potential danger or destruction, heroin use was portrayed as a predictable, effective and optimal solution to life's troubles. It was "what I wanted my whole life", "better than a thousand orgasms", "nothing else comes close". The pleasures of heroin were described as so good that it almost seemed irrational *not* to use heroin.

> "I remember my first hit and thinking, "fuck, I have actually found it!". Do you know what I mean? Like "this is what I wanted my whole life!" And I believe that throughout my using, I never lost that, never, it never felt worse…" (Anton, C310)

> "…I had been addicted to various substances… so…[heroin] wasn't like a new journey it was just kind of like making an old one easier." (Allen, A853)

The elements of the text that rationalised use appeared to assume that substance use was a given and mitigated against any need to justify use. Very little text engaged with the possibility that people should weigh up the pros and cons of inebriation and instead they tended to focus on the practical benefits of using heroin. Accepting that to be 'high' was an unquestioned priority, set up a circular position. That is, it constructed the informants' available choices as limited to choosing between different substances and excluded other possibilities, such as not using substances at all. This assumption, together with the focus on the profile of individual substances, also supported substance use by attributing the problems experienced by the informant, such as low productivity, to incorrectly selecting a substance rather than to use per se.

3. Heroin Use as Functional

A large proportion of the transcripts highlighted the functional elements of using heroin, with all of the informants portraying use as more than the consumption of a substance in order to experience its pleasurable or physiological effects. Some of the more prominent functions of heroin use are explored, particularly those which were thought to offer insight into addiction and its associated behaviours.

3.1 Personal enhancement

Heroin use was portrayed as highly beneficial, functional and rewarding. Informants convincingly argued that using heroin improved their ability to function and provided benefits which they remembered or thought of fondly.

> "I was in a way, in the beginning, more functional because I mean I could stand in a queue at the bank and I could do, clean my car and clean my room and stuff like that, stuff that I really struggled with. You know suddenly I… could deal with stressful situations… if someone [overdosed] I would just sort it out… I miss that, ja I miss that." (Desmond, C271)

At times, using heroin enabled them to feel omnipotent, allowing them to remain calm, objective and capable through the most trying experiences. It left them "untouchable", insulated them with "double glazing" and gave them the confidence and motivation to do things that they would not ordinarily have been able to accomplish. With heroin they were "superhuman".

Although the researcher expected that the informants who had been in recovery for longer periods would describe heroin use in less positive ways, this was not the case. In fact, while the negative aspects were alluded to, those with the longest clean time presented use in the most glowing terms. Some implications of this are explored at a later stage in this chapter.

> "I think it's fantastic, ja I mean ten years down the line I still remember that feeling with a great deal of, love. Romance, whatever you want to call it…. I think, it's overstating it to say, for me, that it was kind of god-like experience, but you know, it was immaculate, that was fantastic, I mean no pain, no anxiety, it didn't mean anything. I was kind of ruthless and I remember that feeling. I was very calm, I think still, and very untouchable." (Anton, C260)

The focus on the benefits of heroin was common throughout the transcripts with little sense of being at the mercy of the substance or of losing control. Accounts of ordinary or initial use appeared to separate the positive aspects of heroin use from the negative ones, as though they were not part and parcel of the same experience, despite the fact that negative effects were often described in other sections of the transcripts. In addition to this separation or splitting of awareness of benefits and costs, other sections of the text portray aspects of use that one might anticipate to be negative as though they were positive. For example, in the extract below Renaldo describes how the apathy and social alienation related to heroin use added to its beneficial functions for him.

> "It is not an illusion, to a degree it is real, because I found as well that the apathy and the distancing as you were saying from society that can be used as a… very effective tool… nothing could really intimidate me… I liked that feeling." (Renaldo, A585)

Renaldo's statement emerged in response to another informant challenging portrayals of the positive effects of heroin by describing them as illusionary. Renaldo's defence surprised the researcher since he expected that as a recovered informant Renaldo would be less inclined to defend the virtues of heroin use. However, this was not the case. It may be that maintaining the premise of heroin use as valuable allows the recovered user to justify having used heroin in the past, and presents him/her in a more positive light. Renaldo's portrayal resists pathological descriptions by suggesting that he used heroin because it was beneficial and that he stopped using heroin once the benefits no longer outweighed the costs.

3.2 Gaining acceptance

Gaining acceptance and approval by using heroin was a commonly encountered justification for use, particularly in the accounts of the younger informants. Sections of the text that focused on the social function of heroin presented use as a means through which the informant was able to gain access to, or acceptance from desired groups of peers.

> "Um, I think I can relate… Like my brother is also an addict and um, I just turned sixteen when I first started using heroin…. most of my friends or my social group started using as well and we started hanging out with my brother and his older friends. So a lot of it was acceptance." (Debbie, B59)

One of the more notable features of this aspect was that the informant described being "introduced" to heroin by admired peers. The suggestion of peer pressure and encouragement enabled the informants to present their decision to use heroin as though occurring in part, on a collective level. This presented an effective justification for use that worked on a number of fronts. It presented heroin use as fulfilling an acceptable and ordinary function which most people can relate to, i.e. the need to be accepted. It constructed a situation in which neither the informant nor any other individual was presented as accountable for the decision to use and it drew on the widely accepted idea that most young individuals are subject to peer pressure and hence can be expected to be negatively influenced on occasion.

> "When I started um, I was introduced to it by the social group that… I was, involved with at the time, um, it was mainly a bunch of guys that were quite a bit older than me who had been doing it for, quite a while" (Kerry, A348)

Kerry suggests that the "guys" were "older" and more experienced than her and so presents a picture in which she, as a young girl searching for acceptance and approval can be forgiven for trusting, or being seduced by them. Dan (below) also draws on the assumption of the commonality of the need of acceptance.

> "I remember the first time I used, um, I had used a lot of other drugs, I was fifteen at the time and I was actually really scared. I was standing in the bathroom with two other guys that I had met. I had this like perception about heroin, like I saw in Pulp Fiction, dirty needles, people over dosing, people dying, you know, and um I was really scared but I... The reason I actually used was to be accepted, because I was in a new college, in a new town. Now I felt, I wanted acceptance from other people." (Dan, B27)

This account is interesting because although it presents Dan as anticipating danger it also appears to downplay this danger. Dan describes his fears as stemming from his "perception" of heroin; a perception that he suggests was drawn from a fictional motion picture. Framing his concerns in this

manner appears to present his concerns as less serious and as though they were founded on an inaccurate account of heroin use. This excerpt also emphasises the strength of the perceived peer pressure in normalising the practice of heroin use.

3.3 Relationship substitute

Several of the informants described their substance use in terms that drew upon images of human relationships. The informants' relationship with heroin was depicted as though it was similar to a human relationship and as though similar conventions applied.

> "I don't know, I am quite a one drug kind of guy, you know what I mean, I am quite faithful to whatever I take at the time." (Allen, A336)

This relationship was typically described in idyllic and endearing terms, much like how someone might describe their relationship with their dependable lover, best friend or spouse.

> "Heroin for me… that was like my mother, that was the king of all the drugs, I did any other drugs… but I would always do it with heroin." (Renaldo, A198)

This manner of speaking depicts the informants as wholly satisfied; almost as though they had recaptured the presupposed state of original bliss. So long as heroin was available nothing and no-one else was required. The informants portrayed a state of mind in which they were totally self-sufficient and encapsulated from the world, of which they were now only minimally a part.

> "I miss the fact that I could go anywhere by myself and I would not feel lonely or exposed because I had friends in my pocket and because I was fucking fabulous." (Alice, C352)

This personification of heroin adds another dimension to the nature of the addicts' bond to their substance. The portrayal is one of a tragic, destructive and abusive, but still dependent, relationship, built on love. In much the same way that the abused lover struggles to break free from their beloved but abusive partner, the addict finds that s/he cannot separate from their heroin. Heroin remains the only 'one' able to relieve the suffering, even though it is the very thing that is causing it.

> "It's so sad to be so in love with something and know that it is beating you up everyday and that sooner or later you are going to have to break up, but fuck can't we just be together for a little while longer?" (Alice, C464)

3.4 Self medication

Many of the informants justified their use of heroin by highlighting heroin's ability to reduce, manage and remove their emotional pain. Psychoanalytic explanations of substance use as an emotional 'prosthesis' as well as behavioural reinforcement models appeared to be reflected in this justification. This justification proved to be particularly powerful and difficult to counter, with some informants describing how heroin enabled them to get a glimpse of life without pain for the first time in their lives. The prevalence of this position within the groups suggested that it is widespread amongst the substance using population.

> "[It was] about… not dealing with what was going on for me in my life. You know like. Um, I wasn't a nice person and I wasn't very happy and I was very jealous of other people that were happy or seemed to be happy… I was quite bitter and um ja, for the first time I just stopped caring about all that other shit. So I think for me that was the main thing it was like a huge pay off for me and that's what kept me going back for more." (Jay, A455)

This function of heroin use once again illustrates that substances use was constructed primarily as a means towards a specific end. In this instance that end included a variety of functions such reducing crippling shyness, depression, poor confidence and overpowering envy.

> "Ja, I mean, like an emotional pain killer, like physical and emotional but mainly emotional… I think I was just like, desperately unhappy and somehow other drugs seemed to, numb some feelings and exacerbate others, and when I tried heroin it just kind of took my feelings away completely and that was basically what you are looking for in a substance." (Jay, A444)

This depiction of use offers a powerful explanation of why it can be so difficult to refrain from using. Apart from portraying heroin as capable of managing pain it also constructs sobriety as extremely difficult and filled with unbearable and terrifying suffering.

> "I can handle it but I am scared to handle reality." (Peace, D93)

This position does not attribute the cause of suffering to heroin or substance use. In fact, not only is substance use offered as a solution to the suffering, it is presented as the very best solution.

> "For the first couple of years, everything was better on heroin. I didn't have to feel insecure or guilty, or, sad, or… sad. I was high all the time." (Dan, B75)

This is moving because it portrays a reality in which one's choice is limited to either choosing to use heroin or choosing a life of unbearable emotional pain. This creates a circular logic in which suffering, even if caused by substance use, is justification for further use rather than cessation. This

may account for how the informants are able to view their own continuing use, as a legitimate state of affairs, even in the face of adverse consequences.

> "For me it is also about the feeling thing, like numbing the feelings, like I don't care, there is no concern in the world, when I am like, strung out on heroin. You know I really don't care…. I liked that." (Debbie, B67)

Achieving a reduction of emotional pain is regularly paired with descriptions of not caring, or being unable to care when under the influence of heroin. It is not as though the problems have gone away but rather that their presence is no longer distressing. This depicts a situation in which the speaker is unaccountable for his or her actions or inactions. They cannot care and so are unable to recognise problems, difficulties, discomforts or injustices. They need not see to their health or living conditions and they ignore what many others cannot. Transgressing the law or engaging in acts of moral degradation are easily justified because their consequences are presented as either being of no consequence to the informant, or as becoming of no consequence once the informant is high. Similarly, the position accounts for how individuals are able leave problems unattended to for long periods or to progress into further addiction because it represents problems as though they were invisible.

3.5 Expressing an identity

A prominent feature of all of the focus groups was the degree to which heroin use was presented as representative of the informants' individual and group identities. The informants described heroin use as a means through which they could both define and express themselves. Interestingly, all of the informants were able to present heroin use as though it represented positive elements of who they were and themes of deviance were actively avoided in favour of themes of open mindedness, individuality, and being a critical or artistic thinker.

> "At university I was involved with the whole kind of group of friends like Kerry and um I was perfectly willing to experiment with a lot of things at the time. Being young and I wanted to be rebellious and different I suppose. I don't know. And I wanted to be like cutting edge…" (Renaldo, A362)

Heroin use was presented as though it were part of a system of signifiers through which the informants were able to express a particular identity. For Renaldo, substances use was symbolic of his liberal, 'up for anything', personality and defined him as unique and forward thinking within his social group. It is important to note how he also distances his current self from this by framing it as a part of "being young". This may allow Renaldo to distinguish between past and present aspects of his identity. It also portrays his behaviour as typical of youth and hence presents a socially

acceptable non-deviant image. Several sub-components of heroin's contribution to a particular sense of identity are explored further.

3.5.1 Identity as alternative

All of the interviewed informants portrayed the use of different substances as symbolic of belonging to an alternative social group, with many of the informants portraying their heroin use as similar to how an adolescent might use music or clothing brands as a symbol of their identity.

> "It's the same thing as there is a certain type of person who would drive BMW's as opposed to Audi's." (Allen, A130)

Substance use was put forward as representing a number of aspects of identity such as one's political position or social status, and hence was portrayed as a means through which the individual could claim a degree of social standing or maintain and add to their sense of self-worth.

Allen, below, explains how different categories of substance users are commonly understood to have different traits, with the heroin users being more subversive in that they tend to fit in more with the 'subcultures' or 'alternative' groupings. He is able to explain how heroin use associated him with these groupings and hence with their attributes, i.e. with critical thinking and alternative political philosophies.

> "Certain people kind of serve that coke culture stereotype type of thing and they dress and express themselves a certain way and they preoccupy themselves with a certain thing. Whereas there are kinds of people that are more of a certain subculture. That's kind of like… usually indicative of different paradigms and drugs and that kind of thing." (Allen, A102)

Heroin use is presented as a symbolic activity through which the informants were able to achieve a number of things. They could reinforce their identities as those of independent, critically minded and intellectually superior individuals who were able to avoid the homogenising tendencies of mainstream society. Similarly, heroin use represents a means to actively associate oneself with the fringes of society as well as to make a political statement, e.g. by rejecting dominant social values.

> "…And um I think that with the smack at the time, um I mean just like, it's like a media villain, I mean ja I could have felt a little bit bad…it was kind of like also effectively saying fuck you to everything… because it was like everything else I could ways delude myself into thinking it was kind of ok um and was aiding me in someway and this was quite clearly not and I quite liked that it was kind of like an act of subversion I think." (Allen, A337)

Using heroin defined its user as different and independent from others. To use heroin was portrayed as the opposite of social conformism. It is selected because it is a "media villain" and because social expectations and pressures lean against it. Using heroin is equated with taking a stand against those social pressures which some of the informants felt to be unreasonably stifling.

> "Also one of the reasons why I used was to be kind of rebellious as well, in a way just to assert my independence, on some level. Especially with some kind of drug like that, where it was not the done thing, it wasn't something you were going to find everybody using." (Patricia, C382)

3.5.2 Identity of superiority

Heroin use is also depicted as a marker of certain desirable attributes in its user. It is as though it is not just anyone who is capable of being a heroin addict. For example, in a paragraph presented previously Renaldo depicted heroin use as a means through which he could be "cutting edge" and Allen does the same below.

> "…With every substance I have ever tried that's how it has been, and with heroin it seemed like quite um I supposes cutting edge. I fancied myself as being a bit of a rock-star on the quiet." (Allen, A407)

The extract following illustrates how heroin use is constructed as a marker of something superior in its users and as a means through which one is able to achieve and become associated with greater things. It allows one the possibility of walking in the footsteps of the greats.

"I used socially until I sort of realised I didn't have to be around people but everyone was like "all the great artists" you know, everybody I admired, the greatest musicians, painters, writers; heroin was the glue that bound us together and therefore, for me, if I wanted to be of that calibre I must experience heroin, or now that I am in the throes of full on heroin addiction, now I can amount to something artistically superior…." (Alice, C1243)

Several informants portrayed something similar but they, rather than following in the footsteps of an idol or achieving greater things, presented heroin as providing access to a "larger than life" existence. Some informants provided an account of their life with heroin that resembled a description of a leading role in a motion picture. Everyday was larger than life, fast and filled with electrifying and intoxicating intensity that left an ordinary existence dull by comparison.

The existence of a social pecking order is also alluded to throughout the transcripts. In these accounts, heroin users represent the highest rank in the status of substance users while other substance using groups are portrayed using negative or derogatory undertones.

> "Oh yeah. Without comment. We [heroin addicts] are on top of the food chain. There is no question…. Heroin addicts are immaculate…. There is a drug taking hierarchy…." (Anton, C1252)

> "I was just in Rustlers Valley for the weekend and Rustlers is very psychedelic culture… and they all look a particular way. You know that kind of psychedelic, hippy, crusty, unwashed kind of look." (Jay, A123)

An effect of this groups' consensus was to bolster the status of heroin users by casting them in a superior light and substantiating the notion that distinctions exist and are recognised by other members. This creates a sense of community amongst heroin users and in so doing supported the identity and esteem provided by heroin use. These views were further supported by claiming that this system was universal.

> "Actually in the UK there are two stages above us and the one is the intravenous methadone maintenance, which I was thank you very much. And there is only one above which is the dry amp maintenance." (Anton, C1265)

Claiming that substances universally act as signs of social status adds legitimacy to the positioning of heroin use and users as superior and in so doing justifies its use to a certain degree by adding credence to the social status it is said to provide. This manner of speaking does not simply present substance using individuals as people who use a particular substance, but rather as though they were members of a clan or 'class' identifiable to all those in the know.

