An Exploration of choice in Heroin Addiction: 'An Interpretative Phenomenological Analysis of a small sample of people in recovery'

This Research is submitted in Partial Fulfilment for the requirements of the Doctoral Programme in Counselling Psychology and Psychotherapy at the New School of Psychotherapy and Counselling and Middlesex University joint Programme.

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Abstract

This research investigates the subjective experience of choice in heroin addiction. The aims were to investigate the perceived degree of control participants felt they had in relation to heroin use, and the impact this had on their lives. The idea of choice is the main aspect distinguishing the free-will model from the medical model in the field. Seven participants were interviewed for this study, two females and five males. The participants were recovering heroin addicts with length of recovery varying from 2 months to 7 years from different ethnicities and socially disadvantaged backgrounds. These were recruited and interviewed in two different 12 Step Model recovery centres. The analysis adopted Interpretative Phenomenological Analysis (IPA) as its qualitative approach as this was found to be most suitable for the experiential focus of this study's question. The main themes were; *'not belonging', 'heroin both gives and robs one's identity'* and *'lack of control leads to recovery.'* This research illustrates the limited choices the participants faced in their lives and how change was only possible through acknowledging one's emotional response to a particular situation, rather than a cognitive response; whilst the participants took drugs to numb their emotions, it became impossible to make different choices in their lives. The importance of issues of identity, belonging and trauma were findings consistent with previous literature in the field of addiction. Recommendations for future research focus on a mixed methodology research showing the link between emotions and choices in reframing someone's experience of addiction. Further recommendations would be a focused study on the impact of time in addiction and how the existential approach can contribute to enhancing treatment choices. By looking at how the existential phenomenological approach contributes to the field this research highlights possible preventative issues. The lack of choice is not attributed to disease but rather to a complex set of circumstances illustrated by the participant's interviewed. The implication for those working in the field is to open up choices by focusing on how emotions are the primary way of changing and reinterpreting one's life.

Anonymisation

All transcripts included in this document have been edited in order to preserve the confidentiality of the participants. The participants are identified through pseudonyms used throughout the study to protect confidentiality.

Statement of authorship

I Fernanda Barros confirm that the work presented in this research thesis has been performed and interpreted solely by myself. I confirm that this work is submitted in partial fulfilment for the requirements of the Doctorate in Counselling Psychology and Psychotherapy at the New School of Psychotherapy and Counselling and Middlesex University. This dissertation has been granted ethical clearance from the New School of Psychotherapy and Counselling and the Psychology Department of Middlesex University and has not been submitted elsewhere in any other form for the fulfilment of any other degree or qualification. The author reports no conflict of interest.

An Exploration of Choice in Heroin Addiction

Chapter 1- Introduction

This research explores the concept of choice in heroin addiction from the subjective experience of those who have experienced this addiction. The British system currently sees addiction as a disease of the nervous system that requires medical help, but it is still punishable by law (Witton, Kearney & Strang, 2005.) By contrast, in the US rather than treatment-focused, addiction is seen as a crime controlled by the criminal justice system.

From a Counselling Psychology perspective, it is important to examine the topic from a pluralistic stance by engaging with the different approaches towards the topic of investigation. This dialectical pluralism is central to Counselling Psychology, which aims to generate an informed approach to therapy by allowing openness and flexibility in practice through engaging with a myriad of different models (Kasket & Gill-Rodrigues, 2011 p.22.)

There are two main discourses defining addiction: the disease model or medical model, and the free-will model, also referred to as rational choice theory (RCT) of addiction. The disease model defines addiction as a disease in which users have no control over their behaviour. By contrast the free-will model sees addiction as an active attempt by the user to create meaning in his or her life. The latter states that people use drugs because they want to and because it makes sense for them to do so given their circumstances.

