‘That was then, this is now’

Exploration of identity construction and reconstruction during drug using careers, and the factors that influence identity transformation.

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A THESIS SUBMITTED IN FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF PH.D

SCHOOL OF SOCIAL WORK AND SOCIAL POLICY FACULTY OF SOCIAL AND HUMAN SCIENCES, UNIVERSITY OF DUBLIN, TRINITY COLLEGE

2015
Declaration

I declare that this thesis has not been submitted as an exercise for a degree at this or any other university and that it is entirely my own work except where acknowledged.

I agree that Trinity College may lend or copy this thesis upon request.

_______________________
Siobáin O’Donnell
Summary

According to academic interpretations and media representation, there exists a negative portrayal of the drug user as a deviant, compulsive, 'out of control’ consumer of risk. This portrayal adversely impacts on the drug user who attempts to cease using drugs and embrace a drug free lifestyle. The literature reviewed presents prevalence statistics which indicate that drug using is increasing in Ireland, which is a worrisome status for policy makers and service providers, and for the general public who experience fear of drug users. Historically and culturally mainstream society views drug using as an unacceptable, deviant behaviour, incongruent with the norms and values of society that must be medicated, sanctioned, controlled or eliminated. Drug users respond to this ideology by forming their own subculture which involves adopting alternative norms and values that condone drug using and protect its continuance. Whilst immersed in a drug using subculture, individuals take on a drug user identity which supports their drug using lifestyle. This study is about the construction of a drug user identity during drug using and the reconstruction of a non-drug user identity on cessation of drug using. It set out to explore the challenges experienced by drug users who choose to cease drug using and reconstruct their identity as non-drug user. It is also concerned with how this identity construction and reconstruction influences relapse.

This thesis employed a qualitative methodology. Drawing on the Biographic Narrative Interpretive Method, it conducted two interviews with sixteen participants, all of whom were former drug users at the time of interview. It set out to elicit the views and opinions of former drug users’ experience of identity transformation before, during and after their drug using careers. Through analysis of the data collected, the thesis explores the various supports employed by drug users to aid cessation of drug using and reconstruction of a non-drug user identity, as well as barriers encountered during the transition period. It is concerned with how societal stigma regarding drug using impacts on the identity of the drug user in their attempt to reconstruct their identity or retrieve a spoiled identity. It also seeks to examine how drug users experienced the challenge of negotiating societal stigma, social exclusion and marginalisation and how they employed treatment and other services to help them negotiate these challenges.

The life histories presented by the participants trace their journeys from initial experimentation with drug using, through the chaos of addiction to the search for recovery and stability of drug free lifestyles. Construction of a drug user identity as drug using increases and reconstruction of a non-drug user identity on cessation of drug using are explored. Key elements that supported the reconstruction of a non-drug user identity and enhance the quality of life in a drug free lifestyle were highlighted as well as barriers that hindered identity transition. The challenge of relapse and relapse prevention was stressed, as relapse is a common occurrence indicating unsuccessful identity transition.

The participants of this study initially welcomed the immersion into a drug using lifestyle and found the adoption of a drug user identity was a relatively uncomplicated process. During their drug using careers this identity facilitated the continuation of drug using and helped minimise or deny negative consequences of drug use. Membership of a drug using subculture offset the adverse consequences of societal stigma, marginalisation and social exclusion. Eventually, as drug using became more chaotic, the participants experienced despondency and distress in their daily lives and their drug using lifestyle became too arduous to sustain. The participants described how they became extremely discontented with their drug using situation, experienced depression, isolation, physical and mental health difficulties, and suicide ideation. On reaching
the end of their drug using and determination to change, difficulty arose when endeavouring to transition from drug using to drug free lifestyles.

Challenges in early recovery included loneliness and isolation, difficulties in being accepted by mainstream society, forging new non-drug using friendships and social stigma. These difficulties were exacerbated by the need to process feelings of shame, guilt and remorse, and negative self-concept and to negotiate accepting the responsibilities that come with a drug free lifestyle. The participants described the various supports they employed to help their journey through early recovery and identity transformation. The majority of participants highlighted 12-Step programmes as the most supportive and life-changing assistance they employed. Family and intimate partner support, as well as engaging in recovery positive activities like education, training, exercise, health promotion and self-care were also found to be useful. Most of the participants gained employment in recovery which boosted their self-confidence and enhanced the achievement of identity reconstruction.

Several participants related frequent relapsing behaviour which lasted for years in some cases, and described relapse prevention strategies they found useful. It was noted that Ireland tends to respond to the issue of drug using through a model of acute care, which would contradict the idea of addiction being a ‘chronic relapsing disorder’. Some treatment options offer an aftercare programme, however evidence suggests that the uptake of aftercare is often poor. The majority of drug users are re-admitted to services after a crisis related relapse, when it is too late to circumvent the relapse. Barriers to successful identity reconstruction included lack of support from services in early recovery especially where a history of relapse exists. The participants also highlighted lengthy assessment processes and lengthy waiting periods to access supports. Some participants experienced harsh, confrontative group therapies which they found extremely unhelpful, and commented it may have been more useful to process experiences rather than being confronted which tended to lead to justification instead of processing.

A critical aspect of successful recovery was the transformation of identity that is, moving away from the ‘addict’ identity towards a ‘non-addict’ identity. The participants reported how they gained a sense of themselves as their new identities emerged. The majority of participants reverted to their previous ‘unspoiled’ identity and some participants added that they picked up new skills in recovery. The analysis of the data collected identifies several barriers to effective identity transformation which negatively impacted on successful recovery. The participants said they experienced great difficulty in moving away from their drug using peers as no other social group existed for them to interact with, with the exception of membership of 12-Step programmes. In early recovery they had still not reconciled relationships with family and former friends and felt exceedingly isolated when separated from drug using friends. This interim period was described as lonely, isolating and frightening.

Fourteen of the sixteen participants of this present study related that they experienced membership of 12-Step programmes as the greatest support in recovery. From their reflections this study has found that the telling and retelling of personal narrative, along with a renewed sense of spiritual self and a tradition of helping, all of which exist within 12-Step programmes, facilitate positive identity change. Reframed narratives within the 12-Step framework enabled the availability of a new unstigmatised presentation of everyday self, which permitted a new sense of their subjective social reconstruction of an unspoiled identity. Moving away from the social construction of addiction and deviance, the retold narrative enabled identity transformation to occur.
For my sisters Joan and Marjorie who passed during the writing of this thesis.

May you rest in peace
Acknowledgements

To my employers - I would like to acknowledge the support of Dublin Business School and say a big thank you to Gerry Muldowney and Donal Quill for their generosity.

To my supervisors – Dr Marguerite Woods for her invaluable help and advice over the first three years and Dr. Stephanie Holt for sticking with me through the final years. Thank you both for your considerable help and support.

To my family – I promise to make up for all the events I have had to decline in order to complete this thesis. Thank you to my daughters Ciara, Katherine and Dannielle for your help on checking reference lists, to my sons Paul and Andrew, my son-in-law David and my grandchildren Jordan, Liam, Conor, Laura, Oisin, Aidan and Chloe.

To my friend Mary Bartley – thanks for listening and encouraging me to continue. I no longer need bread, eggs and milk in the ‘bat cave’.

To all the participants – thank you for sharing your life stories so deeply. I feel privileged and honoured that you felt you could disclose such intimate details of your lives with me. Without you, this thesis would not have been possible.
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List of Abbreviations

AA  Alcohols Anonymous
BNIM  Biographic Narrative Interpretive Method
CA  Cocaine Anonymous
CBT  Cognitive Behaviour Therapy
CJS  Criminal Justice System
CSA  Childhood Sexual Abuse
CTL  Central Treatment List
CPAD  Concerned Parents against Drugs
DTCB  Drug Treatment Centre Board
DTF  Drug Task Force
EMCDDA  European Monitoring Centre for Drugs and Drug Addiction
FÁS  Foras Áiseanna Saóthar/Training and Employment Authority
GA  Gamblers Anonymous
GP  General Practitioner
HSE  Health Services Executive
MET  Motivational Enhancement Therapy
MMP  Methadone maintenance programmes
NACD  National Advisory Committee on Drugs
NCCDA  National Co-ordinating Committee on Drug Abuse
NDP  National Development Plan
NDS  National Drugs Strategy
NDST  National Drugs Strategy Team
NDTRS  National Drug Treatment Reporting System
NIDA  National Institute on Drug Abuse
NIH  National Insurance of Health
OTC  Over the Counter
PDU  Problematic Drug User
TC  Therapeutic Community
TRS  Telephone Recovery Support
WHO  World Health Organisation
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CHAPTER ONE

Introduction

The issue of addiction has perturbed sociological, political and psychological thinking for decades. Recently, societal arguments regarding dangerousness, risk to the stability and health of society, public nuisance and criminality have dominated media headlines. At a political level Ireland is spending millions of euro annually on the five pillars of the National Drug Strategy (NDS) and coming up with numerous policies and strategies to deal with the ‘problem of addiction’. Policy is aimed at prevention of sale and supply, research, education and awareness, as well as treatment, rehabilitation and harm reduction procedures. Policy makers are concerned with social protection for the nation. Treatment providers are concerned with helping those involved in addictive behaviours to address their situation. Communities are concerned with the devastating effects of addiction within their geographical environment and the families living within their community. Families are concerned with the effects on their loved ones and wider social circle. Centrally located within all these concerns is the drug user.

This introductory chapter will outline the research aims, context and rationale of this study and describe the definition of terms used within it. It will discuss current trends in drug using and the evolution of drug policy in Ireland. It will also describe the media representation of drug using and drug users, and the issue of public nuisance, both of which impact on the layperson’s view of drug using.

The research context

Many reasons have been suggested as to why individuals engage in drug using, including relief of anxiety and stress, avoidance of painful or negative emotions, curiosity and peer pressure, performance enhancement within the athletic field and feel good factors (NIDA, 2010). Debates arise from attempts to solve the question of how some individuals enjoy recreational use of licit and illicit drugs while others become enmeshed in problematic use (Parker, Measham, & Aldridge, 1995). Peele (1987), Zinberg (1984) and Becker (1973) discussed the notions of spontaneous recovery, maturing out and electively moving away from problematic use without the necessity of formal treatment. However many individuals experience extreme difficulty in breaking the habit of drug using, use multi-modes of treatment and frequently relapse (Marlatt & Gordon, 1985).
Prevalence statistics, described later in this chapter, suggest illicit drug using in Ireland is increasing and that there exists a ready availability of all types of illicit drugs. Butler (2008) suggested this availability has been facilitated by advances in science and technology and increased globalisation easing the transportation of substances around the world. Therefore, availability through diverse media, including purchase via the internet, increasing domestic production and black market networks ensures that illicit drug using maintains a high profile within societies (Parker, Williams & Aldridge, 2002). The statistics show that Ireland has an increasing culture of problematic drug using which includes polydrug use and alcohol (EMCDDA, 2014), while public nuisance is becoming a social challenge for government, city councils, traders, tourism and the general public.

**Research aims**

This thesis is concerned with individuals’ transition from drug using\(^1\) to non-drug using through the subjective lens of the drug user. It focusses on an exploration of identity construction and reconstruction from the perspectives of former drug users. It presents the former drug users’ subjective perception of their identity construction and reconstruction across their non-drug using to drug using to current non-drug using careers. This research also aims to examine how the participants understood the process of identity reconstruction, if they recognised that they were engaged in this process and what, if any, barriers they encountered to successful identity reconstruction.

Secondly, this thesis aims to examine issues that influence identity transformation. It explores how former drug users negotiated these states, examines what issues arose for them and what supports, if any, they utilised. These issues and supports may include such aspects as Irish drug policy and society’s construction of the drug user and of addiction. This research aims to investigate mainstream\(^2\) society’s perception of the drug user through a thorough review of literature, analysis of media representation and from the perspective of the drug user. It examines the ensuing impact of mainstream society’s perception of the drug user on their

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\(^1\) That is, transition from what is commonly referred to as ‘addictive’ or ‘dependent’ drug use.

\(^2\) This thesis uses the term mainstream to denote that which is considered the most typical or conventional by the majority of people. Mainstream is perceived as customary or acceptable by the majority as opposed to subculture or counterculture which can be deemed favoured by minorities. Therefore mainstream relates to the dominant trends, values and norms that are accepted by the majority of people in a given society.
identity and to investigate if stigma, marginalisation and social exclusion impact on the drug user and, if so, in what way and to what extent.

Thirdly, this thesis aims to illuminate how drug users experienced the support, treatment and interventions they engaged with, with a specific focus on how they experienced that support, treatment or intervention assisting positive identity transformation and enhancing recovery from drug using. It examines, from the perspective of former drug users, the efficacy of strategies, supports, treatments and interventions employed while reconstructing their identity. It explores the level of support that former drug users report was available to them. Given the empirical knowledge highlighting the trends in frequent relapse and the struggle to maintain abstinence (NIDA, 2008), this thesis explores the issues of drug use, relapse, relapse prevention and recovery from drug addiction and how a recovery oriented identity, especially in early recovery, can help avoid relapse. Finally this thesis aims to explore how successful identity reconstruction and recovery may support each other and how threats to the newly constructed identity in recovery could trigger relapse or prevent successful transition to a reconstruction of identity.

**Purpose/Rationale for the research**

This research examines the roles of identity and stigma through drug using careers. It sets out to identify how these affect the drug user before, during and after drug using. In order to understand the notion and function of identity within a drug using population it is essential to comprehend how contemporary society views ‘addiction’, and how this view has wider ramifications for the drug user, especially in relation to stigma, marginalisation and social exclusion. Lettieri, Sayers and Pearson (1980)\(^3\) contended that addictionology theorists agree on the intricacy of the notion of addiction which originates from the psychological, biological and social impact on the individual user and on the wider society socially, legally, politically and economically. Consequently, the portrayal or labelling of drug addiction proved equally complex regardless of whether addiction is deemed a maladaptive behaviour, a moral deficit or a disease (Holzinger, Matchinger, Lucht & Angermeyer, 2010)\(^4\).

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\(^3\) Lettieri, Sayers and Pearson (1980) reviewed 43 diverse theories of addiction.

\(^4\) See also Tangney, 1991: Wurmser, 1995
In order to situate the challenge of addiction within society, this research sets out to explore the definition of addiction, its history and the dominant discourses regarding definition. It examines society’s constructions of addiction and deviance drawing on evidence as to whether addiction is viewed as a medical problem requiring treatment or a moral problem requiring sanction. It reviews the notion of addiction as a societal problem leading to social sanctions and social controls, both of which may lead to the marginalisation and stigmatisation of drug users (Lovi & Barr, 2009). It explores the historical, cultural and social aspects of social stigma and social control and their influence on marginalisation and exclusion of the drug user. It considers the subsequent influence of these factors on the identity of the drug user, that is, the construction and reconstruction of identity before, during and after drug using careers. It also considers useful supports to enhance successful recovery from drug using and prevent relapse.

This research investigates the notion that drug users frequently respond to society’s attitude by forming their own exclusive drug using subculture, endorsing their own social controls, social sanctions and rituals. Within the drug using subculture, a drug user identity can be constructed for many reasons. When a drug user decides to stop using drugs and forgo membership of the subculture, s/he faces the dilemma of restructuring a ‘non-addict’ identity. This research examines the notion of identity, issues that affect identity and challenges to reconstructing identity after drug using. It investigates the value of perusing the notion of using personal narrative as a tool to aid understanding of drug users’ commitment to identity reconstruction and recovery from problematic drug use. Finally it considers treatment and social supports that were useful to former drug users in their effort to reconstruct their identity, maintain abstinence and prevent or avoid relapse.

**Definition of terms**

There is no firm consensus on a theory of addiction (West, 2006). West outlines the many definitions and theories of addiction and concludes that these definitions and theories are majorly dependent on the model or theory of causation they are based on. West points out that the notion of addiction remains a hotly contested subject and that the unresolved debates regarding definition and theory impact on the perception of the drug user from policy makers, service providers and the general public which in turn impact on treatment methods.

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5 See also Crocker & Major, 1989; Goffman, 1963; Link & Phelan, 2001
This thesis interprets drug addiction to be where drug use is drug taking that causes harm to the individual, their loved ones and friends and the wider community and where the drug user has suffered medical, social, psychological and physical implications (Cox & Lawless, 1999). In this present study, the term ‘drug’ refers to illicit drugs or non-prescribed medication, including heroin, cocaine, benzodiazepine, methadone and other stimulants and depressants, synthetic drugs and alcohol. This thesis proposes to allow individuals to determine their own definition or description of drug addiction⁶ so that they can decide whether they are former drug users or not. Through their own personal reflections, only they can make that decision.

This thesis uses the terms non-drug user, drug user, drug using, drug using career, former drug user and drug addiction. Where the terms ‘addict’ or ‘Junkie’ are used, the use was drawn from a quotation from another author or a quotation from a participant, where the use of colloquial terminology was deemed appropriate.

The researcher employs terms involving the word ‘use’ in order to minimise stigma and judgement. According to Wills (1997) the term drug use is nondescript, does not allow for separation of the medicinal agent from the recreational drug. However, the term ‘drug abuse’ is deemed inappropriate as it can reflect negatively on the user and be considered judgemental. Drug misuse tends to imply that a drug has an appropriate use and is being used for an incorrect reason. For many illicit substances, including those synthetically manufactured, there is no other or appropriate use – the singular use is as a psychoactive drug (Wills, 1997). The World Health Organisation (1981) maintains that both ‘abuse’ and ‘misuse’ are unsatisfactory terms as they tend to invoke value judgements.

This chapter will now contextualise the research against a backdrop of current issues regarding problematic drug use in Ireland. It will illustrate the trends and prevalence of drug use to demonstrate that this issue is still a concern at governmental and societal level. It will trace how drugs policy and treatment methods have responded to the issue of drug use over the past fifty years. Finally it will examine the perception of the drug user from the perspective of the media and the general public to situate concern regarding drug use within contemporary thought.

⁶This loose or informal definition may include two of the key criteria which are conventionally to be found in the literature: 1) that neurologically there has been adaptation to drug use so that abrupt cessation is accompanied by physical withdrawal symptoms; 2) that the drug use has become compulsive so that such users experience of loss of control.
Understanding drug use in Ireland: trends in drug use and public expenditure

Over the past fifty years Ireland has experienced an upward trend in drug using. It is acknowledged that a change in the actual drug used has occurred: that is, polydrug use combining cannabis, new psychoactive, manufactured or synthetic drugs and non-prescribed medications are becoming more popular while the use of heroin is decreasing. Alcohol has recently been included in policy statements as its use is also on an upward trend. However, public expenditure to address this increase in use has reduced (NACD and PHIRB, 2012).

Trends in drug using

Illicit drug use has increased globally manifold over the past fifty years (UNODC, 2012; NACD and PHIRB, 2012). In 2010 it was estimated that worldwide, between 153-300 million adults aged 15-64 had used illicit drugs in the previous year (UNODC7, 2012). In Ireland, The 2010/2011 Drug Prevalence Survey8 estimated that 27.2% of all adults had used an illicit substance at some point in their lives. The percentage rises to 35.7 for persons aged between 15 to 34 years. Statistics for 2003 for the same two aged groups were significantly lower at 18.5% and 25.9% respectively (NACD and PHIRB, 2012) indicating a considerable rise in illicit drug use.

The main findings in the European Monitoring Centre for Drugs and Drug Addiction’s (EMCDDA, 2014)9 analysis of the European drug problem during 2013, indicated that heroin use is on the decline while the use of stimulants, synthetic drugs including synthetic opioids, cannabis and medicinal products is increasing. This report also highlighted that across Europe, heroin related deaths are also declining but deaths related to synthetic opioids are increasing and in some areas exceed those related to heroin10. The EMCDDA report suggested new or obscure and highly potent substances that have caused or contributed to death may be difficult to detect as concentrations of the substances in the blood stream may be very low. In 2013, 81

7 The United Nations Office on Drugs and Crimes 2012 World Drug Report
8 Implemented by The Regional Drug Task Force in the Republic of Ireland and The Health and Social Care Trust of Northern Ireland
10 The evidence suggests that overdoses generally occur when individuals have consumed several different substances including new psychoactive substances and ‘legal highs’, therefore it is difficult to pinpoint exact causation of fatality (EMCDDA, 2014).
new psychoactive substances were notified to the EU Early Warning System\(^{11}\), bringing the number of substances monitored in that year to over 350.

The 2014 report cited above raises several concerns of relevance to this present study. Firstly, the increase in cannabis use and domestic production indicated the rise in cannabis as profitable for organised crime groups. Secondly, associated problems, for example, rising attendant social costs, violence and other forms of offending, are placing added pressure on law enforcement agencies. Thirdly, in Central Europe increased manufacture and sale of methamphetamine involves organised criminal groups, who historically were concerned mainly with heroin, were now reported to be using established heroin routes to traffic cocaine and methamphetamine in the European Union. And, finally, the increase in the use of new psychoactive substances and ‘Legal Highs’, have become a major concern.

The Irish Focal Point Report (2013)\(^{12}\) stated that with the exception of heroin users, it is not possible to accurately record the number of injecting drug users or Problematic Drug Users (PDUs)\(^{13}\) currently in contact with treatment services\(^{14}\). A national 3-source capture-recapture (CRC) study commissioned by the National Advisory Committee on Drugs (NACD) to provide estimates of the prevalence of opiate use was undertaken in 2001 and 2006. The 2006 study (Kelly, Carvalho & Teljeur, 2009) indicated that use had increased since the 2001\(^{15}\) survey. In the 2006 study it was estimated that, in Ireland, there were 11,807 known opiate users with a further 8,983\(^{16}\) hidden users. The estimate suggested there were between 18,136 and 23,576 opiate users in 2006. The point estimate\(^{17}\) was 20,790. In 2001 the point estimate was 14,681

\(^{11}\) http://www.emcdda.europa.eu/themes/new-drugs/early-warning ‘When a new psychoactive substance is first detected, detailed information on the manufacture, traffic and use, including supplementary information on possible medical use is sent by the EU Member States to the European Police Office (Europol) in the Hague and to the EMCDDA in Lisbon via the Europol National Units and the REITOX national focal points, taking into account the respective mandates of these two bodies. Europol and the EMCDDA collect the information and communicate it immediately to each other and to the Europol National Units and the representatives of the Reitox network of the Member States, the European Commission and to the London-based European Medicines Agency (EMA)’.


\(^{13}\) A PDU is defined as an ‘injecting drug user or long duration/regular user of opiates, cocaine and/or amphetamines’ (EMCDDA 2004)

\(^{14}\) National Drug Treatment Reporting System (NDTRS) does not use a unique identifier.

\(^{15}\) Kelly, Carvalho & Teljeur, 2003.

\(^{16}\) Hidden refers to drug users who had not come into contact with hospitals, treatment services or the CJS.

\(^{17}\) Dr. Des Corrigan, in the foreword of the report states ‘One of the key methodologies favoured by the EMCDDA for estimating the number of opiate users is the capture recapture method. This report, which updates a similar national study for the years 2000-2001, uses the capture recapture method in order to estimate the extent of opiate use in Ireland for 2006. Notwithstanding the fact that the methodology used is that suggested by the EMCDDA and that the researchers have conducted a rigorous high-quality scientific evaluation of the data, the NACD believes that the overall estimate in this report must be treated with a considerable degree of caution.'
giving an increase of 42%. From 2001 to 2006 the national methadone treatment programme was greatly expanded which could account for the increase. In 2001 the amount of opiate users outside of Dublin was relatively small, rising by 165% as outlined in the 2006 study to 2,365 persons with a hidden estimate of a further 3,521.

According to the 2012 EMCDDA annual report, Ireland had the highest number of heroin users in Europe along with Latvia, Luxembourg and Malta. The estimate was 7 per 1,000 people which translated to approximately 30,000 users. Ireland was also reported to have the third highest death rate from drug use in Europe, behind only Norway and Estonia. The EU average is 21 deaths per million people; for Ireland, it was reported to be 68 per million.

Public expenditure

The following table represents the amount of public expenditure within drugs services in Ireland from 2008 to 2012 (Irish Focal Point, 2013). Due to cut-backs in government spending across the board, there has been a decrease of 12% in expenditure over the 5-year period.

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The expansion of places on the methadone treatment programme between 2001 and 2006 … has led to technical complications in the estimation of the hidden opiate user population via capture recapture methods. For the reasons given in the report, the figures for Dublin are considered likely to be inflated. The inflation in the estimate for the rest of Ireland is thought to be proportionally larger. Unfortunately, the NACD is not in a position to determine the extent of the inflation of the estimate. In light of these issues, the NACD proposes to undertake research during 2010 into other methods of estimating the prevalence of drug use’.
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</tbody>
</table>

Irish Focal Point (2013) also reported a predicted 17% decrease in spending on the Drugs Initiative Programmes from 2011 to 2014. These programmes are those administered by the Drugs Programmes Unit in the Department of Health, the programmes funded under the Drugs Initiative, drug-related projects and Local Drug Task Force initiatives under the National Drugs Strategy 2009–2016. Over the four year period expenditure in €000 was - 2011 - 33,667; 2012 - 31,375; 2013 - 29,951; 2014 - 27,951.

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18 Source: Drug Policy Unit in the Department of Health (unpublished data).
Despite extensive drug policies and expenditure over the past number of decades drug using continues to be an issue of concern. Charleton (1995) discussed the problem of a second generation drug users in Ireland while O’Mahony (2008) suggested Ireland is now experiencing a third generation. Irish drugs policies and treatment responding to the growing issue of drug use have evolved in a rather haphazard fashion over the last fifty years, as outlined below.

**Responding to the issue of drug use: The policy and treatment context**

Irish drugs policy and treatment methods have changed and adapted over the years in accordance with varying trends and prevalence in drug use. The current policy document National Drugs Strategy (interim) 2009-2016\(^\text{19}\) has included rehabilitation and support for families within its remit. Contemporary drug policy has a dual focus on the care of the drug user, family and wider community as well as law enforcement to reduce the supply and demand for drugs.

*The Policy context*

Table 2 illustrates the evolution of Ireland’s drug policy\(^\text{20}\), within the context of international and EU policy development, since the 1960s.

\(^{19}\) National Drugs Strategy (interim) 2009-2016, Department of Community, Rural and Gaeltacht Affairs, 2009

\(^{20}\) Published by the European Monitoring Centre for Drugs and Drug Addiction in their Drug Profiles series (EMCDDA, Lisbon, February, 2013).
### Table 2 - Evolution of drug policy since the 1960s - Drug policy profiles — Ireland

<table>
<thead>
<tr>
<th>International and EU</th>
<th>Year</th>
<th>Ireland</th>
</tr>
</thead>
<tbody>
<tr>
<td>UN Single Convention on Narcotic Drugs</td>
<td>1934</td>
<td>Dangerous Drugs Act 1934</td>
</tr>
<tr>
<td>UN Convention on Psychotropic Substances</td>
<td>1961</td>
<td></td>
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<tr>
<td></td>
<td>1966</td>
<td>Report of the Commission of Inquiry on Mental Illness</td>
</tr>
<tr>
<td>UN Convention Against Illicit Trafficking in Narcotic Drugs and Psychotropic Substances</td>
<td>1971</td>
<td>Report of the Working Party on Drug Abuse</td>
</tr>
<tr>
<td></td>
<td>1973</td>
<td>Ireland joins the European Economic Community</td>
</tr>
<tr>
<td></td>
<td>1977</td>
<td>Misuse of Drugs Act 1977</td>
</tr>
<tr>
<td></td>
<td>1983</td>
<td>Report of Special Government Task Force on Drug Abuse</td>
</tr>
<tr>
<td></td>
<td>1984</td>
<td>Misuse of Drugs Act 1984</td>
</tr>
<tr>
<td>European Plan to Combat Drugs</td>
<td>1988</td>
<td></td>
</tr>
<tr>
<td>Report on the European Plan to Combat Drugs</td>
<td>1990</td>
<td></td>
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<tr>
<td></td>
<td>1991</td>
<td>Government Strategy to Prevent Drug Misuse</td>
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<tr>
<td>EU Plan to Combat Drugs 1995–1999</td>
<td>1992</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1995</td>
<td></td>
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<tr>
<td></td>
<td>1996</td>
<td>First report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs</td>
</tr>
<tr>
<td></td>
<td>1997</td>
<td>Local drugs task forces become operational</td>
</tr>
<tr>
<td>UN General Assembly Special Session on the World Drug Problem</td>
<td>1998</td>
<td></td>
</tr>
<tr>
<td>EU Drugs Strategy 2000–04</td>
<td>2000</td>
<td>National Advisory Committee on Drugs established</td>
</tr>
<tr>
<td></td>
<td>2004</td>
<td>Mid-term review of the national drugs strategy</td>
</tr>
<tr>
<td>EU Drugs Strategy 2005/12 EU Drugs Action Plan 2005/08</td>
<td>2005</td>
<td>Regional drugs task forces become operational</td>
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<td></td>
<td>2007</td>
<td>Report of the Working Group on Drugs Rehabilitation</td>
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<tr>
<td></td>
<td>2010</td>
<td>Criminal Justice (Psychoactive Substances) Act 2010 becomes law</td>
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<td></td>
<td>2012</td>
<td>Steering group report on a national substance misuse strategy</td>
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</table>
Butler (1991) traced the progress of Irish drug policy from 1966 to 1979. In his 1991 paper he presents a succinct chronology of this evolution. Highlighting the 1966 Report of the Commission of Inquiry on Mental Illness as the first official Irish policy document to include drug use, Butler noted the warning contained within this document that unless Ireland addresses the issue of drug prevention, drug using could reach serious proportions. The issue of drug addiction had been in the realm of the psychiatric services since the publication of the Mental Treatment Act 1945. The 1966 Report of the Commission of Inquiry on Mental Illness agreed that addiction should remain within the mental health arena but advocated for dedicated treatment centres rather than generic mental health services to respond to this emerging issue (Butler, 1991).

Butler (1991) outlined policy changes from within the Criminal Justice System (CJS) as well as the Health Department. In 1968, An Garda Síochána established a special Drug Squad to address the growing concerns of drug using. A Working Party on Drug Abuse, established in 1970 to investigate the extent of drug use and to advise the government accordingly, recommended that drug users should be treated as ‘sick’ people needing medical treatment, although policy, legislation, penalties and sanctions should still be in place. Therefore the emphasis shifted from a mental health response to a combination of intervention by healthcare and the CJS. The 1971 Report encouraged preventative education in schools and agreed with the 1966 Report of the Commission of Inquiry on Mental Illness that specialised drug treatment centres should be established. In 1969 the National Drug Advisory and Treatment Centre was set up in Jervis Street hospital as an out-patient service and in 1973 a residential service was set up in Coolmine Therapeutic Community (TC) in Blanchardstown in Dublin. Both Coolmine TC and Jervis Street centres demanded total abstinence as the sole treatment goal. This provision cemented the shift in moving drug services from mental health to healthcare providers (Butler, 1991).

In 1979 there was a marked increase in the amount of heroin available in Western Europe leading to the ‘opiate epidemic’ in Ireland, primarily in Dublin city (Dean, O’Hare, O’Connor, Kelly & Kelly, 1985). The early 1980s gave rise to increased heroin use, a relatively new trend in IV administration and an increased drug market (Flynn & Yeates, 1985). The 1983 Bradshaw

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21 Ireland’s national police force
23 The drug treatment service was originally located at the ‘Charitable Infirmary’, Jervis Street Hospital, Dublin 1, which was established in 1718 as the first voluntary hospital in Ireland (DMRD, 2004).
Report (Bradshaw & Dean, 1983) found that in north central Dublin, 10% of 15–24 year olds had used heroin in the previous year; this figure was 12% for 15–19 year olds, and 13% for females of the same age group. The report also confirmed Dublin as the main centre for heroin use. In 1983, a Special Governmental Task Force on Drug Abuse was set up to respond to the escalating problem of heroin use and trafficking culminating in the Misuse of Drugs Act 1984\(^{24}\). This Act introduced more severe penalties for those apprehended on drugs charges, mostly those found using and selling drugs. Political discourse was concerned with the salient impetus being to control and sanction drug use rather than treat or care for drug users (Butler, 1991).

By 1985 conflict grew between the Eastern Health Board\(^{25}\) who were still providing scant services for drug users and local lower socio-economic communities who were experiencing the fallout from the ‘opiate epidemic’ (Butler, 1991). The lack of resolution of this conflict and consultation on the provision of services led to the establishment of the Concerned Parents against Drugs (CPAD) groups which began in St. Teresa’s Gardens\(^{26}\). CPAD groups arose in similar communities like Dolphin’s Barn, Ballymun and Tallaght (Lyder, 2005). The response to the upsurge in opiate use and drug dealing, was the establishment of National Coordinating Committee on Drug Abuse (NCCDA), which was charged with providing annual reports on the drug situation to the government (Butler, 1991).

Butler (1991) noted that the drugs issue was complicated by HIV/AIDS in the 1980s, observing that the NCCDA seemed to pay scant attention to this complication. Butler (1991:9) stated although there was ‘no continuing interest in, or commitment to, drug policy among Department of Health officials’, several changes did come about. The new committee was ‘reconstituted’. Another new strategy appeared in 1991 - the Government Strategy to Prevent Drug Misuse. Changes were also made in terms of harm reduction measures and methadone maintenance treatment in the Jervis Street Centre and a National AIDS Coordinator was recruited. The Drug Treatment Centre Board (DTCB) moved to Trinity Court in 1988 following the closure of Jervis Street hospital.

1989 saw the opening of the first needle exchange programme (Butler & Mayock, 2005). This represented a shift in the original abstinence policy of the DTCB from total abstinence to harm

\(^{24}\) Due to a relative stability in the trends of drug using over the next few years, The Misuse of Drugs Act of 1977 was not enacted until 1979.

\(^{25}\) The Eastern Health Board was the main provider of direct services for drug users.

\(^{26}\) St. Teresa’s Gardens is lower socio-economic community in Dublin’s inner city.
reduction as the threat of the spread of HIV/AIDS was considered a greater danger to society than drug use itself (Barry, 2002). By 1996 there were an estimated 13,460 opiate users in Ireland (Comiskey & Barry, 2001).

Moran, O’Brien, Dillon and Farrell with Mayock (2001) commented that since 1996 the Irish drugs strategy had been informed by the recommendations of two reports of the Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996, 1997). The overarching aim of the drugs strategy was to initiate an interagency response to problems arising from drug use and to work with the communities who were most concerned. Local Drug Task Forces were set up in those communities and services were delivered locally within the National Development Plan 2000-2006 (NDP, 2000) and Social Partnership framework. The National Advisory Committee on Drugs (NACD) was established in July 2000 with the responsibility to advise the government regarding the prevalence, prevention, treatment and consequences of problem drug use in Ireland. Although the main objective was towards encouraging a drug free lifestyle, it was acknowledged that harm reduction interventions must be included in service provision. A new national drug strategy was published in May 2001 - National Drugs Strategy 2001-2008 (2001)27. Moran et al. (2011) commented that it focussed on four pillars, namely supply reduction, prevention, treatment and research. Regional Drug Task Forces were established to cope with the growing use of drugs outside of Dublin (Moran et al., 2001) and the new strategy increased public involvement in drug policy (EMCDDA, 2013).

The National Drugs Strategy (interim) 2009–2016 (NDS)28 holds the overall responsibility for the implementation of Irish illicit drugs policy. The overall strategic objective is ‘To tackle the harm caused to individuals and society by the misuse of drugs through a concerted focus on the five pillars of supply reduction, prevention, treatment, rehabilitation and research’. Implementation of the NDS29 embraces a ‘partnership’ approach which includes more than twenty statutory agencies, multiple service providers and community and voluntary groups. Strategies are carried out through a national network of regional and local drugs task forces (DTFs).

29 The Minister for Health has overall responsibility for the NDS, and an Oversight Forum on Drugs (OFD), chaired by the Minister of State for Primary Care within the Department of Health, and comprising senior representatives of the various statutory agencies involved in delivering on the Strategy.
Treatment services have also responded according to trends and prevalence in drug use and policy decisions. Harm reduction measures and methadone maintenance figured prominently along with abstinence based programmes. User friendly websites like www.drugs.ie list services available for anyone who has a concern about drug using.

Despite changes in policy and the introduction of new treatment methods the death rate from drug using is still extremely high. The National Drug-Related Deaths Index shows a slight decrease in the number of drug-related deaths from 645 in 2011 to 633 in 2012.

Table 3: Number of deaths, by year, NDRDI 2004 to 2012 (N=5,289)

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</thead>
<tbody>
<tr>
<td>All deaths</td>
<td>432</td>
<td>505</td>
<td>561</td>
<td>626</td>
<td>626</td>
<td>656</td>
<td>605</td>
<td>645</td>
<td>633</td>
</tr>
<tr>
<td>Poisonings</td>
<td>267</td>
<td>300</td>
<td>325</td>
<td>382</td>
<td>386</td>
<td>374</td>
<td>341</td>
<td>387</td>
<td>350</td>
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<tr>
<td>(3,112)</td>
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<tr>
<td>Non poisonings</td>
<td>165</td>
<td>205</td>
<td>236</td>
<td>244</td>
<td>240</td>
<td>282</td>
<td>264</td>
<td>258</td>
<td>283</td>
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<tr>
<td>(2,177)</td>
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Treatment

In terms of drug related treatment two broad philosophies underlie the main approaches in Ireland – medication free therapy and medication assisted treatment. Approaches, such as therapeutic communities and the Minnesota Model, use medication free therapies. Some services have adapted these models to suit their particular clients’ needs. Medication free programmes advocate the outcome of total abstinence, although they may initially use medically assisted detoxification in the short term. They aim to facilitate the drug user to achieve and maintain a drug free lifestyle. Medication assisted treatment comprises substitution.

30 Deaths are calculated from four sources: Coroners’ records, Hospital In-patient Enquiry Scheme, Central Treatment List and General Mortality Register

31 The Therapeutic Community (TC) for the treatment of addiction has been in use for almost 50 years. Generally, TCs are abstinence based, residential settings using a hierarchical model which brings patients through stages of recovery reflecting increased levels of personal and social responsibility. Peer influence and group work form the basis of the programme. TCs use a mix of professional staff and (trained nonprofessional) individuals in recovery as key agents of change, adopting the ‘community as method’ approach (NIDA, 2002).

32 The Minnesota Model, also known as the abstinence model, of addiction treatment was created in a state mental hospital in the 1950s. The key element of this approach was the use of professional and trained nonprofessional (recovering) staff around the principles of Alcoholics Anonymous (AA). Each patient had an individual treatment plan with active family involvement in a 28-day inpatient setting. Participation in AA during and after treatment was part of the programme. Patients and families were educated about the disease of addiction. (Anderson, McGovern & DuPont, 1999).
for opiates, detoxification therapies for opiates, alcohol and benzodiazepines and psychiatric treatment. Medication assisted programmes generally espouse harm reduction practices due to the acknowledgement that drug users cannot or do not wish to become and remain abstinent. The ethos of harm reduction is to perform therapeutic interventions that reduce harm to the drug user and the wider community. For example, the most common form of harm reduction is opiate substitution therapy\textsuperscript{33}, which offers an alternative from heroin which is a short-acting, illegal drug to a longer-acting, prescribed drug (Moore et al., 2004). Both philosophies use various types of counselling to a greater or smaller extent. Some community projects include alternative therapies in their programmes\textsuperscript{34}.

The Central Treatment List (CTL)\textsuperscript{35}, administered by the DTCB on behalf of the Health Service Executive (HSE), registers all clients in receipt of methadone maintenance for treatment of opiate use in Ireland. This figure currently stands at 8,650. The National Drug Treatment Reporting System (NDTRS)\textsuperscript{36} collects data on treated\textsuperscript{37} drug and alcohol use in Ireland from all treatment services including public and private outpatient services, inpatient centres and low-threshold services. A total of 15,699 clients were treated for problem drug or alcohol use in 2012, of whom 3,857 reported an opiate as their main problem drug\textsuperscript{38}.

Service uptake for active drug users has increased over the past few years. For example, Merchants Quay Ireland\textsuperscript{39} reported increased uptake in most services in 2013. The homeless service had over 8,000 visits and provided over 85,000 meals. The primary health service tended 1,623 people over 4,500 visits which was an increase of 30\% on 2012. The needle exchange programme had 22,898 visits from 3,260 people, 614 of which were first time clients. This was an increase of 23\% on 2012 figures. Counselling sessions increased from 10,293 in 2011 to 11,452 in 2013 and there was a 10\% increase of clients using the prison addiction service at 2,444 clients. Most clients were polydrug users using a combination of opiates and prescription drugs, mostly benzodiazepines and 10\% reported as using steroids.

\textsuperscript{33} Primarily methadone maintenance
\textsuperscript{34} Drug treatment overview, EMCDDA, May, 2014.
\textsuperscript{36} The NDTRS is co-ordinated by the Health Research Board (HRB) on behalf of the Department of Health and Children.
\textsuperscript{37} NDTRS broadly define treatment as ‘any activity which aims to ameliorate the psychological, medical or social state of individuals who seek help for their substance misuse problems’.
\textsuperscript{39} Merchants Quay Ireland, Annual Review 2013, published 12\textsuperscript{th} September 2014
The issue of drug use within the public arena from the perspective of media and the general public.

Although the uptake of services is encouraging there is still widespread visible evidence of drug using and drug users in prominent areas of the cities and towns throughout Ireland. This visibility causes concern for the general public in terms of fear, distress and public nuisance. Media, reporting on the issue of drug using, can exacerbate negative feelings and emotions experienced by non-drug users.

Media representation of the problem of addiction

Media representation of drugs and drug users tends to influence not only mainstream society’s perception of addiction but often the drug users views of themselves. McMurran (2006) implied that the manner in which drug users are reported in the media may stigmatise and marginalise them and exacerbate negative social reaction. However, not only does social reaction become more negative, the drug users’ subjective perception also adopts a negative judgement. Keane (2002) argued that these factors reinforce the ‘once an addict always an addict’ paradigm and may lead to permanent and irretrievable identity change which in turn impacts on drug users efforts to transform their lifestyle to accommodate recovery oriented change. Several aspects of media reports and societal judgement make it difficult for former drug users to be accepted in a non-drug using world where the ‘once an addict always an addict’ paradigm is an unforgiving assumption. This is mainly due to the extent of negative thinking surrounding drug using.

Public drug using is considered a public nuisance (Broadhead, Kerr, Grund & Altice, 2002) and a threat to the stability of society (Kimber, Dolan, Vanbeek, Hedrich & Zurhold, 2003). Connolly (2006) noted that drug related public nuisance was mentioned in the EMCDDA’s annual report of 2005, where it was described as not a new phenomenon but becoming more prominent across the EU. Drug related public nuisance, as noted in this report, included a wide range of behaviours that were seen to violate social norms and values. These behaviours ranged

40 See also Cohen, 1972; Hardiman, 1998.
41 The Disease Theory of causation describes addiction as a lifelong condition containing both biological and environmental elements whereby changes in brain structure and function compromise an individual’s ability to stop the addictive behaviour. The Disease Theory holds that an individual can never be ‘cured’ from addiction and that the individual will always be at risk of relapse. However, the individual can arrest the disease through abstention. The Disease Theory is the main supporter of the notion ‘once an addict, always an addict’.
from minor deviant acts which caused discomfort for the general public to serious acts of
criminality and violence causing extreme intimidation, distress, fear and insecurity.
Behaviours included public drug using and injecting, obvious intoxication, discarded drug
using paraphernalia, open street dealing and crime, verbal and physical confrontation with
other users, dealers and members of the public and the vulnerability of children involved with
these behaviours. Connolly (2006:17) stated that the perception of public nuisance is influenced
by media representation, where the media has ‘a significant influence in forming and distorting
public perceptions in this respect’.

Irish media representation of drug related public nuisance tends to focus on inner city locations.
Journalists use emotive and derogatory language to emphasise the disapproval and vexation
experienced by mainstream society. For example, in 2008 Jim Clarke penned the headline ‘It's
only 9:30 in the morning and already junkies are selling drugs and shooting up in Dublin's
Temple Bar’. In his article he describes how a ‘Junkie’ emerged from a back alley after buying
drugs. The reader could wonder if the author witnessed the transaction or surmised this had
happened. Clarke related how local residents and business people ‘are forced to watch the
junkies and their dealers carry out their dirty trade every day’. He reported this issue arose
when Gardaí moved drug users away from the popular tourist trail of the Liffey Boardwalks
and drug users simply moved towards the Temple Bar area. Clarke mentioned visitors, tourists
and locals using the popular tourist area and the fear existed that the area would turn into ‘a
hard drug haven’ which would discourage visitors. Clarke described how one resident
complained drug users are ‘jacking up, selling drugs, dropping used needles’ and local TDs\(^\text{42}\)
are quoted as using phrases like ‘the blight of heroin’ where ‘the cocaine epidemic ... has
allowed the heroin crisis to fester’.

More recently on 13\(^\text{th}\) December 2013 The Journal.ie published an article which headlined
‘Man injects himself in the groin on the Luas at three o’clock in the afternoon’. The article
described how ‘passengers were horrified’. A female witness reported on RTÉ’s\(^\text{43}\) Liveline
programme that it ‘made her feel sick’. On 1\(^\text{st}\) May 2014 Loving Dublin blogger Niall Harbison
mentioned public complaints about the amount of ‘addicts, drunks and beggars’ where

\(^{42}\text{A member of the government is called a Teachta Dála, (TD) or a Deputy to the Dáil. There are 166 members of Dail Éireann, the Irish Parliament.}\)

\(^{43}\text{Raidió Teilifís Éireann, (RTE) Ireland’s national television and radio broadcaster}\)
demands for money were constant and that ‘Large parts of our city smell of piss, are littered with the remnants of addicts and make people watch their backs’.

Cathal McMahon, reporting for the Irish Sunday Mirror on 6th July 2014 with a headline: ‘Drugs scourge gripping Dublin city: Traders demand action’, stated that inner city Dublin was ‘infested with more junkies and dealers than ever before’ and ‘Dublin’s busiest streets are rife with more drug dealers, addicts and their filthy waste’. He stated that although Gardaí try to move drug users ‘the problem is now worse than ever’. He described how an undercover team witnessed ‘shocking scenes’ of open dealing, open injecting, human faeces in shop doorways and ‘discarded blood-filled syringes strewn across Temple Bar’s iconic cobblestones’. Business people in the area, were quoted as noting a significant fall in trade. McMahon quoted Councillor Mannix Flynn saying that the issue of public nuisance had reached a crisis level where ‘Regular people are having to step over drug users, drug paraphernalia and excrement. It is disgraceful’. Traders were reported describing threats, fear and assaults on the streets. On the 7th August 2014, Joyce Fegan reporting in the Herald described public phone boxes in South Great Georges Street, being used for injecting heroin and that local traders and residents were concerned about their businesses and homes. One business man was reported saying the phone boxes resembled ‘an open sewer’. The Journal.ie on the 13th September 2014 included an article on gun-related crime. It was reported that gun crime has shown a steady increase over the past forty years which has placed a further ‘burden on hospital services’. These regular media reports help to instil fear of drug users and discourage empathy for them within mainstream society.

The layperson’s perception of drug addiction

Since the nineteenth century drug using has been understood in terms of a social problem which incorporates crime (Seddon, 2006), disease (Parssinen & Kerner, 1980; Reinarman, 2005) and addiction (Berridge & Mars, 2004). Seddon (2006) further suggested that this social problem

44 Member of An Garda Síochána, Ireland’s national police force
45 The article quoted a new study, published in the Irish Medical Journal, which examined all gunshot admissions to Connolly Hospital Emergency Department during the 10-year period from 2001 to 2010. Sixty five patients were treated for gunshot wounds.
has been the nucleus of a sizeable body of research, much of which assuming inevitable harm, has focused on reduction of harm and prevention of the problem.

Understanding of the concept ‘drug user’ is confused by the sheer complexity of it. It is difficult to predict how the layperson perceives addiction and what influences this perception (Agar, 1977). Franzwa (1999) proposed a working definition that could aid understanding for the non-professional; that drug addiction is a dysfunctional dependency, which fulfils drug users’ needs at the cost of their overall daily functioning. Using illegal drugs has become part of our culture. In spite of exhaustive processes adopted to eliminate it, drug use is prevalent among all ages, ethnicities, genders and social strata.

Myths surrounding drug users describe characteristics from being untrustworthy, stealing and cheating to abject deviance and criminality to uncontrollable madness (Davies, 1997). This stereotype, created by media and public unease, reflects an acceptance of the ‘dope fiend myth’ where drug users are deemed unproductive, non-contributing and worthless criminals due to a decreased or distorted level of functioning (Clinard & Meier, 2001:262). It heightens negative schema towards drug users regardless of where they are in their drug using career or the circumstances surrounding their drug use. Derrida (1995) added that drug users are perceived as scavengers existing at a subsistence level and are often detested and feared and Becker (1963) highlighted that the use of drugs, regularly equated with deviant behaviour, is punishable in many countries since the early 20th Century.

Tomlinson (1991) viewed drug addiction as removing personal freedoms presumed as part of modern society. These freedoms include the right to free will, options and decision making. Since drug addiction within the medical model, is viewed as a disease that eradicates these freedoms, then drug users are living outside of the majority while coping with a physical disease which is considered a threat to others (Doweiko, 2007). The Medical Model endorsed

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46 Many psychoactive substances that are labelled ‘drugs’ have been around for millennia, with many uses, for example, pain relief, religious and community ceremonies and rituals and they contribute to the formation and maintenance of cultural identities (Davies, 1997; South, 1999).
47 Heyman (2009) stated that not only is drug using unproductive but tends to undermine more productive and satisfying lifestyles.
48 Therefore, drug users neither conform to social order nor become involved in valuable production.
49 Not only do they take from society, threaten its values and aspirations, but also, are unable to add to the economy (Morgan, 1981).
50 This identity is reinforced by the existing stereotype that is a product of many historical discourses on drugs and drug users (Derrida, 1995; Morgan, 1981; Murphy, 1996).
51 See also Ben-Yehuda, 1990; Bloom & Steinhart, 1993; Charleton, 1995; Clinard & Meier, 2001; Galliher, 1989; Gossop, 1995; Kitsuse, 1980; May, Hough & Edmunds, 2000; Menninger, 1968; O’Mahony, 1993.
52 See also Davies, 1997; Jellinek, 1960; Weimer, 2003
the ‘slippery slope’ paradigm\textsuperscript{53} and the metaphor ‘once an addict always an addict’ leading to permanent identity change (Keane, 2002).

Medical issues, legal sanctions and social stigma leave many laypeople holding serious contempt for drugs and drug users (Parrott, Moss, & Scholey, 2004)\textsuperscript{54}. Misinformation, often through the media, is reported with hysterical alarm rather than factual information (Coomber, 2006). Media representation traces the drug user’s career from initial recreational use through the inevitable ‘slippery slope’ into abject addiction, with many unsuccessful cessation attempts, eventually to reach only either cure or death. Media, treatment centres, government and policy makers tend to pursue the theory of the helpless drug user powerless over his/her behaviour and the evil dealer, furtively concealed on street corners or school gates, ensnaring young people. These images play a crucial role in the formation of the layperson’s thinking, attitudes and beliefs\textsuperscript{55} (Link, Struening, Rahav, Phelan & Nuttbrock, 1997). The addictive power of the drug is so great that the person will succumb almost immediately and enter a nightmare life of uncontrollable need for drugs, withdrawal symptoms and involuntary criminality. In reality, this theory does not necessarily reflect the true nature of drug addiction. Rather, it assigns drugs with an external power over drug users (Davies, 1997)\textsuperscript{56}. Media overemphasis on chaos\textsuperscript{57} and poverty and lack of coverage of the routine, mundane everyday lives of the drug user, proves financially beneficial in sales of column inches and promoting public interest (Coomber, 2006). Societal cost of addiction is measured in terms of money, harm, distress and public nuisance. Davies (2006) suggested that stereotypical, inaccurate depictions of addiction can even adversely influence those working within the field.

The media portrayal of drug issues in Ireland supports the prohibitionist discourse which is also dominant at political level. This viewpoint is emotionally charged with descriptions of the harmful consequences for the drug user and for society, where individuals, families and communities are devastated by this harm (O’Mahony, 2008). Popular media coverage concentrating on harms and violence heightens the drug war paranoia and legitimises the ‘war’ to ward off the potentially uncontrollable threat of drug use (Massumi, 1998). The media, with its view of heroin use as a social disease equated to a plague or ‘heroin epidemic’, dramatically

\textsuperscript{53} Where some drugs produce an instantaneous drug addiction
\textsuperscript{54} See also Clinard & Meier, 2001
\textsuperscript{55} Davies (2006) suggested this erroneous message is largely due to media’s insistence of representing drug use stemming from a single cause which, although easily understood, is false.
\textsuperscript{56} See also O’Mahony, 1993; South, 1999
\textsuperscript{57} Addiction introduces chaos, unhappy social relations and medical complications resulting in policy decisions that are often more expensive than effective (Heyman, 2009).
opposes drug using with a multitude of horrific examples, for example, psychosis caused by ‘bad trips’ on psychedelic drugs or soap operas, serials and films where the drug users are portrayed as contemptible villains or pitiful victims (Zinberg, 1984). Media portrayal of criminal acts ranges from property crime to horrific carnage in gangland warfare and drug related atrocities which threaten the nation’s stability. O’Mahony (2008) proposed that the media supports the ‘War on Drugs’ which was originally conceived as a metaphor for a global concentrated effort to reduce America’s drug related crime. He proposed that this strategy became a war on drug using citizens and attempts to console society, with the promise of eradication of drugs and drug related harms, remains unfulfilled.

Responses to drug related public nuisance

Responses to drug addiction and drug related public nuisance include those of policy, law enforcement, treatment services and rehabilitation (Chandler, Fletcher & Volkow, 2009). These responses have a primary aim to reduce harm to society and the drug user with the notion of socialising the drug user as a functional and useful member of society (Bull, 2010). However, in contemporary society, the belief that certain harm reduction measures actually exacerbate harm has been voiced (Ritter & Cameron, 2005; Roe, 2006).

Connolly (2006) highlighted that numerous legislative and policy responses to drug related public nuisance exist. Among them, general public order legislation and the removal of open drug scenes seemed to receive most attention. Van Hout and Bingham (2013) carried out a qualitative study investigating open drug scenes in Dublin’s inner city. The study involved sixty one drug service users and business, transport, community, voluntary, and statutory stakeholders. They found that due to increased homelessness, increased mobility of drug and alcohol users using city metro systems and loitering, public nuisance was more visible. Behaviours included open drug, prescribed medication and alcohol using, drug injecting, intimidation and knife crime. Van Hout and Bingham (2013) noted common characteristics within the responses to drug-related nuisance. They commented that multi-agency approaches based their responses in local communities, driven by local community organisations.

Responses include prevention and repression of nuisance behaviour and assistance to drug

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58 This portrayal has created a whole new category of crime for both drug users and sellers, which inevitably leads to criminalising a large number of otherwise law abiding citizens (O’Mahony, 2008)

59 The White House (1995) report states that, despite vast anti-drug campaigns over the last several decades, the rate of ‘hard core’ drug use remains relatively static and much higher than desired.
users, as well as relocating treatment services away from city centre areas, supporting the enlargement of availability and access to harm reduction strategies, urban regeneration, improved community rehabilitation services and increased policing in target areas.

Law enforcement responses in Dublin included such strategies as direct monitoring of problematic geographical areas. In March 2014, the Irish News reported on ‘Operation Spire’, launched in January 2014 by Store Street Gardaí. Gardaí were going to ‘get tough on city drug pushers’ preceding the St. Patrick’s Day celebrations and the forthcoming 1916 centenary celebrations. The public perception was that O’Connell Street and surrounding areas were unsafe to visit. Gardaí were to patrol and use CCTV to monitor deviant activity and take immediate action where appropriate. In February 2014 Operation Pier was launched by Pearse Street Garda station to clamp down on street drug dealing and anti-social problems. However, repeated Garda cutbacks have limited the scope of these operations.

Chapter Summary and Outline of the thesis

This thesis involves of a small, qualitative study on how drug users move through a process of redefining themselves as former drug users. It is conducted against a background of diverse notions about drugs and drug users, the changing trends in drug use and the changing policies that inform law enforcement, treatment and service provision. It questions the role of identity during this journey which begins with the acceptance of a negative identity of ‘addict’ towards a positive identity which encompasses abstinence from drugs and alcohol, the re-building of a positive self-image and the acceptance of a former drug user identity.

This chapter has presented an introduction to the main aims of this thesis and the rationale supporting those aims. It outlined the extent of drug using in Ireland, the evolution of drug policy and treatment responses and described the media portrayal of drug using, the concern over public nuisance and the response to that concern. Drug related public nuisance inevitably leads to a negative perception of drug using and drug users especially for laypeople within the general public. Finally this chapter has reiterated the purpose of this research.

Chapter Two conducts a review of relevant literature. It presents an understanding of the history, definition and predominant discourses regarding addiction. It reviews the social construction of deviance and drug addiction and the resultant societal unacceptability of drug using behaviour and social stigma. It appraises the notions of the existence of a drug using
subculture and the group cohesion, social rituals and controls within the drug using group. It examines the notion of identity construction and reconstruction before, during and after drug using careers and the adoption of identity within a drug using subculture. It briefly overviews treatment and aftercare, 12-Step programmes, family and other social supports and relapse prevention strategies.

Chapter Three presents the methodological issues associated with this thesis, describing the theoretical framework, epistemological issues and ontological perspectives. This chapter describes the design, data gathering and analysis processes involved as well as explaining the process undertaken in the recruitment of participants, interview process and ethical considerations. This thesis employs a qualitative approach, modelled on the Biographic Narrative Interpretive Method, in its attempt to offer an understanding of the lived experienced of drug users, where sixteen former drug users relate their experiences before, during and after drug using careers in a process involving their participation in two interviews.

Chapters Four to Seven present and discuss the findings of the study. These chapters are organised around the themes of identity before, during and after drug using, stigma, treatment, recovery and relapse prevention. The analysis also attends to supports for drug users and unresolved issues that may lead to relapse.

The final chapter, Chapter Eight, discusses the findings and conclusions of this present research in the context of the literature review in chapter two and the data collected. It examines the themes that have emerged from the data collected and the implications of these themes for drug users.
Chapter Two - The challenge of addiction – A review of the literature

Introduction

This chapter presents a review of relevant historical and contemporary literature. It is divided into five main sections in its attempt to understand the challenge of addiction.

The first section explores the social construction of addiction and how the Theory of Social Construction of Reality influences attitudes to addiction and deviance. It outlines various definitions of addiction, its history and the dominant discourses regarding definition and theory. It reviews the history of drug use leading to the conception of the ‘War on Drugs’. It explores the social construction of deviance with regard to addiction drawing on evidence as to whether addiction is viewed as a medical issue where the drug user is viewed as a patient requiring treatment or a moral issue which involves the perception of the drug user as a criminal requiring sanction. It reviews the notion of addiction as a societal problem leading to social sanctions and social controls, both of which may lead to the marginalisation and stigmatisation of drug users.

The second section of this chapter examines society’s unacceptability of drug using. It investigates the historical, cultural and social aspects of social sanction, social stigma and social control and their influence on the marginalisation and exclusion of the drug user. It examines the subsequent influence of these factors on the identity of the drug user specifically with regard to the construction and reconstruction of identity before, during and after their drug using careers.

The third section of this chapter investigates the notion that drug users frequently respond to society’s attitude by forming their own exclusive drug using subculture, endorsing their own social controls, social sanctions and rituals. Within the drug using subculture, a drug user identity can be constructed for many reasons.

The fourth section examines the notion of identity, issues that affect identity and challenges to reconstructing identity after drug using, for example stigmatisation and marginalisation. It identifies how these issues affect the drug users’ drug-using careers, before, during and after drug using. It investigates the value of perusing the notion of using personal narrative as a tool to aid an understanding of drug users’ commitment to identity reconstruction and recovery from problematic drug use.
The final section considers treatment, 12-Step programmes and social supports that were utilised by former drug users in their effort to reconstruct their identity, enhance successful recovery from drug using, maintain abstinence and prevent or avoid relapse.

**Social Construction of Reality**

The Social Construction of Reality put forward by Berger and Luckmann (1966) proposed that reality is socially constructed by knowledge, including common-sense knowledge. That is, reality is not a social fact per sé but has been conceived by humans and its meaning has been passed on through various systems of communication. Berger and Luckmann discussed a two way relationship whereby humans are a product of society and society is a product of humans. They maintained that there are three steps towards the social construction of society.

- **a)** Externalisation – the ongoing production of humans into the world which includes both their physical and mental activities.
- **b)** Objectivation – the product of these physical and mental activities which conceives a reality external to humans, becoming institutionalised.
- **c)** Internalisation – the re-adoption of this reality from objective, external structures into subjective consciousness leading to socialisation.

Berger and Luckmann (1966) proposed that individuals develop patterns of behaviour which become useful and efficient as fundamental guides to handling situations as they occur and recur. Many of these behaviours become automatic or habitualised, expend the least possible effort and when they are routinely performed with the same efficiency of economical effort become embedded in an individual’s general stock of knowledge. Psychologically habitualisation narrows choices, decreases tensions that accompany routine decision making and allows energy to be focused on non-routine decisions that may arise at certain times.

Individuals tend to observe and respond to each other’s habits, anticipate and depend on them and share them among society members. Shared expectations regarding established public habits become institutions which encourage the development of expected roles associated with those whom act within the institutional capacity. When roles are assumed the actor adopts the expected habitual behaviours and is interacted with as part of that institution rather than an individual. They are bestowed descriptive titles like policeman, priest, teacher and so on and
act according to society’s expectations of those roles, along with publically shared norms of society. When the public interacts with individuals in these institutional roles, they interact according to the shared expectations of the role. Therefore, when an individual is conferred the role of ‘addict’ or deviant society interacts with that individual also according to the shared expectations of those roles.

Consequently, the central concept of the Social Construction of Reality is that when these roles are adopted by members of society, accepted and played out, the reciprocal interactions become institutionalised and their meaning becomes entrenched in society along with knowledge and people’s belief of what reality is. Thus, according to Berger and Luckmann (1966) social reality is deemed to be socially constructed.

It can be expected that institutions assert societal control due to the establishment of behavioural rules, and for this control to persevere each new generation must be educated about these institutions and trained to perform expected roles within them. This process legitimises, maintains and strengthens institutions and encourages their existence. However, Berger and Luckmann (1966) stress that the socially constructed world can be threatened by human self-interest, ignorance and forgetfulness and must be maintained by socialisation, legitimation and social order where social order is part of an ongoing human production and the ongoing process of externalisation. Social order cannot evolve from nature or the environment. Rather it evolves from human activity – past, present and future.

Berger and Luckmann (1966) acknowledged that social context must be considered:

“What is ‘real’ to a Tibetan monk may not be ‘real’ to an American Businessman. The ‘knowledge’ of the criminal differs from the ‘knowledge’ of the criminologist. It follows that specific agglomerations of ‘reality’ and ‘knowledge’ pertain to specific social contexts, and that these relationships will have to be included in an adequate sociological analysis of these contexts.” (1966:15)

Individuals tend to perceive their world view around their own subjective ‘here and now’ which comes from their awareness of knowledge and reality. Berger and Luckmann (1966) stated that, due to the fact that society and social order are man-made, society is an objective reality.

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60 Some institutions become so firmly established that people tend to forget that they are human constructions and they become so real that they are viewed as part of the reality of the natural world.
Members of an institution are more likely to conform to the constraints of that institution. Social disorder is caused by non-members who are not involved in the maintenance of that institution. In order to socialise these non-members and prevent deviance, sanctions are put in place to prevent rule breaking. Those who deviate find solace in the solidarity of other deviants who legitimise their cause.

_Historical influences in the social construction of addiction: Predominant Discourses on Addiction_

To assist gaining an understanding of the challenge of addiction it is critical to understand how this phenomenon has evolved within society. Sremac (2010), acknowledging that no single etiopathogenic model of addiction exists, stated that historically in addiction research, many diverse models have been suggested. Prominent discourse includes environmental, social and coping theories, social learning, reinforcement and conditioning theories, physiological and genetic theories, intrapsychic and personality theories, transtheroetical models of change, excessive and compulsive behavioural theories, integrative and biopsychosocial theories. Keene (2010) maintained that the diverse theories and understandings of addiction, various solutions, measurements and definitions of failure or success can actually limit the help that may be offered, the time margin for help and the cohort that help is offered to.

The terms ‘addict’ and ‘addiction’ have become colloquialised into everyday vernacular, often without realistic reflection on their significance. The term addiction conveys different meanings depending on the position held by the interpreter (Butler, 2008). Addiction is a problematic concept to define, dependent on the purpose of that definition (Parrott et al., 2004). Specific definitions discuss the degree of involvement in a behaviour, substance or process that is multifunctional (Doweiko, 2007).

The actual description of drug users’ behaviour also presents definitional difficulty. The terms addict, addiction, abuse and dependence have been culturally and socially defined and

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61 For example, in discussing social harm, solutions are measured in terms of reduction of supply and demand rather than treatment.
62 For example, to provide pleasure, relief from pain, to compensate for inadequate coping skills or reduce negative emotions.
64 The term ‘drug abuse’ is deemed inappropriate or judgemental, reflecting negatively on the drug user. However, contemporary alternatives are unsatisfactory. ‘Drug use’ is nondescript, not allowing for separation of
redefined\textsuperscript{65}. Keene (2010) maintained that drug use is not only controversial but also a political concern\textsuperscript{66}. However, drug use has become the most popular term used by service providers and policy makers in recent times.

Politicians, academics, treatment providers and drug users continue to have no real agreement regarding what categorises a drug problem, or indeed an effective solution. Diverse theories of addiction and models of treatment are dependent on policy and practice. Various stages in the history of addiction have championed specific models encompassing moral, spiritual, social deprivation, neuroscientific, cognitive-behavioural, disease and public health. Problematic involvement is generally associated with physical, social, financial, spiritual and emotional harm to both the drug user and the wider community along with the inability to reduce or stop the behaviour (Naaken, 1988; Parrott \textit{et al.}, 2004). Neve (2005) proposed that society generally assumes\textsuperscript{67} the drug user is trapped in a hopeless condition of dependency and commented that DSM IV\textsuperscript{68} coined the term ‘Substance Dependent’ which was welcomed by criminologists and social policy makers. Neve (2005) further suggested that historians, in an effort to demystify and comprehend drug addiction history, welcomed the notion of dependency. Therefore, in Neve’s view, the understanding and definition of drug addiction has been taken over by the medical model, enveloping health, behavioural and psychiatric pathologies and by the moral model, based on the notion of free will and threats to social stability. Keene, Stenner, Connor and Fenley (2007) commented that the Criminal Justice System (CJS) supports the argument for free will and personal responsibility, by offering offenders tough choices when charged with drug related offences. Both the medical model and the moral model envision drug users as hopeless\textsuperscript{69} and in need of sanction, intervention, treatment or assistance (Neve, 2005)\textsuperscript{70}.

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\textsuperscript{65} Often they are understood when the rewards of the behaviour are outweighed by the costs. Contemporary thinking questions why people continue their involvement in a behaviour which seems to cause more problems than it initially sought to solve or relieve (Cox & Lawless, 1999; Donovan & Marlatt, 2007; Goodman, 1990; Naaken, 1988).

\textsuperscript{66} This thesis is utilising the terms ‘drug use’, ‘drug user’ and ‘drug using’ in connection with individuals who have been diagnosed or self-reported as having a dependency on drugs and alcohol.

\textsuperscript{67} This assumption is a product of 20th century thinking coming from social policy, criminology, medical and scientific discourses.

\textsuperscript{68} DSM V has adopted the term substance use disorder to describe addiction.

\textsuperscript{69} Neve discussed the fact that language describing alcohol dependents and addiction has changed, where “drunks” and “sots” became “inebriates” then “chronic alcoholics” or “addicts”. This terminology perceives “addicts” as helpless and depraved (Davies, 1979).

\textsuperscript{70} See also O’Mahony, 2008; Parrott \textit{et al.}, 2004
Mainstream society predicts that this hopelessness can lead to destitution and death. In reality, although drug users are certainly at risk of a range of medical and societal consequences, it is by no means the norm to either die from drug addiction or fail to find recovery (O’Mahony, 2008). Drug users are actively involved in acquiring their habits but they also have a choice related to cease drug use (Becker, 1973). Heyman (2009) argued that drug users rarely choose to become addicted but generally choose to stop when the costs of drug use become too heavy to bear. Heyman (2009) further noted that drug use is often referred to as compulsive and compulsive acts are usually deemed irresistible. However voluntary acts are resistible giving weight to the idea of choice (McIntosh & McKeganey, 2000). Therefore, many authors support the notion that drug users are autonomous, informed and responsible individuals who choose to be consumers of risk (Fischer, 2003).

Medical definitions

Butler (2008) discussed the interminable search for definition within the academic arena. He proposed that very few definitions are as scientific or exact as they aspire to be. Their description and value judgement depend on the time, purpose, place and necessity, leading to a diversity of definitions and ensuing dilemma of which definition to use. Baker (2000) carried out a qualitative study with seventeen women in treatment, investigating their perception of their identity and the impact of intimate relationships, and questioned the reliance on any definition. She wondered what exactly is meant by drug addiction, whether it is a vice, behaviour problem, personality disorder, progressive disease or all or none of these. The medical view lost some importance in Britain under the influence of the American War on Drugs but regained it in the 1980s when the perception of the drug user fluctuated between

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71 See also Ben-Yehuda, 1990; Biernacki, 1986; Dally, 1995; Davies, 1997; Donovan & Marlatt, 2007; Lemanski, 2001; Sterk, 1999; Waldorf, 1983
72 See also Donovan & Marlatt, 1977
73 See also Erikson, Riley, Cheung & O’Hare, 1997; Miller, 2001; O’Malley, 1999; Riley et al., 1999; Valverde, 1998
74 Numerous definitions reveal both the complexity of this phenomenon and the diverse interests and perspectives of researchers, authors and workers in the area.
75 In her study, Baker (2000) maintained that a fundamental characteristic of most treatment centres is the personal acceptance of oneself as a drug user or alcoholic. The 12-Step Programme is the most famous platform to use this basic assumption as a precursor to recovery. Within Alcoholics/Narcotics Anonymous self-diagnosis and self-treatment became something of an institution. Baker found many of the women identified themselves as drug user after hearing other women’s narratives, realising the particulars of drug addiction and were able to accept their own drug addiction.
criminal and patient where the latter can be cured by methadone and counselling, resulting in medical definitions continuing to exist and flourish.

Parssinen (1983:86) outlined the earliest medical notion suggested by Levinstein in 1878. Levinstein described the ‘new’ disease of substance addiction:

‘Uncontrollable desire of a person to use morphia as a stimulant and a tonic, and the diseased state of the system caused by the injudicious use of the said remedy’.

Therefore, he identified two concepts: the actual compulsion to use drugs and the physiological consequences. A third concept, added by Kerr (1894), was the notion of psychological dependence.

Addiction science proposed the disease model as the foremost explanation for addiction, where the disease is triggered by ingesting substances. The American Academy of Pain Medicine, The American Pain Society and The American Society of Drug Addiction issued a joint definition in 2001, defining drug addiction as a primary, chronic, neurobiological disease with genetic, psychosocial and environmental factors influencing its development and manifestations, characterised by behaviours that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm and craving (Hojsted & Sjogren, 2002). DiClemente (2003) proposed that addiction defines self-destructive behaviours that are induced by a pharmacological element. Heyman (2009) maintained that many authors view addiction either as a syndrome of varying degrees and symptoms or as a pattern of maladaptive behaviour while Ferentzy and Turner (2012) commented on the paradigm of the chronic, progressive and rather mysterious nature of the disease. The medical discourse defines drug addiction as:

‘A chronically neurobiological disorder that is defined by two major characteristics: a compulsion to take drugs with a narrowing of the behavioural repertoire toward excessive drug intake and a loss of control in limiting intake’.  

Similarly, the US National Institute on Drug Abuse (NIDA) defines addiction as:

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76 Medicalisation is a reaction to the ‘official’ definition of the user as criminal (O’Mahony, 2008).
‘A chronic, relapsing brain disease that is characterised by compulsive drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs change the brain ... its structure and how it works.’

The disease paradigm, rather than identifying addiction as a maladaptive behaviour, categorises addiction as a treatable condition to be located within a medical context in the domain of public health (Smith & Seymour, 2004).

Mosbys’ (1998) definition stated that drug addiction is represented by a pattern of continual pathological use of non-prescribed medication, leading to negative consequences which include failure to fulfil social, family and work obligations alongside financial and legal difficulties. Mosbys distinguished between abuse and dependence, describing abuse as use of substances outside sociocultural expectations, while dependence includes physiological and behavioural symptoms. For Koob and Kreek (2007) drug addiction is described in terms of pathology, where the disorder progresses to an acute stage involving drug use, drug seeking behaviour, probability of relapse and a marked decline in response to stimuli that may offer a natural reward.