3.5.3 Group identity

Stemming from the perspective just presented, when an individual begins to use a substance they are also initiated into that substance's society as they progress in their use and as they identify with a particular substance. Substance use is not presented as the mere act of consuming a chemical, instead it in part represents the selection of a particular culture and its associated doctrine within the broader culture of the substance using community. This community is presented as pre-existing the individual and as one which is entered rather than newly created.

In this sense, the community maintains a stable symbolic system and set of values and rules. Those in the know or who form part of this community understand this system and are able to operate within it with a degree of consistency. Members of groups are able to interpret the symbols of other groups and easily identify their members, sometimes simply by looking at them.

> "When I go to NA meetings I look in the room and I'm like "oh that person is definitely a coke addict", you can just tell by their personality. I try like guess who is like on my team. Team smack." (Alice, C1293)

A consequence of this is that it constructs the realm of substance abuse as an entirely separate social reality, complete with its own system of norms and values. The substance user is no longer for example, the psychiatrically ill patient whose physiology has adapted to the presence of a substance. S/he is now a member of an alternative subculture and in a sense follows a different doctrine to that of 'mainstream society'.

> "I am thinking maybe in terms of opiate addicts if they do have something that maybe is different to other sort of so called 'addicts', that is that they are the uber snobs of addiction. Like opiate addicts think that they are the hardest, the baddest, the most exclusive the most unclassifiable." (Jay, A275)

We might then expect that an individual who moves from one substance to another is not only using a different drug but is also living in accordance with his/her group's expectations and climbing within its ranks. S/he does not merely shift from cocaine to heroin use but rather graduates to the next level. In this way behaviour which might ordinarily be associated with degeneration is positioned as a promotion.

Supporting the idea that the texts present heroin use as a distinct culture which is bought into, was the manner in which the informants used a shared jargon to communicate with each other. This suggests that these informants have access to a highly developed system of shared meanings regarding substance use. From this perspective heroin use or dependence is portrayed as far more complicated than chemical dependence. Chemical dependence implies that the user's struggle lies with the chemical itself, however, the informants' portrayal places them within a culture upon which they depend and which they must leave in order to recover. This is further complicated by the number of functions that the substance serves and is seen particularly clearly in the sections of text addressing the informants' lifestyles.

> "Well, I think… as much as I was addicted to the heroin, I was addicted to the lifestyle… like getting, scoring, hustling… you know… I mean like that was part of the reason I took heroin. I loved that feeling." (Dan, B240)

Another related feature which appeared throughout the transcripts was the informants' tendency to portray themselves as being fundamentally different and/or as belonging to a different class of person, i.e. the addict. Their difficulties were presented as though they could not be compared to those of "normal people", "Joe Soap" or "civilians" and hence could only be understood by those who have experienced addiction themselves, i.e. other addicts.

> "You know when I start talking to Joe Soap about the hole in the soul he sort of looks at me as if I have smoked too much crack. And he is probably right. Do you know what I mean? So it's ok forget that I said that Joe…. Let's talk about football. You know and then we can communicate." (Anton, C1129)

The highlighting of difference was not limited to addicts vs. non-addicts, but also extended to other users of different substances. To understand the experience of a heroin addict one has to have been a heroin addict. It is not the same as other addictions. In this manner the realm of addiction or substance abuse is portrayed as profoundly complex and as a world of its own.

> "[Desmond was] a kindred sprit. Because he got me, because, you know, he was a smack head, we get each other, and like those crack heads, like you know, we kind of get them but you know they don't really get us." (Anton, C1289)

Explaining one's experiences as though they can be only be understood by other heroin addicts has far reaching consequences. It produces the addict as fundamentally different to the 'ordinary' population and so alienates them. Their identity is defined upon the basis of otherness. To feel understood by a non addict may imply that their experience was similar to that of ordinary others and hence might well be experienced as threatening. Accepting this can help us understand some of the difficulty involved in accepting treatment, taking the advice of others or feeling understood in an 'ordinary' world.

In the extract below we see how Renaldo, in his humorous testing of the interviewer, highlights the existence of a distinction between substance users and non-users and between those in the know and those on the outside.

Renaldo:	"How did you come to that interest [in addiction]?"
Interviewer:	"I am an addict."
Renaldo:	"A friend of yours?"
Interviewer:	"No me."
Renaldo:	"What?"
Interviewer:	"Welconal".
Renaldo:	"Ok. How long?"
Interviewer:	"Two and a half years."
Renaldo:	"Did you go to rehab?"
Interviewer:	"Many times."
Renaldo:	"Ok you passed the test." (A25)

Further support for the existence of this identification with difference was found in the informants' descriptions of how the employment of recovered addicts as counsellors, and attending groups such as NA helped them to recover. Some mention of this is made in Desmond's account below. Here we see how he implies that it was difficult for him to take the opinions of non-addicts seriously. It is as though these individuals and professionals cannot truly understand his predicament and hence are unable to help him.

> "And um my counsellor here, was a recovering heroin addict... and I think that, because I have never been to a psychologist now even… I think maybe my junkie pride was just so hectic that I could, listen to a recovering heroin addict… um, he had the credentials. Ja, and that's kind of what worked for me." (Desmond, C800)

In conclusion, section one has explored the characterisation of heroin use as initial or commonplace. This was carried out by outlining how the informants portrayed their use as ordinary, rational and functional. The third element was explored in detail and several of the functions of heroin use presented by the informants were outlined. The analysis now moves to the second characterisation of use.

Section Two - Addiction

The second characterisation of use is that of addiction. Unlike the characterisation of initial or ordinary use which highlights the normality and benefits of heroin use, addiction embraces the pathological and negative aspects of use. Although addiction was presented as though it were in binary opposition to initial or ordinary use, this is misleading since the informants drew on both characterisations at different points in the texts to refer to the same periods of use.

> "I remember my first hit and thinking, "fuck, I have actually found it!"… Like "this is what I wanted my whole life." And I believe that throughout my using, I never lost that, never it never felt worse." (Anton, C310)

> "And I mean you know (I wanted to use heroin) less and less as it went on, you know I mean, and I think the last four years, I kind of really really really wanted to stop but I could not." (Anton, C500)

The researcher understood this apparent contradiction as evidence that these representations of heroin use were both descriptive and functional. If the descriptions of ordinary or initial use served to present heroin use as a reasonable activity then characterising use as addiction provided a means through which continued use, in the face of severe negative consequence, could appear justified and legitimate, or at the very least understandable.

The remainder of this section provides a detailed outline of how the portrayal of addiction is achieved along with some of its features, related discursive strategies and consequences. The task is approached in two subsections. The first subsection explores how the informants constructed addiction vs. initial or ordinary use. Four aspects are outlined. The first is the presentation of addiction as unsustainable. The second is the description of a different pattern of use that reflects changes in behaviour and a shift in moral code. The third is the portrayal of substance use as mandatory and three examples of how this was achieved are presented (highlighting psychological deficiencies, abstinence and physiological cravings). The fourth is the presentation of a reduced sense of agency. The last mentioned is also explored in the second part of this section because; while it distinguishes between ordinary/initial use and addiction, it also offers significant insight into addiction as a characterisation of use.

The second part of this section more explicitly explores some of the discursive acts or functions that the discussion seemed to perform that sustained and perpetuated ongoing heroin use. Four strategies were identified which included the displacement of agency, the presentation of heroin as a solution to problems of its own making, the *invention* of justifications to use, and the presentation of reality as a

place in which stopping is impossible. Each of these various themes and strategies is explored in turn.

1 Initial Use vs. Addiction

All of the transcripts drew on a number of features in dividing substance use into two distinct forms of use, i.e. initial use vs. addiction.

1.1 Unsustainable / insatiable

The first manner through which the informants were able to distinguish between ordinary or initial use and addiction was by describing the progressive nature of use (i.e. tolerance) and highlighting the increasing difficulty that they experienced while trying to achieve or sustain an inebriated state. Once addicted, the informants required increasing amounts of the substance over time in order to function normally. Indeed, the degree to which they were able to function was described as virtually entirely dependent upon whether their acquired minimum daily requirement was met, or preferably, exceeded.

> "[How much I use] depends on how things look, four bags, twenty, twenty four bags. If I don't have any [money] I can take one thirty bag the whole day… but I wont feel good, I will feel lazy, sad maybe, unhappy…. but the more I have the more talkative I am the more flexy I am." (Peace, D35)

The minimum requirement was described as ever increasing and hence addiction was presented as a progression that became more and more difficult to satisfy.

> "Definitely… it progresses to the point where it doesn't even work properly. And then you switch to needles… and then you have to switch to so much and so much until things like stealing and criminal activity. You do anything to get money because your tolerance has become so high and you will be sick, you will get jungle fever if you don't have it, so..." (Renaldo, A396)

The informants did not necessarily highlight their dependence in terms of the *amount* of substance that they needed to use and instead often focused on the ability of the substance to achieve its desired effect. Hence the functionality attributed to use described in the previous section of this study continued even in the informants' accounts of addiction.

> "You know um, the thing with the needle hey, well at least for me, you know I started smoking… and once I discovered the needle it was like… if I didn't, I could go through like ten, whatever amount of bags and still I'd, I'd actually be addicted to the needle feeling you know. Cause schnaffing didn't work any more… I would still have this anxiety because I need a shot." (Mark, B104)

Jack's account below describes how it is difficult to refrain from use because in so doing the function that the substance serves is removed and the informant must then face what they have worked so hard to avoid. Indeed removing the substance puts Jack back in touch with the very reasons he used it in the first place.

> "One thing I have realised since I have been here is like after the physical pain is [gone] you start to deal with like the emotional pain … I wouldn't know where it was coming from, and then that would come up again after you put down the drug and had gone through physical withdrawal, um, ja, I think that's also why every time you pick up. You don't know what you are feeling, you don't want to know at that point." (Jack, 159)

Another significant feature of this account is that it does not portray the discomfort which the informant experiences as caused by heroin use. Instead it is caused by its discontinuation. Several informants also portrayed the discomfort that they experienced in either the absence or lack of effectiveness of heroin as though the discomfort had existed prior to their initiation of heroin use.

> "Ja you know, now when you start, when I started using it was like, so lekker and it was nice to be a heroin addict and um, say the last year it gets to the point where like, you use and ok, you don't get as high, it doesn't cover up your insecurities, it doesn't cover up the shame and the guilt any more… you know the heroin is not doing what it is supposed to any more…. It is not working any more it is not as effective as it used to be." (Dan, B410)

This appears to be a problematic position because it substantiates further use by highlighting how dreadful life without effective substances use is, rather than supporting the discontinuation of use through highlighting the unavoidable negative consequences of use and the benefits of sobriety. At the point of failure of effectiveness, instead of stopping heroin the informants describe using it more and more insistently, with the objective of trying to recapture how using had been experienced before addiction developed.

> "And I mean, you know, the difficulty is, you know, is unlike these people who were quite sensible and two years later managed to give it up, I spent the next ten years, trying to get back in control. Do you know what I mean? Really! I wasn't going to stop I just needed to get it back in control. And I spent ten years trying to control my addiction…" (Anton, C456)

1.2 Distinct pattern of use

1.2.1 Changes in behaviour

The second predominant feature distinguishing ordinary or initial use from addiction was the altered form that use was said to take, as will become clearer in the ensuing discussion. Paradoxically, informants suggested that as the intoxicating effects of heroin diminished, so it became increasingly important in their lives. Addiction was thus presented as a situation in which informants became increasingly preoccupied with procuring and consuming heroin. This progressed to the point where their lives no longer resembled those of 'ordinary people' and heroin formed the centre point around which everything revolved.

> "Eventually those effects diminish and… it becomes your life, and everything you do see becomes about heroin and going to get it and using it. And having enough for the next day or whatever… and eventually it gets to the point… [where] you ostracize yourself from all of your friends and family. You live on the marginal lines of society…" (Renaldo, A480)

The degree to which heroin took on this pivotal identity is illustrated clearly in the extract below. Here we see how using heroin has come to form the basis of so much in Susan's life, to the extent that she even frames stopping heroin in terms of potentially enhancing further use.

> "… always I have thought to myself "okay if you can do this [go to rehab] then you can live a life that you can have a bit and just really-really enjoy it." (Susan, D665)

1.2.2 Changes in moral code

A number of the informants paired their accounts of how heroin use increasingly occupied their minds with descriptions of increasing levels of desperation for the substance. This desperation was regularly put forward as intense enough to justify virtually any behaviour that might reduce it.

> "…I promise you if I could have sold my mother to the Nigerians for drugs I would have. Like that's the like desperation to use." (Debbie, B535)

Hence addiction is presented as a state or social reality in which the usual conventions and rules of society do not apply. However, in addiction it is the suffering the informant experiences that is used to justify their socially unacceptable activities rather than any primarily antisocial motivation.

> "And I also think that… you get to a state, you drop, your pride, your standards, your morals, anything at times. And you can hate yourself for it but god if you need a fix…. For twenty rand. I can make you do things that you

> would never had wanted to or hurt people indirectly that you would never dream of hurting or you will make yourself believe that you can fix the situation once you feel right and that and you can't." (Emily, D221)

This is interesting because it enables the informants to portray their morally reprehensible behaviour as the result of something other than the informants' own actions or morality, i.e. it is presented as *caused* by addiction. This position preserves the informant as a moral citizen who would not ordinarily partake in such activities and will not once they have fully recovered from their addictions.

> "And then? Somewhere it went wrong, and I am not at fault here, it was terrible and it went wrong and all of a sudden I just needed more of this and ten of those and I don't know how it happened…" (Alice, C379)

> "Money wasn't really a problem until I moved up here… and um, [my girlfriend] she started… prostituting herself and then, I just basically allowed it… Under normal circumstances I would be like "are you mad?"... You get to the point like they said where you don't really; you make it all as if it is all right. As long as you can, get more money to get more drugs…" (Jack, B557)

1.3 Use constructed as mandatory

The third defining feature of addiction was that use became portrayed as unquestionable and mandatory.

1.3.1 Psychological Need

The informants presented their situation in a manner that suggested that they had little choice but to use heroin given their difficult personal or psychological circumstances.

> "… I am hectically shy, and that's one of my biggest fears of stopping heroin, heroin of all the drugs I have taken has reduced the shyness the most… I'm so scared to go back to that level of shyness because it is a problem, really it is. I have nearly lost jobs from it and stuff, um its just, it's so horrible to go through that, it's torture… so for me that's security on one level and on another level I am a slave to it, I can't make a plan for one week down the line because I don't know if I will have money for heroin." (Emily, D62)

Emily links her use to overcoming serious psychological distress and so portrays her life without heroin as unliveable. "It's so horrible to go through that, it's torture". Heroin use is not negotiable, despite her recognition of its significant drawbacks. Interestingly the drawbacks are framed in terms of her insufficient funds rather than heroin addiction.

In the extract below, Peace justifies the mandatory nature of her heroin use by referring to her past and her upbringing in a manner that presents her as unable to face reality without heroin.

> "For me I can say, maybe… it's from where I come from… Like from my parents, the way I grew up, I didn't have that love like normal kids… knowing how to live on reality, growing up always angry, wishing…" (Peace, D81)

Peace's self is presented as deficient and as requiring heroin in order to function normally. It is important to note that this deficit is depicted as predating her heroin use and hence her reliance on heroin. The informants with the greatest recovery times approached this differently and tended to ascribe the difficulties that they experienced to heroin use rather than other circumstances.

1.3.2 Abstinence Syndrome

The informants also substantiated the position that heroin use was mandatory by highlighting the 'abstinence syndrome'. This 'syndrome' was regularly used to portray the informants' struggle with heroin addiction as being more difficult than the struggle faced by other substances users.

> "Crack and heroin are on a par. The things that people do. I have never heard of anyone prostituting themselves for ecstasy." (Dan, B546)

Apart from facilitating the expression of an identity of being tough and allowing the recovered informants to depict themselves as having achieved something remarkable, describing heroin addiction as tougher than other addictions also provided a powerful justification for continued use. Heroin addicts are not like cocaine addicts who can simply "sleep it off". The heroin addict *must* have heroin or suffer the consequences of withdrawal. This comparative strategy locates heroin addiction at the level of biological addiction and hence well beyond the informant's control or agency.

> "Well um, first when you start you want to get high; it's nice to get high. Then it's like… basically it comes down to you do it just to be normal… because I mean walking around all in pain, shees, you know, your mind is somewhere else… that's how it is… I didn't want to do it. I would go to bed every night and say this is my last day…. and then the next day I wake up and I say "I just can't handle this shit and I must go and use!" (Mark, B396)

Two of the currently using informants described life without heroin as far too difficult and the prospect of withdrawal as so overwhelming that there seemed little point in fighting addiction. This depiction perpetuates use through attributing the pain experienced in the absence of heroin to the absence per se, rather than to heroin use in the first instance. Addiction is also distinguished from ordinary or initial use as something painful, negative and as occurring against the informant's will.