Regarding the disease model, the Diagnostic and Statistical Manual IV (DSM-IV), defines addiction as a:

> '*Maladaptive pattern of substance use leading to significant impairment or distress as manifested by three (or more) of the following, occurring at any time in the same 12 month period: (1) substance is taken in larger amounts or over longer period than intended; (2) persistent desire or unsuccessful efforts to cut down (3) a great deal of time is spent in activities necessary to obtain the substance; (4) social or recreational activities given up or reduced; (5) continued substance use despite persistent psychological, or physical problem exacerbated by use of the substance; (6) tolerance;(7) withdrawal, manifested by either characteristic withdrawal syndrome for the substance;* (DSM-IV, 2000 p.197.)

This predominant model identifies addiction as a disease to be treated using the conventional medical model. Addiction is defined as a syndrome at the centre of which is impaired control over a behaviour leading to harm (West, 2006.)

Proponents of this model now acknowledge that it fails to address other influencing factors such as: political, social, economic and the interaction of human desire and responsibility (Kalant, 2010.) There is a small body of literature regarding the free-will model of addiction which emphasises a different aspect of addiction, one which is not disorder-oriented but highlights how individuals have made and continue to make choices about aspects of their life and their using.

Reviewing the literature on the subject, themes of identity and choice were found to be important. This is due to the fact that whether addiction is seen as a disease or not, the way we see ourselves or our mental representations and sense of ourselves, influences how our self-control operates. For example, categorical self-labels that we attach to ourselves (i.e. addict or non-addict) help to prevent 'behavioural deviances'. Hence, our ideas about what we are capable of achieving (self-efficacy) influence actions that we attempt and the energy

and commitment we devote to those actions (West, 2006.) Research shows that if someone believes they have no choice over their drug use, they will have a 'disease model' concept of addiction (Jarvinen & Andersen, 2009.)

The policy implications vary according to which model is being adhered to. The dominant view with its emphasis on harm means that addiction is currently dealt with by the criminal justice system. The free-will model suggests that the dominant view can be detrimental to treatment as it takes away self-efficacy. At present, there is a gap in research looking at people's subjective experience of drug use and choice (Larkin & Griffiths, 2002.) According to Larkin (2002) the key issue in addiction is volition and how the person in question feels unable to direct their intent towards other objects. Although addiction has inevitable biological consequences, the 'loss of control' in addiction means it is categorized as a non-volitional activity (Larkin, 2002 p.92.) In order to address this gap in the relationship between the person and context, and look at addiction phenomena more holistically, this study aims to address both arguments.

'There is a pressing need for existential-phenomenological research on the nature of addiction and ways of working with people presenting with issues related to addiction to provide a counterbalance to the majority of research carried out to date in which outcomes (and particularly abstinence) play such an important role. Solution-focused therapy provides the context for addiction and the emphasis remains on pathologizing addiction or correcting maladaptive patterns of behaviour. This imbalance may be partly addressed by the publication of detailed client studies which present 'addiction' in the context of the client's struggle to make meaning in their lives' (Du Plock and Fisher, 2005 p.76.)

As identified by the above quote, this study will explore the concept of choice in addiction as an attempt by participants to create meaning in their lives. According to Larkin, the emphasis needs to be placed on identifying the 'conditions' under which people are more likely to become addicted rather than searching for narrow and reductive explanations of genetic predisposition and 'addictive personality' types. In order to explore this issue, the addict's subjective experiences must be solicited and explored. According to Schaler (2000), Szasz (2003) and Burrell & Jaffe (1999), the dominance of the disease model is the main reason why free-will and agency are not explored in the field. The mainstream models promote acceptance of an 'addict identity' (Burrell & Jaffe, 1999), which restricts the experience of choice, (Beasley, 1998) and discourages wilfulness (Schaler, 2000.) Telling addicts they are suffering from a disease is only useful if it enables them to stay clean. However, the evidence has shown it does not (Davies, 2000.) In order to deal with a drug problem it is important for them to have a sense that they can control their drug use themselves.