The DSM IV defined substance dependence or substance abuse using the mechanism of a three stage representation, namely preoccupation/anticipation, binge/intoxication and withdrawal/negative affect. The presumption of tolerance, withdrawal, loss of control and decrease in attention to responsibilities are among the criteria listed. Heyman (2009) argued that in everyday vernacular self-destructive drug users are labelled ‘addicts’ while the DSM categorises them as ‘substance dependent’. Use of diverse terminology suggests that somehow there is a difference between addiction and substance dependence. However, Heyman maintained that, according to contemporary evidence, the terms are synonyms. He pointed out that according to the DSM IV classification, the most destructive type of drug use is substance dependence while this is labelled ‘addiction’ in everyday vernacular. Heyman also compared the criteria used to diagnose substance dependence within the DSM IV and concluded that addiction and substance dependence are one and the same, where the only difference is the descriptive terminology. In contrast to Heyman, the World Health Organisation (WHO) also

78 Most disease concepts tend to focus on aetiology rather than change (Sremac, 2010).
79 See also Goodman, 1990; Parrott et al., 2004
80 Within Mosbys’ definition, the use of illicit drugs or non-prescribed drugs that contravene the norms of society falls under the umbrella of abuse.
81 For example, compulsive use, withdrawal, tolerance, relapse and choosing drug using over other responsibilities and commitments
differentiated between substance abuse and substance dependence, where substance abuse, which is the harmful or hazardous use of psychoactive substances, can lead to a dependence syndrome. The WHO also included preoccupation, loss of control, tolerance, withdrawal symptoms, adverse consequences and decline in fulfilling everyday obligations. DSM V added the notion of craving or a strong desire or urge to use a substance (DSM V, 2013).

The conclusions of the Medical Model suggest that the individual does not choose a path of deviance, predisposed to the use of drugs, but the use of drugs carries the diseasing properties which are inherently addictive where the drug user is mentally and physically ill or impaired. The acute withdrawal symptoms and their exaggerated severity confirms the notion of the impossibility of voluntarily cessation. The Medical Model supported the perception that continuing drug use is no longer a choice, but a behaviour that is somehow created by the drug.

Levine (1978), reviewing the discoveries of physicians over the centuries, explained Benjamin Rush’s idea that alcohol became the salient ingredient of the function of drinking changing the action from voluntary to involuntary. By the late 19th century, doctors interested in the phenomenon of alcohol and drug use equated destructive use with disease (Levine, 1978). Within medical education, scholarly text included a chapter on the ‘morphia habit’ (Berridge, 1990). Public perception thought people used drugs and alcohol because they chose to do so not because they had to. Physicians believed patients who sought their services did so because they were sick and viewed inebriates as sick people looking for help. At that time there was no

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82 Dependence is identified by a cluster of cognitive and behavioural conditions developing after prolonged use.
83 Highlights of Changes from DSM-IV-TR to DSM-5 - 2013 ‘APA DSM-5 does not separate the diagnoses of substance abuse and dependence as in DSM-IV. Rather, criteria are provided for substance use disorder, accompanied by criteria for intoxication, withdrawal, substance/medication-induced disorders, and unspecified substance-induced disorders, where relevant. The DSM-5 substance use disorder criteria are nearly identical to the DSM-IV substance abuse and dependence criteria combined into a single list, with two exceptions. The DSM-IV recurrent legal problems criterion for substance abuse has been deleted from DSM-5 and a new criterion craving/strong desire or urge to use a substance, has been added. In addition, the threshold for substance use disorder diagnosis in DSM-5 is set at two or more criteria, in contrast to a threshold of one or more criteria for a diagnosis of DSM-IV substance abuse and three or more for DSM-IV substance dependence. Cannabis withdrawal is new for DSM-5, as is caffeine withdrawal (which was in DSM-IV Appendix B, “Criteria Sets and Axes Provided for Further Study”) … Severity of the DSM-5 substance use disorders is based on the number of criteria endorsed: 2–3 criteria indicate a mild disorder; 4–5 criteria, a moderate disorder; and 6 or more, a severe disorder. The DSM-IV specifier for a physiological subtype has been eliminated in DSM-5, as has the DSM-IV diagnosis of polysubstance dependence. Early remission from a DSM-5 substance use disorder is defined as at least 3 but less than 12 months without substance use disorder criteria (except craving), and sustained remission is defined as at least 12 months without criteria (except craving).’
84 This notion widely used in the media since the 1930s often significantly impacts on the identity construction of the drug user (Burroughs, 1993).
85 In the late 18th and early 19th centuries Rush had an abundance of supporters.
86 Towards the end of the 19th century ‘morphine disease’ had become a rapidly growing area of medical research and expertise. This specialist interest in addiction led to the formation of ‘The Society for the Study and Cure of Inebriety’, a new medical organisation and the publication of a new medical journal ‘Inebriety’.
87 The medical model became the favoured response to opiate using until the Harrison Act 1914.
alternative label available. Generally, the inebriate had not broken the law, was often wealthy and educated, was not suffering from mental health issues and was deemed respectable, apart from their drug and alcohol use. Due to the lack of an alternative label, ‘sick’ seemed appropriate (Levine, 1978). The drug user was represented as influenced and changed by the drug, rendered incapable of stopping. The inevitable progression from occasional use to confirmed drug user corroborated the notion that any drug use, even occasional, non-addictive use will in the long run, lead to chronic addiction.88

Throughout the 20th Century, medical discourse portrayed the locus of control as transferring from the drug user to an external force inherent in the drug’s properties.89 This further reinforced the inevitability of death as this externalised force was ultimately regarded as lethal and overwhelming, rendering the drug user defenceless against the power of the disease and unable to save him/herself. Advocates of the medical model promoted total abstinence (Jellinek, 1960).90 Despite massive evidence to the contrary, many remain unshaken in this conviction. The construction of addiction as a disease which renders the user ‘out of control’ is assimilated through the mechanism of social construction (Geertz, 1973).91

Clinicians, researchers and the media embraced the disease model and advocated for addiction to be listed as a chronic, relapsing brain disease and classified with other serious conditions like diabetes and asthma (Mack, Franklin & Frances, 2003).92 Influential support for the disease concept promoted the humane, compassionate element.93 Conversely, Leshner (1997) stated that the gulf between the view of the deviant and the sick patient was too wide to cross given that many people would not support compassion and treatment for drug users. However, supporters of the medical model suggested it should lead to effective treatment programmes and endeavoured to discover a cure.

The dichotomy exists in that if addiction is viewed as a choice, then the appropriate solution resides in punishment and sanction to address the wrongs inflicted (Miller & Chapper, 1991). However, if addiction is classified with diseases like Alzheimer’s, hypertension or diabetes,

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88 It removed the ability for change from the drug user as the locus of control was beyond his/her grasp.
89 The drug user became the helpless victim, rather than a criminal who chose to continue using.
90 See also McLellan et al., 2000; Pattison, Sobell & Sobell, 1977; Valliant, 1990
91 Within this social construction, divisions emerged. While opium eaters sought medical help, heroin sniffers and opium smokers tended not to. Therefore doctors treated the former while the latter were served by law enforcement officers. This division widened not only because of their drug using but also due to the enforcement of the Harrison Act 1914 (Heyman, 2009).
92 See also McLellan et al., 2000; O’Brien, & McLellan, 1996
93 For example, Dr. Norman Kerr, one of the early advocates of the disease concept, differentiated the medical approach with the traditional notion that all inebriates were depraved and vicious sinners (Berridge, 1990).
then it would be cruel to subject those who are diagnosed to condemnation and criminal charges (Leshner 1997). Gordis (1995:75) supported this idea, stating the ‘disease concept ... has helped remove the stigma from a chronic disorder [alcoholism] that is no more inherently immoral than diabetes or heart disease’. However, McLellan, Lewis, O'Brien and Kleber, (2000) noted that insurance companies did not offer the same policies for addiction as are on offer for more traditional diseases and Heyman (2009) observed that 12-Step Programmes did not spontaneously materialise for Alzheimer’s, hypertension, diabetes or similar diseases. Heyman (2009) suggested that although A.A. and similar 12-Step Programmes support the notion of disease, cure was not included in their doctrine. They champion activities that compete with drug using and encourage members to envision a bright, spiritual future without the use of their addictive behaviour, which when successful, generates positive outcomes without the use of medication or treatment.95

One commonality with 12-Step Programmes and medical treatments, ‘once an addict, always an addict’ views sobriety as a fragile, temporary state and drug using may resume even after years of abstinence (Heyman, 2009). Burroughs (1959;xxxix) hypothesised

‘Junk yields a basic formula of ‘evil’ virus ... A dope fiend is a man in total need of dope. Beyond a certain frequency need knows absolutely no limit or control ... Dope fiends are sick people who cannot act other than they do. A rabid dog cannot choose but bite.’

McLellan et al. (2000) believed relapse to be a frequent occurrence, with cure considered unrealistic and addiction therefore needing to be classified with disorders that require life-long support and treatment. Mack et al. (2003) reiterated this notion stating that 12-Step programmes, treatment organisations and psychiatric text referred to ‘recovering’ rather than ‘recovered’, regardless of the length of time in sobriety, where recovery is a life-long process and the idea of a ‘cure’ should be avoided.

Keene (2010) claimed that current thinking on drug use has changed little over the past century. Opinion ranges from the medical approach where the salient ingredient is physiological dependence, the 12-Step approach where personal pathology and loss of control dominate

94 See also McLellan et al., 2000; O’Brien & McLellan, 1996
95 Dr. W.D. Silkworth, in the preface to the ‘Big Book’ Alcoholics Anonymous (1939) suggested that alcoholics have an ‘allergy’ to alcohol and part of the allergic reaction results in a loss of control.
thinking and the cognitive behaviour approach where the habitual behaviour belongs within personal choice. There are few commonalities within these approaches. Practitioners are concerned with the salience of physical and behavioural factors. Each places emphasis on diverse factors. An amalgamation of these approaches into a Biopsychosocial Approach introduces an integrated, multidisciplinary model which is extensively used internationally. The Biopsychosocial Model attempts to recognise addiction through a multidisciplinary lens that views the interaction of biological, psychological and social factors as crucial to understanding addiction. It suggests that no single factor can fully explain the phenomenon (Griffiths, 2005).

Drug using in the 19th and early 20th Centuries

It is essential for this study to examine the evolution of the social construction of addiction to understand the ensuing labelling, stigma marginalisation and exclusion which have profound effects on individuals’ identity before, during and after drug using careers. The history of drug use including legislation, the controversial ‘War on Drugs’ and society’s understanding of drug using as an unacceptable, deviant behaviour, helps to explain society’s perception of drug using which leads to the marginalisation and stigmatisation of drug users.

The history of explanations of drug addiction illustrates how definitions change over time depending on current scientific and medical knowledge, popular and cultural beliefs and public and societal attitudes. Research was strongly influenced by the moralistic view that all illicit drug use was ‘bad’, psychologically and/or physiologically addictive, and also by the medical view that unequivocal abstention was the only response to ward off inevitable harm (O’Mahony, 2008). Given that psychiatrists, psychologists, doctors, social workers and policy makers hold diverse theoretical understandings of addiction causation and treatment, Berridge (1998) suggested that the arguments between opium advocators, politicians and social reformers in the 19th century are similar to those of contemporary professionals.

Historically, religious discourse aligned addiction with moral failings and possession by evil spirits (Berridge, 1979), with medical discourse concentrating on the disease hypothesis and

97 Physiological factors in the medical approach include craving, tolerance and withdrawal. Psychological approaches investigate behavioural and cognitive features.

98 See also Agar, 1985; Davies, 1997; Goodman, 1990; Zerai & Banks, 2002; Zinberg & Harding, 1982

99 See also Dunnington, 2011; Harding, 1986; Husak, 2004
the perception of opiates exerting control over the drug user (Weimer, 2003)\(^{100}\) and criminological discourse equating drug using with deviance (O’Mahony, 2008)\(^{101}\). Therefore, agreeing with Abadinsky (1941)\(^{102}\) where using chemicals outside of medical supervision constitutes misuse, society holds that medicinal drugs are only acceptable in healthcare settings, licit drugs, like coffee, tobacco and alcohol, used for socialising and relaxation are liberally accepted while illicit and unprescribed drugs are unacceptable.

Scare tactics used by anti-opium groups in the US to encourage abstinence depicted graphic, exaggerated descriptions of withdrawal symptoms (Musto, 1973). The dramatisation of the evils of opium helped garner public support for prohibition (Murphy, 1996)\(^{103}\). The Temperance Movements attempted to change the view of chronic alcoholism from something to be ignored, tolerated or leniently punished to something deemed sick or evil (Shaffer, 1996)\(^{104}\). Subsequently, the notion of disease was conceived. Public health authorities concerned about the excessive, potentially dangerous, use of opium, aspired to relegate its use within the realm of public health\(^{105}\). Medicalising certain forms of deviance successfully extended the reach of the medical profession (Doweiko, 2007)\(^{106}\). The global notion of disease is supported by the success of 12-Step programmes (Bodin & Romelsjo, 2006)\(^{107}\). Along with the arrest of the disease of addiction, 12-Step programmes aid former drug users’ attainment of social support (Davey-Rothwell, Kuramoto & Latkin, 2008)\(^{108}\) and the provision of wider support to their families (Copello et al., 2009)\(^{109}\).

Brecher (1972:52-53) examined drug use preceding the Harrison Act,\(^{110}\) describing America as a ‘dope fiend’s paradise’. He suggested that, before prohibition, drug users were no less law abiding than non-drug users. He related the 1936 report from a policeman, August Vollmer:

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\(^{100}\) See also Bastos, 1992; Burroughs, 1992; Duster, 1970

\(^{101}\) See also Charleton, 1995; Fattah, 1989; Fergusson & Horwood, 2000; Galliher, 1989

\(^{102}\) Illustrating that little has changed in over seventy years

\(^{103}\) See also O’Mahony, 1993; 2008

\(^{104}\) Thus began a movement in social thought regarding drug addiction as a social problem (Levine, 1978).

\(^{105}\) Labelling drug addiction as a disease ensured it would remain within their domain.


\(^{107}\) See also Groh, Jason, Ferarri & Davis, 2009; Moos, 2007; Timko & Debedenetti, 2007; Walitzer, Dermer & Barrick, 2009; Zenmore & Kaskutas, 2008.

\(^{108}\) See also Elliott, Jackson, Orr & Watson, 2005a, 2005b; Gyarmathy & Latkin, 2008.

\(^{109}\) See also Elliott et al., 2005a, 2005b

\(^{110}\) Harrison Narcotics Act 1914 regulated and taxed production, importation, and distribution of opiates.
Legal prohibitions forced the ‘helpless addict ... resort to crime in order to get money for the drug which is absolutely indispensable for his comfortable existence ... drug addiction ... is not a police problem ... it is first and last a medical problem.

Brecher continued with the opinion of the sociologist Alfred Lindesmith:

Punishment and imprisonment of addicts is as cruel and pointless as a similar treatment for persons infected with syphilis ... the treatment of addicts in the United States is on no higher plane than the persecution of witches in other ages.

These examples show how many professionals believed the response to addiction should come from the medical arena rather than the CJS.\textsuperscript{111} It has historically involved both.\textsuperscript{112}

Prior to the Harrison Act 1914, opium was widely available in pharmacies, local shops, from travelling salesmen and by mail order\textsuperscript{113}. Self-treatments containing alcohol, opiates and cocaine were unregulated, advertised as necessary to healthy living (Heyman, 2009). These remedies treated minor and more serious complaints (Anderson & Berridge, 2000). Opium eating became popular among the working class (Berridge & Edwards, 1981)\textsuperscript{114}. In Britain for most of the early 19\textsuperscript{th} century, eating imported opium was viewed somewhere between a minor vice and a bad habit. Harding (1988) quotes Medicus, illustrating how opium taking holds diverse perceptions based on class:

Working class consumption was attributed to poor housing conditions and fever epidemics while its consumption among the middle classes was held as a result from their experience of pressure from severe mental distress (Lancet, 1851:694).

Opium eaters did not associate with opium smokers and heroin sniffers and tended to use in private. Laudanum\textsuperscript{115} drinkers were not viewed as a public nuisance or a threat to society. They were perceived as needing help rather than punishment and did not provoke public outcry regarding prohibition (Day, 1868). Courtwright (1982) explained that during the mid-19\textsuperscript{th}

\textsuperscript{111} The predominant view was that addiction would fit more comfortably within a psychiatric or medical setting than criminal but the contemporary and widely accepted notion of addiction as a disease has not diminished the role of the CJS in dealing with drug users.
\textsuperscript{112} This may not mean addiction is either a disease or a crime, but that the popular two-pronged approach, which can lead to inappropriate punishment and general misunderstanding, should be widened (Heyman, 2009).
\textsuperscript{113} From Sears, Roebuck and Company and other national emporiums
\textsuperscript{114} See also Berridge & Stanton, 1999; Harding, 1988
\textsuperscript{115} Laudanum (an alcoholic tincture of opium), made of 10% opium and 90% alcohol, flavoured with cinnamon or saffron was first used by the ancient Greeks. In the 19\textsuperscript{th} C it was mostly used as painkiller, sleeping pill, or tranquilizer. It was cheaper than poppy oil and was consumed like any alcoholic drink.
century tens of thousands of poor, male Chinese immigrated to America seeking employment. They were socially isolated and marginalised and many smoked opium which was, at that time, extremely problematic in China. They were socially out-casted and looked upon as the 'yellow peril'. Men were described as 'evil' and women as 'ill-famed' (Booth, 1996; McCoy, 1991). Heroin sniffers were generally young, unemployed, early school leaving males with a history of offending. Labelled ‘Heroin boys’, they enjoyed instant gratification, drifted and engaged in petty crime but were not perceived as a serious threat. Those who smoked opium were labelled as foolish and delinquent (Spence, 1975).

Courtwright (1982) estimated that the use of opiates reached a peak in the 1890s, well before the introduction of prohibition, with a prevalence rate of approximately 4.6 users per 1,000 persons. In four studies conducted from 1914 to 1924, Kolb and Du Mez (1981/1924) reported that since the introduction of regulation, ‘addicts’ were perceived as abnormal individuals with large, unrestrained appetites for opiates while ‘normal’ people did not get addicted or generally got cured very quickly.

Courtwright, Joseph and Des Jarlais, (1989) reported that the legislative branch of the US government did not agree with the Society for the Study and Cure of Inebriety. The government decided that drug using was a criminal matter rather than a health issue as drug use was not symptomatic of disease which altered patterns and trends of drug use. There ensued an almost total disappearance of laudanum drinkers and opium smokers. The illegal use of heroin associated with deviancy and criminal activity became more widespread. Distribution, mixing, cutting and pricing was organised by criminal gangs. Heyman (2009) maintained that heroin users, even those who had no association with criminality, were no longer ‘heroin boys’ seeking adventure but linked with law-breaking and serious criminality.

116 Unlike the public consumption of laudanum, opium smoking was a private affair conducted in ‘opium dens’.
117 Sex workers
118 Heroin sniffing became part of their initiation exhibiting rebellion against authority and contempt for conforming to mundane, minimum wage employment (Bailey, 1916).
119 Interestingly the figure is similar to contemporary statistics (Conway, Crompton, Stinson & Grant, 2006). 2001 – 2002 figures estimated 3.4 opiate addicts per 1,000 persons and 10.8 non-addicted heavy opiate users (Grant & Dawson, 2006). Almost 14% of Americans, aged over 18 have a history of addiction, 12.5% addicted to alcohol, 3% addicted to an illicit drug and between 1-2% were addicted to both (Stinson et al., 2005).
120 Founded February 25, 1884 to investigate the various causes of inebriety and educate professional and public minds to recognise the physical aspect of habitual intemperance in British Journal of Inebriety (1901), 1 (1): 1-4.
121 Due to the dilution of content through mixing or cutting, individuals who normally snorted heroin resorted to injecting in search of the same effect.
Policy decisions and legislation since the 1857 Sales of Poisons Bill\textsuperscript{122} led to changing perceptions regarding drug using. Opium use was rapidly perceived as problematic and users were treated with aversion, became offenders and were out-casted. The Society for the Suppression of the Opium Trade\textsuperscript{123} controlled drug use for decades by proposing opiate use, rather than being a consequence of social evil, was actually a cause. The regulation\textsuperscript{124} of drugs and their legal status influenced choices regarding their use. When international treaties and laws of the 20\textsuperscript{th} Century outlawed the misuse of controlled drugs, drug users became criminals\textsuperscript{125} and the acceptable Victorian habit of relaxing with opium or cocaine was frowned upon (Bull, 2013; Dally, 1995). The Pure Food and Drug Act 1906 was the first step towards criminalisation of drugs\textsuperscript{126} (Bull, 2013; Musto, 1999). The Harrison Act of 1914\textsuperscript{127} framed modern drug legislation, permitting opium and cocaine to be prescribed only for medicinal use. Doctors could no longer prescribe for drug users, leaving them with little option but seek alternative suppliers.\textsuperscript{128} This encouraged a booming black market drug economy which could not have existed before legislation. America’s illegal drug trade flourished (Dally, 1995)\textsuperscript{129}.

Early 1900s Britain experienced class tension with middle class condemnation exaggerating the evils of lower class opium consumption (Berridge & Edwards, 1981). Control over drugs\textsuperscript{130} was added to legislation\textsuperscript{131}. These changes in legislation and the Rolleston Report of 1926\textsuperscript{132} confirmed drug addiction as a disease in British social policy. Maintenance treatment\textsuperscript{133}

\textsuperscript{122} Opium came under The Sale of Poisons Act and was to be locked away. In 1868 it was included in the Pharmacy Act and only available to medical professionals (Bull, 2013)

\textsuperscript{123} Founded in 1874

\textsuperscript{124} The Poisons and Pharmacy Act of 1868 was the first regulation of opiate use in the general population.

\textsuperscript{125} The purchase and sale of opium was limited by the Poisons and Pharmacy Act 1868 to discourage the abuse of opiates, returning use medicinal prescription only. The drug control laws created in 1870s were intended to curtail Chinese opium smokers in San Francisco and cocaine using by African Americans.

\textsuperscript{126} The original food and drug act demanded that all patent medicines list the drugs they contain. Strict prohibition of cocaine in soft drinks followed. Pharmacists who dispensed “poisons” to drug users were prosecuted. The World War on Opium Traffic in Shanghai 1909 and the subsequent The Hague Convention 1912 gave rise to the Harrison Act of 1914.

\textsuperscript{127} US Congress authorised the federal government to regulate the sale and supply of heroin and cocaine.

\textsuperscript{128} Jones Miller Act 1922 set up Narcotics Control Board. Conferred mandatory sentences of 5 years for dealers

\textsuperscript{129} See also Musto, 1999; O’Mahony, 1993

\textsuperscript{130} During the First World War attention turned to drug use when soldiers on leave used cocaine rumoured to be supplied by sex workers who were available to the servicemen.

\textsuperscript{131} Defence of the Realm Act 1916, the Dangerous Drugs Act 1920 and the Dangerous Drugs Regulations 1921.

\textsuperscript{132} Departmental Committee on Morphine and Heroin Addiction (Rolleston) 1926 – “to consider and advise as to the circumstances, if any, in which the supply of morphine and heroin (including preparations containing morphine and heroin) to persons suffering from addiction to those drugs may be regarded as medically advisable, and as to the precautions which it is desirable that medical practitioners administering or prescribing morphine or heroin should adopt for the avoidance of abuse, and to suggest any administrative measures that seem expedient for securing observance of such precautions” Minute of the appointment of the Committee.

\textsuperscript{133} Heyman (2009) commented on the multibillion expenditure of taxpayer’s money and the training of thousands of professionals who work tirelessly in an attempt to resolve the problem of drug use.
became the norm (Kohn, 1987). In Britain the Dangerous Drugs Act 1920 permitted the prescription of maintenance medication for drug users and subsequently did not experience the huge increase of black market drug trade as was the case in America. This situation remained relatively constant until The League of Nations regulated world drug production for medicinal purposes only\(^\text{134}\). The Brain Committee reports (1961; 1965) condemned the widespread prescription of maintenance treatment and restricted heroin prescription to doctors working in specialised addiction centres (Plant, 1987, cited in M. Plant, 1992). The consequence was a massive increase in illicit drug trafficking (Silver, 1979). The Brain Committee\(^\text{135}\) compared drug addiction to an infectious disease and drug users to sick, helpless people who could easily become menaces to society (Kohn, 1987).

US and UK official policy involves both medical organisations and the CJS. The latter prosecutes drug users and dealers with sanctions and prison while the former treats them with clinics and hospitals. The diametrically opposed nature of these well established and respected institutions\(^\text{136}\) suggests a dilemma in the response to addiction (Keene, 2010). It is extremely unusual to promote sanction and treatment for the same activity but seems accepted practice for addiction. Addiction is the only concept within the medical model where the symptom – illicit drug use – is considered an illegal activity. Conversely, illegal drug use is the sole illegal action that may be treated medically (Heyman, 2009).

The CJS documented difficulty in sanctioning drug users and separating activities that are subject to punishment and those that are not. This distinction is often discussed under the concepts of responsibility and free will, where individuals are responsible for freely chosen activities but should not be held responsible for involuntary acts. In attempting to explain acts that are both freely chosen and self-destructive,\(^\text{137}\) Heyman (2009) suggested that drug users choose to use drugs in a self-destructive manner. The dichotomy, disease versus criminal behaviour, influenced treatment options (Krebs, Lindquist, Koetse, & Lattimore, 2007).

\(^{134}\) Ratified in 1933

\(^{135}\) The Interdepartmental Committee on Drug Addiction, called the Brain Committee after its chairman Sir Russell Brain was formed by the Home Office in 1958 to investigate issues related to drugs and drug addiction in the UK. It examined whether or not certain drugs should be considered addictive, whether there was a medical need to provide specialised treatment, including institutional care, beyond the resources already available, for persons addicted to drugs. It was to make recommendations, including proposals for administrative measures, to the Minister for Health and the Secretary of State in for Scotland.

\(^{136}\) Both systems have strong institutional affiliations. The Drug Enforcement Agency within the Department of Justice retains an annual multi-billion dollar bureaucracy while The National Institute of Drug Abuse serves as a billion dollar per year research and service component of the National Institutes of Health.

\(^{137}\) When discussing the legal account of the difference between voluntary and involuntary acts Heyman (2009) questioned how an act can simultaneously be voluntary and destructive.
Heyman commented that this controversy caused inequality in treatment methods. It was unfair to treat some and punish others engaging in the same behaviours and differing responses could lead to inefficiency. If the correct response was to medically treat drug users, then sanctions would prove ineffective and counterproductive. Conversely if punishment was the correct approach then treatment options may not offer effective programmes.

**The War on Drugs**

Drugs classification was controlled by powerful groups in society (Barrett & De Palo, 1999). Hence, effective control measures perceived certain drugs as beneficial to society, for example prescribed medications and moderate alcohol consumption, while uncontrolled use, for example, crack cocaine, ecstasy and IV heroin were detrimental (Gossop, 1989). O’Mahony (2008) suggested that the ‘War on Drugs’ can be held directly responsible for many of the social harms which have been blamed on the effects of drug use. As law enforcement increases, so do crime rates. Prisons are overflowing with small time dealers. O’Mahony (1993; 2008) advocated that society should not continue to support such draconian anti-drug regulations which whip up hysteria with anti-drug propaganda.

Weimer (2003) stated that historically in the U.S. drug addiction was viewed as a dangerous, antisocial behaviour manifesting in individuals living in marginalised sections of society. Drug use increased and permeated mainstream society, although the US government strenuously denied this, promoting the ideal that addiction was un-American behaviour. In July 1971, President Nixon related drug use to public enemy number one using the phrase 'national emergency' to guide the War against Drugs. He promoted increasing the powers of the CJS to cope with the increase of crime, created new anti-drug legislation and increased treatment

138 Heyman could not envision how such diverse responses could complement each other. The formulation of a more coherent and cohesive response could be more effective and less expensive.

139 The need to control and classify drugs extended to legislation controlling possession, use, sale, supply, public health warnings and codes of practice for advertising.

140 A number of reasons can be put forward for control of certain substances including concern for a person’s well-being or the reduction of antisocial elements creeping into mainstream society

141 See also Burroughs, 1993: Campbell, 1992; Dally, 1995; Decorte, 2001; Gossop, 1995; Keogh, 1997; Marlowe, 1999; McCarthy & Hagan, 2001; Murphy, 1996; Shearing, 1995; Weimer, 2003

142 Gossop (1995) mentioned the financial side of control involving the manufacture and distribution of substances and the elimination of competition. He stated medical professionals, doctors and pharmacists, hold the powers of prescription and sale of controlled substances, which in turn enhances their professional status in society and secures their future within their elitist occupations.

143 Globally the number of people incarcerated for drug related offences has risen to an all-time high.

144 Bigger dealers, fearful of arrest, are more likely to become involved in serious crime including murder.
options. Nixon’s notion of American national identity did not include addicted persons who were a threat to society, security and national identity. Drug users, due to the draconian U.S. anti-drug policies, were socially excluded from the construction of America’s national identity, as they would undermine and complicate it. Nixon validated this ideology by calling drug addiction a ‘cancerous growth ... that comes quietly into homes and destroys children’, inferring that ‘normal’ Americans were dedicated family people with strong anti-drug beliefs and that healthy society should be disease free. Szasz (1974) proposed that modern man fell for the ‘drug as devil’ paradigm just as medieval man fell for the outcry of witchcraft. In 1986, President Reagan reinforced the labelling of drug addiction as a threat to national security, saying this threat affected all Americans (Weimer 2003).

Legislation represents the opposite to prohibition (Wijngaart, 1991). Since it is obvious that many people desire to continue drug using, prohibition fails on many levels (Bewley-Taylor, 2003; O’Mahony, 2008). Therefore legislation attempts to pave the way for alternative drug control and to abolish prohibition, which in its failure to eradicate drugs actually proved counter-productive (Gossop, 1995). By preventing legal use, prohibition artificially limits drug availability, reinforces society’s anti-drug attitude and by creating uncontrolled availability, creates a highly profitable drug market. The War on Drugs generated an ideology that condemned, marginalised, stigmatised and criminalised drug addiction and drug users. The urgency to eliminate drug using has funded research, literature and treatment (Baker, 2000). Categories and classifications establish moral or legal responsibility to

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145 Burroughs (1993) suggested that the drug user could not exist within capitalist modernity and that American policy aimed to normalise or reform drug users to take their place in modern, capitalist society.

146 The War on Drugs insured this marginalisation by identifying addiction as un-American behaviour and medicalised the problem (Campbell, 1992).

147 The drugs as disease metaphor contributed to society’s belief of the danger of drug addiction and referred to drug addiction as sickness or pollution (Campbell, 1992).

148 U.S. Congress, 1971a, 20597-598.

149 National Security Decision Directive (NSDD no. 221)

150 Prohibition demands abstention based on the society’s view of the unacceptability of drug using.

151 This perspective does not mean that prohibition is an all-out war on drugs and legislation will allow uncontrolled availability, rather prohibition symbolises their illegal status while legislation denotes the opposite state, in which drugs are legal.

152 See also O’Mahony, 1993; Wijngaart, 1991

153 The drug user has little option but to become involved in a criminal underworld and develop social networks with other drug users (Grund, 1993; O’Mahony, 1993; 2008).

154 “Contemporary thinking in the USA, Japan, Sweden and most of the former Soviet Bloc nations want to maintain and tighten worldwide prohibition, supported by the International Narcotics Control Board, Australia, Canada. Some EU states are in technical compliance with the Conventions, but their policies make parts of the conventions ineffective. Against the wishes of the UK and USA, Latin America and Caribbean countries want stronger demand reduction policies among the main ‘drug consumer’ states”, (Fazey, 2003; 2).

155 Baker reiterates behaviour, generally coming from weak willed and sinful individuals, contravening societal norms was perceived as dangerous socially or having a heavy nuisance value.
prevent, eliminate or at least cope with drug using (Long, 1992). Long challenged the medical viewpoint by arguing that if a phenomenon is described solely in terms of disease then this neglects any co-existing social or personal dimension and does not consider elements beyond biological and psychological aspects. Long further proposed that many addictive behaviours have little in common, that there is no typical drug user or alcoholic and the medical diagnosis discourages self-help and encourages moral irresponsibility by endorsing the fact that the disease of drug addiction is beyond the control of the individual. Davies (1979) proposed that society’s interpretation of drug addiction included a probability of helplessness in relation to the drug user. Psychoactive drugs are labelled as dangerous and a scourge to humanity leading to the desire to eradicate the non-medicinal use of all drugs (Teeson, Delenhurst & Hall, 2002).

The prohibitionist perspective which maintains drugs need to be controlled and eventually eradicated impinged on the Irish understanding of addiction. Although social policy recognises that prohibition attempts have failed and that any ‘War on Drugs’ presents a huge challenge for law enforcement and government (Youngers & Rosin, 2005), the enduring goal to remove drug use drives policy. Therefore, the War on Drugs discourse is still predominant in Irish political and social thinking (Murphy, 1996; O’Mahony, 2008).

The Social Construction of Deviance

Menninger (1968) proposed that society gains secret enjoyment from crime, including the mishandling of it. Crime is part of our daily lives and the ritual of crime and punishment is necessary for the survival of society. Crime sells newspapers and escalates television and film viewing ratings. It can be defined using four main platforms: legalistic, political, sociological

156 Long proposed that drug addiction and its coexisting problems had a significant political and ethical meaning as well as being under the auspices of the scientific and medical domain.
157 See also Dally, 1995; Davies, 1997; Goodman, 1990; Haller, 1991
158 The term drug has been socially constructed, associated with negative connotations heightened by the illegal, non-medicinal use, the effect on the drug user and the ensuing negative consequences within the drug user’s ability to organise his/her life
159 A growing body of research (Yucel & Luban, 2007) suggested drug using can exacerbate cognitive defects in decision making which not only undermine self-control but tend to last for quite a period of time after drug using has stopped. However, this notion of deficit in cognitive functioning is refuted by, for example, Rapeli et al., (2005) and Selby and Arzin (1998).
160 See also Gossop, 1985; Keogh, 1997; Krivanek, 2000; Rasmussen, 2000
and psychological (Schmalleger, 2006). From a legalistic perspective\textsuperscript{161}, crime is a violation of laws created by those who have the power to create them – government or state\textsuperscript{162} (Schmalleger, 2006). The political perspective acknowledges that laws have been put in place by society’s powerful groups and labels undesirable behaviours as illegal. Shearing (1995) suggested that criminology needs to go beyond the political definition of crime otherwise investigation into other behaviours will be constrained, leading to negative outcomes for the greater good of society. From a sociological\textsuperscript{163} standpoint, Mannheim (1965) claimed that antisocial behaviour has to be included in any realistic definition of crime. The crime label is mostly reserved for the actions of the poor, neglecting to take into account actions of the powerful\textsuperscript{164} (Reiman, 1997).\textsuperscript{165} Psychology perceived crime as a form of social maladjustment, where the individual has profound difficulty in living within the generally accepted norms of society and social arrangements. Robinson\textsuperscript{166} (2000) suggested that any maladaptive behaviour should be considered a crime and that the scope of criminality should broaden. Therefore human conduct is defined by the powerful in a politically organised society and crimes threaten their interests\textsuperscript{167}.

Society has norms and expectations\textsuperscript{168} that help predict behaviour and stabilise social order. Behaviour like drug using is perceived to deviate from the norm and the role of drug user assumed as unacceptable within ‘normal’ roles of society. Social behaviour is a question of acceptability mirrored by how society responds to it (Charleton, 1995). Rules are created by those who hope they can enforce them (Becker, 1963)\textsuperscript{169}. Becker maintained that rule breakers, deviants, were ‘Outsiders’ because they do not conform. Often the rule breaker may not agree

\begin{itemize}
  \item Schmalleger (2006) - limitations within this approach. Firstly, the powerful elite, who are coming from a position of high moral ground, can define laws and crimes and decide on penalties. Therefore crime becomes whatever society decides it is. Secondly, immoral behaviours that may not break the law are not recognised as criminal. Thirdly, although some immoral behaviours have been written into law the CJS works within common law where prosecutions for violation of norms may take place even though a crime has not taken place.
  \item Within this thinking, unless a law has been broken, a crime has not been committed no matter how abhorrent the behaviour. Behaviour is seen as any human activity whereas conduct is seen as a wilful act. Crime is any conduct that comprises of a wilful act in violation of current law that is penalised by the state.
  \item Fattah (1989) and Classen (2000), in discussing the antisocial nature of crime, asserted it should be controlled to preserve the existing nature of the social system. Crime should be viewed firstly as wrongdoing against human relationships and secondly as a law violation.
  \item for example, harm in the workplace or world hunger although food is destroyed to maintain prices
  \item See also Schwendinger & Schwendinger, 1975
  \item All harmful and potentially harmful behaviours should be studied in order to put practices in place whereby people can be protected from all harm not just the acts that are considered criminal within today’s laws.
  \item Galliher (1989) explained crime in a class structured society as powerful groups using their power to label and sanction those less powerful who may threaten their power where society holds with the notion that crime is a violation of criminal law then the actual subject matter of criminality will be severely limited.
  \item Individuals, due to their position in society, adopt roles that have certain expectations and rules of behaviour.
  \item See also Ben-Yehuda, 1990; Jones et al., 1984; Schur, 1971
\end{itemize}
with the rule being enforced. Becker suggested that once a person is labelled deviant and an outsider, they tend to maintain the label of deviance. This label helps to further their deviance and they continue to engage in the deviant behaviour by maintaining membership of a deviant subculture to minimise or justify the trouble they are in. Being deviant becomes their master status held over and above all other statuses that may define or identify them. Becker’s (1963) theory has stood the test of time as drug controls are still heavily involved with prohibition and social control (Hallstone, 2002). His notion of subculture of secrecy still remains (Johnson, Bardhi, Sifaneck & Dunlop, 2006).

Deviancy theories on drug using are concerned with the use of stringent social controls in morally ambiguous areas. Drug users are subjected to forceful drug controls that attempt to limit supply and demand, ensure drug using is kept secret and defined as immoral (Becker, 1963). Legislation does not allow for lifestyle choices in experimentation (Gershuny, 2000) nor the search for pleasure and excitement (Manning, 2007; Parker et al., 1998). Despite being told that drug users and drug dealers are incapable of rational thought, many young people choose to use drugs, taking responsibility for risk as well as pleasure (Caulkins & MacCoun, 2003). For them, drug using becomes the norm and only the minority do not experiment (Measham, Aldridge & Parker, 2001). Therefore non-drug using could be considered deviant and behaving against the expected norm (Parker et al., 2002). Heyman (2009) maintained that society with its rules, lifestyles, shared understandings and religious or moral values, does not endorse excessive appetites with regard to drug consumption. Elingsen and Johannsson (2008) agreed, saying that rules are deeply embedded in signs of approval and disapproval that emphasise restraint. Those who most stringently conformed to legal and religious norms were least likely to use drugs (Newcomb, Vargas-Carmona, & Galaif, 1999). Therefore, according to Heyman (2009) addiction indicates rejection of social values where the

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170 A deviant act is one which elicits a negative response and consequently the rule breaker is labelled as deviant.
171 Becker studied two groups, marijuana users and musicians, both groups labelled deviant. For both, the decision of whether to conform to society or not, determined the extent of their deviant career paths. Becker believed rules have to be enforced when something provokes the enforcement. However, rules mostly punish the deviant because rules are created to serve the interests of the “Moral Entrepreneur” who invokes them.
172 After initially breaking the rule and getting caught, the individual earns the label of deviant.
173 See also Measham et al., 2001; Parker et al., 1998; Parker et al., 2002
174 See also Cohen, 1971; Young, 1971
175 See also Hadfield & Measham, 2009; Hobbs, Hadfield, Lister & Winlow, 2003; Rojek, 2000; Young, 1999
176 See also Garland, 2001; Hunt & Evans, 2007; Sandberg, 2008
177 See also Measham, Newcombe & Parker, 1994; Measham, Parker & Aldridge, 1998; Williams & Aldridge, 2002; Williams & Parker, 2001
drug user has either never advocated the values that limit drug use or has abandoned them due to drug using\(^\text{178}\).

**Section summary**

This section opened with a description of the Social Construction of Reality which explains how individuals respond to and react with those that they come into contact with. It examined the understanding of how individuals who are labelled deviant react to that label. This section continued with an historical examination of the social construction of addiction. The complexity of reaching an agreement on the definition of addiction further confounds both the social construction of addiction and the choice of theory of causation. Predominant discourse remains conflicted as to whether addiction is a medical issue where the patient requires treatment or a moral issue where the deviant requires sanction. The history of drug use including prohibition, the Harrison Act and drug classification highlight that drug using has moved towards a position of unacceptable behaviour requiring some type of professional intervention to safeguard mainstream society. This idea leads to the examination of the social construction of deviance where stringent controls and sanctions exist. Powerful policy makers decide the who, what and where of acceptable use which leads to marginalisation and stigmatisation of those who do not conform. The next section further explores the idea of the social unacceptability of drug use and the ensuing repercussions for drug users.

**Societal unacceptability of drug using behaviour**

*Drug addiction - Deviance or Medical enigma*

Moos (2007;2008) advised that social science research should assist in the understanding of the social processes that promote chronic drug use which influence both social inclusion and rates of relapse. However, contemporary thinking may still be enmeshed, as indicated by Berridge (1998), in 19\(^\text{th}\) Century thinking. Berridge maintained that theories of addiction, instead of being progressive, are swamped in circular reasoning with current policy more

\(^{178}\text{Drug use is a trajectory for serious health risks, delinquency and criminality.}\)
reflective of the Victorian emphasis on control of drug use and security of public health rather than concentrating efforts at treatment more suitable to contemporary\textsuperscript{179} times.

Laws against drugs simultaneously reflect and cause society’s disapproval. Drug using poses a threat to society and is perceived as harmful. Media supports the legal perspective, depicting deplorable crimes caused by drug use, implying that the drug user, through criminal activity, has adopted a criminal status. Additionally, media portrayal of vicious atrocities committed while under the influence of drugs, illustrate the devastating consequence of use, the suspicion around using and the fear when this use becomes a group phenomenon. This is evidenced by the CJS construction of the drug user as a criminal requiring sanction. Treatment methods, in many instances, also reflect this disapproval. When conjoined, these notions attempt to protect mainstream society from the criminal who threatens the stability of both social order and the health of the nation (Gould & Stratford, 2002)\textsuperscript{180}. Anti-drug hysteria, depicting drug users as deviant and criminal, utilises notions of mental illness, disfiguring disease and unwarranted violence to reinforce the need to incarcerate or treat transgressors. The ‘sickness’ associated with drug using is described as obscene and disgusting, for example involuntary hallucinations of crawling flesh, where the drug user is physically and mentally debilitated. The element of control within this discourse facilitates the view that the drug user is unclean, self-destructive and somewhat inhuman (Burroughs, 1992). Therefore the representation of drug users whose drug using is beyond volitional control is the product of both these discourses (Grund, 1993). The legal framework has constructed drug addiction as a culpable offence, while the medical discourse has constructed it as a disease that is beyond conscious control (O’Mahony, 1993).

Davies (1997) proposed that legal sanctions are used for reparation and to induce behaviour change\textsuperscript{181}. If sanction is deemed inappropriate, medical intervention is the pragmatic alternative and the drug user is labelled ‘patient’ rather than ‘deviant’\textsuperscript{182}. Davies further suggested that given the choice between punishment and treatment, most drug users will choose treatment in order to deflect the stigmatisation of deviance, justify ‘out of control’ use and remove their personal responsibility by attributing drug using to disease. They embrace the notion that it is something they have rather than something they do, and relocate the associated problems

\textsuperscript{179} Contemporary notions perceive drug users as either law breakers needing sanction and punishment or patients in need of professional treatment.

\textsuperscript{180} See also Gourley, 2004; Pearson & Shiner, 2002

\textsuperscript{181} Assumes that there is an element of conscious control regarding drug using and the associated behaviours.

\textsuperscript{182} Realistically this label will invoke similar consequences sometimes including involuntary incarceration, for example forced detoxification, if a professional deems it the only appropriate cure.
within the drug. Therefore drug use which has been stigmatised as deviant, is represented in a manner that partially removes the drug user’s responsibility for those who are willing to cooperate with medically assisted treatment. The perception of drug addiction being beyond the drug user’s control removes the volition component, absolves guilt and, as often depicted by media and literature, has become an essential component of the ‘Junkie’ stereotype (Baker, 2000). Burroughs (1992) suggested that many of the problems are caused by the dominant discourses conferring their ideology into law and public opinion. The medicalisation of addiction has reclassified it from deviant and culpable to non-volitional, out of control behaviour rendering the drug user incapable of choice.

Contemporary thinking suggests that the social construction of drug addiction has been created to generate fear in mainstream society, stigmatise a minority group by labelling them as deviant and enhance the power of social control over this group. Szasz (1985) maintained that three mechanisms are utilised to reinforce this thinking. Firstly, the classification and prohibition of controlled substances as ‘dangerous narcotics’ secondly, the extreme social controls exerted by a somewhat corrupt CJS on those labelled drug users, and thirdly the recurrent claim that use of ‘dangerous narcotics’ is increasing at an alarming rate, thus reiterating the popularity of using drugs, which although illegal, are widely available through black market networks. Clinard and Meier (2001) argued that these three mechanisms neglect to include the choices and contribution made by the drug user to the construction of the drug user identity, where their behaviour aids the formation of society’s perception of the drug user. However, they do agree that the social consequence and experience of drug addiction varies with the prevailing social and legal sanctions. For Clinard and Meier (2001), the construct of the drug user originated from diverse discourses – moral, judicial, medical and pharmacological, along with representation by media and literature. Throughout Western society, these discourses conferred a negative identity upon the drug user. The associated stigma portrayed drug users as disreputable, having criminal associations and deviating from acceptable societal norms. This condemnatory deviant identity, popular in the 20th Century differs from the 19th Century disapproval and pity. Use by middle classes and females was more acceptable than use by those

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183 See also Burroughs, 1992; Grund, 1993; Zinberg & Harding, 1982.
184 Burroughs (1992) questioned the usefulness of the ‘Junkie’ stereotype of prohibitionist discourse along with the media’s transformation of the drug user into vicious criminal. Deviant identities separate drug users from mainstream, moving them into the realm of the Other or Outsider where they are considered fundamentally different rather than people who exhibit extreme behaviours caused by drug using (Becker, 1963).
185 Many of these are neither dangerous nor narcotic and are extremely popular with those who choose to consume them.
from lower socioeconomic classes. Similarly today, the most prolific drug use is associated with squalid neighbourhoods\textsuperscript{186}, rising crime rates, sex working and health problems, further emphasising that drug use causes immense harm to drug users and society (Murphy, 1996; O’Mahony, 2008). The representation of illegal drug scenes concentrated in inner city areas, includes the image of disorder, unhealthy drug users openly dealing and soliciting and petty crime (Dolan \textit{et al.}, 2000)\textsuperscript{187}. Undesirable, deviant populations are increasingly marginalised into ghetto like environments. In an effort to reclaim popular or financially viable city areas under the umbrella of urban renewal, the poor are further concealed and socially excluded (Young, 2002)\textsuperscript{188}. Social conditions which include the influence of social networks (Neaigus \textit{et al.} 2001)\textsuperscript{189}, low educational attainment (Dunn & Laranjeira, 1999)\textsuperscript{190}, history of sexual abuse (Miller, 1999), sex work at a young age (Fuller \textit{et al.}, 2002) and polydrug use (Darke \textit{et al.}, 1994) influence drug using and IV administration.

The profile of the Irish drug user began with young people living in the poorer, disadvantaged areas of Dublin which had a very high rate of unemployment and crime. Crime in these areas included acquisitive crime to finance serious drug habits (Mayock & Moran, 2002)\textsuperscript{191}. In recent decades, addiction to illicit drugs has spread to marginalised areas of almost every town and city in Ireland (Moran \textit{et al.}, 2001).

The drug user is perceived as ‘sick’ requiring treatment, criminal requiring punishment, deviant from society’s norms or victimised by law enforcement, by the drug use itself or by social stigmatisation. Therefore the drug user is seen as the object of judgement or diagnosis. Although the disease model has been challenged in recent times, approaches to dealing with undesirable drug using behaviour still contain elements of moral, medical and legislative principles and the social stigma remains relatively unchallenged.

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\textsuperscript{186} Many urban centres have a concentration of poverty, crime and drug using leading to urban decay whilst the middle class, middle aged population tend to inhabit suburbia (Flint, 2002; Perry, 2000).
\textsuperscript{187} See also Kemmesies, 1997; Zurhold, Degkwitz, Verthein & Hassan, 2003
\textsuperscript{188} See also Blomley, 1994; Perry, 2000
\textsuperscript{189} See also Des Jarlais, Casriel, Friedman & Rosenbaum, 1992; Gamella, 1994
\textsuperscript{190} See also Crofts, Louie, Rosenthal & Jolley, 1996
\textsuperscript{191} See also Murphy-Lawless, 2002; O’Higgins, 1998; O’Mahony, 2008
Fear of drug using behaviour

An Irish nationwide survey examining the general public’s drug related beliefs and attitudes found that 75% reported being fearful of drug users. Participants who knew someone who was using drugs were more accepting of illicit drug use and held less negative attitudes towards drug users (The 2010/2011 Drug Prevalence Survey). In previous research, MacCoun (1998) who conducted several studies examining harm reduction policies, reported that the public found the aspect of loss of control threatening. Bryan, Moran, Farrell and O’Brien (2000) suggested that drug use is a hidden activity due to legal sanctions and high public disapproval. Pearson (2001) added that drug use is invisible outside of trusted groups However within youth groups, negative attitudes are less frequently recorded and drug using is equated as another recreational activity (Duff, 2004). However Goode (2006) suggested that the majority public attitude viewed drug using as a normative violation and considered it deviant.

In studies on youth subcultures Johnson, MacDonald, Mason, Ridley and Webster, (2000) suggested that the majority of drug users tend to come from the lower socioeconomic groups. Welfare maintenance barely covers basic needs so drug users on social welfare, who need additional resources to purchase drugs, lack a reasonable safety net. Due to prohibition, drugs without quality control, are sold at exorbitantly high prices in closed, black market networks and drug users are forced underground (O’Mahony, 2008). They have minimal political power and limited recognised lobby groups. Unwilling to risk reprisal, formal and informal sanctions and criticism, the drug user ensures his/her use remains undetected. The link between drug use and crime is firmly conferred to a class of outcasts. If drugs were viewed as commodities that drug users want to consume, instead of with the stigma of illegal substances used by criminals, drug use could emulate consumerism. However, the drug user is considered deviant and associated business dealings criminal (Anderson, 1995).

192 This is due to the Normalisation Debate where recreational illicit drug use is becoming more acceptable with younger people (Duff, 2004; Parker, 2005; Parker et al., 1998; Parker et al., 2002) and not using would be seen as conforming to authority (Tatarsky, 2003).
193 Society attempts to classify drugs and control use. The most extreme reaction, criminalising drugs and their use, forced their prohibition. Recreational or controlled users generally have roles and responsibilities that prevent them from drifting into addiction. Patterns of drug use and perceived control depend largely on situation, environment, events and where one is in relation to drug using. Self-regulation is the one determining factor that wards off the proposed evils of addiction (Gossop, 1995; O’Mahony, 1993; Zinberg, 1984).
194 Social stigma was negligible prior to the Harrison Act 1914 (Moore & Wegner, 1995; Musto, 1989; O’Mahony, 1993).
195 Becker (1963) commented that the drug user consuming opium has not changed his/her basic character. The change lies in the paralysis of their ability to perform.
196 See also Burroughs, 1992; Marlowe, 1999.
Charleton’s (1995) report on drugs and crime suggested that Dublin is witnessing a second generation of drug users where deviant behaviour is accompanied by serious transmitted diseases like Hepatitis C and HIV/AIDS. He commented that drug using was spreading through every class in society and quoted the 1979/1980 Garda Crime Report which stated that the dramatic increase in heroin has coincided with the upward trend in crime statistics. Charleton stated that the fear of drugs and drug using leaves people suffering because of what is currently happening and dreading what is yet to come. O’Mahony (2008), in his study commented on the third generation of drug users. Since the 1970s when heroin became the most popular drug of choice, the extent and consequences of drug use had been unanticipated and far reaching. Crime rates had risen dramatically, including confrontational and violent crime, apart from the period from 1996 to 2000 which coincided with the introduction of methadone maintenance programmes and increased incarceration for drug users.

Therefore, legislation and media contribute to the fear of drug using with increased hysterical reactions (Bunton, 2001; O’Malley, 1999). There exists fear of public drug using, drug markets and increased crime (Chevigny, 2003), fear of gangland crime (Covington & Taylor, 1991; Lane, 2002) and the fear that drug taking would take over the world (Fitzgerald & Threadgold, 2004). The chaotic world of drug using and the street drug market induces fear and establishes ‘no go’ areas (Fitzgerald & Threadgold, 2004). This fear is reinforced by visible, offensive signs of drug using in the streets, for example, drugs paraphernalia, blood, urine and vomit in back alleys and doorways. The media eagerly report statistics on the menace of drug using, devastating effects on the drug user, highly shocking visual images and exaggerated stories.

**Social Stigma**

Goffman’s (1963:3) classic interactionist work defined stigma as any ‘deeply discrediting’ fact that accounts for a deviation from the normative construct, for example, a given identity that undermines the individual’s social identity and becomes a master status. Stigmatisation becomes an informal social control creating obstacles to social interaction (Schur, 1971). Behaviours and populations who are considered deviant or dangerous (Plancherel et al.,

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197 Drug use steadily increased and spread nationwide (Moran et al., 2001).
198 Demonstrated by the increase of seizures
199 See also Crank, Giacomazzi & Heck 2003; Fitzgerald & Threadgold, 2004; Swift, 2003
are socially excluded (Young, 2002). Assigning stigma involves negotiation, resistance and bargaining power (Ben-Yehuda, 1990; Schur, 1971). Central to this assignation is the effect on the individual’s identity, considering issues like labelling, judgement and isolation (Lemert, 1951). The recipient has limited opportunity to challenge the label or the powerful system assigning it (Clinard & Meier, 1992). Labelling permits society to construct criminals (Beck, 1963). Stigma creates a ‘self-fulfilling prophesy’ due to identification with and adoption of the label which may increase the likelihood of criminal behaviour (O’Mahony, 2002). O’Mahony (2008:6) commented ‘Naming things is a function of how we see the world around us … a manner in which we construct that reality’.

Szasz (2003) believed that it was impossible to quantify the power of labelling on shaping societies’ moral processes. Braithwaite (1989) said that shaming deviant individuals could help decrease crime rates, but conversely that shaming could reinforce stigmatisation, exacerbating criminal activity thus making some criminal subcultures more attractive. O’Mahony (2008) agreed stating that the CJS further stigmatises drug users by the separation of drug related offences from other offences. O’Mahony suggested that the Irish public internalise the diverse social categories of offences and support the legal system’s view of drug related activities. He believed that this type of labelling can lead to a high rate of recidivism of drug related crime.

Szasz (1994) described addiction as socially disapproved, pharmacological behaviour. The classification of certain drugs is a social convention which need not necessarily be a universal truth. In reality, Szasz suggested that society observes individuals’ enjoyment of drugs and involvement in groups that are socially stigmatised. Individuals who are seen to choose to enjoy the effects of drugs are perceived as dangerous (Corrigan et al., 1999; Link et al., 1999). Social

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200 See also Ben-Yehuda, 1990; Dean & Rud, 1984; Power, Power & Gibson, 1996; Zastowny et al., 1993
201 See also Albrecht, Walker & Levy, 1982; Cunningham, Sobell & Chow, 1992; Link, Phelan, Bresnahan, Stueve & Pescosolido., 1999; Link & Phelan, 2001; Merry, 2001; White & Sutton, 1995
202 Szasz suggested labelling mirrored scapegoating with "pseudoscientific and pseudomedical use of language in the form of ‘drug traffickers’ and ‘drug abusers’ thus emphasises the process of marginalisation that ensues for individuals who engage in this ‘prohibited’ behaviour” (2003:20) and asked if scapegoating can supersede a more useful remedy and release society of accountability which could not only improve life for the drug user but also that of mainstream society.
203 Through the Misuse of Drugs Act 1977
204 Szasz suggested the common belief that the drug is addictive comes from society’s mistaken view that drug addiction is due to the chemical properties of the drug.
205 Drug addiction is not due to a substance’s pharmacological make up. In 18th Century Britain, for example, alcohol was widely consumed and opiates publicly sold in shops as a pain killer. Consumption of these was the norm but drunkenness or disorder was frowned upon.
stigma emanates from unacceptable behaviour that is labelled deviant (Szasz, 1985) and from the risk of disease and death associated with drug using (ACMD, 1988).

Working class poverty and disregard for the law in 18th Century Britain was associated with drunkenness. Criminals and sex workers frequented taverns and gin houses and were blamed not only for excessive drinking but also vice, crime and social disorder (Shaw & McKay, 1942). Social alcohol consumption and the use of opium as pain medication was viewed as good for society but when ‘abuse’ caused nuisance it was classified as a social problem. Concurrently in America, social consumption of alcohol was considered good whilst over imbibing in the ‘Demon Rum’ was sinful (Keller, 1976). Punitive methods of social control exacerbated negative perceptions of drug users. Moral and legal anti-drug campaigns confirmed these negative perceptions. They defined who should be stigmatised and created an identity based on anticipated behaviour. The ‘Junkie’ stereotype reflected the perception of drug use within an underworld of vice, crime and physical disease (Duster, 1970).

Temperance movements which associated drunkenness with laziness, ignorance and immorality were founded to eliminate these characteristics that threatened the stability of society (Cole and Postgate, 1971). Within the Temperance Movements, drugs were equated with evil and sin, deviating from the norm, where those afflicted failed to comply with societal norms and succumbed to temptation. Evil became a war to be fought against. Drugs were seen as foreign substances and drug users as deviants to be persecuted and punished not only for drug using but also for being defiant members of a counter culture (Szasz, 1994). Prohibition reinforced the stereotypical negative image which ostracises those who are labelled drug users, describing them as criminal, undependable, dishonest, pitiful, hostile, violent and aggressive (Thoumi, 2003). This negative image gave rise to a stigma which precludes inclusion into society, prevents the assignation of positive attributes and may lead to unfair

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206 Efforts to stem the production and sale of gin through the mechanisms of taxation and stricter licensing laws were implemented in an attempt to quell the rising social problem of drunk and disorderly behaviour, for which punishment included imprisonment, fines, and the public humiliation (Heather & Robertson, 1985).

207 Social problems related to drug addiction became more apparent as society industrialised and alcohol and opium interfered with workforce performance and safety. Then the issue necessitated social control.

208 The social construction and stigmatisation of drug users was amplified with the passage of the Harrison Narcotics Act of 1914 and continues to grow with successive global wars on drugs (Ben-Yehuda, 1990).

209 See also Morgan, 1981; Musto, 1989

210 The American Temperance Society was formed in 1826, in Scotland in 1828 and in Britain the Teetotal Temperance Society in 1830

211 This perception of evil originated with bible teaching and religious ideals of clean and unclean therefore what is permissible or not.

212 for example, opium introduced to America by Chinese workers, infiltrating society
sanctions like job loss, exclusion from education or training, denial of mental or physical healthcare or extreme social controls like eviction or incarceration (Agencia, Brasil/Radiobrás, 2006)\textsuperscript{213}.

The perception of drugs as disease viewed drug use as contagious\textsuperscript{214}, where infection could extend to the wider population. Within medical treatment, the patient had limited choices. Being cured by the doctor was the rational choice because surely only a ‘crazy’ person would refuse to be cured. Mental illness or psychological disease encompass the ‘impossible to quit’ paradigm, culminating in incarceration, suicide or death (Barrett & de Palo, 1999)\textsuperscript{215}. The mental health paradigm views drug addiction as spiralling out of control by an unavoidable, extrinsic force. This is based on the notion of craving, which sets the drug user apart from the recreational user by an irresistible urge that cannot be ignored or conquered (Levine, 1979).

In contemporary society, public drug using is regarded as a nuisance (Broadhead \textit{et al.}, 2002), a threat to society and a challenge to local authority and the CJS (Kimber \textit{et al.}, 2003)\textsuperscript{216} and seen to affect tourism and cultural values (Fischer, 1995). The identity of the drug user has been redefined in terms of ubiquitous risk which includes the representation of the drug user as contaminated by ever present confrontation of death or disease and dirty,\textsuperscript{217} due to the lack of housing, hygiene and services (Alcabes & Friedland, 1995)\textsuperscript{218}. Popular anti-drug strategies present the drug user as deviating from the norm, using drugs that are unacceptable to society, potentially acting like a foreigner, deviating from mental or physical health and from the morals of the majority. Therefore, the stigma attached to drug addiction causes problems for both the drug user and society. Instead of alleviating social problems\textsuperscript{219} it tends to exacerbate them (Anderson & Ripullo, 1996; Grund, 1993)\textsuperscript{220}. Goffman (1963) proposed that stigma negatively impacts on social relations and identification between drug users and society. An equally

\textsuperscript{213}See also Grund, 1993; Murphy, 1996; Wijngaart, 1991
\textsuperscript{214}The disease metaphor, which has become a key component in the ‘War on Drugs’ created the urgency for drastic measures against drug users including social quarantine by incarceration. War attempts to defeat the enemy, drugs, and protect the innocent victims, mainstream society (O’Mahony, 2008).
\textsuperscript{215}See also Gossop, 1995; Szasz, 1994
\textsuperscript{216}See also Fischer, Rhem, Kim & Robins, 2002
\textsuperscript{217}Kristeva (1982) expanded on the idea of unclean conditions saying that it is not just the dirt itself that causes problems, but these are confounded by disruption of identity, system and order.
\textsuperscript{218}See also Cherubin & Sapira, 1993; Coutinho, 1998.
\textsuperscript{219}Many of the problems emerging from social stigma, for example, societal intolerance and ignorance, decreased life chances for drug users, increased social isolation and stress, are more likely to promote marginalisation and segregation than deter further drug addiction.
\textsuperscript{220}For example, in the 1980s in New York, the ‘War on Drugs’ responded to the ‘crack epidemic’ among poor, young, urban IV drug users, when violence among dealers escalated. The result was further stigmatisation of all drug users, and increased hostility and incarceration (Friedman, Curtis, Neaigus, Jose & Des Jarlais, 1999).
prejudicial view of the drug user as social outcast, invoking the stereotype where the drug user is seen as a subordinate victim exploited by violence and enslaved by drug using leading to tragic fatalism, can be misleading (Moore & Campbell, 2000; Tosches, 2000). Individuals, with stigma potential, hide their drug use from public knowledge. Stigma decreases life’s opportunities and hinders abstinence success (Clinard & Meier, 1992; Link et al., 1997). The stigma of relapse, where relapse equals failure, further reinforces negative self-image and strengthens the ‘once an addict, always an addict’ paradigm as a major aspect of the ‘Junkie’ stereotype (Herman 1993; Ulmer, 1994).

Consequently freedom to achieve what is considered a normal life structure is severely limited (Link et al., 1997). When the individual is viewed as responsible for earning the stigma, unfavourable treatment intensifies (Jones et al., 1984). Grund (1993) conducted a participant observation with 192 heroin and cocaine users, observing their rituals around routes of administration. He noted many effects of being involved in a drug using subculture and proposed that drug users’ chances of attaining legally recognised professional skills were limited. This limitation leads to an alternative criminal lifestyle learning the skills associated with criminality. He added that, due to the fact that the criminal lifestyle may have developed before drug using or very shortly after initial use, many drug users have never had legal employment. Membership of a lower socioeconomic class exacerbates the drug user’s chance of stigmatisation where several deviant statuses may be co-occurring (Bryan et al., 2000).

Illegal activities, for example, acquisitive crime, drug dealing and sex working, provide life’s structure for drug users who have minimal chance of alternative employment. As a result of this stigma, contemporary drug education often used deceitful scaremongering supported by media, legislation and policy. The warning against drugs uses horrific images based on drug user stereotypes. Many drug users, contrary to common stereotypes, indulge in volitional use rather than being a physical depiction of the images constructed by the discourses on drugs. The criminalisation and vilification of drugs have the reverse effect and force drug users underground (Becker, 1963).

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221 Drug addiction and related factors, exacerbated by ‘Junkie’ stereotype stigmatisation, resulting low self-esteem, seriously impede the hope of a ‘normal’ life structure, (Clinard & Meier, 1992).

222 See also MacGreil, 1996; Schur, 1971

223 In addition problems like homelessness, impaired mental and physical health and lack of aspiration for the future renders change almost impossible (Foster, 2000; Grund, 1993).

224 This tactic is often ineffective because many teenagers know people who have used psychoactive drugs and do not fit that drug user stereotype.

225 Stereotypes reflect contemporary social and legal attitudes towards drugs (Becker, 1963).
Stigma is exacerbated by unacceptable behaviour. Decorte (2001) examined cultures and contextual norms with regard to controlled and uncontrolled drug using and recognised many drug users use too much, too often and suffer negative physical and social effects. Because of illegal activity, use of IV drugs and negative physical and mental health effects, they are looked down on and described using negative terminology. Hence the stigmatisation of users, that reached an apex with the ‘Junkie’ stereotype in the mid-20th Century, has proved remarkably resilient to change. Stigma is a powerful, dynamic social phenomenon, leading to social exclusion, which strongly influences services, policy and treatment including human rights to healthcare, housing, welfare and employment (Neale, 2006). Gaitley and Seed, (1989) remarked that due to the association with drug using peers and the stigma of illicit drug use, many drug users are excluded from non-drug using groups which exacerbates the problem of engaging with non-drug using social support networks and employment. The disease model alleviated stigma in terms of responsibility and encouraged users towards services (Ferentzy and Turner, 2012). However since this model has been challenged, the lack of uptake of services can result in harm to mental, physical and social health which exacerbates poverty, isolation and health issues (Brener, von Hippel & Kippax, 2007)\textsuperscript{226}. The consequence of social stigma can create profound and enduring changes in the drug user’s identity (Buchanan, 2004)\textsuperscript{227}. Drug users do have to accept responsibility for their lifestyle choices and associated behaviours where they commit crime, join gangs and inject drugs (Bourdieu, 1990; Giddens, 1984). However, it is seldom acknowledged that they also watch television, have babies, and eat dinner like the majority of the population. They have normal social roles – brother, sister, husband or wife like the rest of the community and do not deserve the condemnation coming from social stigma and the resulting prejudice and discrimination (Deleuze, 1968/1994).

\textit{Social Controls}

Moderate, social or recreational alcohol and drug consumption occurs within the social norms, attitudes and values of society. Social conditions regulate how and when they are used and by whom. Cultural variations exist regarding the substances and level of acceptable\textsuperscript{228} use,
regulate patterns of use and negate consequences (Heath, 2000). However, modern industrial societies tend to ignore accepted rules governing drug use and how a breakdown in social control\textsuperscript{229} can lead to drug use (Teeson \textit{et al.}, 2002). Drug users’ failure to conform to normative standards of socially appropriate behaviour is directly associated with their powerlessness over the external force of addictive cravings\textsuperscript{230} (Heath, 2000).

Historically, the deviant practice of drug using was credited to ethnic minorities,\textsuperscript{231} therefore, addiction was alleged to be contained within these minority factions\textsuperscript{232} (Gossop, 1995; Szasz, 1975). However, some authorities recorded a rise in drug using, which was probably more accurate\textsuperscript{233}. Drug users were connected with dissent as well as deviancy and fought back. They recognised the possibility of adverse effects but did not accept their inevitability. Peer experience contrasted with scaremongering and exaggerated media reports. Many fatalities ascribed to overdose, presented as undeniable proof of the dangerousness of drugs, were accidental due to uncertainty, impure drugs, or circumstance. Stories about the many drug users who live long and reasonably fulfilling lives were seldom told (O’Mahony, 1993). A significant effect of prohibition and criminalisation is the fear of detection and punishment. Many drug users enjoy the challenge of evading authorities which often enhances the attraction of drug use for adolescents. They disobey social controls in an effort to establish their identity. Young people experiment with drugs, provoke authority figures and renounce parents’ moral value systems. If drug education\textsuperscript{234} adopted a more rational approach and experimentation was considered normal initiation, adolescents would be denied the opportunity to gain an enigmatic occult experience. Consequently, criminalisation of drugs did not result in any significant reduction in drug using (Mac Donald & Marsh, 2002)\textsuperscript{235}.

\textsuperscript{229} Social and legal taboos against non-medical, illicit drug use are reinforced by the view that these drugs are so overwhelming or so hazardous that their continued use inevitably leads to addiction. The physiological and psychological damage familiar to chronic drug users is habitually cited as proof of this pharmacomythology.

\textsuperscript{230} This ideology not only resides in popular mythology but also in several scientific theories

\textsuperscript{231} For example, opium smoking by Chinese immigrants or marijuana using by Mexican immigrants, certain minority groups like musicians and sex workers or criminals and impressionable youth, who were morally weak.

\textsuperscript{232} Increased efforts to discredit drug users, labelling them as ‘juvenile delinquents’ silenced their voices and transformed them into the class of a despised minority (Miller, 2007).

\textsuperscript{233} The preceding restrained level of social control was intensified and eventually became the ‘War on Drugs’.

\textsuperscript{234} Most drug education programmes are criticised for their inability to reach young people. The lack of accurate information about drug effects has given rise to a biased debate and scepticism among youth regarding public health messages and drug use (Swift, Copeland, and Lenton, 2000). Schaler (2006) stated that young people observe their friends and peers enjoy drug using peers without experiencing the anticipated adverse consequences as predicted by these programmes.

\textsuperscript{235} See also Shearing, 1995; White, 1998
There is a price to pay for drug using where social controls carry the threat of punishment. The deterrent argument, reflecting society’s disapproval, is the only realistic basis for punishment (Carver, 2004; McKeganey, 2005). To ensure social control, this disapproval has to remain potent (Blackman, 2007). Victims of addiction fortify disapproval. Fear, through the ‘slippery slope’ paradigm, scaremongering and moral panic strengthens society’s censure (Mac Donald & Marsh, 2002). However many drug control efforts are counterproductive (Butler, 1991; Rolles, Kushlick & Jay, 2004). Increased drug using counteracts punitive drug controls (Stares, 1996). From the 1980s the increase in the transmission of infectious disease, rate of overdose death and associated harms show that drug controls are somewhat ineffective (Dolan et al., 2000). Butler (2002a) suggested that society has to accept that drug using is part of everyday experience. Controls have to adjust rather than strictly adhere to ineffective, dogmatic and punitive policies (Report of the Working Party on Drug Abuse, 1971).

Section summary

This section examined social unacceptability of drug using, highlighting how drug use is perceived as harmful and a threat to social order and the health of society. It questioned the usefulness of the ‘Junkie stereotype’ where the drug user is depicted as an outsider, fundamentally different to other people and somehow less than human. The social construction of addiction creates fear of the drug user, confers a negative identity on them, stigmatises them with the deviant label and enhances the power of social control over them. Several authors maintain this fear is often justified due to chaotic lifestyles and criminality. The drug user often accepts the consigned label which becomes a self-fulfilling prophesy and enters the underworld of vice, deviance, criminality and physical disease leading to social exclusion and social stigma. This section stressed how social stigma prevents assignation of positive attributes,

Social sanctions fulfil several requirements; punishment, deterrence and cure, although treatment through incarceration is a contradiction in terms (O’Mahony, 2008). One aspect of social control is the severity of the possible punishment and increasing drug testing in schools, workplaces and leisure venues.

See also Butler & Mayock, 2005; Fitzgerald & Threadgold, 2004

For example neglected children, targets of acquisitive crime, devastated communities and families who suffer at the hands of their loved one’s drug addiction.

See also O’Mahony, 2008; Shearing, 1995; White, 1998

For example, the UK has one of the most severe drug control regimes and a vast illicit drug market (Reuter & Stevens, 2008) and in the US, despite the ‘War on Drugs’ the drug using situation is higher than ever (MacCoun & Reuter, 2001).

See also Fischer, 1995; Fischer, Rehm & Blitz-Miller, 2000; Nadelmann, McNeely & Drucker, 1997
decreases life’s chances of gaining entry into education or legal employment and can lead to extreme sanctions like eviction and imprisonment. Normal social roles enacted by drug users are lost within the portrait of the deviant outsider. The section concluded by investigating how the unacceptability of drug using can lead to powerful social controls. The next section appraises how drug users respond to the issues presented above.