> "But also like being physically addicted to that… It was like I wanted to stop, and I tried to stop like a lot of times, but you know, the withdrawal would be so overwhelming… I just wanted to be ok." (Debbie, B132)

In the extract below Anton describes how powerfully the need for heroin occupied his mind and how there were literally very few limits to what he would do in order to get heroin. The choice he presents is not one of having heroin or not, but between being sane or insane.

> "I never tried that. 72 hours!!! I mean like if I was like twelve hours… it would be really really really uncomfortable… I would go twelve maybe twenty four hours without and…I would go mad … I was obsessed with getting, like if you, if you had money and I could get it off you… I wanted to be with it… and I think the last four years, I kind of really, really wanted to stop but I could not." (Anton, C484)

Calling upon the withdrawal syndrome to explain continued use is a difficult position to challenge because of its roots in medical discourse. When this was used to justify continued use the informants spoke with a sense of absolute conviction. That fact that many of them had stopped using and had survived withdrawals was never raised or engaged with as a challenge to this perception. That heroin was physically addictive and that this was a reason that made stopping near impossible was held up as a natural and predictable law from which no one could escape. The unchallengeable nature of this 'fact' was emphasised by portraying the experience as though it was something all heroin addicts shared.

> "Let's say you are fighting a war and you are with these other soldiers and you experience a similar situation to them. It's a different war and a different experience. As for alcoholics or with opiates we all know like the pain of quitting heroin or whatever we were on… we all have been through it, we all know the symptoms…" (Renaldo, A257)

Only one informant (Anton) raised the fact that some individuals use opiates regularly (e.g. in hospital for pain) and yet never develop an addictive pattern of use, despite exhibiting withdrawal symptoms. Anton, however, raised this point in support of the NA disease model of addiction which, like the medical model, locates the origin of addiction as inherent within the individual and as beyond the bounds of conscious control.

1.3.3 Cravings

Another means through which heroin use was portrayed as essential, was in using emotive terminology, such as the notion of "cravings". Here "cravings" are portrayed as a distinct phenomenon. They are presented as though they share no similarity with desire or want and are constructed as the consequence of a physiological process.

> "…And I don't want to like elevate heroin addiction, but when it's got you it's got you… When you are clean you get physical cravings as well. Last night I craved." (Dan, B186)

The use of the term cravings, as opposed to desire, is significant for two reasons. It describes the impulse as belonging to something other than the self by constructing it as a personal intrusion that exists beyond the realm of one's control. Craving is a term typically used to describe strong physiological urges signifying a biological need for some substance. Pregnant woman 'crave' unusual combinations of food as a greater demand is placed on their bodies for nutrition. We crave oranges and say that we need vitamin C, or crave food when we are hungry. Cravings designate an urge for something absolutely necessary, rather than optional.

1.4 Reduced sense of mastery

The fourth defining characteristic of addiction, as opposed to initial use, was that informants presented addiction as a state in which they experienced a reduced sense of mastery over their use. Several of the informants explained that with addiction heroin use changed from something that had served a valuable function in their lives to something which they began to serve.

> "…They were doing me I wasn't doing drugs any more. Does that make sense?" (Alice, C368)

A feature of this distinction was that heroin was often presented as though it had developed an agency of its own and had begun to either actively enslave the informant or mould them to its own agenda. This manner of speaking again cast the informants as less accountable for their actions by failing to directly link their behaviour with the consequence of that behaviour. A further unintended consequence of this type of speech is that it could itself reduce the informants' sense of mastery by reflexively constructing their reality as beyond the bounds of their control.

> "Yes and also I never saw it as my saviour. In fact that was something that kind of progressed rather than diminished because it was like when I started it was quite, I was quite terrified and like the pay offs weren't quite that huge but as it kind of developed into it… as I got more and more into it they became clearer and clearer and it was just kind of like… self sustaining really, because it was like, it created a need for itself." (Allen, A510)

Allen's portrayal very clearly presents heroin as the agent to be held responsible for his addiction. It is almost as though heroin operated like a parasite working to ensure its own survival by creating "a need for itself", rather than Allen actively choosing to use heroin and then gradually becoming dependent upon its effects.

> "It was weird though, it was never a major passion, I never felt the same way as I had felt about other substances… but it just became, it was like the path of least resistance and… it was also about letting go of all responsibility and letting go of all that sort of stuff and kind of, subverting." (Allen, A419)

Allen's account constructs his move into heroin addiction as less of an action (doing something) than an inaction (doing nothing). This description of the continuation of use was encountered in several informants' accounts and appeared across all of the interviewed focus groups. In these accounts the continuation of use was consistently portrayed as though it were inaction, whereas stopping was reciprocally described as taking action. This construction is curious given how much of the informants' day would be consumed by procuring and using substances. In similar vein, continued use was also presented as an expression of not taking responsibility, as though fate became responsible for outcome and not the users' actions.

> "The fact of the matter is that when you are using drugs it's like chancing things, it's that dangerous kind of mentality. I'll push it to the edge I want to see how it feels and I will get so fucking loaded tonight and if I wake up then I wake up. You know, the big man will decide…" (Renaldo, A1046)

Although different informants attributed agency to heroin in a variety of ways the effect of their so doing was always the same. It represented an externalisation of the informant's locus of control and presented a description of use in which the informants' accountability for their actions was reduced. In the account below Jay explains why he believes addiction is a disease by distinguishing between ordinary behaviours and addictive ones. He suggests that addictive behaviours are actions that occur independent of will. It is as though he depicts his addict self as a marionette moved against his will by addiction's personified agenda.

> "The parallel that I always like draw is like, I decide that I don't… like diet coke. You know I don't like the effect of diet coke so I don't drink it. Right? Great! I don't drink diet coke. I never wake up, suddenly, and say "I must drink diet coke!" Like, it never happens. You know I don't like this program on TV. I never find myself watching it against my will." (Jay, A1177)

Having outlined some of the strategies used to present addiction as a distinct construct, the analysis now moves to explore four strategies that appeared to specifically sustain or perpetuate ongoing heroin use.

2. Discursive Strategies Perpetuating Use

The following subsection presents the sections of the text that appear to support and perpetuate substance use in their construction of various aspects of use and addiction. The discursive strategies outlined in this subsection appeared primarily in the transcripts of the current users and those early into their recoveries. References to these strategies were found in the other transcripts, however these tended to describe such features in the past tense rather than illustrate them live in the text.

2.1 Displacing agency

The first strategy to be presented closely overlaps the theme of a 'reduced sense of mastery' and similarly operates through attributing agency away from the self. However, sections of the text took this reattribution of agency to the point where the informants' behaviour was presented as though it were not under their control at all, reflecting a peculiar and helpless position.

> "Phew it is starting to get to me a little bit... not that I don't trust myself it's that I don't trust myself. It's kind of like one of those things… it's going to be like a whole totally different experience because I haven't really been this clean… So it is going to be like this different reality… I am confident but not over confident, I have got that fear that is kind of keeping me in check the whole time. I don't really know what is going to happen…" (Jack, B227)

Statements such as "I don't trust myself" and "I don't really know what is going to happen" depict the informant as unable to predict or control their behaviour. While statements like "It's kind of like one of those things" suggests that things cannot be changed and hence should be accepted just the way they are. The extract suggests little sense that Jack can influence his destiny or act on his environment. This position was typical of many of the informants with little recovery behind them, and, in its lack of emphasis on personal agency, may promote further use by failing to link actions which are within the informants' control with potential further substance use.

> "…And um, and I cut myself and like, like, cause you know I don't want to go through this, I am sick of hurting everyone, I am sick of hurting myself, but I don't know how to stop, I don't know how to live another life." (Mark, B403)

Another strategy through which the informants presented themselves as unable to control their behaviour was by portraying the decisions that they took as having no bearing on subsequent behaviour. The informants described a process known to them as 'shifting the goal posts'. Shifting the goal posts referred to the addicted informants' tendency to automatically adjust their limits to accommodate their increased use.

> "It's called 'shifting the goal posts'… I always thought I would never do heroin I'll never do cocaine, I'll never smoke crack. And it wasn't even six months later that I was on heroin and smoking crack. I would never steal from anyone and, then I was stealing from people. I'll never prostitute myself. A few months later I found myself on Sea Point main road prostituting myself… Every time I said I would never do something I would land up doing it. Because that's what addiction does." (Dan, B506)

'Shifting the goal posts' was not portrayed as a process of reconsidering prior decisions and electing to take new ones. Instead it was presented as though changes in use behaviour, as an aspect of addiction, occurred beyond the realm of control or awareness. This use of language appeared to perpetuate the construction of a reality in which the informant is cast as unable to change and in which their sense of agency is reduced. Dan "found" himself prostituting himself, almost as though he woke up from a dream and there he was. He explains how "that's what addiction does" rather than referring to what he did.

> "It's the most amazing thing for me. I started on, you know here's, here's the ball park and I started smoking weed but I was like acid "that's really bad I am never going to do that". And then it was like I will shift the goal posts a little. I am doing acid and weed but cocaine that's terrible, people who do coke are out of control. And then it was like ok acid, coke and weed, but heroin that's the killer, that's really, those people are fucked. And then again, just keep on changing the game." (Alice, C599)

The net effect of portraying themselves as unable to control their behaviour is that it suggested in turn that the informants were unable to facilitate their own recovery. The choices they make are presented as ineffectual and hence whatever they decide to do will fail. All of the informants that were currently using heroin expressed the desire to stop, however, they insisted that this was impossible. This strategy represented one of the most robust aspects of addiction in that it relentlessly implicitly constructed further use as the only available possibility.

> "I mean all of us have basically tried to stop on numerous occasions and it's just not worked… it's not like we accept that this is our way of life…. It's not like we are in the middle of a jol… None of us likes what we do although we do it…. I don't accept this as my life style, I mean, it's always been a case of I wanted to stop it's just a problem of how to do it?" (Susan, D168)

None of the actively using informants engaged with any of the available means of quitting (e.g. looking for a sponsor) or with how they might gain access to means which they presented as unavailable.

> "Ja. Well I mean, certainly for me, as you know I am going away [to rehab]. I am incredibly lucky because quite honestly I never thought there was an option…" (Susan, D264)

Very little attention was paid to how one might go about changing one's situation. Instead emphasis was placed on why the situation was the way it was and why changing it was impossible. The discursive production is one of a reality with no alternatives and no means. The habitual and near automatic use of this form of speech reflexively supported the status quo by preventing the consideration of alternatives through excluding them from the informants' speech repertoire and world view. For example, when challenged, these informants would not engage with the possibility of change and without fail continued to produce further justifications for why stopping was not possible.

> "I think we just don't believe that we are worth any better. We don't trust ourselves. We don't think we can achieve more in life and that. We lose a lot of our self-confidence. We don't believe in ourselves enough…. We are scared of failure as well." (Emily, D581)

Below Emily describes how she appreciates the feeling of sobriety that she wakes up with in the morning. She portrays herself as longing for that feeling but resigned to the impossibility of sustaining it because it is not she herself but her body that is ultimately in charge.

> "Or even sometimes before you feel the full intensity of the Thai sick in the morning your brain feels like in a nice space. Like things seem… brighter and clearer… before the depression kicks in and the aches and all that, and you quite like that straightness that straight feeling it feels good… and you wish you could sometimes stay on that level without knowing that you have to go and get a substance… Ja but you can't because you know your body is going to want afterwards, the aches and pains are going to win." (Emily, D112)

Emily's account depicts a situation in which failure is guaranteed. Her body *will* want more heroin and "the aches and pains *are* going to win". This form of speech substantiates her position as defeated. For example, Peace's disclosure (below) portrays a scenario where choosing to stop using heroin makes no difference because she always goes back on her word the following day. This depiction supports a position in which ones ability to commit to the decision to stop is inevitably compromised by constructing that decision as inconsequential.

> "You so are sick. It's like your soul, everything about you is low, you have got no power for nothing, you can't talk to people, you just, you negative, cause you know that the minute you see it you can carry on and there will be a hand, you can't be sick forever but you so weak, your mind tells you "no let me just have a last one and then tomorrow I will stop and you can't"…. Ja, we always think we will, I am going to stop, I am going to stop, this is the last time… but then the next day you are sick and you go again…" (Peace, D155)

The manner of speaking illustrated in this subsection perpetuates use in the employment of a kind of fatalistic construction of the relationship between heroin (and its effects) and the individual. Not only does the drug, and in turn the 'addicted body', take care control of the 'self', but any attempt to resist this domination is doomed to failure from the outset. Intentions *cannot* be translated into agency and behaviour change.

2.2 Presenting heroin as a solution to problems of its very making

An interesting manner through which heroin use was perpetuated in discourse was by constructing or presenting heroin use as a solution to the problems that it induced in the first instance. The most apparent illustration of this means of viewing and talking about use has already been touched on and involves the manner in which heroin is portrayed as the solution to withdrawal. Heroin withdrawal is presented as though it were the consequence of a lack of heroin rather than caused by regular heroin use; hence using heroin is presented as a rational means to reduce the negative effects of the withdrawal process.

Other examples include informants discussing how feelings of guilt resulting from substance use or accompanying behaviours (e.g. prostitution) were easily managed by further substance use.

> "Ja, I think I made things ok for myself for quite a while. I also did the whole prostitution thing. And I swore I never would. But as long as I had the drugs I didn't care." (Debbie, B533)

Jack explained that heroin was a solution to the cold he experienced at home. Being a heroin addict prevented him from owning the amenities necessary to keep warm during the winter months but this did not matter because heroin kept him inured to the cold.

> "When it is like cold. And that's why I started using. Winters get really cold in the west. And it's, it's one of those things where you don't really live in a place that is well furnished… any excuse basically, but kind of it takes, takes those things away, as well. Physical pain, emotional pain..." (Jack, B84)

Heroin use is portrayed as a means through which the informants can avoid confronting or experiencing problems and distress, and hence it enables the user to avoid engaging with the negative implications of use. Similarly, several informants described heroin as able to produce a state in which they did not care and hence, by implication, that they were unable to take any heroin associated problems seriously. These features are significant because they help understand the difficulties experienced in quitting, an activity which can only occur after facing the negative

realities of substance use, which are impossible to appreciate if one does not care or if one is impervious to these consequences.

The discursive strategy illustrated in this subsection perpetuated use through a circularity of reasoning that consistently presented further use as appropriate and hence prevented authentic engagement with the possibility of abstinence.

2.3 Inventing justifications

A related strategy to that just discussed involved developing representations of circumstances that would invariably justify further use. Any number of situations could be made to appear to the informant as an appropriate reason to use heroin. This process allowed informants to understand their use as caused by something external to themselves and thus to absolve them of any sense of responsibility.

> "I mean, like in the past I would use any excuse to use, I lost my job, my mom said this, my dog died, you know any excuse to go and use. Basically I didn't even need that excuse because I wanted to go and use but I know for myself I like to find excuses because then I can avoid the responsibility. It was… because of that and not because I wanted to go and use." (Dan, B477)

As with the other strategies used to externalise the informants' locus of control, this strategy may render the user less able to control their use by perpetually portraying use as justified. This is illustrated in the following quotation where Mark describes actively constructing justifying situations. This extract demonstrates quite clearly how this process effectively constructs the informant's actions as though caused by others and hence beyond personal control.

> "Ja I am like this, I used to build situations up. Maybe I'm sitting at home and… even before I got really addicted you know… and I sit and my mother would say "come and wash the dishes and stuff" and I was like "what are you trying to say? That I'm not washing the dishes? What the hell is happening here?!"… I build these little situations up and manoeuvre people around me just so that I could find a gap and go and use." (Mark, B484)

Doing this not only leaves the user feeling justified in using heroin, but also allows him to understand his use as an automatic consequence of some external circumstance, in this case as a response to other people's misbehaviour.

> "Um, when times are shit, we came back from the rehab experience and we went seriously to stop and that. We came back, we didn't have jobs, there was nothing to do, we were feeling down and depressed, everything like that. And its, its childishness on our behalf. Like being a brat not getting what you want… It was "So we will

> take drugs!"… I don't know. Sometimes it's as if you will show other people, sometimes it's as if we can control it, sometimes us junkies have the attitude that life owes us something." (Emily, D470)

The transcripts taken from the currently using informants who were not in recovery consistently portrayed practically any situation in a manner that justified further use. Evidence of the addicts' ability to construe and construct the world in ways that justified use appeared in the accounts of all the users who had some clean time behind them, usually accompanied by some form of self reflection. These informants repeatedly suggested that the way they perceived the world as an addict was different from how they perceived it in the present.

> "…the whole physiological thing is kind of irrelevant [in addiction] and it's all kind of like me and kind of the way I see the world." (Allen, A905)

Such descriptions supported the idea that the reality of the addict was malleable and easily transformed into whatever shape best suited the continuation of heroin use.