Moreover, from a counselling psychology perspective, the critical position assumed aims to consider and engage with multiple perspectives both in theory and practice. As seen in Kasket & Gill-Rodriguez (2011), in order to reconcile these multiple models the approaches must be simultaneously acknowledged to adhere to the need to retain a critical outlook.

As described in Kasket & Gill-Rodrigues (2011), from a pluralistic stance to evidence-based practice, the tension underlying Counselling Psychology's approach is to value the individual's subjective and phenomenological experience. The authors argue how it is important to wrestle with these multiple perspectives predominant in the field whilst maintaining a context aware stance that values and appreciates the diversity of individuals' subjective experiences. Using this approach this research aims to be transparent yet make an original and valuable contribution to the field of addiction studies. This study utilises IPA to investigate the experience of choice in heroin addiction from the viewpoint of those

interviewed. There is a significant gap in research addressing the sense of self-efficacy and volition in individuals' experience to address and control their own drug usage. IPA research is concerned with detailed lived experience and it is the method of choice to give voice to those who were previously marginalised by a social context which tends to take away individual choice.

Chapter 2- Literature Review

Heroin was developed in 1874 by a team in St Mary's Hospital London testing a drug related to morphine. Heroin is a strong painkiller; it changes into morphine in the brain producing a more dramatic and intense euphoric feeling than morphine, with more rapid and severe withdrawal symptoms. It produces pleasurable sensations which can lead to strong physical and psychological dependence (Stone & Darlington, 2000 p.93.) It is the drug considered most harmful by the medical model because of its strong physiological effects. The danger of heroin addiction is associated more to the psychology of the addict and the way the addict uses the drug because some show a real lack of concern and disregard for their physical wellbeing (Gossop, 2007 p.138.) As an opiate drug, heroin works through the central nervous system creating a strong physical addiction (Biernacki, 1986.) Heroin creates dependency, has harmful effects and extreme withdrawal symptoms, including the danger of overdose and its ability to 'completely take control over the life of the user' (Biernacki, 1986.) While crack is known for its rapid and short-lived pharmacological effects (Davies, 2006), the effect of heroine tolerance and withdrawal is long-lasting (Biernacki, 1986.)

According to neurobiology studies, heroin induces changes in specific brain neurons 'trapping' the addict in a pattern of escalating drug use and relapse, lasting for weeks and months, even after the addict has stopped using the drug (Kalivas & Volkow, 2005.) According to this model, once the person has started using heroin, they become 'addicted' and unable to control their drug use, spiralling into a vicious circle of dependency and harm. While the free-will model places choice and responsibility at the centre of addiction, the disease model suggests that there is little choice involved at all.

This study explores choice in addiction. Heroin was identified as the ideal drug for the topic because it is seen by the medical model as being the drug over which users have the least

amount of choice. According to Larkin (2002) heroin users are portrayed as 'out of control', unable to resist their cravings. On the other hand, heroin use has also been portrayed as an act of wilful and poetic exclusion from the mundane world of people (Larkin, 2002 p.69.) These paradoxical attributions show the criteria for which people are judged, where the word 'addiction' always denotes negativity.

A summary of the relevant literature outlining this debate and the study's aims is addressed below. My intention is not to provide an extensive summary but to draw attention to the relevant aspects in regards to the topic under investigation.

2.1- What is Addiction? Definitions

The literature review specifies two main prevailing views of addiction: the 'free-will' model (rational choice model) and the medical model (disease model). The latter pertains to the dominant neurobiological medical tradition and the former to the view that people actively and consciously choose to use drugs. As noted by Larkin (2002) the word *addiction* almost always denotes negativity, specifying an excessive involvement in harmful or destructive activities. The term addiction has an inconsistency of meaning and this study aims to investigate addicts' experiences of this phenomenon. As questioned by Larkin (2002); does the word 'addiction' define a distinct phenomenon; something beyond problematic behaviour and distinct from normal conscious action? It is worth noting how the concept of and definitions of addiction have changed throughout history.