Drug users’ response to societal perception of addiction

Social learning theory

Social learning theory explains how groups of drug users transcend into an organised, functioning drug using subculture\(^\text{242}\). Edwin Sutherland within the structure of Differential Association, proposed a network of associations between behaviour and attitudes that govern decisions regarding continuing the behaviour. Following Sutherland’s work, Burgess and Akers (1966) Differential Association Reinforcement Theory suggested that reinforcement comes from the social environment and that the learning of deviant behaviour comes from close interaction with reinforcers from significant others, usually the peer group\(^\text{243}\). Peers define what is acceptable or unacceptable and allow this definition to guide their behaviour which is then reinforced according to the definition\(^\text{244}\). Akers (1985) described two types of discriminative stimuli: those that show approval by reward and positive reinforcement and those that help avoid unjustified punishment or negative reinforcement which allows the peer group to disregard the norms of society that would judge their behaviour as unacceptable.

When refining his Theory of Differential Reinforcement Jeffery (1965) suggested that people do not share the same past experiences\(^\text{245}\) and past experience alone is not enough to reinforce behaviour. The most definitive reinforcers are reward or the promise of reward\(^\text{246}\). Bandura (1973) maintained that direct reinforcement is not necessary. People learn by watching others and modelling their behaviour\(^\text{247}\). The greatest impact comes from models who hold the most

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\(^{242}\) Deviant behaviour is not innate but requires learning and training, interaction, communication and association with other deviants in small, intimate groups.

\(^{243}\) The learning stems from differential association, definitions, differential reinforcement and imitation.

\(^{244}\) The definition is crucial as it represents the acceptability within moral and social reasoning in the peer group.

\(^{245}\) For example, some people enjoyed reward for deviance while others suffered punishment

\(^{246}\) Jeffery (1965) - strength of reinforcement lies in the brain along with the pleasure and pain centres that interpret stimuli and primary reinforcement is biological and social reinforcement comes in second place.

\(^{247}\) Becker (1963) described the social learning process of the drug user as having three stages – learning the technique, learning to expect the effects and finally learning to enjoy the effects.
respect or significance and if the observers see the model enjoying a reward. It follows then that drug users, who are socially excluded from mainstream society by the social constructions of both addiction and deviance, will seek a subculture that accepts the enjoyment of drug using and the role of the drug user.

According to Peele (1990), people become addicted to experiences. The addictive experience is constructed in terms of the individual’s personal involvement and that of the wider cultural experience. The ensuing dysfunctional attachment is a result of social learning because the individual gains extreme reward from the experience. Therefore, the principles of Social Learning Theory help explain the initiation and continuance of deviant subcultural behaviour. Association within the subculture reaffirms members due to a sense of belonging.

**Drug using subculture**

Decorte (2000) proposed that the social definition of drug use is repressive as it emanates from social policy. Social agreement about drug use became a mix of the official dichotomy of addiction and ‘abuse’, drug policy and the official attempt to control illicit drug use. From a moralistic perspective, society believed that drug use should be moderate and acceptable. Therefore, drug use outside of these limits erodes social and cultural boundaries. The media, through reporting on social reality, actually helps to define that reality. They choose scapegoats who become symbolic of what is amiss in contemporary society while other issues can be ignored or minimised. The ensuing result of social reaction and social control may help the ‘deviant’ individual identify with the label that has been attached to him/her, thus perceiving him/herself as being more deviant and socially excluded. This type of isolation aids

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248 Behaviour is less likely to be imitated if the result is punishment.
249 Social Learning - drug users, using both past experience and social conditioning, learn to anticipate that drug using will accompany a pleasant experience and help solve dilemmas (Long, 1992; Mc Murran, 2006).
250 Social Learning Theory explains the development and maintenance of drug addiction by modelling and imitation and the importance of the peer group.
251 Deviant behaviour is learned by way of operant conditioning. It is learned in both situations and social interactions that are either reinforcing or discriminating. Much of the learning happens within groups that are most likely to reinforce the individual. The strength, availability and significance of the reinforcers aid learning and maintain the behaviour. The learning can be lessened or weakened by punishment or the quality and strength of reinforcement of alternative behaviour. The learning can be direct through conditioning or indirect through modelling or imitation.
252 The 1963 drug revolution was likened to a major threat to the dominant cultural values of hard work, family and national loyalty. Threat and fear were closely interlinked as drugs were widely believed to lead to psychosis, suicide and even murder (Frosch & Stern, 1967).
253 Media reports on drug using in a selective way that marginalises drug users and heightens social reaction.
the organisation of subculture. Subcultures tend to represent crisis within dominant culture and become forms of resistance\(^{254}\) (Mc Murran, 2006)\(^ {255}\).

According to Becker, (1963) society\(^ {256}\) creates deviance by applying rules that when broken, label the rule breakers as ‘outsiders’ or deviants. Being labelled\(^ {257}\) as deviant has significant consequences for social inclusion and self-image, evoking radical changes in the person’s public identity. Committing the deviant act and being publically caught confers a new type of status. The deviant identity becomes the most important factor where a self-fulfilling prophecy is produced. People who are stigmatised and labelled may experience discrepancy between their authentic and implied social identity. Deviance is not a characteristic of the rule breaker, as conforming to the rules of one group may demand breaking the rules of another (Clark, 2004)\(^ {258}\).

When an individual carries the stigmatised deviant label\(^ {259}\), s/he is no longer in control of their social world but becomes a passive recipient of systematically determined forces. It becomes difficult to continue normal, everyday routines so the individual continues to perform ‘abnormal’ actions (Schmalleger, 2006)\(^ {260}\) and gradually changes their life structure. Choices for group participation are limited, initiating participation in the subculture. Distinct advantages of becoming part of this new group appear like comfort, security, moral support, acceptance and camaraderie\(^ {261}\) (Des Jarlais, Friedman & Strug, 1986; Ouellet, Jiminez, Johnson & Wibel, 1991). S/he can converse\(^ {262}\) with people who understand labelling, stigma, marginalisation and exclusion and can learn all the tricks to continue the deviant behaviour, hopefully without detection (Atkinson, Atkinson, Smyth, Bem, Nolen-Hoeksema, 2000)\(^ {263}\).

\(^{254}\) Secondary deviance, for example, resistance, is a product of accepting the deviant label assigned and reorganising identity. Social reaction and social control are not mere responses to deviance but active participants in the foundation and promotion of it

\(^{255}\) See also Cohen, 1972; Hardiman, 1998

\(^{256}\) Deviance is socially constructed by rule makers. When rules are broken, the rule breakers are labelled as deviant. Rule makers label certain behaviour as deviant and the individuals responsible as deviants.

\(^{257}\) Within labelling theory, deviance is negotiated. People construct their social worlds by interacting with other individuals and groups.

\(^{258}\) See also Donnellan, Conger & Burzette, 2007; Reynolds, 2006

\(^{259}\) Labels are universally recognised and accepted, in accordance with a consensus of beliefs and values. Once a person is publically labelled as deviant, he/she is removed from the dominant value structure and develops alternative structures which highlight their deviancy.

\(^{260}\) See also Atkinson et al., 2000; Carlson, Martin & Buskist, 2004; Gross, 2007

\(^{261}\) Drug using groups function on formal and informal controls and authority

\(^{262}\) People within subcultures have a vast stock of folklore and myth and are more than willing to divulge information to the eager newcomer

\(^{263}\) See also Carlson et al., 2004; Gross, 2007; Schmalleger, 2006
Gourley (2004), in her research on subcultural theories of deviance, conducted semi-structured interviews with 12 ecstasy users aged 20-22 years and observed young people in six social locations in Canberra and Sydney. She found that drug using mostly took place within deviant subcultures and that youth drug use has been placed within the theoretical framework of subcultural theories of deviance. These theories hold that deviance comes from acquiring deviant norms and values. They stress the importance of deviant subcultures initiating and maintaining the deviant behaviour, arguing that deviance is the acquisition of deviant values and norms within the context of a subculture (Clinard & Meier, 1992). Subcultures connect those who have similar lifestyles. Members understand their newly constructed social world which offers routine activities that help settle into it. A set of norms and values organise a self-justifying reasoning that counteracts doubts and provides consistent reasons for continuing the deviant behaviour. These norms differ enormously from mainstream culture (Grund, 1993). The more a deviant group is separated from mainstream society and threatened by rule makers, the more it will profile as a subcultural deviant group. Subsequently, the more stereotypical deviant behaviour, norms and values are reinforced, the more intra-dependent and mono-focused the subculture becomes. Eventually, members mistrust mainstream culture (Grund, 1993; Hebdige, 1999) and create alternative lifestyles and identities which confer relative autonomy within social order (Hebdige, 1999).

Early research on drug using subcultures suggested that members embracing the group’s ideology, are reinforced with diverse notions of the value and nature of drug use (Becker, 1964). Pavis and Cunningham-Burley (1999), studied young, male street culture and corroborated that drug use is not singularly the remit of a youth subculture and that drugs are a widely available, commonplace commodity. However, it is recognised that the majority of associated social problems are located in marginalised communities. In disadvantaged areas,

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264 A subculture is considered deviant only if it rejects social norms. Since whole groups may engage in deviant behaviour, the concept of a deviant subculture emerges where members subscribe to their own group norms that oppose the norms of larger cultures.

265 Social learning and social controls functioning in drug subcultures form the framework regarding administration, procurement, control and enjoyment of drugs (Becker, 1963; Decorte, 2001; Zinberg, 1984).

266 Moore (2004) argued that this framework does not adequately describe the drug using subculture, saying that there had been a shift from the perception of subcultures being close knit systems of social organisation (Gordon, 1947), to lifestyles and social relationships that are not predetermined to any particular group (Cohen, 1985; Thornton, 1997a). Moore suggested that subcultures formed collective responses to social problems.

267 They develop distinct patterns of behaviour that express their social experience by imposing their own unique rules, meanings, structure and values (Hall & Jefferson, 1975).

268 See also Bloor, Frischer & Taylor, 1994; Parker, Baker & Newcombe, 1988; Young 1971

269 Additionally, due to economic pressure, theoretical focus encompassed the wider economic, social and political arrangements that influence ‘street’ subcultures. However, the focus on marginalised ‘street drug users’ based in certain socioeconomically disadvantaged areas remained unchanged (Johnson et al., 2000).
where inequality is highlighted, young peoples’ social experience tends to influence their thinking and behaviour. Subcultures become a response to powerlessness to change socioeconomic status, and youth rebel against mainstream society in an effort to proffer their own, albeit perceived as deviant, solution to their circumstances (Johnson et al., 2000).

Although drug using is often symbolic of the rejection of society’s rules, values and morals (Lenson, 1995), drug users do not differ so much from users of legally sanctioned drugs in their search for identity, security and solidarity. The subculture becomes a strong support system which reinforces solidarity (Sandoval, 1977). Kail and Litwak (1989) suggested that the compulsion to use drugs and the welcoming of intoxication strengthens the social bonds, but due to the illegal status of drugs, use is concealed. Conventional society considers drug using unacceptable and sinister and rarely legislates for socially controlled use. Therefore, drug users redefine what is considered deviant behaviour into acceptable behaviour within the subculture (Harding & Zinberg, 1977).

Becker (1963) suggested individuals could use a drug for pleasure only when they learned that it could be pleasurable. This learning, facilitated by experienced users, equipped the beginner with the tools to assimilate their drug experience, technique of using, perception of pleasurable effects and learning to enjoy the effects. Gourley (2004) commented that the interaction with the group cemented the experience of the newcomer. Derrida (1995) suggested that drug addiction cuts individuals off from mainstream society and de-socialises them. Drug users are removed from mainstream culture into a subculture where the pleasure of drug addiction is far beyond the boundary of pleasure permitted by conventional society (Loose, 2002). The DSM V mentioned giving up other activities in favour of drug using. The drug using subculture supplies new activities to replace old ones (Derrida, 1995). Common activities and sharing powerful experiences, like the ‘high’, maximising the drug effect or the intensity of withdrawal, and sharing drugs and money strengthen positive bonds.

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270 See also MacDonald et al., 2001; MacDonald and Marsh, 2002
271 Well defined social controls are organised for using alcohol and tobacco but no such controls operate to tolerate the use of illegal drugs (Bourguignon, 1977; Cleckner, 1977; Collins, 1989; Durkheim, 1964).
272 Becker’s (1963) study of a group of marijuana users and a group of musicians focused on how one becomes a drug user and studied the process of learning within a subculture including the initiation and maintenance of use.
273 Many drug users are given their first injection by a close friend or intimate partner (Harocopos, Goldsamt, Kobrak, Jost & Clatts, 2009).
274 See also Hardiman, Curcio & Fortune 1998
275 A strong example of enhancing solidarity can be found in drug sharing (Grund, 1993). Sharing aids socialising, affirms relationships, demonstrates strength and generosity, shows acceptance of obligations to fellow members, quells disharmony, ensures continuity and diminishes financial insecurity. It becomes a
Due to the deviant label and exclusion from society, drug users become mutually dependent for satisfying their fundamental human needs (Carlson, Martin & Buskist, 2004) which are the driving force behind the subculture. The subculture becomes a conditioned response to the hostile environment of law enforcement. Social stigma prevents participation in conventional society, leading to increasing immersion in the subculture (Becker, 1973; Goffman, 1963), where drug users organise their social space for undisturbed procurement and administration of drugs. The need for harmony, socialisation and cohesion maintains this subculture, with its survival, secrecy, values, rules and rituals (Grund, 1993; Radcliffe-Brown, 1952). It becomes a functional mechanism where drug users create an ordered social life within a chaotic environment which exists because of prohibition (Grund, 1993). Members create social norms and values around drug using, injecting, relationships, networks and living conditions which facilitates the identification as drug user (Rhodes, 2002).

Beliefs that drug users hold within the drug using subculture regarding treatment and recovery are dissimilar to those of professionals, academics and service providers. Keene (2010) commented that peers within the drug using subculture promoted drug using rather than abstinence or treatment. Due to the lack of non-drug using friends, abstinence was an extremely lonely state peppered with frequent relapses where the drug user returned to the social life with friends in the drug using subculture. Many of the participants in Keene’s study had intimate partners who remained drug users within the drug using lifestyle. The initial drug using was seen as embracing a new social network while stopping was antisocial incorporating a breakaway. Relapse reintegrated the drug user. Participants said they relied on social interaction with drug using peers showing the importance of the social support of other drug users while the individual is isolated from non-drug using mainstream society. The inclusive drug using subculture combats this isolation but exacerbates problems when trying to stop. The individual may have to face isolation and marginalisation while trying to negotiate new relationships with reciprocal exchange of the most valued item and transforms individuals into cohesive, efficient groups (Partridge, 1977). Sharing separates the in group from the out group.

See also Anderson, 1999; Anderson & Ripullo, 1996; Becker, 1973
See also Bourgois, Lettiere & Quesada, 1997; Koester, 1994
Mac Donald (2005) suggested that this alternative ideology generated by the drug using subculture reinforces the dogma regarding the nature and value of drug using.

Keene et al. (2007) recognised that these beliefs begin to change with initial contact with services and continue to change while individuals engaged in helping or treatment programmes and supported the idea that often when drug users contacted and began to use services their thinking fell into line with that of professionals they were working with.
non-drug users and social groups. Therefore drug using subcultures contribute to relapse as well as continuing use\textsuperscript{280}.

Keene (2010) further contended that due to the criminal behaviour associated with drug using, the further a drug user became dependent on the social network of offenders, the more excluded they became from non-offending groups. A consequence of membership of a drug using subculture is immersion in the black market of drug selling, dealing and buying. This exacerbates issues when trying to become abstinent. Along with loneliness and social isolation, individuals also lost their means of making money and often their living space, with little chance of breaking into new networks that would provide these resources\textsuperscript{281}. The drug using subculture provides an inclusive lifestyle. Many drug users found it was as difficult to move away from the lifestyle as it was to give up drug using. Drug using and non-drug using social networks\textsuperscript{282} can be mutually exclusive. Relationships within the drug using subculture are critical to the reinforcement of drug using. Continued membership becomes impossible when a member tries to stop drug using (Keene, 2010).

\textit{Cohesion and activity of group/peers}

Drug culture reinforces users’ discovery that drug using is not bad, evil or harmful as professed by adults, religious, teachers, policy makers and law enforcement. Drug using peers inform new users without the parental, church, school, legal or media warnings of negative effect (Zinberg 1984). Peele (1990) stated that drug users are crucially influenced by peers and their environment. They relate to companionship and approval of peers. People refocus their values as their using progresses, often into criminality, stealing, sex working, even murder, which can be acceptable depending on the rules within that group. The peer group influences an individual’s initiation into and maintenance of drug using and the attitudes held by this group are predictive of future use. Individuals who evolve into heavy drug using generally associate

\textsuperscript{280} In Keene et al’s (2007) study many participants felt excluded from other social networks because of their association with drug using social groups. They became more reliant on the drug using subculture for needs like accommodation, employment and money although often through illegal activity because they were excluded from the conventional means to satisfy these needs.

\textsuperscript{281} Solivetti (1994) examined the link between drug using, poverty, powerlessness and the lack of equality of opportunity for accessing employment. MacDonald (2005) and Tilki (2006) discussed how poverty and social inequality can often be reproduced within certain social networks. They noted that although a network of supportive peers can be a valuable resource in terms of social capital, it can simultaneously limit opportunities and possibilities to evade social exclusion.

\textsuperscript{282} Drug use increases the association with drug using peers and associated deviant behaviour and decreases the association with non-drug using family members, partners and social networks.
with peers who have similar drug using patterns (Fergusson & Harwood, 1997; Hoefler et al., 1999). Group cohesion is crucial to survival. Conflict between the CJS and the group’s approval of drug use may lead to anxiety. With strong members the decision to continue drug using usually champions. The group, in order to dispel anxiety, may act out with shows of bravado or exhibitionism or suffer from paranoia or antisocial feelings. It is necessary for the group to work together to diffuse social or personal conflict (Zinberg, 1984). Groups develop their own unique code of ethics, techniques, rules and rituals. Their harsh reality invokes repetitive and routine performance of rituals to ensure survival. Finance determines buoyancy of attitude and behaviour. Survival depends on mutual support in defence of the ‘Other’ which generally includes the external hostile environment and the eternal ‘Junkie’ stereotype where drug users are perceived as criminal, cunning, selfish and manipulative (Grund, 1993). Mere survival loses intensity when drugs are freely available, but during scarcity members revert to basics, and survival becomes critical. Scarcity increases the value and cost of drugs. This increases financial pressures where members are forced to engage in even more criminal activity to source money. Economic factors urge more efficient administration methods often leading to opportunistic, unsafe use (Faupel, 1987; Grund, 1993).

Homeless drug users are doubly stigmatised and socially excluded (Bradshaw, Kemp, Baldwin & Rowe, 2003). Often for homeless drug users suitable shelter cannot be accessed (Downing-Orr, 1996). Large numbers, excluded from accommodation services (Neale, Godfrey, Parrott, Scheard & Tompkins, 2007) share basic amenities in unsuitable or derelict buildings (Bourgois, 1998). In many cases there are neither safe drinking water nor washing or toilet facilities where transmission of disease is more likely (Des Jarlais & Friedman, 1997).

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283 Zinberg (1984) mentioned that since drug using is a covert, illegal activity, often individuals do not have a large number of groups to choose from and finding a suitable group is down to chance rather than choice. Initially, an individual may become entrenched in a group that is quite ignorant of drug use and ruled by risk taking behaviour (Colon et al., 2001) and compulsive use (Zinberg, 1984).

284 Often denial is one of the mechanisms used to dispel cognitive dissonance or conflict (Johnson, 1990).

285 Wisdom and mythology is passed on orally although in some instances information can be inaccurate (Southgate & Hopwood, 1999; Treloar & Abelson, 2005).

286 Many subcultural groups have their own language to communicate codes.

287 When availability is certain the group broadens their activities and survival is no longer the salient goal. In periods of scarcity the number of members in the group diminishes only including those who are most closely connected. Free availability increases numbers of people who have less intimate connections.

288 See also Foster, 2000; MacDonald & Marsh, 2002; March et al., 2006; Pleace, 1998

289 See also March, Oviedo-Joekes & Romero, 2006; Robertson, Zlotnick & Westerfelt, 1997

290 See also Dept. of Human Services AUS, 1998; Pleace, Jones & England, 2000.

291 See also Murphy & Waldorf, 1991.
Lack of amenities often oblige homeless drug users to inject in public (Klee & Morris, 1995) increasing health risks by such practices as using dirty puddle water, using larger quantities, more frequent using, hasty injecting increasing damage to veins, sharing drug paraphernalia (Rhodes et al., 2006), risky sexual behaviour (Koopman, Rosario & Rotheram-Borus, 1994) and increased mental health problems with an increased risk of suicide (Baron, 1999). Poverty and the stigma of HIV/AIDS further marginalises them (Brener, von Hippel & Kippax, 2007). Social and family problems, violence and sexual abuse are exacerbated (Lloyd, 1998). Many homeless drug users become polydrug users, more out of financial necessity than preference (Flemen, 1997; Kershaw, Singleton & Meltzer, 2000) and are exposed to even more negative prejudice from community and professional services (Neale, 2008). They tend to underuse services due to concerns about the service and lack of knowledge, lack of money, embarrassment and fear that services would contact family members (Rosenthal, Mallett, Milburn & Rotheram-Borus, 2008).

Group cohesion is further enhanced by the anxiety of the ever present threat of danger. Grund (1993) lists popular cult figures – Kurt Cobain, River Phoenix, Janis Joplin, Jean Michel Basquiat, Elvis Presley, Billie Holiday and Marilyn Munroe who have died as a result of drug related danger. In recent years celebrities who have been victims of drug related deaths include Gerry Ryan, Heath Ledger, Michael Jackson, Amy Winehouse, Witney Houston, Philip Seymour Hoffman and Peaches Geldof. Fear and pain are daily experiences and defying death becomes a critical ingredient of the drug user’s identity (Wieloch, 2002). Members of the subculture help when problems arise and morally support each other. Items of value, like drugs, clothes, food, social welfare and housing are shared as friendships develop. Group bonds are strongest in the IV subculture. Injecting and sharing ‘works’ reinforce social relationships (Des Jarlais et al., 1986). Drug users understand that drug using is the most important value in the
group but outside of using, they spend time on other social activities (Faupel, 1987; Kaplan, De Vires, Grund & Adriaans, 1990).

The subculture enhances social cohesion. It provides access to drugs and equipment (Burris, Strathdee & Vernick, 2003) although members often share equipment with people they do not know (Chitwood, 1990) which may increase the risk of disease transmission (Caiaffa et al., 2006). The group helps those who experience difficulty injecting (Carlson, 2000) and exchanges information on local drug markets, police presence and so on (Stopka, Singer, Santelices & Eiserman, 2003). Drug users feel safer (Kimber & Dolan, 2000) and members know their roles ((Friedman et al., 1998). The group endeavours to maximise safety for individuals and the wider group (Rhodes et al., 2006). The complex social context of drug injecting along with associated risk behaviours involves interaction of group members and opportunity for social control and safety in the form of adopting their own method of harm reduction (Rhodes & Treloar, 2008). Economic incentives, market forces (Neaigus et al., 2001), increase in prices (Chitwood et al., 2000; Frank, 2000), pooling resources, buying drugs at optimal prices, drug sharing (Koester, Glanz & Baron, 2005), psychosocial factors, close relationships, adhering to peer norms and injecting with intimate partners (Celentano, Cohn, Davis & Vlahov, 2002) all strengthen bonds within the group.

Subcultural groups have functional order. What is usually described as a chaotic lifestyle is ordered by getting money, legitimately or not, procuring and using drugs, and enjoying the effects. As long as drugs are illegal, procurement is work. Drug users, like any consumers, change their routine to suit their methods of purchase, swap tips on the best places to score, not unlike housewives sharing tips on grocery sales. Focussing life around drug using is not too far removed from focussing life around work, business or shopping. Drugs can be equated to consumerism that helps regulate life within the subculture (Marlowe, 1999).

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299 See also Des Jarlais et al., 2000; Latkin et al., 1994, Latkin, Mandell, Vlahov, Oziemkowska & Celentano, 1996; Nelson et al., 2002.
300 See also McKeeganey, Friedman & Mesquita, 1998.
301 See also Fuller et al., 2003; Hagan et al., 2001; Hahn et al., 2002; Howe et al., 2005; Thorpe et al., 2002.
302 See also Murphy & Waldorf, 1991.
303 See also Des Jarlais et al., 1986; Fuller et al., 2003; Latkin & Forman, 2001.
304 See also Longshore, 1996; Ouellet et al., 1991; Page, Smith & Kane, 1991; Stimson et al., 2006.
305 See also Bloor, 1995; Draus & Carlson, 2009; Howard & Borges, 1970; McKeeganey & Barnard, 1992; McKeeganey et al., 1998.
306 See also Frank & Galea, 1998; Hamid et al., 1997.
307 See also Grund, Kaplan, Adriaans & Blanked, 1991; Needle et al., 1998.
Initiation into IV drug use is not led by peer pressure, but a reciprocal relationship within shared beliefs and attitudes (Coggans & McKellar, 1994). Roy, Haley, Leclerc, Cedras and Boivin (2002) administered questionnaires to 980 drug users in Montreal, 530 of whom had injected heroin. Of those 530, 505 had first injected, mostly in a public place, with an acquaintance, a close friend or intimate partner. Their findings reinforced that the decision to inject becomes part of group decisions, enhances cohesion and cements rituals. Observing the enjoyment of injecting has a positive impact on the non-IV drug user. Exposure to pleasurable effects of injecting enhances the likelihood of it becoming a desirable mode of administration. The desirable effects reinforce the link between drug using and euphoria (Duff, 2007). Initiating into injecting becomes a process of communication (Harocopos et al., 2009) and once IV use is introduced into the group it easily becomes the preferred practice (Gamella, 1994; Hunt & Chambers, 1976). New members learn that IV administration increases the euphoria and is financially beneficial although the economic gain is short lived with heightened tolerance (Bravo et al., 2003).

On the negative side, drug use tends to increase when the drug user joins the group. Membership of the group and escalation in drug use can have negative consequences with family, social problems, stress, social exclusion, poverty and violence (Anderson, 1995), risk of transmission of infectious diseases (Caiaffa et al., 2006), risky sexual behaviour (Absalon et al., 2006) and mental illness (Razzouk, Bordin & Jorge, 2000). Despite the initial sense of intimacy, identification and belonging, increasing use can negatively affect group relationships. This breakdown in relationships and the previously assigned social stigma can obliterate the drug user’s new found contentment (Baker, 2000). Overcrowded environments carry potential harm, increased risk of needle stick injury, poverty and economic hardship but are still preferred to environments that do not ensure privacy (Kimber & Dolan, 2000). Poor

See also Dwyer, 2007; Fitzgerald, Louie, Rosenthal & Crofts, 1999; Maclean, 2005; Valentine & Fraser, 2008
See also Crofts et al., 1996; Grund, 1998; Sherman et al., 2002; Stenbacka, 1990
IV drug users are more prone to HIV/AIDS and Hepatitis infections (Thorpe, Ouellet, Levy, Williams & Monterroso, 2000), risk associated harms, vein damage and overdose (Chitwood et al., 2000; Des Jarlais et al., 1999; Scott, 2005) taboo, risk and danger often add to the attraction (Dwyer, 2007; Maclean, 2005).
See also Fitzgerald et al., 1999; Giddings, Christo & Davy, 2003; van Ameijden, van der Hoek, Hartgers & Coutinho, 1994
See also Des Jarlais, Friedman, Sotheran & Stoneburger, 1988; Willis, 1977
See also Heimer, Bray, Burris, Khoshnood & Blankenship, 2002; Lau et al., 2007; Sherman et al., 2002; Vignoles et al., 2006; Yang, Latkin, Celentano & Luo, 2006; Zocratto, 2006
See also Kuyper et al., 2004; Tun, Celentano, Vlahov & Strathdee, 2003; Quan et al., 2004; Tyndall et al., 2002
See also Bourgois, 1998; Page et al., 1991
living conditions, lack of injecting hygiene, blood on walls and discarded dirty drug using paraphernalia, along with the fact that some drugs induce violence and paranoia, illustrate the squalor and danger of some drug using settings (Bourgois, 1998)\textsuperscript{317}. These living situations are mostly located in areas near drug markets (Des Jarlais \textit{et al.}, 1986), often used by drug using sex workers between clients (Ouellet \textit{et al.}, 1991). Criminal activity aids group cohesion. The level of drug use is much higher amongst those brought to the attention of the CJS (Bennet, 1998a; 1998b; Newburn & Eliot, 1999). Problematic drug use is associated with higher levels of crime due to the immersion in illegal activities and the level of acquisitive crime to finance procurement of drugs (Gossop, Marsden, Stewart, & Rolfe, 2000b)\textsuperscript{318}. Additionally criminal activity provides access to drug using subcultures where drugs are available (Hammersley, Forsyth & Lavelle, 1990).

\textit{Social Controls within drug using groups}

Not all drug users conform to the subcultural group’s established norms. Some cheat each other and dealers, steal money and drugs, break rules and transgress codes of behaviour. Lack of conformity is mainly due to lack of life structure, scarcity of drugs or money. These members violate the rules and the subculture cannot survive on negative relationships. Positive relationships and trust are essential for its survival (Faupel, 1987; Grund, 1993).

Within the drug using subculture drug users generally adopt roles to avoid detection and ensure money, procurement and administration of drugs (Des Jarlais \textit{et al.}, 1986). Zinberg (1984) suggested that two types of norms exist, formal norms of the CJS and policy makers and informal norms within the subculture. Formal norms that prohibit drug use are violated repeatedly. Informal norms teach the drug user how to minimise negative effects while maintaining the level and pattern of use. Laws tend to lose their deterrent power as drug users are not as concerned about rule breaking as staying ahead of the enforcers. Parkin and Coomber (2009) conducted research on the phenomenon of ‘\textit{Shooting galleries}’ with a sample of IV drug users in South East England. They proposed that drug users develop their own concept of social control within their subculture, where values, patterns of behaviour and rules of conduct

\textsuperscript{317} See also Des Jarlais \textit{et al.}, 1986; Murphy & Waldorf, 1991
\textsuperscript{318} See also Gossop, Marsden, Stewart & Treacy, 2001, Strang & Gossop, 1994
become ritualised\textsuperscript{319} and sanctioned\textsuperscript{320--321}. Social sanctions and rituals form the basis for formal\textsuperscript{322} and informal social controls\textsuperscript{323}. They maintained that conflict arises between the formal laws of society and informal social controls. Formal legislation aims to regulate drug use while the group approves of using. Therefore, social control contains the informal rules of the group and formal laws\textsuperscript{324} and policies of authority figures. In his research on controlled use, Zinberg (1984) proposed that sanctions delineate moderate use, mediate the social setting of drug use, limit frequency and condemn compulsive use (Parkin & Coomber, 2009). Sanctions\textsuperscript{325} aid safety by situating use in relatively secure social settings to help safeguard the experience of the user and identify potential unpleasant effects (Zinberg, 1984)\textsuperscript{326}.

When evaluating the effect of drug consumption and social controls within the drug using subculture, Zinberg (1984) emphasised the salience of drug, set and setting\textsuperscript{327}. He described set as drug users’ personal experiences of drugs, expectations of the experience, biological make up, personality traits, and mood. Setting depicts the environmental factors of the social scene. Both set and setting can minimise or maximise the experience depending on the presenting variables. The ritual of learning how to use drugs effectively to achieve maximum results stresses the importance of expectation and setting. As familiarity grows, the ritual itself adds to the experience of getting high (Zinberg, 1984)\textsuperscript{328}. The ritual includes giving assistance, say in the case of collapsed veins and injury from missing veins or inability to inject due to impaired vision (Parkin & Coomber, 2009). Setting\textsuperscript{329}, through interaction with social

\begin{itemize}
\item \textsuperscript{319} Social rituals are the prearranged patterns of behaviour of drug using. They involve procuring and administering the drug, selecting the social setting for use, deciding upon the activities undertaken after use and attempting to prevent negative drug effect. Rituals support the group and its behaviour and strengthen sanctions.
\item \textsuperscript{320} Social sanctions dictate how and when a particular drug should be used and attempt to reduce risk.
\item \textsuperscript{321} See also Zinberg, Harding & Winkeller, 1981
\item \textsuperscript{322} These formal and informal social controls apply to the use of all drugs in a variety of social settings (Harding & Zinberg, 1977).
\item \textsuperscript{323} See also Maloffet \textit{et al.} 1982; Zinberg, Harding & Winkeller, 1981
\item \textsuperscript{324} Legislation and policy reflect the principles of mainstream society, not those of the drug user (Zinberg & Harding 1977).
\item \textsuperscript{325} Sanctions include advice on when, how and with whom to use, the best way to come down and so on and vary from group to group though some rituals spread through groups
\item \textsuperscript{326} Within controlled using sanctions compartmentalise drug use and allow time for other obligations. When drug use is out of control sanctions still exist in an effort to reduce anxiety and safeguard the user who adopts these sanctions. Depending on the stage of using, sanctions are integrated into behaviour to varying degrees.
\item \textsuperscript{327} Zinberg stressed the importance of the interaction of the drug with non-drug factors, set and setting.
\item \textsuperscript{328} See also Grund, Kaplan & De Vries, 1994; Waskow, Olsson, Salzmann & Katz, 1970
\item \textsuperscript{329} Within setting, drug users are in a state of ambivalence because drug addiction itself provides a rollercoaster of punishments and rewards. The effect of the drug increases pleasure or reduces pain. The lifestyle can bring tremendous excitement. These are juxtaposed with devastating negative consequences including physical and psychological problems, difficulties with family and social circumstances and legal and financial dilemmas (Brehm & Khantzian, 1997; Mid-Atlantic Node, 2000; Moore, 1993).
\end{itemize}

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sanctions and rituals, helps drug users control their drug using\textsuperscript{330}. The classic example of the importance of expectation and the role of setting was explored in Zinberg’s (1984) study of Vietnam veterans,\textsuperscript{331} where he examined the influence of setting on drug using\textsuperscript{332}. He proposed that social controls were a mix of social sanctions relating to values and rules of conduct and social rituals which were patterns of behaviour.

\textit{Social Rituals within drug using groups}

Social rituals are the behaviour patterns that secure group socialisation\textsuperscript{333}. Rituals include procurement, mode of administration and selection of the physical environment. They control activities before, during and after use and methods adopted to minimise negative effects. Rituals serve to structure, reinforce and symbolise social sanctions (Zinberg, 1984)\textsuperscript{334}. In her work observing rituals and rules that dominate the subculture of regular cocaine and heroin users, Grund (1993) proposed that rituals are the main predictors of drug use and self-regulation of controlled users. Ritual is a highly meaningful, basic cultural interaction, revealing crucial information on the culture’s beliefs\textsuperscript{335}. Ritual\textsuperscript{336} is a predictable behaviour where the relationship between the means and the end is not intrinsic\textsuperscript{337}.

\textsuperscript{330} This theory negates the idea of the external force of drug addiction and re-empowers the drug user (Zinberg & DeLong, 1974; Zinberg, Jacobson & Harding, 1975).

\textsuperscript{331} Many of the soldiers who were addicted to heroin while on active service in Vietnam stopped their drug using on return to the U.S experiencing very few side effects of sudden abstinence.

\textsuperscript{332} Society’s tendency to overemphasise the pharmacological properties and effects of drugs leads to the under emphasis of the sociocultural factors that enhance drug using behaviour (Zinberg & Harding, 1982). The moralistic standpoint concludes that illicit drug use was not only harmful causing negative effects but also causes psychological and physiological drug addiction resulting in abstention being the preferred alternative. (McMurran, 2003; Zinberg & Harding, 1982).

\textsuperscript{333} Decorte (2000) proposed most of the control mechanisms are informal, unconscious rules often applied unknowingly. Drug users see the rules as part of themselves rather than enforced social sanctions and rituals. Some groups do not identify the rules until they are broken. Therefore rules, created and enforced in an informal way, become an integral part of the group structure (Decorte, 2000).

\textsuperscript{334} See also Grund, Kaplan & de Vires, 1994

\textsuperscript{335} Performing the ritual is a source of comfort and assurance enhancing effect, thought and emotion. It induces an alternative state of consciousness that enables actors to perform a routine outside of the everyday realm.

\textsuperscript{336} Ritual is a specific, fixed sequence of behaviour that does not allow for uncertainty (Wallace, 1966).

\textsuperscript{337} It must hold an acceptance of a value or belief that is unquestioned. It can be rational or not, include repetitive action and remain confined to limited contexts. In its rigidity and regularity it guards against arbitrary interference (Carter, 1977). Ritual performance needs at least two people present to focus their attention on the object of the ritual, to be aware of each other’s attention to the object and share a common sentiment or passion. This unity separates them from people outside the ritual (Collins, 1989).
Grund (1993) suggested that because rituals are intrinsic in the drug market place, where drug users procure their drugs, use and socialise, the market place itself becomes sub-culturally ingrained. They depend on members to participate in using and dealing networks where they acquire money making and drug taking skills and knowledge of drug distribution networks (Hall & Jefferson, 1975). Due to legal constraints, accessing these networks is problematic. There is distrust of strangers and concealment of activities. Ritual interactions distinguish drug users from non-drug users to minimise police detection (Anderson, 1999). Repeated ritual teaches efficiency, enhances readiness to perform, boosts confidence, decreases anxiety and fear, and helps members to focus on the ritual object in order to execute the ritual. Role ambiguity does not exist. Experienced members teach newcomers group rules by social and formal methods. Bonds are strengthened, intimacy is created, solidarity is reinforced (Wallace, 1966). The ritual forms a central role in the social experience of using which impacts on control. As Zinberg (1984) reported, often while one person was performing the ritual, the others watched in silent anticipation. Important functions of ritual include controlling the amount used, ensuring each dose yields the potential maximum, managing positive and negative effects and reducing secondary harms (Grund, 1993; Krivanek, 2000). Drug users see themselves as practicing harm reduction to avoid transmission of infection or risk of overdose (Rhodes et al., 2006). The ritual sequence remains free from anxiety and produces a mindset where the drug user is confident of obtaining the perfect ‘high’ (Nagendra, 1971; Wallace, 1966). In his study, Agar (1977) described in detail the ritual objects – ‘works’, drugs, the ritual sequence, the result – the ‘high’ and the significance of these for the drug user. Because of the special meaning attached to the ritual sequence, some drug users comment that the ritual sequence is almost as important as the actual ingestion.

338 Procurement of drugs carries its own skills, knowing where to buy, familiarity with prices and recognising a good, safe deal. Drug users need current information on where selling is happening and prevailing codes which can only be gained by active participation in the subcultural network. Specific rituals and codes in dealing transactions are prompted by society’s formal drug legislation.

339 See also Anderson & Ripullo, 1996; Becker, 1973; Cleckner, 1977; Grund, 1993.

340 Roles and status are defined by the group within a hierarchical structure. The cohesive mechanism of ritual quiets arguments and removes the threat of conflict or danger by promoting unity, order and harmony. Ritual prays on the collective consciousness dismissing any apprehension that may affect the group’s survival. Satisfaction is derived from membership and interaction which informs identification and self-definition. Ritual satisfies the need for social solidarity which is a fundamental human impulse (Durkheim, 1964).

341 Within drug using groups, specific rituals articulate the basic social controls, for example, who can join the group, how and when a drug should be used, how to come down from a high and so forth.

342 Drug rituals include smoking, constructing cooking pots and ‘works’, bazing and injecting – all of which add to the process of getting high.

343 See also de Jong & van Noort, 1987; Friedman, 1996; Friedman & Des Jarlais, 1987; Friedman, Des Jarlais & Sotheran, 1986; Friedman et al., 1987.
The availability of both drugs and money influence the administration ritual and add social importance. Limited availability adds to the objective importance of the drug. Scarcity alerts the collective consciousness to this objective importance and adds value to the ritual. In times of scarcity, the administration controls the management of drug use and defines social relationships within the group (Grund, Kaplan & de Vries, 1994). The social functions of drug administration rituals are illustrated in the sharing of drugs. Drug sharing provides a socialisation ritual that strengthens group cohesion. Sharing of needles and equipment is also commonplace and expected (Des Jarlais et al., 1986). Symbols of drug use are important to ritual and the separation of the drug user with mainstream society. The hypodermic needle is perhaps the most recognisable and dominant symbol of addiction to ‘hard’ drugs. Addiction defies the socially constructed use of the hypodermic needle and upsets the accepted image within the medical profession. Many drug users are aware of the symbolic significance and power of both the objects of the ritual and the sequence (Hardiman, 1998). Zinberg (1984) maintained that the drug subculture develops new rituals and sanctions along with existing ones and passes on new information in an informal manner. Therefore rituals and rules form the basis of a drug using subculture to explain the drug experience and the social world where drugs are used.

The role of women in the drug using subculture

Gender roles in addiction carry significant differences. Oliver, (1872), wrote:

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344 Rituals convey the norms of the subculture which include rules regarding relationships and appropriate behaviour. They operate to maintain the essential social structures that satisfy the drug users’ needs. Rituals determine and limit the amount of drug using and maintain a certain degree of life structure which is essential to ensure drug availability. Self-regulation of consumption demands balance and a somewhat ordered life structure (Grund, 1993; Krivanek, 2000; Wallace, 1996).

345 Sharing is a typical human interaction displayed through most human organisations.

346 The sharing ritual is subject to social control, for example, reciprocity, preventing withdrawal and helping sick drug users.

347 Without medical approval, using the hypodermic needle, as a voluntary medium to permeate the body with an illegal pollutant, is seen as a violation.

348 For some, who have been injecting in excess of twenty years, the hypodermic has become an essential part of their life structure bringing with it a sense of security and comfort.

349 See also Grund et al., 1994; Manderson, 1995.

350 Ritual actions are demonstrations of cultural values and evolve into a system of non-verbal communication.

351 Society as a whole fully adopts and encourages widespread social rituals and sanctions. Subcultural group sanctions and rituals tend to be more diverse and more closely related to the immediate environment and circumstances (Zinberg, 1984). Sub cultura lly based social controls, that is rituals and sanctions, exist within a variety of drug using settings and apply to the use of all drugs (Harding and Zinberg, 1977).
The fact that women constitute so large a proportion of opium takers is due more to moral than to physical causes. Doomed to a life of disappointment and physical and mental inaction and in the smaller more remote towns not infrequently to utter seclusion, deprived of all wholesome social diversion, it is not strange that nervous depression, with all its concomitant evils should sometimes follow – opium being discretely selected as the safest and most agreeable remedy (162-77).

Gender stereotypes dictate appropriate gender roles, behaviour and attitudes. How rule breakers are identified and treated varies between genders. Drug using women oppose traditional feminine roles and are grouped according to specific stereotypical notions. A double standard exists where women are exposed to extreme social pressure to fulfil implicitly assigned roles of upholding society’s moral and spiritual values. Female drug users do not fit the hegemonic model of good mother and carer (Hunt & Barker, 1999). The moral condemnation if a woman fails in her ‘duty’, leads to secrecy around her addiction often creating additional barriers to help seeking (Hepburn, 2002). Traditional roles perceive drug using women as sexually promiscuous, creating a double deviance which becomes a more negative stereotype (Vimpani, 2005). Ettorre, who has been researching women and addiction since the 1970s, suggested that society needs to revision their thinking about female drug users to encourage harm minimisation procedures. Ettorre (2004:333) said:

‘Revisioning’ means letting go of damaging, outdated images and ideas about drug users, while constructing ‘gender-sensitive’, embodied perceptions.

The existing stigma, along with sexism and classism plays a vital role in the social construction of drug using mothers being perceived as ‘evil’. A pregnant drug user is generally viewed with contempt as she violates the maternal image to the extent that some societies respond with
involuntary treatment (Barnard & McKeganey, 2004). The fact that the majority of pregnant drug using women experience immense guilt, remorse and shame often goes unrecorded (Carter, 2002). Women, labelled as drug users, experience less respect and care and fear that their children will be removed from their care (Boyd, 1999). Often society unfairly judges female drug users, questions their parenting abilities (Smarsh, Hogan, Myers, & Elswick, 2006) and penalises them by removing their children (Barnard & McKeganey, 2004). Motherhood is a culturally reinforcing attachment which sustains a grounding identity within chaos, and when drug using women had their children removed, children remained of critical importance. By holding on to motherhood, the woman could maintain an identity that was not overwhelmed by addiction. Recovery includes creating a new identity and recreating life as a mother.

Homeless female drug users experience additional serious problems including physical and sexual violence, especially if sleeping rough (Kearney, Murphy & Rosenbaum, 1994). They submit to the heightened chaos and accept the abnormal as normal (Woodhouse, 1992). Polydrug use indicates a high level of drug using and difficulty responding to worsening social conditions (Carrick, 2004). Their new life structure impacts profoundly on their self-image where they internalise the ‘loser’ identity. Assuming limited options for constructing new and different lives, women settle for less and often become involved in crime (Biernacki, 1986; Kearney et al., 1994) and sex work in an effort to procure drugs (Mulia, 2001). Drug using women who engage in sex work experience high levels of social sanction, isolation and poverty (Culhane, 2003), unequal treatment in services and the CJS (Koss, 2000), lack of safety, withdrawal sickness, emotional, sexual and physical abuse from boyfriends, pimps and ‘dates’ (Scheper-Hughes, 1996), infection, STIs and HIV/AIDS (O’Connell, Kerr & Li, 2005).

harassment, neglect, abandonment and victimisation (Bourdieu, 2001) and increased drug using to cope with the stress of sex work (Comas-Diaz, 1999). Assault and the disappearance of sex workers have been recorded globally (Bowen, 2006). Sex work and sexual objectification is viewed as another type of pathology involving powerlessness (Inciardi & Surrat 2001). Women experience the additional difficulty of maintaining multiple identities as sex worker, wife, mother, provider and carer (Wolffers et al., 1999).

Addictive and criminal involvement frequently stem through intimate relationships, family or friends. Intimate partners habitually introduce women to drugs and crime, becoming their suppliers. Failure to raise money by criminality or sex work, and attempts to stop using often evoke violent responses (Fals-Stewart & Kennedy, 2005). Nevertheless, many women stay with their partners despite neglect and ill treatment (Chesney-Lind, 1997). The association of criminality with female addiction seriously disturbs the norms of society. Due to economic vulnerability and lack of social interaction, drug addiction, shoplifting, fraud, property crime and sex work become the norm for the majority of female drug users where they generally have a dominant male accomplice (Bloom, 1998b). Female drug users are more likely to have criminal records and a high percentage of incarcerated women have drug using histories (Merlo & Pollock, 1995). They are automatically perceived as bad mothers while male law breakers are not automatically labelled as bad fathers (Covington, 2002). They are portrayed as incompetent and unnatural mothers who neglect their children. This inept view causes anxiety and fear within society as mothers should surely be capable of socialising the

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367 See also Cusik, 2006; Epele, 2002; George, 1998; Go et al., 2003; Gossop, Powis, Griffiths & Strang, 1995; Shrotri et al., 2003
368 See also Romero-Daza, Weeks & Singer, 2003; Vanwesenbeeck, 2001
369 See also Cler-Cunningham & Christensen, 2001; Goodyear & Cusick, 2007; Lowman, 2000
370 See also Inciardi, Lockwood & Pottinger, 1993; McCoy & Inciardi, 1995
371 Sex work supports the financial capital of the drug black markets. It maintains the survival of the drug market in several ways. Profits, for predominantly male dealers, are secured by both the clients spending their money on drugs and sex and the women using their earnings to purchase drugs. Sex workers also introduce new financial resources from clients outside the drug markets. Income from sex work is plentiful and a stable source of revenue due to the unwavering desire for sex (May et al., 2000).
372 See also Flanzer, 2000; Hegarty, Hindmarsh & Gilles, 2000; Taft, 2002.
373 The primary motivator for most women in relationships is connection not separation. Connection enhances self-worth. Caring, mutually respectful and empathic relationships produce positive psychological outcomes. Miller (1990) listed increased vitality, empowerment, knowledge of self and others, self-worth and desire for more connection as among the positive effects. Disconnection or separation leads to diminished vitality, disempowerment, confusion, diminished self-worth and rejecting further relationships.
374 See also Owen, 1998; Owen and Bloom, 1995; Pollock, 1998
375 Research on female drug users and criminal activity, discussed the notion of dysfunctional lives as well as abuse, discrimination, manipulation and exploitation (Zerai & Banks, 2002).
376 Many women use drugs as a reaction to neglect, physical or sexual abuse or violent trauma early in life
377 The vast majority were using drugs when committing offences, mostly to acquire funds to buy drugs
upcoming generation (Coll, Surrey, Buccio-Notaro & Molla, 1998). In reality, one of the more serious aspects of incarceration for women is missing the children they have lost contact with (Baunach, 1985; Bloom & Steinhart, 1993).

Illegal drug markets, generally found in marginalised, socially excluded communities (Anderson, 1999) are overwhelmingly male dominated where men hold high status roles. Few women directly sell or distribute and are generally relegated to lower positions (Anderson, 2005). The patriarchal structure allows men to dominate while women, who are subject to victimisation and exploitation, occupy marginal positions and tend to routine activities (Moore & Frazier, 2006). Behind the scenes, women support the drug dealing process and help the market flourish mainly through the sex industry. Many women supply a safe space to use or sell drugs in exchange for drugs for their own use (Klee, 1997).

Women often access the drug market through intimate partners. The importance of their participation relies on the strength of that partnership (CASA, 2003). Therefore, female participation is controlled and exploited by men. They are given the high risk, low paying jobs or are bullied into giving their profit to men (Sommers et al., 2000). However, women’s contribution is recognised as valuable if they gain a sense of identity and empowerment which allows some level of independence (McCarthy & Hagan, 2001). Anderson (2005) maintained that even though women are dominated by men, they do extend a certain power within the illicit drug market and that their contribution is central to the social and financial organisation. Women gain more independence if their partner fails to meet the increasing demand for drugs or is incarcerated (Hardesty, 1999). However, their entrenchment in the drug market causes them to fall deeper into illegal practices (Inciardi, Lockwood & Pottieger, 1993).

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378 For example, the literature supporting the moral panic over ‘crack babies’ and ‘crack baby syndrome’ excluded important variables like polydrug use, the women’s overall health, social living conditions and access to and compliance with prenatal health care (Goode & Ben-Yehuda, 1994).

379 Coll et al. (1998) - women act out with negative behaviour and resistance to authority because of the shame, guilt and remorse, concerning their maternal role, which overwhelms them. The majority struggle to be ‘good mothers’ and prioritise their children’s needs, despite life’s challenges.

380 See also Connell, 1987; Evans, Forsyth & Gauthier, 2002

381 Often these become polydrug using environments that provide an informal safety net against drug related harms like overdosing

382 See also Bourgois and Dunlap, 1993; Inciardi et al., 1993; Maher, 1997; Rosenbaum, 1981; Sommers, Baskin, & Fagan, 2000; Sterk, 1999

383 See also Cross, Johnson, Davis, & Liberty, 2001; Inciardi et al., 1993

384 Anderson’s alternative to the pathology of powerlessness debate suggests several female activities that are essential to the survival of the market. Women participate to some extent in the purchase and sale of drugs. More importantly, women, especially those collecting housing support, provide shelter and sustenance. The asset of housing adds to the overall financial resource and women continue to maintain a home despite social and legal risk.
where they use several methods for financial gain, including theft, sex work and drug trafficking (Ettorre, 1992; Fagan, 1994, 1995).

Section summary

This section examined drug users’ response to society’s unacceptability to drug using. Due to social exclusion, marginalisation and stigma the drug user seeks an environment that will prove less hostile, will accept drug using and where the role of drug user becomes the norm. This section explained how the drug using subculture offers acceptance, comfort, security, moral support and friendship which is the opposite of what is being offered from mainstream society. The drug using subculture becomes the new socially constructed world with alternative norms and values. It creates an alternative lifestyle with strong social bonds. It redefines deviant behaviour, creates an ordered social life within chaos and helps satisfy basic human needs. Social norms created within the subculture further exclude drug users so they develop their own social rituals and social controls. This section also highlighted the negative aspects of the drug using subculture where, as drug using increases, so do negative consequences associated with that use. However, within the drug using subculture, members developed their own social controls which rather than being punitive helped minimise these negative consequences and conflict between the formal laws of society and the informal social controls of the drug using subculture. Social controls are solidified by social ritual which also serve to maintain the social structures of the group, to secure group socialisation, to reduce anxiety and to attempt to perform harm reduction strategies. This section concluded with an examination of the role of women within the drug using subculture and highlighted how women, especially pregnant women or mothers, are often exposed to a double standard, experience additional negative, stereotypical assumptions emanating from their drug using. The next section explores the issue of identity.

The issue of identity

The definition of identity

The concept of identity has been variously defined (Erikson, 1968; Mead, 1934; Vygotsky, 1978). Identity is constructed and reconstructed through life’s experiences and the telling of
personal narratives which are influenced by experiences and memories (Giddens, 1991). Walters (1994:10) examined the complex relationship between addiction, recovery and identity:

‘Identity is operationally defined ... as the unique set of characteristics by which a person comes to recognize him or herself. Being both perceptual and interpersonal in nature, identity is conceived as a perception derived from image (Johnson, 1987), self (Pratkanis & Greenwald, 1985) and relational (Baldwin, 1992) schema that then merge to form an organized sense of self’.

A related term, identification, describes how an individual establishes a sense of identity. Identification forms with goals, values, people, organisations, activities and events. While identity is the individual’s sense of self, identification is how this sense is realised. Identification plays a key role across drug using careers – initial use, maintenance, cessation, abstinence and in the case of relapse.

An individual’s identity develops through their self-concept, relationships and social roles (Mead 1962 [1934]; Stryker 1980). It is both personal and interpersonal (Dindia, 2000; Mokros, 2003) and described in personal, social and relational terms. Personal identity is self-attributed where individuals have control over the expression of individual personality traits (Snow and Anderson 1987) while social identity is assigned by others (Mead 1962 [1934]). Social identity limits personal agency due to contextual social and environmental experiences. Relational identity further curtails personal agency due to minimal control over the influence of relational partners. The individual’s concept of who they are is influenced by how they relate to others (Hogg & Abrams, 1988). Identities show how individuals construct and reconstruct their lives within a wider societal context, motivate behaviour change and adopt patterns of behaviour or rituals. Identities can change depending on an individual’s social role therefore identity transformation is commonplace (Katovich, 1986).

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385 Freud (1927) and Erikson (1963) discussed personal identity and subsequent theorists examined the roles of determinants of behaviour like beliefs and motives which make up the individual (Morling & Lamoreaux, 2008) with their sense of self-determination (Chirkov, Kim, Ryan, & Kaplan, 2003; Ryan & Deci, 2000).

386 Individuals construct their personal identity to support their self-concept, while social identity comes from associations with groups, activities and social arrangements (Vryan, Adler & Adler, 2003).

387 Therefore identity is a process born out of the individual’s interaction with their social environment. The individual recognises him/herself through a set of characteristics that evolve from self (Pratkanis & Greenwald, 1985), image (Johnson, 1987) and relations (Baldwin, 1992). These blend to form a sense of self (Markus & Wurf, 1987) and continuously renegotiate personal identity.
Goffman (1959) proposed that when an individual interacts with others, s/he attempts to control the impression they imprint by manipulating aspects of the encounter, while simultaneously the receivers of the interaction are trying to obtain information about the individual. Goffman’s analysis\(^{388}\) describes the relationship between performance and life as taking place in a setting which includes a frontstage and a backstage, both of which have props directing the actor’s performance. The actor\(^{389}\) performs for the audience but also becomes the audience for his viewer’s own play. The audience observe the role playing and react to it. Goffman maintained that the social actor chooses his props, stage, costume and such depending on the demands of the situation and that adjustments are made to suit each situation. All persons involved in the interaction need to be aware of the definition of the situation and perform so as to reflect well on themselves as well as encouraging others to act in a similar fashion (Macionis & Gerber, 2010; Ritzer, 2008).

Goffman (1990a) proposed that each social interaction has three main regions where the performance is played out:

a) The front region where the actors are on stage in front of their audience. Positive, desired impressions are highlighted. Goffman (1990a) maintained the ‘front’ was made up of a setting which included the physical layout of the individual’s life and illustrated the individual’s identity, social status and occupation using scripts which confirm the expected outcomes of the role play.

b) The back region is depicted as a hidden or secret, private place where individuals can be themselves outside of their role or identity in society. They can act informally and step out of character without fear of being observed.

c) The outside region is where individual actors meet audience members independently of the team performance. Specific performances may be given when the audience is split up or fragmented (Goffman, 1990a).

Goffman (1990a:14) proposed that each interaction involves not only the information that is presented but also the information that is absorbed, that is, the impression that the individual verbally ‘gives’, and the one that they non-verbally ‘give off’\(^{390}\).

\(^{388}\) He likened this to a theatrical performance by using dramaturgical analysis (Mitchell, 1978; Welsh, 1990).

\(^{389}\) Actors tend to stay in character while being observed to ensure the correct impression is given.

\(^{390}\) Smith (2006) explained that Goffman used a dramaturgical analysis to assess whether the individual could make the audience believe the performance and accept the identity which was being projected or not.
Goffman (1990a) further proposed that the establishment of social identity was closely linked with the individual’s performance on the ‘front’ where the individual takes on a social role and communicates that role in a consistent manner. Goffman termed each individual’s “performance” as the presentation of self, that is, their effort at impression management, creating specific impressions in the minds of others.

Goffman perceived the individual as making conscious and unconscious choices on how to project the image they wish to portray, which Scheff (2006) proposed was a valuable part of Goffman’s theory. Scheff noted that Goffman included the impact of emotions within social interactions. Given that the self can be influenced by society, Scheff proposed that it followed that the self was not a fixed, determined entity. Dramaturgical theory proposed that an individual’s social identity is not a stable and independent psychological entity, but rather, it is frequently reconstructed as the person interacts with others.

Goffman explored group dynamics, using the idea of the ‘team’ where a group of individuals co-operate in their performance to communicate roles on behalf of the group. He suggested that the team ‘co-operate to present to an audience a given definition of the situation’ (1990a:231). Individuals within teams are under pressure to conform as deviance reduces credibility of the group. Conflict, dissent or difference is resolved in the backstage region to lessen any threat or damage to the group as well as the individual. This delineates a clear division between the actors and the audience, where the official group roles are visible on the ‘front’. Goffman (1963:42) stated that marginalised groups can become “discredited or discreditable groups, based on the nature of their stigma” which limits their potential to become accepted by mainstream society.

Goffman stated that most performances tend to accept and incorporate society’s values even though some individuals may not wholly adhere to those values. He proposed that some individuals ‘may privately maintain standards of behaviour which he does not personally believe in ... because of a lively belief that an unseen audience is present who will punish

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391 The individual prepares the impression that s/he wants to make, controls the performance to convince the audience of the veracity of the role assumed and presents an idealised version which is more consistent with the norms of society than his/her behaviour when not before an audience. Therefore the performance presented on the ‘front’ legitimises the social role and the setting within which it is presented. The goal of the performance is to gain acceptance from the audience resulting in the audience regarding the actor as s/he wants to be viewed.

392 Teams were generally made up of family, friends, interrelated groups, colleagues and so on and their interactions were dependent on the various settings they were involved in (Hebdige, 1979).

393 When a stigma exists, groups tend to become alienated from the rest of society which decreases their interaction with that society.
deviations from these standards’ (1990a:87). Goffman (1963) proposed that society establishes social roles and the attributes that belong to those roles. When an individual or group does not fit into these predefined roles ‘they are seen as deficient and thus attributed with a stigma’ (1990b:12). Therefore a stigma is based on social standards, outside of the individual. Goffman goes on to explore the notion of a spoiled identity where an event or situation changes an individual’s status and s/he can no longer maintain their current identity. Goffman (1963) uses the term ‘spoiled identity’ to describe those who are stigmatised and no longer considered one of the ‘normals’ of society, rendering them somehow less worthy. Goffman stressed that the stigma becomes internalised and influences an individual’s self-concept and that the individual no longer has full social acceptance and may turn to other stigmatised individuals for social support.

Included in Goffman’s understanding of the structure underlying social interaction is his work on Asylums (1961a) he coined the notion of total institutions, where individuals who entered the asylum were basically stripped of their former identity and cut off from mainstream society. Goffman observed social interactions of staff and patients in Asylums and posed the questions as to whether an asylum could provide a genuine haven against the stress of society or if they created devastating tensions for patients who were already challenged with mental health difficulties. He investigated how patients coped with the institutionalised life within the asylum and suggested they were moulded to conform and be contained within some socially approved purpose. He used the term total institution to describe how patients experienced a sense of betrayal and loss of identity as the now invalidated rules of their previous lifestyles would no longer apply, where they no longer have contact outside of the institution.

Goffman (1961a:24) proposed that once inside the asylum patients go through a series of humiliations and profanations where they are methodically, often unintentionally, mortified. Even the entry process typically causes loss and mortification, for example assessment procedures, taking life history, fingerprinting, assigning numbers and advising of rules and procedures. The inpatient is shaped and coded into an object that conforms to administrative systems and routine operations. Goffman proposed that the more the ‘civilian’ self is stripped of connections to the outside world, the more they give themselves up to the rituals and routines of conformity within the institution. Therefore, the mortification of self is exacerbated by the amount of conformity to the social arrangements within the institution and the letting go of
previous roles and rituals of life outside the institution. Physical barriers, for example high walls, barbed wire and locked doors as well as social barriers add to the sense of erosion.

One of the main features of this type of institution is that they serve the ritual function of ensuring that both staff and patients know their function and social role which institutionalises them. In the asylum many patients take on the role of good patient which renders them ‘dull, harmless and inconspicuous’ which in turn reinforces the severity of mental health issues. The patient’s notion of self changes drastically for the worse as a direct response to the debilitating atmosphere in all total institutions. Their previous roles and sense of identity are systematically eroded and their sense of self is mortified\textsuperscript{394}. Often, rather than curing the patient, they passively surrender to their situation and can no longer manage their own lives outside of the institution. Goffman called this process disculturation. Being removed from their identity and previous roles and acculturating to life within a total institution ensures that the patient will be unprepared for life outside and will remain dependent on the institution. Goffman suggested that to remove a patient from their normal life context, admitting them to a psychiatric hospital and then returning the person to their initial life context is like taking a drowning man out of a lake, teaching him how to ride a bicycle and putting him back into the lake.

Goffman believed that inmates of institutions felt that society had abandoned them and that time spent in the intuition is time wasted where it could have been better spent continuing with normal everyday life\textsuperscript{395}. Their care is handled in a bureaucratic, impersonal fashion, where a huge social distance exists between patients and staff. However, patients eventually adjust to their role and conform to the rules and rituals of the institution. Complying with and deferring to staff add to the dispossession of self as well as exposure to others that are not chosen or desired to be in close relationships with. Often when a patient cannot totally surrender a ‘will-breaking contest: an inmate who shows defiance receives immediate visible punishment, which increases until he openly ‘cries uncle’ and humbles himself’ (Goffman, 1961a:26-27) can occur. Goffman (1961a:24) added that patients experience a fundamental shift in their ‘moral career’ due to changes in how others perceive them and attitudes towards them and that there

\textsuperscript{394} Goffman added that these losses ‘are irrevocable and may be painfully experienced as such. It may not be possible to make up, at a later phase of the life cycle, the time now not spent in educational or job advancement, in courting or in rearing one’s children’ (1961a:25).

\textsuperscript{395} Through membership in a total institution, notes Goffman (p. 24), “sequential scheduling of a person’s roles, both in the life cycle and in the repeated daily round” is automatically disrupted, “since the inmate’s separation from the wider world lasts around the clock and may continue for years. Role dispossession therefore occurs.”
was an underlife in prisons and hospitals where inmates attempted to retain a sense of self and some self-respect.

Goffman concluded that the medical model of treatment was implemented in a very routine, mechanical manner which was rarely disclosed to the patient and could have been described as inhumane or even harmful. Mosher (1983) agreed saying that the process whereby patients were inducted and treated perpetuated powerless and degradation in those who should have been helped and nurtured.

*Identity construction within drug using*

The dominant discourses’ emphasis on dangerousness enhances the attraction of drug using. Similarly, the counter-productive effects of prohibition include the gratification of evading detection whilst rule breaking. These issues compound the notion of constructing an alternative identity through drug using. The ‘addict’ can be criminal, victim, patient, madman, rebel or hedonist simply by using drugs. It is important to reflect on the images evoked by the word ‘addict’. The archetypal ‘addict as Junkie’ is the IV heroin user, symbolising the images of deteriorating physical and mental health, deviance, and out of control, chaotic lifestyle. This stereotype, often represented in the media, can establish the self-construction of ‘addict’ identity. Succumbing to it becomes an extremely detrimental self-fulfilling prophecy. Acceptance or rejection of this identity is based on choice (Marlowe, 1999). Marlowe contests that society’s view of drug users’ identity includes the notions of dirt, disease and foreignness. Drug use is seen as dirty – ‘Junk’, ‘Dirty Junkie’, ‘dirty urines’ and so forth. Former drug users are described as living clean and sober and giving clean urine. Drug using is detested, aligned with people who do not wash and use drugs in disgusting settings. Booth (1999) explained the perception of opiates as dirty is found in the history of their use.

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396 Medicinal discourse describes the physical and psychological effects of drugs and defines the ‘proper use’ for some substances. Judicial discourse dictates the laws that define legal and illegal use of drugs. Legal discourse analyses judicial discourse. Identities are influenced by the ideologies of the legal, medicinal and moral models, by the use of social controls and social sanctions and the dominant anti-drug rhetoric in contemporary society.

397 The ‘War on Drugs’ is supported by the notion of removing dirt, often described as noxious or foreign. With prohibition the aspect of disease and foreignness increased by the illegal drug use by ethnic minorities.

398 When opium was still widely used for medicinal purposes only the Chinese immigrants who smoked opium held the stigma of foreignness. Administration by hypodermic syringe was viewed as cleaner and non-addictive. Impurities, not the active principle, caused addiction. It was also widely believed that avoiding oral administration lessened the chance of addiction to opiates, which still held when heroin was commercially produced and deemed less addictive than morphine.
prohibition. The ‘War on Drugs’\(^{399}\) linking drugs, disease, foreignness\(^{400}\) and deviance, contributes to the stereotype shaping the ‘addict’ identity\(^{401}\).

Although the lay person depicts identity as static, sociology and psychology view identity as hybrid and dynamic (Erikson, 1968; Mead, 1934; Vygotsky, 1978). Davies (1997) explained static identity as defined by internalised, stable and permanent characteristics. Therefore if continued drug use is acknowledged as internalised and stable, it can be inferred that this state has become permanent and part of the user’s identity. However, if identity is viewed as hybrid and dynamic, it has interchangeable components. The latter concept limits the influence of regular drug use which dominates identity as within the boundaries of the ‘Essential Addict Identity’. Davies explained this hybrid identity is a chosen identity where the use of drugs is a choice and the drug user chooses to remain addicted.

### Essential Addict Identity

The Essential Addict Identity\(^{402}\) holds that drug use affects all aspects of drug users’ lives and their identities are changed permanently. Many drug users have a hybrid identity. They acknowledge that they are drug users but maintain that they are still themselves, with the same values they held prior to drug using. While this hybrid identity is plausible, the existence of the Essential Addict Identity is doubtful. Davies (1997) proposes that the identity of the drug user is not permanently changed, but the influence of the dominant discourses\(^{403}\) reinforces the Essential Addict Identity. The drug user is viewed as being out of control and identity is irreparably changed. This transformation can explain antisocial or inappropriate behaviours in a way that lessens attribution of blame. It becomes useful to the drug user and to those who cannot understand why a person chooses drug using. However, Davies suggests that the Essential Addict Identity, in the sense of permanent and fundamental identity change, does not really exist. It is a concept which explains chosen behaviour where blame and responsibility

\(^{399}\) Wars are generally fought against dangerous, foreign powers or invaders. Drugs are equated to foreign invaders, where drug users’ have been contaminated. Those who support the invader are criminalised dealers.

\(^{400}\) If drug use was viewed as a consumer choice instead of foreign pollutant, then the ‘War on Drugs’ would become a war on drug consumers (Sontag, 2009).

\(^{401}\) The perception of deviance has developed into a fundamental component of identity. The dominant discourses of the 20\(^{th}\) Century portraying the drug user as criminal and patient influences the self-construction of ‘addict’ identity (Burroughs, 1993; Davies, 1997).

\(^{402}\) The common representation is of a dysfunctional deviant whose self-destructive, anti-social behaviour is concentrated on drug use, where nothing matters beyond procurement and administration of drugs.

\(^{403}\) The view that drug using is some external force that happens to people, brought on by the inescapable pharmacological property of the drug rather than something people choose to do.
can be reassigned. The Essential Addict Identity is a chosen identity where the drug user maintains that drug use is beyond control and not volitional. This identity can be detrimental for both the drug user and society. The willingness to comply with it and reassign blame and responsibility, instead of lessening problems tends to exacerbate them (Davies, 1997). Complying enables the drug user to justify selfish, antisocial, criminal or irresponsible behaviours and attribute them to the omnipotent drug and ‘addict’ identity therefore avoid taking responsibility (Rhodes, Singer, Bourgois, Friedman & Strathdee, 2005).

**Entangled Identity**

In contrast to the Essential Addict Identity, Strauss (1993) reflected on the emergence of a user identity. In his study there was a large discrepancy in the length of time taken for a drug-using identity to emerge. For some participants, identity transformation was gradual while for others identity changed very quickly. Entangled Identities emerged through the gradual exchange of drug-using rituals replacing those of everyday life. In their study on Entangled Identities involving twenty five participants recruited from drug detoxification programmes, recovery units post detoxification and a drug rehabilitation unit Gibson, Acquah and Robinson (2004) proposed that drug users described a sense of entangled identities where they could no longer separate their identity from their drug use. Some participants described the constant struggle between reducing withdrawal symptoms, desire to get high and the expectation of becoming ‘normal’. Gibson et al. (2004) developed the idea of Entangled Identities, where ‘entangled’ described how identity becomes unidentifiable from drug use. Their participants spoke of their recovery from addiction rather than their recovery of self.

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404 See also Burroughs, 1993; Davies, 1997; Hunt, 2004; Husak, 2002
405 Interestingly, Strauss (1993) added that some participants had no sense of self before drug using. One of his participants reported having used drugs since he was twelve years old and was trying to discover what type of person he was in recovery.
406 They understood addiction in terms of the ‘myth of addiction’ (Hammersley and Reid, 2002), where drug use can become a long lasting, if not permanent, state.
Collective identity within the drug using subculture

Relational identity influences personal expression of identity while social identity involves the wider relationships of collective identity\textsuperscript{407} (Hogg, 2006)\textsuperscript{408}. Taylor and Whittier (1992) researched collective identity in social movement communities and linked aspects of raising consciousness, building boundaries and negotiation of identity. In any community, material, relational, psychological and social resources garner collective identity and enrich the community (Carpiano, 2006)\textsuperscript{409}. Taylor and Whittier (1992) suggested collective identity mobilisation\textsuperscript{410} depends on establishing inclusion and exclusion criteria and consciousness that secures meaning for the group, ensuring the group’s identity is apparent to outsiders. Snow and Benford (1992) added the notions of punctuation\textsuperscript{411} and articulation\textsuperscript{412} which stress the importance of meaning within the group. Group members oppose negative stigma and hostility from outsiders and exclude them. They differentiate between the in-group and individuals, institutions, and agencies that are hostile, victimising, unsupportive, and oppressive. Increasing conscious awareness boosts meaning for the group, demands collective action and creates collective identity\textsuperscript{413}. Collective identity aids group cohesion, strengthens bonds, encourages engagement in rituals and practices, informs social controls and sanctions and presents a united front to communicate that identity (Hawe & Shiell, 2000)\textsuperscript{414}. Collective identity, using knowledge, relationships and shared emotions, is strengthened by familiarity and interaction (Carpiano, 2006)\textsuperscript{415}.

By identifying with the marginalised drug using subculture, individuals are perceived as outside of conventional, mainstream institutions – somewhat untouchable, which in itself is

\textsuperscript{407} As soon as an individual adopts the notion of collective identity shared representation of who one is and how one should behave s/he adopts the group’s morals, values and behaviours and is provided with the social cohesion that allows emotional commitment to that identity (Burr, 1995).

\textsuperscript{408} See also Jenkins, 2008; Tajfel & Turner, 1979

\textsuperscript{409} See also Bourdieu, 1986; Campbell & MacPhail, 2002; Hawe & Shiell, 2000; Putnam, 1993; Portes, 1998

\textsuperscript{410} Social movement theorists suggested collective identity formation is essential for community mobilisation (Melucci, 1985; Snow & McAdam, 2000).

\textsuperscript{411} Emphasising social injustices extended to the group

\textsuperscript{412} The reason for the group’s existence.

\textsuperscript{413} Members create an identity that transforms their lives to enable participation autonomous from mainstream society. They counteract effects of stigma by constructing a collective identity and build insider affiliations. Collective identity defines how individuals immerse themselves within a larger group (Brewer & Gardner, 1996; Furst & Balletto, 2012) where that identity is shaped by the culture of the group (Berger & Luckmann, 1996).