> "I don't think there is enough perspective, at all when… you are sort of living in it… I don't know what my views of addiction were really… I think they were whatever served my purpose best at the time. And they were likely to change rapidly. And they would totally contradict themselves." (Kerry, A910)

While this moulding of reality was typically described as something the addict does, it was also presented as something that they are unable to recognise. It is not that addicts consciously searched for ways to justify their behaviour. Instead this perspective was presented as though that was the way they actually saw the world.

> "I did a lot of things that I didn't want to do that hurt people; that I didn't want... But now, only now do I realise. Back then it was like I am living the life I want to live." (Mark, B521)

2.4 Emphasising why one can't stop

A prominent feature of the transcript taken from the currently using group was the repeated assertion that recovery was impossible because the means to stop were not available. Sections of text depicted a situation in which the informants lack the necessary resources to stop using heroin (e.g. money for rehabilitation) and hence are left with no choice but to continue using.

> "Ja. Well I mean, certainly for me, as you know I am going away. I am incredibly lucky because quite honestly I never thought there was an option…. I mean it's a huge amount of money you know, and you can't, ok Noupoort wasn't hugely expensive but if you go the other, there aren't many options hey, as, as, as, a South African person not on a medical aid, without money behind you there is absolutely no, well there is almost no

> choice…. so um, basically there is no option for a person, unless you have got money behind you, to stop taking drugs, unless you are going to do it on your own, go get a script from a doctor and do it on your own, but the point is… you have got to get out of your situation and, ok I am the lucky one here, I have got the, I have got the chance to do it, but as far as Peace goes, as far as Emily goes, where can they go? How can they do it? There is nowhere to go." (Susan, D264)

Susan outlines a number of available avenues for help but then systematically portrays each option as either ineffective, inappropriate or out of reach. Recovery is portrayed as dependent upon a host of unattainable factors, beyond the informant's personal realm of control. This kind of talk constructs the informants as unable to stop even if they wanted to.

A similar strategy to describing the impossibility of stopping was to express the intensity of the desire to continue. While apparently opposite constructions in that one focuses on the desire to stop while the other looks at the desire to continue, both approaches justify the continuation of use and shut down the possibility for recovery. For example, in the extract below Emily explains that she no longer wants to stop when the means do so become available because it is only when times are bad that one wants to stop.

> "But sometimes you do want to be in this space as well. Everyone can shout "I don't want to be here" but then someone will put the opportunity in front of your face and you will think "just wait not, not quite yet"… Like why would I have like, when I have had good jobs and lots of money and that why didn't I take the opportunity then? Because it was lekker! I could afford the drugs everyday, it was easy. Only when you are down and struggling and that and you are basically a hobo and you have got no dignity left or anything then you seriously start thinking of pulling out." (Emily, D306)

Interestingly, although Emily suggests that it is only when she is down and out that she seriously considers stopping, in the paragraph below she explains that trying to stop because of negative circumstances does not work because you need to be able to stop on your own terms.

> "…I know when you feel ready to stop… the circumstances around you don't allow you that, and there are times when you are almost in a situation where you are forced, where you have to stop because of finance or something, then… there is something in you that you don't want to then, because you want to stop on your own time, not be forced in a sense." (Emily, D193)

The above two apparently contradictory paragraphs demonstrate how Emily's constructions of use portray a situation in which stopping is impossible, not because the means are unavailable but because her construction does not allow for the possibility of stopping. At best, her construction suggests that stopping maybe be possible if she somehow finds herself no longer wanting to use

heroin while enjoying a trouble free relationship with heroin, an unlikely occurrence. Peace outlines a very similar position in the extract below.

> "I think also the best way to stop drugs is when you can afford them everyday and you smoke them enough of it, so like when you are a hobo you can't afford it and you want it… now you are forced to stop because you can afford it, your heart is telling you that you have to stop because, I mean I am suffering. So you stop, you have a chance to stop, when you are clean you come out, you still have that little bit of a mind to just have a full one." (Peace, D320)

The manner of speaking illustrated in this subsection perpetuated use by continually and consistently foregrounding obstacles to stopping, at the expense of considering how one might overcome these obstacles or make use of resources which were and are available.

In conclusion, section two addressed the characterisation of addiction. This was approached by outlining how the informants' distinguished addiction from ordinary or initial use and was followed by presenting some of the key discursive strategies which appear to sustain and perpetuate heroin use. The analysis now moves to explore the final characterisation of use identified in the transcripts.

Section Three - Recovery

The final characterisation of use is that of recovery. This third section is approached by outlining some of the discursive features that appeared to facilitate recovery. One of the primary distinctions between these features and those of the previous sections is that they tended to directly oppose use and challenged many of the positions outlined earlier. The identified strategies associated with discussions of recovery close down the possibility for further use in much the same way that some of the strategies identified previously reduced the possibility of recovery.

Five of the most dominant strategies are covered and each is presented under its own heading. The first theme explores the re-evaluation of heroin. This is covered in two subsections. One illustrates how the informants portray their initial assessment of heroin as illusionary while the next explores their re-portrayal of heroin as counterproductive. The second strategy explored is the informants' acceptance of addiction as an impossible condition. The third is an exploration of the informant's adoption of a recovering addict identity. The fourth subsection examines their portrayal of addicts as inherently different and the fifth area of commentary concerns the (re-)portrayal of the informants as active agents.

1. Revaluating Heroin

Sections of the transcripts, particularly those belonging to the two groups further into their recoveries, actively challenged the value that was once ascribed to heroin use. These excerpts suggested that the informants had reconstructed their earlier views of heroin in favour of a less positive portrayal.

1.1 Benefits as imaginary

One manner in which the above was accomplished was by portraying the effects that they once attributed to heroin as imaginary.

> "Ja it gives, there is the illusion of control that you can still do those things." (Kerry, D320)

The idea that the informants were able to accomplish more on heroin, engage in everyday activities without appearing inebriated, or that heroin allowed them to be high while commanding a state of lucidity was presented as illusionary.

> "That makes sense to me I can understand that… one of the draw cards for me was that I could still be "haha" productive but um…" (Kerry, A560)

Jay actively and repeatedly challenged the view that heroin use offered an incorporation of a superior identity by insisting that believing that heroin use set him apart from other substance users was counterproductive.

> "Like is there such a thing as another type of addict. Like do addicts fall into categories just because you used certain drugs? Like I don't know because I think the end result is the same?" (Jay, A219)

Jay undermined any distinctions between addictions to particular substances and portrayed all addicts as the same. His account focused on the effects of addiction rather than the meanings surrounding the use of any particular substance and so highlighted the difficulties associated with addiction rather than the identity provided by it.

> "I am thinking maybe in terms of opiate addicts if they do have something that maybe is different to other… addicts, that is that they are the uber snobs of addiction. Like opiate addicts think that they are the hardest, the baddest, the most exclusive, the most unclassifiable. I even found that with myself." (Jay, A275)

In such talk heroin use was rendered significantly less beneficial by diluting the status that is/was afforded it and by portraying the belief in some sort of superior status in a condescending manner. Jay describes heroin addicts' sense of superiority as inaccurate and irrational ("most unclassifiable"). He implies that while he once saw himself in this light, his view is now different. His new identity is put forward as relying far more heavily on the tenets offered by NA and recovery. This position facilitates his recovery by allowing him to find support through the NA program, and highlighting the problems of addiction over its benefits.

> "My angle is slightly more hard-line NA which is basically like you have got to look for the similarities and not the differences. There are differences but they are generally quite superficial. So it's like I sneeze like eighty times and I like have cold shivers but ultimately I would do anything to get that drug and so would a cocaine user and so would like a weed head." (Jay, A266)

What these range of examples suggest is a deconstruction of what are seem as the 'myths' associated with heroin use (functionality, superiority etc.) that can only be appreciated with hindsight. This deconstruction seems both necessary to and consequent upon recovery. The manner in which the informants talk about these issues ironically also seems to reflect a kind of superiority, with a critical eye being cast upon their formally 'addicted selves' and other current users.

1.2 Counterproductive

The recovered informants were more likely to focus on the negative consequences or aspects of heroin use and tended to recast heroin as something that, while it brought certain advantages, for the most part hindered them in their lives.

> "I didn't like losing my feelings. I was an actor I needed my feelings, it was my craft, I had studied at university. I had like, been a good actor and, losing my feelings was one of the most frightening things." (Patricia, C388)

Recovered/recovering informants appeared to attribute importance to aspects of their lives that were incompatible with substances use and downplayed effects which they had previously presented as attractive. For example, Patricia highlights the importance of her craft over substance use while Kerry points out that the things she felt were important before are now irrelevant.

Kerry:	"I don't know it's just… there's a…a… I don't want to say distance… but… there's almost… a lot of it seems irrelevant, now… not… not irrelevant… but… it just doesn't… really seem that important, like…what you were using or… those are just the details and… it doesn't… um.."
Interviewer:	"What starts to seem important?"
Kerry:	"Um,… God like bills getting paid, ha ha and um." (A685)

Reengagement with a non-intoxicated lifestyle is portrayed as important and 'normal' in the extracts associated with discontinuation and recovery.

2. Accepting that Addiction is an Impossible Condition

The presentation of addiction or heroin use as an impossible situation appeared most clearly in the transcript taken from the group with the longest recovery time. This theme entailed the adoption of a disease discourse of addiction which became the means through which informants justified permanently stopping heroin use. Informants highlighted how their increasing need for heroin led to a situation in which it was impossible to use heroin in a controlled way or to consistently achieve and sustain the desired effect.

> "I can relate to that. I think firstly I was using and I was happy using. I didn't want to stop. I really didn't. It was cool. Even if I was using everyday even if it was, I kind of got this, I need to have. I just took it because I liked it… I liked the way it made me feel. And for three years I used and it wasn't really kind of… well what happened is I became kind of obsessed with it… Like all I was really interested in was getting that feeling and getting, and as I was developing a tolerance for it so I needed more of it and I think after three years I got to the point where I couldn't maintain. I could not maintain my habit. Because even if, you know, I could earn enough money to buy a ten pound bag a day, I needed a twenty pound bag, and if I earned enough to buy a twenty

> pound bag I needed a thirty pound a day, and if I had thirty I needed a fifty, and if I had fifty I needed a hundred… Then I came back and detoxed and whatever and I started again at like you know this much but I could not keep it at this much I had to have more and I had to have more and I had to have more and it just got chaotic and chaotic and chaotic. And I spent half the time wavering around sick waiting and waiting for that feeling and the other half sitting in a chair with the feeling. If it were just sitting in the chair it would be fine. But I couldn't because it didn't, it doesn't work like that, heroin just doesn't work like that. You couldn't convince me that heroin is not a fantastic feeling, but addiction is just an impossible condition." (Anton, C412)

The construction of addiction as an impossible situation depicts a scenario in which there is little point in continuing with heroin use since the progression of addiction is inevitable. The only options available to the informants are either continuing to use heroin in an uncontrolled way or to stop using entirely.

> "Ja I mean for me that was, I mean, I came, I arrived at rehab and I wanted to stop the heroin and use other substances, and then I was basically introduced to the idea of addition as a disease, and for me that was the turning point, because suddenly I realised I fucking can't control it. And I still, when I tried to control it and fucked up and very quickly, again, and then I just gave up and I thought fuck it I can't do this any more. I mean if I could use successfully, I would, but I just can't do it." (Desmond, C697)

Anton's account portrays this recognition of the impossibility of sustained satisfaction in use quite clearly in the extract below. He explains that encountering NA and its portrayal of addiction as a disease, together with his recognition of tolerance and his experience of endlessly pursuing something ultimately unattainable, enabled him to quit.

> "Hell I mean essentially understanding. For me that's what the key to this was like understood what was going on and being offered an alternative. It was like as soon as I understood that if I used once the rest is inevitable. I can't have smack on a weekend. Do you know what? I mean because that's what I wanted to do. Its like I don't want to stop but I want to get it under control. I want to get it under control so that I can go to work have a job and have a family and have a life and have friends and have all the good things in life and use heroin in a controlled way on weekends and maybe on the odd week night and I would still be doing that if it were possible... Understanding why that it is impossible made a difference for me. It was like "ok I have got to choose". The choice is between this and between complete abstinence. And eventually after a few; quite a few; you know; struggles to come to terms with that, that is what the choice is. When I accepted that I can either carry on going, as chaotic, as fucked up, as damaged as whatever or I have got to stop completely. And I thought 'Ok I have got to stop completely then'." (Anton, C677)

Through the adoption of this position Anton was able to take the decision to stop using heroin with absolute conviction.

> "I have had enough now. Today give me, come in here and hold a gun to my head and offer me heroin. Then pull the fucking trigger! Do you know what I mean? Because I am not using heroin!" (Anton, C845)

Alice describes a similar position below. Her view is slightly different in that she does not emphasize the negative effects of the substance but rather descriptions of herself as deficient. Her account also closes down the option of further use by presenting negative patterns of use as unavoidable, and controlled or appropriate substance use as impossible for her to achieve.

> "For me I see my addict as very alive and well and if I feed it then it will grow. If I don't feed it, it is not going to go away but it does hopefully get a bit thinner. I had this experience. I was driving to work the other day and I thought wow I am going to be four years. That's fantastic. I am cured. I am going to start smoking a little bit of spliff. I thought fuck that would be so great to smoke a little skyf on the way to work every morning. And then I just cancelled it out right there… The problem [is that] I have no clue, no conception of when will be ok and when it won't and that was one of the things. Ah ha, now that's why I can't even start smoking weed let alone the heroin. That's what brought it home to me again. Okay that's why I don't do anything because like I just don't know where to draw the line." (Alice, C704)

What is also interesting about Alice's position is that it no longer presents addiction as a state in which the user has no control and recovery as the process of reclaiming control. Instead it portrays addiction as a state in which the user insists that it is possible to use heroin on one's own terms while avoiding the negative consequences, and recovery as the acceptance of a position in which this is viewed as impossible.

> "It's not a control breaking through at least for me it [was] me saying that I am powerless over this thing. As long as I try to control it, it will beat me every time. Know what, "I quit. I give up because you win." And you step away. It's not getting control over it, it's letting go. Its saying "I can't, I can't by myself I need help." (Alice, C749)

Ironically in fully recognising her own feelings of helplessness or loss of control to heroin, Alice is able to establish a different kind of control in which she avoids using the substance precisely because of its potential control over her.

3. The Recovering Addict Identity

The transcripts taken from groups no longer using heroin suggested that those informants had relinquished their identities as heroin addicts in favour of adopting the identity of being 'addicts in recovery'.

> "Ja I agree it's like I would not want to be the person I was before I started taking drugs, because that was the guy that started taking drugs." (Jay, A1010)

The adoption of the identity of a recovering addict appeared to facilitate recovery on a number of levels; not least of which was by highlighting that recovery was possible. In the extract below Jay explains that NA has taught him to focus on the difficulties experienced by addicts generally, rather than heroin addicts specifically. In so doing Jay reconstructs his heroin use in a manner that allows him to take the NA recovery narrative on board. He highlights that the narrative applies to his situation and portrays the tendency to discredit tenets of NA as a symptom of addiction.

> "I try and see the commonality amongst addicts… Cause I know for me and it is something that I learnt like in NA and in the program is that it's a dangerous thing for me to start setting myself apart and going like well, I am different in X amount of ways and therefore this doesn't apply to me. You know because there is like, like NA is a very broad solution for all types of addiction. Well the twelve step program. So it works across the board it doesn't matter what substance you use. If you want it to work it will work." (Jay, A632)

Jay reaffirms his identity as a *recovering addict*, as opposed to a *heroin addict*. Although some process of reconstruction (such as that just described) appeared in all of the recovering informants' accounts, not all of them relied on the NA recovery narrative, and some utilised more idiosyncratic descriptions. For example, in the extract below, Renaldo gives an account in which he equates substance use to serving time in prison. Now that he has served his time and paid his dues he has allowed himself to be freed from punishment.

> "You mentioned you were trying to hurt yourself you were trying to be self-destructive and in a way I think a lot of drug addicts are like. It's almost a bizarre thing, you almost flog yourself and it's your kind of penance. It's like your penance for living. I don't know why but sometimes that's the sense like this is the punishment for something and when you get over it, it's a bizarre thing to achieve, like now my time, I have served my time, hopefully, and I'm beyond it and I'm absolved of that in a way." (Renaldo, A1019)

Something that was observed amongst the recovered informants was their ability to present personalised, idiosyncratic accounts of addiction and their ability to stand up to the challenges others brought to their accounts. While the less recovered groups appeared to present a far more

homogenous view, we see Patricia in the extract below disagree with Anton's account of addiction. This is important, as it implies that such robust, independent positions may support individuals through difficult times and hence facilitate ongoing recovery.