There are many variations of these two seemingly opposed views and one of them, the theory of 'addiction as a motivational disorder', which is a variation of the disease model will also be discussed.

The traditional or 'medical' model of addiction proposed by Sellman (2010) defines addiction as:

(1) a chronic relapsing disorder

(2) about compulsive behaviour

(3) outside of someone's conscious choice (2010; p.6.)

In 2000, the American Psychiatric Association classified substance dependence as: 'a cluster of cognitive, behavioural and physiological symptoms indicating that the individual continues the use of the substance despite significant substance-related problems' (DSM-IV, 2000 p.192.)

On the contrary, advocates of the 'free-will' model including Thomas Szasz (2003), Jeffrey Schaler (2000), Christopher Wurm (2003) and John Booth Davies (2000) define addiction as a socio-economic and political construct; defined by an individual's attempt to create meaning in their lives. The premise is that people use drugs because they don't find any reasons not to, rather than because they are victims of an addictive illness that removes their capacity for voluntary behaviour (Davies, 2000.)

Commonalities between these two approaches lie in their mutual agreement that addiction is defined by compulsion, self-administration and continued use in spite of real and perceived negative consequences. The models diverge in how they approach the causes of addiction. The medical model summarized below sees addiction as a behavioural disorder and a chronic relapsing condition (Kalant, 2010); and the 'free-will' model believes addiction is a state negotiated through human desire and intent (Davies, 2000.) *Attributional theories*, or theories that investigate the impact of beliefs on behaviour (Davies, 2000), disagree with the view that addiction is something that *happens to* people, and instead seek to prove that people

take drugs because it makes sense for them to do so given the choices available. The *attributional theory* models will be expanded in the treatment section of this paper.

2.2- The Disease Model

The medical model of addiction characterizes addiction by its compulsive, repetitive use in spite of negative consequences and lack of control (Hyman & Malenka, 2001.) Addiction is defined as a treatable but incurable disease (Newman, 2008.) The main objective in neurobiological research is to identify molecular structures that can lead to new treatments for addiction, and break its pattern of chronic relapse.

This model states that drug addiction results from adaptations in specific brain neurons caused by repeated exposure (Nestler et al., 2007.) The drug activates reward centres in the brain and is confused in the hippocampus with naturally rewarding activities such as eating (Hyman & Malenka, 2001; Nestler & Malenka, 2004.) Chronic drug use induces a change in brain structure which will last for weeks or even months after the addict stops using the drug. It is believed that this adaptation is what traps the addict in a pattern of escalating drug use and relapse (Kalivas & Volkow, 2005.) There are many hypotheses as to how dopamine leads to the development of addictive behaviour (Gossop, 2007.) Yet research in the field that sees addiction as simply a motivational disorder linked to brain systems does not provide a full and accurate picture.

Whereas neurobiology research has showed over 1500 genes linked to addiction, the research in the field is still mechanistic, because drugs alone do not cause addiction. Generally, most neurobiological studies hereby reviewed concluded that addiction can be classified as a behavioural disorder generated within an extremely complex system. Hence, from a medical position, as seen in Kalant (2010), this model is still reductive at present. It still remains to discover primary causes of addiction, but neurobiologists acknowledge that addiction must be

explored by neurobiological, pharmacological and psychological approaches combined in order to be fully understood (Kalant, 2010.) Furthermore, studies investigating the 'addiction gene' or the assumption that individuals are biologically-wired to become addicted have proven inconclusive, and the findings do not explain variations between those who become addicted and those who do not. Comings et al. (1994) argue that it is inappropriate to speak of a genetic explanation for addictions because some people identified with the gene do not experience addictions and many 'addicts' who do, do not possess the gene. In fact, genes do not operate in isolation but as part of a complex system interacting with the individual's environmental circumstances. We can begin to understand addiction as part of a complex and multidimensional phenomena (Larkin, 2002 p.57.)