\textsuperscript{414} See also Bourdieu, 1986; Campbell & MacPhail, 2002; Carpiano, 2006; Putnam, 1993; Portes, 1998; Taylor & Whittier, 1992

\textsuperscript{415} See also Bourdieu, 1986; Campbell & MacPhail, 2002; Hawe & Shiell, 2000; Melucci, 1985; Putnam, 1993; Portes, 1998; Taylor & Whittier, 1992
attractive. Addiction researchers noted various labels for the collective identity of urban drug users like ‘dope fiends,’ ‘junkies’ ‘crack heads,’ and ‘loners’. Their collective identification as ‘other’ plays a role in the subculture’s internal identity construction (Schneider, 2008). The individual, aware that s/he is part of the group, accepts the collective identity as a symbol of belonging. Marginalised individuals seek others like themselves. Mutual acceptance enhances the sense of belonging where the common bond of drug using becomes their only means of participation (Becker, 1963). The negative characteristics imposed by stereotyping increases the strength of this common bond (Kallen, 1989). Group cohesion is enhanced further strengthening members’ bonds.

Drug users re-define stigma by using it as status. Their collective identity becomes an alternative status. By collectively challenging mainstream institutions, drug users construct their own social definitions (Wieloch, 2002) to respond to sanction, discrimination and marginalisation (Cohen, 1985; Kitsuse, 1980). Taylor and Whittier (1992) proposed that members oppose mainstream institutions by expressing difference to and criticism of them. Social practices of drug using produce strong drug using relationships and reproduce the conditions for continuing use. These practices are crucial to the construction and maintenance of identity. If a drug user stopped participating in drug using practices, this would equate to ceasing being themselves (Hammersley & Reid, 2002).

For adolescents, there are several consequences when drug use escalates. S/he moves away from mainstream peers towards the drug using subculture, bypassing the normal adolescent developmental stages to develop an immature, self-centeredness characterised by immediate gratification and impulsivity which is prevalent in the drug subcultural group. Relationships within the peer group are non-confrontational regarding antisocial behaviours. The adolescent does not successfully master normal social goals. S/he readily accepts inclusion into the subculture along with the ensuing stigmatisation and ostracism leading to alienation which

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416 See also Fiddle, 1967; Furst, Johnson, Dunlap, & Curtis, 1999; Hanson, Beschner, Walters & Bovelle, 1985; Stimson, 1973; Sutter, 1966; Waldorf, 1983
417 See also Grossberg, 1994; 1997; Thornton, 1996
418 Harre (1983) suggested two constructs of identity. The first is forming an identity that is honoured and respected in society. The second involves defending a chosen identity.
419 See also Hall & Jefferson, 1975; Melucci, 1985
420 Drug using has been assigned a distinctive currency within certain subcultures. Dropping out of society, rebelling against authority and turning to drug using lifestyle maintain the importance of the subcultural identity.
421 Members are recognised as different which further confirms their membership of a subculture and adds strength to the foundation of their newly constructed identity.
422 See also Hughes 2007; Gibson, Acquah & Robinson, 2004; Vitellone, 2004

A significant complication of collective identity is the escalation of drug use. Hendler and Stephens (1977) observed drug users move from initial heroin use to dependence through increased association with other drug users, decreased association with non-drug using peers and a growing identity as ‘street addict’. Spunt (1993) suggested that heroin users who identified as ‘street addict’ were more likely to get involved in criminality. Walters (1994) found identification with addictive behaviour led to increased involvement in it, while identification with behaviours incompatible with addiction led to reduced involvement. In their research involving twenty injecting drug users, Plumridge and Chetwynd (1999) found that young men who identified as ‘recreational users’ felt in control of their drug using and used much less than those who identified as ‘junkies’. The latter group reported ever increasing drug use with higher incidents of risk taking. Brener, Von Hippel, and Von Hippel (2012) explored the link between drug using, identity and the necessity to reconstruct a non-addict identity in recovery. They found that heroin users tended to use more, depending on how strong their drug user identity was. The escalation in drug using and associated behaviours had increasingly negative effects on social relationships outside of drug users, diminishing the strength of supportive relationships leading to further isolation.

Identity re-construction

Sociological theory has accentuated the relationship between drug use, recovery and identity (Waldorf, 1983). Borrowing from Goffman’s (1968) work on stigma and ‘spoiled identity’, recovery aids the reconstruction of this ‘spoiled identity’ which was due to the association of drug use, addiction, criminality, disease and lack of control (Radcliffe & Stevens, 2008). It can be restored but the drug user must evoke a renewed self-identity often against ‘powerful countervailing forces’ (McIntosh & McKeeganey, 2000b:81). A vital component of the process of recovery is to establish a ‘non-addict’ identity which develops through the reinterpretation

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423 The drug using identity and influence of the subculture impact on values and behaviours that are necessary to embrace to adopt a positive identity, for example, self-esteem, self-control, moral development and so forth.

424 This factor, exacerbated by social stigma, reinforces the ‘addict’ identity (Baker, 2000).

425 See also Waldorf & Biernacki, 1981

426 See also McIntosh & McKeeganey, 2001, 2000a, 2000b
of a lifestyle that no longer incorporates drug using and associated networks (McIntosh & McKeeganey, 2000). Recovery encompasses an intricate process of personal and social identity transition (Radcliffe, 2009)\textsuperscript{427}, often more dependent on socially embedded identity transition than clinical withdrawal (Hughes, 2007)\textsuperscript{428}. Some authors based this notion on cases where heavy drug users enter recovery without any treatment as their lifestyle adapts to embrace adulthood, partners and children (Biernacki, 1986)\textsuperscript{429}. Strauss (1993) explained that some drug users endeavoured to separate from their drug using self and that recovery was an arduous task involving disentangling their identity from drug use.

Labelling and stigma complicate the transition from deviant to non-deviant identity (Becker 1963). Goffman (1963) held that when one’s identity is stigmatised, one is also assumed to be deficient and ensuing discriminatory practices are perpetrated on the ‘discredited’ by the ‘normals’. Interactionists studying deviance indicated the importance identity transformation has on both the commencement and the ending of drug using (Becker, 1963; Biernacki, 1986; Ray, 1968)\textsuperscript{430}. Acquiring a deviant identity is extremely difficult to change as individuals become increasingly immersed in fulfilment of the deviant role (Goode, 1984; Schur, 1971). The majority of drug users reject the ‘Junkie’ stereotype saying that they have many social roles outside of drug using (Boeri, 2004)\textsuperscript{431}. Koski-Jannes (2002) in her study on long-term identity changes in former drug users suggested identity change involves fundamental changes in self-concept, social status, values and relationships. The initial task is to acquire a non-addict self-concept which can predict positive treatment outcomes (Kellogg, 1993)\textsuperscript{432}, whereas unsuccessful identity change can predict relapse (Holmberg, 1995). While the drug user often becomes comfortable with adapting to a ‘Junkie’ lifestyle, transformation of identity is an indispensable psychosocial component of the recovery process. Individuals who successfully create and maintain identities that are not solely focused on drug use are more likely to moderate or discontinue use (Anderson, 1996)\textsuperscript{433}. Markus and Nurlus (1986) agreed that identity is a critical component in maintaining change. Gibson et al.’s (2004) work on entangled identities suggested that the entanglement, the enmeshment between drug using

\textsuperscript{427} See also Hughes, 2007; McIntosh & McKeeganey, 2001, 2000a, 2000b
\textsuperscript{428} See also Anderson & Mott, 1998; Baker, 2000; Etherington, 2006; Gibson, Acquah, & Robinson, 2004; McIntosh & McKeeganey, 2001, 2000a, 2000b
\textsuperscript{429} See also Waldorf 1983; Winick, 1962
\textsuperscript{430} Stigmatisation associated with drug using has a profound effect on identity. The deviant identity and ensuing stigma seriously limit social participation and life chances (Clinard & Meier, 1992; Link et al., 1997).
\textsuperscript{431} See also Burris et al., 2004 Notley, 2005
\textsuperscript{432} See also Walters, 1994; Shadel, Mermelstein & Boreiil, 1996
\textsuperscript{433} See also Biernacki, 1986; Christiansen, 1999; Granfield & Cloud, 1996; Kellogg, 1993
rituals and controls, becomes part of self-concept in everyday life. Therefore recovery involves the disentanglement of these elements.

It is vitally important for drug users to construct a new, positive identity when trying to stop using and become abstinent. Abstinence requires both a new identity that differs completely from a drug using identity and one that will blend in with abstinent individuals\footnote{Many former drug users mention a cognitive transformation leading to a key turning point in their drug using careers. These turning points have significant behavioural changes including safer use, reducing use, help seeking and stopping using.} (Tebes, Irish, Vasquez & Perkins, 2004)\footnote{See also Horowitz, 1987; Flach, 1988; Rutter, 1993}. New or reconstructed identities help former drug users avoid tension in many work, family and social settings. Becoming a former drug user includes reconstruction of lives, relationships and identities (Waldorf, 1983). Recovery styles reflect diverse identity reconstructions. The extent of the drug user’s problems, the degree that the individual identifies with others in recovery and the actual recovery process all influence the new, emerging identity\footnote{Their lack of a stable identity, that is the ability to articulate their past history, adds to the self-construction of an ‘addict’ identity which is often not based on personal history and experience but on the perceived need to organise their lives (Anderson, 1993).}.

White and Kurtz (2005) put forward three types of recovery identities. Firstly, recovery neutral identities, where former drug users have resolved severe problems but who do not self-identify as drug user or as being in recovery. Secondly, recovery positive identities, where for the former drug user, the recovery status has become an integral part of their personal identities. Thirdly, recovery negative identities, where addiction and recovery status is self-acknowledged but not shared with others due shame or guilt. These identities, rather than being mutually exclusive, can form at any stage during a prolonged recovery career.

Hughes (2007) proposed two essential ingredients to successful identity change. Firstly, the drug user had to believe in their ability to change. Drug users are often pessimistic, have little sense of a positive future and find difficulty in seeing beyond negative possible selves\footnote{Klingemann’s (1992) study showed how individuals who had successfully negotiated identity transformation helped others who had similar problems and challenges.}. They need to realise that they have the capacity to change, heal and become something other than drug user\footnote{New identities become competing identities that promise happiness and meaning but also are incompatible with drug use.}. Secondly, the acknowledgement that social structures, including friendships, family, living practices and in some cases engagement with services, had to change. Initially the drug user needs to accept a new non-addict orientation (Koski-Jannes, 2002) and encourage
the public acceptance of this new, ‘non-stigmatised identity’ (Stall & Biernacki, 1986:13).
Doukas (2011) described how drug users who were prescribed methadone moved away from
chaos and embraced a more ‘normal’ lifestyle which included, working, returning to education
and taking up leisure activities. Doukas said participants, by redeeming themselves with family
and friends, boosted their self-esteem and confidence. McIntosh and McKeeganey (2000) noted
that the process of identity transformation involved making new lifestyle choices and avoiding
people associated with drug using. Their participants reported that moving away from the drug
using subculture and replacing drug using rituals with other activities were vital elements in
forming a non-addict identity. Hughes (2007:687) commented that ‘attempting to re-orient
their living and identity practices as part of a transformative project towards becoming a non-
user’ is vital. Transforming to a socially acceptable identity leads to changing self-concepts
and which often proves extremely difficult for marginalised populations who experience high
levels of social stigma (Larkin & Griffiths, 2002).

Biernacki (1986) formulated three types of identity change in former drug users, emerging
- creating a new identity, reverting - reassuming an unspoiled identity and revising - enhancing
an unspoiled identity. Emergent identities may be opposite to drug using identity, for example
from deviant to non-deviant (Anderson, 1994). Biernacki maintained that most drug users
expressed a wish to become ordinary rather than different and suggested that addiction ceases
when a person’s identity clashes with other identities uninvolved with drug use. The key to
recovery is when the person can talk about their experience and restore a sense of self by either
reawakening their former identity or establishing a new one. The emerging identity strengthens
the vow of recovery. Change and recovery typically involve removal from a drug using
subculture to a new social context that may not seem to be as rewarding, at least not at first
(Kellogg & Kreek, 2005). The promise of enjoyment and fulfilment, becoming involved in
non-drug using activities and behaviours that are related to other identities, for example, work,
family and/or religion and becoming engaged in other relationships can seem daunting at first.
As these relationships and activities are nurtured, a restructuring of identity becomes possible
(Biernacki, 1986). Holding the vision of a better future and goal setting towards a more
fulfilling lifestyle encourages the identity transformation to former drug users. Many

439 See also Gibson et al., 2004
440 See also Becker, 1963
441 See also Kellogg & Kreek, 2005; Stryker & Srpé, 1982
individuals report developing a new and more positive perception of their self-worth despite past mistakes, negative emotions and negative experiences (Tebes et al., 2004).

Successful recovery is supported and strengthened by successful identity transition. The most salient points aiding identity transformation were reported to be belief in ability to change (Gibson et al., 2004; McIntosh and McKeganey, 2000), creating new lifestyles which included employment, exercise and fitness and engaging in activities which helped move from addiction. Participants in Hughes (2007) study mentioned returning to the ‘old’ me and reorienting themselves as non-users.

Identity re-construction for women

Women and women with children have significant milestones to consider. It is essential to move away from drug using friends and practices and take on the care of their children (Klee, 2002b). However this can become socially isolating. Women missed the sense of belonging to former social networks which left a huge void that was difficult to fill (Martin, 2011). Also some women felt their former ‘junkie’ identity had shamed and discredited them (Klee, 2002b). Warr (2005) agreed with McDonald’s (1999) findings that the women in their research had severed contact with their drug using friends and partners but found difficulty negotiating relationships with non-drug users. The women who did make new friendships felt unable to reveal their past for fear of suspicion or reprisal. Hughes (2007) identified that some women missed the euphoria of drug using and the ritual, structure and meaning of a drug using lifestyle. Martin (2011) felt this ritual had disappeared with nothing to replace it. Hughes (2007:678) argued that forgoing the ritual is like stopping being oneself and the process of recovery demands ‘purposeful changes in living and identity practices,’ and ‘forging and re-forging relationships’.

McIntosh and McKeganey (2000b:189) reported that the women in their study did not glorify their drug using. They equated that period of their lives with ‘negative contexting’ reminding themselves how horrific life was and how much they could lose if they relapsed. They refused to become the ‘junkie mum’, which motivated their moving away from drug using friends,

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442 See also McIntosh & McKeganey, 2001, 2000b
443 Rejection of the past limited their ability to integrate it into their stories. It may have been more useful in terms of processing past and present lives to acknowledge this important lived experience.
maintaining abstinence, or at least reducing use. Martin (2011) in her study examining mothers’ narratives of disengaging from IV drug use, agreed that this was an extremely complex process, adding that the women’s struggle was exacerbated by continuing stigmatisation and their inability to bond with non-drug using people and groups. Many women perceived themselves as damaged and unworthy of a new status (Keane, 2000).

Pregnancy and motherhood can encourage women to engage with treatment services with some women using it as an ideal opportunity to reinvent themselves (Tobin, 2005; Taylor, 1993). Klee (2002b:268) suggested that pregnancy was the ‘most likely life event that will empower a woman to abstain’. Motherhood may motivate recovery as it enables women to re-embrace normative feminine roles (Radcliffe, 2009). However motherhood can also be a complication when attempting to restore a ‘spoiled identity’. Ettorre (2007) suggested drug using women who are pregnant or mothers are heavily stigmatised and carefully monitored by professionals in social, health and welfare arenas and that lack of engagement in treatment merits social controls from judgement to removal of their children. Fear of these social controls builds barriers to treatment and the fear of being judged as an unfit mother prevents inclusion in new social relationships (Simpson & McNulty, 2008).

Shame is a feeling of inferiority, where the individual perceives him/herself as defective or flawed (Brown, 1991). Wiechelt and Sales (2001) discussed the notion of internalised shame which was an important issue for women attempting to cease alcohol use. They indicated that a high level of shame existed within their sample which was associated with difficulty in recovery. They found that women with higher shame scores experienced more difficulty with social adjustment during recovery and reported a higher rate of relapse. Interestingly, shame scores were lower for the women who were further along in recovery.

444 Martin (2011) also suggested that the women, although they wanted to care for their children, were ambivalent about ceasing drug using which had become part of their identity.
445 See also Plumridge & Chetwynd, 1999; Vitelleone, 2004
446 Women’s identities as mother and homemaker are powerful examples of the opportunity to enhance an unspoiled identity (Anderson, 2005).
447 See also Baker, 2000; Baker & Carson, 1999; Kearney, 1996
448 See also Boyd, 1999; Ettorre, 1992; Murphy & Rosenbaum, 1999; Perry, 1979; Radcliffe, 2009; Rosenbaum, 1981; Sterk, 1999; Taylor, 1993
449 See also Appell, 1998; Boyd, 1999; Mulia, 2002; Murphy & Rosenbaum, 1999; Paltrow, 1999; Toscano, 2005; Young, 1994
450 See also Jessup, Humphries, Brinds, & Lee, 2003; McMahon, Winkle, Suchman, & Luthar, 2001; Mulia, 2002; Sword, 1999; Tobin, 2005
451 See also Tangney, Miller, Flicker & Barlow, 1996
452 Shame strongly influences sense of self and becomes part of identity where one can experience vulnerability, painful emotions, disconnection, isolation and abandonment (Kaufman, 1993).
However, internalised shame is often neglected in addiction treatment. Women remain vulnerable to painful levels of internalized shame which may intensify especially for women who have a history of child sexual abuse (Playter, 1990).

Groups labelled as deviant generally experience a high level of stigma. Some individuals capitalise on their deviant identities when transitioning to a professional career (Brown, 1991) but this does not seem applicable to sex workers. Sex workers are among the most highly stigmatised leading to their work becoming perhaps the most salient aspect of their identity. This highly genderised profession is also considered low status (Chapkis, 1997). Labelling theory suggests that the negative label afforded to sex workers easily becomes internalised (Becker 1963). Sex workers in Brown’s (1991) study were unable to use a pre-existing deviant identity to help them shift to a professional identity and role due to the negative stigma associated with a ‘spoiled identity’ (Goffman 1963). Sanders (2007) found that street sex workers, when quitting sex working, attempted somewhat successfully to evade deviant labels as they were more likely to use services to support their decision to stop sex working and leave the streets (Porter and Bonilla 2000). This engagement with services was most useful in reconstruction of identity.

*Identity reconstruction and 12-Step Programmes*

Lifestyle change is an essential component of recovery. More radical change requires more identity work. 12-Step Programmes can provide the framework to facilitate change where previously held beliefs are exchanged for recovery oriented lifestyles (Koski-Jännes, 2002). Baumeister (1991) suggested that members of 12-Step Programmes report that becoming part of something greater motivates recovery. Meaningful relationships and activities not only help prevent relapse but also motivate self-regulation. Kellogg (1993) proposed that membership of a 12-Step Programme offered new or forgotten tools which can be incorporated into daily life to create a new identity. New members model socially acceptable behaviour, process a change in self-concept and adopt a new role in helping others, all of which combine to restructure their identity into one which will prove more rewarding.

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455 See also Lawless, Kippax & Crawford, 1996; Pheterson 1996
454 They experienced high levels of physical and sexual abuse, arrests, and drug use
453 See also Alexander 1987; Arnold, Stewart & McNeese, 2000; Dalla 2000; Davis, 2000; Forbes 1993
The speed of identity change is relative to the individual. Many former drug users affiliate with positive groups (Markus & Nurlus, 1986). Some who join 12-Step Programmes reported radical conversions or spiritual awakenings where this conversion or identity transformation was an essential part of successful abstinence (Anderson, 1994). Greil and Rudy (1984) argued that members of Alcoholics Anonymous (AA) often experience radical conversion because AA and other self-help groups qualify as Identity Transformation Organisations, promoting identity conversion through re-construction of personal biographies. However, some former drug users report gradual identity change since their membership in an Identity Transformation Organisation encourages letting go of previous drug using identities.

Identity transformation involves moving from one social context to another incurring behavioural change in order to recover from destructive drug using careers (Strauss, 1962). Often this behaviour change allows the former drug user to revert to their identity prior to drug using (Anderson, 1994). Sometimes by joining a 12-Step Programme, former drug users reflect on their drug using careers and separate these from their real self. They re-define themselves as former drug user and re-identify with their past selves. Their past identity could be assumed again as it was located in a different social context and it was possible to adapt it into the new social context in which the individual is now located (Brown, 1991). Revising an unspoiled identity can be achieved by the recognition by many former drug users that while in their drug using careers, they gave negative descriptions of themselves and claimed that their drug using identity was completely fabricated. Adopted drug using identities were no longer desirable or necessary. The prior identity which could remain unspoiled became more appealing (Kellogg & Kreek, 2005).

Koski-Jannes (2002) added that addressing isolation by becoming part of a larger whole helped ground the changing social identity. Joining in to become a valuable and honourable member (Harre, 1983) conceiving a new meaning in life and discovering satisfactory alternative behaviours aided identity transformation. However members tend to hold anonymity as they

456 Bankston, Forsyth and Floyd (1981) suggest that changes to identity often occur during social movements where ‘radical conversions’ often follow from cult membership or addiction and alcoholism.
457 AA and the many 12-Step Programmes based on its principles are expanding (Putnam 2000) demonstrating the popularity of joining a new in-group.
458 See also Denzin, 1987; Greil & Rudy 1984
459 See also Anderson, 1994
460 See also Biernacki, 1986; DeFulio & Silverman, 2011; Waldorf, 1983; Wong & Silverman, 2007
fear the story of their past may interfere with their newly created social identity (Kellogg, 1993).

*Recovery versus recovered*

As different understandings of addiction and recovery emerge, there is space for former drug users to identify as recovered rather than being in a state of recovery. This identity is no longer associated with the individual being described as being in denial of the disease of addiction. Doukas and Cullen (2009) argue that the debate is essentially embedded in ideology and terminology used by former drug users. The disagreement arises from the mutually exclusive notions of recovery as an ongoing process or recovered as in mastery over a life event. Blume (1977) discussed stages of recovery. He defined an individual in recovery as in the early stages of non-drug or alcohol using whereas recovering alluded to the stage of stable readjustment where the individual had returned to a state of good health and functionality. Blume reinforced the idea of the liquidity of the recovery process which requires vigilance to sustain, but acknowledged the term recovered soothes families by implying the hope of permanent recovery. White (2000) expanded on this work highlighting that most of the disagreement over these terms is based on whether recovery is seen as an ongoing process or a life event that can be mastered. These recovery-based terms have been used interchangeably since 1860, with Harrison (cited in White, 2000) discussing residents in the Washington Home as reforming rather than reformed alcoholics. White (2000:2) has researched terminology over the years including: ‘reclaimed, redeemed, reformed, reforming, arrested, dry (drunkard), cured, sobriate (a sober inebriate), recovered, recovering, ex-(sot, drinker, alcoholic, addict).’ White (2002) suggested that the most controversial terminology included the use of the prefix ‘ex’.

The recovering versus recovered argument may have arisen from the diverse notions of the DSM IV (APA 2000) and The Big Book of Alcoholics Anonymous (AA, 1976). The DSM IV discussed the possibility of a full remission of addiction if associated behaviours do not recur within a one year period. The Big Book of Alcoholics Anonymous (AA 1976:44 and appendix) equated recovery with a spiritual awakening that caused a distinct change in personality which in turn leads to recovery. It envisaged alcoholism as an allergy. Therefore the DSM IV discussed an external behavioural change while AA suggested internal change is critical to recovery. The DSM IV discussed the championing of addiction while AA implied the allergic reaction created by the substance will remain with the individual. Reith (2004) discussed AA’s
notion of the potential alcoholic where an individual so described can relapse at any given time. Reith proposed that the message that an individual could relapse even after years of sobriety was stigmatising, a constant reminder of former addiction requiring equally constant monitoring and questioned the term ‘recovered’. He questioned the usefulness of the association with groups like AA, NA, and GA, whose essential philosophy held with the ‘identification with essential 'addict identity' that is fixed and unchanging ... based on an incurable disease’ (Reith 2004:292-93). Hughes (2007) proposed that during identity transformation, the individual becomes a non-drug user and untangles his/her identity by embracing a non-using lifestyle. This individual, after a long period of sobriety, should be able to identify as recovered.

**Barriers to reconstruction of identity**

Deviant identities require radical change to combat barriers including vocabulary, social settings, roles and relationships, (Biernacki, 1986; Koski-Jannes, 2002). Individuals have to assimilate and accommodate new social settings, behaviours and language, enabling them to feel a sense of normality to facilitate fitting in with their new social relations (Treloar, Fraser, & Valentine, 2007)\(^{461}\). Kellogg (1993) valued the importance of social validation and social acceptance of the transformed identity. However, some individuals still felt a sense of rejection because of the strength of stigma and the belief in the ‘once an addict always an addict’ dogma. Kellogg acknowledged that this stigma is often sustained within the addiction treatment services. Doukas (2011) proposed that the resolution of identity issues and the ensuing identity transformation could prove challenging. Not only does the former drug user have to cope with societal stigma but they have to discover their new lifestyle as a non-user.

**Section summary**

This section opened with a definition of identity and described Goffman’s notion of how individuals present themselves in everyday life and his idea that stigma influences identity. It introduced the idea of non-conformity with acceptable pre-defined roles in society and the ensuing construction of an alternative identity within the drug using subculture. This section

\(^{461}\) See also Waldorf and Biernacki, 1981
examined contemporary notions of identity within the drug using subculture including collective identity. The value of adopting or constructing an ‘addict’ identity was investigated including the positive and negative effects of identifying as a drug user individually and within a group. This section also presented the difficulties associated with identity construction and reconstruction as well as highlighting additional complications for women. The situation for women can be more complex due to gender differences, pregnancy, motherhood and sex working. An examination of the 12-Step programmes showed that these programmes could provide a framework that facilitates identity change. This section concluded with mention of barriers to successful identity reconstruction. The next section presents an overview of treatment services and demonstrates how treatment can assist identity transformation.

**Overview of treatment and recovery supports**

In the US, White and Kelly (2011) suggested from listening to the lived experience of drug users, that addiction tends to be chronic rather than short term, yet most treatment services offer an acute service, with and without aftercare, rather than a long term response which may be more suitable. They maintain that current treatment services can ably manage crises and stabilise symptoms but offer little in the way of long term support. The most common response from drug users has been a short remission, followed by several periods of relapse and readmission to services. They also suggest that if treatment strategies really believed in the notion of ‘chronic, relapsing disorder’, they would have designed a much more robust treatment support system. Therefore they suggest that there is a need to expand the quality of support offered to drug users who want to stop using drugs.

In the US there are approximately 14,000 treatment programmes working with approximately two million individuals at a cost of eleven billion dollars annually\(^{(462)}\). These incorporate diverse settings, levels of care and models of treatment but mostly share the principles of an acute care intervention which has guided addiction treatment. This is generally a ‘single episode of self-contained and unlinked intervention focused on symptom reduction and delivered within a short time-frame’ (Kelly & White, 2011:1). Treatment effects are often short-lived and many drug users join a rollercoaster of treatment, abstinence, relapse and readmission which can

continue for years. Kelly and White suggested it is not only ill-advised but also unethical to promise long-term recovery after short-term intervention. They listed the components of the typical addiction service which included assessment, intervention focussed on elimination of symptoms and a short period of aftercare and argued that addiction services tend to overemphasise the long-term recovery benefit of a short episode of treatment. Generally individuals ‘graduate’ to great applause and are released unsupported back to their lives. White (2002:2006) maintained that this acute care model is being challenged and that the notion of a more sustained recovery management system should be put in place. This concept is supported by professionals for a number of reasons. Some professionals suggest that addiction treatment should be linked to a more enduring model of personal recovery involving family and community networks, while in effect many services operate in isolation with little or no cross referral to other agencies (White, 2006). Professionals have also commented that some programmes are more concerned with financial gain, administration and regulation than treatment outcome (White, 2002). A number of authors have proposed that the addiction services are no longer functioning effectively and change needs to happen (Miller, 2007)\textsuperscript{463}. This notion is supported by the fact that a growing number of drug users relapse and are readmitted to services after a relatively short space of time at great financial and emotional costs (Scott, Foss & Dennis, 2005). Many individuals are not offered ongoing support or aftercare and only come to the attention of treatment providers after relapse\textsuperscript{464} (Kelly & White, 2011).

\textit{Recovery capital}

Best and Laudet (2010) claimed that the field of addiction has many references to ‘recovery’ and that treatment providers are increasingly becoming ‘recovery-focused’. However there exists a confusion as to what exactly recovery is and how it is achieved. Professionals have limited knowledge of what enables recovery or when recovery happens and is sustainable. Best and Laudet acknowledged that recovery can occur with or without professional help and when professional help is involved, the extent and role of that help is unclear.

\textsuperscript{463} See also Dennis, Scott, Funk & Foss, 2005; Moos, 2003
\textsuperscript{464} Due to the high rate of relapse after treatment, many individuals find treatment is not a once off event but experience several types of treatment over an extended period of time (Hser, Longshore & Anglin, 2007).
Recovery capital as defined by the UK Drug Policy Commission (2008:6) is:

‘Voluntarily sustained control over substance use which maximises health and wellbeing and participation in the rights, roles and responsibilities of society’.

Recovery capital encompasses the quantity and quality of internal and external resources that can be mobilised to initiate and sustain recovery from addiction. Robust recovery capital is vital as personal change does not occur in a vacuum. It is influenced by the social setting that can either encourage or discourage recovery. Resources developed through social interaction and social relationships add to recovery capital. Personal and social resources help sustain recovery (Scott, Foss, & Dennis, 2002). Cloud and Granfield (2001) found that individuals who achieved sustained recovery without treatment had a strong network of recovery capital including recovery oriented peers and family, good jobs and enhanced coping skills.

Laudet and White (2008) conducted a study with 312 individuals in recovery from crack and heroin. Their participants, mostly New York inner-city, ethnic minority members, were interviewed twice at a one-year interval in between April 2003 and April 2005. They suggested that most studies concentrate on treatment outcome rather than recovery support. As the journey to recovery is both challenging and stressful, Laudet and White’s study concentrated on recovery capital, primarily social supports, spirituality, religiousness, life meaning, and 12-step affiliation, all of which they maintained, enhanced both the ability to cope with stress and life satisfaction. Laudet and White put forward the notion that the higher the level of recovery capital prospectively, the better prediction for sustained recovery, higher quality of life and lower stress. They also investigated the variance of effects of recovery capital at various stages of recovery. They concluded that different strengths and types of recovery capital were salient at different recovery stages. Cloud and Granfield (2008) examined the personal and social resources that an individual can access in order to support them when trying to stop drug using. They discussed the concept of negative recovery capital which were aspects that could prevent or hinder successful recovery like lack of access to treatment programmes and lack of personal and social resources. They concluded that access to large amounts of positive recovery capital improves the chance of sustaining recovery.
Many drug users have lengthy careers in drug using and are described as having a ‘chronic’ dependence on drugs and alcohol. If addiction is considered as a ‘chronic relapsing disorder’, then ideally, treatment programmes and interventions should embrace this notion. It has to be acknowledged that not all drug users relapse, nor do they all need intense treatment and monitoring. Many individuals recover without any treatment and maintain long term recovery without professional support or monitoring (White & McLellan, 2008). However, most individuals require varying levels of ongoing support.

In Ireland, drug addiction treatment and rehabilitation services are provided by a diverse network of publicly-funded agencies and private treatment centres. Publically-funded agencies include the Health Service Executive (HSE), community-based GPs and pharmacies under contract to the HSE, community and voluntary groups and the CJS. Local and regional drugs task forces plan and coordinate a range of services. The National Drugs Strategy 2001-2008 set out two main objectives for drug addiction treatment and rehabilitation services. Firstly, to facilitate drug users to avail of treatment with a view to improve overall health and well-being and ultimately, lead to a drug-free lifestyle. The second objective was concerned with harm reduction strategies which included methadone maintenance. At the end of 2007 more than 8,000 individuals were receiving methadone treatment (Comptroller and Auditor General Special Report, 2009). Currently there are 9,615.

This present study is concerned with individuals who are striving towards drug free-lifestyles. The majority of programmes and interventions in Ireland which promote abstinence tend to focus on acute care rather than long term support where individuals attend brief episodes of care with short term aftercare generally delivered on a weekly basis after treatment. The rehabilitation programmes offered by treatment providers use diverse approaches including therapeutic communities, 12-Step Programmes, Community Reinforcement Approaches, Mindfulness and cognitive behavioural therapy. Programmes last from four weeks to seven months. Most residential programmes include aftercare support for up to two years after

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465 Often they go through multiple treatment programmes and interventions and have multiple relapses before finding stability in recovery.

466 The Department of Community, Rural and Gaeltacht Affairs had responsibility for co-ordinating the implementation of the National Drugs Strategy 2001 – 2008, Building on Experience. The Strategy, which was launched in May 2001, was the result of a request by the Cabinet Committee on Social Inclusion for a review of the national drug strategy.

467 There were 9,615 patients receiving opioid substitution treatment as at the end of January 2014 according to the National Drug Treatment Centre Central Treatment List.
completion of the programme (Comptroller and Auditor General Special Report, 2009). Smyth et al. (2005) suggest that higher abstinence rates are recorded for drug users who complete residential programmes and attend aftercare for at least six months. However, drop-out rates are recorded as high and the uptake of aftercare is recorded as low (Gossop, Marsden, Stewart & Kidd, 2003). Studies indicate that both the rate of drop out and lack of uptake of aftercare severely limit the chance of maintaining abstinence (Velde, Schaap & Land, 1998). For example, a study conducted by Lincolnshire County Council (2013) stated that two-thirds of treatment dropouts occur within the first six months, which accounts for 96% of unplanned exits. The report also stated that there was a limited uptake of aftercare.

Ireland has a two-tier system of addiction treatment—public and private, both of which have in-patient and out-patient services. One of the largest providers of public, residential treatment is the Cuan Mhuire network. Cuan Mhuire in Athy and Brúee in Limerick are covered by health insurance while the other Cuan Mhuire residential facilities are partially funded by the HSE and clients pay approximately €140 per week, generally from their social welfare payment. Coolmine TC is also a public provision where clients pay a percentage of their social welfare payment. An example of private provision is the residential service in St. John of God’s Hospital which costs approximately €600 per day for a 28-day programme and endorses a programme of holistic care. Ireland also has private provision by centres that have adopted the Minnesota Model of treatment, for example, the Rutland Centre at €11,500 for 28 days or Aiséiri at €6,804 for 28 days. Treatment methodologies have evolved over

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468 The programme consists of a twelve-week residential treatment which includes two weeks of detoxification, if required, and two years of weekly aftercare.
469 The Cuan Mhuire centres, founded by Sr. Consilio in 1966, are Ireland’s largest voluntary providers of treatment and rehabilitation for drug users. To date over 75,000 people have been treated. The nationwide centres in counties Limerick, Cork, Kildare, Galway and Down have the capacity for 600.
470 The therapeutic community model is a treatment and rehabilitation approach where clients live in small structured drug-free communities working towards drug-free lifestyles. The treatment approach is based on peer support, offering a holistic approach to dealing with addiction. The residential period is six months with a further six months of weekly aftercare.
471 The programme in St. John of God’s Hospital, Stillorgan, Dublin offers a 28-day residential programme based on a holistic philosophy and a one-year weekly aftercare programme.
472 Both Rutland and Aiséiri have 28-day residential programmes with a two-year weekly aftercare programme.
473 The Rutland Centre, based in south Dublin, was founded in 1978. It is a private addiction rehabilitation centre. The residential programme is drug free, involving a multidisciplinary team to support the individual to become free from addictive substances and behaviours.
474 Aiséiri has four centres in Ireland. Along with a drug-free philosophy and 12-Step treatment programme, Aiséiri runs family-oriented day and residential programmes.
475 Costs for private services can be covered by private health insurance.
time. Several treatment services, for example the Rutland Centre and Aiséiri incorporate 12-Step programmes into their delivery.

12-Step programmes

The American Temperance Movement began in 1825 and continued throughout Prohibition. Although self-help was not the ethos, some reformed alcoholics used the Temperance Movement as a self-help group. In 1840 six reformed alcoholics began the Washingtonian Temperance Movement with self-help as its core ethos and leaders and members were reformed alcoholics. Recovery was based on attendance and abstinence\textsuperscript{476}. AA originated in Akron, Ohio in the US in 1935. It built on the most successful elements of the previous movements and developed the Twelve Traditions\textsuperscript{477} to help manage outside influences like religion, politics, media and press. NA was founded in the early 1950s, adopted the AA approach and adjusted it to suit narcotic use.

New alcohol treatment services began in the 1940s and 1950s to deal with the fallout of increased alcoholism following the end of Prohibition. There were three main responses within addiction services to this problem of alcoholism. In Minnesota, Pioneer House, Hazelden and the Willmar State Hospital formed the Minnesota Model where staff included individuals in recovery. Patients were expected to attend AA during their in-patient stay, embrace a number of the 12 Steps and continue allegiance to AA post discharge. The California Social Model has a similar connection with AA and only recruited former alcoholics as staff members. The Therapeutic Community\textsuperscript{478} also recruited staff in recovery but initially avoided the 12-Step philosophy (Borkman, Kaskutas & Owen, 2007). Many treatment models in contemporary times follow the pioneering models of the 1940s and 1950s. However most tend to advocate for attendance at 12-Step meetings after discharge. Due to restrictions of treatment intensity and duration and a lack of funding for long-term aftercare, 12-Step programmes can become a

\textsuperscript{476} Other ‘moderation societies’ appeared over the next fifty years (Blumberg and Pittman, 1991). 1906 saw the beginning of the Emmanuel Movement which was a spiritual group that that worked through therapy towards full self disclosure and total abstinence. In 1908 the Oxford Group was founded. It also espoused self disclosure but also the principles of restitution and altruism for other alcoholics. Simultaneously the Salvation Army had been working with alcoholics since 1880. Their main objective, apart from feeding and clothing the homeless, endeavoured to bring abstention and religion to them (McKinley, 1986). These programmes initiated the ideal of recovery for those struggling with addiction.

\textsuperscript{477} The traditions outlined a primary purpose of carrying the message to the still suffering alcoholic and prohibited taking any leadership, political, legal or religious role that would distract from this (AA, 1957).

\textsuperscript{478} In 1958 Charles Dederich founded the Synanon therapeutic Community where the residents were narcotic users and became a long term residential model.
free and readily available long-term support mechanism. Participation is peer led, focused on positive behaviour change, encourages personal responsibility for recovery and supports attendance at social events and activities associated with the programme (Schmidt & Weisner, 1993).

The 12-Step movement has spread internationally to 134 countries and was adapted up to 200 times to address problems other than alcohol to include other substances like cocaine and behavioural addictions like gambling and food addiction (Morgan, 1981). A 2000 survey found there are 3,300 meetings per week in the UK and 97,000 meetings worldwide. Membership in the UK stands at 40-50,000 and worldwide figures are just over 2 million. Literature is available in many languages, braille, sign-language, audio and other formats (AA members survey 2000 Alcoholics Anonymous). There are approximately 850 AA groups in Ireland with approximately 12,000 members479. The resource of 12-Step programmes is free and widely available, flexible and supportive, can be used in conjunction with a range of other therapies and treatment options and is available when many other agencies are not, for example, out of hours, holidays and such.

12-Step programmes, closely linked with the disease model, believe individuals have lost control over their addiction and have a lifelong vulnerability to relapse. Addiction can be arrested but never cured. Abstinence is the only response to this potentially fatal condition (Petersen & McBride, 2009). The 12-Step approach encompasses the use of a new social network of support and the informal use of several therapies and has been indicated to address addiction with relative success. CBT techniques are mirrored in the use of slogans for purposes of affirmation and changes in cognitive thinking. Carl Rogers’ (1951) person centred approach is reflected in the philosophy of non-judgemental helping and support. Social Learning Theory (Bandura, 1977) is exhibited in peer support from other members, positive role models and sponsors, who show positive, rewarding outcomes within the sober lifestyle. The success of these positive role models shows the newcomer that change is possible and all members have the ability to change. Newcomers respect and value successful role models and in turn want to be respected and valued (Azjen & Fishbein, 1980).

Evidence based research outlining the ‘success’ of 12-Step programmes is difficult to obtain due to the basic principle of anonymity. However, the growth in the uptake of membership could be seen as self-evident. Miller (1995) found that most treatment methods are equally

479 http://www.alcoholicsanonymous.ie/Information-on-AA
effective in the short-term but 12-Step programmes have a better long term outcome. Chappel and DuPont (1999) reviewed a number of studies including Humphreys, Moos and Cohen’s 1997 study which was an eight year follow up of 628 previously untreated alcoholics. Their findings indicated that the number of AA meetings attended in the first three years was a predictor of sustained abstinence, lower rates of depression and higher rates of satisfying social relationships. The Project MATCH study of drinking outcomes (1997) found 12-Step facilitation was equally as effective as Cognitive Behavioural Therapy (CBT) or Motivational Enhancement Therapy (MET). Christo (1999) conducted research on individuals who did and did not attend NA post treatment. NA attendance was positively related to less drug using and less occurrence of relapse.

12-Step programme participation can become an integral part of the support system for the former drug user. It offers safe settings for individuals to explore their emotions, disclose their narrative and improve their communication skills. There are connected by social and spiritual activities that help foster well-being and inclusion. The programme is goal directed, peer led and abstinence oriented. It is associated with a shared ideology that supports identification, guiding principles for change, higher likelihood of long-term remission and stable recovery (Atkins & Hawdon, 2007). The emphasis on spirituality can promote new meaning, hope and a sense of purpose (Magura, 2008). Practical skills include drug using and relapse avoidance as well as tips on how to enjoy sober living and address life’s challenges. Members have sponsors to guide them, 12-Step friends to socialise with and an abstinence oriented goal to strive for (Kelly, 2003). Helping and guiding others, especially new comers, becomes a critical aspect of 12-Step participation. Helping performs the role of improving self-efficacy and commitment to staying abstinent, increases the sense of purpose and strengthens the sponsor network within the programme. Sobell and Sobell (2000) and McKay (2001) researched the usefulness of helping within the 12-Step programme. They agreed that helping activity increased self-esteem and peer bonding and members who helped others were more likely to achieve lasting abstinence.

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12-Step programmes are organised by drug of choice, for example, Cocaine Anonymous, Alcoholics Anonymous and so on and new members can easily identify with like-minded peers. The identities of new members are often so enmeshed with their drug of choice that seeing this reflected in others helps with feelings of inclusion and security.
Family and other social supports

Historically research focussed on the wives of ‘alcoholics’ in an attempt to explain why their husbands were drinking so much, which was founded on the idea of blaming negative traits of female spouses as a factor exacerbating male alcohol use, therefore reducing the wives’ pathology would subsequently reduce the husbands’ alcohol intake (Orford, 1994). This thinking has changed dramatically in recent decades. Vetere (1998) suggested that family and couples interventions should be included in treatment services. Vellerman (2000) recognised that family members suffer biopsychosocial stresses coping within the environment of drug using and these stresses negatively affect their physical and mental health.

Services for families and friends have not kept pace with the services provided for the drug user (Robinson & Hassall, 2000). Although there is growing provision for families, this is still a neglected area within drug treatment service provision. Only in recent decades has the family has been considered with something near equal status as the drug user mainly due to the publication of the Al-Anon Family Groups in 1955, closely followed by the foundation of Alateen in 1957 (Brown, 1985). Interventions typically fall under the headings of family therapies, co-operative counselling, community reinforcement approaches, stress coping supports, family and social network supports and family 12-Step programmes (Peterson & McBride, 2009). Brown (1994) maintained that family recovery is a process that can take years rather than weeks or months. She stated that families that adjusted to worsening conditions during drug using often reach breaking-point in early recovery where crises in close relationships frequently occur. The toxicity that developed in relationships during drug using needs to be stabilised in recovery. Fernandez, Begley and Marlatt (2006) stated that family 12-Step programmes help family members, who have been affected by a member’s drug using, to become independent and increase their own sense of well-being and self-esteem. Strong support from spouses, close family members and friends who also help with supervision and goal setting for former drug users is associated with lessened drug using and longer periods of abstinence leading to stable recovery. Moos, Finney and Cronkite (1990), in a long-term follow up study, found individuals with supportive spouses and a strong, cohesive family were more likely to gain abstinence. Tracy, Kelly and Moos (2005) studied intimate partner relationships. They found that individuals who remained in their relationship were more likely to maintain abstinence than those who separated within the year. They suggested abstinence success was

481 For example Nar-Anon, Al-Anon and Alateen
due to the close bond and monitoring within a stable relationship. Marital status and the involvement of a family member or partner in the treatment leads to significantly more positive outcomes (Beattie, 2001). These studies highlighted the importance of goal setting, monitoring and supervision supported by family, friends, work colleagues and social support networks. Social participation and engagement in rewarding non-drug using activities predict long-term recovery. Stable recovery is enhanced by employment, recreational activities that do not involve drug using and enjoyment of hobbies. Individuals tend to enjoy the long-term rewards of conventional activities rather than the short-term rewards of drug using (Moos et al., 1990).

Support for families in Ireland is twofold, coming from a diverse range of sources. The website www.drugs.ie which provides drugs and alcohol information and support relates that:

*Community Alcohol Services and Community Drug Services are run by many Health Boards and are generally free. Many provide support and information for families to maintain their dignity and sanity when a family member is abusing drugs or alcohol.*

The website lists support for family members for their own issues with a loved one’s drug using and mechanisms to help support that loved one. Citywide has developed a network of family support groups which have helped many families deal with the challenge of addiction. In-patient and out-patient treatment providers often run concurrent programmes for family members. Counselling services are offered by the Irish Association of Alcohol and Addiction Counsellors (IAAAC) and by the Irish Association for Counselling and Psychotherapy (IACP).

*Relapse and Relapse prevention strategies*

According to the medical model, addiction is fuelled by a strong compulsion to engage in the behaviour and impaired capacity to control it, thus causing tremendous difficulty in remaining abstinent (Gossop, 1989). Where frequently it is relatively unproblematic to stop, it is extremely challenging to stay ‘clean’. Therefore for many individuals, relapse is recurrent and can become a chronic battle. It is estimated that between 50-70% of individuals relapse within

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482 Citywide promotes and supports a community development approach to facing the challenges presented to drug users, their families and communities. Citywide promotes the development of family support groups and networks throughout Ireland. It raises awareness of the difficulties and challenges presented to families who are coping with family members’ drug use. It recognises the vital role of the family in supporting members to cease drug using. Citywide have published an information pack for families - Citywide (2004), Citywide Family Support Network resource pack: a handbook for families dealing with drug use. Citywide, Dublin
the first year after treatment. Most relapse within the first three months (Hser, Grella, Chou & Anglin, 1998). Between 20-25% will be re-admitted to a treatment facility within the first year and 50% within two to five years (Simpson et al., 1999).

Relapse Prevention refers to a suite of interventions primarily aimed at changing maladaptive behaviour patterns that cause the drug user to relapse (Marlatt & Gordon, 1985). Marlatt and Gordon proposed that the purpose of Relapse Prevention is twofold. Firstly, it aims to prevent a relapse in the first instance and secondly, to prevent a relapse returning to full blown drug using again. They put forward a series of responses to relapse which included CBT, Social Learning Theory and elements of social and cognitive psychology. The key elements in Relapse Prevention interventions include assessment of high risk situations: that is, triggers and cues, developing self-monitoring and coping strategies if these emerge and ensuring planned escape routes are available.

McAuliffe (1990) found that recipients of Relapse Prevention strategies post treatment had higher abstinence rates, less involvement in criminality and higher employment records than those who did not engage with Relapse Prevention strategies. Carroll, Rounsaville and Gawin, (1991) and Rawson, Obert, McKann and Marinelli-Casey (1993) reviewed Relapse Prevention as a standalone treatment and within a combination of treatments and found that Relapse Prevention worked more efficiently when combined with other therapies. Carroll (1996) reviewed twenty four clinical trials of Relapse Prevention and suggested that Relapse Prevention supported former drug users more than no treatment. However, as is often the case with addiction treatment, whereas some treatment is better than none, no particular treatment method is superior to any other.

Many authors dislike the idea of addiction being termed as a ‘chronic relapsing condition’, for example Brown (1998), who maintained this relapsing disorder element of addiction is supporting a pessimistic view of inability to change. However Relapse Prevention has moved the thinking around relapse from a blameworthy non-conformity with treatment to a process which can be anticipated and addressed which helps clinicians target problem areas with clients (Gossop et al., 1997).
Section summary

This section opened with an overview of treatment and support available to drug users and an assessment of the indispensable nature of recovery capital[483] which is essential to sustain abstinence. The overview of treatment services examined in-patient and out-patient services which are provided either by public or private financial arrangements. The lack of uptake of aftercare was noted as a concern. Next follows an assessment of 12-Step programmes and family and other social supports. It was opined that strong family and social support enhances recovery for both the drug user and their families. The section closed with mention of the relapse prevention strategies which also proved an essential support to sustained recovery.

Chapter Summary

This chapter presented relevant literature relating to the challenge of addiction. It considered evidence of the difficulty regarding definition and theoretical foundation and traced the historical account of increased drug use globally. This increased use led to the War on Drugs and various strategies of control, classification and sanction adopted to curb the use of drugs. However, these strategies encouraged a thriving black market and organised drug trade.

This chapter also reviewed research regarding notions of addiction which remain deeply contested as do methods of treatment or punishment. Historically addiction is perceived through discrete lenses which lead to diametrically opposed responses. The moralistic view perceives drug using as bad or evil and users are possessed by evil spirits. The medical view treats the hopeless victim of the disease of addiction as non-treatment inevitably leads to physical horror or death. The legal viewpoint discusses criminality and deviance. Media representation concentrates on public nuisance and stories of danger, devastating consequences for society and the drug user which instil fear in the general public. Society is unsure whether to choose the view of hopeless patient in need of treatment or dangerous criminal in need of sanction.

This chapter examined the social construction of reality which lead to discourse regarding the social construction of addiction and of deviance. It appraised research on the concept that the social construction of addiction can lead to labelling, stigma, marginalisation and social

[483] Recovery capital is the extent of internal and external resources an individual can rely on to support recovery.
exclusion. The drug user deviates from the norm, is non-conforming and a threat to social order. The role of the drug user is unacceptable within normal roles in society. Drug using becomes a secret occupation and the drug user is seen as an outsider, patient or rule breaker. The paradox exists whether drug use is deviance or a medical problem.

The literature reviewed in this chapter suggests drug use is associated with squalid neighbourhoods, public nuisance, crime, illegal drug markets, poverty, disease, urban decay, sex working and horrific social conditions. Individuals who choose to enjoy drug using are perceived as dangerous and are blamed for vice, crime and social disorder. On the other hand, the ‘drugs as disease’ paradigm views addiction as contagious, where infection can spread to the wider population. Addiction spirals out of control and drug users are contaminated by disease and dirt due to the complication of mental and physical illness which becomes part of the ‘impossible to quit’ myth. The negative stereotypical image of the ‘Junkie’ encourages stigma. Drug users have little opportunity to challenge this notion.

This chapter further reviewed evidence suggesting labelling and stigma have negative implications in terms of social relations and identity by decreasing life’s chances and opportunities, hindering abstinence success and may encourage relapse which is often deemed failure. Stigma and negative terminology aimed at drug users lead to unfavourable treatment and social exclusion, limiting the freedom to achieve and minimising the chances of legal employment.

This chapter evaluated evidence that drug users often respond to social stigma by forming their own organised, functional drug using subcultural group with their own social controls, rituals and sanctions. The deviant identity becomes a self-fulfilling prophecy. This subculture is part of a collective response to negative stereotyping. It provides comfort, security, friendship, peer acceptance and a sense of belonging. New norms and values which facilitate continuing drug use create an ordered lifestyle within chaos and attempt to regulate life. Membership has consequences like increase in drug using, risk, mental health and physical health complications. Individuals become immersed in a black market economy which provides their basic human needs. It becomes extremely difficult to move away from this lifestyle. This chapter also reviewed the role of women within the drug using subculture, where women, especially pregnant women or mothers, are doubly stigmatised. Female criminality and sex work violates the maternal image. Women coming into recovery reported high levels of shame and difficulty relating to their past drug using behaviours.
This chapter conducted a review of literature on identity and examined how drug users experienced identity change before, during and after drug using. It examined notions of the Essential Addict Identity, Entangled Identities and collective identity. A drug using identity is useful while drug using but causes complications when an individual tries to stop using. This chapter reviewed evidence of identity reconstruction in recovery and the treatments and supports that enhanced that transition. Restoring a spoiled identity necessitates removal from the drug using subculture which can be very lonely and isolating. Former drug users experience difficulty when trying to socially interact with non-drug using groups due to rejection based on the strength of the stigma imposed. However lifestyle change is essential to maintain recovery.

This chapter also examined the idea of support and treatment that is available for drug users who choose to stop drug using. Treatment programmes, 12-Step programmes and family support can be useful to strengthen motivation to stop, help move from drug using to a non-drug using social network and encourage identity transition. Research shows that drug users often avail of several treatment programmes and most need on-going support and relapse prevention strategies to assist them maintain abstinence. Recovery capital was included in this review of literature, which provides robust support and help with identity transition from drug user to former drug user.

Having conducted a thorough review of literature this chapter concludes with an introduction to Chapter Three. The approaches to research reviewed in this chapter have informed the next chapter. Chapter Three describes the theoretical framework underlying this present study, the methodology employed to conduct it, the rationale behind the methodological design and an outline of the participants involved in this study.
Chapter 3 Methodology

Introduction

This chapter describes how the aims and objectives of this research were achieved. It outlines the theoretical, methodological and paradigmatic influences, the research strategy and epistemological considerations and the research method along with the rationale for employing it. It outlines the recruitment of participants, sampling strategy, access to participants and ethical considerations. It also discusses the data gathering interview process and analytical approaches employed.

Research aims

This thesis focusses on an exploration of identity construction and reconstruction from the perspectives of former drug users. It investigates mainstream society’s perception of the drug user and the ensuing impact on drug users’ identity. It presents the former drug users’ subjective perception of their identity construction and reconstruction across their non-drug using to drug using to current non-drug using careers. It explores how they negotiated these states, examines what problems and issues arose for them and what supports, if any, they utilised. It also explores the efficacy of strategies, supports and treatments employed by the participants while reconstructing their identities. This research also examines how the participants understood the process of identity reconstruction, if they recognised that they were engaged in this process and what, if any, barriers they encountered to successful identity reconstruction, especially in relation to stigma, marginalisation and social exclusion. It explores the issues of relapse, relapse prevention and recovery from drug addiction and the dilemma of how a sense of identity fits in with recovery especially in early recovery. This thesis explores how successful identity reconstruction and recovery may support each other. Finally the research investigates threats to the newly constructed identity that could trigger relapse or prevent successful transition to a reconstruction of identity.

Research strategy

Delanty and Strydom (2003) define epistemology as the study which investigates the origin, structure, likelihood, limits, methods and reliability of knowledge and how that
knowledge can be attained, validated and applied in real world research. More simply, Walker and Evers (1982) define epistemology as how phenomena can be made known to the researcher. Brewerton and Millward (2001) add the critical factor that this knowledge comes not from mere opinion, but from beliefs that can be upheld and defended. Epistemological questions enquire about the relationship between the researcher and the object of the research. Denzin and Lincoln, (1998:20) state that ontological enquiry relates to issues and actions in the real world. Therefore epistemology impacts on the choice of data collection methods and the methodology employed in a research process (Marsh & Furlong, 2002).

This research adopts an interpretive approach in the pursuit of subjective knowledge. Bevir and Kedar (2008) propose that interpretive methodologies view human action as meaningful and historically dependent. This approach enables the researcher to appreciate how and why events occur, how they unfold over time and how change impacts and brings further change. Interpretive methodologies place the experience of the subject at the centre of the investigation (Punch, 2005). This present research did not commence with predetermined ideas, rather sought to allow themes to emerge from the data collected. Interpretive research focuses on the analysis of data to generate discussion (Clandinin & Connelly, 2000).

Interpretive research typically employs qualitative methods in order to manage complex, dynamic environments. The basic conjecture guiding qualitative research is that it uses everyday life and experience and investigates how meaning is created (Smith, 1998). Scott and Usher (1999:24) maintain that ‘human action ... is inseparable from meaning, and experiences are classified and ordered through interpretive frames and pre-understandings mediated by tradition’. Researchers then have to work with and interpret data collected from their enquiry.

**Research Method**

This thesis utilised qualitative, inductive approaches. It used a basic structure derived from the Biographic Narrative Interpretive Method (BNIM) as developed by Chamberlayne, Bornat and Wengraf (2000) at the Centre for Biography in Social Policy, University of East London.
Chamberlayne and King (2000) credit the rising popularity of the narrative method to the efficient exploration of subjective and cultural phenomena which ameliorates researchers in-depth understanding of human reality. By discarding the structured interview format, the position of the researcher changes from informed investigator to passive listener (Freeman, 1993). The Biographic Narrative Interpretive Method was modelled for this current study due to key concepts contained in the study - firstly, that all stories are unique and secondly, that what is volunteered from participants is much more valuable that using research assumptions to prompt responses. Research assumptions are often based on bias or preconceived ideas (Flyvbjerg, 2006).

Narrative analysis explains how narrative and identity cannot be separated as they represent each other. Using narrative approaches, new identities can emerge as the participant freely moves between public and private, personal and cultural, past and present life stories. It also adds to the growing awareness of the therapeutic value of narrative methods of research. Participants can endeavour to make sense of their lives and their addiction without emphasising negative internalised stigma around damaging stereotypes based on their self-concept of identity as fixed and ‘damaged’. Narrative analysis methods help restore a sense of valued self and establish a preferable identity which, by expressing their inner voices, becomes a rich story development of the person’s life (White & Kurtz, 2005).

**Biographic Narrative Interpretive Method**

The Biographic Narrative Interpretative Method has evolved from a method developed in Germany in the early 1990s by Rosenthal and others, initiated by Shuetze’s 1976 method of story and text analysis and Oevermann’s (1980) objective hermeneutical case reconstruction (Rosenthal & Bar-On, 1992; Chamberlayne et al., 2000; Wengraf, 2000). Biographical narrative methods use participatory and inclusive means to document hidden life histories (Rickarh, 2001). Narrative attempts to establish equality between the researcher and the participant by not allowing the researcher hide behind the question and answer format (Denzen, 2001). This method crosses the barriers of individual self within society and the compartmentalisation of the past, present and future (Miller, 2000).

This dynamic method belongs in the arena of life history, oral history and narrative approaches, but differs slightly from them (Chamberlayne & King, 2000). This objective hermeneutic
method moves slowly, employing a step by step approach, where proto-hypothesis is immediately evaluated against interview transcript material. This method gives participants the opportunity to re-story their histories and encourages healing of the connections between trauma and ensuing addiction. Participants can make sense of their lives and addiction in ways, so as not to support negative, internalised, and stigmatising stereotypes based on the ideal that their identity is static or damaged. They can add value to the sense of who they are and their ideal or reconstructed identity (White, 2007; White & Kurtz, 2005).

The Biographic Narrative Interpretive Method interview technique uses one initial question, for example, “Tell me your story,” (Wengraf 2000:10). Miller (2000:1) comments:

>This apparently simple request has led to a quiet revolution in social science practice. For it even to be seen as a legitimate query required a shift in paradigmatic viewpoints about the nature of the social scientific enterprise.

This change in research technique demonstrates the researcher’s willingness to give control of the situation to the participant which enhances the participant’s feeling of power. The aim is not to guide the interview, to probe or ask questions, but to fulfil its potential for revealing the contradictions of everyday subjective reality (Plummer, 1983). The Gestalt of the participant’s story, described by Hollway and Jefferson as:

>A whole which is more than the sum of its parts, an order or hidden agenda informing each person’s life (2000:34)

This is one of the vital theoretical components underlying this technique. Passive, non-interruption encourages the Gestalt of the participant’s story, which constructs their story including their motivation, themes and so forth. In the Biographic Narrative Interpretive Method, the first part of the interview is followed by a second session, where a more focussed probe, based upon themes emerging from the Gestalt of the initial interview and the ordering of themes presented by the participant, is conducted. After the second session, additional material can then be included in the data analysis (Wengraf, 2000).

Following the interviews the participant’s narrative of the former and reconstructed identities is analysed. The analysis identifies themes running through the ‘told story’ of the ‘lived life’ of the participants. Analysis of the data considers the participants’ interpretations of their lives and their classification of their experiences into thematic fields. Rosenthal (1993) explains that the thematic field includes all events and situations that connect to form a central theme. Millar
(1998:3) further suggests that although the thematic field is holistic, it must be organised to facilitate the development of themes at each stage of the analysis. The participants’ stories and interviews, with their biographical details and emerging themes are also checked for hesitancy or pauses, contradictions or repetitions.

The sample of participants generally remains small due to the fact that the Biographic Narrative Interpretive Method requires the initial storytelling, a follow up interview and a labour intensive analytical process (Benner, 1994). Careful sample selection, including a diverse range of participants, is essential to elicit rich and meaningful data. Within qualitative analysis, it is generally accepted that what may be lost from not involving a larger sample is more than compensated for by rich, powerful and meaningful data. Further hypotheses can be generated as information is processed (Chamberlayne & King 2000).

**Rationale for research method – Narrative Interview**

This interview process and data collection began with listening to the lived experiences of former drug users. During the narrative interview the researcher facilitated participants to use their own words, values and thoughts when telling their stories, unlike highly structured quantitative methods, as described by Patton (1990) and Posavac and Carey (1997). Elaboration and free association were widely encouraged in this current research, in order to obtain as much detail of background and history as possible. One of the main advantages of the narrative interview is the flexibility of the design of the interview process and the ability to change it. Life history interviews aid the understanding of concepts like cause and effect, problematic drug using, other circumstances and influences on this pattern of use and the factors that motivate change. Over the past three decades, qualitative methodologies, because they are, by nature, exploratory, have made significant contributions to the study of drug users and addiction (Feldman & Aldrich, 1990). These methodologies help fill the gaps in our

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484 “Originally, life story referred to the account given by an individual about his or her life. When this personal account was backed up by additional external sources ... the validated life story was called a life history. This concern with triangulation – the validation of narrated life stories through information from additional, preferably quantified, sources has not remained central to most current biographical practice. Nowadays ... ‘life history’ refers to a series of substantive events arranged in chronological order ... ‘Life story’ still refers to the account given by an individual, only with emphasis upon the ordering into themes or topics that the individual chooses to adopt or omit as s/he tells the story” (Miller 2000:19).

485 “Life story and life history always come together. They are continuously dialectically linked and produce each other; this is the reason why we must reconstruct both levels no matter whether our main target is the life history or the life story” (Rosenthal 1993:61)

486 See also Agar, 1985; Akins and Beschner, 1980
knowledge base in the subject area and pave the way for more in depth scientific inquiry. During the descriptive, exploratory stage, qualitative methods significantly contribute to the body of existing knowledge, help understand social problems and pose questions that may aid quantitative research. It is difficult to conduct initial quantitative research with hidden populations. Personal narrative or life history can help to address this issue. Spradley (1980) conducted interviews in drug service agencies, the drug users’ own homes and local clubs and cafes. He reported that this informal approach helped ease participants who had no prior experience of research, ensured that their privacy was respected and aided adherence to the ethical principles of informed consent, confidentiality and anonymity. He suggested that the qualitative approach, using flexible interview formats harvested a more in-depth exploration and collected richer data containing the drug users’ subjective narrative rather than the objective issue of drug use.

Personal narrative or life history helps to inform research regarding the lived experiences of individuals and how they mediate, organise, structure and respond to those experiences. Isay (2007) suggests that a lot can be learned from personal narratives. He believes that people can make a difference by telling their stories, not only to individuals but also as a view of trends in society. In recent decades, many authors (Häninnen & Koski-Jännes, 1999; 2004) in the field of addiction research have utilised the narrative approach, focussing on the participants’ personal narratives of their lived experience. This approach presents a holistic view of addiction and recovery, believing that the best way to hear and understand the drug users’ unique experience is through their own voice. McKeganey, Bloor, Robertson, Neale and MacDougall (2006) maintained that the growth and influence of the client perspective has become a significant development in the field. Keene (1997a) commented that clients’ views can be of equal importance in predicting successful outcomes as professional opinions.

One of the first theorists to use the narrative approach was Biernacki (1986), who emphasised the role identity played for the recovering drug user. McIntosh and McKeeganey (2002:44) indicate that the recovery narrative plays a crucial part in the construction of a “non-addict identity” and enhanced the transformation towards positive outcomes. They believe that an important motivation to stop using drugs is the drug users’ desire to reinstate their “spoiled identity”. McIntosh and McKeeganey (2002) interviewed seventy recovering drug users in

487 See also McIntosh & McKeeganey, 2002; Taieb, 2008; Castel et al., 1998; Hurwitz et al, 2006
488 See also McKeeganey, Morris, Néale and Robertson (2004)
Glasgow and identified three key areas where the drug users’ recovery narratives could be viewed as aids to constructing a non-addict identity. The three key areas were in relation to reinterpreting certain features of their drug using lifestyles, the reconstruction of their sense of self and providing credible explanations for their drug free lifestyle. Within the narrative, the past drug using lifestyle was viewed in a negative manner, the reconstructed sense of self was linked with restoring identity and the credible explanation for a drug free lifestyle was viewed in a positive light.

In their study of fifty one life histories of recovery, Hänninen and Koski-Jännes (2004) identified five story types: “AA, Growth, Co-dependence, Love and Mastery Story”489. These story types help participants understand the process of addiction and recovery. They suggest “if the narrative anticipation of recovery passes the test of reality, the full recovery story results; if not, a new cycle begins” (2004:244). In Wiklund’s (2008) study, several themes emerged including meaning, described as meaningless, loneliness, connected and life, life described as death and freedom, responsibility, adjustment, guilt, control and chaos. She identified caring needs that were associated with the themes mentioned, as:

\begin{quote}
    The need to create a new frame of reference for interpreting of life, the need to experience coherence in life, restored dignity as well as the need for a sense of community and attachment, confirmation and acceptance (2008:2435).
\end{quote}

Wiklund maintains that the narratives play an active role in the construction and reconstruction of the participants’ identities by their narration, adding that the most salient feature of the narratives was the participants’ constant search for meaning, freedom and release from addiction.

Davies (1997) asserted that the more society envisages and attempts to treat drug users as if they were inadequate, deviant, sick or helpless people, the more drug users will adopt this stereotype and present themselves within this framework. Consequently the more society will produce and encounter drug users who fit that description. Narrative literature can present an

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489 Hänninen and Koski-Jännes found that along with the AA story participants had other types of story which traced their journey out of addiction. Each story type mentioned relationships with other people and had a central value which was salient in the maintenance of their lifestyle change. For example the ‘Growth Story’ related experiences of breaking away from oppressive relationships and the ‘Co-dependence Story’ reported breaking away from dependent relationships, the ‘Love Story’ described love and affirmation and the ‘Mastery Story’ described how participants replaced defiance with responsibility.
alternative framework. This alternative empowers drug users to make active choices about all aspects of their lives. Davies (1997) challenges the effects of stigmatisation and explores the experiences of those who, historically, have been voiceless or devalued (Paivinen & Bade, 2008). Hall (1999) stresses that emotional pain, especially for the marginalised drug user, is exacerbated by their lack of voice. This framework has frequently been ignored or discounted because within its breadth, the representations of drug users do not comply with the addiction attribution or the essential addict identity. This is due to such representations being incompatible with the framework of knowledge produced by the dominant discourses (Davies, 1997). Narrative literature represents the drug user from their personal perspective, rather than an account offered by the dominant discourses (Paivinen & Bade, 2008).

There is a wealth of contemporary literature and popular confessional memoirs authored by drug users and former drug users. Works of drama, fiction, non-fiction and poetry depict drug use and drug users in various ways (Lenson, 1995). Many drug users have positive feelings and descriptions of drug using when discussing them in a non-judgemental atmosphere (Agar, 1977). Lenson (1995) suggests that the drug user’s point of view was traditionally not taken into consideration. However, narrative literature provides great insight into the self-construction of identity by drug users and traces the identity change from drug user to former drug user. He suggests that credible self constructions are presented in narrative literature mainly because the drug user is the main character and not just a prop to enhance an exciting story line. Some of the works of popular narrative are pure fiction, but the large majority are either autobiographically influenced fiction or autobiographical works with some fictionalism of the representation of drug use. For example, the film ‘Trainspotting’ (Welsh, 1994), emphasises the pleasure in drug using and suggests opiates simplify life with the drug as the organising factor in the user’s life, while the documentary film ‘Black Tar Heroin’ (Okazaki, 1999) depicts drug using as chaotic, dangerous and a very much unwanted lifestyle for the majority of the characters. Narrative can influence the media and policy makers by focussing on personal and humane issues (Maher, 2002: McKeaganey, 2003).

An example of narrative that conflicts with the dominant representation of the drug user can be found in Burroughs’ (1953) novel ‘Junky’. Burroughs began his drug using career in the 1940s and his first novel, ‘Junky’, concerned drug users and addiction from his subjective experience. He uses the medium of the novel to expose myths surrounding the drug user, especially those created by the media which typically result in hysteria. He did not paint the drug user as victim of unscrupulous pushers, which would have complied with the media hyped stereotype of the
1940s and 1950s. His portrayal illustrated how the drug user plays an active role in acquiring and maintaining the habit and experiences pleasure while drug using.

The earliest identification of personal narratives in recovery can be found in the tradition of Alcoholics Anonymous. Traditionally men used the medium of personal testimony and non-confrontational narrative as an aid to recovery (Baker, 2000). Hall (1996) commented that this system of non-confrontational or monologic narrative was a system used by men who preferred not to invite a response. Griel and Rudy (1984) used the term ‘Identity Transformation Organisations’ to describe organisations like 12-Step groups, where identity can be structured and re-structured within the ‘sharing’ medium. Members adopt a therapeutic discourse, introduce themselves by saying something like “Hi my name is X and I am an addict”, and relay their personal histories in a way that can account for their drug using careers (McCrady, 1994; Summerson-Carr, 2006). The familiar introduction and the ensuing structured, often rehearsed account that follows, become staples for former drug users to acknowledge and accommodate their new emerging and positively re-structured identity. Following the account of their drug using careers, members establish a link between this traumatic past and an abstinent, clean future. The value of these narratives allows them to safely explore their inner selves, acknowledge damage and anguish and move into a framework of healing and reconstruction of identity (MacIntosh & McKeganey, 2000). It should be acknowledged that, for the participants of this present research who may have attended 12-Step meetings, the instance may exist that the narrative presented to the researcher is a narrative which may have been greatly influenced by constant telling and re-telling at fellowship meetings.

Autobiographical discourse helps drug users recognise denial, locate their drug using careers in reality and eventually discover their true identity (Baker, 2000). Within either the twelve step meeting or the therapeutic setting, former drug users verbally disclose traumatic events and memories, reveal the sins of the past and the enduring remorse and shame of the present. Former drug users realise that denial is an intrinsic part of addiction (Lemanski, 2001). Denial is a primitive psychological defence mechanism. Former drug users often employ this mechanism in recovery in their attempts to understand what has happened to them. It helps

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490 See also Cain, 1991; Fish, 1993; Hänninen & Koski-Jannes, 1999; Mink, 1997; Rapping, 1996; Skull, 1992; Young, 1994.
491 See also Biernacki, 1986; Wilcox, 1998
492 See also Rasmussen, 2000; White, 1998
493 Denial is at its most destructive when the drug user refuses to acknowledge the absolute truth – that they are addicted to drug using. Denial is a mechanism used to protect against threat and block awareness of unacceptable reality (McDowell & Spitz, 1999).
them deal with reality but it also becomes a focussed delusional system in which the drug user can avoid reality (McDowell & Spitz, 1999). Recovery entails letting go of denial and realising that the denied self is a drug user (White, 1998). Walters (1994) suggests that because the function of denial is to lay blame onto external situations, treatment should redirect the drug users’ focus to their responsibility for their own addictions.

Giddens (1991) explains that by using personal narrative, an individual can form an identity which cannot be gained through behaviour. Riessman (1994) says that telling our story is an essential way of working out who we are. Narratives of our subjective, socio-cultural experience allow us to create what we are and construct clear pictures of our everyday life social situations. McIntosh and McKegeaney (2000) used the medium of personal narrative to investigate how drug users in recovery construct a non-user identity. They say that drug users, by presenting a personal narrative of their recovery, can actually hope to achieve recovery. Narratives helped drug users to focus on their past experiences, to reinterpret these experiences and construct a new non-addict identity and to provide explanations of their recovery. The process of telling the narrative, which allowed the identity transformation, was the essential ingredient to achieve recovery.