> "You see, can I give my little understanding and I think there is a difference between how male and female addicts actually, this is just my little five cents worth, please do not take it as the truth. However, I think that male addicts are particularly emotionally retarded. No, I do, and I think that male addicts struggle a lot with feelings. Female addicts like are manic feelers. Female addicts they like feel too much and there is this kind of very opposite kind of way of these two opposite forces kind of dealing with things. So I think for men they like feeling nothing." (Patricia, C291)

It is also apparent that such ways of speaking entail 'refection about', rather than 'immersion in' heroin use. Such more distantiated reflection seemed to be intrinsic to a recovering/recovered addict identity.

4. Positioning Addicts as Different

An aspect of the development of a recovering addict identity was the presentation of addiction as the result of something inherent to the informant, for example, vulnerability to a disease. Mainstream discourses of addiction (e.g. the addictive personality or addiction as a disease) were often referenced, however these were used to support aspects of recovery rather than to substantiate further use.

> "…Um, but, I think I went through a phase where I was quite like anti drugs, like drugs are bad um, but like now I know that they are just bad for me." (Jay, A951)

When speaking in this manner the informants presented themselves as somehow different from the ordinary population. They described themselves as *addicts* and hence as though a different set of rules applied to them. Interestingly, the factors that set addicts apart did not necessarily stem, from the effect of the substances on their particular systems and instead were relayed to inherent characteristics of the informant.

> "I think now that's addiction. It doesn't say anything about the nature of heroin. It doesn't say anything about the nature of beer. It just says something about the nature of addiction, the disease that I suffer from. Because my brother, doesn't have the same illness… he will buy a gram of coke, and you know he drinks and does coke, but he will buy a gram and he will have a line and he will go out and will just party all night and maybe if he stays up late enough he will have another line. And then he will go home and he will put it in the drawer by his bed and he will shut the drawer and he will go to sleep. And… weeks later you will open the drawer and there is a gram of coke in there and it's like "Oh, shall we have some?" and he is "No we'll have a bit on Friday night

> you know when we go out"… he doesn't have the same illness that I have because me, if there is a gram of coke, I can think of nothing else and I am not going to bed until it is finished." (Anton, C935)

The addict was identified on the basis of a distinct pattern of use, rather than on the basis of the addictive substances used. For example, they were described as unable to moderate their use and as assessing their needs very differently from 'normal' people.

> "It's not enough. Normal people, one would be enough, but me, no I need eight [painkillers]." (Alice, C867)

> "I mean I remember when I was as like little, wanting more. I mean like literally, when I was little, like wanting more of my mother's breast." (Patricia, C133)

This vulnerability was not presented as the consequence of having used substances but was constructed as having pre-existed substance use, almost as though it represented an intrinsic temperamental quality. Some of the informants, particularly those from the group with the longest duration of recovery, did not portray themselves as accountable for their habit but rather attributed their pattern of use to a disease which had been with them all along. This formulation of addiction is characteristic of the informants who subscribed to the NA philosophy.

> "Heroin causes problems in people's lives, don't get me wrong. Like Desmond's friends that died and my friends that died. They were not addicts, they used heroin. They are dead because they used heroin not addicts… Alcohol. Lots of people die of alcohol without being alcoholic but alcoholism is an illness. Drug addiction is an illness. You can't cause that… You are either prone to it or you are not." (Anton, C1070)

The position draws on determinist and essentialist notions to portray addiction as unavoidable once exposure to substances has occurred.

> "I can give you the girly version of why I am an addict or I can give you like the butch rough version of why I am an addict. They are both kind of the same thing. I was born with this and it manifested itself and ended with heroin addiction, but it could have gone into shoplifting, sex, eating disorder, um, pick an obsessive, self destructive behaviour, it just happened to be heroin. Well that's what I entered my illustrious self-destructive career on, heroin, but the addictive behaviour was there." (Alice, C103)

Adopting a construction of addiction as a pre-existing disease or behavioural propensity seemed to facilitate recovery in a number of ways. It portrayed the informant as largely unaccountable and hence offered an identity that is both positive and easy to adopt. It offered the informant a means to understand why others are able to use the substance in a controlled way without suggesting that the

addict should be able to use in a similar way. Most importantly it provided a position from which absolute abstinence could be advocated as essential, and hence shut down the option for further use.

Patricia: "I know people that have experimented with heroin. They did it for like two weeks. They said "shit I woke up, I started sweating, I started feeling a bit uncomfortable and I thought like fuck this". And never did it again."

Anton: "Look at me, I woke up. After two weeks I woke up, I felt a bit sweaty and I thought "fuck this I have got to get more." (C644)

Locating the cause of addiction within the informant rather than the substance is significant. Apart from offering a reason as to why the informants should not use substances, it also defines their difficulties as extending beyond substance use and justifies a broader examination of the stresses and difficulties of their lives.

> "For me it's just like, I always convinced myself, it's like I honestly thought, like two years ago that heroin was my problem, you know like if I didn't use heroin I could use any other drugs. Ja I mean, like it's only recently that I have realised that I am my problem and that's why I use drugs." (Debbie, B171)

Debbie's account attributes her problems with substances to her faulty appraisal of the situation. This depiction is valuable because it locates the problem within her world view and hence suggests that changing her understanding (something within her control) could lead to the problem's resolution. Hence unlike the strategies presented in Section Two, Debbie's account constructs change as possible and as within her grasp.

The importance of this aspect is highlighted in Anton's account below. Here his description of addiction suggests that different narratives allow different possibilities and hence that the explanation of addiction that he adopts must provide him with a solution. Anton accepts that he has an illness rather than an addictive personality because accepting that he has an illness offers him the possibility of managing that illness. This highlights how the utility of the description is what is of importance, rather than whether the argument is necessarily logical, consistent or empirically verifiable.

> "Well I think for me, I think we must make a differentiation between an addictive personality and an illness. You don't have a kind of schizophrenic personality do you? I mean you have schizophrenia or you don't and they are two very different things that we are talking about. When you say she is a bit schitzo we are not saying that she is suffering from the illness of schizophrenia are we and I think that's the same with addiction. For me, I don't have an addictive personality I have an illness, and that illness manifests in all the ways that they are talking about… You see if it's an illness I can do something about it, I can change it. Then I can kind of gain some level of control over it, by maintaining abstinence or by being aware of it, and kind of responsible for the

> management of my illness. If its personality, if it's my personality then it's who I am and then that's the [end] of that kind of story…" (Anton, C111)

Accepting that his illness leaves him vulnerable to using substances in a very different way to non-addicts supports Anton's identity as a recovering addict. He accepts that since he is unable to use substances in moderation, he cannot use them at all.

> "If I start drinking it's not a nice beer at the rugby or a nice glass of wine at a dinner party. What's the point? I want to get wasted and if I can't get wasted then ok. Do you know what I mean? And I know that." (Anton, C910)

Desmond also highlighted how understanding his addiction as a disease helped him to achieve recovery by enabling him to perceive change as possible.

> "Ja no that [understanding] for me was the whole key. The whole thing. Because it suddenly, it wasn't about stopping a particular substance… I mean I could see it in my family, it's like all alcoholics, and I mean I could see, people didn't talk about that shit but it fucked their lives up completely… I knew that I was an addict, I was quite comfortable with it, on some level, but to know that I had a disease, basically it meant that my father's disease was the same thing that I had, then I had something to work with." (Desmond, C1096)

Jay's account below illustrates how locating the cause of addiction within the informant facilitates the adoption of an identity that discourages substance use by portraying all substance use as risky. In his account he describes a potentially dangerous encounter with a group of people who use hallucinogenic substances as part of a 'shamanic' experience.

> "…there is the whole field of like, um ethno-pharmacology and all that kind of stuff, but I know for me it's just, it's not something that I really wanna, like, I don't want to feed my curiosity with stuff like that." (Jay, A933)

> "Ja, before I, see because I know for me that it is very dangerous, I can find a justification." (Jay, A939)

Although he recounted how several people found the 'shamanic' experience life changing and positive, he explained that he was unwilling to try the experience because it presented a particular set of dangers for him as an addict. He explained that, since he, as an addict, was able to create justifications for using, he had taken the decision never to use any substances again.

The extract below illustrates Susan at a different stage of recovery but also grappling with her own world view. She portrays her current approach to life as unable to facilitate change yet her account allows her to consider that a recovery is possible.

> "I certainly believe that I am an addict... as in genetically, kind of family history, definitely, ja. I'm, I've got the disease. I have fully accepted the fact that I have got the disease of addiction and I have got to treat it accordingly…. But I understand now that it's not a choice. Basically yes it is my choice to pick up the drugs but basically, ok, in comparison with the next guy in the street is that… Unfortunately I am kind of allergic to those substances, you know, in as much as when I want them I want more and more and more and more… Whereas the next guy will actually realise "hang on a second" "there is a price to be paid here". I just don't have that you know… It's lekker. I want I want I want. You know. So ja, the question "do you" ja I fully believe that all three of us sitting in this room are addicts. And it's, we are different to other people and we have to treat it accordingly, you know. And I have got to treat my disease." (Susan, D487)

Highlighting that Susan is unable to see things in the same way as other people enables her to accept help by presenting others as capable of seeing things that she is not and also herself as able to learn how to do things differently. These factors are important because while they highlight a problem they also imply a solution and hence construct a version of reality in which continuing to use heroin is only one of many available options.

> "I just think that we have got to be taught otherwise, you know, because sometimes things are so logical to one person and, and so logical to one person but it has never even entered into my head, unless it gets shown to me. Like I just had quite a lot of intense therapy lately so just things that I should know by myself have kind of been spelled out for me and I think "Jesus, you are quite right you know." And like looking at it in that direction, if you get given those choices and options that maybe it's sitting here and maybe I choose not to see and then, you know it will be ok, I will know how to deal with it. I just got the feeling if I can get an answer to this whole problem, if I can understand it better and break it down…Then I can deal with it." (Susan, D535)

Representing addiction as something caused by a disease or something inherent to the informant was also paradoxically beneficial in improving the informants' self-esteem by suggesting that their destructive behaviour was caused by something beyond their control. Such positions enable the informant to 'save face', while also preventing further use by suggesting that the way they may intend to use substances and the way that they inevitably do, are not connected. The disease construction also represents the choice they are faced with as being between abstinence and totally destructive use; a position from which it appears easier for the informant to choose abstinence.

> "I don't accept that it was self-inflicted. I do accept that I chose to use drugs but I didn't know when I chose to use them that I would be unable to choose to stop to use them. Does that make sense? And I think it's a kind of brain disease um, um, having exposed myself to the agent, to heroin. Actually before that I think I was addicted to other drugs before I was addicted to heroin. When I exposed myself to drugs I did not realise kind of that I was not going to be able to stop and I think um, I made a choice to start and I could not make a choice to stop. I

> think in that sense it is an illness, it is a psychogenic illness. It was not something that I chose to do." (Anton, C54)

There is an interesting contradiction in this manner of speaking in that while it presents addiction as a state entered into independent of the informants' will, it paradoxically suggests that the informant must exercise will in order to stop. That is, despite Anton's insistence that he was unable to choose to not use the substance, this is precisely what he has done. This is not something particular to Anton's account and was an implicit contradiction running throughout all of the texts produced by recovered users.

5. Highlighting Agency

A further feature distinguishing the currently using informants from those in recovery was that those in recovery described the desire to use substances as something within their control. Rather than portraying this desire as an intrusive symptom of addiction, Dan (below) describes this as a consequence of his actions, in this instance of not following the NA program. This distinction is significant because it places Dan as responsible for his desires as opposed to being subjected to them and so provides a workable solution to control them. His account places agency as central in his recovery by highlighting the link between his behaviour and its consequences.

> "The only thing that has actually worked for me because I have taken it and for the first time actually tried to work the program is the NA program. And it's difficult because sometimes there are days where I just want to leave and go and use, and that's because I have to think about why I want to use, I am not working the program I am not doing what I need to do." (Dan, B305)

This position directly challenges the addicted position in which the informants describe a state in which very little can or should be done to change their behaviour. Dan reiterates the stance of personal agency in the quotation below where he not only describes a way out of addiction but presents it as guaranteed if the addict simply follows the prescribed steps.

> "I think bottom line is like 90 meetings in 90 days, you do your step work, you get a sponsor, you keep it simple. That's how you stay clean. It's a promise that NA makes. They say you will never find a person who doesn't recover. Work the program and you won't relapse. You are going to have bad days but even people who are not addicts have bad days." (Dan, B702)

His account also challenges the sense that the troubles experienced by the addict are unique to them and unique to addiction. He explains that everyone has bad days and in so doing suggests that there are ways to manage those bad days that do not necessitate substance use. His account presents life's

problems as ordinary and manageable rather than awful and intolerable. Presented in this manner, his account allows for the possibility of a life without heroin and hence presents this as an acceptable and achievable option.

> "That's what I was going to say it [stopping] becomes an individualistic decision." (Renaldo, A955)

The importance of agency (and its lack) in the informants' speech became particularly evident in the transcript taken from currently using informants. This group only had one member who was approaching recovery and her style of speech was starkly contrasted against those of the other informants in the group. In the extract below we see how Susan is able to portray the existence of a choice in a group dominated by discussions of how there really is no choice. Her stance clearly portrays herself as able to choose, as having chosen and as entertaining potential recovery.

> "I am just saying you know that basically, there is that time when you are forced into rehab and those where you are not and at the moment… I am going in purely by choice and when things have been reasonably good. Because I mean really for the two months that I have been here… we haven't had to battle and sell our fucking souls like we did in the past, you know, so its going to be quite interesting that I am going in, in that kind of head space…. Ja I mean I could, you know, carry on, but I don't want to." (Susan, D438)

Susan's account also describes how this attempt to stop using substances is different from other times that she has tried to stop. The point she highlights is that she is not forced to enter rehab this time and hence, that the outcome may be more successful.

Susan's account of her ability to make this decision shared something in common with many of the other more recovered informants. Her account was closely followed by a portrayal of the positive aspects of heroin use as inseparable from its negative effects. This was in contrast to the portions of the texts supporting addiction, which tended to separate the effects of the substance (positive) from the effects of addiction (negative).

> "If it didn't effect your.. life style, like make you, sort of, you know, morally fuck you up and emotionally fuck you up and all the other things. If it was purely that you could have that sensation and it didn't fuck your life up for all, god I would carry on taking drugs forever. But, you know, its that price that you have got to pay, for every, you know, the ying and yang of it, for every good there is a bad and unfortunately with this it is intensely good but the badness that goes with it is intensely bad..." (Susan, D455)

Separating these effects allows for a position in which the possibility that the one can be had without the other exists; i.e. that the informant may be able to overcome their addiction and use substances in a non-addictive way. Portraying these two aspects of use as inseparable closes down this possibility

by reinforcing the position or choice as being between destructive use and no use at all. We see Susan use the depiction of such an ultimatum in the paragraph below.

> "I know when I go back [to rehab] on Sunday there is no turning back. I am not going to use drugs again. That's it. As lekker as they are. It's just that it might be lekker to stick a knife in your heart every second day but, you know, it's going to kill you… And the thing is that I know that drugs are going to kill me and I am not going to die. I am not going to die. I want to live." (Susan, D547)

This section of the analysis outlined the recovered informants' reassessment of their heroin use, their adoption of a recovering addict identity and their reattribution of agency.

In conclusion, the analysis has identified and outlined three distinct manners in which the informants portrayed their use. Each manner represented a specific characterisation of use and the implications of these characterisations were explored. The groups of members who were currently using or with the least recovery time tended to draw on portrayals that substantiated or justified continuing heroin use while the 'recovered' groups tended to place a greater emphasis on factors supporting and enabling a position of abstinence, e.g. focusing on consequence and highlighting agency. An overview of the research findings and their implications for treatment and further research is presented in the following concluding chapter.

Chapter 6 – Overview of Research Findings and Conclusion

The chapter begins with a summary of the main findings of the report. This is followed by a brief section on reflexivity which outlines aspects of the researcher's position, and its possible impact on the research findings. A section describing some of the implications of the findings for treatment approaches follows. The chapter ends with a brief discussion of the limitations of the findings and some suggested avenues for further research.

1. Summary

This research report applied the theoretical insights of discursive psychology to the study of opiate addiction and provided an exploration into the workings of addiction and the manner in which using and non-using informants were able to constitute addiction through discourse. By comparing discursive accounts of self-defined recovered, recovering and currently addicted users, the study highlighted how ways of talking about substances and their use are implicated in the maintenance and cessation of addiction.

The analysis revealed that important differences existed between the groups in terms of the self employed discursive practices that they used in constructing their experience of addiction. These were explored in detail together with their potential implications, functions and how they appeared to impact on the capacity to refrain from further use, or to maintain abstinence as opposed to continuing to use.