The concept of choice and intent is unacknowledged in most neurobiological studies investigating addiction. According to this view, human beings are at the mercy of cravings and impulses where there is no conscious choice. Thus addiction is understood as a non-volitional activity. Stemming from this model, the 12-step approach is the predominant treatment in the addiction field.

2.3- The 12-Step Approach

The 12-Step Approach or Minnesota Model supports the medical model's view of addiction as a disease. This model offers a solution to the lack of apparent choice in addiction in terms of a 12 treatment philosophy that must be adopted. It is a mutual aid model founded 1935-1938 by the pioneers of Alcoholic Anonymous (AA). It was developed at a time when formal treatment options were limited, and is based on the premise of one addict helping another (Magura, 2007.) Before 1952 when the model was developed, addiction had not yet been classified as a 'disease' by the American Psychiatric Association's Diagnostic and Statistical

Manual (DSM), and was instead considered a sin (Magura, 2007.) The 12-Step Approach is classified as a spiritual model following the main principles that; *addicts must recognize they are powerless over their addictions; they must recognize that a greater power can restore them to sanity and turn their will over to this higher power; they must make a moral inventory of themselves and admit their wrongdoings; they must make amends to people they harmed and carry this message in all to other addicts.* (Note: AA substitutes alcoholics for addicts and alcoholism for addictions)

The 12-Step Approach has been criticized by advocates of the free-will model of addiction for discouraging wilfulness, and requiring a convergence to a particular AA/NA worldview. (Schaler, 2000 p.76) According to Schaler (2000) and Beasley (1998) the 12-Step focus on abstinence is an inflexibility that alienates help-seekers. Schaler (2000) argues that membership in the group requires a radical transformation of personal identity and reinterpretation of personal experiences. Others found that the 12-Step attempts to restore self-worth by providing the addict with a new identity (Larkin & Griffiths, 2002) and offers stability, relatedness and belonging where before life was only chaos (Beasley, 1998.) The approach's rigidity and emphasis on total abstinence was found to restrict the experience of choice and define the addict's self-concept solely by the disease model. This means the addict label is substituted only by the label of 'addict in recovery' (Beasley, 1998.)

2.4- The Free–Will Model

Moving away from the disease mind-set, Stanton Peele (2000) states that addiction is not a specific invariant biological phenomenon and people can be addicted to powerful non-substance activities. He mentions how even those who were classified as addicts tend to terminate their addictions more often than not and usually without treatment. However,

according to Peele, addiction is still a powerful, useful and evocative concept with life and death consequences. He believes that cultural trends will affect the addicted and those who study the phenomena.

As described in Kwee (2007) Peele's view is that addiction must be understood as something apart from a disease, but in experiential terms as a *'state of being'*. For example, while some people get addicted, others do not, and others who do can mature out of this excessive behaviour without any treatment. Some writers in the field, described in Kwee (2007), see addiction as a state of being characterized by repeated attempts of increasing futility to replicate a false experience of escape, power and security. The addict feels compelled to repeat this experience due to his/her existential insecurity. He/she creates a state of organized predictability in which addiction becomes the only tolerable condition of life.

This theory states that people use drugs because they like using them, rather than because they are struggling with pharmacological forces beyond their control. Human beings are seen as actively constructing their world to pursue their addictions (Schaler, 2000.)

In his paper *'Is "Addiction" a helpful concept?'* Wurm (2003) describes the idea of addiction as deflecting attention from how individuals make choices to create a self-fulfilling prophecy. The use of language in 'addiction' does not permit for choice-making ideas in our society. He argues for the implementation of notions of choice and responsibility in recovery, which in turn would influence the motivation of a client to change their behaviour. However, taking time off work due to a 'medical condition' requires less effort than changing one's life. From this viewpoint then, addiction might be a helpful concept in understanding those determined against personal responsibility and choice.