Vasas (2005) maintains that drug using women encounter many barriers when trying to access forums that are directly related to their life’s issues. These barriers impact significantly, cause marginalisation, create conditions that exert fear and power and exacerbate difficulties by assigning stereotypical labels and determining social outcomes. Women often begin their drug using careers in order to cope with negative socialisation experiences. Inevitably this decreases the likelihood of them using their strengths to reduce harm to themselves and their families. When women present for help or treatment for drug using, barriers are erected that victimise and disempower them. It is essential to ensure the safety of those women who share testimonies and other personal narratives. Professionals have to create safe spaces where marginalised voices can be heard in confidence. Drug using women need to be heard and feel that they are being valued (Vasas, 2005).

In their study of treatment for drug using women, Brown and Strega (2005) reported that the women found it difficult to talk and were terrified of being judged. This study highlighted the humanity beyond the stigma of drug using, asserting that this stigma actually demonises drug using. Women were encouraged to acknowledge this stigma, and through narrative, art and drama, its power was reduced. Baker (2000) in her research on gender sensitive treatment
programs, found that when she analysed her participants’ stories of recovery; there were significant shifts in identity. She maintains that the women’s identities transformed through the process of self-discovery, as they verbalised their life stories. The verbalisation encouraged them to recognise truths about their addiction, parenting skills and emotional well-being. She concludes that personal narratives can greatly contribute to the analysis and understanding of many issues. Banwell and Bammer (2006) reinforce the notion that personal narrative enquiry provides richer data. In their study, drug using women could discuss feelings of isolation from their families and former friends and lack of daily support to help care for their children. The women stated that they excluded themselves from mother and child activities because social stigma made them feel different and not good enough to socialise with non-drug using mothers. Their stories illustrated how their behaviour reflected internalised negative feelings coming from dominant addiction discourse (Arendell, 1999).

Data collection

Using the principles of the Biographic Narrative Interpretative Method narrative interviews were conducted with each participant across two sessions. The first session was unstructured asking a single question like – ‘tell me your story’. The interviewer did not interrupt the story telling but used some probes or phrases to encourage the continuation of the narrative. The second session adopted a more structured format. The researcher formulated questions based on the first interview in order to clarify or expand on any points mentioned. Questions were asked in the order that they were mentioned in the first interview and included mention of the themes outlined in the Participant Information Letter if these had not occurred naturally during the participants telling of their story.

Recruitment of participants

Due to the fact that qualitative research is labour intensive and in-depth, samples tend to be small compared to the larger quantitative methods that produce broader information (Ritchie & Lewis, 2003). In order to study former drug users, contact has firstly to be made with them. Most studies with a drug using population have been conducted in treatment centres,

494See Appendix A
methadone clinics, residential and community settings and prisons (Rosenbaum & Murphy, 1990). By using the social networks of former drug users, the researcher can acquire an adequate sample of a population that may not otherwise be accessible. The sampling strategy employed in this present research was purposive and non-random, in that participation adhered to certain selection criteria (Patton, 1990; Strauss & Corbin, 1990).

Drug users are generally considered a ‘hard-to-reach population’ (Kearney & Taylor, 2005). Therefore the present study invited professionals working in the field of addiction in Dublin city to act as gatekeepers and nominate one or two participants. Participants who agreed to take part in the study were invited to nominate further participants and so on using a snowballing technique. Snowball or chain referral sampling techniques are typically used to gain access to relatively hidden populations and permit access to particular groups of difficult to access populations through the use of key informants (Shaw, Bloor, Cormack, & Williamson, 1996).

The sample of participants was initially recruited through gatekeepers who were professionals working with former drug users. The gatekeepers included two drug project workers, two counsellors working with former drug users and two addiction treatment aftercare workers. All of these gatekeepers were known to the researcher and agreed to approach individuals who met the inclusion criteria. The inclusion criteria included participants in recovery, who had not relapsed for at least two years, were over eighteen years of age and defined themselves as former drug users. The researcher did not use any diagnostic assessment although some of the participants may have undergone assessment during various connections with treatment services. Any person who was under eighteen years of age or less than two years in recovery was excluded from the sample. The gatekeepers gave prospective participants a general, written, prepared outline of the study along with the researcher’s name and telephone details. Individuals, who agreed to participate, were in turn requested to recruit or nominate up to four other individuals and so on. This snowballing method of sampling (Ritchie & Lewis, 2003) was used to recruit a diverse group of participants – not confined to individuals from a specific socio-economic background or to individuals who have accessed services. The researcher contacted participants nominated within the snowball sampling method to ensure that they met the inclusion criteria before arrangements were made to conduct the interviews.

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495 See also Goode, 2000; Hogan, 1997
496 See Appendix A
Due to the fact that recovering from addiction or stopping drug using is largely a covert activity, it is difficult to judge the amount of people involved in order to estimate a representative sample. The chain referral process yielded sixteen participants in total comprising of nine men and seven women. Their ages ranged from twenty five to sixty one years, giving a mean age of 39.375 years. Participants were drug free from between two to twenty eight years (mean 10.625 years).

**Interviewing process**

Each participant was invited to attend two interviews with the researcher. Prior to the interviews commencing, the researcher disseminated information about the rationale for the study and what was required from the participant. The participants were given several days to consider taking part in the research and formally consented to do so. Permission to tape record the sessions was sought and granted by all the participants. The interviews lasted from fifty minutes to one hour and forty minutes. All recorded interviews were transcribed verbatim for later analysis.

Before the first interview began, participants were asked to fill out a short questionnaire which captured demographic information. The first interview with each participant began with the simple probe ‘tell me your story’. The interviewer informed the participant that they could take as much time as they needed and that their telling of their story would not be interrupted. Sarbin (1986: 235) found it most useful to allow the participants to end the session. “If we allow respondents to continue in their own way until they indicate they have finished their answer, we are likely to find stories; if we cut them off ... if we do not appear to be listening to their stories ... then we are unlikely to find stories”. Attentive listening techniques were employed and the researcher did not interject except for verbally confirming, or using eye contact, body language and so forth. Encouraging phrases were spoken, such as the researcher showing empathy or agreement, but no further questions were asked.

The researcher listened to the recorded interview, making notes and a list of questions that were asked at the second interview. The questions were based on information from the first interview, for example developing themes, clarifying points, clearing any confusion, asking for more detail in certain areas. In the second interview, questions and themes to be expanded on were presented in the same order as they arose in the first interview. The researcher used the
participant’s words to try to recreate or maintain the Gestalt of the first interview. At the end of the second interview the researcher invited the participant to add anything that may have been missed, overlooked or forgotten.

Post interview processes

It was essential for the researcher to compile their own debriefing notes and listen to recordings as soon as possible after the interview sessions. Debriefing notes recorded feelings or issues raised by the interview. Documenting debriefing notes and listening to the recordings are pivotal to the understanding of the material and the process itself. Free association allows the researcher to consider their own understanding of and reactions to the interviews (Wengraf, 2000). These notes were included in the data as critical documents for reflection on the process (Gergen, 1999).

Ethical considerations

Social research acknowledges that the rights and protection of subjects is of primary ethical concern and that it must protect all subjects from any harm that could result from their participation (Hugman, Pittaway & Bartolomei, 2011). Barnes (1979) noted that this concern dated back to the mid-20th century, where atrocities under the name of social, scientific and medical research were committed under Nazism (Johnstone, 1994). Arendt (1964) commented that although many of the researchers defended their method saying that it was their duty rather than self-interest, an international war crimes tribunal found otherwise. The tribunal noted that although many researchers did not participate in such atrocities, for those that did the ethic of duty was a grave concept that ignored the Hippocratic Oath of ‘do no harm’.

In order to address this concern the tribunal set out a code of practice which was known as the Nuremberg Code (1949) and this was subsequently further developed in the Declaration of Helsinki (WMA, 1964). The salient principles laid out were that research should not use human subjects against their will, either by force or deception, and that, even when subjects conferred informed consent, they should not be exposed to undue risk of harm. These basic principles continue to inform research ethics and endure as the consensus view (Ellis, Kia-Keating, Yusuf, Lincoln & Nur 2007).
A key document published in 1979 by the National Commission for the Protection of Human Subjects of Biomedical and Behavioural Research, *The Belmont Report* (National Institutes of Health, 1979), outlines the main ethical considerations when conducting research with human participants. Three basic principles were put forward. The first principle, respect for persons, obliges researchers to treat all human subjects as autonomous agents and protect that autonomy by way of procuring informed consent and safeguarding their confidential information. This principle also covers protections for persons with diminished autonomy. The second principle, beneficence, requires the well-being of participants to be paramount where robust research methods maximise potential benefits and minimise participants’ risks. Beauchamp and Childress (2009) highlighted that this principle embodied the obligation to do no harm. The third principle, justice, adheres to the commitment to fairly distribute the costs and benefits of the research including selection and dissemination procedures. The Belmont Principles also include guidelines for equitable and non-coercive recruitment of research participants and for the informed, rational, and voluntary consent to research participation (DHHS, 2005).

The National Insurance of Health (NIH, 1979) suggested that the design and implementation of research may conflict with these basic principles. Rather than suggesting a serial ordering of one principle over the other, they recommended that researchers make allowance for the actual research context within which the principles will be applied. NIH stated that contextually sensitive application of ethical principles is especially relevant for ethical dilemmas that may surface during addiction research implementation. While some dilemmas may be foreseen, the life situations of drug users along with the socio-ecological context in which addiction research is conducted often raise unique and unexpected conflicts between different ethical principles (Stockwell, Reist, Macdonald, Benoit & Jansson, 2009). Butler (2002) proposed that ethics in social research should go beyond this benchmark. Butler (2002:243) proposed that researchers should consider the ‘scope’ of practice and take responsibility for making sense of these principles given that each research situation must balance these principles to fit in with the current research. He gave the example of ‘empowerment’ where respect for the researchers’ moral agency and beneficence is combined. He quoted Husband’s (1995) notion of the ‘morally

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497 In 1979, in the US, the *Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research* was published. This report provided a concise description of the regulations and guidelines concerning the use of human subjects in research in the U.S., and other countries.
active practitioner’, and proposed that each unique situation would dictate how the researcher applied the core ethical principles. Barsky (2010) agreed, commenting that research cannot adopt a specific formula or become a routine due to differing complexities within the research situation.

There is little research on moral reasoning among drug users with regard to addiction research ethics. The few published studies tend to focus on general levels of socio-moral reasoning, public attitudes regarding the morality of drug use, research ethics and perceptions of research risk interpreted through traditional moral development theory or guidelines for the protection of human participants (Rhodes, Zikic, Prodanovic, Kuneski & Bernays, 2008; Slomka, Mc Curdy, Ratcliff, Timpson & Williams, 2008; Stevenson, Hall & Innes, 2004). Klockars and O’Connor (1979) argued that the difficulty arises as using traditional ethical considerations on a population who deviates from traditional social norms may not adequately reflect the practical ethical challenges confronted by addiction researchers and does not make allowances for how these populations perceive and organise their moral worlds. Fisher (2011) added that moral precepts, including respect, beneficence, justice, relationality, professional obligations, rules, and pragmatic self-interest must be contextually sensitive in keeping with the multiple vulnerabilities of certain populations.

Researcher’s personal choices in relation to ethical considerations must also take into account that their work can impact both the social dimension and the participants in the research. Cloke, Cooke, Cursons, Milbourne and Widdowfield (2000: 151) highlighted ‘[f]or good or ill, the very act of entering the worlds of other people means that the research and the researcher become part co-constituents of those worlds. Therefore we cannot but have impact on those with whom we come into contact, and indeed on those with whom we have not had direct contact, but who belong in the social worlds of those we have talked to. Much of this impact is, frankly, unknown’’. Essentially the researcher must be ethically aware of such influences.

Therefore, in addition to the Belmont Principles, the ethical codes of addiction research institutions include principles and standards of conduct identifying moral norms within their fields (Beauchamp & Childress, 2009; Fisher, 2009). These norms include the responsibility to clarify their professional roles and obligations, the commitment to ethical compliance and the promotion of accuracy and honesty. Researchers are also expected to keep promises they may make, avoid vague commitments, establish trust relationships with colleagues and be aware of their responsibilities to communities and society (American Anthropological Association,
All research, especially research which involves the use of human participants, should be conducted in an ethical manner, where the researcher(s) reflects on the nature of their planned research and identifies the key ethical issues. Approval to conduct data collection for this present research was requested and granted by TCD Research Ethical Approval Committee.

Informed consent was sought and granted from all participants. Participants need to have risks explained clearly and simply and researchers need to be aware that, especially in qualitative research, participants may need to be reminded of their rights during data collection (Redwood and Todres, 2006; Mackenzie et al., 2007; Maiter et al., 2008). For example, some participants easily understand research issues, but others who have no experience of a research process may hold unrealistic expectations about the benefits of providing information. Hugman, Pittaway and Bartolomei, (2011) stated that if a situation arose where researcher(s) actively deceive participants regarding the purpose for which their consent is sought, this situation breaches the terms of all codes of ethics and is therefore reprehensible. Slomka, McCurdy, Ratliff, Timpson and Williams, (2008) agreed describing when they were conducting their research with minority drug users, they highlighted that researchers must understand exactly how participants perceive risk. They espoused that a balance must be held between guidelines that are too lax that may subject participants to harm and those that are too inflexible that would hamper the collection of robust data.

Protecting anonymity can present complexities. In some cases anonymizing a transcript can be more difficult that first considered (Costa 2013; Kaiser 2009; van den Hoonnaard 2003), and in other cases some participants do not wish to remain anonymous (Einwohner 2011; Janovicek 2006; Swauger 2011). Richards and Schwartz (2002:138) stressed that for some participants ‘‘identification with their expressed beliefs may help participants to maintain ownership of the content and meaning of their narratives’’ and Einwohner (2011) further suggested that anonymising transcripts can be interpreted as outrageous and victimising the participants, equating this process to erasing the identity of holocaust testimonies. However in this present study the potential use of research data was clearly explained to all participants, as well as procedures taken to respect their anonymity and confidentiality. It was explained that anonymity would be guaranteed in so far as that was possible. Where certain details, events or
characteristics that may be identifiable appear, these were removed and data was anonymised and put into safe storage.

The principle of ‘do no harm’ was adhered to during the study when collecting data and when analysing the findings. In view of the Belmont Report’s principles and subsequent considerations, this present research identified a significant ethical consideration. This study explored participants lived experiences of drug using, their lives prior to drug using and the changes they enacted to re-identify as former drug user. These experiences, when disclosed, had the potential to arouse emotional reactions, distress or anxiety or other thoughts and feelings that could prove stressful. Each participant was made fully aware of this and given ample time to consider if they wished to be involved in the study. An evaluation session occurred immediately after each interview. The researcher evaluated the interview process with the participant and invited feedback before the participant left. The researcher ensured, in so far as it was possible, that the participant was comfortable or if not, was prepared to give the names and telephone numbers of two counsellors who had agreed to support the participants post interview. Counselling support was made freely available to participants at any stage of the process, however, none of the participants required counselling support.

No payment was offered to participants but a ‘Thank You’ note was be posted, given or delivered to the participants when the interviews were concluded.

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Data Analysis

Patton (1990) maintains that the main task of analysing qualitative data is to identify primary patterns. Thematic content analysis was used in this research to code and categorise data and identify primary patterns according to certain themes that were inductively derived during the analysis phase. Inductive rather than deductive reasoning focuses on the relationships between concepts (Ratcliff, 2000). Often direct quotations, in the participant’s vernacular help to illustrate themes and allow the reader to envision and emphasise with the participant’s experience, as expressed from their perspective. Microanalysis of the participant’s narrative of the former and reconstructed identities was conducted sequentially and separately, involving thematic ordering of the narration, based on the participants’ interpretations of their lives and their classification of experiences (Rosenthal, 1991).

The goal of qualitative research is to accurately present the reality of the situation being researched. Analytic induction initially works with the whole, although separate elements and the relationships that may intertwine within them are included in analysis. There does not have to be a representative model of the concepts or ideas being researched. However it is essential to endeavour to uncover patterns or trends that may be useful for analysis or on which themes could be theorised (Robinson, 1951). Analytic induction attempts to cautiously define the phenomenon, develop a hypothesis and investigate as to whether the hypothesis can be upheld. Failure to uphold the hypothesis results in redefining or revising either the hypothesis or the phenomenon. The research continues to confirm the newly revised hypothesis or revise the hypothesis if negative cases continue to refute it. Analytic induction uses all the available data to test as well as generate theory (Ratcliff, 2001).

Narrative analysis generally employs an open ended structure that focuses on the participant. It can explain the interpretation of unexpected results or mixed findings and highlight problems within the study. The end result should yield a more humanistic, accurate and complete picture (Stahler and Cohen, 2000).
Emerging themes

It is not possible to predict emerging themes, nor should a researcher try to do so. However, information from the review of literature and themes that may emerge, were explored while maintaining a flexible approach. The interviews rested with the interviewer’s understanding and interpretation of material. Lines of thought emerging from earlier interviews were added as the interviews proceeded. Data was interpreted using a thematic analysis approach which provided a well-established systematic approach to the analysis.

The quality of data and extent to which participants relate their narrative, depended on the researcher’s ability to establish rapport. It is generally a challenge to find a suitable framework, where participants can comfortably talk about themselves, their lives, hopes, feelings, motivations, needs, values and personal philosophies. This process involves the experience of, and successful resolution of, dissonance or emotional conflicts in order to continue to engage in the interview process fully, and create a climate for exploration of subjective experience and understanding. If trust is established, a wealth of rich data can be gained from participants that may not be forthcoming by other methods. This data should not be inhibited or influenced by pre-determined notions (Patton, 1990; Walters, 1980). The presence of the researcher may influence the context of replies or the behaviour of the participant: therefore the researcher must endeavour to establish an open and honest relationship with the participants, explaining exactly what the research is about and what it hopes to examine. With honesty and integrity, a mutual relationship of trust and acceptance should develop (Patton, 1990).

Limitations

One limitation of this study is the fact that the sample size of only sixteen participants is small. However within qualitative analysis, it is generally accepted that what may be lost from not involving a larger sample is more than compensated for by rich, powerful and meaningful data. The BNIM generally involves collection of a large amount of rich, in-depth data from participants, within the structure of interview sessions (Chamberlayne & King 2000).

The researcher also has to acknowledge that life histories or personal narratives are not concrete, factual histories: rather they are personal accounts which have been influenced by the participants’ subjective experience before, during and after drug using and their exposure to diverse treatment modalities. Being aware of the impact that the social process of data
collection has on the setting studied is methodologically very relevant. To be aware that data can be gathered only through socially involving with the social or institutional setting means to question how the data can be analytically used. For example, in relation to the issue of veracity of interview accounts Silverman (1993: 114) points out ‘in studying accounts, we are studying displays of cultural particulars as well as displays of members’ artful practices in assembling those particulars’. Interview accounts, as any other account, are treated as artful accomplishments which are adequate for the practical purpose at hand. Therefore, the issue of the veracity of the content of interview accounts can be perceived differently, becoming aware of how the interviewee may be interpreting the interview situation, and dealing with it, for example interview accounts, as other accounts, can be analytically used as a display of moral forms (Baruch 1981).

**Chapter summary**

This chapter has presented the methodological issues associated with this thesis. It has described the theoretical framework, epistemological issues and ontological perspective of this research. This chapter described the design, data gathering and analysis processes involved as well as describing the recruitment of participants, interview process and ethical considerations. This thesis used a qualitative approach, modelled on the Biographic Narrative Interpretive Method, in its attempt to offer an understanding of the lived experienced of drug users where sixteen former drug users related their experiences before, during and after drug using careers.

This chapter links the theoretical positions with regard to drug users, identity and recovery outlined in Chapter Two, which reviewed relevant literature, to the following four chapters which present the findings of this study and to the final chapter which discusses the findings in light of the literature reviewed.
Chapter Four Construction of Drug User Identity as drug using increases

Introduction

The following four chapters present the findings emerging from this present study. As the previous chapter outlined, the BNIM was employed, engaging sixteen participants in two separate interviews. During the narrative interviews, the participants of the study described their lives before they started to use drugs, the locations and communities they grew up in and their families of origin. They related their early introduction to drug using and how that early use escalated into dependency. They described the many problematic issues that arose for them during their drug using careers and identified their motivations to cease drug using. Finally the participants related their subjective stories of recovery, the supports and treatments they engaged with, their membership of 12-Step programmes, their family and social relationships and their efforts to secure future employment. The themes that emerged from the narratives are organised around the notions of identity before, during and after drug using, stigma, marginalisation, social exclusion, treatment, relapse prevention and recovery.

Commencing with an overview profile of the sixteen participants in this study and a description of their notion of their identities before they became involved in a drug using subculture and as their drug using increased, this first findings chapter outlines the challenges that were reported by these participants, which arose from both from their childhoods and their drug using careers and how they responded to these issues through their drug using experiences. The participants described concerns that impacted on their identities, especially in terms of relating to their family members, their peers and the wider society.

This chapter traces the research participants’ pattern and trajectory of drug use from early onset drug using, becoming enmeshed in a drug using subculture to an emerging sense of discontent within their drug using lifestyles and finally making the decision to cease using. It reflects on how the participants reported changes in their identity as drug using increased and how that change impacted on their lives.

Chapter five outlines further experiences as reported by the participants when they attempted to stop drug using and to reconstruct a non-drug using identity. Chapter five also describes the challenges the participants reported facing and overcoming in their journey to recovery. Chapter six presents the participants accounts of the supports they used on this journey. They described treatment programmes, 12-Step programmes and family as their main supports. They
also acknowledged their own self-change they asserted had enhanced their recovery. Chapter seven outlines the participants’ experience of relapse and relapse prevention as reported by them and their accounts of their personal recovery process, which enabled permanence in their emergent non-drug using identities.

Profile of participants

A total of sixteen people participated in this study, comprising of nine men and seven women. Their ages ranged from twenty five to sixty one years, giving a mean age of 39.375 years. Participants were drug free from between two to twenty eight years (mean 10.625 years). All of the participants described themselves as being born and reared in suburban areas of Dublin, with eight participants reporting being from middle class homes and the remaining eight reporting being from lower socioeconomic backgrounds. Four participants stated they were from single parent families while the remaining twelve participants reported that they had grown up with both parents living in the home. All of the participants reported having at least one sibling. The table below illustrates the age and gender of the participants, the drugs the participants reported that they used and the number of years they declared they were in recovery. This table also illustrates the reported occurrence of physical and sexual abuse suffered by the participants, mental health issues of the participants and their families and reports of suicide ideation, suicide attempts and of self-harm.

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500 Two of the female participants reported that they came from large families with between eleven to thirteen siblings. The average for the remaining fourteen participants was 2.85 siblings.
501 This thesis will use the 2005 definition of recovery suggested by the Substance Abuse and Mental Health Services Administration (SAMHSA) which states “Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness and quality of life.”
### Table 4 – Overview of participants

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Years in recovery</th>
<th>Main drug of use</th>
<th>Participant Mental health issues</th>
<th>Family mental health issues and addiction reported by participants</th>
<th>Participant Suicide ideation/attempt</th>
<th>Self harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>502</td>
<td>59</td>
<td>28</td>
<td>Alcohol</td>
<td>Depression Anxiety</td>
<td>None</td>
<td>Parents teetotal</td>
<td>Ideation</td>
</tr>
<tr>
<td>503</td>
<td>43</td>
<td>9</td>
<td>Heroin Alcohol Cocaine</td>
<td>None</td>
<td>Father – alcoholic</td>
<td>Sister – heroin user</td>
<td>Attempts</td>
</tr>
<tr>
<td>504</td>
<td>34</td>
<td>4</td>
<td>Alcohol Cocaine</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Ideation</td>
</tr>
<tr>
<td>505</td>
<td>50</td>
<td>25</td>
<td>Alcohol Hash Tablets</td>
<td>None</td>
<td>Father – alcoholic</td>
<td>Mother – valium</td>
<td>Ideation</td>
</tr>
<tr>
<td>506</td>
<td>29</td>
<td>4</td>
<td>Alcohol Cocaine Heroin Hash Tablets</td>
<td>Depression Anxiety Described self as having undiagnosed ADHD</td>
<td>Mother - depression</td>
<td>Ideation</td>
<td></td>
</tr>
<tr>
<td>507</td>
<td>33</td>
<td>2</td>
<td>Alcohol Cocaine Heroin Hash Tablets</td>
<td>Anxiety</td>
<td>2 brothers - heavy drug users</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>508</td>
<td>40</td>
<td>6</td>
<td>Alcohol Cocaine Tablets Hash</td>
<td></td>
<td>Father – alcoholic, extremely physically and verbally abusive Mother – binge drinker, depression, extreme violence. Brother – bipolar schizophrenia Sister - schizophrenia 1 brother drug user Grandmother – dementia</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>509</td>
<td>34</td>
<td>3</td>
<td>Alcohol Cocaine Heroin Hash Tablets</td>
<td>Childhood anxiety</td>
<td>None</td>
<td>Attempts</td>
<td></td>
</tr>
<tr>
<td>510</td>
<td>53</td>
<td>19</td>
<td>Alcohol Tablets</td>
<td>None</td>
<td>Mother – tablets extreme anxiety and agoraphobia Sister - alcoholic Two brothers - severe depression</td>
<td>Ideation</td>
<td></td>
</tr>
<tr>
<td>511</td>
<td>36</td>
<td>8</td>
<td>Alcohol Cocaine Heroin Hash</td>
<td>CSA Extreme physical violence</td>
<td>Mother – depression Tablets</td>
<td>Attempts</td>
<td>Self harm</td>
</tr>
<tr>
<td>512</td>
<td>29</td>
<td>13</td>
<td>Cocaine Heroin Hash</td>
<td>Depression</td>
<td>Father – alcoholic Brother - schizophrenia</td>
<td>Self harm</td>
<td></td>
</tr>
</tbody>
</table>

502 All participants have been given pseudonyms to ensure anonymity
503 Several of the participants reported that they had no mental health issues, yet they reported suicide attempts and suicide ideation. Suicide attempts, using drugs as method and incidents of self-harm are considered risk factors in a drug using population rather than mental health issues per sé (Darke & Ross, 2002).
<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Years</th>
<th>Substance</th>
<th>CSA (also 1 sister and brother were abused by same person)</th>
<th>Father - Physical abuse</th>
<th>Mother - codeine Schizophrenia - 2 sisters and 2 nephews Grandmother - dementia</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rita</td>
<td>58</td>
<td>27</td>
<td>Alcohol</td>
<td>Father - Extreme physical and verbal abuse</td>
<td>Parents teetotal</td>
<td>Family history of mental illness: 2 sisters and 2 nephews. Grandmother - dementia</td>
<td>None</td>
</tr>
<tr>
<td>Joan</td>
<td>30</td>
<td>8</td>
<td>Alcohol</td>
<td>Described self as ‘over anxious as child’ Reported OCD and perfectionism in adulthood.</td>
<td>None</td>
<td></td>
<td>Attempts</td>
</tr>
<tr>
<td>Wendy</td>
<td>28</td>
<td>5</td>
<td>Cocaine Hash Tablets</td>
<td>Father physically abusive Body dysmorphia\textsuperscript{504} trichotillomania\textsuperscript{505} eating disorders in early recovery</td>
<td>None</td>
<td></td>
<td>Attempts</td>
</tr>
</tbody>
</table>
| Jenny | 5   |       | Alcohol Cocaine Hash Tablets | CSA Eating disorder in early recovery | Mother alcoholic/ tablets 1 sister alcoholic/drug user eating disorder 1 Daughter – alcoholic/ drug user 2 brothers alcoholic/drug user | Ideation | **DSM-IV** diagnostic criteria for body dysmorphic disorder A. Preoccupation with an imagined defect in appearance. If a slight physical anomaly is present, the person’s concern is markedly excessive. B. The preoccupation causes clinically significant distress or impairment in social, occupational, or other important areas of functioning. C. The preoccupation is not better accounted for by another mental disorder (e.g. dissatisfaction with body shape and size in Anorexia Nervosa).  
**DSM-IV** diagnostic criteria for trichotillomania A. Recurrent pulling out one’s hair resulting in noticeable hair loss B. An increasing sense of tension immediately before pulling out the hair or when attempting to resist the behaviour C. Pleasure, gratification, or relief when pulling out the hair D. The disturbance is not better accounted for by another mental disorder and is not due to a general medical condition (e.g. a dermatological condition) E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
The following table illustrates the treatment methods used by the participants and their current situation with regard to education, employment and family status.

**Table 5 – Overview of treatment and support utilised and current social and employment situation**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Treatment</th>
<th>12-Step Programme</th>
<th>Return to college</th>
<th>Current career</th>
<th>Family status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gary</td>
<td>None</td>
<td>AA</td>
<td>BA</td>
<td>Not working. Voluntary counselling in Community Drug Team project</td>
<td>Separated 3 children</td>
</tr>
<tr>
<td>Martin</td>
<td>Residential X 2 (Same centre)</td>
<td>AA</td>
<td>BA Addiction Studies</td>
<td>Team leader in Drug treatment project</td>
<td>Separated 2 children</td>
</tr>
<tr>
<td>Tommy</td>
<td>Residential X 1 Aftercare Counselling</td>
<td>AA NA</td>
<td>BA Addiction Studies</td>
<td>Working in Drug treatment project</td>
<td>Married 3 children</td>
</tr>
<tr>
<td>Colin</td>
<td>Residential X 1 Aftercare Counselling</td>
<td>AA NA</td>
<td>Diploma Addiction Studies, Counselling and psychotherapy.</td>
<td>Fast food delivery</td>
<td>Partner 1 child</td>
</tr>
<tr>
<td>Clint</td>
<td>Day programme Aftercare</td>
<td>AA NA</td>
<td>No</td>
<td>Retired plumber</td>
<td>Married 2 children</td>
</tr>
<tr>
<td>Eddie</td>
<td>Residential X 5 Aftercare</td>
<td>NA AA for 1 year</td>
<td>Diploma Social Care/Studies</td>
<td>Special CE Scheme in Youth Project</td>
<td>Married 4 children</td>
</tr>
<tr>
<td>Brian</td>
<td>Detox X 2 Residential X 5 1 Day programme Aftercare</td>
<td>NA</td>
<td>Certificate Computer and Electronic engineering</td>
<td>Not working</td>
<td>Single 0 children</td>
</tr>
<tr>
<td>Kevin</td>
<td>Counselling Group therapy</td>
<td>NA</td>
<td>BA Counselling</td>
<td>Not working Volunteer facilitator in drug treatment setting</td>
<td>Girlfriend 0 children</td>
</tr>
<tr>
<td>Jordan</td>
<td>Detox X 1 Residential X 3 Aftercare</td>
<td>NA CA</td>
<td>Diploma Human Growth and Social Studies</td>
<td>Not working</td>
<td>Single 0 children</td>
</tr>
<tr>
<td>Name</td>
<td>Counselling</td>
<td>Access course – Social Care</td>
<td>Occupation</td>
<td>Relationship</td>
<td>Children</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
<td>-----------------------------</td>
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<td>Joan</td>
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<td>AA, NA</td>
<td>Cert Addiction Studies</td>
<td>Full time student Holistic Health care</td>
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Participants described varying degrees of addiction and physical and sexual abuse in their homes while they were growing up. Several participants reported parental use of alcohol and drugs which often led to incidents of extreme violence. For example, one participant described her mother as addicted to prescribed and non-prescribed medication and being exceedingly ‘volatile’ especially during arguments with whom she described as an ‘extremely abusive’ father. Parental mental health issues were also reported by some participants, which often exacerbated problems within the home, including domestic violence. In all, seven participants reported continuous acts of violence. Four participants reported incidents of childhood sexual abuse (CSA) where two of these reported that their experience of CSA continued for extended periods of time. Several participants also reported mental health and addiction issues
concerning their own mental health and that of their siblings and children, which often added to disharmony and incidents of violence within their homes.

Eleven participants reported engaging in a treatment programme with ten of these reporting having more than one treatment episode. Of the five participants that did not report going to a treatment centre or attending a treatment programme, three of these were engaged in counselling. In all, ten participants reported going to counselling for periods ranging from several months to several years. All sixteen participants reported going to a 12-Step programme meeting for at least one year after ceasing drug use. Fourteen participants mentioned that they still attend meetings, even after many years in recovery.

Thirteen participants reported going back to college. Academic levels ranging from Certificate to Masters were reported. Seven participants stated being involved in a salaried or voluntary capacity in drug treatment services while two participants reported being employed in Youth Projects.

Participants’ identity before drug using

Analysis of the data from the interviews led to the emergence of a number of themes relating to how participants identified themselves before the onset of drug use. These themes highlighted the changes in identity for the participants before, during and after their drug using careers and the factors that influenced those changes both positively and negatively. This section describes participants’ reports of physical, social and psychological challenges that arose for them and negatively affected their sense of self prior to drug using.

Not fitting in

Prior to the onset of drug using, the participants in this present study reported low self-esteem, anxiety, fear and insecurity, but the overarching feeling expressed was lack of identification with mainstream society – ‘not fitting in’. Interestingly, Strauss (1993) described how some participants in his study had no sense of self before drug using, which was exacerbated by the fact that they had started drug using at a very early age before they could figure out who they were. Participants in the current study similarly recollected using drugs and alcohol from a very young age. Clint remembered stealing his parents’ alcohol from the age of eight and Brian
recalled sniffing solvents between the ages of nine or ten. The participants asserted that the excitement of the initial experience led them to continue to experiment in their early teenage years. Gary reported spending all of his money on alcohol when he left school at age fifteen, while Wendy, Scarlett and Kevin recalled having their first drink at age thirteen. Looking back to when she was thirteen, Wendy recalled ‘Even at that age just wanting to get hash, just wanting to get drink, wanting to be out of it’. Similarly Scarlett stated:

I was thirteen and started drinking all the ends of the drinks that were left on the tables. I have no idea what I drank, anything and everything ... I was hammered ... I just loved the drunk feeling. (Scarlett)

Eleven participants in this current study reported problems fitting in with their family, peer group and the wider society. They proffered diverse reasons for this. Tommy and Scarlett reported difficulty making friends. Scarlett asserted: ‘I didn’t have many friends, usually just one close friend. I always felt like an outsider’ while Tommy recalled:

Everyone in the area was a hard chaw and who could beat up who ... I found it very hard to fit in ... I was always trying to fight my corner and trying to be accepted ... When I look back, I would have been a kind of sensitive soul. I would have got hurt by the emotional – cry. (Tommy)

Brian described how, although he was bright and intelligent, he felt shy and had difficulty communicating with peers and ‘struggled to find my place amongst my friends ... difficult to mix ... felt on the outside’. Sandra explained that their family frequently moved house and when she was twelve years old, they settled into a totally different socioeconomic area, and had to make new friends in a new school:

I never felt like I was one of the girls ... I always felt different ... We were poor and a lot of these people ... had money ... my mother didn’t like the way we spoke ... it wasn’t ok to be where we were from, to talk the way we talked. (Sandra).

Likewise, Jenny described a lack of connection with people, stating that drug using helped her fit in:

I never felt part of anything ... I just felt there was glass around me. I didn’t connect ... I’d be looking and they are all laughing and I’d be saying “How are they all so happy
together?” I was just never happy. There was always this sadness ... this loss about me. When I started taking drugs, I fitted in and it was great. (Jenny)

Clint reported he ‘came in to my family at the wrong time.’ He described how his mother had been very ill, hospitalised with tuberculosis for a number of years, and was only home ten months when he was born. Clint recalled his older siblings had been living with relatives and had not seen their mother for years. He reported feeling she was more involved with regaining a relationship with them than caring for him, resulting in him feeling that he was: ‘outside my family ... I wasn’t one of them’. He suggested his early rebellion and drug using was a cry for attention from his family: ‘I was bringing the police to the door from an early age ... always in trouble’.

For another participant, Joan, being a twin had a huge impact on her life. Describing herself as a tomboy who loved to play with the boys she found that she could not identify with girls, which caused a lot of friction between her mother and herself. She recalled being in awe of her twin and wanted to be just like him, adding:

I didn’t really know who I was ... I was living through [twin brother]. We were always referred to as the twins ... I was never an individual ... It was always, like, where are the twins? (Joan)

Prior to identification in a drug using subculture the participants in this research described not only not fitting in, but also feeling lonely, anxious and isolated. They reported that using drugs and alcohol helped them with their difficulty in fitting in with peer groups. One participant, Brian said from the age of nine or ten, he was an anxious person and:

I found myself sniffing solvents in the school toilet alone and I wanted to escape. I always had a dark feeling ... I felt sad and lonely and miserable ... as time went on I found an escape in taking substances and drugs. (Brian)

Likewise, Colin explained how alcohol seemed to provide the answer for his anxiety:

Before I started drinking ... I was always a bit anxious, a bit nervous ... felt like an outsider ... when I had that first drink it was like I arrived. I could be whoever I wanted to be (Colin)

Underpinning many participants’ narratives of ‘not fitting in’ were issues like low self-esteem, lack of confidence and poor self-image as the next section outlines.
All of the participants described poor self-image, lack of confidence and low self-esteem before they started drug using and the not knowing or understanding why they felt like this. However, Hall and Jefferson (1975) and Nowinski (1990) described how a drug using identity and group influence can impact on values and behaviours that are essential to create a positive identity, for example, self-esteem, self-control and moral development. Therefore addiction and related considerations, for example the ‘Junkie’ stereotype stigmatisation, can add to low self-esteem, and block the hope of a ‘normal’ life structure, as highlighted by Clinard and Meier (1992). The participants in this present research gave examples of their initial feelings of inclusion and stated that initially, drug using helped heighten their self-image. For example, Brian described how he started sniffing solvents on his own but later found using drugs and alcohol could help him mix with friends. In this next quote, he described how he thought the use of drugs and alcohol helped his social identity:

_I suffered a lot from anxiety, low self-esteem and poor self-image amongst my friends … I thought I would have to prove myself to gain acceptance … I would go to great lengths to do that … I found it difficult to mix and I think when I drank or when I took drugs I found it that little bit easier. It took away some of the inhibitions that I had … gave me a boost. It made me think that I was something different._ (Brian)

Brian reported how he discovered opiates during three month stay in hospital:

_They [opiates] took all of that stuff away. I didn't care any more about what people thought of me, about what way I viewed myself … it acted as a buffer in social situations … I wasn’t particularly bothered by what anybody thought._ (Brian)

Similarly, Joan reported that the use of alcohol changed her self-concept: ‘It was great, because of the way it would make me feel. I would just act differently’, and Colin spoke of ‘years of self-doubts and self-loathing’ and how the use of alcohol ‘gave me, this confidence … my equilibrium was balanced again … gave me a tenacity for life’.

Several participants linked the idea of ‘not fitting in’ and low self-esteem with the difficulties they reported encountering at school. Brian reported that he found the transition from primary school to secondary school: ‘particularly traumatic’ where he ‘struggled to find my place

506 See also Link et al, 1997
amongst my friends’. Gary recalled how from the age of eleven he was always in trouble in school and was expelled from a number of schools, including a boarding school, for drinking.

Difficult family relationships

Some participants described difficult familial relationships especially with their fathers, including physical and emotional abuse. Rita spoke about her father, who she described as a ‘very intelligent man who was respected in the community’, but recalled how he would ridicule, beat and kick her every day on their way to work, resulting in poor self-confidence. Kevin recalled a similar story:

A lot of psychological and emotional abuse … physical confrontation … ridiculing and getting put down, name calling, pretty sadistic stuff. He used to punch me … rip my clothes, turn the light off if I was in the shower … sick, twisted stuff. Eventually it had an effect on me … beaten down … I became very introverted … embarrassed and my confidence just knocked out of me. I think I was traumatised from the stuff I’d seen kind of growing up … My teenage years were a fucking nightmare. (Kevin)

Some participants recalled adopting different personae to counter feelings of inadequacy, both within the family and with groups of peers. Goffman’s (1959, 1990a) idea of presentation of self is illustrated by the following quotations. Wendy’s description of playing as a child, and ‘pretending to be someone else on camera’ explained how she took on a ‘persona of overly confident and loud and a bully and violent and angry’, with a ‘hard image for fighting, attack before being attacked’ while she reported she really felt very vulnerable. She related how she experienced extreme anxiety ‘wanting to be someone else’ but reported feeling comfortable out on the streets. Finally she identified with the gaunt appearance of the drug user, as she explained ‘I always wanted that look cos I used to think it was so cool … to be a drug addict’.

Likewise, Colin, Eddie and Gary mentioned living within a façade which they described as a ‘mask’. They described this mask as shielding them from harm, ridicule and bullying, creating a persona to present to the world. Eddie likened his mask to a protective shield: ‘I probably would have killed myself as a child, only for I learned how to put on a mask and act and con’.

In keeping with Zinberg’s (1984) idea that many individuals, especially those associated with the drug using subculture, act out with shows of bravado or exhibitionism, Gary reported being
an extreme extrovert, ‘full of bravado’ despite the fact that he was very shy and lacking in confidence:

* I over-compensated by doing absolutely outrageous stuff ... while I was drinking ... I had to be the maddest, wildest person ... some of the stuff I did was totally insane. I just had to be wilder than anybody else. (Gary)

Not only did the participants of this study report a low self-esteem due to social and psychological issues, but some participants recalled physical issues that negatively affected their self-esteem. Eight participants suggested that their image of their physical bodies impacted on their ability to be accepted by their peers and themselves. Brian and Martin both recalled serious car accidents occurring when they were young. Martin described the impact:

* It was quite significant to wake up in the hospital ... lucky to be alive ... I’ll never forget it ... I didn’t know at the time there was a little girl and she was crushed507 ... that was a big impact on my life ... because it took huge getting used to508. (Martin)

Brian similarly described an accident, when he was a teenager, where he almost died:

* I broke my neck and I broke my right leg and I was nearly killed. So that compounded my view of myself. I ended up with scars and always felt a little bit weaker than I was before ... It affected me and I viewed myself as maybe weaker than my peers. (Brian)

Wendy shared feeling ‘insecure and ugly’ while Rita also had great difficulty with her body image. She described how her difficulty arose, not from disfiguring or debilitating accidents, but from how her father’s treatment of her impacted on her:

* He used to call me names ... “fuckin boat horse face”...“fuckin ugly” ... I was very, very hurt ... I hated him with a passion. He once kicked me in front of people I worked with ... I left the job because I said I couldn’t stand that auld fella to give me a lift anymore cos every morning this used to happen ... from fifteen to nineteen ... I was painfully disturbed ... about my self-image ... It destroyed me ... I wasn’t aware that it had destroyed me. I was just aware that I had no confidence, I looked awful and I felt that I was fat ... huge and ugly ... when I took that drink, that took that away and I remember going to a dance, dancing, and feeling happy. (Rita)

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507 A young girl lost her life in the accident
508 Martin lost four fingers off his left hand.
Some participants in this study reported that, no matter how they tried both at home and at school, they felt unwanted and never just quite good enough which is further explored in the next section.

Not good enough, feeling unwanted

Describing growing up in a climate of not being cherished and praised, feeling unwanted or never ‘good enough’, intensified issues of low self-esteem and lack of confidence, which exacerbated drug and alcohol use for the participants. Sandra recollected ‘being in that negativity and not sure whether somebody wanted you or didn’t want you’ even though, as this next quote illuminates, she reported working relentlessly to try to please her mother:

I would make the dinner, bake scones, wash the kids, have them out playing, have them bathed, fire lit, house clean and my mother would come in and find something wrong. Something wasn’t good enough ... that was constant ... no matter what, I wasn’t good enough. It didn’t matter what I did or how hard I tried ... I think that I am not good enough for lots of people because of having that ingrained message for such long period of time. (Sandra)

Echoing this notion, Tommy, Scarlett and Colin shared their stories about never feeling good enough. Tommy explained how this impacted on his ability to defend himself in discussions or conflicts in later years:

I felt intimidated, I always felt I wasn't good enough so I had allowed other people to speak down to me ... never felt I had a voice or a leg to stand on ... or thought what I had to say was important. (Tommy)

Scarlett also remembered not talking much, feeling ‘second rate’ due to a lack of confidence and Colin recalled his experience of constantly being told ‘You’re no good, you’re stupid’.

I started getting slagged in school and jeered ... it was very hurtful and I took everything on board, soaked it up like a sponge ... when I became a teenager ... I couldn’t mix, it was low confidence ... I drank ... it gave me this confidence. (Colin)
Miller (1999) highlighted the issue of childhood sexual abuse (CSA) and its impact on survivors. Four of the participants in this study, a percentage which mirrors the national average as reported by One in Four, recalled the trauma of CSA. Playter (1990) discussed not only the actual abuse but also the sense of internalised shame, which was a huge barrier often neglected treatment settings, and paralysed survivors in terms of help-seeking. Bloom (1998b) further suggested that many women become involved with drug using due to neglect, physical or sexual abuse or violent trauma early in life. Difficulties emerged for the four participants of this study around disclosure, being believed and reconciliation. One male participant disclosed that he had never spoken to his father about the CSA he experienced and two of the women, who reported experiencing CSA, understood the feelings of internalised shame especially when they not believed by their mothers upon disclosure. Meryl explained:

Mam's partner was violent and abusive ... he sexually abused me. I told the teacher and the teacher told my Mam and I was brought to [Health Clinic] to find out why I was telling these lies and things went ... from bad to worse from that point. (Meryl)

Eddie explained how his life changed after a prolonged period of CSA:

Before the abuse ... I would have been quite soft growing up, innocent ... a mammy's boy ... I was easily amused but that all changed. It took a lot for me to be amused. I always wanted more. And if I set my mind that I wanted something, then up to the maddest things that a human being can possibly say I want that and I'm gonna get it. I pulled it off ... I never spoke of it [CSA] to anybody. Very bitter, very angry, hated the world, hated teachers, hated police, hated neighbours ... I totally rebelled. (Eddie)

Reflecting Keene’s (2010) findings, the participants in this study reported how initial experimenting with drugs and alcohol seemed to resolve their emotional difficulties, discontent, low self-esteem and lack of confidence. However the participants also testified they did not realise they were vulnerable to developing dependence. The next section focusses on their early drug using careers.

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509 One in Four quotes statistics from the following reports – SAVI, Ferns, Murphy and Ryan and states that ‘In Ireland research has shown that one in four children (27%) will experience sexual abuse before the age of 18’. 510 One in Four is a professional organisation in Ireland which supports men and women who have experienced sexual violence, many of them during childhood.
Early drug using

Schaler (2006) stated that initially, drug users do not anticipate problems associated with drug use. Echoing this, Brian recalled that he ‘found an escape in taking substances’. Clint described how he associated drinking with fun and parties, while Scarlett reported how she experienced alcohol helping her socialise, as she explained:

*I always wanted to be something different … I don’t know what I wanted to be – just not me. The drink helped with socialising and getting on with people. It helped me feel more secure and confident or I just didn’t care as much.* (Scarlett)

Several clear aspects emerged from the participants’ narratives connected to their early drug using. Acceptance by peers was one of the main influences that motivated the participants in this study to engage in drug using.

Peer influence

Zinberg (1984) stated that peers reinforce users’ perception that drug using is not bad, evil or harmful as perceived by parents, teachers and authority figures. Young people often experiment with drugs to provoke authority and reject parents’ value systems. When the participants of this study discovered drugs and alcohol and made friends with like-minded people, they described feeling happy and being accepted and included by peers. However, Colon et al., (2001) stressed that initially an individual may mix with a group that is quite ignorant of drug use and ruled by risk taking behaviour and compulsive use. Echoing this literature, Sandra recalled actively seeking like-minded peers where getting drunk was quite acceptable and not considered dangerous or risky, as she explained:

*I’d move from friends to friends. If they didn’t drink I couldn’t hang around with them anymore and I’d move on to the next … I was drinking every weekend … always pissed … knacker drinking*. (Sandra)

In agreement with Keene’s (2010) research, the majority of the participants in this present study explained how they educated themselves about drug using within their peer group, where the group influenced initiation into and maintenance of drug using behaviour. One participant,

511 Drinking alcohol in groups in fields and obscure locations.
Tommy stated: ‘I got in with a group ... doing gas and hanging out in the fields’ while Martin, remembered ‘around fifteen ... pals I was with in school ... started drinking and smoking hash’. Grund (1993) argued that immersion in groups of drug using peers with the accompanying rituals of drug using helps individuals fit in and decreases anxiety and fear. Wallace (1996) agreed, saying that within the drug using subculture bonds are strengthened, intimacy is created, solidarity is reinforced which is a welcome change for individuals who feel excluded and isolated.

Literature reviewed in chapter two indicated that the peer group’s values and attitudes predict future use, where individuals who evolve into heavy drug using, generally associate with peers who have similar drug using patterns. Zinberg (1984) asserted that since drug using is a clandestine, illegal activity, individuals do not have a large array of groups to choose from and finding a suitable group is often reached by chance rather than choice. In keeping with this notion, Meryl reported finding a group ‘who were into drinking and using ... and a couple of older men who were into other drugs ... we just partied all the time’. Other participants also recalled how they initially welcomed immersion in the drug using subculture and commented that they felt more confident, relaxed and sociable when using with others. For example, Joan reported that she was ‘funny and the girls were able to relate to me ... gave me confidence’. She further added that at the age of thirteen or fourteen:

_I began to experiment with aerosols. A couple of girls in school were messing around and inhaling aerosol ... then the drinking started ... and smoking._ (Joan)

Bandura (1973) stated that individuals learn by watching others and imitate behaviour especially when highly respected models enjoy pleasurable experiences. Behaviour is less likely to be imitated if it results in punishment or sanction. Echoing this, Tommy commented on the pleasurable experience of feeling accepted by the new crowd, where ‘[E] gave me confidence. I was accepted. I was talking to people I never knew. I was wrapped up in a whole buzz which I thought was love’. Tommy’s quote resonates Kail and Litwak’s (1989) assertion that the compulsion to use drugs, along with the welcoming feeling of intoxication, strengthened social bonds with peers.

All of the participants recalled the importance of being included and accepted by peers. In their early drug using careers, ‘hanging around’ drinking alcohol with friends was more important

512 See Fergusson & Harwood, 1997; Hoefler et al., 1999
than other roles in their lives. Joan remembered neglecting her other roles: ‘What I used to do all the time – skip school, go drinking’. Wendy also recalled peer inclusion outweighing day to day responsibilities as her quote illuminates:

_"I didn’t want to be at home. I wanted to be hanging around … with the girls. I wanted to be drunk … be around music – we’d be sitting in fields with cans and we’d be singing these songs. A lot of them times were … innocent."_ (Wendy)

Grund (1993) commented that the sharing of common activities and powerful, emotional experiences strengthens positive bonds. Solidarity can be enhanced by sharing. Sharing and reciprocity cements group cohesion, stabilises relationships, establishes responsibilities and obligations within the drug using subculture and ensures continuity of supply. In agreement with Grund (1993), Clint recalled the reciprocal sharing of stolen alcohol with his peers:

_"At fourteen … I wanted to leave school and get a job and drink with the guys in the fields. Drink cider with the older boys… my first job … I was able to steal … wine … share with the guys … then sharing whatever they were after stealing."_ (Clint)

Reflecting Wallace’s (1966) assertion that repeated ritual behaviour increases confidence and dispels anxiety and fear, one participant, Rita remembered ‘_this is the answer … what I’ve been missing all my life. It took away all that pain._’ Wallace (1996) maintained that group members knew what was expected, like Tommy who recollected that ‘_to become accepted I started taking it … enjoyed the craic, good laughs._’. Grund (1993) similarly found that as new members join groups, solidarity is reinforced and bonds strengthened. Participants in this present study reported feeling validated, accepted and finally ‘_part of something_’, as Colin explained:

_"I wanted to go cos I wanted people to validate me. I wanted people to make me feel a part of, so I went in and I done E, ecstasy, because all my friends were. I thought they will like me … and I’d like myself._” (Colin)

Many participants reported that they felt they had finally found what they had been searching for all their lives. They reported wanting to get away from themselves and searching for ‘_something else_.’ Eddie recalled:

_‘The first time I drank … I got totally legless … I thought yes. This was for me. This was what I wanted. All I wanted to do was get away from me … Then the speed came_
in and then ecstasy and every new drug I tried I said 'that's it. That's for me'. Anything just to take me away from myself that bit further. (Eddie)

Some participants reported finding a whole new social scene that they were drawn to, again feeling ‘part of something’ – no longer on the outside, as Brian explained:

_I got caught up in the whole rave scene ... found a place and a purpose in that. I felt a part of something ... when I was taking a certain substance it was easier for me to communicate ... to be somebody that I wasn't ... had I not had that low self-image and poor self-esteem ... I probably wouldn't have taken those drugs._ (Brian)

A number of participants testified finding they had an extremely high tolerance for drugs and alcohol at a young age which they recalled proved extremely useful as they became more immersed in their drug using. Sandra remembered, at age fourteen, not only drinking her share but also that of her friends who were unable to finish theirs. Echoing this, Joan narrated ‘_The others would be throwing up in the corner, I was just able to drink and drink._’ Tommy also related feeling very proud of his ability to drink and of the accompanying respect, as this next quote illuminates:

_I was good at drinking. Where the lads would drink two cans and fall over I could drink four ... people were ... looking up to me ... Tommy is a bleeding great drinker so that was enjoyable._ (Tommy)

In keeping with the medical model, Jellinek (1960) predicted that any drug use, even occasional recreational use will lead to chronic addiction. Whether a disease, an environmental factor, a response to underlying issues or coming under the umbrella of the biopsychosocial model, many participants reported that they thought they were ‘addicted’ from the first using experience. In accordance with Keene’s (2002) notion of the ‘slippery slope’ where drug using inevitably leads to addiction, Eddie recounted: ‘hash was the first drug ... done it to go along with the lads ... straight away got addicted’ and Martin recalled his first use of cocaine: ‘hooked on the first snort’. Social learning theory suggests that drug users, due to their own experience and social conditioning, anticipate that further drug using will bring pleasant experiences and facilitate problem solving (Mc Murran, 2006)\(^{513}\). Echoing this, Colin recalled:

\(^{513}\) See also Long, 1992
As soon as I took ecstasy that was it. I got very, very much obsessed with it ... most beautiful experience I ever had in my life. I never felt anything like it before. (Colin)

Similarly, Meryl recollected her early drug using:

From that very first time I used a can of deodorant with a plastic bag I don’t know if there was very many days ... that I didn’t use some kind of substance. (Meryl)

Becker (1963) described the social learning process as learning the technique of using, perception of pleasurable effects and learning to enjoy the effects, all of which are facilitated by experienced users. Resonating this, Tommy and Jordan reported that while they realised the danger of drug using, the pleasurable side of the experience rendered them determined not to be left behind. Jordan explained how he ‘progressed to LSD ... had a few bad experiences ... yet ... the next week I would take them again’ and Tommy recalled:

This sort of thing can kill you... but as everyone started taking E ... I'm gonna be left out here and I started taking it ... absolutely loved the whole buzz. (Tommy)

Even though the participants in this study reported welcoming the sense of intoxication and enjoying their drug use, over time they reported how their drug using became progressively more chaotic as they fell deeper into dependence. They described effects that extended to all areas of their lives – psychological, spiritual, social, financial and physical, and negative consequences that became ever more precarious. The next section explores how the participants reported their patterns of drug using had changed significantly.

Changing pattern of drug using

The medical model holds that the drug user is influenced and changed by the drug. Jellinek (1960) suggested that progression to chronic drug using was inevitable often leading to death. This inevitability is underscored by lack of choice or loss of control. Echoing this, Colin described how he was banned from drinking at home because of his violent behaviour. Similarly, Gary explained how he tried unsuccessfully to stop using, describing his drinking as a ‘runaway train’ and that as he became addicted to alcohol, he felt he was ‘absolutely, utterly powerless over the choice ... I had no choice’.
Long (1992) asserted that drug using is perceived to have negative effects on the user, negative consequences, difficulties when trying to stop and difficulty in organising daily lives. Furthermore, Ycel and Luban (2007) suggested that drug using can undermine decision making and self-control. In keeping with these difficulties, Eddie recognised that ‘everything had totally gone out of control ... I was doing a lot of stuff on myself – secret drinking and stuff’. Walters (1996) stated that during this period the significance of identity becomes apparent and when drug users begin to identify with other users, many difficulties arise along with an escalation of drug use. In agreement with Walters (1996), Tommy recalled:

\[ I \text{ could not go out and take one \[E\] of a night or take one on a Friday and one on a Saturday. I'd be taking them Thursday nights ... not even going to clubs but taking them at home in the bedroom on my own. } (\text{Tommy}) \]

Hendler and Stephens’ (1977) assertion that increased association with drug using peers and decreased association with non-drug using peers intensifies drug use and speeds up the progression from use to dependence, also emerged in this present research as Clint recollected:

\[ 'I \text{ went to maybe twenty five concerts with those guys ... I have only seen about three of the headline acts. The rest of the time we just wasted ... just out of my head'. } (\text{Clint}) \]

Sandra reported how drug using peers introduced her to crack cocaine and Meryl explained how her life situation and drug using changed as her association with drug users deepened:

\[ I \text{ was using every day ... got kicked out of school and sent to [Youth Organisation] where I met other people who were also using drugs and began using heroin ... once a week twice a week ... progressed into daily use ... I moved out of my Mam's ... I was fifteen ... I shared a flat with another girl who used drugs and with her I got very, very heavily involved in the drugs scene. } (\text{Meryl}) \]

Some participants in this study reported becoming mentally unwell, as Jordan reported becoming ‘very paranoid’. Similarly, participants described getting physically sick during their drug using but carried on regardless, as this quote from Sandra illuminates:

\[ \text{It tasted horrible, made me feel like I wanted to fucking gag. Straight away I was pumped ... so at ease, so warm, so relaxed, then I threw up all over the place and that is how it went for me ... I got sick even when I was used to it like and then when I was sick, I got sick waiting to get some into me. I’d be vomiting green bile and I’d be trying} \]
to get lines into me and I’d be vomiting ... then I’d started to settle the sick. That went on for years. (Sandra)

All of the participants in this present study reported negative consequences arising from their drug using. Colin recalled that he ‘couldn’t go out ... terrified ... madness and chaos’. He further reported:

I used to stick the needles into my feet ... into my arm cos I couldn’t really bang up right. I was destroying myself. Doing tablets, I’d do the tablets to get stoned and go blank for two weeks. (Colin)

Using copious amounts of alcohol along with using drugs exacerbated problems for the majority of the participants in this study, and in many cases added to the dangerousness of their individual situations. Kevin mentioned that he ‘started taking ecstasy ... during the day to stay awake so I could drink more’ and depicted:

Waking up with empty bottles of whiskey ... couldn’t remember where they came from. I would be drinking consistently for days ... I was in trouble but I was totally oblivious’ (Kevin)

Rita similarly remembered refusing a career advancement opportunity as it ‘would interfere with my drinking’ and she recalled how her drinking escalated into every part of her life. On a work social event, Rita commented:

They had to tie me to a chair and I came in like a crab apparently with the chair tied to me back squrealing “ye’s pack of f’rs I was only enjoying me self” ... next thing I remember I woke up in a strange house ... I thought where am I? (Rita)

As Rita related her narrative, it was easy to see the progression of her dependence. She recalled having no social life outside of drinking situations and that she did not buy or cook any food. She recalled an incident where she used her remaining money to buy a small bottle of vodka, but dropped the bottle and broke it while crossing the road, as she explained.

I got on the ground. The cars were beeping and I can still see the end of the bottle. I was licking it off the ground ... this car was beeping. Fuck off I had to get this. Yet the next day I’d get up as if nothing had happened. (Rita)
Plumridge and Chetwynd (1999) found that drug users who identified as ‘recreational users’ felt in control of their drug using and used much less than those who identified as ‘junkies’. Burroughs (1992) and Baker (2000) suggested that this factor, exacerbated by social stigma, reinforces the ‘addict’ identity. Brener et al. (2012) agreed, stating that heroin users tended to use more depending on how strong their drug user identity was. As the participants became more engaged with drug using and their drug using peer group, they recalled how they discovered changes in their lifestyles including increased risk taking behaviours. They reported that increased drug using and associated behaviours led to further isolation from mainstream society, negatively affected social relationships outside of drug users and lessened the strength of supportive relationships. Echoing this, Brian reported that while he felt detached from society, he nonetheless was ‘comfortable with it ... but as my addiction progressed, I was beginning to suffer consequences’.

Joan and Colin also recalled their progression into addiction. Joan remembered how her employment was terminated as she was drinking at work and that, due to starting to use cocaine, her ‘health began to deteriorate. I looked terrible. I was losing weight’. This quote from Colin encapsulates the effect that increased drug and alcohol use was having on him:

*I used to drink at the weekends ... ended up drinking during week days ... I was in a group of people and we all drank. And were addicts as well ... I didn’t drink just to be social. I drank to get drunk ... I got violent and hit people ... caused mayhem. I got killed more times than enough ... I was angry inside. I didn’t have the boundaries. It unleashed the monster inside me ... couldn’t control it.* (Colin)

Colin equated his increasing violent outbursts with breaking his own moral code. Several participants in this study stated that as their drug using continued, they began breaking their moral codes and pushing their own boundaries. It seemed inevitable, a self-fulfilling prophecy, that moral codes would be broken as soon as they were acknowledged. Heyman (2009) suggested that drug users either abandon social values that control drug using or that they never held them in the first place. In agreement with Heyman, Colin recalled: ‘*once I crossed that boundary with ecstasy I crossed all the boundaries ... then you cross that boundary into heroin ... and then that’s it*.’ Similarly, Eddie remembered:

*The drink came in and that was another one of my morals that I broke. I swore I’d never do it because of the way my father was. I didn’t want to turn out like my father.* (Eddie)
Long (1992) proposed that the medical model discouraged taking responsibility for decisions and encouraged moral irresponsibility by endorsing the idea of loss of control due to the disease of addiction. Echoing this, Sandra described how change happened slowly for her.

I wouldn’t snort cos that would be real drugs then I’ll just take E ... then it would happen ... I wouldn’t do needles I wouldn’t do heroin, I wouldn’t do coke ... It was like every line I drew in the sand I stepped over it ... sometimes as soon as I had said it, sometimes shortly afterwards. It was inevitable. (Sandra)

Within the concept of breaking their moral code, some participants, while endeavouring to conceal their drug use, reported that they were leading hidden or separate lives – one which contained drug using behaviours while the other denied them. Goffman’s (1959) notion of the ‘backstage’ performance is reflected in the descriptions of the hidden side of addiction. Behaviours and activities that have heavy stigma potential are often hidden from friends and family (Goffman, 1959, 1990b). Gary explained how he was ‘leading the two lives’.

From the first drink I was telling lies ... Hiding how much I drank ... drinking was always something secret, certainly the extent of it and the quantity and the frequency ... from the very beginning I had a separate ... existence with alcohol (Gary)

Martin recalled he was ‘living a double life by my late teens’ where in work ‘I was giving a ... different perception of me’. Similarly, in keeping with Anderson’s (1999) observation that drug users often distrust individuals and authority figures who have the power to sanction them and hide their drug use, Sandra described hiding her drug using, even from some of the people she used with:

I was living fucking two different lives. So this guy I used to meet and get methadone and tablets off had no idea that I was using heroin ... my partner didn’t know I was getting methadone every day off this other guy. I was just like trying to balance the two ... it was just horrible ... trying to keep the lies up ... scamming and scheming ... everything was just overwhelming. (Sandra)

Many drug users respond to this type of cognitive dissonance by becoming more involved in a drug using subculture. Zinberg (1984) suggested that drug users tend to gravitate towards each

514 See also Clinard & Meier, 1992, Link et al., 1997
515 See also Anderson & Ripullo, 1996; Becker, 1973; Cleckner, 1977; Grund, 1993
other in an attempt to resolve difficulties that emerge. The findings on participants’ engagement in a drug using subculture are presented in the next section.

Drug using subculture

Drug users move towards a drug using subculture when their drug using becomes difficult to assimilate into everyday life. Des Jarlais et al. (1986) suggested that they create their own social controls, sanctions and rituals in an effort to protect their drug using, minimise the negative effects and avoid detection. Jenny described her inclusion within her peer group:

*I was part of the group ... there was about ten of us and we stayed together ... we bought our drugs in [Area] ... we always got “lay ons” and we’d go out shop lifting. We were one group and we ran together for years.* (Jenny)

Jenny’s description of how the subculture becomes a strong support system echoes Grund’s (1993) observation that individuals create an alternative social world by interacting with like-minded groups. A drug using identity is constructed, which can cause difficulty when attempting to reconstruct a non-user identity. Within the drug using lifestyle, the participants in this study reported they would easily accommodate drug using behaviours to fit in with their peer group. Jenny described how she resumed drug using after the birth of her daughter and had to adjust her method of administration to reintegrate with her drug using peers:

*I came back and using tablets I knew there was something wrong, they were keeping the needles – keeping me away from them ... there was something I wasn’t a part of ... I was on the outside so I realised it was injecting so I started injecting straight away to fit in. I remember one of the first occasions I injected ... I overdosed and was in bits for days. But, it didn’t matter. I was part of the group.* (Jenny)

Initiation into IV drug use is not led by peer pressure, but a reciprocal relationship where people share common beliefs and attitudes (Coggans & McKellar, 1994). Roy et al. (2002) further stipulated that IV drug use becomes part of group decisions, enhances cohesion and cements rituals. Jenny strove for inclusion within her peer group and incorporated the changes into her own drug using. Reflecting this, Colin recalled ‘I remember a fella got a needle out and I stuck out my arm and I said “Please just take me away from the pain” ... of just living, of just being me.’
Conflict arises, especially when legislation and policy reflect the principles of mainstream society but not those of the subcultural group (Zinberg & Harding, 1977) who take on the label of being deeply discredited and heavily stigmatised (Goffman, 1990a). Jenny reported experiencing this conflict and explained how sometimes, even though the lifestyle did not suit her, she continued to ‘run’ with the group.

\[ I \text{ got myself into situations that I didn’t want to be in ... robbing or we would be doing stuff that I didn’t want to do. But I used to do it anyway just to feel part of the crowd. I didn’t want to be on the outside. I wanted to be kept in the middle of that crowd. I wanted to belong, to have a sense of belonging. I felt wanted or needed or whatever needs were being met but I was part of that crowd and was staying in it. (Jenny)}\]

Another participant, Meryl echoed this sense of collective identity. She described leaving home at fifteen because ‘I found people I could identify with ... it was only when I got clean that I stopped identifying with them ... damaged people we found each other.’ The participants of this study agreed on the importance of a sense of collective identity as described by Furst and Balletto (2012)\(^516\), which establishes inclusion and exclusion criteria, ensuring meaning and identity for the group that is apparent to outsiders. Snow and Benford (1992) added that group members exclude outsiders and attempt to oppose negative stigma and hostility. Brian described wanting to be immersed in the peer group where he ‘found a place and a purpose ... felt a part of something’. Similarly, Tommy described how taking ecstasy initiated his belonging within the group. He recalled ‘everyone started taking them, I thought, I’m gonna be left out here. I started taking it’. Hawe and Shiell (2000)\(^517\) observed that subcultural members present a united front to mainstream society to communicate their identity, which remodels their lives to create an independent living arrangement exclusive to mainstream society. Nine of the participants reported that they began to associate with like-minded people and were comfortable encouraging relationships with them. The new peer group enabled a sense of belonging which had been described as missing in most of the participants’ lives. Within the drug using subculture, drug users adopt a drug using lifestyle, which eventually bears negative consequences, as the next section explores.

\(^{516}\) See also Brewer & Gardner, 1996; Taylor & Whittier, 1992
\(^{517}\) See also Bourdieu, 1986; Campbell & MacPhail, 2002; Carpiano, 2006; Putnam, 1993; Portes, 1998.
Drug using lifestyle

This lifestyle differs remarkably from mainstream and becomes more intra-dependent and mono-focussed. The mistrust of mainstream society that Grund (1993) described also emerged in this research, with several participants speaking of the attractiveness of the life of a drug user where they joined in wholeheartedly assuaging any reservations they may have held. Their new lifestyle invited danger and anxiety, which according to Szasz (1985) can enhance group cohesion. Participants in this study described this new lifestyle, being lived outside of mainstream society, was very much frowned upon by family and authority figures. This echoes Thornton’s (1996) assertion that when drug users forgo mainstream convention and identify with the marginalised drug using subculture, they are perceived as somewhat untouchable, which in itself is attractive. Martin echoed this, stating: ‘I felt untouchable. I felt like a gangster’.

As drug using progressed, several participants reported discontent with living conditions and social relationships outside of their drug using friends. Membership of the group and escalation in drug using can impact negatively on families. Participants in this study, especially those who became homeless, described experiencing hardship on a daily basis. For example, one participant Brian recalled being homeless was ‘horrific, horrific ... I felt disowned by my family, I felt alone ... in the world.’

Kimber and Dolan (2007) noted that within the drug using subculture, overcrowded environments carry potential harm, increased risk of needle stick injury, poverty and economic hardship but are still preferred to environments that do not ensure privacy. Despite the initial sense of intimacy, identification and belonging, increasing use can negatively affect group relationships. This breakdown in relationships which can obliterate the drug user’s new found contentment (Baker, 2000) emerged in this present research. Wendy reported increased avoidance of her drug using peers.

There was gangs and I could go to them if I wanted ... Some days I might be feeling a bit lonely and say let’s go and hang around with this gang ... but ... in later years. I’d score on my own, use on my own, get money on my own. (Wendy)

Within a drug using lifestyle, empirical research asserts that polydrug using increases with membership of a subcultural group (Bravo et al., 2003). All of the participants in this study, 518 See also Bourgois, 1998; Page et al., 1991
without exception, declared polydrug\(^{519}\) use especially in latter years. They shared their experience of polydrug use and mixing drugs and alcohol, for example, Colin stated ‘I was a polydrug user ... and a very bad alcoholic’. Similarly, Wendy described risky, polydrug use:

> [Friend] whose Nanna ... had Alzheimer’s ... arthritis and a heart condition. We used to take her tablets ... I wouldn’t even know what I would be taking and I’d be swallowing them back with whiskey. I was drinking bottles and bottles of whiskey ... and heroin. (Wendy)

Jordan stated ‘I had my bag of gear and my joint ... It was the start of my chemical romance or my heroin romance’. He said he never identified a ‘drug of choice’ but used combinations of cocaine, tablets and methadone or heroin and hash depending on which group of friends he was using with.

**Deviance and Criminality**

Gourley (2004) maintained that the drug using subculture has been firmly placed among deviant subcultures, and with the adoption of deviant norms and values, deviant behaviour is initiated and maintained\(^{520}\). Berger and Luckmann’s (1966) work discussing social construction of reality mentions society’s response to roles adopted by some members. The participants of this present study reported acting differently as their new role demanded and being treated differently by others. Many of the participants reported being involved with deviant lifestyles which they were not completely comfortable with. Kevin recalled trying to adopt the identity of a drug dealer to maintain his own drug using:

> I was about twenty one ... brother was sending me drugs ... I wasn’t programmed to be a drug dealer. He was giving me drugs and I was spending money on clothes, drinking, having the crack and I wasn’t really paying for the drugs ... There was a bill accumulating ... I had myself thinking that I can manage this. I could be a drug dealer and a criminal but I wasn’t. I was just a fucking lost, mixed up kid.

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\(^{519}\) Early experience was reported as using alcohol, hash, solvents, ecstasy, speed and club drugs. The most popular substances used in various combinations in later years were reported to be alcohol, hash, heroin (smoking, IV), cocaine, (smoking, snorting, IV), methadone and tablets, mostly benzodiazepines and sleeping tablets.

\(^{520}\) See also Becker, 1963, 1967; Clinard & Meier, 1992; Decorte, 2001; Zinberg, 1984
(Kevin)

Eddie also described how he felt pushed into the deviant role, where according to Becker (1963), society and powerful rule makers, create deviance by applying rules that when broken label the rule breakers as ‘outsiders’ or deviants. Eddie mentioned problems in school and in his local neighbourhood which exacerbated his move towards drug using and criminality:

> I had a lot of trouble in school ... On the road I would have got branded very quickly as the scumbag ... friends I would have grew up with weren't allowed to be with me ... that just pushed me further into ... influences that I had with criminality and drugs and everything that goes with it. (Eddie)

Within labelling theory, deviance is negotiated. Deviance is not a characteristic of the rule breaker as conforming to the rules of one group may demand breaking the rules of another (Clark, 2004)\(^{521}\). Individuals become passive recipients of the deviant label and associated stereotype and stigma and lose control of their social world. Similar to Mayock and Moran’s (2002)\(^{522}\) findings regarding higher rates of crime in disadvantaged areas, eight participants in this study reported living in lower socioeconomic areas and several gave examples of how they got caught up in criminality. Some participants reported that criminality was commonplace where they lived. Eddie described enjoying the mark of respect that came with his criminal status. He reported being sexually abused in childhood and believed the ‘gangster’ status would protect him from further harm. Kevin described growing up in a very violent lower socioeconomic area of social housing and his unsuccessful attempt to detach from it:

> A lot of joyriding and a lot of crime ... it wasn’t really frowned upon. It was just accepted. If anything it was promoted ... as a young kid it was attractive ... I knew at a very early age ... there’s two ways out ... crime or education. I said I’m not going to be a criminal. I’m going to have to get educated ... I studied accountancy for a year but ... given the level of [childhood] trauma ... there was no way I could go on ... What was going to happen was that I was going to end up in trouble, which was substance abuse or whatever. (Kevin)

Kevin recalled how he realised how difficult it would be to lead a conventional lifestyle and admired his older brother’s lifestyle where ‘he was making money and it was very kind of

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\(^{521}\) See also Donnellan et al., 2007; Reynolds, 2006

\(^{522}\) See also Murphy & Lawless, 2002; O’Higgins, 1998; O’Mahony, 2008
attractive. He had lovely clothes, he was respected’. Kevin remembered succumbing to a deviant existence: ‘I was lost at that stage … so I ending up leaving college’.