Three distinct manners of speaking or characterisations of use were identified, i.e. *initial* or *everyday* use, *addiction* and *recovery*. Each characterisation consisted of two discursive elements, firstly, the discursive resources drawn upon to constitute the characterisation and secondly, the manner in which those resources were used and what they achieved. Characterisations did not necessarily represent distinct stages of use, and aspects of different characterisation were sometimes drawn upon to describe the same period of use. It was the manner in which the characterisation operated and the end to which it was put that distinguished it from other characterisations. However, the characterisation of addiction was most apparent in the texts generated from the informants who were still using heroin, while the characterisation of recovery was most frequently employed by those no longer using.

The characterisation of use as *initial* or *ordinary* presented opiate use as similar to other everyday human activities. This portrayal emphasised the rational and functional elements of use, justified both present and past use and presented the informants as largely unaccountable for their use, and as

lucid and reasonable. This characterisation presented substance use from the perspective of substance using cultures and reflected the value systems inherent to those cultures, e.g. heroin use was presented as a signifier of social status. Drawing on these discourses enabled the informants to depict a reality in which substance use was not only ordinary but, at times, even optimal or a superior form of behaviour.

The characterisation of use as *addiction* accounted for the pathological and negative aspects of use and provided a means to justify ongoing use in the face of negative consequence. This characterisation first distinguished between addiction and ordinary use, and then utilised this distinction to justify further use as well as associated addictive behaviours. Several elements of this characterisation also appeared to reflexively support further use, for example by highlighting the impossibility of stopping, depicting heroin use as mandatory and/or presenting attempts to control behaviour as futile. While, this characterisation called on a number of mainstream discourses (e.g. aspects of psychological and medical theory) it convincingly employed these discourses in a manner which appeared to justify and/or promote further ongoing use.

The characterisation of use in terms of *recovery* consisted of a particular retrospective portrayal of use that supported abstinence by challenging elements of the previous characterisations and employing available discourses in a manner that closed down the possibility for further use. Informants using this characterisation also drew on mainstream discourses, however, the manner in which these were used consistently justified the discontinuation of use and promoted sustained abstinence. Of particular note in this third characterisation of use was evidence of an alteration in talk of agency and control and the adoption of a more distantiated position. Speaking of 'recovery' seemed to involve a meta perspective on opiate use in which paradoxes were identified, recognised and/or engaged with.

2. Reflexivity

Qualitative researchers understand that their subjectivity impacts on the production of knowledge in their research. This is often seen as something which is not only unavoidable but intrinsic to the research process and the production of knowledge, rather than being viewed as an interfering variable which is to be excluded as far as possible. A brief outline of some aspects of the researcher's position is provided. This is intended to contextualise aspects of the research and analysis and to aid the readers' appreciation of the findings.

The researcher is a 29 year old, Greek Italian South African, middle class, male. His training in clinical psychology and therapeutic approach are primarily psychoanalytic, however he is also influenced by critical social theory and attempts to retain a critical and independent position. His own view of addiction is that addiction represents a pathological pattern of substance use that is destructive to the individual and society at large. He understands this dependence to be founded predominantly in individual and group psychology and while he considers physiological factors to be important, his view is that these factors are easily overstated.

The researcher's own life was disrupted by excessive personal opiate use and this has brought a number of consequences to bear on the analysis. It has allowed the researcher to identify with and use the language of the informants and thus facilitated a degree of openness in the discussions that might have been more difficult to accomplish if his background had been different. While the researcher's history was not disclosed as a matter of procedure, some informants were curious about how the researcher had arrived at his interest and he answered questions that were posed by the groups honestly. Instances where these questions led to the disclosure of the researcher's drug abusing history tended to be followed by a change in the informants' attitudes towards him. They now spoke to him as though he would identify with what they said and as though he understood something others would not. This highlighted an exclusionary element of the informant's discourse that was not easily noted in the texts but which implied that only opiate addicts could really understand use. The researcher's 'insider' perspective allowed him to appreciate this aspect as well as other features of the texts which may have been missed without the same awareness of language use and strategy.

The researcher's experience with opiate use has also left him with a degree of emotional involvement with the subject that at times amplified his reading of certain aspects of texts, particularly those that evoked critical or anxious feelings. This may have contributed to an underlying, and sometimes unconscious frustration with the using subjects which possibly led him to overstate the consequences of their speech. It is hoped that this attitudinal bias was not conveyed to the participants themselves. From their speech it seemed that there was a considerable degree of openness in their discussion of their opiate use.

Although the researcher expected that researching opiate addiction would be emotionally trying he had not anticipated how taxing it could become. This contributed to some delay in both data collection and analysis as it prevented the researcher from focusing as much attention on the study as he would have liked. The elements of over identification and avoidance also made it difficult to

synthesize and present the findings as succinctly as was desired, despite repeated editing. Nevertheless it is believed that the final discussion presented does justice to most of the key issues of interest.

The impact of the remnants of his struggle for abstinence also impacted upon the researcher's formulation of addiction. Addiction is presented as a pathological version of use and, more importantly, as something that the addict actively *does*. The researcher, in retrospect, suspects that the adoption of this representation or formulation of addiction reflects his effort to maintain a sense of agency. In highlighting the accountability of addicts to foster and maintain a healthy lifestyle, he perhaps implicitly supported a representation of himself as in control. In some respects, the analysis represents more than an academic exercise. It also represents the researcher's attempt at reparation and his attempt to derive some benefit from the negative aspects of his history through working to further an understanding of addiction. This having been acknowledged, it is believed that the analysis offers a coherent, thought provoking, plausible and somewhat original formulation of opiate use, addiction and recovery.

Hopefully this brief discussion on reflexive elements of the study has illustrated that the researcher's position seems to have introduced both benefits and detractions. The close involvement of his supervisor in discussing, interrogating and formulating the analysis and findings was intended to balance some of the possible biases in interpretation.

3. Implications for Treatment

This section outlines some implications of the findings of this study for the treatment of addiction.

- The findings of this study are largely consistent with the treatment approach called Motivational Interviewing (MI) (Miller, & Rollnick, 2002). Similarly to this study, the MI approach recognises that clients occupy different stages of recovery. MI tries to match the interviewers' agenda and technique with the particular stage of change that a client appears to fit. These stages are based on the Stages of Change Model (DiClemente, Norcross, & Prochaska, 1994) and include pre-contemplation, contemplation, preparation, action, and finally, maintenance and/or relapse prevention. The function of the MI interviewer is to try to move the client from one stage to the next by reflecting aspects of what the client has said or by asking questions that encourage the client to speak about the value of change, the consequences of not changing and the actions within the client's control that can facilitate change (Miller, & Rollnick, 2002). Thus, MI encourages clients to speak in a manner and

adopt a way of thinking which closely resembles the *recovery* characterisation of use outlined in the analysis.

- The observation that the informants structured their accounts in ways which distinguished between users and non-users, and those in the know vs. those who do not understand, suggests that interventions should facilitate the client's sense of being accepted and understood. While a concrete way of achieving this may be to utilise recovered addicts as counsellors, a focus on the counsellors' style of the intervention is likely to be more important than their personal history. The active listening and other interventions routinely recommended by MI aim to operate from *within* the clients' frame of reference and have been shown to facilitate a sense of rapport and reduce the resistance commonly associated with these clients (Miller, & Rollnick, 2002). Aggressive interventions such as those which are aimed at consistently confronting the client and breaking through their 'denial' are contraindicated as the findings of this report suggest they are likely to alienate the client.

- The findings of the report also support the incorporation of the NA program into treatment facilities. Informants suggested that elements of the NA program substituted for certain functions served by heroin. These include: providing a: sense of belonging; a recovering addict identity; increased self-esteem; and an environment in which recovering users can feel accepted and understood. The fellowship of NA also provides a range of discursive resources that both support recovery and hold commonsense credibility. Despite its theoretical shortcomings, the NA disease model appears to provide a useful and effective framework through which recovering addicts can understand and manage their addictions. However, some recovered informants expressed an aversion for NA and this suggested that the addition of NA (or a religious component for that matter) may be most effective if clients are encouraged to attend such programs on a voluntary basis.

4. Limitations and Avenues for Further Research

The following brief section outlines some of the limitations of this study. Recommendations for further relevant research are made, particularly with regard to overcoming the limitations outlined.

- Although the findings of the study provide insight into substances use and recovery there are limits to the extent to which these insights can be generalised. That is, while it is likely that the discursive positions of other addicted individuals may resemble those explored here, their specific strategies may differ from those used by the informants in this study. Hence, while

the findings and methods of this study may inform the reader's understanding of circumstances beyond the bounds of this research, they are not directly generalisable across populations.

- Furthermore, the analysis carried out by this study has been subjectively guided by the researcher. The results are not purely descriptive and represent a selection of the researchers' subjective observations and interpretations. These, and the process through which they were selected, have been influenced by the researcher's own position and could differ from the findings that another researcher examining the same material might have reached.

- The initial intention of the study was to compare two groups of informants with a significant degree of recovery against two groups of currently using informants. Structuring the groups in this manner was expected to provide data that would reflect the informants' disparate patterns of use and hence highlight differences more clearly. Unfortunately, difficulties were encountered in obtaining such specific sample groups and hence the informants were divided into four less disparate groups. While this may have made some differences between the groups more difficult to identify, it did add value by allowing the observation of a range of positions, i.e. those adopted by informants with years of recovery, those just beginning to recover, and those currently using.

- A further potential limitation of the study lies in its assumption that the informants' behaviour is reflexively driven by their discursive construction of reality. While the validity of this assumption maybe argued from a number of theoretical positions, it is yet to be demonstrated empirically and research attempting to do so (e.g. research seeking links between attitudes and behaviour) has been inconclusive (Davies, 1997). Thus, the reader should bear in mind that this assumption is a reflection of the researcher's selected theoretical orientation rather than of proven scientific validity.

- The analysis has at times been based upon the assumption that some differences noted between the groups relate to each of the groups' respective levels of recovery. While this is plausible, differences could also be explained by other factors. Variables such as the informants' histories (e.g. exposure to treatment modalities), personalities, group dynamics or other intentions (e.g. trying to impress the interviewer) may also account for some of these differences. A follow up study might allow for closer observation of such patterns or features

by adopting a longitudinal design and by comparing a particular individual's accounts across time.

- While this study demonstrates how accounts of use can be related to an individual's current pattern of use, the research design prevents it from offering any predictive value. A longitudinal study design may enable the analysis to track changes in patterns of use and discourse as they occur over time, and hence could examine whether a correlation between patterns of discourse and particular outcomes could be identified. This design would enable the researcher to assess whether the presence of a particular discursive pattern and certain treatment outcomes are associated. Such a study was beyond the scope of the current research project.

In conclusion it is argued that the research study has demonstrated that discursive aspects of substance abuse and addiction are worthy of study and may provide an added dimension to understanding and treating addictive conditions. Ways of talking about substance use, and in this instance opiate/heroin use in particular, appear to operate to sustain and reinforce both use and abstinence in different ways. Appreciating such discursive patterns and strategies is likely to be beneficial in the ongoing refinement of treatment approaches.

Reference List

Alcoholics Anonymous. (1965). *AA in hospitals*. New York: Alcoholics Anonymous World Services.

Alcoholics Anonymous. (1976). *The story of how many thousands of men and women have recovered from alcoholism (3rd ed.).* New York: Alcoholics Anonymous World Services, Inc.

Alexander, B. K., & Schweighofer, A. (1988). Defining "addiction". *Canadian Psychology*, 29, 151-162.

American Psychiatric Association. (2000) *Diagnostic and statistical manual of mental disorders (4th ed.), text revision.* Washington, DC.: American Psychiatric Association.

Antaki, C. (1994). *Explaining and arguing*. London: Sage.

Anthenelli, R., & Schuckit, M. (1997). Genetics. In J. Lowinson, P. Ruiz, R. Millman, & J. Langrod, (Eds.), *Substance abuse. A comprehensive text book.* USA: Williams & Wilkins.

Aquilino, W. S. (1994). Interviewer mode effects in surveys of drug and alcohol use. *Public Opinion Quarterly*, 58:210-240. Cited in, M. P. White, & J. B. Davies, (1998). The effects of context and sensitivity on self reported attitudes towards drugs. *Journal of Substances Misuse*, 3, 213-220.

Baer, H., Jia, Z., Singer, M., & Valentine, F. (1992). Why does Juan Garcia have a drinking problem? The perspective of critical medical anthropology. *Medical Anthropology*, 14, 77-108.

Baker, R., & Davies, J. B. (1987). The impact of self presentation and interviewer bias effects on self-reported heroin use. *British Journal of Addiction*, 82:907-912. Cited in, M. P. White, & J.B. Davies, (1998). The effects of context and sensitivity on self reported attitudes towards drugs. *Journal of Substances Misuse*, 3, 213-220.

Best, D., Davies, J, B., MacMillan, D., & Mortimer, R. (1995). Evaluation of Fast Forward: Peer research project and 'bolt ya radge'. Centre for Applied Social Psychology, University of Strathclyde. Report to Fast Forward's Scottish office. Cited in, M. P. White, & J. B. Davies, (1998). The effects of context and sensitivity on self reported attitudes towards drugs. *Journal of Substances Misuse*, 3, 213-220.

Biernacki, P., & Stall, R. (1986). Spontaneous remission from the problematic use of substances: An inductive model derived from a comparative analysis of the alcohol, opiate, tobacco, and food obesity literatures. *The International Journal of the Addictions*, 21, 1-23.

Billig, M. (1996). *Arguing and thinking (2nd ed.)*. Cambridge: Cambridge University Press.

Brecher, E. (1972). *Licit and illicit drugs.* Boston: Little, Brown & Company.

Brehm, N., & Khantzian (1997). Psychodynamics. In J. Lowinson, P. Ruiz, R. Millman, & J. Langrod, (Eds.) *Substance abuse. A comprehensive text book*. USA: Williams & Wilkins.

Bunton, R., & Petersen, A. (1997). *Foucault, health and medicine*. London: Routledge.

Bury, M. (1996). Disability and the myth of the independent researcher: A reply. *Disability & Society*, 11, 1.

Chappel, J., & Miller, N. (1991). History of the disease concept. *Psychiatric Annals*, 21, 196-205.

Cheyne, B., Davies, J. B., Heim, D., & Smallwood, J. (2001). Addiction as a functional representation. *Journal of Community & Applied Social Psychology*. 11, 57-62.

Cohen, P. (1990). *Drugs as a Social Construct*. Amsterdam: University of Amsterdam.

Crime Information Analysis Centre - South African Police Service (SAPS). (2004). *Crime in the RSA for the period April to March 1994/1995 to 2003/2004.* Retrieved January 21, 2005, from http://www.capegateway.gov.za/eng/pubs/public_info/C/86878/1

Cunningham, J. A. (1999). Resolving alcohol-related problems with and without treatment: The effects of different problem criteria. *Journal of Studies on Alcohol*, 60, 463-466.

Daneels, C. (2004). *Substance abuse problems and treatment in the Limpopo province.* Retrieved January 21, 2005, from http://www.hsrc.ac.za/research/output/outputDocuments/3081_Peltzer_ReportofalcoholproblemsinSouthAfrica.pdf

Davies, J. B. (1992). *The myth of addiction*. Glasgow: Harwood Academic Publishers.

Davies, J. B. (1997). *Drug speak*. Glasgow: Harwood Academic Publishers.

Davies, J. B. (2003). Drugs crime and the law. In, D. Carson, & R. Bull, (Eds.). *Handbook of psychology in legal contexts (2nd ed.).* Glasgow: John Wiley and Sons.

Davies, J. B., & White, M. P. & (1998). The effects of context and sensitivity on self reported attitudes towards drugs. *Journal of Substances Misuse*, 3, 213-220.

Davies, J. B., Heffernan, D. D., O'Connor, S. M., & Van Eijk, R. (2003). An alternative method for predicting attrition from an alcohol treatment program. *Alcohol and Alcoholism*, 38 (6), 568-573.

Davies, J. B., Heim, D., Ross, A., & Wallace, B. (2004). Evidence of social learning in the self-presentation of alcohol problems. In Press. Submitted to *Alcohol and Alcoholism*. 03/04/04.

DiClemente, C, C., Norcross, J, C., & Prochaska, J, O. (1994). *Changing for good*. New York: Morrow.

Dixon, R. A. (1995). *Compensating for psychological deficit and decline.* Erlbaum: Mahwah.

Doweiko, H. E. (1993). *Concepts of chemical dependency (2nd ed.)*. USA: Brooks & Cole.

Edwards, D. (1991). Categories are for talking. *Theory and Psychology*, 1, 515-542.

Edwards, D. (1994). Script formulations: An analysis of event descriptions in conversation. *Journal of Language and Social Psychology*, 13, 211-247.

Edwards, D. (1995). Sacks and psychology. *Theory and Psychology*, 5, 579-596.

Edwards, D. (1997). *Discourse and cognition*. London: Sage.

Edwards, D., & Potter, J. (1992) *Discursive psychology*. London: Sage.

Edwards, D., & Potter, J. (1993). Language and causation: A discursive action model of description and attribution. *Psychological Review*, 100, 23-41.