Similarly, Schaler (2000) opposes the idea of involuntary addiction and points out how it is demoralizing for those trying to change their behaviour. He states that often there is a

problem underlying addiction and once this is resolved, the person abandons their harmful addiction. Schaler describes nine declarations, summarized below:

> *(1) The best way to overcome addiction is to rely on your own will power; (2) People stop depending on drugs once they develop other ways to deal with life; (3) Addiction has more to do with the environments rather than the drugs; (4) People often outgrow drug and alcohol addiction; (5) Drug addicts can learn to cut down or moderate their drug use; (6) People become addicted to drugs and alcohol when life is going badly for them; (7) They can often find their way out of their addictions without outside help; (8) You have to rely on yourself to overcome an addiction; (9) Addiction is often a way people rely on to cope with, or avoid coping with the world* (Schaler, 2000 p.9.)

The concept of choice and deliberate intent remains at the centre of the free-will approach. Human beings are not seen as simply responding to brain impulses or cravings, but as negotiating their desires and intent in relation to their world. The aim of this approach is to look at the meanings connected with substance use, how people are choosing and anticipating the future, and how a person remains an active agent, even when there is a perceived lack of control. The free-will approach, in line with the existential model, argues that while there may be a cost to organising one's life around one's addiction, there may also be complex benefits associated with it (Burrell & Jaffe, 1999 p.53.)

2.5- Choice and emotions from an existential viewpoint

Choice and clarification of meaning is the focus of the existential phenomenological tradition. The existential approach promotes the notion that people can become involved in ordinary activities when they become invested with meaning (Du Plock, 2001.) For instance,

taking drugs can be seen as a way of making oneself passive to the world and escaping responsibility (Sartre, 2003.)

Although Sartre's (2003) core philosophy states that man is condemned to be free and experiences this freedom as anguish, Spinelli (2007) expands on how we are not always free to choose. Spinelli (2007) describes how there are conditions by which no choice presents itself. For example, human beings are thrown into a particular time, a particular body and a particular context. This 'thrownness' means that choice only arises within a situated inter-relational context. (Spinelli, 2007 p.48) According to this premise, choice is situated in the meaning and interpretation given to an event as well as the attitudes and values adopted towards it. In addiction, the power of choice is seen to be placed in someone else's and something else's control. Spinelli proposes that not all choices are available at all times and this freedom to choose is only at an interpretative level. Similarly, Heidegger's (1962) philosophy distinguishes that; 'freedom...is only the choice of *one* possibility- that is, in tolerating one's not having chosen the others and one's not being able to choose them.' (Heidegger, 1962, p.331)

As seen in Spinelli(2007), the existential philosophy '*emphasises the interrelational and interpretative dimensions of choice, freedom and responsibility.'*(2007; p.50) This is important in order to understand the phenomena of addiction holistically.

According to Damasio (2006), reasoning and deciding are seen as interchangeably implying that the decider has knowledge about: (a) the situation which calls for a decision, (b) the different options of action, and (c) the consequences of each of those options. He writes about how biological drives and emotions influence decision making, especially in personal and social domains. Feelings connected to the sense of responsibility and about one's particular

situation are what allow an emotional response. Therefore, feelings are a powerful influence on reason which guides decision making (Damasio, 2006 p.245.)

As described in this section, when understood in terms of throwness, choice only becomes possible within the limits of interpretation and attitudes towards one's given context. In the following section, I explore one further theory which aims to combine the idea of voluntary and involuntary behaviour in addiction before addressing the important notions of identity, treatment and choice.

2.6- Addiction as a Motivational Disorder

In his book *Theory of Addiction*, Robert West (2006) looks at different theories of addiction stemming from these two main models and develops a new theory named the '*motivational theory of addiction'*. The main relevant points of his theory will be summarized in this section.