Some of the participants reported being attracted to criminal activity with the prospect of making large amounts of ‘easy’ money. Resonating Marlowe’s (1999) assertion that part of this magnetism was the challenge of evading detection, Kevin identified with the attraction:

This was the best thing … getting mixed up with a crowd … willing to take part in stuff that was gonna land me in trouble … I started selling drugs … I attained this identity to fit in, to run with the pack … I had progressed from being an ordinary, decent fella (Kevin)

Similarly, Eddie described how he enjoyed the ‘making money, crime and gangsters’ lifestyle and status where he ‘was fascinated by it. I ate, slept and drank that type of life’.

For some participants, experiences of criminality were everyday occurrences that were accepted as just part of the lifestyle. For others, the extent of criminality was becoming very dangerous. Echoing Peele’s (1990) assertion that within the drug using subculture it is critically important to gain the companionship, respect and approval of peers which can lead to increased criminality and Spunt (1993) who suggested that heroin users who identified as ‘street addict’ were more likely to get involved in criminality. Eddie reported that he wanted to be part of the gang:

I was starting to sell cocaine… I got caught back up in the criminality … I wanted to be one of the big lads … I was … gone out of control … that big, gangster person … I got quite violent with hammers and chains … Full of hate, very violent and started making money. (Eddie)

Increased criminality generally increases group cohesion and increases drug consumption (Newburn and Eliot, 1999)523, leading to the abandonment of other interests and responsibilities (Gossop et al., 2000b)524. Reflecting on this, Kevin explained how his increasing involvement with criminality became more important than other relationships:

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523 See also Bennet, 1998a; 1998b
524 See also Hammersley et al., 1990
I was going with the same girl from fifteen. At eighteen we split up ... I had no time for her and I had no time for my family. I was just spending it all with these ... We were living the high life ... Everything was great ... It was like Miami Vice. (Kevin)

In the case of female drug users, Bloom (1998b) listed shoplifting, fraud, property crime and sex work as the main offences. Rita shared instances of criminality in the workplace where she was ‘robbing in the job ... had access to money so I started robbing ... scamming and scheming... forge signatures ... robbing the till’.

Two female participants in this study reported sex working for a number of years. Drug using women who engage in sex work experience high levels of social sanction, isolation and poverty (Culhane, 2003)\(^{525}\), lack of safety, emotional, sexual and physical abuse (Schepber-Hughes, 1996)\(^{526}\) and added risk of infection (O’Connell et al., 2005)\(^{527}\). When describing the day to day life as a Sex Worker, Wendy explained that she had to earn approximately €500 per week and described the dangerousness of that work.

> I started working as a prostitute when I was nineteen ... I was being brought off to flats ... think I’m not even gonna get out of here ... gone into houses with men and thinking I’m not gonna get out of here. It was just a chance I’d taken with my life every single day. (Wendy)

Comas-Diaz (1999)\(^{528}\) noted that many female drug users report increased drug using to cope with the stress of sex work, which was reflected by Meryl, who reported: ‘I really didn’t have the ability to shoplift or to mug so I started working on the streets.’ She recalled how her drug using went out of control and thought sex working had a huge effect on her:

> It went really downhill because no matter how much I used it would only last a couple of hours and then the reality of what I was doing would sink in ... I was probably fifteen and a half ... I had been out on the street. One of the other girls had robbed me and I was dying sick and I remember just sitting on the street bawling. (Meryl)

Echoing Bloom’s (1998b) assertion that it was commonplace for women to have a dominant male accomplice, Wendy reported accompanying her partner when he robbed off-licenses:

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\(^{525}\) See also Cusik, 2006; Farley et al., 2005

\(^{526}\) See also Amnesty International, 2004; Maher, 1997; Nencel, 2001; Pyett & Warr, 1997

\(^{527}\) See also Spittal et al., 2002

\(^{528}\) See also Romero-Daza et al., 2003; Vanwesenbeeck, 2001
I’d sit in a taxi and he’d go in with a hammer, very romantic … We’d get the money, get heroin and we’d go off to his house and we’d be having sex and smoking heroin, drinking … like Bonnie and Clyde and we were on Crimeline\(^{529}\). (Wendy)

**Gangs**

Involvement with criminal gangs and organised crime heightened the dangerousness for some of the male participants. Reflecting Grund’s (1993) observation that problems around availability of drugs and increasing prices lead to financial pressures and deeper involvement in criminality, participants in this present study discussed gang involvement, initially in terms of excitement and inclusion, and for some fulfilling their aspirations to become a ‘gangster’. However the euphoria was soon replaced by fear and danger as Kevin explained:

*I started selling drugs and the habit just kind of went through the roof ... Straight into cocaine ... I’d gotten stuff to sell and went through it and there was a lot of money owed and physically I was in danger.* (Kevin)

The participants reported many reasons for danger existing. In some cases drug users do not conform to the accepted rules of the drug using group. Cheating on each other, stealing from each other or running up large debts with little hope of repaying them were also cited. Kevin mentioned being ‘backed into a corner’ several times during his interview. This concurs with Faupels’ (1987) observation that when members violate the rules, trouble and fractured group cohesion was inevitable, and added cohesion must be maintained for group survival.

The popular media representation of gangland carnage and drug related atrocities causes fear for the public (O’Mahony, 2008) and is a reality within some gangland behaviours. Kevin reported how he felt ‘blessed’ to be able to cease association with a criminal gang: ‘I was in with a very dangerous gang ... lucky enough I was able to break away completely’.

Similarly, Eddie recalled how he managed to break away from the gang:

*I’m very lucky that I didn’t end up ... set up or god knows what which comes as part of it ... I ended up down in [County] ... it broke me away from the circle that I was in ... cos I was getting in very deep and it was around the time that all that [Area] feud and

\(^{529}\) Irish television programme where the Gardaí ask the public to help solving crimes
everything kicked off ... I would have been in the depth of that. I would have been dead by now ... I basically wasn't bulletproof and things started to get dicey ... everything that goes with that lifestyle. (Eddie)

The male participants who got involved in criminal gangs felt ‘lucky’ that they were neither badly hurt, killed, or served lengthy prison sentences. The Criminal Justice System (CJS) envisions the drug user as a criminal to be sanctioned for the protection of society (Gould & Stratford, 2002). Two participants reported being incarcerated for periods of less than one year and one for more than one year. Conflict with law enforcement became an almost daily struggle. Wendy remembered ‘being brought in by the police all the time, being arrested ... getting charged’. She described this as being a nuisance but according to Mc Donald and Marsh (2002), many drug users enjoy the challenge of evading law enforcement which can enhance the attraction of drug use for adolescents, where they disregard social controls in an effort to establish their own identity. Participants reported that being apprehended by the Gardaí was an accepted part of the lifestyle. Jordan described often being apprehended and searched, while Colin smiled as he remembered: ‘I wasn’t a great robber. When I did rob I got caught’. Committing the deviant act and being publically caught confers a new type of status. Eddie described how constantly trying to be seen differently and gain respect from peers was more important than clashes with law enforcement.

Physical danger – impulsive or risky behaviour

Physical danger was not exclusively the result of gangland violence or criminal activity. Being susceptible to or causing physical danger was accepted by the participants of this study as commonplace due to impulsive or risky behaviour. For some participants in this study, their living conditions were similar to Bourgois’ (1998) description of the squalor and danger of dreadful living conditions. Rita recalled ‘We lived in squalor’ and Wendy described her physical situation while sex working ‘I was squatting in different places ... with all these dirty clothes, I had lice and I had scabies’.

Rita recalled getting involved in very dangerous situations and Scarlett described incidents from when she was sixteen:

530 See also Gourley, 2004; Pearson & Shiner, 2002
531 See also Des Jarlais et al., 1986; Murphy & Waldorf, 1991
Danger was, to a certain extent, played down by most participants. Echoing Wieloch’s (2002) assertion that defying death and dealing with pain and sickness are all part of the daily life within the drug using subculture, Colin described a nightclub where ‘it was a dangerous place. People got shot and stabbed ... I wanted to go in cos I wanted people to validate me’. Sandra and Jenny reported damaging themselves in their attempts to stop using. Sandra related: ‘I jumped out of windows twice, damaged my hip, cut my wrist, cut my foot putting it through a window’ while Jenny recalled:

*I was strung out to bits ... I hurt myself. I broke my foot with a hammer ... I done horrible things to myself to try to stop using ... I still got out of the flat on my arse, down the stairs, out of the flats and got over to [Area] to score.* (Jenny)

Through the above patterns of behaviour, although sometimes the participants reported feeling extremely uncomfortable, they fell further into drug using trying to change what they perceived was the matter in their lives. For example, Eddie talked about how his association with crime was an attempt to change how he felt about himself, ‘It [CSA] was forced ... that's why it was so important for me to be the big man ... The gangster’. The participants in this study stated that they were searching for a new identity through drug using.

**The ‘Drug User’ identity**

Becker (1963) suggested that the individual drug user accepts the collective identity of other marginalised individuals in an effort to belong, as belonging is welcomed even though negative characteristics imposed by stereotyping and social stigma exist (Goffman, 1959). Participants in the current study realised they had become the ‘junkie’ and while they were not completely happy with the lifestyle, they acknowledged that it existed. However, they discussed more negative than positive attributions connected with this identity. Wendy described herself as ‘as underweight, unloved, lost child’. She remembered that she ‘looked frightening ... the lowest of the low ... I had turned into that junkie’. And Jordan described the mistrust that accompanies the attitude to the role of ‘junkie’ as identified by Berger and Luckmann (1966):
I was a different person. If I was coming up to your house you locked the doors ... It wasn’t like people would be delighted to see me. It would be more ah god, here’s this fella ... watch your handbag. (Jordan)

During their drug using careers all of the participants related how they lost their sense of self, self-respect, self-care and dignity. Tommy maintained he was ‘riddled with self-hatred’ while Wendy reported: ‘your whole self- dignity and everything just goes ... smoking heroin and vomiting all over the place’. Rita recalled how years of neglect of self-care evolved to wearing a filthy black dress and reported: ‘I was what I’d call dressed-up ... I’d a pair of shoes high heels, the thing was all curled up from being worn down ... big old stitching in the shoes cos they’d burst ... and a bag with a big hole.’

Not only did the participants lose their sense of self but at times were unaware of how they were behaving and living, demonstrating a total lack of self-awareness. Rita explained how she became totally self-deluded and unaware of how her colleagues viewed her:

I was quite insane ... I thought I was so sane ... I was very aggressive ... people were afraid of me. I didn’t know they were afraid of me. I thought that they thought that I was just the belle of the ball ... people were terrified that I was going to sit in their company. (Rita)

Wendy reported when she was deeply engaged in drug using and sex working she lost all sense of herself. She described ‘having these out of body experiences that I just didn’t belong there ... No awareness of my body, what I liked or what was acceptable ... no confidence’. She recalled ‘searching for happiness in men, drugs, friendships but never finding it’ and being left feeling both ashamed and embarrassed, and that sex work:

Brought me to a whole new self-loathing. Depths ... I had never reached before. Anxiety and paranoia through using ... there was something morally wrong with me, that it wasn’t just a drug problem. (Wendy)

The majority of the participants described how dreadfully unhappy they became as their drug using took over their lives. The Drug User identity did not sit well with them and caused huge anxiety and pain.
Unhappy in drug user identity

The participants in this study expressed their discontent with their extensive involvement with drug using and the adoption of the drug user identity. For example, Kevin when discussing his involvement in criminality recalled:

* * * 
I wasn’t like people that were involved in that kind of lifestyle ... I attained this identity to fit in, to run with the pack. When I look back ... I just see a lost young fella, who has no reference point to ground himself with. (Kevin)

He recalled maintaining his deviant identity although he realised it did not fit:

* * * 
I was just a fucking lost, mixed up kid ... It was a false identity. I wasn’t a criminal. I wasn’t a drug dealer. I wasn’t a hard man ... I was trying to make myself something that I’m not ... trying to fit a square peg into a round hole, (Kevin)

According to Becker (1963), continuing deviant behaviour helps justify the amount of trouble individuals get into. Being deviant becomes a master status held above other statuses that may define or identify them. Eddie explained how he perceived his ‘gangster’ status earned respect and protected him from harm.

Participants described extreme unhappiness, including mental and physical health issues. Jordan recalled ‘I just became a nut case’ while Sandra reported being ‘lost in a fucking haze of lunacy and bad luck’. Colin reflected that even though he knew his problems stemmed from drug using he still could not stop, as his next quote illuminates:

* * * 
I was paranoid ... panic attacks ... I never experienced anything like that before but I knew it was the ecstasy and smoking hash ... my confidence was going down ... I didn’t know what was wrong ... I was trapped in my house ... terrified to go out. I knew it was the drugs but I couldn’t stop ... I was absolutely terrified. (Colin)

Changes in personality were also noted by the participants in this study. Clint stated: ‘I remember being very young and being a very caring person ... I became very selfish and uncaring’ and Tommy recalled the inability to stop using:

* * * 
I wasn't where I wanted to be in my life ... looking for ways out and trying to stop. I genuinely believe I did want to stop ... I just wanted to be a Dad, just wanted to be a husband ... I just didn't want to be me. I just wanted to stop. (Tommy)
Although the participants strove for acceptance of their situation the reality of addiction was not something that had been bargained for. Their new life structure impacted profoundly on their self-image where they internalised the ‘loser’ identity. Meryl stated ‘I played the victim a lot … I needed to learn I was not a victim. I was a survivor’. Joan remembered a period where she felt helpless and lost ‘I just get flash backs … It was crazy … I was so unhappy’.

As Covington (2002) stated, female drug users who are mothers are automatically perceived as bad mothers while males are not automatically labelled as bad fathers. Gary recalled an experience where he was looking after his baby daughter showing that either gender can be irresponsible when drug using:

I was minding my baby daughter who was … 6 weeks old at the time and in the shade of the bright sun. Anyway I was drinking and I fell asleep and the sun moved … she went from the shade into the light and was beginning to get pretty burnt when my wife arrived home … I was asleep, panned out. (Gary)

The majority of female drug users as stated by Hunt and Barker (1999), struggled to be ‘good mothers’ and prioritise children’s needs despite life’s challenges so a double standard exists where women are under pressure to fulfil their gendered roles within society. Scarlett and Sandra remembered their inability to maintain being ‘good mothers’. Sandra recalled her helplessness to change her behaviour:

I was very aware of my behaviour … I knew I’d left my kids. I knew I was still leaving my kids. I knew I was using … I couldn’t understand for the life of me how I was still doing what I was doing. I just had no power over it. (Sandra)

Scarlett also spoke very regretfully when she reflected on her children:

I would get the kids off to bed early and drink vodka till I collapsed. I used to just love that – never saw the harm in it … Never thought about being responsible for little children on my own and passed out with vodka. (Scarlett)

Agreeing with Inciardi and Surrat (2001) Meryl and Wendy described experiencing stigma arising from their involvement in sex work. Both women reported being aware that they were in trouble and were becoming deeply unhappy. Meryl remembered that she ‘didn’t want to live the life we were living’ while Wendy said ‘deep down there was no denying that I didn’t want

532 See also Inciardi, Lockwood & Pottinger, 1993; McCoy & Inciardi, 1995
to be doing what I was doing.’ Several participants, both male and female, stated their deepening discomfort with their lives isolated them, not only from mainstream society, but also from their drug using peers, as explained further in the next section.

Isolation

The participants in this study reported continued drug use became difficult to sustain even within the drug using subculture. Initially drug users accept the label that has been attached to them and isolate themselves within the drug using subculture seeing themselves as socially excluded (Mc Murran, 2006). Slowly, they break away from the group to the further exclusion and isolation of a lonely existence, as Kevin recalls:

Eighteen months where I didn’t really leave the house ... I was just in pure utter isolation. It was an awful fucking way to end up. It was a miserable, painful, fucking awful existence ... horrible fucking ordeal. (Kevin)

Baker (2000) noted that the accumulation of the impact of social stigma and the subsequent decrease of non-drug using relationships increases isolation and stress for the drug user. This promotes further marginalisation rather than reducing drug using. Colin described being ‘terrified of everything ... I couldn’t be around people any more. I isolated myself so much I didn’t go out. I locked myself away for two years’, adding that he was ‘demented using drugs but I wouldn’t stop’. Social stigma can also lead to shame which can become part of the individual’s identity leading to further vulnerability, disconnection, isolation and abandonment (Kaufman, 1996). Many of the participants created a world of desperate isolation in the final years of their drug using. Reasons for this isolation included panic, anxiety, fear and distrust of others. Colin also recalled how he became very depressed:

It became very depressing. Very, very isolated, very lying on the couch on my own, didn't give me confidence, actually shut me up ... the desperation was isolation, the degradation; the absolute horror of addiction ... it was mental. (Colin)

Wendy also described changes in her mental health as she isolated herself:

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533 See also Cohen, 1972; Hardiman, 1998
I was just going to work at night time and I wasn’t hanging around with anybody. I was just using on my own ...The interaction would be with the girls but I didn’t trust anybody ... I didn’t want my drugs taken off me. The paranoia had set in and I was having a big phobia going outside because the paranoia from the coke. (Wendy)

**Discontent but not ready to stop**

All of the participants reported that they eventually realised that they were in serious trouble as a result of their drug use and associated behaviours but still could not reconcile themselves to a life of abstinence. They continued drug using for years after this realisation had dawned. On a certain level, they reported a deep awareness causing an uncomfortable cognitive dissonance. Although this awareness was spoken about, all the participants described a reluctance to change regardless of their feelings of isolation, loneliness, pain, fear and powerlessness. They reflected that this was an extremely horrific time in their lives that they did not know how to change. Kevin mentioned when he realised he was in trouble:

*I was standing outside an early house ... 7 o’clock in the morning ... waiting on the pub to open and I was fucking shaking, with the DTs ... I was in bits.* (Kevin)

Even though they did not want to be living that life, they were not ready to stop. Wendy recalled being: ‘*broken, destroyed, but yet still wanting to use*’ and being sent to treatment by the court where she was ‘*sick and I was in trouble with the police but I wasn’t finished using*’. She related her many attempts to stop using over the next four years, but knew she was not ready. Kevin also reported having a lengthy battle lasting eleven years to achieve abstinence. He described:

*I was dealing with something that was bigger than me, stronger than me, that would outmanoeuvre me and that had me no matter what happened, whatever way the denial dressed it up, it was always there. I knew from that point on I was fucked.* (Kevin)

Colin remembered feelings of guilt, shame and remorse, isolation and fear where he was ‘*terrified of prison. I was terrified of everything*’ and that he ‘*couldn’t be around people any more*’. He stated: ‘*The desperation, the isolation, the degradation; the absolute horror of addiction ... was mental*’. Brian shared his despair around homelessness ‘*While I was using 80% of the time I was on my own so there was no trust, there was no friendship ... horrific life. I wouldn’t wish it on anyone*’.
All of the participants expressed feelings of pain and fear when trying to cease drug using, described how they came to the end of their drug using careers and managed to reconcile the awareness that the drug using needed to stop in order for them to continue their lives.

End of drug using

Many participants initially surrendered to a hopeless drug using existence where they thought there was no solution. Tommy reported he genuinely could not see a way out and Wendy recalled:

*I had accepted that I was going to die ... no longer trying to get clean. Hope had gone ... it was just darkness ... a hopeless situation and this is how I’m gonna live my life ... surrendering to this kind of life ... I can’t fight anymore.*(Wendy)

Levine (1979) discussed the ‘impossible to quit’ paradigm where mental health issues and psychological disease predict the drug user will surely suffer incarceration, suicide or death. Participants spoke about their situations at the end of their drug using careers. Regarding his frequent relapses, Martin recalled how he ‘was friendless in the end’. He stated: ‘I destroyed myself ... sitting in a crack house for two weeks, no food ... I was bones ... getting sores where the skin was starting to cut through’. Wendy shared how increased drug use impacted on her physically, psychologically and spiritually:

*Injecting coke ... brought me to my knees quicker than any other drug ... mentally destroyed me. Physically I was destroyed from trying to inject ... I had thrombosis in my neck and in my arms so I started injecting in my groin. But the spiritual death ... new depth of despair ... I was still injecting heroin for the come down. I’d inject loads of coke... I’d go to work and need to make ... €400 ... every night ... the pressure ... stay out and the cold, with a leg that was ... two times the size from clots. My breathing had shortened to a few breaths ... I looked like death.* (Wendy534)

Towards the end of drug using Sandra recalled: ‘*Everything was just overwhelming and I just wanted to feel nothing*’, Brian talked about the ‘*chaos or the torment*’, while Kevin described the ‘*miserable, painful, fucking awful existence*’ he was enduring. The participants were no

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534 Eventually Wendy suffered a severe infection from using a dirty needle and ended up in a near death situation at home on her own. Luckily she was found by her sister and brought to hospital where her life was saved and her recovery began.
longer getting a pleasurable experience from using. They mentioned that the drugs just stopped working. Several of the participants in this study mentioned they frequently thought about suicide and some attempted it, others self-harmed by cutting their arms and such.

**Suicide attempt/ideation**

In keeping with Baron (1999)\(^{535}\) who stated as drug using careers become more enmeshed and chaotic, drug users experience increased mental health problems with an increased risk of suicide, eleven participants mentioned suicide ideation, suicide attempts and episodes of self-harming, especially in the final years their drug using careers, which would indicate deep distress and discontent. Clint recalled his plan for ending his life: ‘*filling the room full of gas, striking my lighter and blow the place up*’. Likewise, Eddie remembered feeling very ‘*raw*’ and recollected ‘*every time I woke up was I’m gonna kill myself* and I could never do it’. Tommy recalled being wracked with guilt for what he was putting his family through.

Meryl mentioned self-harming, saying she ‘*did use blades ... scratch myself until I bleed or thump myself ... or I would cut my arms or cut my stomach or whatever*’. Martin also recalled suicidal ideation and self-harming: ‘*I started to harm myself. I cut my arms ... I was in that much trouble ... I was planning on killing myself*’. Joan described using tablets in an attempt to complete suicide and reported how disappointed she was to wake up the next day:

> *I really genuinely wanted to die. It wasn’t a cry for help ... I remember taking just handfuls of tablets... and Perdrotti wine ... I remember waking up [in hospital] and thinking I can’t believe I’m alive, fuck! I can’t even kill myself properly.* (Joan)

For many participants in this study, only the thought of their loved ones prevented them from completing suicide. Eddie remembered thinking about his wife and son, reporting that he had ‘*an overdose in the syringe that would have killed me within seconds*’ but held back because of his ‘*family and I thought it was the answer for me ... it filled something that I didn't have beforehand*’. For Sandra, the recollection of her brothers prevented her from completing suicide and Clint remembered thinking about his sons and shared:

\(^{535}\) See also Greene & Ringwalt, 1996; Kipke, Montgomery & MacKenzie, 1993; Mundy, Robertson & Robertson, 1990; Rotheram-Borus, 1993; Stiffman, 1989
The worst thing I could do was leave them the legacy that their father committed suicide and if they ever got into trouble … they would see it as an option. And that's what stopped me doing it. (Clint)

For some of the participants in this present study, suicide ideation and numerous attempts exacerbated the end of their drug using. For others, they reported they ‘just had enough’.

**Determination to stop using**

Eventually all of the participants reported ceasing drug using. Some mentioned being ready to stop, while others reported experiencing a ‘spiritual awakening’. Wendy said she ‘was just ready ... I could have been in and out of centres for another ten years’. Brian remembered that he ‘reached the point where I came to the conclusion that I don't want to use again’ and Jenny described the early stages of quitting, as she explained.

*I had tried to stop using and gave away all my works, locked myself in and was left sitting here watching the clock or listening to it ticking ... bleeding hours would feel like weeks. The depression, the sadness and the emptiness ... horrible ... I wasn’t going back. I was determined ... I didn’t care what pain I was in. I had had it.* (Jenny)

Some participants reported specific incidents that encouraged the final decision. Meryl reported being picked up by the Gardaí who ‘brought me [Home] ... I arrived at my door my Mam's door ... and told her... I’m strung out on gear’. Kevin remembered his father barring him from the family home. ‘The police threw me out ... I was more or less homeless ... I had no money ... I was strung out to death, in a world of pain and living a miserable existence’. Several participants shared how they finally decided to go into treatment. Jordan recalled preparing himself by ‘saying goodbye to the drugs. I took everything ... I was just mad out of it’. Scarlett described how she ‘just couldn’t go on any longer’.

*Finally my mental and physical injuries had taken their toll ... I had no fight left in me ... I had only two choices – to try to get to the off license or to try to get to hospital. There was no in between. The withdrawals were so bad that I couldn’t possibly have survived the day at home* (Scarlett)

Regardless of how the end of drug using occurred, all of the participants reported that stopping using was an extremely difficult, painful and anxiety provoking process.
Chapter summary

Chapter four has presented a profile of the sixteen participants who took part in this study. It illustrated demographic factors as well as providing information regarding drug use, mental and physical health issues, the participants’ families and their social and employment setting. It has also mentioned treatment, counselling, 12-Step programmes and college courses that the participants reported availing of.

This chapter traced the drug using careers of the sixteen participants. It discussed participants’ notions of their identity before they commenced drug using and some of the issues that arose for them, for example, feelings of ‘not fitting in’, issues around low self-esteem, lack of confidence and poor self-image. It also described difficulties within the family, school and community as reported by the participants as well as issues concerning body dysmorphia and Childhood Sexual Abuse. This chapter then examined how the participants experienced mental, physical and emotional change as their drug using progressed and the influence that this change had on them throughout their drug using careers until finally they made the decision to stop drug using.

Chapter Five will outline the reconstruction of a non-drug using identity and examine measures participants reported using to enhance this new identity. It will explore their journey through early recovery to the achievement of a more satisfying and stable lifestyle.
Chapter Five – Reconstruction of Non-drug User Identity on cessation of drug using

Introduction

The previous chapter outlined the drug using careers of the participants of this study. It described their notion of their identities prior to becoming involved in drug using and detailed their accounts of how their identities changed as they became more enmeshed within their drug using careers. Chapter Four also illustrated the participants’ accounts of how they became immersed in a drug using subculture where they adopted a drug user identity. Finally it outlined how they reported their decision to stop drug using to embrace abstinent lifestyles.

This chapter traces how the participants of this study reported that they negotiated identity change from a drug using identity to a non-drug using identity and what measures they used, if any, to enhance that new identity. It describes their accounts of challenges they faced in early recovery whilst attempting to achieve stability in abstinence. It examines how the participants’ subjective view changed, both gradually and radically, and how that change impacted on their sense of identity. This chapter also explores the effect of social stigma on identity change and the notion of anonymity in recovery as reported by the participants.

Challenges in early recovery

The participants of this research identified several challenges to their identity transition from drug user to non-drug user. They depicted struggling with their identity in early recovery. Koski-Jannes (2002) proposed that deviant identities require radical change especially in social relationships. According to Treloar et al. (2007), individuals, undergoing identity transition, need to assimilate and accommodate new social settings, behaviours and language to assist them regain a sense of ‘normality’ so that they can be comfortable within a new social arrangement. Examples of the main challenges experienced by the participants are briefly outlined below.

536 See also Biernacki, 1986
537 See also Waldorf and Biernacki, (1981).
Acceptance from others

Becker (1963) discussed the exclusion of ‘outsiders’ and the difficulty of being accepted into mainstream society when the stigma of being an outsider still exists. This notion reinforces the work of Berger and Luckmann (1966) who advocated that individuals are treated according to the role that they adopt within their notion of social construction of reality. Several participants in this present study described how they sought acceptance from non-drug using social groups when they ceased drug using. Wendy’s experience of early recovery was experienced as being tentative around new friendships where she reported she conformed to be accepted and ‘still looked for acceptance off people’. Tommy similarly reported his need for acceptance came from lack of confidence: ‘Self-esteem issues ... lack of belief within myself ... looking for outside affirmation’.

In contrast, Martin, after nine years in recovery, reported that his thinking changed. He described how he did not ‘care as much anymore’ what others think of him so long as he knew he was doing his best. He added that was a big change for him due to the fact that ‘I'm a long time clean and I'm a bit together ... I can come across ok, and I am in a way’.

Loneliness and difficulty making new friends

Gaitley and Seed (1989) suggested that many former drug users are excluded from non-drug using groups and social support networks. The participants in this study reported feeling lonely when they moved away from their drug using friends. Drug using and non-drug using social networks are generally mutually exclusive. Keene (2010) asserted that relationships within the drug using subculture which condone and control drug using are critical to the establishment and reinforcement of drug using and that continued membership is impossible when a member tries to stop. Therefore drug users have to find new non-drug using friends to fill the void. Echoing this, Meryl described her attempt to persuade one of her drug using friends to stop drug using with her but ‘she didn’t want to get clean’. Brian described the return of his childhood feelings of being outside of society, of not fitting in and of not having friends.

Keene (2010) found that abstinence was a lonely state and that individuals relapsed frequently if they returned to their drug using social life and friends. Reflecting Keene’s (2010) finding, Scarlett recalled that before alcohol and drug use she had great difficulty finding friends she could trust, asserting that: ‘all through my life I have never really trusted anyone, never really
fitted in, never really had a true confidant that I could tell everything to and trust’. In early recovery, she reported that she still had problems creating friendships and declared she was ‘still not really comfortable with people I don’t know very well’ but found she could negotiate life much more easily especially in the workplace. She stated: ‘I am fine at work and with AA friends but otherwise I don’t really go out much anymore ... life is quiet but it is good and much easier’.

Many of Keene’s (2010) participants had intimate partners who chose to continue using drugs. Sandra described her experience of her partner’s continued drug use:

He was after smoking heroin, then “I’m after ringing a few dealers” … “no get the fuck away from me” … I was still very weak and then I’d get a meeting and I’d talk to someone they’d say you just need to do this and keep yourself safe ... I asked him to move out ... He moved out and I shit myself ... I was like this is the wrong thing to do ... when I’m just fucking trying to get clean. But ... I wasn’t going to be able to do it when he was there because anytime we’d done it before it didn’t work. So just got loads of meetings in. Eventually I finished with him. (Sandra)

**Facing responsibilities**

For the participants in this present study, challenges were difficult to negotiate, due to both a lack of tools to do so and the negative feelings prior to addiction which reoccurred in early recovery. Brian spoke of facing responsibilities ‘head on’:

Being clean hasn't been easy ... I've faced numerous challenges ... and worked through ... it gives me a bit of a stronger purpose, bit of a sense of achievement ... I have a belief now that I can better myself or that I can face challenges and get through them ... I have come out stronger ... it takes some reflection to look back at what I've been through to realise that I am capable of persevering and capable of achieving ... finishing things that I have started. (Brian)

Sandra recalled responsibilities in her employment and feeling glad her employers were unaware of her past ‘budgets and huge amounts of money ... I just get a flashback and think where I came from and what happened in between’. She also spoke of the responsibility of taking care of her child:
You would see him lying there “fuck I’m a mother”, not that you would have forgotten...it’s just like ... I’ve a child. I’m a mother I’m going to have to take care of him for the rest of his life. (Sandra)

The above reflects Nowinski’s (1990) assertion that the drug user, although very ‘streetwise’ does not successfully master normal social goals. Their identity becomes a drug using identity with all the negative aspects that affect moral development and they develop an immature, impulsive self-centeredness.

_Shame, guilt and remorse_

The female participants in this present study shared added difficulties around guilt and remorse concerning their children, their feelings around their physical bodies and their sexuality. Klee (2002b)\(^538\) noted that women and women with children have significant issues to address. Ettorre (2007)\(^539\) further suggested that drug using women who are pregnant or who are mothers suffer greater stigmatisation and monitoring by professionals. The female participants in this study described issues regarding their children with shame and remorse. Scarlett remembered her irresponsibility, saying she ‘never thought about being responsible for little children on my own and passed out’. Sandra stated that close relationships highlighted all the negative aspects of drug using: ‘The most difficult is relationships ... like family, partner children even kids ... Show you every fucking flaw in you’.

Therefore, as suggested by Alicea (1997), motherhood can also be a complication when attempting to restore a ‘spoiled identity’. In keeping with this, Jenny reported she was aware of her behaviour concerning her children while she was drug using and admitted her powerlessness to stop at that time. She remembered the shock when she realised the true effect of her drug using on her children: ‘in my using I didn’t cause much damage ... Well, I did concerning my Mam and my Da and my kids – loads – heavy damage there’. Jenny described how her daughter became involved in heavy drug using and how they began methadone maintenance together. ‘I was on a clinic ... my daughter was on another clinic’. She reported

\(^538\) See also McIntosh & McKeagney, 2001, 2000b
\(^539\) See also Boyd, 1999; Ettorre, 1992; Murphy & Rosenbaum, 1999; Perry, 1979; Radcliffe, 2009; Rosenbaum, 1981; Sterk, 1999; Taylor, 1993
that her daughter was still using drugs and stated ‘I do my part with her but I’ll just have to wait till she comes forward. Her room is in there waiting for her’.

Negative self-concept

Some women felt shamed by their former ‘junkie’ identity (Klee, 2002b) and perceived themselves as damaged and unworthy of a new status (Keane, 2000). Wendy shared that sex working contributed greatly to her negative self-concept, as she explained:

‘I just felt like a big, fat mess … the shame and guilt about what I was after doing and working as a prostitute used to come into my head all the time. I’m filthy … I’m for the skip. (Wendy)

Rita recalled difficult issues emanating from her childhood relationship with her father. She reported having a fear of intimacy due to her beliefs about her mental health and physical self:

How could I subject a man to look at me? … my fear was what my father had said to me. Nobody would look at you. You’re so disgusting. You are horrible and I married a man … I was to be rejected. I remember him turning his back and he’d have this look of disgust on his face. (Rita)

Initially, Rita reported relief when she was diagnosed as an alcoholic ‘and not schizophrenic’. She recalled attending therapy to work through issues around her sexuality and shared that she still felt ‘damaged’ and that it took a long time to work through her negative self-concept: ‘I couldn’t subject a man to that kind of revulsion to have to look at me naked … I was sober then … five years sober’ but she did acknowledge eventually regaining a sense of self-worth:

I was very damaged … but I have a worth of myself now that I never had before. I don’t have that anxiety of ‘I wonder what they think of me’ … I know that I’m okay. (Rita)

Meryl shared her negative self-concept which she worked through during counselling. She spoke about self-harming before she stopped using and a ‘pervasive sense of self-hatred’ in early recovery. She stated:

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540 See also Plumridge & Chetwynd, 1999; Vitelleone, 2003
I just despised everything about myself, my body, my whole being. That’s not there anymore. I like who I am ... most of the time I’m really ok with me ... I would have used self-destructive behaviours ... the first few years of recovery (Meryl)

Social stigma

Some participants reported still feeling excluded due to the strength of stigma (Goffman, 1990a) and the resilience of the ‘once an addict always an addict’ dogma which often exists, according to Kellogg (1993), even within the addiction treatment services. For example, Colin shared the reaction of his manager to his disclosure that he was in recovery when he was working in a Community Drug Team project. He described how shocked the manager was at his disclosure and that he subsequently lost his job: ‘When I told [Manager] she nearly fell off the thing ... cos she didn’t like addicts. She hated them’.

Brian described how, even in early recovery, the treatment at the hands of his brother and his brother’s friends impacted on him. He reported that when they called him a ‘junkie’ he felt that he fulfilled the role, felt like an ‘outcast’ and that was ‘all I was worth, I was never gonna achieve anything’. He reported that it took a lot of personal work and time to shake that feeling:

*I have been through many years of [Stigma] ... some days that stuff can still be with me ... It’s somewhat better than what it was today. I still have work that I need to do in that area. I still kinda carry that added stigma around with me some days. (Brian)*

Social stigma has a profound effect on identity. Becker (1963) maintained that labelling and stigma complicate the transition from deviant to non-deviant identity. Szasz (2003) agreed, stating that it is almost impossible to measure the power of labelling on society’s moral attitudes. One participant, Clint recalled with great pride how, after a number of years he managed to shake off negative feelings towards himself and reconcile his relationship with his mother: ‘The black sheep of the family became her shining light’ although, according to Neale (2006), the ‘junkie’ stigma is extremely resistant to change. The participants in this study were initially confused regarding any notion of identity, before moving more easily into a non-drug using identity, as the next section explores.
Finding a new identity

Identity transformation has critical importance for both the beginning and the end of drug using (Biernacki, 1986). Doukas (2011) realised the extent of the challenge of identity transformation. Not only does the former drug user have to cope with societal stigma but they have to re-discover a lifestyle as a non-user. Meryl spoke of identity change, saying ‘the whole question of identity and finding my identity, I just think of how slow a process it is and how hard’. Similarly, Wendy said initially she thought ‘I had to walk around with the weight of the world on my shoulders, cos that’s what I felt I deserved’ but later she reported that, although she feared change, she started to ‘live in the real world’. She explained:

\[ \text{I’m still putting my foot in the water … but I am completely different than who I was in active addiction. There’s no doubt … I had to change everything. (Wendy)} \]

Similarly, Jordan recalled his confusion when he initially stopped using drugs:

\[ \text{When you get clean you don’t know whether you’re gay or straight … what you like … you’re really starting from scratch … to get to know yourself … you still have the addict head. You still feel like an addict and you think everybody knows. If you walk into a shop … you say ‘the security guard, he’s watching me’. (Jordan)} \]

Gary also described confusion when he stated that when he came in to recovery, as initially he reported did not know who he was or what was normal:

\[ \text{I imitated people who I thought were normal. I had no idea so what I did was acting … I didn’t know my own personality … it was absolutely important to me people’s opinions because at that time people’s opinions told me – if they were positive then that meant I was doing the right thing. I didn’t know what it was to be myself. (Gary)} \]

Eventually the participants in this present study reported moving more comfortably into a non-drug using identity. Kellogg and Kreek (2005) proposed that recovery brings change which involves leaving the drug using world to move towards a lifestyle that may not initially be as rewarding. Embracing the new lifestyle, joining in non-drug using activities and being involved with new relationships held fear and trepidation for the participants rather than enjoyment at first. Eddie spoke about the fear of taking on his responsibilities but when he worked through

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\(^{541}\) See also Becker, 1963; Ray, 1968
the fear, he was happy to take on a drug free life and hoped his loved one's opinions of him would change as his identity changed.

Was I going to be able to actually get it together this time? A fear in myself ... they depend on me ... I found my purpose in life ... years ago I wanted to be away from the kids and [Wife] and my family ... they knew me a certain way and I didn't want to be that way anymore ... I wanted to be someone else or I didn't want a reminder of anything or didn't want to have to have anybody to mind. I couldn't mind myself ... Now it’s gone the total opposite. I am happy to be a father and I’m happy to be a husband.

(Eddie)

Biernacki (1986)\textsuperscript{542} noted that as non-drug using relationships and activities develop, the reconstruction of identity occurs. Identity transformation becomes easier when the individual set goals to strive towards a better future. Tebes et al. (2004) maintained that individuals work through their negative memories, emotions and experiences and enhance their sense of self-worth. Colin reported still feeling shame when memories came flooding back, where he would get embarrassed: ‘go “Oh” and get that cringe ... it’s not as bad as it used to be. I can let it go now cos I have other things in my life.’ He also mentioned shame when describing how neighbours judged him, again reflecting mainstreams attitudes towards certain roles in society (Berger & Luckmann, 1966). He explained:

\textit{Around the estate I still would feel a bit ashamed... a lot of policemen in my estate ... would have known about me or have seen my tattoos. I have loads of tattoos but I hide them cos they judge you straight away. I remember walking up the road only three months ago he was walking down, the retired guard and his wife, and he was saying “Look at him. There’s one for you”.} (Colin)

Colin reconciled that shame as he embraced new activities in his life and was able to trace positive identity change. He stated:

\textit{I try to get on just the best I can ... when I was using ... I had nothing else to insulate myself. But now I have so many things and I’m not that person anyway. I’m changing. I have changed and evolved from the addict, to scumbag, to Colin ... I’m a father who}

\textsuperscript{542} See also Kellogg & Kreek, 2005; Stryker & Serpé, 1982
wants to work and wants to educate myself. He’s not stupid. He’s quite smart when he wants to be, articulate. (Colin)

Jordan also spoke about gradual changes in his life. Initially he was not ready to forgo all aspects of his drug using life saying he ‘didn’t want responsibilities’. He said he did not have the skills or confidence to cope with a sober lifestyle until he found his own apartment and went to college. He recalled that he wanted to hold the ‘hard man’ image but simultaneously wanted people to know he was no longer involved in drug using and criminality: ‘I don’t want them to think I’m a scumbag. It’s about getting this balance’. Jordan spoke about going to college and changes that had happened for him. He said ‘it’s a bit more comfortable for me to wear the clothes I like to wear instead of the clothes that give off this persona’. He reported that he felt like he was ‘on my own with the normal people’ initially in the class but began to enjoy it and aspired to succeed, which he stated was also a big change for him.

Successful recovery is supported and strengthened by successful identity transition. A critical aspect motivating identity transformation, according to Gibson et al. (2004), is the belief in the ability to change and create new lifestyles which included employment, exercise and fitness and non-drug using activities Jenny described very definite healthy changes in her lifestyle, genuine self-belief and excitement about her future:

I’m lightening up, having fun … I feel different … I’m dressing different, talking different, looking different and behaving different … I am after having a shift in me … I have my own beliefs now. I was taking on everyone else’s beliefs … I have moved to a better place in myself, a more centred, comfortable place … I will be mixing with normal people … [College] will be my little walk back into the stream of normal life. (Jenny)

Jenny also spoke about a new Christian belief where she enjoyed peace and friendship at a Sunday mass, describing: ‘everybody’s singing. … It’s lovely and it’s relaxing and I do just love the Holy Spirit … I’m meeting all different people’.

Grund (1993) suggested that drug use limits access to legally recognised professional skills. Many drug users may never have had legal employment relying on illegal employment within the drug using network. The majority of participants in this study went back to education in recovery to gain skills to join the workforce. Along with going to school, Meryl immersed

See also McIntosh & McKeeganey, 2000
herself in therapy, 12-Step programmes and new friends from meetings. She struggled with trying to engage in social relationships and to find who she was in the midst her new, sober living. She reported gradual change where she learned to have faith in herself:

_I went back ... to school. I did a diploma. I started working ... my life revolved around recovery and meetings and counselling and group therapy ... meditation groups and retreats ... I had no faith in myself. If I didn’t do all of these things I was going to use. If I didn’t surround myself with addicts nobody else could understand me ... as the years went on I became less afraid I began to see that there was a life outside drugs that I could talk to so called normal people ... The longer I stayed clean the more things I began to do. I took up hobbies I started doing stuff outside of recovery ... with time and a lot of work on myself I began to know myself again._ (Meryl)

Participants in Hughes’ (2007) study mentioned returning to the ‘old’ me and reorienting themselves as non-users. Tommy shared searching in alcohol and drugs to figure out who he was but only realised in recovery that he had begun to find his identity. He reported:

_Through getting recovery, I actually found my personality again. I started to become the person that I always dreamt of being ... I looked in every drink, in every drug ... to try and find what I believed was missing and through doing the work on myself I started to realise that actually everything was inside me and I just needed to touch on it. The confidence, the self-belief, the liking of yourself – it was all in there._ (Tommy)

Similarly, Wendy remembered the relentless search for herself in drug use and relationships. She recognised that there were no answers to be found until she stopped using drugs. She described being unsure where her life was going but gave herself the space to work it out:

_I have found something that I looked for... in all them different drugs... I kept thinking that all them drugs were gonna make me who I’ve really become today ... live clean and you’ll be free ... what an awakening. What a change ... From who I was till now ... who am I today? ... I don’t know. I’m still figuring out who I am._ (Wendy)

Gary acknowledged that he has fears and anxieties but they were part of ‘normal living’ and he was comfortable with them. He could be himself with people and in situations. He stated:

_I realise I can stand up. I’m okay ... which I wouldn’t have said before ...even though I can be nervous, I can be anxious, I can be frightened and I can get down ... it’s still
fine. It doesn’t mean that these things have gone away. It just means that they are okay... part of me (Gary)

Similarly, Meryl acknowledged her past but spoke happily about other roles in her life today which had taken on greater importance. She explained ‘I can be confident in some areas and not confident in others but I definitely feel I have a sense of self’. Jordan also mentioned that he feels much better about himself today and can look towards helping others coming into recovery: ‘Today, I try and live right. I try not to hurt anyone. You know if somebody wants a dig out, I’ll give them a dig out’. When considering his identity, Clint said ‘My name is Clint. I am an alcoholic and a drug addict and in recovery for 25 years’. He reported identifying very strongly with membership of the 12-Step programmes and illustrated his changing identity over the years by mentioning his parents’ funerals, saying: ‘When my father died I made a bollocks of myself at the funeral and then when [Mother] died I was part of organising the funeral. And that was the difference’.

In early recovery, participants in this study reported stumbling along trying to work out how to negotiate this new direction in life. As time went by life got easier. Slowly change started to happen whether through counselling, treatment, going back to college, accepting family responsibilities and so on. The participants acknowledged that change in all areas of their lives had to occur before they could begin to re-identify al ‘non-addict’. Eventually the participants began to allow other identities to emerge. Membership of 12-Step programmes helped the majority to transition. Meryl recalled how change evolved for her: ‘I had an identity. I was Meryl the addict and then I was Meryl the member or the chair or group secretary’. Jenny recounted a lot of uncertainty:

I don’t know what identity I took on when I came into NA but, I was grabbing on to the fellowship and I was grabbing on to the 12 steps, I was believing what everyone was telling me and I was wanting to be right and wanted to do things right. (Jenny)

As time passed, some of the participants were able to let go of the ‘addict’ identity in recovery. They preferred to identify with other roles in their lives. They expressed the sentiment that their lives had moved on and that other roles had become more important. Jordan mentioned roles in his new lifestyle that had taken precedence ‘I have a great relationship with my family, I’m a son today. I’m a brother’.
Sociology stresses the importance of the relationship between drug use, recovery and identity (Waldorf, 1983)\textsuperscript{544}. Borrowing from Goffman’s (1968) work on stigma and ‘spoiled identity’, recovery is essential for the reconstruction of a ‘spoiled identity’ which can be restored but the drug user must achieve a renewed self-identity often against “powerful countervailing forces” (McIntosh & McKeganey, 2000b;81). Brian spoke about his effort to reinvent himself by immersing himself in new activities and learning self-caring techniques:

\[ I \text{ have had to make changes in my life … create a new persona … reinvent myself as a different, functioning member of society … taken up hobbies and interests … found my place in a 12-Step programme … I dress differently … act differently … leave the stigma of addiction behind me. I've got my own place. I'm doing it up the way I want it. It's clean, it's respectable, it's bright … I have found a sense of self-respect around that. I look after my basic needs … which helps me to feel better about myself. (Brian) \]

Essentially, according to McIntosh and McKeganey (2000), the former drug user must establish a ‘non-addict’ identity through the reinterpretation of a lifestyle that no longer incorporates drug using and associated networks. Colin recalled how help from his NA sponsor gave him the strength to change: ‘I got just kindness off him and I could be myself. You see it had taken me years. The mask … I could be kind’. He reported that this validation helped him reintegrate into his family. He acknowledged his past and the fact that a stigma still existed, but held hope for the future mainly because of changes he was making. He stated:

\[ I \text{ try to live better, work on the past and I have my family back in my life. I have a different sense of purpose within that family … my parents can tell me that they are proud of me, I'm not causing them any harm … they are not waiting on a phone call to say that I'm dead … I have that kind of stuff to feel good about, but sometimes on the inside I still carry that stigma of being a drug addict … If they want to judge me that's them. That's their loss because I'm a good person. (Colin) \]

Recovery encourages personal and social identity transition. Radcliffe (2009)\textsuperscript{545} maintained that changes like becoming competent in the workplace positively affirm new identities. Sandra credited herself with a lot of hard work and dedication to secure a career she enjoys: ‘my first management role … I worked my ass off’. Martin also recounted his hard work since ceasing drug using, saying: ‘I live a fairly decent life … for the last eight or nine years’. He reported

\textsuperscript{544} See also Waldorf & Biernacki, 1981

\textsuperscript{545} See also Hughes, 2007; McIntosh & McKeganey, 2001, 2000a, 2000b
that he had become honest ‘I can understand my past ... I'm not saying it was ok or something. I've made loads of amends’ and had earned the reputation of being a good worker in ‘a career that I never ... dreamed of’ which has become part of his non-drug user identity.

Biernacki (1986) noted how former drug users’ lifestyles adapt to embrace adulthood, partners and children. As well as enjoying his career, Eddie reported being able to accept his past and take on the roles of father and family man, as he explained:

My relationship with my mother and my father has improved ... I have accepted a lot the way they are ... it’s a big part of my life now – my past ... a reminder where I was and who I am now ... I love to work at what I do. I love helping people. That will be part of my identity now. And I'm a family man, basically. I love my family. I love my kids ... seeing them happy makes me happy ... that's the way a father should be... getting reward from the kids, seeing the kids grow up and seeing them happy and stuff and I didn't have that. (Eddie)

Echoing Strauss’s (1993) assertion that participants in his study disentangled their non-addict identity from their former drug use, Joan recognised how far she has moved on from active addiction: ‘God, that is like a different life to me’. Successful recovery and identity transformation, for Biernacki (1986), happens either by reverting to a former identity or allowing an emergent identity to evolve. Wendy and Tommy reported their identities had become obscured with drug using. Clint, Martin and Meryl reported returning to their former identities although there were some new elements that had been learned in recovery. Clint reported: ‘I probably went back to the person I was ... I am very soft - not a fighter’. Martin said ‘That’s part of my identity, part of who I was ... we get masked up with all the issues ’ adding that in recovery ‘we go through life and we take them all away and this is the natural self again’. Meryl rediscovered her competitiveness and love of learning and recognised that both these traits were still part of her identity. She also identified new traits:

Some of it is recovered and I think some of it is new ... another thing I got from NA was I suppose a set of morals and a code of ethics ... then there were things I just discovered as I went along ... it’s a bit of both I think. (Meryl)

546 See also Waldorf 1983; Winick, 1962
Enhancing new identity

All of the participants in this present study spoke of how they enhanced and enjoyed their new or reclaimed ‘non-addict’ identity. Transformation of identity is an undeniable psychosocial element of the recovery process. Waldorf (1983) proposed that it is vitally important for former drug users to construct a new, positive identity. Becoming a former drug user necessitates a reconstruction of identity that includes all aspects of their lives and relationships. Jenny shared positive hopes for her future. She was looking forward to not only moving away from drug using but also from work and study involving addiction. She was starting a new course in alternative healing. She reported:

*I have been talking for the last year about moving out of this work and now I’m actually doing it. I’m getting trained in a different way ... I want to walk into this new course that I’m not Jenny NA ... It’s time. I’ve spent the last 5 years holding on to that job and holding Addiction Studies and Counselling Theory ... it served its purpose ... It’s time now.* (Jenny)

New or reconstructed identities help former drug users minimise tension in work, family and social settings. The new identity must differ significantly from a drug using identity, embracing non-drug using individuals, groups and activities. Brian reported how changes in him reflected within his family relationships:

*I try to live better, work on the past and I have my family back in my life. I have a different sense of purpose within that family, you know, they are my own family now... I have that kind of stuff to feel good about.* (Brian)

Hughes (2007) proposed two essential ingredients to successful identity change. Firstly, the individual has to believe in their ability to change and stop drug using. Drug users are often pessimistic, finding it difficult to envisage a positive future away from the negativity they had experienced. Their sense of a positive future is restricted and tenuous. The conviction in the capacity to change, heal and become something other than drug user is vital to successful identity change. New identities that promise happiness compete with drug using identities. Several participants gave examples of their ability to change.

Brian described how he had become stronger and more determined through facing challenges and realising he is capable of achievement. He recalled regretting the wasted years but valuing the fact that the experience will enhance his future. He explained:
I have hope for the future ... I have somewhat wasted a certain amount of years of my life. Sometimes I get the impression that I can’t get them back or that I am maybe playing catch up ... but where I am at today is far better than anywhere I have ever been in my life ... I have somewhere to live, I have prospects, I've got a future and a wealth of life experiences... Have I changed my identity? I still believe I am the same person. I challenge myself a lot more than what I have over the past ... I am much more than just a drug addict, I am a person who is capable ... I'm not stupid. I know that. I always knew I wasn't stupid. But, I’ve done stupid things. (Brian)

Joan described how a combination of time and realising her ambitions opened a new life for her ‘Things have changed in my head. My priorities, like what I'm doing, working – in my job I suppose’. Similarly, Kevin, who was working as a security man at a university social event, realised that he was capable of change. He reported:

I was looking at the possibilities and opportunities that [the students] would have ... there was sadness in me that I missed out ... I thought I can do better. I can go to college ... there’s nothing really fucking stopping me now’. (Kevin)

Kevin explained how subsequently a new sense of purpose supported his transformation to a non-addict identity. Correspondingly, Tommy spoke about ‘finding my voice’ which helped his confidence in his transition to non-drug using. He recollected his fear of confrontation which had paralysed his confidence:

I'm not afraid to talk anymore and would say what I need to say if I need to say it, which is a big, big change for me ... there was a lot of learning around that sorta stuff ... The fear was from me with having a conflict ... I was always protecting myself ... I am starting to see that for what it was. (Tommy)

The second essential ingredient according to Hughes (2007) was the acknowledgement that social structures, including friendships, family, living practices and engagement with services, had to change. The former drug user needs to accept a new non-addict orientation (Koski-Jannes, 2002) and encourage others to accept their new, ‘non-stigmatised identity’ (Stall & Biernacki, 1986; 13). For Colin, change began when he finally accepted that he was an ‘addict’ and could plan towards a drug free future. He explains:

Once you accept that you’re an addict, truly in the heart, not in the head I don’t think you’d ever go back cos ... I don’t want to die ... I want to live. (Colin)
Meryl also spoke about seeking change and negotiating different experiences:

*Trying to grow and develop and change and studied and learned ... began to do different things and travelled and saw other parts of the world and learned that there is a life outside of drugs ... outside of recovery that it is not all it doesn’t all have to be hard it doesn’t all have to be scary and life is pretty good.* (Meryl)

Reflecting Doukas’ (2011) observation on how drug users moved away from chaos and embraced a more ‘normal’ lifestyle including working, returning to education and taking up leisure activities, most of the participants in this study returned to college in recovery. Brian and Kevin described their return to education. Brian realised he was capable of completing a course, explaining: ‘I have training and I would have done particular courses ... achieved ... I know I'm capable’. Kevin also completed some courses, stating: ‘I done a diploma ... I got a degree. I got a little job. I got a ... little one bedroomeed house. I started working’.

Doukas (2011) also stated that participants who redeemed themselves with family and friends boosted their self-esteem and confidence. Anderson (1996) added former drug users who efficaciously create and maintain identities that are concerned with non-drug using activities are more likely to successfully cease using. Colin recalled his renewed relationship with his partner and birth of his daughter. He talked about his love for life and dreams for the future:

*I have a partner who is gorgeous. I have a daughter who I love. Having a daughter is like having a spiritual awakening. It gives me another sense of love that I never felt before in my life. It’s beautiful ... I live my life ... I earn my money ... I’m buying a house ... That’s the gifts of recovery, of staying clean on a daily basis.* (Colin)

Kevin reported feeling protective towards his family and being capable of supporting them:

*That's a natural thing ... the protector thing and I've gotten like that with my family ... before stuff was always unrrational and unthough and I'd dive into things totally off the wall. Where now I'm a lot more stable ... I can trust my own thinking.* (Kevin)

He also reported being engaged in voluntary work with marginalised youth where he ‘would do good now in order to make up for all the bad I’d done’, and added:

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See also Biernacki, 1986; Christiansen, 1999; Granfield & Cloud, 1996; Kellogg, 1993
That would be a major satisfaction for me. I was always missing something and that fills something for me. To be helping others. (Kevin)

Clint and Jordan also described using their experience to help others through service in the 12-Step programmes. Clint declared ‘I will have had a part in helping to keep recovery alive. To keep fellowships going’, while Jordan said:

If I keep working with people ... this whole unselfish thing. It works for me. It genuinely does and my life has a purpose and I can turn that years of misery and crap into a positive thing which I think is brilliant. (Jordan)

Biernacki (1986) maintained that most drug users wanted to become ordinary rather than different and suggested that addiction ceases when a person’s identity clashes with other identities uninvolved with drug use. In agreement, Scarlett recalled ‘I just want to be seen and treated as a normal, down to earth ordinary person’. The key to recovery is when the person can disclose their experience and restore a sense of self by either reawakening their former identity or establishing a new one. Being unable to talk about their past adds to the self-construction of an ‘addict’ identity (Anderson, 1993), while the emerging identity strengthens recovery. Meryl recounted working through her sense of shame regarding sex working by talking to a very competent and sensitive therapist. She recalled:

In early recovery when the girls would talk about sex I would cringe inside ... I felt abnormal ... like I wasn’t a proper woman whereas today I have a great relationship. I’ve a healthy satisfying sexual life and it doesn’t frighten me anymore. (Meryl)

Recovery styles reflect diverse identity reconstructions. The extent of the drug user’s problems, the degree that the individual identifies with others in recovery and the recovery process all influence the new, emerging identity. Wendy reflected on her relationship with a Higher Power548 which she gained through her 12-Step programme. She stated that this relationship sustained her through difficult experiences and memories of her past:

548 The second step of a 12-Step programme states - Came to believe that a Power greater than ourselves could restore us to sanity. According to the Twelve Steps and Twelve Traditions, p. 33, ‘Step Two is the rallying point for all of us. Whether agnostic, atheist, or former believer, we can stand together on this Step. True humility and an open mind can lead us to faith, and every A.A. meeting is an assurance that God will restore us to sanity if we rightly relate ourselves to Him’. The concept of God is often difficult for members to relate to, therefore ‘God as we understand him’ (Step Four) is interchangeable with Higher Power.
Close relationship with a higher power, absolutely ... I still have it in me ... to hate myself, to have a loathing, to have insecurities, to have big fears, and I’m not worth it and to go back into them moments where something triggers me ... yesterday I had to meet someone down at [Area]. I haven’t been down there since I got clean and so it brought up a lot for me ... when I was standing there I was starting to feel this stuff. And, what I instantly done was ... to see God a bit while I’m standing there, and just say ... this is ok, this is now ... it’s not then. To me it’s really important, always having a connection with a God. My recovery is worthless without it. (Wendy)

Kevin and Joan reported how on-going therapy helped them change. Joan reflected that it ‘reaffirms ... that I am on track’ and Kevin reported attending group therapy where ‘the power of the therapeutic group is kind of magnified by ten to the experience of one to one’.

The majority of the participants joined 12-Step programmes. Rita said:

It’s about life ... not about living in AA. It’s about living and about having that vibrancy and taking the risks ... all of the things that I would never have done. (Rita)

For Martin, the motivation to change came from his drug using experience. He stated: ‘What helped me was my past was pushing me on to do it. The consequences and the terrible mental state that I was left in. I wanted to live again’. Sandra described her notions of self-care: ‘I’m on now reiki level two. I would do that a lot where I would clear the room, light a candle and actually love doing that, just chilling out’. Scarlett talked about living a very peaceful lifestyle:

I don’t do anything very exciting but I do have a good life. I have no financial worries, I have my own house paid for and my kids are doing great, I can afford a nice car and holidays and I can help the kids out if they need some money. (Scarlett)

When the participants of this study were discussing identity change, many of them mentioned the concept of anonymity in recovery. Within their account of their experience of making decisions about disclosing their past drug using, social stigma and its influence on anonymity was mentioned as the next section outlines.
The influence of Social Stigma on Anonymity

Fifteen participants concurred that a social stigma around addiction still existed for them. They expressed relief that this stigma was no longer associated with them or at least not quite as disturbingly now that they were in recovery. Only one participant, Gary, disagreed that stigma around addiction still exists. Gary contended that the public were better informed about addiction and less likely to pass judgement. On the contrary, Colin commented ‘People aren’t educated around addiction. People are afraid of addicts … the paper has sensationalised addicts going around stabbing’.

The social construction of the drug user comes from diverse disciplines, moral, judicial, medical and pharmacological as well as the viewpoint of press and literature (Berger & Luckmann, 1966: Clinard & Meier, 2001). People who are stigmatised and labelled as different may experience discrepancy between their authentic and implied social identity (Becker, 1963). Scarlett agreed with this idea ‘I hate the stigma around addiction. It is as if you are weak, unclean and not trustworthy’.

Being labelled as deviant has significant consequences for social inclusion and self-image evoking radical changes in the person’s public identity. O’Mahony (2008) stated that social and criminological addiction research was influenced by a moralistic interpretation. Several participants spoke of a lack of trust. Martin said ‘wait till the handbag goes missing … that’s the labelling.’ Jenny agreed, stating: ‘they would see me as different … watching me. No trust in me. They’d be watching the handbags … she’s a junkie. We are all tarred with the one brush’. Rita shared that it took many years before she earned trust again, saying ‘they never really learned to trust me for years … don’t mind her she will be all over the place and she will be drinking again’. Wendy had similar thoughts, remembering that she used to:

Feel embarrassed that people were kinda looking at me, going ‘watch your bag’... I knew that people sensed something off me. I always felt really uncomfortable with that, but in a way I liked it because, to me, that kept people away, (Wendy)

According to Gordis (1995), the disease concept has helped remove social stigma from addiction. However, the most prolific drug use is concentrated in lower socioeconomic, inner city areas where rising crime rates, sex working and health problems, all of which carry high stigma value, cause harm to the drug user and wider society. In Ireland, Moran et al. (2001) reported in recent decades drug use has spread to marginalised areas of almost every town and
city. Brian reported living in a marginalised area, but he felt his anonymity was important even within his neighbourhood. He stated:

\[
\text{I don't have to tell anyone I'm an addict and I don't need to. What I do is my own business, you know. I don't want any neighbours knowing \ldots I don't think people need to know that I am in recovery. I think that's a very personal thing. (Brian)}
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Brian said ‘sometimes on the inside I still carry that stigma of being a drug addict’. He explained that ‘trying to move away from that stigma can sometimes be difficult’. Rita shared that even after years in recovery, the stigma remained. Rita reckoned she must have had ‘a profound effect on these people’ due to the fact when she was six years sober, her colleagues still talked about her drinking behaviour. She stated that stigma ‘leaves a big stamp on you \ldots it is not something that is wiped away’.

Scarlett mentioned her childhood feelings of low self-worth could easily return if she was stigmatised due to her addiction. She reported: ‘I never break my anonymity. Even my best friend \ldots does not know I am in recovery. I don’t want to be judged or have people feel sorry for me or treat me differently’.

Social agreement about drug use became a mix of addiction and ‘abuse’, drug policy and the effort to control it. Morally society believed that drug use should be moderate, therefore, excessive use was deemed unacceptable. Grund (1993) stated this negative judgement leads to exclusion\(^{549}\) and unfair sanctions. Martin reported that he experienced stigma as disempowering: ‘the labelling ... social stigmas ...where you don’t have a say’.

Twelve participants in this study declared that they would not disclose their former drug using in the workplace as the stigma attached would encroach on their lives. For them a major problem was fear and lack of trust. MacCoun (1998) identified that the public found the aspect of ‘out of control’ threatening and Mc Donald and Marsh (2002)\(^{550}\) identified fear due to the ‘slippery slope’ paradigm, scaremongering and moral panic further strengthened society’s censure. The majority of the participants stated that the general public held very harsh attitudes to drug using, which influenced their holding or breaking their anonymity and the decision of where and to whom anonymity could be broken. Echoing Kellogg’s (1993) assertion that AA members tend to hold anonymity as they fear their history may interfere with their newly

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\(^{549}\) See also Plancherel et al., 2005, Young (2002)

\(^{550}\) See also O’Mahony, 2008; Shearing, 1995; White, 1998
created social identity, Rita spoke about attitudes and lack of trust in the workplace and how she felt individuals in recovery were also stigmatised. She remembered a female colleague who helped her and agreed with the notion of double stigmatisation:

*She had broken her anonymity ... said she was in AA ... She had a little baby ... and that time a single mother was a jezebel so ... she took a huge risk ... They would say to her look I’m sorry you are not suitable to here. She was an alcoholic* (Rita)

Likewise, Sandra, Colin and Scarlett maintained that they would hold their anonymity in work. Sandra reported that she did not disclose her former drug using for fear of a negative response, as she explained:

*It was always ingrained ... never tell anybody anything that you wouldn’t want them to use against you in a fight ... I went on telling nobody nothing ... I became very boundaried after about three or four years.* (Sandra)

Colin, who had been working in a Community Drug Team and disclosed being let go when his manager found out he was a former drug user. He explained that he learned from this experience: ‘*I had to be prudent ... I won’t tell them about it the next job ... I have been judged on it’*. In his current job he delivers food for a fast food restaurant and handles cash. He testified that he felt he would be the first suspect if money went missing.

Scarlett reported a sense of self-worth especially in the workplace. She spoke about accepting her drug using past but felt it belonged firmly in her past: ‘*It’s not that I regret it or want to change my past. It just has no place in my life today*’. She reported that she did not disclose her addiction to work colleagues as she thought it would influence their view of her:

*I think they would judge very harshly and see me differently. I don’t want to be seen as some type of victim or useless person. I am very competent and I know my boss knows that and values me ... I used to think if they ever knew where I came from I’d get the sack pronto.* (Scarlett)

Jenny testified that when she applied for a college course she had to admit to getting her funding from the Drugs Task Force which broke her anonymity. She reported: ‘*I was fucking fuming*’. She stated that when she applied for her present job she did not discuss her past, but due to the fact that she is in the field of addiction, she often meets people who are aware of it.
The majority of the participants said they would not disclose former drug using unless that disclosure would assist someone struggling with addiction. Rita told some of her family members she was going to AA and, consequently, two brothers and one sister decided to stop drug and alcohol use and go to meetings with her. Rita described all four as ‘still living sober lives’. Rita also reported that the only time she would break her anonymity in the workplace was if a colleague was struggling with addiction, and otherwise she stated she would not tell ‘because of the stigma and stuff that is attached to that’. Martin, Sandra and Colin work in addiction treatment programmes and said they would not lie if clients or staff asked them. Martin added that he was conflicted in the workplace for a long time, saying:

*I would hold it back in most circumstances... I was having a bit of a hang up ... Whether to tell them and it was conflicting with me. I talked to ... one of the lecturers ... he suggested, it is a personal thing but, there's no point lying ... I don’t lie so, but I don’t really say ... Somebody that I'm supporting ... they ask me out straight ... I probably won’t lie to them ... it's not the end of the world if people find out you were once problematic ... I'm a long time clean ... I'm keeping both separate, keep boundaries and keep my work separate and AA. Two different lives.* (Martin)

Colin reported he used to tell all his clients as he felt it helped him feeling worthy of sitting with them but that that has changed with experience. He recalled:

*I have to get more boundaried ... I wouldn’t give my number out to anybody ... I wouldn’t tell them I was an addict ... I felt I had to prove I was an addict just for acceptance now I just sit with them, maybe the odd one I might say ... I’ve been through that ... if it might help someone ... but I would never expand on it. I would say ‘but this is about you’.* (Colin)

Sandra recalled an interesting experience with staff she was managing in an aftercare team. She described how some of her staff were aware of her past but most were not. She declared ‘if you are willing to tell, be willing to tell them everything they want to know what drug was it, did you do this did you do that ... when did you stop ... how long I was clean’. In this instance, she decided not to break her anonymity as she felt some of the staff may use information against her and that the disclosure would ‘have just added to the difficulty of trying to be their leader’.
With regard to close friendships, most of the participants stated that they would break their anonymity if they trusted the individual. Clint asserted that he considered that ‘anonymity is very important’ but that he would confide in someone he trusted. Meryl also mentioned the necessity of complete trust: ‘when I trust somebody, when I feel connected to somebody I sometimes tell them when they ask’ and Wendy reported being very careful regarding who she would confide in. Some of the participants said they had become more cautious when sharing about their past. Meryl, Jordan and Sandra said in early recovery they told ‘everyone’ but as time went by they felt it was more prudent to avoid judgement. Changes in how people viewed her were commented on by Meryl, as she explained:

_When I started working in the field it was the first thing I said at every interview. I am an addict myself. I am in recovery. I don’t do that anymore. You know the last interview I went for I didn’t tell them. I didn’t think it was any of their business … people can judge, people can see you differently when you tell them. I’ve had that experience a few times where I’ve told people and they judge you._ (Meryl)

Sandra reported that it is like ‘trying to get a balance between like ego and avoid judgement’ and Jordan spoke of losing power. He stated that he was going in to a new class in college and would refrain from disclosing because of ‘being judged … I lose power then as well … Once it comes out it’s not mine anymore … it would be more like the “junkie” thing’.

In some circumstances, other people knew about the participants circumstances for many different reasons. Tommy, who was working as an addiction counsellor, said everyone knew about his former drug using and that he did not really care who knew. Some participants in this study who were in recovery for a long time tended to share more about their past and were very accepting of it as part of their life. Eddie reported that it would just depend who was asking and why. He stated: ‘I have the past I have. It’s pretty much part of my life now. I’m not ashamed of it’ and added that if he were asked to disclose he ‘wouldn’t be trying to hide. That was my life then and this is me now … I wouldn’t feel uncomfortable telling anybody’. Gary recognised the freedom of no longer having to hide his past:

_I have no problem with it. It would be like telling them where I lived or how many people are in my family … my addiction was a big part of my life … hiding it was what I did for fifty years. I’m not going to spend whatever time I have left hiding even from myself. I have more freedom now that I have acknowledged the reality of the situation that I’m in._ (Gary)
In the main, the participants of this present study reported a reluctance to break their anonymity, especially in later years. They voiced an awareness of having to feel ‘safe’ if they made the decision to disclose their past histories.

Chapter Summary

This chapter outlined the participants of this study’s journey through early recovery to their creation of a non-drug user identity. It outlined the main challenges that participants encountered during this transition from drug user to non-drug user. The participants agreed that it was not easy to change a deviant, stigmatised identity. Initially, they experienced difficulty in forging new relationships with non-drug using individuals and groups and strove for acceptance from them. This resulted in loneliness and isolation. Another perplexing factor was that of recognising and accepting responsibilities, and re-learning the skills necessary to deal with them. The participants reported that they needed support to help them process feelings of guilt, remorse and shame and their issues of negative self-concept. However, this chapter described how the participants realised the work they needed to do, the issues they had to process and the steps they needed to take in order to find a new identity. This chapter also discussed how they settled in to their new identity and the factors that enhanced this identity. The question of anonymity was raised, along with the influence of stigma on anonymity. This chapter examined how participants struggled with their decision whether to break their anonymity or to hold it.

Chapter Six will examine the treatment methods employed by the participants, and other supports they found useful in sustaining their recovery process. It will discuss the role of 12-Step programmes, and how this role impacted on the participants and their families. It will also explore the varying levels of engagement with 12-Step programmes as recounted by the participants.
Chapter Six – Supporting the Reconstruction of Identity: Treatment, 12-Step programmes, family and self-change

Introduction

The previous chapter outlined the participants of this study’s account of their transition from drug using to non-drug using identities. It described their accounts of the challenges they faced in their early recovery whilst attempting to achieve stability in abstinence, how they settled in to their new identity and the factors they identified that enhanced that identity. It also examined how the participants’ subjective view changed, both gradually and radically, and how that change impacted on their sense of identity. This chapter also examined the effect of social stigma on identity change and the notion of anonymity in recovery as reported by the participants.

This chapter focuses on the supports employed by the participants throughout the recovery process and how those supports were experienced. The participants, in agreement with Copello et al. (2009)551, reported that support was critical to successful identity transition. This chapter outlines which supports were reported as successful and which were not perceived as successful. These supports include treatment, counselling, and the family supports that participants said they drew upon. It also discusses the role of 12-Step programmes, as recounted by the participants of this study.

Treatment methods

When a drug user is still enmeshed within the drug using subculture, they view treatment and recovery very differently compared to professionals, academics and service providers. Goffman’s (1961a) observation on the notion of total institution describes how individuals are institutionalised when entering regimented, bureaucratic situations. However, Keene et al. (2007) recognised that this perception does change with positive engagement in helping or treatment programmes. Consistent with Keene et al.’s findings, the participants of this study reported that when they made the decision to stop drug using, they utilised various treatment methods and reported many positive attributes within these services. Acceptance of addiction, introduction of the disease model incorporating a 12-Step programme and various social

551 See also Davey-Rothwell et al., 2008
supports for drug users and their families initially helped the participants review their drug using. The participants disclosed that they experienced a diverse range of treatment services in their quest for recovery which incorporated identity change. Generally they concurred that when someone is ready to stop, they stop regardless of treatment modality, ‘they just get it when they are ready’, as Sandra asserted. The participants agreed that if drug users are not ready to stop they will continue to use, regardless of treatment and abstinence attempts.