Edwards, D., & Potter, J. (1995). Memory. In R. Harre, & P. Stearns, (Eds.), *Discursive psychology in practice*. Sage: London.

Eikelboom, R., de Wit, H., & Stewart, J. (1984). Role of unconditioned and conditioned drug effects in the self-administration of opiates and stimulants. *Psychological Review,* 91, 251-268.

Epstein, E. E., & McCrady, B. S. (1996). Theoretical bases of family approaches to substance abuse treatment. In F. Rotgers, D. S. Keller, & J. Morgenstern, (Eds.), *Treating substance abuse: theory and technique*. New York: Guilford Press.

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). (2000). Retrieved January 21, 2005, from http://www.emcdda.eu.int/index.cfm

Fingarette, H. (1988). *Heavy drinking: The myth of alcoholism as a disease*. Berkeley: University of California Press.

Flavin, D. K., & Morse, R. M. (1992). The definition of alcoholism. *Journal of the American Medical Association*, 268 (8), 1012-1014.

Foucault, M. (1980). *Power/Knowledge: Selected interviews and other writings 1972-1977*. C. Gordon, (Ed.). New York: Pantheon.

Foucault, M. (1982). The subject of power. In H. Dreyfus, & P. Rabinow, (Eds.), *Michel Foucault: Beyond structuralism and hermeneutics*. Brighton: Harvester.

Fowler, J. S., Volkow, N. D., & Wang, G. (2003). The addicted human brain: Insights from imaging studies. *Journal of Clinical Investigation*, 111 (10), 1444–1451.

Freeman, E, M. (1992). *The addiction process: Effective social work approaches*. New York: Longman.

Gardner, E. (1997). Brain reward mechanisms. In J. Lowinson, P. Ruiz, R. Millman, & J. Langrod, (Eds.), *Substance abuse: A comprehensive text book*. USA: Williams & Wilkins.

George, R, L. (1990). *Counselling the chemically dependent.* New Jersey: Prentice Hall.

Gillet, G., & Harré, R. (1994). *The discursive mind*. London: Sage.

Glover, E. (1932). On the aetiology of drug addiction. *Journal of Psychoanalysis,* 13, 298-328.

Haidiman, M. (1998). *The common sense approach*. London: New Leaf.

Hanninen, V., & Koski-Jannes, A. (1999). Narratives of recovery from addictive behaviours. *Journal of Addiction*, 94 (12), 1837-48.

Harré, R. (1995). Discursive psychology. In J. A. Smith, R. Harré, & L. van Langenhove, (Eds.), *Rethinking psychology*. London: Sage.

Harré, R. (1999). The rediscovery of the human mind. Presented at the 50th anniversary conference of the Korean Psychological Association, edited by Uichol Kim, Psychology dept, Chung-ang University, Seoul, Korea.

Jaffe, J. H. (1980). Drug addiction and drug abuse. In A. G. Gilman, L. S. Goodman, & A. Gilman, (Eds.), *Goodman & Gilman's: The pharmacological basis of therapeutics.* New York: MacMillan.

Jaffe, J. H. (1992). Current concepts of addiction. In C. P. O'Brien, & J. H. Jaffe, (Eds.), *Addictive states*. New York: Raven Press.

Jellinek, E. M. (1946). Phases in the drinking history of alcoholics. *Quarterly Journal Studies on Alcohol*, 7, 1-88.

Jellinek, E. M. (1952). Phases of alcohol addiction. *Quarterly Journal of Studies on Alcohol*, 13, 673-684.

Jellinek, E. M. (1960). *The disease concept of alcoholism.* New Haven: Hillhouse Press.

Johnson, B., & Muffler, J. (1997). Sociocultural. In J. Lowinson, P. Ruiz, R. Millman, & J. Langrod, (Eds.), *Substance abuse. A comprehensive text book.* USA: Williams & Wilkins.

Johnson, T.P., & Parsons, J.A. (1994). Interviewer effects on self-reported substance use among homeless persons. *Addictive Behaviours,* 19, 83-93.

Kalant, H. (1989). The nature of addiction: An analysis of the problem. In A. Goldstein, (Ed.), *Molecular and cellular aspects of the substance addictions*. New York: Verlag.

Kaplan, H. I., & Sadock, B. J. (1997). *Synopsis of psychiatry (8th ed.).* Lippincott: Williams & Wilkins.

Keller, E. L. (1992). Addiction as a form of perversion. *Bulletin of the Menninger Clinic*, 56, 221-231.

Kernberg, O. F. (1975). *Borderline conditions and pathological narcissism*. New York: Janson Aronson.

Khantzian E. J. (1974). Opiate addiction: A critique of theory and some implications for treatment. *American Journal of Psychotherapy*. 28, 59-70.

Khantzian, E. J. (1985). The self-medication hypothesis of addictive disorders: Focus on heroin and cocaine dependence. *American Journal of Psychiatry*, 142 (11), 1259-1264.

Kissin, B. (1983). The disease concept of alcoholism. In R. G. Smart, F. B. Glaser, Y. Israel, H. Kalant, R. E. Popham, & W. Schmidt, (Eds.), *Research advances in alcoholism and drug problems*. New York: Plenum Press.

Klingemann, H. (1994). Environmental influences which promote or impede change in substance behaviour. In G. Edwards, & M. Lander, (Eds.), *Addiction: Processes of change.* Oxford: Oxford University Press.

Koob, G. F. (1992). "Substances of abuse: Anatomy, pharmacology, and function of reward pathways," *Trends in Pharmacological Sciences,* 13, 177-184.

Krystal, H., & Raskin, H. A. (1970). *Drug dependence: Aspects of ego functions.* Detroit: Wayne State University Press.

Levine, H. G. (1979). "The discovery of addiction: Changing conceptions of habitual drunkenness in America." *Journal of Studies on Alcohol,* 15, 493-506.

Lewis, D. C. (1991). Comparison of alcoholism and other medical diseases: An internist's view. *Psychiatric Annals*, 21, 256-265.

Lock, A. (2004) *Against cognitivism: The discursive construction of cognitive mechanisms*. Retrieved January 21, 2005, from http://www.massey.ac.nz/~alock/webdck/webdck.htm

Maltzman, I. (1994). Why alcoholism is a disease. *Journal of Psychoactive Drugs*, 26, 13- 31.

McIntosh, J., & McKeganey, N. (2000). Addicts' narratives of recovery from drug use: Constructing a non-addicted identity. *Journal of Social Science and Medicine*, 50 (10), 1501-1510.

McMurran, M. (1994). *The psychology of addiction*. London: Taylor and Francis.

Miller, W, R., & Rollnick, S. (2002). *Motivational interviewing: preparing people to change*. New York: Guilford.

Musto, D. (1997). Historical perspectives. Substance abuse. In J. Lowinson, P. Ruiz, R. Millman, & J. Langrod, (Eds.), *Substance abuse. A comprehensive text Book.* USA: Williams & Wilkins.

Narcotics Anonymous (NA). (1994). *The twelve steps of NA*. Retrieved June 14, 2005, from http://www.na.org/ips/an/an-IP16.htm

Nargolis, R., & Zweben, J. (1998). *Treating patients with alcohol and other drug problems: An integrated approach*. Washington, D.C: American Psychological Association.

National Institute of Health (NIH). (1997). *Effective medical treatment of opiate addiction*. Retrieved January 21, 2005, from http://odp.od.nih.gov/consensus/cons/108/108_statement.htm

Nichter, M., & Quintero, G. (1996). The semantics of addiction: Moving beyond expert models to lay understandings. *Journal of Psychoactive Drugs*, 28 (3), 219-28.

Orford, J. (1992) *Excessive appetites: A psychological view of addictions.* London: Biddles ltd.

Parker, I. (1992). *Discourse dynamics*. London: Routledge.

Peele, S. (1976). *Addiction as social disease*. Retrieved January 21, 2005, from www.peele.net

Peele, S. (1985). *The meaning of addiction: Compulsive experience and its interpretation*. Lexington: Lexington Books.

Peele, S. (1987). A moral vision of addiction: How people's values determine whether they become and remain addicts. *The Journal of Drug Issues*, 17, 187-215.

Peele, S. (1990). Addiction as a cultural concept. *The Annals of the New York Academy of Sciences*. 602, 205-220.

Pittman, D. J., & Snyder, C. R. (Eds.) (1962). *Society, culture, and drinking patterns.* Carbondale: Southern Illinois University Press.

Polkinghorne, D. E. (1996). Transformative narratives: From victimic to agentic life plots. *American Journal of Occupational Therapy*, 50 (5), 299-305.

Potter, J. (1996). *Representing reality*. London: Sage.

Potter, J. (2000). Post cognitive psychology. *Theory and Psychology*, 10 (1), 31-37.

Potter, J. (2003). Discourse analysis and discursive psychology. *Qualitative Research in Psychology: Expanding Perspectives in Methodology and Design.* Washington, D.C.: American Psychological Association.

Potter, J., & Wetherell, M. (1987). *Discourse and social psychology*. London: Sage.

Potter, J., & Wetherell, M. (1995). Discourse analysis. In J. A. Smith, R. Harré, & L. van Langenhove, (Eds.), *Rethinking methods in psychology*. London: Sage.

Rado, S. (1926). The psychic effects of intoxicants: An attempt to evolve a psychoanalytic theory of morbid cravings. *International Journal of Psychoanalysis*. 7.

Robins, S. (2000). Derrida. Unpublished paper presented at the University of the Witwatersrand: South Africa.

Room, R. (1983). Sociological aspects of the disease concept of alcoholism. In R. G. Smart, F. B. Glaser, Y. Israel, H. Kalant, R. E. Popham, & W. Schmidt, (Eds.), *Research Advances in Alcoholism and Drug Problems*, 7, 47-91.

Sacks, H. (1992). *Lectures on conversation. Vols. I & II.* Oxford: Basil Blackwell.

Schaffer, H. J. (1991). Towards an epistemology of "addictive disease". *Behavioural Science and the Law*. 9, 269-86.

Schaffer, H. J. (1992). The psychology of stage change: The transition from addiction to recovery. In J. Lowinson, P. Ruiz, R. Millman, & J. Langrod, (Eds.), *Substance abuse. A comprehensive text book.* USA: Williams & Wilkins.

Schneider, J. W. (1978). Deviant drinking as a disease: Alcoholism as a social accomplishment. *Social Problems*, 25, 361 – 72.

Selekman, M. (1991). Post-Milan and constructivist perspectives on substance abuse. *Journal of Strategic and Systemic Therapies*, 10 (1), 1-2.

Shaw, M. (1998). *Organised crime in post apartheid South Africa*. Retrieved January 21, 2005, from http://www.iss.co.za/Pubs/PAPERS/28/Paper28.html

Shi-Xu. (1998). *The discourses of mind: A social constructionist linguistic outlook.* Paper presented at 'New relativities in discourses of thinking and feeling', American Anthropological Association, 19th annual meeting, Philadelphia, USA.

South African Community Epidemiology Network on Drug Use (SACENDU). (2004). Retrieved January 21, 2005, from http://www.sahealthinfo.org/admodule/sacendu.htm

Steinberg, H. (1969). *Scientific basis of drug dependence*. London: J & A Churchill ltd.

Steiner, J. (1990). Pathological organizations as obstacles to mourning: The role of unbearable guilt. *International Journal of Psychoanalysis*, 71, 87-94.

Thombs, D. L. (1994). *Introduction to addictive behaviours*. New York: Guilford Press.

Truan, F. (1993). Addiction as a social construction: A post empirical view. *Journal of Psychology*, 127 (5), 489-99.

United Nations Information Services (UNIS). (2002). *African governments respond to illicit drug trafficking and abuse*. Retrieved January 21, 2005, from http://www.unodc.org/unodc/en/press_release_2002-04-15_1.html

Vygotsky, L. S. (1978). *Mind in society*. Cambridge: Harvard University Press.

Weedon, C. (1997). *Feminist practice and poststructuralist theory (2nd ed.).* Blackwell: Oxford.

Willis, J. H. (1970). *Drug dependence*. London: Faber and Faber.

Wittgenstein, L. (1953/1958). *Philosophical investigations (2nd ed.).* Oxford: Anscombe Blackwell.

Wurmser, L. (1974). Psychoanalytic considerations of the etiology of compulsive drug use. *Journal of the American Psychoanalytic Association*, 22, 820-843.

Wurmser, L. (1984). The role of superego conflicts in substance abuse and their treatment. *International Journal of Psychoanalytic Psychotherapy*, 10, 227-258.

Appendices

Appendix A: DSM IV TR Criteria for Substance Related Disorders

Substance Dependence

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifest by any three (or more) of the following, occurring at any time in the same 12-month period

Tolerance, as defined by either of the following:
A need for marked increased amounts of the substance to achieve intoxication or desired effect.
Marked diminished effect with continued use of the same amount of the substance.
Withdrawal as manifested by either of the following:
The characteristic withdrawal syndrome for the substance (refer to criteria A and B of the criteria sets for withdrawal from the specific substance)
The same or closely related substance is taken to relieve or avoid withdrawal symptoms.

The substance is often taken in larger amounts or over a longer period than was intended
There is a persistent desire or unsuccessful efforts to cut down or control substance use
A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain smoking), or recover from its effects
Important social, occupational, or recreational activities are given up or reduced because of the substance
The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological that is likely to have been caused or exasperated by the substance (e.g. current cocaine use despite recognition of cocaine induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption)

Specify if:
With physiological dependence: evidence of tolerance or withdrawal (i.e., either item 1 or 2 is present)
Without physiological dependence: no evidence of tolerance or withdrawal (i.e., neither item 1 nor 2 is present)

Course specifies (see text for definitions)
- Early full remission
- Early partial remission
- Sustained full remission
- Sustained partial remission
- On agonist therapy
- In a controlled environment

(American Psychiatric Association, 2000)

Appendix B: The Twelve Steps of Narcotics Anonymous

1. We admitted that we were powerless over addiction, that our lives had become unmanageable.
2. We came to believe that a Power greater than ourselves could restore us to sanity.
3. We made a decision to turn our will and our lives over to the care of God *as we understood Him.*
4. We made a searching and fearless moral inventory of ourselves.
5. We admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. We were entirely ready to have God remove all these defects of character.
7. We humbly asked Him to remove our shortcomings.
8. We made a list of all persons we had harmed, and became willing to make amends to them all.
9. We made direct amends to such people wherever possible, except when to do so would injure them or others.
10. We continued to take personal inventory and when we were wrong promptly admitted it.
11. We sought through prayer and meditation to improve our conscious contact with God *as we understood Him*, praying only for knowledge of His will for us and the power to carry that out.
12. Having had a spiritual awakening as a result of these steps, we tried to carry this message to addicts, and to practice these principles in all our affairs.

(Narcotics Anonymous, 1994)

Appendix C: Letters of Consent

Letter of Informed Consent to Participation

Vincenzo Sinisi
Ma Clinical Psych III
University of the
Witwatersrand
Date:

Dear Potential Informant,

My name is Vincenzo Sinisi. I am currently completing a research report in fulfilment of my master's degree in clinical psychology at the University of the Witwatersrand. This research aims to describe the way that people who are or have been addicted to opiate drugs (e.g. heroin, pinks etc.) speak about the substances, their experiences and their use. I want to understand how users of these drugs explain their own use.

All volunteering informants in the study will remain anonymous in that, while their words will be made public, their identities will remain confidential. The interviewing process will take place in focus groups of 4 people for approximately one and a half hours. The other group members would be people who also use or have used opiate substances and have been involved in treatment for this. All informants will be asked to sign a document undertaking to keep confidential all information discussed in the group and the identity of the other informants (nick names can be used if desired). I must make it clear that I cannot guarantee that informants will abide by their undertaking. In addition, as a researcher I am not protected by law in terms of client confidentiality so that any self or other incriminating material you choose to disclose could hypothetically be used as evidence against you if the records of the study were subpoenaed. Although I have no reason to suspect that this would happen. I will remind informants again at the beginning of the group about the risks of disclosing any self or other incriminating material and will ask everyone to sign a confidentiality undertaking, in addition to this informed consent sheet. Interviewees may refuse to answer any question and may withdraw at any point that they wish. Non-participation in the study will not compromise your treatment or access to social or psychological services in any way.

Debriefing will be made available should it be required. Each interview will be audio recorded and later transcribed. Sections of the transcriptions will be included in the final work with all identifying remarks and names changed. Feedback regarding the study's outcomes will be made available to all those interested.

You are in no way required to participate in this study. It is necessary for me to obtain informed consent from each interested informant before I can begin the study. Your signature below indicates that you understand and accept the above conditions.

Yours faithfully,

_____ _____
Vincenzo Sinisi. Tel 083 742 0114 Informant

_____ _____
Witness Witness

Letter of Consent to Audio Recording

Vincenzo Sinisi
Ma Clinical Psych III
University of the
Witwatersrand
Date:

Dear Informant,

The focus group that you have elected to attend will be audio recorded. The recordings are intended to allow the researcher to transcribe (type) what was said during the group. All facts that may lead to the identification of any particular informant will be changed in the final transcription. This will apply to all names and any identifying statements made.