Reports from the participants included unsuccessful attempts at treatment, going ‘cold turkey’, methadone maintenance programmes (MMP), single treatment episodes with no relapses or a mixture of services, while others reported spending years in and out of various residential and day treatments. All sixteen participants reported varied engagement with 12-Step programmes. The findings on these assorted treatments are discussed in more detail in this chapter.

*Deciding to go ‘Cold Turkey’*

A number of participants described how they experienced non-medically assisted home detoxification, tolerating the accompanying withdrawal sickness. For Sandra, this process was completed with the support of a 12-Step programme, as her quote illuminates:

*I just roughed it at meetings ... went through the sickness ... I just made the decision. Went to meetings and I was very sick ... so fucking skinny and in bits like hot and cold pains in my legs. I don’t know how I did it ... But I just kept getting up and trying.*

(Sandra)

Eddie identified using a local day programme for support during his home detoxification, while Martin reported being determined to stop but had no knowledge of services. Another participant, Wendy, also recalled detoxing herself at home without support, stating ‘I never went through withdrawals like I went through that time. I will never forget ... I was walking the walls’. Wendy further described how her body was exhausted but her ‘brain wouldn’t go to sleep’. Kevin shared how when he eventually tried a home detoxification, he recalled ‘lying against the wall, shaking and rattling ... the DTs and it was fucking awful, awful ... experience’.

Some participants reported going on a MMP, others reported having some contact with a variety of services, albeit for some, that contact was minimal. The next sections describe the services that the participants reported availing of.
Methadone Maintenance and Detoxification

‘Cold turkey’ or unassisted home detoxification is often too difficult to contemplate and many drug users seek medically assisted options. Half of the participants in this present study reported engaging with MMPs. MMPs became the norm in Britain, using doctors with specialised training (Plant, 1992). Ireland’s policy regarding methadone followed this example and many MMP clinics were created. Some participants shared their experience of methadone maintenance and methadone detoxification. One participant, Martin, described how he initially went on an eighteen day methadone detoxification programme, while another participant, Colin, reported that while methadone helped with withdrawal symptoms, it did not however deal with the cause or effects of addiction. He added that most drug users continue to use heroin and other drugs while on methadone as he explained:

People think when you’re on methadone they give you so much of a dose that you won’t use heroin but of course you do … They don’t deal with the obsession … its deals with the sickness and the withdrawals but it doesn’t deal with the addict minds. Most people who are on methadone will abuse tablets or heroin … or alcohol. (Colin)

Jordan’s experience of a MMP, which is a prime example of Goffman’s notion of total institutions, was described as, ‘a miserable existence … going over to the doctors every week … always feeling sick’. He highlighted the power he perceived the doctor held over his life: ‘he dictated what my week was going to be like’. Jordan also recounted his obsession with drug using, admitting he gave his father a very hard time for years:

My poor Da used to mind my methadone … his heart was broke … I was always at him … “give us an extra 20 mls” … he used to keep my methadone in his bedroom … I used to break into his room … they talk about obsession like; nothing was going to stop me getting on the other side of that bedroom door … no love, emotion, nothing. (Jordan)

Jordan asserted that he was never advised to detoxify from methadone. Eventually, he recalled how his father helped him:

I never got told … “why don’t you get off this stuff” … I had no idea of the support that was out there … no idea of meetings, none of that stuff … my Da started bringing me down … It took a long time … three years. (Jordan)

552 Methadone and opiate dependence treatment, introduced in 1998
Treatment supports

According to White and McLellan (2008), most individuals require varying levels of ongoing support, although it is acknowledged that many individuals recover without any treatment and maintain long term recovery without professional support or monitoring. The participants of this present study described support from a range of services which are described in the following sections. The treatment supports can be divided into three main categories:

a) A diverse mix of services, including counselling and 12-Step programmes (eight participants),

b) One treatment service, counselling and 12-Step programmes (six participants),

c) A few weeks counselling and 12-Step programmes (two participants).

When discussing treatment centres, again the question of readiness to stop arose. Wendy shared that until she had made the decision to cease using, she could have ‘been in and out of centres for another ten years’. For Colin, the acceptance of his addiction was the most important factor in his recovery, and he described using treatment services, counselling and a 12-Step programme to help maintain abstinence. Eddie stated that the treatment centre he attended ‘saved my life … the lifestyle that I lived … I had done stuff when I was younger that I couldn’t come to terms with’. He described the support he received as:

Changing your behaviours and faults … responsibilities and being honest … getting back into the workforce … learning how to live like a normal person in normal society, I learned that in that in them two places. (Eddie)

Some participants reported combining a day programme with a 12-Step programme. Miller (1995) found that most treatment methods are equally effective in the short-term but 12-Step programmes have a better long term outcome. Additionally, Chappel and DuPont (1999) suggested that engagement with a 12-Step programme along with another treatment intervention reinforced a more positive outcome. Martin stated he experienced both a day programme and residential treatment, but relapsed and returned to treatment a year later. Second time around, he reported he took treatment a lot more seriously. Clint remembered before he entered a day programme, he was attending AA but ‘I did nothing about recovery. I just didn’t drink. I thought not drinking would be enough and I had no idea about alcoholism’. He recounted relapsing on prescribed medication a few years later and was medically detoxified over a three month period. Subsequently, he reported going with his wife, to a day
programme, saying ‘There was enough hope left in us that we could salvage the marriage’. Echoing Tracy et al. (2005) and Beattie’s (2001) findings that stable marital relationships and the involvement of a family member or partner in treatment, leads to significantly more positive outcomes, Clint described the support both he and his wife received as ‘we didn't realise how much damage we had done to each other’. Clint added that the programme was worthwhile as ‘Our next anniversary is 35 years’.

Treatment became a valuable experience for Tommy who acknowledged that he did want to stop using but he thought a residential stay would keep the peace and ‘get me out of the way for a while’. Within the treatment programme he gained many personal insights including recognising the need to stand up for himself and address his relationship with his wife, in order for a meaningful recovery to occur.

The combination of 12-Step programmes, counselling and treatment proved useful for Scarlett and Jenny who both reflected on how these methods complimented each other. In agreement with Atkins and Hawdon’s (2007) finding that there are both social and spiritual activities that help foster well-being and inclusion, Scarlett reported that she used AA, attending up to four or five meetings a week, while Jenny considered the network of NA vital to maintain recovery. She believed:

What you do in a treatment centre is very good and professionals are great ... But, I believe that we need an awful lot more support than that. It’s great getting to issues but you need support when you come out ... the support, the network, that’s what keeps me clean. That's what keeps me alive, is the support of other recovering fellow addicts ...

I believe in the 12-Step programme. (Jenny)

Jenny highlighted as significant, the relationships she had fostered over the years within the fellowship and getting help from counselling where she could share more deeply.

Several participants reported being in several treatment centres. Eddie and Jordan, for example, spoke about being in and out of several programmes before they eventually became abstinent. In his first attempt as a teenager, Eddie admitted he was going to a treatment centre for the wrong reason:

I thought it would be fun ... take me away cos all I ever wanted to do was escape ... a bit of crack, get to know people and that was really my mind-set around it. (Eddie)
Eddie reported trying several residential and day-programmes over the next few years and eventually went ‘cold turkey’. He reported completing a home detoxification, with the support of his wife, who he described as nursing him ‘as if I had cancer’. Recognising that he had a lot to learn about himself, Eddie reported continuing to attend the day programme and counselling and eventually went in to residential treatment again, where he asserted ‘I learned who I was ... learned an awful lot about myself and found myself’.

Jordan shared what he described as a frightening experience of preparing to go to hospital for a detoxification prior to going to treatment. He recalled how he had isolated himself for years, and he related ‘I was that terrified I couldn’t focus ... I was watching every one. I was just a nervous wreck’. However, Jordan reported when he eventually dealt with his fear, he moved on to another treatment centre. As he grew stronger physically and emotionally he realised ‘the real work starts when you get out into life’. He described how he continued his journey through treatment, began to find enjoyment in his life and he found the strength and resolve he had gained through the various treatment programmes, helped him maintain abstinence. Jordan reported he has life-long support from the treatment centre and that he is no longer alone or frightened to speak, safe in the knowledge that if he has an anxiety he can contact the centre and re-engage with counselling. Both treatment centres had recent celebrations which he described attending: ‘it’s great to be part of something’. Jordan said maintaining his sobriety is life-long as ‘it can be very easy to forget where you came from, especially when things are going well’.

Meryl also recalled attending several treatment programmes, presenting for counselling, joining NA and experiencing numerous attempts to cease drug using. She reported her effort to cease drug using started with a detoxification at age fifteen, which was the first of six attempts at detoxification at various times over the years and two residential treatment centres. Sanders (2007) found that street sex workers, when ceasing sex working and trying to become abstinent, were more likely to use services. In agreement, Porter and Bonilla (2000), added that this engagement with services was the most useful in reconstruction of identity and helped sidestep deviant labelling. Meryl described how she finally decided she had ‘had enough’ and her final treatment was combined with counselling and NA meetings, all of which she became open to and found useful.

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553 See also Alexander 1987; Arnold Stewart & McNeece, 2000; Dalla 2000; Davis, 2000; Forbes 1993
Another participant, Wendy, in her quest for abstinence, had been to a priest, a doctor, a hospital, had completed two medically assisted detoxifications, was on a MMP, attended four residential treatment centres and counselling, before eventually becoming ‘clean’. Admitted for her first residential treatment when she was seventeen years of age, Wendy talked about a pendulum like process of treatment and relapse which lasted for seven years, at which stage she became very ill and was sectioned to a mental health facility. Experiencing significant difficulties on a MMP with observed urines, Wendy related how she eventually finished using methadone:

_A very lovely doctor on a clinic contacted me ... said he’d like to take me back on and let me give urines on my own. ... I just feel like writing to him to tell him that I’m still clean because he obviously seen something in me or he believed in me ... I detoxed 6mls a week._ (Wendy)

The recovery process, however, was not easy for Wendy, who described suicide ideation, reflective of her experience of feeling suicidal when she was younger. She recalled attending counselling, where she felt the counsellor, like the doctor in the clinic, believed in her and really wanted her to get well, as she explains:

_I just felt like a big, fat mess ... the shame and guilt about what I was after doing and working as a prostitute used to come into my head all the time. I’m filthy ... I went to so much counselling and I cried and cried and cried about this ... The counsellor was great ... He really empowered me ... gave me a lot of positive feedback ... I couldn’t hear him when he would say to me I was worth this. I would be ... thinking how much I hated myself but he used to repeat stuff to me and it eventually went in._ (Wendy)

Martin, Jordan and Tommy shared their experience of aftercare. Gossop _et al._ (2003) and Velde _et al._ (1998) agree that uptake of aftercare reduces drop-out rates and enhances the chance of maintaining abstinence. Martin reported also attending AA and trying to ‘convert’ members of the aftercare group.

_I was doing well in the aftercare ...I was going to AA every day and I was preaching to them in the aftercare and trying to get them to come. And a few of them did ... I was always talking it up ... so I encouraged a lot of people._ (Martin)
After a relapse, Jordan reported getting support and friendship from the aftercare group which strengthened his resolve to remain abstinent. Tommy recalled that his wife attended aftercare with him and found her own strength and support there.

[Wife] came to Aftercare with me ... they suggested to her that you are here for yourself, you are not here to look after Tommy. You need to grow along lines you have been affected. She jumped at that and she grew along that side. (Tommy)

Gary, who reported being twenty eight years clean, was the only participant who did not go to either treatment or counselling, in part due to a lack of awareness of those services. He reported using AA as his only form of support. Brian stated that while he was grateful for the counselling he received, that counselling was only a small part of his recovery, as this next quote explains:

I put the work in this time. I got a bit of direction from certain people ... I got a good insight into myself through counselling ... but I wouldn't place extreme value on it being honest. (Brian)

Many of the participants reported counselling was useful to guide their journey through personal awareness and for advice, especially during critical times. Tommy remembered his first meeting with his counsellor ‘tears were pouring down my face ... I'm here to get help. I want to stop ... I want to be happy’. This next quote from Rita concerns her experience of feeling safe in counselling:

I did go to counselling ... for a year and nine months... dealt with childhood stuff ... when we were kids not feeling safe ... because my mother was on codeine so she was spaced out ... angry and crazy, mad ... the crazy stuff in my early teens, my father’s attitude to me. (Rita)

Kevin initially engaged with personal therapy, before moving into group therapy as part of his counselling training where he was with other trainee psychotherapists who had not come from a place of addiction. He reflected that he was ‘in a huge amount of pain ... severely traumatised’ due to what he described as a dysfunctional upbringing. He described the therapeutic group as an intense group but a wonderful experience in personal and professional development. He reported being so grateful for the chance to work through his emotions, as he explained:

I dropped into a deeper level of stuff and that rattled me ... Therapy is rough ... emotionally it will shake you. I wasn’t strong enough that I could give myself permission
to have the cathartic experience ... if I needed to cry, if I needed a release, process an emotion I can do it and be okay with it. Whereas before it was either moments of detachment or rage ... No middle ground ... I wasn’t strong enough to deal with emotions ... therapy gave me the ability to handle emotions. (Kevin)

**Distressing treatment interventions**

Some participants related very distressing experiences in treatment centres, especially those who were there more than ten years ago, where they felt humiliated and degraded again reflecting Goffman’s (1961a) notion of total institutions. Gould and Stafford (2002) suggested that treatment methods often mirrored society’s disapproval of drug using and drug users. Echoing this, Scarlett shared her discontent with the residential programme she attended, stating that while she got physically well while in there, emotionally and psychologically the experience actually damaged her:

That treatment centre was an absolute horror story ... At that time, nearly twenty years ago, it was still the break them down and build them back up again philosophy. But they never built you up again ... You were left broken and miserable ... I think if someone had helped me work through stuff it would have been much better. (Scarlett)

Similarly, Jenny related a negative treatment experience from seventeen years ago, where she attested that the treatment was overly harsh:

The way they dealt with it was you took real responsibility cos they beat it into you. There was no empathy, no compassion ... you’re wrong, you’re horrible, how could you do that? I came out of that treatment centre and carried that with me. (Jenny)

Likewise, Meryl shared a tough treatment experience, especially when being confronted in group therapy, where she said everyone in the group: ‘has been humiliated, has been broken, beaten down and we don’t need that. We need to be nurtured on some level’. Meryl expressed gratitude for practical support but her next quote explains, she got little therapeutic support:

I don’t feel it was a supportive environment ... it taught me a lot of practical things like how to cook and clean, wash myself, take care of myself. Some of the groups were good ... we would talk about our childhood and do very deep work ... but sitting on a chair and being screamed ... just felt like attacks which I didn’t find helpful. (Meryl)
Colin also described an unhappy experience in a residential setting, where he could not speak in group: ‘I was terrified ... sweating, couldn’t talk to people. I was like that the whole time’. He considered that he did not have the coping mechanisms to manage in crowds, and did not have the language to convey when he felt scared or vulnerable. However, he recognised it did show hope for the future. The most helpful aspect Colin noted was being directed towards NA, as some of the counsellors working in the centre were ‘ex-alkies and they understood’. However, he recalled issues that were not resolved and he left treatment without resolving them, as he explained: ‘when they opened the can of worms I was just so vulnerable ... it still hurt. It wasn’t solved ... I felt alone’.

Eddie shared a similar story where his issues were left unresolved. He also used the phrase ‘opened up a can of worms’, and like Colin found the issue, which for him was the CSA he had suffered, was not dealt with. He remembered that the treatment centre did not offer one to one therapy and explained:

> I was raw then. I couldn't deal with it ... I needed a certain type of therapy and I wasn't getting it in places like that ... they just hadn't got that thing that I needed. I got suicidal and had to leave because of policies and insurance. (Eddie)

All of the participants of this present research reported varying degrees of engagement with 12-Step programmes. The following section reflects on that engagement.

**12-Step Programmes**

The speed and success of identity transition is ultimately individual according to Markus and Nurlus (1986), who also claimed that many former drug users affiliate with positive groups like 12-Step groups. In this study fourteen of the participants described 12-Step Programmes as the most useful method of facilitating change to a non-drug user identity and staying ‘clean’, especially in early recovery.

The majority of these fourteen participants reported still going to meetings regularly and helping others, especially newcomers. Koski-Jännes’s (2002) assertion that 12-Step Programmes can facilitate change due to the fact that the core beliefs of the programme do not support continued drug using, is supported by several participants in this study. For example,
initially Gary, Tommy and Jordan recalled using 12-Step Programmes to maintain their drug using but soon found out that would not work. Gary explained:

_I turned up at the meeting... I heard that there were twelve steps ... I would probably do one of these a week and in three months I would have a certificate or my diploma and be able to get out and get on with my life ... I thought that this was going to fix me ... I tried it for a couple of weeks ... Then I decided ... if I went to AA two or three nights a week, four maybe I’d be able to drink on the in-between nights ... cutting my drinking down by half and that couldn’t be a bad thing ... that idea lasted for a week or two ... I was back worse than ever._ (Gary)

Tommy reported his introduction to NA was similar, where he was still using cocaine while going to meetings. Jordan had a similar plan – to use meetings as a type of harm reduction measure. Jordan stated that although he was attending meetings, he ‘had it in my head that I could [use]’, and relapsed several times. Eventually he remembered that he ‘surrendered. I know fuck all about recovery ... But these people do’. Jordan described along with the realisation that he could not juggle meetings and using, he noticed a huge behaviour shift ‘all or nothing’.

Several participants, although they felt initial trepidation, recalled how membership of a 12-Step Programme helped them initiate change. Greil and Rudy (1984) suggested that gradual identity change was possible within Identity Transformation Organisations, like 12-Step programmes, as they promoted letting go of previous drug using identities. Sandra described her programmes as ‘integrated’ into her, while Rita reported the confusion of simultaneously feeling comfortable but also very frightened and vulnerable, remembering ‘going into meetings feeling very at home but also feeling like somebody had a zip and they zipped me open, everything was exposed and that was a big fear in me’.

Baumeister’s (1991) suggestion that becoming part of a bigger unit through membership of 12-Step Programmes motivates recovery, resonated in this study. Wendy shared an example of doing service within the group and gaining confidence as she became more accepted by members: ‘Doing secretary is a great achievement for me cos I used to get very anxious in crowds’. White’s (2006) assertion that new members gain strength when long-term members show kindness was illustrated in Kevin’s recollection of feeling overwhelmed that anyone could care about him, saying ‘it touched me that there was someone who would think about me, or care about me or ... help me’. As time passed, Kevin described feeling part of the group
and started helping newcomers. Helping and providing service is empowering for members of 12-Step programmes. It helps with connecting with others and aids identity transformation. Bloomberg and Pittman (1991) proposed that the main effect of service is internal rather than external reward. In accordance with this, Kevin recalled:

*I felt I was a part of it. I was standing at the end, the Serenity Prayer ... a fella says ... “Why do WE stand together in a circle?”... It was a great feeling being part of something I actually wanted to be part of.* (Kevin)

Rita shared that she aspired to be like the members she met in AA, who had supported her through difficult issues. She described how she had stopped going to meetings after a few years, suffered a crisis shortly after she got married and returned to AA. She continued to confide in AA friends in good times and bad, explaining: ‘I remember he [second husband] had an affair ... was great to have AA .... somewhere to go to talk about it’.

By joining a 12-Step Programme, former drug users reflect on their drug using careers through sharing with the group. Brown (1991) suggested that members re-define themselves as former drug user and re-identify with their past selves, where their past identity could be assumed again, as it would fit in with their new social context. Colin shared how his new social context within the 12-Step Programmes helped him realise the extent of his addiction, remembering how difficult it was in the beginning, but getting easier as time passed. Brown (1991) further explained that many former drug users realised that while drug using, they adopted a drug using identity to fit that particular social context. The new social context encourages revising an unspoiled identity. Adopted drug using identities were no longer desirable or necessary. In a similar vein, Sandra reported changing her social context by leaving her partner who was still drug using, while she moved on to a new drug free lifestyle. Initially, she described how she attended meetings to encourage her partner to go, but reported that she stayed – he did not:

*I never looked back. That was eight and a half years ago. He was stoned and he left ... but I kept going and realised that I wasn’t going as a support for him ... I ended up there. .... once I got a couple of meetings in, I did not pick up drugs.* (Sandra)

Kevin reported that when he reached the end of his drug using career, he realised he had to make some radical changes and turned to meetings for help. He recalled, initially, feeling ‘full

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554 See also Denzin, 1987; Greil & Rudy 1984
of shame’ with holes in his shoes, having to borrow clothes that were too small for him and being brought to meetings by friends, like ‘a child being brought to school’. He recalled feeling very empowered the first time he refused the offer of some drugs which helped strengthen his resolve. He spoke about his initial fragility:

*There was a homeless fella … sleeping in the doorway … I said to [Friend] “that’s gonna be me if this shit doesn’t work”. And he said “that could be any one of us”. It was a very profound thing that he said … He said “You are no different than anyone in there … no better or worse than anyone else” and that lifted me … I’m gonna give this a shot and if you fuck it up you fuck it up but at least you gave it a shot.* (Kevin)

Meryl initially remembered her relationship with NA as a dependency. She reported feeling fine at meetings and having coffee with NA friends, but when it became time to walk to the bus, she would ‘become consumed with panic, I would feel anxious and I would be afraid’. For a long time, she recalled asking her mother to collect her. She continued to go to two or three meetings every day for two years and said:

*I became dependent on members. I had no friends that were not members. Everything in my life revolved around NA, doing service, working steps and going to meet me sponsor, going for coffee with newcomers and doing chairs.* (Meryl)

Eventually, Meryl reported that she learned to trust herself and others. For Martin the adoption of AA was instant as he recalled he was ‘willing to do anything. I took direction from the AA guys’. Martin reflected that he owed his life to AA and still goes to meetings twice weekly. On the other hand, Clint shared he did not feel good enough to go to AA when he was so physically sick giving up drugs and alcohol. He recalled being afraid he would not be accepted and that AA members would advise him to go to hospital. However, when he went to the first meeting he fitted in.

Joining in, becoming a valuable member, conceiving a new meaning in life and discovering satisfactory alternative behaviours, according to Harre (1983) aids identity transformation. Membership of the 12-Step programme provided a similar secure setting and feeling of ‘fitting in’ as the initial immersion into the drug using subculture. However the reason for membership and outcome of that membership were very different. Significant non-drug using relationships and activities help prevent relapse and motivate change. Concurring with this, Martin shared

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555 See also Biernacki, 1986; DeFulio & Silverman, 2011; Waldorf, 1983; Wong & Silverman, 2007
that AA ‘covers everything for me’. Tommy similarly remembered being attracted to listening to long-time members talking about their lives, explaining:

I didn't want to go back out and use ... I wanted to be one of them fellas who were eight years clean ... thirty years clean ... talking about getting on with life and having their family and I wanted that'. (Tommy)

Identity transformation happens by moving from one social context to another, inviting behavioural change, in order to recover from destructive drug using careers. Kevin reflected that NA helped influence all areas of his life.

My girlfriend’s is actually in recovery too. I came into NA and got housing through NA, and then I was doing relief work in a homeless shelter. The manager recommended I go for a course in [Organisation], I was seeing a counsellor in [Organisation]. So I ended up doing counselling course in recovery. And I ended up getting work through recovery. But everything kind of came through that. (Kevin)

Strauss (1962) reflected that behaviour change helps the former drug user revert to their identity prior to drug using. Kellogg (1993) proposed that 12-Step membership offered new or forgotten social tools which can be incorporated into daily life to help create a new identity. New members model socially acceptable behaviour, bringing about a change in self-concept and adopt a new role in helping others, all of which combine to restructure their identity into one which will prove more rewarding. Echoing this, Brian reported finding deep and satisfying change through the fellowships. He remembered:

Finding a fellowship, finding a purpose within that ... trying to do right by my family ... developing living skills and being capable of independent living ... immersed myself in a fellowship ... I go to meetings regularly and try to work a programme, I try to live better, work on the past and I have my family back in my life. (Brian)

Many participants in this study described how they identified with other members, wanted what they had, were happy to grasp the hand of fellowship and accept advice from people in recovery. Koski-Jannes (2002) suggested that the isolation suffered by separation from drug using peers was somewhat addressed by becoming part of a larger whole, helping to ground their changing social identity. The participants asserted that friendships in the 12-Step Programmes had helped them adjust to a new lifestyle. Colin reported: ‘I got a sponsor ... He put his hand out ... It’s about reaching out to another addict alcoholic’. Scarlett also
remembered building up a network of good friends and developing a social life with them: *We all would go to a cafe after meetings... I still had huge problems... but at least now I had somewhere to talk about it*. After her relapse Scarlett reported ‘I went back to AA and renewed a lot of my old friendships. I admitted I’d lost my way... and was grateful that I was back’. 

Clint shared about the support he got from members at his niece’s funeral, throughout the whole process and were ready to talk if Clint needed a friend. He recounted:

> They just stayed in the background. And whenever I needed to talk I just went over and talked to them... That's the fellowship... when your back is to the wall... that's where the fellowship really kicked in for me. (Clint)

The participants reflected on the experience of getting a sponsor, which is expanded on in the next section.

> Getting a sponsor and working through the steps.

All of the participants who joined 12-Step fellowships described how they accepted help as they worked through the twelve steps\(^5\) with a sponsor and other fellowship members. Sandra recalled how she was attracted to the calmness of her first sponsor:

> I asked this really calm woman... she’d be talking about “I’m just going to go home now tonight, make a hot chocolate and watch ER” and I’m like what? I was fucking like a schizophrenic... I couldn’t even turn the fucking television on... I wanted to be able to sit in the chair and have a hot chocolate and watch a bit of telly but it was not possible for me for such a long time. (Sandra)

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\(^5\) The twelve steps of AA - 1. We admitted we were powerless over alcohol - that our lives had become unmanageable 2. Came to believe that a Power greater than ourselves could restore us to sanity 3. Made a decision to turn our will and our lives over to the care of God as we understood Him 4. Made a searching and fearless moral inventory of ourselves 5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs 6. Were entirely ready to have God remove all these defects of character 7. Humbly asked Him to remove our shortcomings 8. Made a list of all persons we had harmed, and became willing to make amends to them all 9. Made direct amends to such people wherever possible, except when to do so would injure them or others 10. Continued to take personal inventory and when we were wrong promptly admitted it 11. 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 the result of these steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs
The participants reported that working through the twelve steps was difficult but very rewarding and essential to attain their aspirations. For example, Brian reported how he experienced the practice of working through guilt and shame, saying that step work can be tough. He explained that ‘there’s a lot of stuff in there that is unpleasant, I’m ashamed of or feeling guilt over’. Sandra explained how step work was like a process for her:

*The first step gave me the awareness of what the fuck I’d been doing for the last fucking ten years ... when I did each step something happened ... I was processing things ... I was learning that it was ok to talk to other women ... learning about trust ... about healthy relationships ... I needed a solution ... it was the steps to work on me and make peace with myself ... let go of the things that were dragging me down.* (Sandra)

The participants all reported noticing changes in their behaviour, where they described how working through the steps helped them accept elements that they disliked about themselves. Colin remarked that he ‘started on the steps ... started to get a bit of normality into my life’. Rita also reminisced about the challenge of doing the fourth and fifth steps and being re-introduced to life changing concepts like honesty, humility and pride. Clint spoke about following the AA philosophy of making amends to people, including those he did not like or who did not like him. He commented on the benefits of the 12-Step Programme as a programme of recovery where ‘it’s a very serious thing and if you don't get involved in it you don't get the benefits’.

*Service in 12-Step meetings*

In keeping with the 12-Step philosophy, members are encouraged to do service and help other members. The participants who regularly went to meetings, found this practice benefited them as well as the recipient of the help. They spoke about doing service at meetings by taking on the roles of secretary or ‘doing the chair’ where they lead the meeting by telling their ‘experience, strength and hope’. They also spoke about sponsoring newcomers when they had attended meetings for a few years. Sandra explained how this philosophy is put into practice saying that she ‘started to work with other girls taking them through and that also helped me

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557 12-Step programme expression where the person who ‘does the chair’ sits at the top table and leads the meeting by sharing ‘their experience, strength and hope’ and inviting other members to share their recovery narrative.
a huge amount ... the continuity of the programme is when you help someone and you see them helping someone else’.

Helping and supporting others, especially new comers, becomes an integral part of the programme. Helping boosts self-efficacy and commitment to staying abstinent, increases the sense of purpose and strengthens the sponsor network within the programme. Sobell and Sobell (2000) and McKay (2001) researched the usefulness of helping within 12-Step programmes. They agreed that helping activity increased self-esteem and peer bonding, and members who helped others were more likely to achieve lasting abstinence. Colin described the satisfaction and sense of pride he felt when helping others:

I love working with people ... People have become themselves with me. I know a fella and he’s clean now ... not cos of me, just maybe I said the right questions to him ... that’s what it’s about and this is going to sound real selfish but it helps me and him ... it’s great. It’s beautiful. (Colin)

The participants shared the notions of identifying with others and no longer feeling alone. Sandra remembered when she went to meetings she got ‘a feeling ... a little bit of hope inside’. She identified with other members stories and recalled gaining hope that she too could recover. While Jordan feared for his mental health for quite some time he explained that change happened for him when he found CA and discovered:

I’m not on my own with my thinking any more ... the relief ... it was like these people are the same as me ... like I’m home ... I’m with my own kind and that’s priceless. (Jordan)

Experiencing a spiritual awakening or a higher power

Many former drug users associating with 12-Step Programmes, according to Markus and Nurlus (1986), report radical conversions or spiritual awakenings which, for them, becomes an essential part of their identity change and successful abstinence. Several participants of this study reported the experience of a ‘spiritual awakening’. The participants described a sudden phenomenon that they could not put in to words. Wendy described being introduced to the 12-Step programme in hospital. She stated ‘something happened that I can’t explain, because, to me, I was still a drug addict’. Reflecting on the spiritual aspect of the 12-Step programme,
Wendy asserted it gave her a ‘spiritual well-being’ and ‘lots of principles that I try to apply to my life which was the complete opposite of active addiction’. Some participants reported a renewed sense of spirituality or belief in God. Kevin described ‘All of a sudden it just happened’ and attributed the change to living the AA philosophy for several years and trying to live every day as best he could. Clint reported: ‘I don’t know whether God answered me or not, but I heard these words, “Go to AA and everything will be alright”’ and Sandra recalled: ‘Something strange happened me didn’t know what it was, couldn’t explain it. I didn’t have the desire to use anymore’. She explained:

I just went to meetings and something was different ... It wasn’t necessarily something I heard. It was just like something I took out of the room ... a subliminal common sort of purpose ... It’s a strange kind of power and I just would get through. (Sandra)

Jenny recalled how her faith in God brought a sense of security and safety. Both Martin and Wendy reported having a ‘spiritual awakening’ and that their faith in God was very important to them. Martin described it as ‘Some type of an awakening’ while Wendy reported sensing something was taking care of her as she explains:

I just started having a desire to live ... I started attending meetings, I started taking care of my health, I started washing myself, eating, staying away from people, places and things, I wasn’t hanging around with anybody I used to use with, I was getting drawn towards the 12-step programme and seeing the way they were living their lives and wanted to live that life ... gave me the fucking courage and the hope that I’ll be ok ... There was a great fear there, but... I had this sorta reassuring voice ... from a higher power that I couldn’t identify then. (Wendy)

For Kevin, change happened more slowly and he reported finding himself homeless and prayed for help:

When I was six weeks clean ... ended up in a hotel ... it was the first time I prayed ... please God help me ... thinking there was no way I could live like that. It was a very scary place to be on your own and fucking homeless ... I said “Please God, help me” and I got up the next day and I went to a meeting. (Kevin)

The majority of the participants reported still attending meetings regularly and maintaining strong friendships within the 12-Step programmes. Others like Meryl, who previously shared
becoming dependent on meetings in early recovery, maintained that people eventually move
on in their own lives: ‘when you’re obviously drug free in recovery for quite a number of years,
beginning to let go of the meetings because I think people move on’.

When the 12-Step programme was not experienced as useful

While two of the participants of this study asserted that 12-Step programmes did not suit them,
others highlighted certain aspects of the programme that did not work for them. Eddie
maintained that the 12-Step Programme did not work for him because he ‘sabotaged doing the
steps ... and then relapse ... I wasn't ready to confide in someone like that’. Joan spoke of
trying different meetings: ‘gay meetings, all female, mixed, I tried everything’. She reported
she could not identify with the ‘old stories, war stories, how drunk they got’ stories that were
being told, and added: ‘I found them quite negative and it was seeping off on me’

Some participants who embraced 12-step meetings had negative views on some aspects of the
programme. Chappel and DuPont (1999) and Christo (1999) agreed that although 12-Step
programmes helped many former drug users maintain abstinence, there were also many who
did not engage with them for various reasons. This was corroborated in this present study, for
example, Kevin mentioned that in some groups seeking help from therapists can be frowned
upon. Colin found the attitude of other members to the fact that he was on prescribed
medication quite unsettling. He recalled ‘I didn’t abuse them [antidepressants] ... but I had
people telling me you’re still using ... so I kept relapsing and went using’. Some participants
struggled with the idea of a higher power or having a God in their lives. Gary and Scarlett
reported never managing to ‘get the God bit’. They both stated that although they tried really
hard in the beginning, they could not accept the belief. Gary explained hearing AA members
saying ‘get God or get drunk’ unnerved him. Finally he reported that he stopped trying but
continued to stay sober.

Sandra reported she found it difficult to follow some of the suggestions put forward in the 12-
Step programmes, like ninety meetings in ninety days. She recalled ‘I got like a couple of
meetings a week’. She also recalled ‘Even though they suggested that you don’t, I slept around
with fellas’. However, Sandra mentioned that she felt very strongly that working through the
twelve steps was the most vital part of the programme:
Everything I’ve learned, I’ve learned from doing step work. I didn’t learn from going to meetings because you won’t get fucking well going to meetings … People say just get a meeting and you’ll be grand. No, you won’t be fucking grand … It’s not a meeting programme it’s a 12-Step Programme and every time you go to a meeting you will hear the twelve steps read out and there is a reason for that. It’s not about going to a meeting and hooking up with people for coffee … you need to do the work, clear the wreckage, clear everything out and carry the message to other people. (Sandra)

Some participants mentioned prudence in sharing at meetings to ensure they protected themselves. For example Wendy said:

*I wouldn’t share about that [sex work] at meetings … you don’t want to leave yourself open … I find that men can go into the rooms or women and say I robbed him with a shotgun and robbed her with a syringe but once you say you’re a prostitute you are like … looked at as if you have 55 heads.* (Wendy)

As well as treatment methods and 12-Step programmes, participants in this study identified other key supports they experienced in their struggle to maintain abstinence. The next section outlines those supports.

**Other supports**

Family and intimate partners featured predominantly in participants’ responses to the question of support. Moos *et al.* (1990) maintained that strong support from spouses, close family members and friends was linked with reduced drug using and increased periods of abstinence leading to stable recovery. In agreement with Moos *et al.* (1990), Eddie identified his wife as his ‘crutch’, acknowledging that although he treated her very badly she still supported him:

*I don't know where she got the strength to stand by me … I don't know how any human being could put up with what she put up with from me … I put that girl through hell over the years.* (Eddie)

Fernandez *et al.* (2006) asserted that joining family 12-Step programmes helps family members, who have been affected by a member’s drug using, to become independent and increase their own sense of well-being and self-esteem. Echoing this, Eddie mentioned the
support his wife got from NarAnon\textsuperscript{558} and other services, which ultimately benefited both of them. Although he did not go to a 12-Step programme, he realised the importance of the meetings and support his wife enjoyed:

\textit{NarAnon and family support had been a big part of my recovery ... because if it wasn't for the support that my family got I wouldn't have been able to do it ... the support she got through them services and the support I was able to get from her - my recovery wouldn't have been the same.} (Eddie)

Half of the participants identified the support they got from their mothers as critical. Wendy recalled that her ‘poor mother never gave up on me ... such a great strength’. Meryl similarly acknowledged that she ‘didn’t feel very strong so for a couple of years I needed that support ... someone to hold my hand’ and that her mother had been there for her. Conversely, Sandra and Joan had the opposite experience regarding their mothers. Sandra described her mother as still ‘alcoholic’ and a source of extreme stress while Joan stated that her continuing sobriety would have been threatened by her mother, who she described as a ‘huge trigger’.

Brown (1994) maintained that family recovery is a process that can take years rather than weeks or months, where family members need to look after their own recovery, as well as helping and supporting the former drug user. Acknowledging how difficult it must have been for his parents trying to rebuild trust in him each time he relapsed, Colin stated that his parents were always there for him ‘even when I was slipping and sliding they were still supporting’. Jordan talked about his parents’ relationship improving as they worked together to support him. He commented that, although they had been separated before he went in to treatment, they nonetheless came in together to visit him to ‘\textit{show a united front}’. Joan spoke about her intimate relationship and the support she received from her family. She commented that counselling was supportive but she reported that she got more support from the close relationship she had with her siblings and from her partner. She commented: ‘\textit{if it weren’t for them I would have packed it all in, definitely. Their unconditional love}’.

Participants in this study also mentioned the support of friends and having a confidante as vital, especially in early recovery. Martin recounted support from friends both inside and outside the

\textsuperscript{558} The Nar-Anon Family Groups are a worldwide fellowship for those affected by someone else’s addiction. As a Twelve-Step Program. Families are offered help by sharing their experience, strength, and hope, which is a similar framework to the 12-Step programmes for drug users. The only requirement for membership is that there is a problem of addiction within the family or friendship network. The program of recovery is adapted from NA and uses Twelve Steps, Twelve Traditions, and Twelve Concepts.
workplace and Tommy highlighted the importance of having a mobile phone to talk to friends. Gary reported it took him a long time to make good friends but now he enjoys social activities and Brian stated: ‘I have friends in my life that I can talk to about anything ... that have the same experiences, similar experiences that I can identify with’.

Participants mentioned other vital supports. Eddie, who was working in the field of addiction at the point of the interview, reflected that his work was ‘a major support’ while Tommy and Scarlett identified the gratification they experienced from college work and study as important contributors to their study. Joan described the cathartic experience of writing her autobiography, describing it as ‘really therapeutic ... I really got a lot out of it myself. It made me feel very good about myself’. Kevin shared how his counselling training helped during his mother’s illness and subsequent death. He feared he may use but remembered: ‘although it was tremendously sad and it was a hugely painful experience I was actually ok with it’. He also mentioned college and spoke of a new relationship:

I have another relationship and I’ve got to credit it to my counselling course ... You have to go through this big rigmarole ... They give you a seal of approval ... it’s a 4 year process then you get the degree so it’s a huge sense of achievement. (Kevin)

In terms of seeking external supports the participants of this study recognised that change in their social settings and drug using behaviours aided identity change by reducing stigma, removing the deviant label and replacing these with more socially acceptable situations and behaviours. Change not only depended on external support. Many participants also reported doing a lot of personal work on themselves to make changes in their lifestyles which is explored in the next section.

**Personal change due to working on self**

The assertion by Kelly and White (2011) that personal self-care supported by family and services is critical to sustaining abstinence was reiterated by several participants. For example, Martin spoke about anxiety and stress and described how he had learned to combat them, by planning ahead, anticipating stress and being proactive. He gave examples of avoiding visiting his sister, her partner and old friends who were still using and avoiding public houses as he explained: ‘I never really put myself at risk’
For Joan, self-care included changes in her social life, like staying home on Friday nights watching television rather than going to nightclubs as that was ‘threatening my sanity’. Similarly, Sandra shared how greater awareness of herself and improved self-care had changed her life. In terms of self-care she described the following:

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\text{I do meditation and DVDs ... Yoga ... relax and unwind and do exercise DVDs, playing with the little fella, just being a kid again ... I’d use my therapy a lot. I’d have good friends and my sister who I’d be pretty close to that I’d talk to ... I’m on level two reiki ... I would clear the room and light a candle and actually love doing that, just chilling out like. (Sandra)}
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Eddie reminisced on his drug using and the tools he now uses to maintain abstinence, which can include working, helping others and counselling: ‘if I find something is coming up, the option of going to a counsellor is there for me’. He said he worked through ‘family issues and stuff ... my real recovery started when I left [Treatment centre] ... I was just constantly working on myself’. The examples above illustrate how the participants of this study value their new drug free identities, lifestyles and their enhanced self-care in recovery.

**Chapter Summary**

This chapter described the supports used by the participants in their efforts to achieve and maintain drug free lifestyles and to attain non-drug user identities. It discussed how they reconstructed their identities to suit that new lifestyle. Participants in this study used several diverse treatment modalities to achieve abstinence. Some participants described very distressing and traumatic treatment experiences, but the majority expressed positive experiences of treatment. Most of the participants embraced aftercare, counselling and 12-Step programmes to maintain their drug free status. The participants also identified other key supports, including family and friends and spoke of their own personal change in recovery. Generally, they expressed a sense of gratitude for the ‘gift of recovery’.

Chapter seven is the final chapter outlining the findings of this thesis. It will discuss other supports in terms of relapse and relapse prevention. Relapse is an integral part of early recovery and it is critical to address the issue of relapse prevention to support drug users, especially in the early years of their drug free lives.
Chapter Seven – Supporting reconstruction of identity: Enhancing recovery

Introduction

The previous chapter outlined the supports that the participants of this research reported they employed, and their accounts of those supports. Supports used included 12-Step programmes, treatment, counselling, and the family supports that participants reported they drew upon. The participants testified using these supports in their efforts to achieve and maintain drug free lifestyles. The chapter discussed how participants described reconstructing their identities to suit that new lifestyle.

This present chapter is the final chapter outlining the findings of this thesis. It describes other supports, as reported by the participants in this study, connected with relapse and relapse prevention. This chapter acknowledges that relapse is a salient part of recovery and that it is critical to address the issue of relapse prevention to support drug users, especially in the early years of their transition to drug free lives. Firstly, it will present how the participants reported experiencing relapse. Then it will explore the participants’ accounts of relapse prevention and how the effects of relapse manifest in recovery.

Relapse

Only two participants in this study reported that they did not relapse. For many of the remaining participants relapse was experienced as a chronic reoccurring issue. Heyman (2009) highlighted a commonality within the medical model of addiction, supported by 12-Step Programmes and medical treatments: the ‘once an addict always an addict’ paradigm which supports the chronic, relapsing brain disease theory. Some participants recalled relapsing into other addictions, for example other substances, ‘over the counter’ (OTC) or prescribed medications or developing a problematic relationship with food. They reported that they thought it was not really a relapse as they were not using ‘hard’ drugs and thought they could deflect the stigma of relapse. Herman (1993) and Ulmer (1994) maintained that the stigma of relapse, where relapse equals failure, further reinforces the negative self-image and strengthens the ‘once an addict, always an addict’ and ‘Junkie’

Mack et al. (2003) suggested clinicians, researchers and media embraced the disease model to the extent of advocating for addiction to be listed as a chronic, relapsing, brain disease and classified with other serious conditions like asthma and diabetes.
stereotypes. Wendy and Jenny spoke about problematic food issues. In this next quote Wendy recalled how her ‘food addiction’ affected her physically and emotionally:

I started self-harming, binge eating, was staying abstinent from other drugs, men and sex and that but was right in there with the food ... destroyed the life out of me for about two years ... Went from ... seven stone four to thirteen and a half stone ... that brought me then to another place, just absolute depression in recovery ... fear and addiction ...
I was destroyed with it, absolutely destroyed. (Wendy)

Wendy reported that she still has to be mindful of her relationship with food. She acknowledged that if she were to relapse again, food would be the primary addiction. Jenny shared a similar experience of bingeing, purging and controlling her food intake:

Food was becoming a bit of an addiction ... Big time ... I still have to watch it ... I nearly lost my head over it ... food in my fridge, bagged, tagged and weighed all down to the single last grain of rice. It was like a science lab – unbelievable. I went on holidays one time ... in my suitcase was one set of clothes and food, bagged, tagged, weighed and boxed ... to make sure. (Jenny)

Meryl identified self-harming, unhealthy, inappropriate relationships and generally risky behaviours in her early recovery. Scarlett, Clint and Joan described how they became dependent on OTC or prescribed medications. Joan highlighted the hidden nature of her OTC and prescription drug using:

Taking [Solpadine] ... twenty four over the twelve hours. So the valium was through the day to help me sleep but ... on days when I wasn’t working ... I’d still be taking the valium ... it just became the norm ... probably a year, year and a half ... I was able to justify it because ... I was sober. I am not forgetting anything. I’m not harming anyone. It was very, very secretive. (Joan)

Scarlett described how she could not cope in a bullying situation at work and started to use OTC medications. She identified the facts that she was twelve years clean, working in the addiction field and had ‘let go of the importance of my own recovery’ all combining to facilitate the relapse. She described how she continued to use tablets to give her the confidence to cope with life, however, she remembered that she denied for a number of years that this use was becoming a problem, but gradually detoxed off the tablets and resumed attending meetings. Similarly, Clint recalled relapsing after an accident, having been prescribed analgesics: ‘I had
a stockpile of tablets … I started slowly taking them’. He remembered being worried when he was half-way through the stockpile and the effect the tablets were having on him:

*I went to different doctors … three prescriptions a week off them instead of one… I was going to AA ... I would talk about the pain of recovery. I had no pain in recovery. I was taking pain killers ... I was just anaesthetised from life.* (Clint)

Colin described a relapse after exposure in hospital to morphine: ‘*I thought all my Christmases were hitting together. Morphine … Oh yes, thank you very much*’. Then, he recalled another aspect regarding medication which took a completely different twist, where he was told in NA meetings that he was still using due to being prescribed medication for depression. He reported that this caused numerous relapses when trying to stop taking antidepressants, as he had problems managing the antidepressant medication as well as trying to address his drug using. He thought the antidepressants diminished his ability to process other issues he needed to work through, as he explained:

*I just didn’t know how to handle it cos I was on antidepressants … when I came off them I couldn’t do anything. I was very bad … in and out of antidepressants … I relapsed ... They used to call me the thirty day wonder. I’d get thirty days and go back out. Then I’d get twenty nine days and go back ... it was like they say a penguin on ice skates – I was slipping and sliding all over the place.* (Colin)

As the above examples indicate, sobriety is often viewed as a fragile, impermanent state, where individuals may relapse even after many years. McLellan et al. (2000) suggested that relapse is a frequent occurrence. For some participants in this study, it was very difficult to recognise the severity of their drug using and make a commitment to change. Kevin shared that he relapsed constantly for over five years, following the same pattern over and over while Colin stated that he could not accept that he was an ‘addict’ or he would meet an old friend and ‘go off using with them’. Martin recalled how he did not equate alcohol with addiction or acknowledge that it would lead to relapse while Wendy commented that although she realised the seriousness of her addiction, she could not commit to a drug free lifestyle, relating that she ‘left the hospital in my pyjamas, in a wheelchair, got a taxi and went to score … I couldn’t even get it into me cos my body was just rejecting it.

Clint suggested that neither himself nor his wife understood the severity of his addiction. His wife gave him an allowance of six pints on a night out. He recounted:
I really worked on not making a mess of things ... I could have six pints and be a good boy. I didn't know anything about alcoholism ... I really thought I could have those few drinks and stop ... while I was off the drink I had saved £1,000. I went to work the next day. I had my bank book in my pocket ... I left the lunch on the bus and went to an early house. I had a few pints till the banks were open ... got some money ... I drank every day ... that money was gone after eleven days. (Clint)

Several participants in this study pinpointed causes that may have led to their relapses. These causes are briefly outlined in the following section.

**Stress**

Some participants identified stress as a causal factor in their relapse. Meryl described being in a treatment centre which she found too stressful due to the confrontational nature of the groups which were part of the treatment programme. She recalled running away from the centre and described herself as soon ‘strung out again’. Mick also identified stressful situations, but acknowledged that sometimes he could be the cause of the stress:

‘I remember the bingeing and going missing all the time ... things were fairly chaotic ... I often say it was my fault560 ... I have a big guilt trip ... what I put her through. She had an ectopic pregnancy ... there was stress. I put her through hell. (Mick)

Similarly, Brian associated relapse with life’s stressors and responsibilities.

Leaving the treatment centre and hit head on with the pressures of life. I would have found myself overwhelmed at times ... So stress and pressure ... I would have found responsibility particularly difficult to cope with ... extremely difficult. (Brian)

**Inability to negotiate relationships**

As well as trying to deal with stress, many participants identified their inability to negotiate intimate relationships and the ending of relationships as significant triggers for relapse. Meryl recalled feeling like an ‘emotional wreck’ when she tried to manage relationships. Colin

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560 Mick explained that his wife had several miscarriages which he blamed himself for.
reported his relapses were due to the emotional pain of rejection, which he described as a ‘searing pain. I couldn’t sleep. I couldn’t eat. I was in constant, constant pain. I relapsed’. He recalled: ‘my past coming back to haunt me because I’d been very, very hurt and abused’. Colin described his current relationship where his new partner was unfaithful to him which triggered another relapse. However, this time he realised the seriousness of relapse and explained how he was able to recover much more quickly. Colin hoped he would not relapse again, but qualified that thought with: ‘I’d say no. hopefully not. Unless my partner leaving me’. Joan mentioned her relationship ending and the fall-out from that: ‘another trigger that could have threatened my sobriety – that break-up ... that was huge’. She went on to talk about her fear that her current relationship may end: ‘this is where I genuinely want to be ... this is the one ... if it were to end, that would be a huge issue. That’s scary’.

**Loneliness**

Keene (2010) commented on the difficulty of separating from peers within the drug using subculture and the ensuing loneliness suffered. When a former drug user moves away from their peers they find abstinence very lonely, due to the lack of non-drug using friends. Jenny explained how alone she felt when she left her drug using friends:

‘No one came into recovery with me. My fella was active, everyone was active. But I knew I had enough. I wanted to get out of addiction’. (Jenny)

It takes time to build new friendships and in early recovery relapses were frequent, where participants reported returning to the social life and friends in the drug using subculture. Relapse reintegrated them with their former social network of drug using friends. Eddie explained how he reintegrated with the group he used with, which inevitably led to relapse.

*I started having a sociable drink ... with an old group of friends, and started on the weekends ... going to parties and doing a lot of the stuff that I hadn't really done, hadn't finished.* (Eddie)

The participants’ narratives in this present study mirrored those of the participants in Keene’s (2010) study, who stated that they relied on the social interaction and support from their drug using peers while they were isolated from non-drug using mainstream society. The inclusive drug using subculture combats this isolation but creates problems when trying to stop. The
transition from a drug using to non-drug using social context includes isolation and marginalisation while trying to negotiate new relationships with non-drug users and social groups. Therefore drug using subcultures contribute to relapse as well as continuing use. Colin shared how he was immediately tempted to relapse when he met a friend: ‘I was out the first day and I went up to a meeting ... He came up and the smell of drink off him. As soon as I smelled it I was gone out drinking with him’. Eddie recalled ‘hooking up’ with a girl who was as prone to relapse as he was. He described how together they relapsed and ended up homeless and using whatever drugs they could procure:

*Chaotic lifestyle ... I was missing for a month before anyone seen me. I was back on the heroin, strung out straight away. And from the cocaine, ended up on crack and injecting cocaine ... it was a binge for five or six months ... living in hostels, B&Bs, I was selling heroin on the streets.* (Eddie)

_Avoiding drug using peers_

White (1996) maintained that individuals feel psychologically naked and vulnerable when trying to change due to what Grund (1993) described as an all-inclusive life within the drug using subculture. Echoing White’s (1996) assertion, Meryl described how relapses were triggered for her, and how she concluded she had to avoid her drug using friends:

*It would have being seeing people I used with or being around drugs ... I kept going back ... I wasn’t willing to let go of my friends ... I didn’t really know whether I could do it or not so I kept using ... I’d get two or three days clean and I’d relapse and I’d get another couple of days ... I got twenty nine days clean four times ... after a few months of that it just I knew I needed to go away.* (Meryl)

Later, when Meryl had been through a treatment programme and was attending NA, she recalled actively avoiding her drug using friends: ‘I was so terrified of using ... and meeting someone who I was using with ... I had no faith in myself and my ability to stay clean’. Conversely, Brian explained that although he saw his old friends using, it did not impact...
negatively on him, explaining that ‘it might be a bit of maturity on my part … understanding that I just can't use drugs successfully’.

Many of the participants in Keene’s (2010) study had intimate partners who remained within the drug using lifestyle. Sandra recalled seeing her ex-partner and remembering their drug using routine. She described how avoiding him got easier as time passed:

_**I passed my ex-partner driving a bus and it was Thursday so it was pay day … I could see he was stoned and that euphoric feeling of always around that time on Thursday. He’d be getting his break and we’d be getting off our face … in relation to relapse prevention it wasn’t about seeing syringes, [it was] seeing somebody I used with on a daily basis.**_ (Sandra)

_Bereavement_

Marlatt and Gordon (1985) identified triggers that may prompt relapse and certain cues that individuals who are trying to cease drug using may be susceptible to. For the participants in this study, bereavement or the thought of losing someone was a risk factor for relapse. Clint recalled the support of being shadowed by AA members during his niece’s funeral and Kevin described how he coped during his mother’s funeral. Several participants talked about their fears of losing someone close. Meryl stated: ‘_The hardest thing for me would be the death of someone that I love_’. Similarly, Joan talked about her fear of her mother dying. Colin talked about losing his parents, saying: ‘_What if, but I have to go through it_’. He reflected ‘_It’s painful but I’ll be okay … I think that’s just an irrational fear … everyone has that_’.

_Social events_

The participants talked about the difficulty of engaging in social events in early recovery. Marlatt and Gordon (1985) highlighted difficult social occasions as a risk of relapse. Martin mentioned his decision not to visit his sister and her partner who he described, at the time of the interview, as heavy drug users. He said, in order to protect himself, he ‘_didn’t have to be there … I chose not to go back up_’. He also recalled being careful regarding social functions:
I didn’t really put myself at risk ... any time I went to a wedding or a family function I’d be the one that would be driving them all home or I’d leave early. My wife understood ... They all understood. (Martin)

Joan shared how she hated going out with her friends in early recovery but also hated thinking that they might laugh at her if she did not go:

I did the whole pretending I was cool going to a pub and having a coke ... took me a good two years to realise that I was actually so unhappy doing that ... like a lunatic pretending that I had had a great night, sober, but I didn’t. It killed me. (Joan)

Brian said he avoided social occasions: ‘I wasn't putting myself in harm's way’. He added: ‘I think the way I'm living my life at the moment is contributing to me not relapsing’. Similarly, Colin also avoided the nightclub scene as he felt he no longer fitted in there. He stated:

I don’t go to nightclubs. I don’t go out dancing. It’s something I used to do but I used to be bleeding wrecked because my friends would be going off with girls and I wouldn’t ... It’s like that nightclub drug scene I don’t think we belong in it ... We are people who were hurt. We don’t need to be in those places where people are ... image and ego. Being ostentatious and that’s not me. (Colin)

Apart from avoiding ‘using’ friends and situations, the participants also acknowledged the importance of relapse prevention strategies in their recovery. The next section presents the findings on relapse prevention.

**Relapse prevention**

Participants in this study outlined their personal relapse prevention strategies as well as support from various services they engaged with. They reported using a range of strategies to help them avoid returning to drug using. Meryl remembered a very stressful time when she had to work really hard to prevent relapse and use all the skills she had learned in recovery to avoid using again. She recalled feeling ‘very isolated, away from my usual supports’ and described having very little internal motivation. She explained:
It was a very stressful year … got on top of me … I felt at one point I can’t manage this … I had no resource cos even though I was going to meetings and I had my counsellor I felt a kind of a brokenness. (Meryl)

Meryl survived the stress of that year by concentrating on her studies but admitted she had to learn alternative relapse prevention strategies that would offer more robust support. Kevin explained how he tried to take care of his recovery. He described his philosophy, saying that he did not believe an individual could say they would never relapse, but that they could protect their recovery by living well and ‘doing the right things’. Sandra described how she felt self-care was vital to recovery:

If I feel that discontent sad feeling and uneasy there is something wrong and if I don’t do something about it, it’s going to get out of control and I’m going to have mental breakdown or use … if I feel a little restless or edgy I need to do something nice for myself, take care, unwind, have a bath, ring a friend it’s like a natural relapse prevention thing. (Sandra)

Joan recounted, in order to protect herself, she changed her occupation. She reported working in hotels but ‘could not be around the alcohol, the hours and the pub work’. She recognised that she ‘got such a buzz out of it I knew if I went back it would have been such a trigger’.

Rita stated that while she never relapsed since she ceased using, she had a very frightening experience. She had a panic attack when on honeymoon but found the nearest meeting to talk about how she was. She blamed this near-relapse situation on stopping going to meetings as a result, returned to attending on a regular basis. Similarly, Tommy suggested the key to maintaining abstinence was communication. Colin and Kevin spoke about the practice of listing reservations in NA where members are encouraged to think about events that may trigger relapse and how they would cope with these events. Colin recalled how he dealt with his list of reservations: ‘I have reservations but I have to keep talking about them and then they are not reservations’ while Kevin described being prescribed an opioid based medication:

There was an effect off them … I started having thoughts like if you started taking four of these you’d be out of your mind … it rattled me … if I was to write the reservations thing again, I would think about if … you had to take medication cos it happens all the time. Because we are addicts. (Kevin)
Wendy reminisced on how places, events and former clients could trigger relapse. She said ‘I wonder how to make peace with that stuff ... maybe I have’. She reported she was attending counselling to assist in dealing with her issues. She mentioned very difficult occasions where former clients of hers came in to NA meetings, as her next quote illustrates:

If customers come in to meetings ... I just kept judging myself ... You met him when you were a prostitute and he’s sitting over there, and she’s talking about sex and I’m all fucked up and people know ... I met another guy ... in a packed meeting ... looked across and there was a guy I’d done business with quite regularly. I just wanted the ground to open up and swallow me. I remember the sheer panic ... I don’t know if he noticed me. I couldn’t stay. I left ... It was just totally the shame of it. (Wendy)

For Eddie, reading about crimes that reminded him of events he got caught up in, was a trigger he had to work through. He described how he felt when reminded about criminality. He recalled phoning friends for support when he felt unsettled. He explains:

If I started thinking I was cured ... although I'm not using NA and I'm not doing counselling at the moment I'm totally aware and open to the fact that if I need something like that I'll do it ... the biggest thing that would sabotage what I have is me. (Eddie)

All of the participants mentioned the challenge of relationships with intimate partners, family, colleagues and friends as triggers for relapse. Jenny listed issues that would threaten her sobriety as: ‘My love for my family and my hurt for my family, wanting my family to get well’. When talking about her daughter, who she described as currently drug using, Jenny reported feeling immense guilt, shame and remorse as she blames herself for her daughter’s drug using: ‘She was brought up in a horrible environment. I just was gone back and I was drunk’. However, she acknowledged ‘I have to stay back or that guilt will kill me’. In order to protect herself, Jenny said she had to detach from her family:

I said not to ring me ... I’m detaching from them ... I need to do it. They have their drugs. I have the pain. I have nothing to hide behind ... I was hiding behind food and destroying myself. I’m not doing it anymore. (Jenny)

As well as talking about her family, Jenny mentioned feeling her sobriety was threatened by her ex-boyfriend. She described how he had come back into her life: ‘like a whirlwind after five years. He was around for three weeks and my life was tumbled’. She stated that these issues were relapse triggers. Jenny said she depended on her faith to help her when her ex-partner
arrived back in her life as she recalled feeling her sobriety was threatened by him. Similarly, Sandra stated: ‘The most difficult is relationships, family, partner children even kids. Show you every fucking flaw in you’. She said she found it extremely difficult when conflict arose. Likewise, Tommy said he continuously works on relationships because he feels insecure and constantly seeks approval especially in the workplace. Tommy also mentioned conflict which was difficult to work through and that the aftercare he attended with his wife helped in this regard.

Intimate relationships proved daunting for some of the participants. Wendy stated that she found it very difficult to ‘put myself out there for relationships’, while Scarlett shared she had given up getting involved in a relationship, stating that she felt happier on her own. Similarly, Brian recalled difficulties with relationships:

‘I didn't feel worthy of the person I was in the relationship with ... I always thought I was going to lose her ... always found relationships particularly tough ... especially being an addict ... carried that into a relationship ... I was overprotective maybe or jealous ... emotionally I have enough to deal with in recovery. (Brian)

Kevin sought counselling to help him work through his emotions. He explained:

Early recovery infatuations and getting messed up with girls actually bothered me. I just couldn’t function as a human being ... Emotionally I got into a relationship when I was about a year clean and broke up ... I was all over the shop emotionally. I just couldn’t hack it ... knew that I could have needed to get a bit of help ... I’m going to therapy and emotionally I’ve developed to a point where I can handle it. (Kevin)

Several participants identified issues that remained unresolved although they were a number of years in recovery. The next section describes how they negotiated these unresolved issues.

Unresolved issues

There were many unresolved issues around events that occurred in childhood and during drug using expressed by the participants in this present study. McLellan et al. (2000) believed relapse is a frequent occurrence due to many factors including unresolved issues. The participants reflected on the difficulty of trying to live with unresolved issues. Joan, Meryl and Jenny illustrated how unresolved family issues could influence relapse. Joan shared that her
family, especially her mother took her revelation that she was lesbian very badly. She said she still seeks approval from her parents and is unsettled when they disapprove of her. She recalled:

*My mum is from a different generation ... She is absolutely heartbroken but she’s been through a lot since then - Deaths of loved ones, cancer, real tragedy, and so for her to compare it to a death ... to sit there and actually hear her say ‘it’s like a death’ ... I was heartbroken. I’ll never get over it ... it will never be the same, never, ever because that’s heart-breaking. You can’t mend that.* (Joan)

For Meryl, the issue of not being believed when she revealed she had been sexually abused as a child was something she identified as still trying to resolve. She described how her mother apologised for not believing her and how it took her a long time to work through her feelings. She used both counselling and the 12-Step programme to reconcile those feelings. Eddie spoke of his decision not to tell his father about the sexual abuse he suffered and named it as the only unresolved issue he is aware of. He said that he wrestled with this decision for a number of years but now has ‘accepted that I don't need him to know’. Rita stated that she never reconciled her relationship with her father but did come to terms with issues that she needed to deal with as a result of that relationship. She maintained that that relationship was a causal factor in her addiction and her subsequent fear of intimacy. She reflected that ‘intimacy ... would be the only unresolved issue at the moment’.

Brian identified childhood anxiety as his main unresolved issue, which reappeared after two years in recovery. He also described finding it really difficult to shake off the stigma of being seen as ‘a junkie’ especially when his brother and friends labelled him so. He stated that although it is not quite so problematic, he can: ‘still carry that added stigma around with me some days’. He reported the ensuing effect as sometimes not feeling part of society and sometimes resenting people who are successful. Jenny reported her relationship with food could still be dangerous for her: ‘I was crazy ... My addiction changed and I was suicidal in recovery. I went into food. I just have to watch that’. Tommy continuously feared he had unresolved mental health issues and that he would have to go in to a mental health facility to address them. He explained that in early recovery:

*I thought I had manic depression. They are going to send you off again to [Mental health facility] ... But it wasn't. I had allowed things slide ... ended up in a ball of shite because I wasn't acknowledging where I was at on a given day ... I ended up in a huge amount of pain.... I thought I'd go back using.* (Tommy)
Many participants acknowledged that, due to these unresolved issues, they would seek help when appropriate. Clint recognised he could ask for help if he felt he needed it. He developed his own coping mechanisms over the years, explaining that he is ‘still evolving as a person … I am angry at the right people … the rage has gone out of me’, while Wendy was still working through issues with her counsellor, where she would ‘gently filter through some stuff … that I got a little bit uncomfortable around’. However, Scarlett shared she was never able to address her addiction with her children. Likewise, Gary said he tended to ignore emotions rather than seek help. He did recover his sense of self-respect with the help of AA but many of his other issues remained. He reflected:

*If it wasn’t causing pain I probably ignored it … I’d find some way around it probably. I mightn’t have dealt with it … which left me with a lot of character defects or flaws or weaknesses … I have been struggling with myself … I felt a lot of what I was doing I was living under false pretences and it turned out to be true … the face I presented to the world wasn’t actually reality a lot of the time.* (Gary)

Similarly, Jordan shared that he still cannot deal with emotional issues. He recalled a bereavement he had experienced where he could not express his sadness in front of his family but acted out at a bus stop when the bus was delayed for twenty minutes. He described how he went ‘ballistic. The emotion was coming out that way. I had a night where “Right, I’m going to use” and I had it in my head’. He mentioned how becoming too complacent about his recovery could cause problems for him. Kevin also spoke about complacency and feeling egotistical in recovery. He described a situation where he was the main speaker at an NA convention, everyone was congratulating him saying “It’s great listening to you” and a new member asked him for a photograph. He reflected on this, saying:

*There’s a part of me that can thrive off that adoration … It can be false, very egotistical but it’s something I really have to be conscious of … you can’t save your face and your arse at the same time. If you are all sounding good and doing real well and having your life together but you can never lose the ability to say what the fuck. I need a bit of help with that. I’m struggling.* (Kevin)

Martin acknowledged the difficulty of reconciling his past, saying that acceptance of his past may be more useful. For Colin, the effect of not working through his issues affected his relationships where he was getting into arguments and having resentments towards others. He explained: ‘it’s the anger we feel inside turns in on ourselves eventually and we just use …
harm ourselves or our partners or something’. Having begun to address these issues, Colin reflected that he ‘can deal with it. I have been given the tools just to calm down. I am more focussed’. Colin described how his counselling was also helping him deal with the treatment he received at work in a local Community Drug Team when he was asked to leave that job, adding it made him question his ability to work with people. He described how the manager was very critical of his work practice, stating it ‘destroyed me’. He mentioned that the project was ‘toxic’ and ‘fake’. However, he identified that he had learned from the experience and had the ability to work through it in a counselling setting.

Meryl reported still having problems reconciling her sex working career and childhood sexual abuse within her new sober lifestyle. She said she had worked through the fact that ‘I hated my body’ but when talking about the sexual abuse she said ‘I think of that as a whole separate recovery’. She described going to a marriage preparation session with her then fiancée and how that brought up a lot of emotion for her, as she explains:

I found that weekend and the week after I didn’t want [Husband] near me. I didn’t want to be touched ... to be honest I’ve never really done any work on the prostitution and sometimes I wonder is that in there. (Meryl)

She explained that she had disclosed her experience of CSA to her husband but not her sex working, which caused problems for her as she explained:

It’s something that I worry about at times ... I used to often think about [Name] who was my best friend when I was using who would have been on the street with me. I used to imagine meeting her with [Husband] ... oh my God and she’d probably say it ... sometimes I am afraid that he will find out ... I don’t know if it’s something that he could accept. (Meryl)

Several participants highlighted the difficulty of reintegrating into ‘normal’ or mainstream society and reflected on their notions of what normal represents to them. Their accounts of returning to a normal life of non-drug using are outlined in the next section.
Returning to a ‘Normal’ lifestyle

The participants in this present study reported that they often felt ‘not normal’ during childhood. Clinard and Meier (1992)\textsuperscript{562} stressed that during drug using, the opportunity to achieve a normal lifestyle becomes severely limited as the challenge to be ‘normal’ changes during drug using, as circumstances are changed by new norms of behaviour. Goffman (1963) proposed that stigma separated the discredited individuals from the ‘normals’ of society. Gary reflected on his confusion around the concept ‘normal’ where he said: ‘I didn’t know what normal was. As a person or as a drinker I had no idea what normal was’. Gary’s experience was typical of the participants who began drug using careers at a very young age. This concurred with Nowinski’s (1990) study which found that early drug use bypassed the normal adolescent developmental stages and encouraged the development of immature self-centeredness where the adolescent does not successfully master normal social goals.

Within the drug using subculture, the pleasure of drug using goes beyond that permitted by mainstream society and drug users were perceived as ‘abnormal’ due to their unhealthy appetites for opiates (Loose, 2002)\textsuperscript{563}. Nixon validated this notion by inferring that ‘normal’ Americans had strong anti-drug beliefs that ensured a disease free society\textsuperscript{564}. Wendy and Tommy illustrated how their drug using became normal to them. Wendy recalled: ‘injecting into groin and neck became normal everyday life rather than risk taking behaviours’.

The DSM V highlighted that individuals give up other activities in favour of drug using, with the drug using subculture supplying new activities to replace old ones. When the participants in this study reflected on their drug using lifestyles, there was agreement that certain behaviours replaced the accepted norms of conventional society. Reflecting Schmalleger’s (2006)\textsuperscript{565} assertion that when an individual carries the deviant label it often becomes difficult to continue normal, everyday routines and ‘abnormal’ behaviours tend to become the norm, Jenny reported that she did not realise the battle she had ahead of her: ‘I thought once I got off the drugs I was going to be ok ... go back to school and just be normal. I was only 15’. When she came into recovery, she recalled incorporating non-drug using activities into her daily routine, where she could ‘talk to so called normal people, they weren’t completely alien to me’.

\textsuperscript{562} See also Link et al., (1997)
\textsuperscript{563} See also Kolb & Du Mez, 1981/1924
\textsuperscript{564} U.S. Congress, 1971a, 20597 -598.
\textsuperscript{565} See also Atkinson et al., (2000); Carlson et al.,(2004); Gross, (2007).
Some participants found attempting to integrate into mainstream society daunting but a greater awareness of what was considered ‘normal’ emerged during treatment and early recovery. Many participants reported great difficulty transitioning into this lifestyle initially, as Brian reflected on coping after residential treatment:

_Leaving the treatment centre and hit head on with the pressures of life, I had used drugs for so many years, I would have found myself maybe overwhelmed at times. So stress and pressure would have been a factor in it. I would have felt it was easier to go back using drugs than what it was to live normally._ (Brian)

In Gibson et al’s (2004) study, some participants experienced cognitive dissonance around the wish to get high, the need to reduce withdrawal symptoms and the expectation of becoming ‘normal’. However, as with the participants in the current study, gradually life got easier. Embracing ‘normality’, although difficult, did not seem impossible. Doukas’ (2011) study on drug users who were prescribed methadone and eventually moved away from chaos, creating a more ‘normal’ lifestyle, reported working, returning to education and taking up leisure activities eased the transition. Doukas asserted that these activities, along with renewed relationships with family and friends, helped boost self-esteem and confidence.

Eddie described how being in treatment helped him ‘live like a normal person in normal society’. Colin commented on support from a 12-Step programme: ‘I started on the steps. I started to get a bit of normality into my life’, and Jordan found going back to college useful but still remembered feeling outside of mainstream society. He recounted:

_I was in a class with mature students ... I saw this one guy and he’s one of us ... I got very close with him. And then he went back using unfortunately so I was left on my own with the normal people._ (Jordan)

However, for all of the participants life did get easier with longer periods of recovery, especially when they were willing to make real changes in their lives, in accordance with Treloar et al. (2007)566 who proposed that individuals have to welcome new social settings, behaviours and language to enable them to feel a sense of normality and fit in with their new social relations. For example, Jenny decided she no longer wanted to be immersed in the world of addiction and recovery, as she explained:

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566 See also Waldorf and Biernacki, 1981
I’d rather be packing shelves and just communicating with normal people … talk about the price of a tin of peas than someone who had been abused or mugged … I’m grateful for all the learning I’ve done but now I need to move on. It will be a bigger challenge for me ... with normal people – non-addicts ... a clean break. It’s a bridge back to normal living. I don’t feel like there’s any normal living in my life ... I will be mixing with normal people ... this will be my little way out, back into the stream of normal life. (Jenny)

Similarly, Scarlett welcomed being part of mainstream society leaving the stigma of addiction located in her past. In keeping with Goffman’s (1963) view that when an individual’s role and identity are stigmatised, they are viewed as somehow deficient and discredited by the ‘normals’, Biernacki (1986) argued that most drug users desired to become normal or ordinary rather than different. In agreement, Scarlett declared that she hated ‘the stigma around addiction. It is as if you are weak, unclean and not trustworthy’ and that she wanted ‘to be seen and treated as a normal, down to earth, ordinary person’.

This striving for normality, as reported by the participants in this study, enabled them to trace the changes in their identity. They declared that change happened slowly but as time passed and they became more stable, that these changes were more apparent. The next section of this chapter outlines changes in early recovery and in later years.