Once the transcriptions are complete all recordings will be deleted.

You are in no way required to participate in this study. It is necessary for me to obtain your informed consent before I can begin the study. Your signature below indicates that you understand and have consented to the above conditions.

Thank you for your support,

Yours faithfully,

_____ _____

Vincenzo Sinisi. Tel. 083 742 0114 Informant

_____ _____

Witness Witness

Letter of Consent to Terms of Confidentiality

Vincenzo Sinisi
Ma Clinical Psych III
University of the
Witwatersrand
Date:

Dear Informant,

Participation in this study is allowed strictly and only on the explicit understanding of the following conditions.

All informants agree not to divulge the identities of or any information disclosed in faith by either the researcher or other informants of the study. However, I cannot guarantee that all informants will abide by this agreement.

The researcher undertakes to maintain confidentiality, as far as possible, as outlined by his governing board, the Health Professions Council of South Africa.

All informants are discouraged from disclosing potentially incriminating information. If you do disclose such information it will be considered to be your responsibility/choice, since the materials generated by this study could be subpoenaed and presented as evidence before a court of law. However, all documentation collected by this study will have been marked "Not for forensic purposes".

You are in no way required to participate in this study. It is necessary for me to obtain your informed consent before I can begin the study. Your signature below indicates that you understand and consent to the above conditions.

Thank you for your support.

Yours faithfully,

_____ _____

Vincenzo Sinisi. Tel. 083 742 0114 Informant

_____ _____

Witness Witness

Appendix D: Topic Schedules

For Current User Groups

What drugs do you and have you used?

Why do or did you choose/use those drugs?

How did you get started?

How do you understand your drug use? Has this understanding changed over time?

How do you perceive drugs? Has this changed over time?

What is its appeal? / Why do you use drugs?

Are things different now to when you first started?

How do you understand addiction? Has this understanding changed?

Would you recommend drugs? Why? Why not?

Have you ever stopped or considered stopping?

If you did, how/why did you stop? If not, why continue?

If so, what was it like?

If so, why did you start again?

What would you say to another abuser who wants to stop or continue?

For Recovered User Groups

What drugs did you use?

Why did you choose/use those drugs?

How did you get started?

How do and did you understand your drug use?

How do and did you perceive drugs?

What was their appeal? / Why did you use drugs?

Is your understanding of your abuse different now to when you first started?

How do and did you understand addiction?

Would you recommend drugs? Why? Why not?

How and why did you stop?

What is it like?

What does it mean to have stopped?

What would you say to an abuser who wants to stop or continue?

Appendix E: Section of Transcript of Focus Group C (Not for Forensic Purposes)

Note: All identifying information (e.g. names of people, places etc.) has been changed to ensure informant anonymity.

One group member (Desmond) is missing from the beginning of the group. He arrives later but the group decides to begin without him due to time constraints.

Interviewer: All right the recorder is on. So you were saying that you have been clean for about three years.

Patricia: On August the eleventh I will be clean for four years.

Anton: On October the 7th I will be ten years.

Alice: And on September the first I will be five years

Interviewer: Well done that's pretty good.

Anton: Thanks very much. It was nothing!

Group: Haha

Interviewer: Like I said, we are really just here to have a conversation about addiction and substances or well substance use. Because I want to look at the way people talk about it. Um, maybe we could start by looking at how people here understand addiction. What it is. What it is about.

Patricia: Well I mean it always sounds so clichéd but I mean I think it is a disease, well what I have understood about it. It's something kind of inherent inside of me. I think it's like a hunger a hunger that can't be filled, actually. A consistent hunger that gets more ferocious. Um, and its not just, for me, as an addict, its not just about the substance, it's my fixation of things, people, places things, you know I have got to constantly try and work, for some serenity, because my instinct is to be a kind of greedy kind of person, and that not something that's even negative it's just that I want more always, always, I want more. And, I never understood it when I was using, when I was using I just kind of used because that was the kind of easiest thing to do, to quell it kind of momentarily but once it, you know the drugs would wear off it would be more and more and more and that's basically how I see it.

Interviewer: Ok… I think I have skipped a step here, does everyone here see themselves as having been an addict?

Alice: No it's a terrible thing but I am in the wrong place.

Group: Hahaha

Alice: My parents thought I had a problem but.

Group: Hahaha

Alice: Yes.

Group: Yes.

Interviewer: Okay, well then does what she says ring true for anyone else?

Anton: Well not all of it! Well some of it. I mean I agree that it is a disease and that I suffer from a disease. Well that's how I make sense of what happens you know. I don't accept that's it was self-inflected. I do accept that I chose to use drugs but I didn't know when I chose to use them that I would be unable to choose to stop to use them. Does that make sense? And I think it's a kind of brain disease um, um, having exposed myself to the agent, to heroin. Actually before that I think I was addicted to other drugs before I was addicted to heroin, when I exposed myself to drugs I did not realise kind of that I was not going to be able to stop and I think um, I made a choice to start and I could not make a choice to stop. I think in that sense it is an illness, it is a psychogenic illness. It was not something that I chose to do.

Interviewer: Hmm, so while you are talking about some kind of personality characteristic of yours. Is that right?

Patricia: No I mean I think I actually agree with Anton. It's not like I believe it was my fault but I believe it is something that is inherent in me. I actually think that that is what the addict is. Those are the kind of feelings that it elicits in me. That kind of hunger for the stuff, um, is I suppose what the addiction does although I do believe that it's not something that I wilfully chose to, to be, do you know what I mean?

Interviewer: Sure but the way Anton is speaking suggests that um, the substance has done something.

Patricia: Ja, well I don't agree with that.

Interviewer: And that he became an addict.

Patricia: I think I was one from birth, I was born hungry.

Anton: So do I, I mean I think I was born with a predisposition for addiction and I think I got from my family. If one looks at the history of my family through the ages you can kind of, you know um, it's just that there is probably a drunkard in the Canterbury tales somewhere who was a Levy.

Interviewer: Ok. But that sounds like a genetic kind of predisposition.

Anton: Certainly.

Interviewer: Where as again what you are speaking about to me still sounds like a personality kind of characteristic.

Patricia: But I do think that genetics and personality are kind of like linked.

Alice: I experience it coming from a more emotive, let me explain to you emotionally, my addict experience where as Anton is much more practical but I get what they are both saying.

Patricia: It's the same thing really.

Alice: I can give you the girly version of why I am an addict or I can give you like the butch rough version of why I am an addict. They are both kind of the same thing. I was born with this and it manifested itself and ended with heroin addiction but it could have gone shoplifting, sex, eating disorder, um, pick an obsessive, self destructive behaviour, I just happened to be heroin. Well that's what I entered my illustrious self destructive career on, heroin, but the addictive behaviour was there. But for me when I was small…

Anton: Well I think for me, I think we must make a differentiation between an addictive personality and an illness. You don't have a kind of schizophrenic personality do you? I mean you have schizophrenia or you don't and they are two very different things that we are talking about. When you say she is a bit schitzo we are not saying that she is suffering from the illness of schizophrenia are we and I think that's the same with addiction. For me I don't have an addictive personality I have an illness, and that illness manifests in all the ways that they are talking about. But my personality. You see if it's an illness I can do something about it I can change it. Then I can kind of gain some level of control over it, by maintaining abstinence or by being aware of it, and kind of responsible for the management of my illness. If its personality, if it's my personality then it's who I am and then that's the end of that kind of story, I can never move away from it, that's who I am, it my personality, kind of disorder if you like. I don't accept that. I think because of my experiences with drugs and because of kind of the decimation of self that that, that I think, that I believe that, all kind of chronic addict would relate to that kind of decimation of self I am left with a kind of emptiness after putting the drugs down that needs to be filled and that leaves me very vulnerable to other addictive behaviours to fill that void, to fill that need, do you know what I mean, but I don't necessarily identify that I had those needs as I was growing up, I wasn't particularly obsessive as I grew up, I wasn't particularly compulsive. I was quite, I mean I was reasonably, um, dare I say, normal? Haha.

Patricia: You see I was never. I was never. I was born, I mean I remember when I was as like little, wanting more. I mean like literally when I was little like wanting more of my mother's breast. I mean, I don't know if I completely agree with Anton about the personality thing.

Desmond (the late comer) walks into the room. The group welcomes him and I suggest that we stop recording while I explain the terms of confidentiality and other administrate aspects of the group.

Interviewer: We are recording again. I'll just tell you where we where or maybe someone from the group could kind of tell Desmond where we kind of picked up from. Anyone?

Patricia: We were trying to say what addiction is about. Um, how we interpret.

Anton: How we make sense of it.

Desmond: What it is?

Interviewer: So there was a bit of a debate as you walked in between two different angles of how people describe addiction and the one was that it is something that kind of happens after you use a substance. It kind of seems to infect you in a certain way so that it changes you and creates strong need. Another perception was to talk about pre-existing desires and strong urges or desires to be kind of excessive that sort of play themselves out with drugs but may have played themselves out in a number of ways should drugs not have been chosen.

Desmond: Well I chose drugs.

Group: Haha.

Desmond: From when I used chemicals when I was young it didn't occur to me really not to use them. I mean I would not do certain things before work in the morning but um, they seemed to have a perceived payoff and so I used them, I mean and um, eventually they kind of took over my life I suppose. Ja.

Interviewer: Okay…

Desmond: I mean maybe in retrospect, I can kind of see that there was kind of stuff that I, in my behaviour, that was around before then but um, I don't know, I don't really, for me it was, about drugs in a way.

Interviewer: You are talking about choosing them and you did that with a particular intention because they satisfied something…

Desmond: Ja.

Interviewer: And there was a pay off right? Okay, now would you say that there was a difference between using a substance because it is fulfilling a function and being addicted to a substance?

Desmond: Definitely.

Interviewer: Or does one lead to another.

Desmond: Definitely a difference.

Anton: I also don't think that using a drug for a payoff, necessarily leads to addiction. I think most people, and certainly from what I have understood, a lot of people that I used with, a lot of people that I smoked grass with when I smoked grass never became addicted. A lot of people that I used coke with when I first used coke never became addicted. A lot of

people that I used heroin when I first used heroin never became addicted. You know and all that, and I don't think that we were going at it from a different angle. I think we were using it the same way. We had the same, you know it was fun, we were getting kicks. It was cool we were having fun. It wasn't need driven. I wasn't kind of, I wasn't desperate for drugs at that stage. It was just, you know enjoying it. It was meeting some… I don't even think that perverse a need. It was a fairly obvious and basic need. Do you know what I mean? Or the need for fun and for enjoyment. The need to relax.

Patricia: My desire was always trying to feel ok myself because I felt uncomfortable with who I was and I mean I know that this sounds a bit shwamy but even Jung said it so I know I can say it. But this whole idea of the spiritual thirst. He he he kind of introduced that concept. You know and I really liked that idea because, I know in recovery the one thing that does like dissuade the hunger is a sense of some kind of union with the spiritual whatever. I mean god if we have to use that word, um, but for me it was kind of looking for a kind of godly experience, especially with heroin, I had a very like nirvana kind of experience whit that drug, I would feel very at home and calm, at one with myself, at one with everything in-fact. It was a very um, kind of godly feeling, what I imagine it must be like to be in heaven, in a sense. And when it wasn't there it was in hell but it was the constant kind of pursuit of that. And in recovery I find that when I am my best is when I am working in a kind of spiritual frame work. Do you understand what I am saying. Not really.

Interviewer: Well I, I am finding it difficult to follow, um, it you know, it just reminded me about what someone was talking about a minute ago. Which was kind of like a void that needed to be filled.

Alice: A hole in the sole.

Interviewer: And you filled it with that, and you find that spirituality fills it for you now? Is that…

Desmond: Well a lot of things fill that. I mean I think, well I know for me when I put down the drugs, I mean I didn't actually fill the emptiness with necessarily spirituality. I filled it with a lot of things. I tried to fill it with relationships, I tried to fill it with sex and I mean fortunately I, I was a part of something where there was a spiritual dimension to it or whatever. But I mean I tried to fill, but I think for me the, you know I thought that when I put down the substances that every thing would be ok but it actually wasn't and I just kind of, floundered around, and filled it with, I mean I wasn't well all of a sudden. In a way like using was like, I was more at home with it because it was something I knew. And being straight was very odd.

Appendix F: Section of Coding/Preparatory Analysis of Focus Group C

Atmosphere of group

This group seemed to focus far more on managing blame and coming to terms with what happened in the past. They spent more energy (than the other groups) on describing how they were not bad people. I wonder if this represents a reflection of their stage of recovery? Recovery may involve arriving at a face saving world view that supports a positive identity and which also allows the shutting down of the possibility to use?

When I started

C35. Using was the easiest way to satisfy my 'as of yet' misunderstood hunger. (The disease pre-existed the addition)

C55. I did not know I would be unable to choose not to use them. You can choose to start but not to stop using drugs. (Interesting paradox seeing as he has recovered)

C160. 930. Never thought of not using. (A position from which it would be impossible not to use?)

Why I started

C165. The pay off. (Focus on benefit)

C200. Normal need for a good time. (Resists images of deviance)

C205. Needed to feel ok. Heroin is nirvana. (Self medication function, also element of transcendence)

C220. Hole in the sole (As above)

C245. The hole was always there. It helped me reach unconsciousness. (The disease pre-existed the addition)

C310. I found what I have been looking for my whole life. (Who can argue with that?)

C345. I was involved with stressful things. (Function)

C385. To be rebellious, independent (Identity)

C1235. I aspired to be of the calibre of these great heroin addicted artists (Identity)

C1245. It allowed me to identify with the greats. (Identity)

C1255 - 1270. Top of the food chain we are (Identity)

C1285 – 1295. Heroin addicts are like family (Identity)

The Payoff

Holding on to heroin's value, once one has stopped using heroin, appears to be a way to legitimate what happened. It seems to provide a rational element to something that could easily be construed as madness. Something to the effect of, "It was good and that's why I did it, but it stopped working out for me so I had to stop. It's not like I was an idiot from the beginning."

C265. 285. Superhuman. It was immaculate. It offered a lot. It made me untouchable.

C270. 345. I could function more effectively.

C305. Don't give a fuck. Vs. giving too much of a fuck (It corrected my weakness)

The Early Days

C410 I didn't want to stop because it was good. (Value additive)

Later On

C210. Pursuit of the heaven (A quest for spiritual fulfilment?)

C285. If I could manage it (If only but I can't). This seems to close down the option to use by simultaneously holding the good with the bad)

C365. It became "oh shit I don't feel so good without this". (Choice is lost. It takes over. Where is the accountability in this statement?)

C375. Not in control any more. (Agency? Definitely a recurring pattern of a reduction in agency, at least in discourse)

C380. I am not at fault here but I needed more. (I don't know how it happened??? Not a consequence of my actions)

C385. 455. Became a victim/slave. Did not like it any more but held withdrawal at bay. (Mandatory)

C415. I became obsessed.

C420. 430. Insatiable

C440. Most of the time was spent trying to get. (Impossible condition)

C485. Three years into it I realised I can't stop! Never wanted to before that or even then. Only realised I was addicted two years after I was addicted. (Delusion or discourse of delusion?)

C530. Only once you try to reduce (Supports delusional assessment of circumstance?)

C600. Goal post shifting (As above)

The End

C125. 235. Addiction left me with a void which leaves me at risk. Drugs damaged me. (Void caused by addiction rather than an ordinary sense of emptiness)

C220. Hole in the sole. (As above)

C225. Tried filling with sex etc. (As above)

C230. Leaving drugs doesn't leave everything ok. Leaving drugs leaves you to face what is left and it is not cool. Drugs are what you know. (It is difficult, very difficult!)

C260. I remember the high with great love. Ten years later. (This is a surprise)

C285. If I could manage my addiction I would be using. (No negative take on the feeling.)

C310. This always felt amazing I did not stop because it changed (I think this serves to legitimate use)

C325. I want more of that feeling still (As above)

C340. I hated the feeling. (How they are able to support different positions is interesting)

C345. I never wanted to stop. I am still trying to get from life what heroin gave me. (Seem NB but not sure why?)

C355. I miss having friends in my pocket and not being lonely. (Relationship)

C455. Tried for ten years to get back in control not to stop. (Something about giving up the fantasy of a perfect union)

C470. Try go without to feel how it was in the beginning. It needed to be maintenance. (Even stopping is about using)

As a Disease

C25. It is inside of me. A hunger that can not be satisfied. Not just the substance but the way I approach things. Greedy. (There is something wrong with me)

C55. 115. It is a disease (Not self inflicted).

C60. The brain disease is activated by the substance.

C10. Either you have it or you don't.

C20. Thinking in terms of disease allows one to think in terms of management. It allows control and change. (Implies addiction is a diseased view of the world rather than a physiological condition)