**Change in Recovery**

Biernacki’s (1986) identification of three types of identity change in former drug users emerging - creating a new identity reverting – reassuming an unspoiled identity and revising - enhancing an unspoiled identity applies to the findings of this study. All of the participants found early recovery exceedingly challenging, and change particularly daunting. Koski-Jannes (2002) asserted that drug using identities require radical change to counteract many barriers that individuals will encounter. Sandra shared how her partner of eight years was still using and continuously offered her drugs while she was trying to stop:

I just stopped everything. I remember being very sick and I had got a couple of meetings in and him saying ‘why don’t you take a dalmaine?’ (Sandra)

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567 See also Biernacki, 1986
She described how she eventually asked her partner to leave, saying she could not achieve abstinence while he was living with her. She recounted how they had tried to cease using drugs together on numerous occasions but that they could not maintain abstinence. She described being frightened as she had never lived alone before but relied on advice from NA members to help her:

I was told to just take care of the fucking small things and the other things would come ... I had to keep it that simple because my mind was in a savage state. (Sandra)

Initially Wendy recalled embracing her new sober identity. She related how, as she got comfortable going to meetings, her self-care improved, she avoided threatening situations that could jeopardise her abstinence and identified with her new social circle of non-drug using friends. As time passed she realised she had quite a challenge ahead. She added that the reality of her situation sank in where she ‘just thought I had a drug problem. I realise that it went a lot deeper than that’. For Wendy, the end of the honeymoon period frightened her. She talked about having genuine fun ‘great times, great laughs, the belly laughs, experienced these amazing things, free and being clean’ but after a few months she recalled:

The depression, the fear, the anxiety, the worry, the self-hatred came back in buckets ... I used to look at myself in the mirror and just wanted to start pulling out my eyelashes again. (Wendy)

Tommy also recalled a honeymoon period before he realised the extent of the challenge ahead as ‘things were great, Jesus life was wonderful, life was fantastic’. However he reported that within a few months he felt himself reverting to try to control his life:

It would be a constant fucking battle ... I was lucky enough because I knew at the time I was being dragged back into addiction. ... it was either put my hand out for help again ... or you are gonna go back and I didn't want to go back. So I put my hand out for help. (Tommy)

As time passed, the participants of this study reported major lifestyle changes that encouraged and sustained abstinence. As Strauss (1962) asserted, recovery from drug using careers requires identity transformation that includes changing social contexts. It was obvious from listening to the narratives as recounted by the participants, that change brought peace of mind and contentment. Several participants became quite emotional when describing ‘the gift of recovery’. For example, Wendy stated: ‘sometimes I don’t even have the words to articulate
what I have found in recovery’. She explained how grateful she was for the ordinary things in life like driving along on a summer day listening to music or playing with her baby daughter, adding that she had ‘found the meaning of life’

Koski-Jannes (2002) proposed that identity change involves fundamental changes in self-concept, social status, values and relationships. The acquisition of a non-addict identity which incorporates these fundamental changes can predict successful treatment outcomes (Kellogg, 1993)\textsuperscript{568}, whereas Holmberg (1995) proposed unsuccessful identity change can predict relapse. The participants of this present study described how these positive changes affected their quality of life on recovery.

Tommy and Rita spoke about being in AA and finding a healthy balance in recovery. Rita maintained that life is for living and enjoying. Likewise, Tommy acknowledged an over-reliance on AA at first, but later achieving a suitable compromise. He elucidated:

\begin{quote}
The fellowships become a part of your life, they don’t become your life. Don’t get embroiled in marching down fucking O’Connell Street for the sake of the fellowship ... You have a wife and two kids at home. They want their husband and they want their Daddy back ... all I really wanted was to be happy. (Tommy)
\end{quote}

Jenny talked about the support she had within the social network of the 12-Step programme which helped her to ‘move to another place in myself’. She said she was really contented with the good relationships she had fostered and that she felt ‘grounded and proud of myself’. She began working in a treatment centre after completing an addiction studies course and added that the courses and the job helped her understand her own addiction. As she immersed herself in the world of addiction she lost the sense of balance Tommy and Rita had spoken of. She recalled reaching a stage where she felt she had to move on:

\begin{quote}
I’m grateful for all the learning but I need to move on. It will be a bigger challenge for me to work with ... normal people – non-addicts ... I’ve had enough of it. I’m getting out ... everything in my life is drugs, drugs, drugs, misery, sadness, life stories, hurt, pain, abuse ... I need to let something go ... My recovery is not going so the job is going ... I feel like there’s a new chapter in my life ... I’m not going back into the field of addiction ... It’s time for me to move on. (Jenny)
\end{quote}

\textsuperscript{568} See also Walters, 1994; Shadel, Mermelstein & Boreil, 1996
Jenny described her contentment, saying that her needs were few and she would happily settle for part time work if she could not secure a full time position, ‘I have a little flat ... I don’t need much money cos I don’t have much needs or wants. I have all I need’.

Meryl also stated that she immersed herself in recovery, addiction studies and counselling. Initially she remembered her life revolved around NA and recovery oriented activities. She put this down to having no faith in herself. She related returning to college, training to be a counsellor and working in a number of treatment centres. She commented that she also developed the social part of her life, took up new hobbies, travelled and learned that there is ‘life outside of drugs and there is a life outside of recovery’. She also said ‘it doesn’t all have to be scary and life is pretty good’. Meryl recalled struggling through the challenges of letting go of the stigma of sex working and being prescribed anti-depressants, with the support of counselling and friends. She mentioned feeling a failure because of the antidepressants but was assured by professionals and members of the fellowship that she was going to be alright.

Jordan juxtaposed the end of his using with the beginning of recovery. He reported:

> Life is so completely different. For years I couldn’t leave my house. I’d have that ball of fear in my stomach. And everything was like a mission ... walking round terrified ... like for ten years ... My personality was anxious ... today, I try and live right. I try not to hurt anyone ... getting clean is terrifying. You just hang in there. (Jordan)

Sandra talked about living in the ‘here and now’. She shared how she negotiated difficult situations without turning to drugs, saying ‘you need to find what works for you’ while Clint spoke about his personal learning and development, making comparisons with his drug using career. He described how he felt his addiction stunted his development and that he had grown up in recovery. He stated: ‘I've learned a lot of stuff that I should have learned in my teenage years as an adult so I probably have a slightly different perspective on it’. Martin recalled the changes in his relationship with his family, where the damage caused by his drug using was being mended. He recounted that at present his family genuinely trust him, unlike in the past where he caused great concern for all of his family, especially his parents. He noted changes in himself which resonated with them:

> Since I've stopped, I haven’t brought my troubles on their doors ... They wouldn’t be worried about me. I’m reliable ... if they ever ask me anything or to attend somewhere, I'm there and I'm in good form most of the time ... I've never rang any of them up to say
I'm depressed or I'm down ... I owe them a bit of peace ... I did bring a bit of trouble on us all. (Martin)

Martin also spoke of the importance of maintaining balance, reducing stress and anxiety and having outside interests. He identified going to the gym and swimming and learning to relax as helping him to ‘keep balanced, understand myself and know what’s right and wrong, live a disciplined type of life’ asserting that there was ‘a lot of stuff I learned in recovery’.

Kevin stated that he had easily settled into a new non-drug using lifestyle. He commented that the simple things in life became the most important to him. He recalled spending the first two years in recovery in a small bedsit as ‘the happiest years of my life’. This next quote from Kevin describes his progression:

You learn to walk, you learn to talk ... I got a kick out of going to meetings ... I went to college, done a diploma and I went on and got a degree. I got a little job. I got another little house, a little one bedroomed house. I started working. (Kevin)

In due course, Kevin remembered mending bridges with his father and brothers which had a ripple effect in his family. He described his convoluted family relationships as typical of the ‘dysfunctional addicted’ family, where several relationships had broken down completely. He described how, when his mother died, due to repairing damaged relationships ‘there’s seven of us and six of us were in the same room for the first time in twenty five years when she passed away, so, that was nice’.

Eddie stated he started working in a Treatment Centre after qualifying for a Community Employment Scheme and reflected that he ‘had this need to be helping people’. Experiencing this job, Eddie reported was the biggest change for him as he ‘was able to set goals for stuff and be able to achieve them and doing them in a positive way’. He explained:

I've learned how to stay away from robbed stuff ... you get offered for drugs ... and it’s just second nature to me now ...I say no and there's no explanation why no ... I've learned to get strong ... I don't feel awkward saying no ... I am happy with what I have now. (Eddie)

Colin reported becoming obsessive about certain activities in early recovery. For example, he started going to the gym as the physical exercise made him feel good, but quickly, this became an obsession for him as he recounted:
I started to run every day obsessively. I am obsessive compulsive. I started to run 5k every day (laughs). I got a treadmill. It was costing me £800 every two months in electricity. (Colin)

He recalled getting a balance in life, went to college on a course fixing computers and passed although the course was very difficult and he experienced it as a huge challenge stating:

I didn’t know about words. Today I’m quite good at words ... That’s the gift of recovery ... I could barely read and write when I left school ... I wanted to educate myself. I was far from stupid even though I thought I was. (Colin)

He described his life today where he is on interferon for hepatitis and taking antidepressants, but following the doctor’s advice, is coping well with both medications. He also spoke about having a partner and daughter whom he adores, is working and hoping to buy a house. He made the comparison with his former ways of coping with medication:

That’s the gifts of recovery, of staying clean on a daily basis ... I feel like I’m trying to sell this at times. But I’m very passionate. I love it. I do suffer from depression ... I came off the antidepressants and for eight months I was in bits. I swear it got worse ... I was going to kill myself. I got up one Friday morning. Everything was so bad. I lost weight. It was horrible. It was a savage state of mind. So I went back on them through a medical but that’s okay ... I don’t abuse them. I just take them like normal. (Colin)

For another participant, Brian, recovery entailed finding a purpose in life and hope for the future. He identified that he had worked tirelessly towards recovery by meeting challenges, trying to make amends to his family. He stated that he was proud not to have ‘chaos or the torment that I had when I was actively using’ and that he was ‘developing living skills and being capable of independent living’. Brian reported that his big challenge at the time of the interview was to engage with education or training to enable him to get back into the workforce and be able to give something back to society, as he felt he had not been a productive member of society but rather ‘a sponger or a leech’ which had impacted on his sense of positive identity.

The above quotes illustrate the profound changes that occurred for the participants of this study as they became more stable and contented in their recovery. As the participants identified with changes and positive progress in their lives, they also more readily identified with a new, emergent, non-drug user identity.
Chapter summary

This is the final chapter in this study outlining the findings which emerged from the interviews with the participants. The previous three chapters along with this present chapter outlined the main findings from the data collected in this study.

Chapter Four traced the drug using careers of the sixteen participants. It discussed their notions of their identity and issues that were of concern to them prior to drug using. These issues included feelings of being an ‘outsider’, and the challenge of low self-esteem, lack of confidence and poor self-image. The participants also reported concerns regarding family, school and community, and body dysmorphia and Childhood Sexual Abuse. This chapter then examined how the participants recalled their experience of mental, physical and emotional change throughout their drug using careers.

Chapter Five discussed the participants’ journey from ceasing drug using, through early recovery to their creation of a non-drug user identity. It outlined the main challenges that confronted them during this transition from drug user to non-drug user. It also discussed how they managed their new identity and the factors that enhanced this identity. This chapter also examined how participants struggled with their decision of whether or not to break their anonymity, given the extensive influence of social stigma.

Chapter Six outlined the main supports used by the participants in their efforts to achieve and maintain drug free lifestyles and to attain non-drug user identities and described how the participants had to reconstruct their identities to suit their new lifestyles. Participants in this study used diverse treatment modalities to achieve abstinence, some of which were described as distressing and traumatic, while others were positive experiences of treatment. Most of the participants engaged with aftercare, counselling and 12-Step programmes to maintain their drug free status and also identified other key supports, including that of family and friends. They also described their experience of their own personal change in recovery. The overall expression was one of a sense of gratitude for the ‘gift of recovery’.

Chapter Seven outlined how the participants experienced their changing sense of identity within recovery and explained how they embraced methods of enhancing their recovery and reconstructing their identities. This chapter described the participants’ struggles with relapse and factors which could contribute to relapse. It also explored supports in terms of relapse prevention as utilised by the participants. Finally it outlined the participants’ descriptions of
trying to return to a ‘normal’ lifestyle which incorporated change throughout their period of time in recovery.

Chapter Eight will present a discussion of all of the findings contained in the last four chapters in light of the research aims and the literature reviewed. It will suggest responses to the research questions and draw conclusions based on these responses.
Chapter Eight - Discussion and conclusion

Introduction

This thesis set out to examine the transition from drug using to non-drug using and focus on an exploration of identity construction and reconstruction, using the subjective lens of sixteen former drug users. Secondly, it set out to investigate issues that influence identity transformation. Thirdly, this thesis aimed to illuminate how drug users experienced the support, treatment and interventions they engaged with, with a specific focus on how these assisted positive identity transformation and enhanced recovery from drug using. Finally, this thesis set out to explore how successful identity reconstruction and recovery may support each other and how threats to the newly constructed identity could prevent successful transition to a reconstruction of identity and subsequently trigger relapse. An assessment of the effect of stigma, marginalisation and social exclusion was an important consideration when evaluating barriers to successful identity reconstruction.

This research was conducted against a backdrop of an established international base and a dense theoretical discourse on addiction from medical, sociological, psychological and criminological viewpoints. It was motivated by the high rate of relapse experienced by drug users, especially in early recovery. Prevalence statistics suggest illicit drug using in Ireland is increasing along with an increasing polydrug use and alcohol. Parker et al. (1995), among many authors, asked why some individuals enjoy recreational drug use while others struggle with problematic use, often for many years. The majority of the participants in this research, experienced extreme difficulty in breaking the habit of drug using, employed multi-modes of treatment and frequently relapsed. Given the empirical knowledge highlighting the trends in frequent relapse and the struggle to maintain abstinence (NIDA, 2008), this thesis set out to explore the issues of drug use, relapse, relapse prevention and recovery and how a recovery oriented identity, especially in early recovery, can help avoid relapse (Moos 2007; 2008).

The challenge of addiction

The literature reviewed highlighted the difficulty regarding the definition and theoretical foundation of addiction leading to diametrically opposed responses (Heyman, 2009). Legal and moralistic views punish, medical views treat and media concentrates on dangerousness and
public nuisance\textsuperscript{569}. The drug using role\textsuperscript{570} is unacceptable within mainstream society. The social construction of addiction assures drug using remains clandestine, where the non-conforming drug user is perceived as a threat to social order (Thoumi, 2003). Evidence suggests labelling and stigma profoundly impact the identity of the drug user, who often responds by joining a drug using subculture\textsuperscript{571}, which facilitates continuing drug use and the deviant ‘addict’ identity becomes a self-fulfilling prophecy (Johnson \textit{et al.}, 2000).

The review of the literature on identity examined how drug users experienced identity change before, during and after drug using. A drug using identity becomes a necessary survival tool while drug using; similarly identity reconstruction or restoring a spoiled identity is a vital component of recovery. When a drug user decides to stop using drugs s/he faces the dilemma of restructing a ‘non-addict’ identity. Significant challenges\textsuperscript{572} were examined and the associated difficulties negotiating these circumstances (Pavis & Cunningham-Burley, 1999). Chapter two concluded the review of literature by considering the notion of recovery capital and treatment and social supports that were useful to former drug users in their effort to reconstruct their identity, maintain abstinence and prevent or avoid relapse.

A number of key research questions were posed in this present study. The following sections will respond to these questions.

\textbf{Implication of recruitment of participants}

This thesis employed a qualitative approach, modelled on the Biographic Narrative Interpretive Method, in its attempt to offer an understanding of the lived experienced of drug users. Sixteen former drug users related their experiences before, during and after drug using careers. The recruitment process involved gatekeepers from various drug treatment services approaching service users who had achieved more than two years of abstinence. Then, these participants

\textsuperscript{569} Therefore the paradox exists whether drug use is a deviant behaviour or a medical problem (Keene, 2010). If addiction is perceived as a societal problem, then social sanctions and social controls will be enforced according to the social construction of deviance and society’s perception of the drug user as criminal requiring sanction. However, within the medical model the drug user is viewed as patient requiring treatment (Lovi & Barr, 2009).

\textsuperscript{570} The negative stereotypical image of the ‘Junkie’ ensures drug users have little opportunity to challenge it.

\textsuperscript{571} This subculture, with its subjective norms and values, forms a collective response to negative stereotyping, providing a parallel lifestyle meeting the basic social needs of the drug user.

\textsuperscript{572} For example, the impact of mainstream society’s perception of the drug user on their identity, especially in relation to stigma, marginalisation and social exclusion further complicates identity reconstruction (Marlowe, 1999).
named others, within a snowball sampling arrangement, to nominate additional prospective participants.

On further analysis of the participants, it emerged that all sixteen participants had engaged with 12-Step programmes, and the majority who had engaged with therapeutic drug treatment services remained involved with therapeutic abstinence based services for quite some period of time as either employees or service users. The services from which participants were recruited advocated abstinence based approaches and recommended engagement with 12-Step programmes. Therefore the majority of the participants championed involvement with therapeutic intervention and 12-Step programmes.

The main implications for analysis of the findings of this study are:

Firstly, there exists a similarity in the narratives presented despite the heterogeneous backgrounds of the participants and their diverse routes into addiction. The narratives offered were the participants’ personal journeys through their drug using careers and their recovery experience. These narratives seemed to be influenced by the 12-Step framework of ‘experience, strength and hope’. Several similarities occurred within the narratives of recovery which were grounded within the structure of a therapeutic service model and 12-Step programme. The participants’ accounts could either represent a form of rehearsed narrative, or an internalised subjective description centred on and influenced by their experience of 12-Step programmes and the therapeutic intervention they encountered. The 12-Step philosophy encourages the telling and retelling of their life histories within that framework, where life histories are constructed and reinforced through long-term participation in 12-step programmes.

Secondly, the sample limits the scope for generalisability. It could be described as a group of ‘successful’ service users who engaged positively with both the therapeutic service and a 12-Step programme. However, this is a sub-population of former drug users that little is known about, therefore the findings do have specific value in their own right.

**Transformation of identity before, during and after drug using**

This thesis explored the role of identity throughout drug using careers and considered how that role affected the drug user. The themes that emerged from the participants’ narratives are organised around the notions of identity before, during and after drug using, stigma,
marginalisation, social exclusion, treatment, relapse prevention and recovery. This present chapter will discuss the implications of these findings in the light of the literature reviewed.

**Before drug-using**

The participants in this present study, when describing their lives before drug using, reported that they experienced fear and insecurity, low self-esteem, lack of confidence and poor self-image, all of which impacted on their sense of identity. However, the most salient negative emotion expressed, by the majority of them, was that they did not ‘fit in’ with family and peers. They described a lack of identification with mainstream society, feeling like ‘outsiders’. Echoing Strauss’ (1993) assertion, the participants reported having no sense of self before drug using, especially those who started drug using at an early age. Some sought out drug using friends and joined groups who were part of a drug using subculture, affirming their identity as drug user. Drug using, along with inclusion within new peer groups of drug users initially addressed problems of not fitting in and the associated psychological and social anxieties (Mead 1962; Stryker 1980). Curiously, the deeply discrediting factor leading to stigma (Goffman, 1963), drug using, was the same factor that helped resolve the issue of not fitting in.

Initially, the participants recalled their drug using as fun and a viable response to their psychological and social distress where they could ‘be someone else’ and feel socially included. Goffman (1990a) proposed that the construction of identity reflects individuals’ presentation of themselves to the world, as they attempt to create an impression. He used the term ‘spoiled identity’ to describe those who were discredited and no longer considered ‘normal’. Many participants in this study described ‘living separate lives’ or presenting a ‘mask’ to the world. They presented a united front to mainstream society to communicate their new found identity and acknowledged that during the construction of their drug user identity, they accommodated drug using behaviours to conform within their peer group, which resonates Goffman’s thinking.

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573 The majority of the participants reported feeling lonely, anxious and isolated and found solace in their early drug using, where their emotional difficulties diminished, as was reported in Keene’s (2010) study.
574 Drug users move towards a drug using subculture when it becomes too difficult to assimilate their drug using into everyday life (Des Jarlais et al., 1986).
575 Joining a subcultural group helps to respond to new-found social circumstances (Johnson et al., 2000).
576 Goffman expanded on this thinking with his idea about teams co-operating, where all members conform even though their performance may evoke further stigma and marginalisation.
577 To ensure inclusion, drug users adopt group norms and values, consistent with further drug using and deviant behaviour, even when those group norms and values conflicted with their own.
Constructing a drug-user identity

Katovich (1986) agreeing with Goffman’s early work, proposed that identity demonstrates how individuals construct and re-construct their lives within their social context, so identity transformation is commonplace rather than unusual. Walters (1996) stated that during early initiation into a new drug using peer group, the significance of identity is critical\textsuperscript{578}, and when new members begin to identify with other users, many problems evolve, including the escalation of drug use. Schaler (2006) highlighted that the majority of drug users do not anticipate problems with continued drug use, but for the participants in this study, their drug using quickly spiralled out of control\textsuperscript{579}, especially as their peer group were using drugs\textsuperscript{580}. As the association with drug using peers increased, all of the participants in this present study described heightened drug use and polydrug using\textsuperscript{581}. The association with drug using peers and the attached stigma not only exacerbates the problem of engaging with non-drug using social support networks\textsuperscript{582} but further impacts on the opportunity of learning professional skills or securing legal employment (Gaitley and Seed, 1989; Grund, 1993). This limitation may also lead to an alternative criminal lifestyle\textsuperscript{583} (Keene, 2010).

The drug subcultural lifestyle mistrusts mainstream society, where anxiety provoking conflict with law enforcement contributes to this mistrust (Grund, 1993). The present study found that although the participants had ascribed to the identity of drug user, some were aware that their new lifestyle invited danger and anxiety which initially tended to enhance group cohesion. Reports of feeling ‘untouchable … like a gangster’ reinforced this notion and highlighted how

\textsuperscript{578} By identifying as drug user, the participants of this research shifted from personal drug using to an all-encompassing drug using lifestyle outside of mainstream society, where covert drug using and deviant behaviours enabled their continued use and peer inclusion replaced their former feelings of ‘not fitting in’.

\textsuperscript{579} The participants initially reported enjoying intoxication, but acknowledged that, over time their drug using became progressively more chaotic, as they became further entrenched into a drug user identity.

\textsuperscript{580} Increased drug using and associated behaviours led to further isolation from mainstream society, negatively affecting non-drug using social relationships and weakening the strength of supportive relationships which exacerbates issues when trying to reconstruct a non-drug user identity.

\textsuperscript{581} Additionally, as Romero-Daza et al. (2003) noted many female drug users report increased drug using to cope with the stress of sex work, which was reflected by the female participants in this study who described their engagement with sex working. They recalled how their drug using went out of control and that sex working greatly influenced increased consumption. They described desperate unhappiness with sex working and the pressure they put upon themselves in order to make as much money as possible.

\textsuperscript{582} Friendships with like-minded others, who experience labelling, stigma, marginalisation and exclusion, became a substitute for relationships with family and former non-drug using associates and they became more entrenched within the groups which confirmed their creation of alternative lifestyles and identities outside of mainstream society.

\textsuperscript{583} Keene (2010) stated that the more a drug user became entrenched in the social network of offenders the more they were excluded from non-offenders.
the participants re-defined stigma by using it as an alternative status. Their collective challenge of mainstream institutions and rebellion against authority defined their response to the societal unacceptability of their behaviour. Being perceived as different strengthened their newly constructed identity, creating a social reality promoting continued drug use and became an essential ingredient to the construction and maintenance of the ‘addict’ identity. This reasoning fits in with Goffman’s idea of how individuals or teams present to the world and Berger and Luckmann’s (1966) social construction of reality where, when one is conferred the role of ‘addict’, society sees this individual as that and interacts with them within the expectations of that role. Berger and Luckmann (1966) added that individuals place their world view around their own subjective ‘here and now’ which suits the context of drug using as it is very much a present reality. This idea is significant when the paradox of construction and reconstruction of identity is considered. However, the identification with the ‘gangster’ status and gang involvement while initially linked to excitement and inclusion, soon became too dangerous to sustain.

In agreement with Schmalleger (2006), the participants in this study experienced the shift towards ‘abnormal’ as gradually changing their life structure. Being susceptible to or causing physical danger was accepted by them as commonplace due to impulsive, criminal or risky behaviour. For some participants, their living conditions were similar to Bourgois’ (1998) description of squalor and danger. They communicated losing their sense of themselves and assuming personae to fit in, being as Becker (1963) described paralysed by their behaviour, where the disaffiliation from society and increased enmeshment into the drug using subculture transformed their lives. Their progression into addiction was accompanied by cognitive dissonance between hating the ‘horrible existence’ and the frustrating inability to change it. Despite this hardship, the participants in this study reported persevering in their drug using, realising they had become the ‘junkie’. Towards the end of their drug using the ‘junkie’ identity caused huge discomfort, anxiety and physical and psychological pain, where they internalised the ‘loser’ identity.

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584 Searching for a new identity the participants who had become more involved with increasing criminality reported initially being very attracted to that lifestyle. The distinct advantages, identified by Des Jarlais et al. (1986), to embracing the drug using subculture resonated in this present study with participants noting how their identity was changing as they became more immersed in a world of drug using and criminality.

585 Extreme negative consequences were experienced by participants who reported involvement in criminality.

586 They described becoming homeless, being disowned by their families, living in ‘crack houses’, or living in squalor with dirty clothes, lice and scabies.
The notion of an Essential Addict Identity did not ring true for the participants of this study, because, as Davies (1997) proposed, the identity of the drug user does not go through a process of permanent change. The Essential Addict Identity may help explain inexplicable behaviour and to decrease blame. However this identity can be damaging. Sociology and psychology perceive identity as transitional (Erikson, 1968) and within the notion of transitional identity drug using can remain a choice. Gibson et al. (2004) proposed the concept of an Entangled Identity where identity becomes unidentifiable from drug use. However, this present research found that membership of a drug using subculture leans towards the idea of collective identity. Identification with the drug using subculture leans towards the idea of collective identity. Identification with the drug using subculture ensures remaining outside conventional societal institutions. Furst and Balletto (2012) highlighted that members of a drug using subculture want to become autonomous from mainstream society and use their collective identity to counteract the consequences of stigma. Berger and Luckmann (1996) said that identity is created by the culture of the group where individuals perceived their position through their subjective ‘here and now’ and that those who deviate seek out other deviants who support their status. Berger and Luckmann further proposed that within The Social Construction of Reality society’s response to subcultural groups depended on the expectations of the roles adopted. Participants of this present study spoke of how they were treated by law enforcement, neighbours and their own family and friends, describing a lack of trust, feelings of abandonment and exclusion. In keeping with the 2010/2011 Drug Prevalence Survey they realised that the general public feared and avoided them. Therefore, the drug using subculture becomes a haven against the hostility of mainstream society and law enforcement (Becker, 1973; Goffman, 1963). Dropping out, rebelling and turning to drug using lifestyle maintain the importance of the subcultural identity.

However the negative consequences tend to eventually outweigh the benefits. Grund (1993) commented that individuals who construct an alternative identity by joining subcultural groups suffer grave difficulty when attempting to reconstruct a non-user identity. The participants in this present research experienced an extreme cognitive dissonance towards the end of their drug using. For example, the participants all narrated horrific situations at the end of their drug using. They spoke of sickness, disease, horrific living conditions, fear and anxiety due to

587 See also Mead, 1934; Vygotsky, 1978
588 Collective identity aids group cohesion, strengthens bonds and presents a united front to hostile, unsupportive or oppressive others (Snow & Benford, 1992). Individual drug users readily accept the collective identity of other excluded individuals to find belongingness even though they pay the heavy price of stereotyping and stigma (Becker, 1963).
involvement with criminal activities and gangland dangers. Social isolation, disconnection and abandonment also figured highly in their narratives, as well as shame, low self-esteem and lack of a sense of self. For many of the participants, continuing drug use became increasingly unsustainable. While initially welcoming the social inclusion of the drug using subculture and the accompanying drug user identity, many participants eventually disengaged from the group, leading to further depression, exclusion and isolation of a lonely existence until that too became unbearable. At the end of their drug using careers many of the participants reported isolating themselves due to overwhelming feelings of panic, anxiety, fear and distrust of others.

While expressing their genuine desire to cease drug using, the majority of the participants in this study experienced great difficulty in doing so due to fear of change and ignorance of what services were available to help. For some, unsuccessful cessation attempts, relapse, suicide ideation, suicide attempts and incidents of self-harm became a pattern which continued for several years. All of the participants described lack of self-respect, low self-esteem, lack of confidence and lack of trust in their ability to change. For many participants, their eventual recovery was a slow process strengthened by engagement with positive role models and institutions and disengagement with drug using.

Reconstruction of non-drug user identity on cessation of drug using

The participants of this research faced many challenges within their identity transition from drug user to non-drug user, especially in early recovery. Within the drug using subculture, the drug user identity was easily constructed. However the challenge for many participants lay in the restructuring of a ‘non-addict’ identity. The main difficulties arose in negotiating new social relationships, social settings and activities and trying to regain a sense of ‘normality’ to transition into new social arrangements. They related how they worked through diverse emotions, as their anxieties and fears resurfaced, but acknowledged that a positive identity transition was critical to maintaining change.

589 Additionally, all the participants described a disinclination to change regardless of their feelings of isolation, loneliness, pain, fear and powerlessness. Although they revealed that this was an extremely horrific time in their lives, some were like Colin who stated that he was ‘demented using drugs but I wouldn’t stop’.

590 They described being caught in a position of ‘desperation, isolation, degradation; the absolute horror of addiction’ but were unsure where to seek help, expressing the desire just to be seen as and treated as normal.

591 For some of the female participants in this present study there existed a double stigmatisation due the combination of drug using and criminal behaviour, and the non-conformity to traditional feminine roles in society, all of which were extremely challenging to process in recovery.
Tebes et al. (2004) proposed that many former drug users credited their identity change to a cognitive transformation. The participants in this present research described issues of cognitive dissonance throughout their narratives and changes that occurred towards the end of their drug using careers, including avoiding drug users and drug using activities. Making changes in their lifestyles, although difficult, evolved slowly as they re-learned skills of self-care.

Tracing their identity change throughout their drug using careers, the participants in this study acknowledged the transition from ‘addict, to scumbag’ to becoming former drug users in recovery. Similar to the existing evidence (Brown, 1991) that some former drug users capitalise on their drug using identities when transitioning to a professional career, several participants in this study returned to education and gained employment in various drug treatment services, which helped address low self-esteem and lack of confidence. The majority of the participants exhibited recovery positive identities where they embraced the 12-Step programmes.

**Issues that negatively influence identity transition**

This research found that quite a number of issues arose for the participants when trying to cease drug using and reconstruct their identity. Difficulty with some services, social barriers, shame, guilt, remorse, stigma, marginalisation and social exclusion, were among the issues that they highlighted as negatively influencing and curtailing positive identity transition. Processing these issues on their journey to recovery was identified as key to the successful adaption of a non-drug user identity.

Many participants of this study expressed extreme gratitude for help and support they received, and indeed were still receiving, from treatment services, and named specific workers who had played a large part in ‘saving’ them. However there were negative issues raised regarding some services. Several participants reported that they did not know where to go to access help. The participants who had engaged with MMPs voiced their concern that professionals did not help or advise them to move away from methadone nor did they listen to them when they expressed a desire to do so. A number of participants described how they detoxified themselves over a period of time without the help of the professionals who were prescribing. Some participants described being assessed by several agencies depending on their presenting issues. For them, the assessment process and the waiting time before being accepted into a treatment programme were particularly difficult. At this vulnerable time they felt they had little support from
agencies, family or friends which often led to relapse, as their recovery capital was severely diminished. They did acknowledge that they understood why service providers had lost trust in them after repeated relapses, but were frustrated nonetheless. Some participants mentioned they had several professionals, keyworkers and project workers belonging to several agencies attending to their concerns. One of the main confusions that arose from the replication of assessment by each agency was the inconsistency of appointment planning. This can be inconvenient, expensive and inefficient especially for those who have a dual diagnosis, where services can be even more perplexing, inconvenient and scattered. Some participants discussed the lack of support and empathy they experienced in some harsh, confrontational treatment settings and a lack of ‘joined-up thinking’ between services.

Social barriers included the difficulty of negotiating challenges and dealing with responsibilities when the participants ceased drug using, due to both a lack of tools to do so and the negative emotions prior to addiction which reoccurred in early recovery. Treloar et al. (2007) suggested identity change has to assimilate and accommodate new social settings and some services and attendance at 12-Step programmes assisted participants to change and recover a sense of normality and an ability to fit in to new social settings.

Kellogg (1993) stressed the importance of social validation to strengthen the transformed identity. However, societal construction of addiction and media representation of drug use influences not only public perception but often the drug users’ own self-concept. Keane (2002) commented that negative social reaction, reinforcing the ‘once an addict always an addict’ paradigm, impacts so significantly on drug users’ self-concept, that it could interfere with their ability towards identity change and a recovery oriented lifestyle. The participants agreed, highlighting that negative perceptions led to a lack of inclusion into non-drug using social activities and groups. Keene (2010) commented that drug using and non-drug using networks maintain mutual exclusivity and former drug users have to relinquish drug using friendships. The participants reported an initial sense of loneliness as they no longer associated with their

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592 Some participants questioned their ability to cope with responsibility and others reported that people close to them equally questioned that ability. However, with time, practice, education and increased trust this situation changed for the better. Some participants spoke of facing responsibilities ‘head on’ while others described maturing in recovery and learning skills that they should have mastered in adolescence. Several participants described the difficulty of managing medication for physical health complications like hepatitis, which has the side effect of causing depression. They expressed a deep gratitude to staff in the agencies they were linked in with for vital support during this difficult period.

593 For some participants, the loneliness they experienced was compounded with the loss of their intimate relationships, their homes and their means of making money.
drug using friends and that it took quite some time to forge new relationships with non-drug users. They experienced great difficulty in moving away from their drug using peers as no other social group existed for them to interact with, with the exception of 12-Step programmes.

Shame, guilt and remorse were reflected potently in the participants’ life stories, particularly for the female participants where their relationships with their children\(^{594}\), their perception of their physical bodies and their sexuality, added an additional layer of complexity to the expression of these emotions. The double layer of stigma and discrimination against women drug users emerged in this research. McIntosh and McKeeganey (2000b) reported the women in their study spoke very negatively of their drug using, recognised how horrific life was and how much they could lose if they relapsed. This was echoed by the women in this study, as they described their drug using careers and disclosed dangerous, criminal or unwelcome situations they were involved in. Drug using women are often perceived as sexually promiscuous, creating a stereotype of double deviance (Vimpani, 2005), which is aggravated by involvement in crime and sex working. The female participants in this study, who became involved in sex working, reported higher levels of self-hatred, stigma, isolation and distress. However, they were able to change the deviant identity by engaging well with services when they decided to stop both sex working and drug using.

The majority of the participants in this study reported being ashamed of their former ‘junkie’ identity, which supported Klee’s (2002b) finding that drug users perceived themselves as damaged and unworthy of a new identity. Several participants felt unworthy of many of the good things that came to them in recovery like intimate relationships, new homes and employment. The participants who reported suffering CSA recalled that the trauma of the actual abuse contributed to the sense of internalised shame, which was a huge barrier often neglected in treatment settings, and experienced as paralysing when help-seeking.

The ‘War on Drugs’ and the social construction of addiction with its labelling, marginalisation and exclusion leading to stigma profoundly affects individuals’ sense of identity throughout drug using careers. As Goffman (1963) noted stigma undermines the individual’s social identity and becomes a form of social control. One of the most pervasive barriers to successful identity transition for the participants of this study was the trauma of stigma, with the ensuing

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\(^{594}\) The female participants described incidents of irresponsibility and neglect of their children and ‘not being present’, however they maintained they had resolved most of these issues through counselling and membership of 12-Step programmes when they stopped drug using.
labelling, marginalisation and exclusion experienced as profoundly impacting on their identity throughout drug using careers.\textsuperscript{595} 

An interesting cycle emerged in this study. As some of the participants became immersed into the drug using subculture, they experienced a respite from their issues around low self-esteem as members of the subculture became validating, significant others (Hall & Jefferson 1975). However, the participants found that the stigmatisation and ostracism that accompanies the drug user identity eroded their self-esteem once again. Due to the perception of addiction as a social problem, Lovi and Barr (2009) ascertained that stigma hinders abstinence success and the effect of stigma, marginalisation and social exclusion decreases life’s opportunities and limits opportunities for successful recovery. The majority of the participants found that the stigma attached to addiction seriously hampered their initial attempts to cease drug using.

While the process of identity transition relies on social validation and social acceptance (Kellogg, 1993), many participants in this study experienced rejection and isolation due to the strength of stigma\textsuperscript{596}, which the literature (Kellogg, 1993; O’Mahony, 2002) acknowledged was also present within the addiction treatment services. Several participants concluded that stigma, both inside and outside of the treatment services, was a contributing factor to relapse. In particular, the participants who became homeless reported feeling excluded, due both to the potency of stigma and the resilience of the ‘once an addict always an addict’ dogma. An example of the strength of social stigma is illustrated by the influence it holds over anonymity in recovery. The majority of the participants stated that they would not disclose former drug using unless that disclosure would assist someone struggling with addiction. For them, a major problem was fear and lack of trust. Although some were many years in recovery, they expressed a suspicion that they would be blamed if anything was stolen in the workplace or would be perceived as different, and perhaps being treated differently. They expressed the fear that their history might interfere with their newly created social identity.

Reflecting Moran et al.’s (2001) reporting, that in recent decades drug use has spread to marginalised areas of almost every town and city in Ireland, half of the participants in this study were born into lower socioeconomic urban areas and several others moved towards these

\textsuperscript{595} Fifteen participants agreed that there still exists a social stigma around addiction. Some of them asserted that they still carry that stigma experiencing it as disempowering and difficult to move away from. 

\textsuperscript{596} Individuals who experience stigma have difficulty managing the discrepancy between the stigmatised identity and their authentic selves (Becker, 1963). Therefore while drug using, through their collective identity, they cope by re-defining stigma by using it as status. This complicates the issue of recovering a spoiled identity.
locations during their drug using careers. As drug consumption increased, the participants reported decreased support from family and non-drug using relationships which led to increased isolation and stress. The social construction of deviancy labels rule breakers as ‘outsiders’ (Becker, 1963) which has grave consequences for social inclusion and self-image evoking radical changes in an individual’s public identity. The participants in this study acknowledged they had to accept responsibility for their lifestyle choices and associated behaviours, and that they did fulfil the ‘deviant role’ while drug using. Those who reported involvement in criminality described a lifestyle laced with danger. Koski-Jannes (2002) suggested identity change involves fundamental changes in values, self-concept, social status, and social relationships which can prove difficult for former drug users who committed serious criminal acts. The participants, who were labelled deviant, experienced a high level of stigma which was extremely difficult to deal with and highlighted that it took several years to persuade the opinion of neighbours, family and former friends to change when they stopped drug using.

**Supporting reconstruction of identity – enhancing recovery**

Labelling and stigma complicate the transition from deviant to non-deviant identity (Becker 1963) especially when individuals become increasing immersed in fulfilment of the deviant role (Goode, 1984). However borrowing from Goffman’s (1968) work on stigma and ‘spoiled identity’, Radcliffe and Stevens (2008) suggested that coming into recovery helps reconstruct a ‘spoiled identity’ as drug related relationships and behaviours are no longer part of the former drug users life. McIntosh and McKeganey (2000b:81) added that former drug users must create their new ‘non-addict’ identity even though many difficult challenges present. Former drug users who successfully create identities that are not solely focused on drug use are more likely find ease of transition to non-drug using identities (Anderson, 1996). Becoming a former drug user requires reconstruction of lives and relationships to foster a new identity that opposes a drug using identity and merges with abstinent individuals (Tebes et al., 2004).

While in early recovery the participants of this current research reported extreme difficulty when attempting to adapt to a ‘non-addict identity’. As time passed however, challenges were faced and overcome, daily life became easier and change occurred. Successful recovery and identity transformation is a consequence of either reverting to a former identity or allowing an emergent identity to evolve (Biernacki, 1986). Several participants claimed that drug using obscured their identities, which they could now revert to, incorporating changes which they
had learned in recovery and that they no longer considered themselves as having an ‘addict’ identity. The participants expressed the preference to identify with other roles in their lives, that their lives had moved on and that other roles had become more important. They reported that in recovery they found several methods to assist them to enhance their new identities.

Enhancing new identities

The participants in this study reported employing diverse combinations of methods of treatment and support to boost their recovery capital, actively embracing moving away from chaos towards more ‘normal’ lifestyle (Doukas, 2011), including changes in employment, family and social spheres. Biernacki (1986) maintained that most drug users wanted to become ordinary rather than different and suggested that addiction ceases when a person’s identity clashes with other identities uninvolved with drug use. In keeping with Radcliffe (2009) who suggested that changes, like becoming proficient in the workplace, positively augment new identities. The majority of the participants in this study reported going back to college where academic levels ranging from Certificate to Masters were reported. Counselling and Addiction Studies were the most favoured choices of programme. Seven participants stated being involved in a salaried or voluntary capacity in a drug treatment service while two participants reported being employed in Youth Projects. Several participants declared that they felt valued in the workplace which positively impacted their self-esteem. Another positive boost to self-esteem and confidence asserted by Doukas (2011) was linked with redemption with family and friends. The participants in this present study identified the ‘gifts of recovery’ to include reconciliation with families and a renewed sense of respect being shown to them by family members and friends. They highlighted the idea of turning their experience of the harsh drug using life into something positive, especially in the realm of helping others and when interacting with family. Hughes (2007) and Gibson et al. (2004) commented that the belief in the ability to change and create new lifestyles were essential for successful identity transition and helped boost self-esteem. Addressing stigma, making positive changes and reconciling with family and friends were all reported as boosting self-esteem and confidence. Anderson (1996) commented that reconciling these issues and embracing non-drug using activities led to more successful identity transition into a drug free lifestyle as was reported by the participants of this study. They found, in agreement with Strauss (1962) and Koski-Jannes (2002) that identity change required extensive change in their social circumstances.
Social change

Holmberg (1995) proposed unsuccessful identity change can predict relapse. However, the acquisition of a non-addict identity incorporating fundamental social change can predict successful treatment outcomes (Kellogg, 1993). The participants of this present study described how these positive changes affected their quality of life in recovery including their level of contentment. They related how they made lifestyle choices (McIntosh & McKeganey, 2000) which were often difficult especially when they were breaking away from drug using friends in order to transition to a non-addict identity (Koski-Jannes, 2002) and encourage the public acceptance of this new, ‘non-stigmatised identity’ (Stall & Biernacki, 1986:13).

The participant’s reflection of the period of time between leaving their drug using friends and gaining non-drug using friends described fear, vulnerability, loneliness and isolation like Keene’s (2010) research. They missed the social interaction from their former peers and several reported having little or no support from family and drug free peers. Similar to Keene’s study the association with drug users led to a reluctance for mainstream society to accept their new status. Many participants described how inclusion in 12-Step meetings helped combat these feelings of exclusion and that the more they immersed themselves in non-drug using activities, the more included they became.

While identity transformation is critically important throughout drug using careers, recovery mandates disengagement with the drug using world and engagement with a non-drug using lifestyle. The participants in this present study reported having the ability to transition towards a non-drug using identity, although that this new lifestyle was not initially experienced as rewarding. This present research revealed that involvement with a new lifestyle, new non-drug using activities and new relationships was often initially a frightening and overwhelming prospect. New robust non-drug using relationships and activities were highlighted as enhancing the reconstruction of identity, supporting the participants in maintaining their identity change and avoiding relapse. Echoing Tebes et al.’s. (2004) assertion that as individuals work through their negative memories, emotions and experiences, they enhance their sense of self-worth, some participants in this study voiced the notion that they became more grounded and felt ‘worthy’ of their new lifestyle, no longer accepting judgement from others.
Kellogg and Kreek (2005) emphasised the importance of changing social contexts in recovery even if the opportunity for reward was modest at first. The participants of this study reported finding change confusing and initially quite depressing, declaring their physical and mental health poor and frequently frightening. A number of participants disclosed that they thought they were losing their sanity and only by attending treatment, counselling or 12-Step meetings did they feel reassured that they were going survive this unsettling period. They reported difficulty envisioning a normal life but with time and the support of professionals, family, friends and members of 12-Step programmes change occurred gradually. Alongside increased independence and involvement in drug-free activities came a more positive perception of their self-worth, despite past mistakes, negative emotions and negative experiences which according to Tebes et al. (2004) supports successful identity transition.

The assertion by Kelly and White (2011) that personal care and self-care are critical to sustaining abstinence was reiterated by several participants in this study, who described how they assimilated relaxation techniques and methods of dealing with stress into their daily lives. They also mentioned looking differently and dressing differently, cooking and cleaning their homes which became a natural progression from their former lifestyles. The participants described their self-care techniques, engagement with health promotion, exercise and sports, education and training and gaining employment as positive change.

Social change incorporates relationships with family members. Family and intimate partners featured predominantly in participants’ narratives, with some participants describing using family members as a ‘crutch’. Echoing Tracy et al.’s (2005) assertion that stable marital relationships and the involvement of a family member or partner in treatment leads to significantly more positive outcomes, the participants who were in stable intimate relationships described support for spouses. One participant reported ‘we didn't realise how much damage we had done to each other’ and added that the aftercare programme they attended was vital to the survival of their marriage. Strong support from spouses, close family members and friends was welcomed by the participants in this study.

The most salient points enhancing identity transformation were reported to be finally accepting the belief in ability to change, supporting and maintaining change, creating a strong network

597 Some participants mentioned learning these practical skills in treatment centres while others said they enjoyed learning self-care as their social circumstances evolved.
of recovery focused friends and encouraging the stability of a ‘non-addict’ identity. The promise of a better life and involvement with non-drug using activities and behaviours that are related to other identities, initially were frightening but as these activities and behaviours are nurtured, a restructuring of identity was possible (Kellogg & Kreek, 2005). The majority of the participants of this present study said they could not have managed the transition without the help and support of a 12-Step programme.

12-Step programmes

Cessation of drug using disengages the individual from the drug using subculture necessitating seeking an alternative. This alternative must be strong enough to replace the former drug using lifestyle. 12-Step programmes, which are free, readily available, long-term support mechanisms, figured most prominently in the recovery narratives of the participants of this present study, with fourteen of the sixteen participants describing these programmes as the most supportive method of facilitating reconstruction of identity and staying ‘clean’, especially in early recovery. All sixteen participants reported attending 12-Step meetings and fourteen of these revealed that they still attend weekly meetings, and help others especially newcomers, even after many years in recovery. They said they still enjoy strong friendships within the 12-Step programmes and socialise with those friends regularly. This may be due to the peer led ethos of the programmes, focussing on positive behaviour encouraging personal responsibility for recovery. Or, it could be a reflection of Greil and Rudy’s (1984) argument that members of AA are part of Identity Transformation Organisations, who promote identity change through the reconstruction of personal narrative thereby relinquishing former drug using identities.

Identity transformation happens by moving from one social context to another, inviting behavioural change. For the participants of this study that transformation was assisted by joining a 12-Step programme, becoming a cherished member, envisioning a new meaning in life and discovering rewarding activities and behaviours. Identifying with other members, wanting what they had and accepting advice and friendship from others in recovery, were common themes. Becoming part of a larger whole offset the isolation and loneliness of leaving drug using friends (Koski-Jannes, 2002) and helped ground their changing social identity which

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598 Chappel and DuPont (1999) and Christo (1999) agreed that although 12-Step programmes helped many former drug users achieve and maintain abstinence, there were also many individuals who did not engage with them for various reasons. This was corroborated in this present study where two participants did not engage with the 12-Step programme although they acknowledged that they were useful for many individuals.
was perceived by the participants as empowering due to a sense of camaraderie and support. The suggestion that this inclusion motivates recovery, resonated in this study. The participants who associated with 12-Step programmes not only embraced new non-drug using friendships, but also adopted non-drug using methods to cope with negative emotions and stressors, finding that recovery oriented relationships and activities aid self-regulation and prevent relapse. The adoption of drug using identities was no longer desirable or necessary.

The participants in this present study identified several salient factors in connection with 12-Step programmes and recalled how membership helped them initiate change. Sharing in meetings, enjoying social inclusion and re-defining their identities were essential to recovery and their former drug using identities became redundant as past identities re-emerged. In agreement with Atkins and Hawdon’s (2007) the combination of both social and spiritual activities helped instigate change.

Several participants reported attending at least one other treatment service along with a 12-Step programme. Miller (1995) found that most treatment methods are equally effective in the short-term but 12-Step programmes have a better long term outcome. Additionally, Chappel and DuPont (1999) suggested that engagement with a 12-Step programme along with any other treatment reinforced a more positive outcome. The combination of 12-Step programmes, counselling and treatment supported the participants who described how these methods complimented each other. Some participants shared a positive experience of aftercare where they felt included and that a sense of camaraderie existed.

The participants of this research agreed that recovery should address identity before, during and after drug using, stigma, support, unresolved issues and relapse and that recovery must be more rewarding than drug using. They could address these issues by situating themselves within a lifestyle that fosters abstinence and encourages a recovery identity. Members of 12-Step programmes who have a strong recovery oriented focus become attractive role models. Inclusion in a 12-Step programme mirrors the seeking out of companionship within the drug using subculture while still drug using. The former drug user needs to find a new group who supports abstinence, can supply a social network including rituals and values of recovery and

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599 Many of the participants reported counselling was useful to guide their journey through personal awareness and for advice, especially during critical times.

600 Gossop et al. (2003) highlights that the uptake of aftercare reduces drop-out rates and enhances the maintenance of abstinence.
replace former drug using associations (White, 1996)\textsuperscript{601}. Otherwise relapse and re-entry into the drug using subculture will occur. The recovery theme emerging from this present study confirmed that membership of a 12-Step programme provided positive relationships and activities, which replaced those from within the drug using subculture, protected against relapse and encouraged change.

Kellogg (1993) proposed that membership of a 12-Step Programme presented new or forgotten skills to incorporate into daily life to create a new identity. Practical skills teach relapse prevention strategies, addressing challenges and enhancing enjoyment of a new sober lifestyle. The participants in this study asserted that this learning helped them model socially acceptable behaviour, process change in self-concept and adopt a new role in helping others. Some participants experienced feelings of inclusion and security when they heard similar life histories and realised that recovery was possible. Although working through the twelve steps was difficult, it was very rewarding and essential to maintain abstinence and restructure their new \textit{non-addict} identity. All of the participants who joined 12-Step fellowships commented on the benefits in terms of personal growth even though they described the difficulty of making amends and struggled with concepts like guilt, shame, honesty and humility.

Several participants of this study reported experiencing a ‘\textit{spiritual awakening}’, describing it as a sudden phenomenon that they could not express verbally. In agreement with Magura (2008), this spiritual awakening was seen as spirituality which promoted new meaning, hope and a sense of purpose. Markus and Nurlus (1986) depicted how some individuals experienced radical conversions or spiritual awakenings which became an essential part of their identity change and successful abstinence. The participants experienced a new sense of purpose and meaning in their lives and spoke of the ‘\textit{gift of recovery}’ where recovery is a new way of life and of thinking, feeling and acting. 12-Step programmes offer a connection through social and spiritual activities and actively champion a shared ideology that supports identification, guiding principles for change leading to a higher prospect of stable recovery (Atkins & Hawdon, 2007). However the participants, like most members of 12-Step programmes, generally protect their anonymity\textsuperscript{602} in case their past impedes their newly created social identity (Kellogg, 1993).

\textsuperscript{601} White (1996) states the former drug user feels psychologically naked and vulnerable initially and strives to diminish that vulnerability by the transfer of identity and affiliation from drug using to a \textit{non-addict} identity.

\textsuperscript{602} There is a dearth of evidence based research regarding the ‘\textit{success}’ of 12-Step programme due to the principle of anonymity but uptake seems to be ever flourishing.
Tradition of helping in 12-Step programmes

One of the main traditions of mutual self-help groups and 12-Step programmes is disclosing personal narrative. The reconstruction of the personal addiction narrative, which is generally situated within the 12-Step framework of ‘experience, strength and hope’ becomes part of the recovery process leading to identity transformation. The old narrative that justifies continuing drug using is replaced by a new recovery oriented narrative. White (1996) highlighted that the telling and retelling of the recovery narrative plays a vital part in helping newcomers to achieve abstinence. White further explained that telling one’s recovery story describes the past and provides self-esteem for the future by showing that one can successfully conquer adversity and achieve recovery, which in turn gives hope to the newcomer.

One of the core activities within self-help movements is service or ‘giving back’. The twelfth step of the 12-Step Programmes advocates helping those who are still struggling with addiction by:

‘Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs’.

Service is empowering, helps with connecting with others and aids identity transformation. The main effect of service is internal rather than external reward (Bloomberg & Pittman, 1991). Sponsoring others teaches an individual to listen to others without judging which in turn helps the former drug user to let go of their own ego and the narcissistic aspect of addiction (Earl, 1989). The act of service and helping promotes internal harmony in recovery not unlike rituals and sharing conducted within the drug using subculture. Similar aspects help organise both groupings, for example helping, friendship, security and connectedness. The big difference is the existence or not of drug using.

Recovery, especially early recovery, is generally dominated by recovery relationships including service and helping others. Members draw strength from others in recovery and associate in activities that are grounded in recovery. This new lifestyle grounds the transition of identity through self exploration to restore personal honour. By embracing the new identity the former drug user has a workable framework to achieve abstinence and to encourage others

603 12th Step of AA as outlined in the Twelve Steps and Twelve Traditions of AA.
604 Initially new members are encouraged to help serve coffee and help set up rooms for meetings. Gradually they begin to feel part of a new community, formal 12-Step work begins and they engage in sponsoring roles and help other newcomers to settle in.
to do likewise. The ability to listen to others with empathy and compassion grows as abstinence increases. Service and ‘carrying the message’ become an integral part of recovery (White, 2006), helping former drug users to experience the world outside of their own subjectivity.

The new sober lifestyle changes to accommodate activities that at least fill the void created by ceasing drug using and leaving the drug using subculture and promotes contentment in a new identity. The participants in this study explained how service and sponsoring others helped them grow and develop within the fellowship. They noted that helping produced a change in their self-concept and eased transition into a more rewarding identity. McKay (2001), while researching the usefulness of helping within the 12-Step programme, found that helping activity increased self-esteem and peer bonding and members who helped others were more likely to achieve lasting, stable abstinence. When the participants of this present study were new members, they reported being overwhelmed by the help, support and care they received from long-term members and were delighted when it was their turn to reciprocate. They reported a sense of pride in having the ability or the skill to help others which in turn boosted their self-esteem. The participants stated that helping was empowering, and guiding others, especially new comers, became a critical aspect of 12-Step participation. Helping improves self-efficacy and commitment to staying abstinent, increases the sense of purpose and strengthens the sponsor network within the programme. Helping also maintains structure within a member’s life. Structured, busy lives tend to be incompatible with relapse just as a lack of daily structure can leave space for relapse to occur.

Relapse

Relapse is an indicator of unsuccessful identity reconstruction. The majority of participants in this study relapsed at least once and a number of them experienced relapse as a chronic, recurring issue. Hser et al. (1998) estimated that more than half of all drug users relapse in the first year after treatment, many of whom will be re-admitted to a treatment facility. Many diverse reasons were put forward as to the cause of relapse. Some participants viewed relapse as a natural consequence of addiction. Others named incidents, situations, emotions, lack of skills and lack of support as causal factors, and yet others mentioned succumbing to cravings, impulse using, and lack of preparation when faced with demanding situations. The participants discussed the loneliness they encountered when transitioning across social networks and some

\[605\] Recovery has been described as a fragile, impermanent state and relapse can occur even after many years.
participants reported that they just felt too ‘raw and vulnerable’. Self-loathing, feeling unworthy of recovery and the inability to negotiate intimate relationships were also listed by participants, as well as taking time out from recovery or relapsing into other addictions. The participants expressed extreme disappointment when relapse occurred and described scenes of abject misery. For example one participant recalled:

_I destroyed myself ... sitting in a crack house ... no food ... I was bones ... getting sores where the skin was starting to cut through._

The participants in this study who experienced chronic relapsing reported that they would have welcomed more support with regard to relapse prevention\(^{606}\) and several participants mentioned that agencies further stigmatised them during their periods of relapse where they felt like ‘a failure’. The participants reported using a range of strategies to help them avoid returning to drug using as well as support from various services they engaged with, maintaining that all former drug users must remain vigilant. They stated that they worked on issues like loneliness, building new associations and social interactions while avoiding former drug using friends and partners, developing strategies to cope with stress and anxiety and ensuring their safety at family and social events. A number of participants voiced the opinion that they would have welcomed more support especially with regard to unresolved issues which could still cause trauma.

_Returning to a ‘Normal’ lifestyle_

The most salient wish expressed by the participants of this study was a desire to be considered ‘normal’. They reported that they often felt ‘not normal’ during childhood and certainly not during their drug using, outside of their drug using peer group. Loose (2002) maintained that drug users were seen as ‘abnormal’ due to unhealthy appetites for drugs and Schmalleger (2006) asserted that when an individual carries the deviant label it becomes difficult to continue normal, everyday routines cemented the fact that ‘abnormal’ behaviours tend to become the norm. The participants reported that indeed abnormal became normal. Several participants described how polydrug using, living in squalor and injecting into their necks and groins became everyday occurrences as did dangerous, criminal activity. However, gradually life got

\(^{606}\) Relapse Prevention is a suite of interventions aimed at changing maladaptive behaviour patterns that cause the drug user to relapse (Marlatt & Gordon, 1985).
easier and embracing ‘normality’, although difficult, did not seem impossible. The participants of this study reported working, returning to education and taking up leisure activities, along with renewed relationships with family and friends, helped boost self-esteem and confidence and facilitated a return to ‘normal’ lifestyles and securing a ‘non-addict’ identity.

Non-addict identity

A ‘non-addict’ identity is established by replacing drug using networks with non-drug using networks. The participants experienced difficulty moving away from drug using activities especially if they were involved in criminality and detaching from friends and family who were still drug using. However, overall when the transition process began, it was easier for them to continue with it.

Recovery styles reflect diverse identity reconstructions. The extent of the drug user’s problems, the degree that the individual identifies with others in recovery and the actual recovery process all influence the new, emerging identity. The majority of participants in this study reported that membership of a 12-Step programme was the most useful instrument of identity change, regardless of how convoluted their drug using careers became. They identified that other members instilled a sense of a positive future, which included change and healing, and demonstrated that it was possible to become something other than drug user. Their recovery of a spoiled identity or emerging ‘non-addict’ identity held a promise of happiness and became incompatible with drug using. The participants agreed that identity transformation was possible and welcomed. They easily identified with other roles in their lives and stated that as their lives moved on, those other roles and new social contexts became more important.

Recovery narrative

Two of the participants of this study did not continue their association with a 12-Step programmes. One of these maintained she could not ‘identify with the old stories, war stories, how drunk they got’. She experienced the re-telling of the narrative as extremely negative, impacting on her peace of mind. Some participants recalled that certain aspects of the programme did not appeal to them but continued to go to meetings and complete their work on the twelve steps with their sponsors. They became active members and the majority of these stated that they still attend meetings, sponsor newcomers and are involved in service.
Within the tradition of 12-Step programmes members in are encouraged to tell and re-tell their recovery narrative, which is deemed crucial to help achieve abstinence and becomes part of identity transformation (White, 1996). Tebes et al. (2004) suggested that members who process negative memories, emotions and experiences through the retelling of their life history enhance their sense of self-worth. Drug using and recovery narratives are incompatible as one justifies continuing drug use while the other promotes recovery. The recovery narrative\textsuperscript{607} acknowledges the past but provides self-esteem for the future by narrating the successful response to the challenges of sober living. The participants agreed that they could either re-establish their former identity or conceive a new identity in recovery and that the telling of their narrative helped them construct a non-drug user identity where they could focus on past experiences, re-interpret them and attempt to chart their recovery path. Their narratives concurred with Biernacki’s (1986) assertion that the key to recovery is when an individual can disclose their experience and restore a sense of self by either reawakening their former identity or establishing a new one. Giddens (1991) proposed that retelling personal narratives is more effective than behaviour in identity formation and Riessman (1994) stated that it becomes an essential method of working out what that identity is and Lenson (1995) added that when the drug user is the main person in the narrative they can form credible self constructions. In keeping with Goffman’s idea of presentation of self in everyday life the participants of this present study used their narrative to create a positive impression of themselves in recovery.

The earliest mention of recovery narratives came with the tradition of sharing in AA meetings where men utilised the practice of non-confrontational personal narrative (Baker, 2000). No response was offered. The trajectory of the narrative followed the pattern of ‘experience, strength and hope’, was often rehearsed and positively endorsed the newly re-structured identity. In later decades women joined 12-Step programmes and found they could tell their narrative in a safe, non-judgemental environment (Vasas, 2005). Members tend to redefine their identity as former drug users although they begin their narrative with the statement ‘Hi, my name is X and I am an addict’. Participants of this study found that reflecting on and telling and retelling their story helped them separate their present sense of real self from their former drug using identity. They reported that this process enabled them to re-assume their former identity or recover a spoiled identity which fitted more easily into their new social context. The

\hspace{1cm} \textsuperscript{607} Greil and Rudy (1984) proposed that 12-Step programmes come under the umbrella of Identity Transformation Organisations, which facilitate identity conversion through re-construction of personal narratives. Members offer their personal narrative in a way that can accommodate their drug using.
participants stated that they were able to make sense of the traumatic events of their past and link this to a future of sober living. In conjunction with doing ‘step work’ the participants described their journey as searching for meaning for their addiction and freedom from it. They expressed that they had the freedom to safely explore their inner selves, acknowledge their trauma and reconstruct their identity within the framework of the 12-Step programme. In agreement with Baker (2000) the participants in this present study had significant identity transformations facilitated by the verbalisation of their narratives. Verbalisation helped the participants to accept many shameful and upsetting truths about their drug using careers. For example, the female participants were able to talk about their experiences of sex working, homelessness, and neglect of themselves and of their children while the males could relate their experiences of criminality and describe emotions like jealousy, loneliness and despair that formerly could not have been broached. The participants also stated that they were able to challenge their own denial concerning their drug using and separate the distorted reality they created when they were drug using from the actual reality of their situations. The majority of the participants expressed a sense of relief that they could finally make sense of their lives and their drug using without internalising the negative stigma that they had endured. They stated that they were able to let go of the notion of being damaged and embrace feeling mentally and physically well within their new life of recovery. The participants who were more than five years drug free described feeling valued by their families, in their workplace and most importantly by themselves.

When the participants were relating their narratives they told of many gruesome and disturbing events, horrific mental and physical pain and situations of abject danger. All of these things they survived although in some cases they recalled losing hope of survival. They expressed regaining a sense of survival instinct and a huge amount of gratitude when they started attending 12-Step programmes. The participants used the medium of sharing to retell their stories and felt themselves getting stronger mentally, physically and emotionally. The retelling of their narrative helped restructure their identity through the framework of AA. They reported feeling socially validated when other members commented that they enjoyed listening to their stories which is common practice within AA membership. Therefore the participants described using the ‘experience, strength and hope’ framework to reframe their identity. They moved away from the socially constructed ‘deviant addict’ towards identity constructed within the framework of 12-Step programme. This practice has been socially constructed by members of 12-Step programmes since AA was founded in 1935 and subsequently the Big Book, which is
full of recovery narratives, was written. Along with narratives of recovery the Big Book described the ethos of AA which includes a strong notion of spirituality and an equally strong tradition of helping.

**Conclusion**

This research was conducted with sixteen former drug users who related their life histories before, during and after drug using. They described the helping and treatment services and supports that they employed and the identity transformations that took place for them. A critical aspect of successful recovery was the transformation of identity that is, moving away from the ‘addict’ identity towards a ‘non-addict’ identity. The participants reported how they gained a sense of themselves as their new identities emerged. The majority of participants reverted to their previous ‘unspoiled’ identity and some participants added that they picked up new skills in recovery.

The analysis of the data collected identifies several barriers to effective identity transformation which negatively impacted on successful recovery. Many participants expressed gratitude for help and support they received from specific drug treatment workers, treatment services, day and aftercare programmes and they acknowledged the support they availed of from 12-Step programmes, with the majority of participants indicating that this was the most effective means of support. However there were some negative issues voiced regarding treatment facilities. They reported that there was a lack of support to stop drug using in early recovery, especially if a pattern of relapse emerged. At this early stage of recovery the participants described several challenges they had to negotiate. Psychologically, childhood fears and anxieties returned along with feelings of low self-esteem and lack of confidence. The participants spoke of unresolved issues which caused distress in early recovery. Some managed to process these issues through counselling and working the 12-Step programme. Others admitted conceding to learn to live with issues remaining unresolved. Socially learning to deal with responsibilities, learning social skills and self-care proved difficult. The impact of social stigma along with rejection and isolation hampered cessation of drug using attempts. Being labelled deviant and the lack of social acceptance and social validation often led to relapse. Financially, many participants stated that they lost their earning power and often their homes as they knew they had to avoid drug using friends, partners and activities. Mental health difficulties, like depression, also posed concerns.
With regard to treatment, although most participants highlighted that they benefitted greatly from the help and support of the services they attended, some participants discussed the lack of support and empathy they experienced in some harsh, confrontational settings and a lack of 'joined-up thinking' between services. The participants agreed that these issues were considerable barriers to successful and lasting identity change.

The participants said they experienced great difficulty in moving away from their drug using peers as no other social group existed for them to interact with, with the exception of membership of 12-Step programmes. In early recovery they had still not reconciled relationships with family and former friends and felt exceedingly isolated when separated from drug using friends. This interim period was described as lonely, isolating and frightening.

Fourteen of the sixteen participants of this present study related that they experienced membership of 12-Step programmes as the greatest support in recovery. From their reflections this study has found that the telling and retelling of personal narrative, along with a renewed sense of spiritual self and a tradition of helping, all of which exist within 12-Step programmes, facilitate positive identity change and were of vital assistance to the former drug users who participated in this research deal with the challenges of recovery as they arise. When they reframed their narratives within the 12-Step framework a new presentation of everyday self (Goffman, 1990) was available to them. This new presentation permitted a new sense of their social construction of their subjective here and now as proposed by Berger and Luckmann (1966) as essential to the social construction of reality. Moving away from the social construction of addiction and deviance, the retold narrative enabled identity transformation to occur. Becker (1963) proposed that the ‘junkie’ was outside of mainstream society due to stigma, labelling and social exclusion. Identification with and membership of a 12-Step programme provided a holding space where the participants could find belonging, safety, comfort, moral support and social acceptance along with providing new social rituals and controls to adhere to. This functioned as a parallel subculture which offset the loneliness and isolation experienced by quitting the drug using subculture and the feeling of being outside society which was created by drug using. The new subculture was recovery oriented rather than dictated by drug using and became a collective response to maintaining abstinence.

Goffman (1990) suggested that individuals use props that will help create the impression they want to create. Conscious and unconscious choices are made regarding portrayal of an image. Within the 12-Step programme new props were found to guide impression management like
participating in helping behaviours, telling of narratives at meetings and working through the twelve Steps in order to facilitate behavioural and psychological change. The fellowship reinforced solidarity and eased the transition from drug user to non-drug user, which in turn eased the transition from ‘addict’ to ‘non-addict’ identity.

From a sociological perspective leaning on the social constructivist work of Becker, Goffman, Berger and Luckmann and to a certain extent the work of O’Mahony, this present thesis concludes that society responds in a very ritualistic, policy driven, bureaucratic manner to the issue of drug using and addiction. The medical response is to prescribe medication or to institutionalise within a treatment setting. The criminal justice response as outlined by O’Mahony is to criminalise, label, sanction and punish. Both responses are highly stigmatised leading to further exclusion of the drug user, whether that individual is perceived to be deviant through the courts or prisons or sick and attending Methadone Maintenance clinics or other treatment systems. However, societal responders do embrace the notion of drug users belonging to some type of recovery so that statistics can be published to bolster the notion that a cure for or eradication of drug use is eminent.

MMPs and treatment services illustrate Goffman’s (1961a) notion of total institutions. The ‘inmates’ have little or no influence on their treatment programme or care plan. They conform for fear of sanction. For example, participants of this present research stated that they asked for reductions of their methadone prescriptions but were denied being part of that decision making process and many years may have passed before any reduction was made. They expressed the notion that many clients of MMP clinics are held involuntarily on methadone for much longer than anticipated. Patients of inpatient programmes follow a strict, highly ritualised routine for a period of time decided by the treatment provider. The mortification described by Goffman takes place, where prospective patients lose their individuality and conform to the stringent assessment procedures which may include the giving of blood or urine samples to ensure the veracity of their accounts. Those, previously labelled as ‘outsiders’ are now admitted into an unrelenting system of rigid treatment where conformity is demanded. On entering treatment the dispossession of personal items reflecting security and individualism described by Goffman (1961a) and the ensuing presentation of ‘standard issue’ paraphernalia further cements the loss of identity. As within the drug using subculture an underlife (Goffman, 1961a) emerges where patients or clients attempt to preserve their individuality and to retain a sense of self. Berger
and Luckmann’s notion of the social construction of reality is reflected in this attempt at self-preservation as opposed to total conformation to the institution.

However, paradoxically, although several of the participants reported deep unhappiness regarding how they were treated in various institutions, especially during assessment and in the early days of treatment or when waiting for admission, several went on to study and embrace careers within the treatment arena becoming those staff members whom they had formerly berated. Therefore, part of their identity transformation may include conforming to the regimes of total institutions and conforming to the principles of the 12-Step programmes in order to be accepted and validated by mainstream society within their new ‘non-addict’ identity.

**Chapter Summary**

This research explored identity and the construction and reconstruction of identity from non-drug user through a drug using career to former drug user. It identified themes that emerged, analysed these themes and formulated conclusions. This research provided insight into identity construction and reconstruction within a group of former drug users. It identified identity construction and reconstruction before, during and after drug using careers, to examine issues that facilitate or enhance reconstruction of identity, as well as barriers that hindered this process. It also examined the efficacy of strategies employed while reconstructing identity and to explore if there is a connection with treatment methods that former drug users may have engaged with. Threats and challenges to the newly constructed identity were examined in order to gauge if these threats and challenges could trigger relapse. The research identified how former drug users deal with issues that may or may not be resolved, when reconstructing identity.
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Appendix A

Hello. My name is Siobáin O’Donnell and I am conducting research for a PhD. The title is “Exploration of the reconstruction of identity as non-drug user after a career in drugs”. I am registered with Trinity College in Dublin and I would like to talk to you about my research and invite you to take part.

This thesis will explore identity construction and reconstruction from non-drug using, during drug using careers and becoming a former drug user. It will present the former drug users’ own ideas of identity construction and reconstruction, how they worked through this, examine what problems and issues arose for them, what supports they found useful, if any and how the process evolved. It will also examine how the participants understood the value of identity reconstruction and if they recognised that they were engaged in this process.

The research aims to explore

A) Construction and reconstruction of identity before, during and after drug using careers

B) Issues that enhance reconstructed identity

C) Efficacy of strategies/treatments employed while reconstructing identity

D) Threats to the newly constructed identity that could trigger relapse
E) How former drug users deal with issues that may or may not be resolved when reconstructing identity

Why have you been invited to participate?

You have asked you to participate because the information you can give me will really help my research. All participants are over 18 and are at least two years in recovery or drug free. It is up to you to self-define as former drug user. I will not be conducting any assessment with you although you may have been assessed before in another setting. The only personal details I want are your age, gender, where you live and just a little about your drug using history.

What does participation involve?

I will conduct two sessions with you – as quickly as possible after each other. I will record the sessions on a mini-disc recorder. This should last anything from ½ hour to 1 hour. The first session is where you tell me your story in your own words. I won’t really be asking any questions at this stage. I just want to hear your story. The second session is based on the first. When I listen to the first session I will pick up on some issues that you have mentioned and ask you to clarify or explain a little more, or talk more deeply on that issue.

Your participation is totally voluntary and you can stop at any time. You don’t need to tell me why you want to stop. There are no risks around personal safety but some of the issues you talk about could bring up memories for you. I have some counsellors on standby to talk to
anyone who feels they want to discuss something outside of the research. Of course, this will be totally confidential and in no way brought into the research.

At the end of our sessions I will invite you to ask me any questions or add anything that you may have forgotten. Also, I will ask you to suggest some other people that you think might be interested in taking part. I hope to have between 35-40 people all together. There is no payment for participation, however, I hope the findings from this work will add to the body of research in the field of addiction.

Issue of confidentiality and anonymity.

The research may be published in journals or articles and used by professionals in the field of addiction but all procedures will be taken to respect your anonymity. Anonymity is guaranteed and where certain details, events or characteristics that may be able to identify you will be removed and data will be anonymised and put into safe storage.

Now, I want you to take as long as you need to make your decision. Phone me if you have any other questions or if you decide you want to take part. Thank you so much for your time and interest.