West summarizes the rational choice, or free-will model stating that addiction is a construct serving particular purposes for particular individuals at certain times. As mentioned earlier, this stance argues that individuals take drugs to cope with or ameliorate life's challenges, to avoid stress or simply because they prefer the life of an addict rather than an alternative. By contrast, the disease model explains addiction as a syndrome in which reward-seeking behaviour takes over the user's life.

The theory of motivation, as described in West (2006), seeks to integrate conscious choice processes and non-conscious motivational systems by adding conscious decision-making to classical conditioning and instrumental learning processes. Classical conditioning is the pairing-up of particular associations within the motivational system, so that when there is a

particular *stimulus* a set response is triggered more readily. Similarly, instrumental learning refers to associations underpinning the system *stimulus-response-outcome* (reward or punishment). These are two examples of different associations that are possible between mental activities.

West combines the disease model and the free-will model shifting the focus onto a *'motivational system'* operating within addiction. The motivation to use drugs can underlie individual pathologies or a motivation to cope with problems in one's life. The author states that the human motivational system operates in five levels of complexity and any of these can function abnormally through addiction. He summarizes this system using the acronym PRIME, standing for *plans, responses, impulses, motives and evaluations*. He believes addiction to be a chronic condition of the motivational system affecting the choices we make, but one that cannot be solely understood in terms of those choices. He also considers that we need to look at the whole system. For example, the individual may not consciously choose but feel a strong impulse to do so. West believes that addictive behaviours are under the partial control of operant learning mechanisms which are automatic, not involving conscious choice.

The motivational theory states that in many cases an addicted lifestyle involves choices made by individuals for whom the activity seems attractive; however, it arises from a susceptibility to the drug's effect on the motivational system, setting off a powerful drive (West, 2006 p.192.)

West (2006) criticises the 'free-will' model for implying that addicts are exercising preferences when they are merely responding to urges and compulsions; and the medical model for being misleading in implying addicts are impotent. His premise is that choices

occur when individuals consciously consider alternatives, while addiction is a habitual activity requiring little conscious attention.

While the motivational theory shifts the focus from brain mechanisms to a 'motivational system', it is still an interesting hybrid between the free-will and medical model.

The concept of choice here is described as a learned response to reward-seeking behaviour. It might be useful to keep this theory of motivation in mind in terms of conflicted choices and cost-benefit analysis when looking at addiction holistically.

2.7- Identity and Choice

Choices can be influenced by a number of different factors, as mentioned in West, including one's sense of self. Given the disease model premise that desire is all encompassing in addiction, the concept of the self and how identity influences our motivations is still missing. It is important to have a sense of self and what we want in order for self-control to operate (West, 2006.) The way we see ourselves means that we will act in ways which will either contradict or complement our identity. As previously mentioned, individuals are more likely to fail at recovery if they attribute the failure to control their behaviour to a condition, such as a disease (West, 2006; Jarvinen & Andersen, 2009.)

In investigating a group of problematic drug users in Copenhagen, Jarvinen & Andersen (2009) found that treatment works only when other problems (i.e. social, economic and health related) are vice user's aims for treatment. What is on offer (methadone maintenance and practical help) is in contrast to what interviewees want for treatment. Abstinence was not seen as a realistic goal at the institutions interviewed.

As a result people adapted their identities and behaviours according to institutional definitions. The authors found that how people see themselves is therefore tied to whether or not they feel they have a choice. This depends on whether people conceptualize addiction as a chronic condition or not. While sometimes clients do not want to become drug-free, they were not allowed to choose their own goals and instead were forced to accept a socially defined identity (Jarvinen & Andersen, 2009.)

Similarly, Burrell and Jaffe's (1999) study identified a lack of research investigating meaning in subjective drug experiences. The authors propose that one of the reasons why people use drugs is to construct solutions to problems of meaning. Therefore, people remain active agents in choosing to use drugs for a variety of different reasons.

This is supported by Larkin & Griffiths' (2002) observational study *'Experiences of Addiction and Recovery'*, where through analysing subjective accounts the authors found self and identity issues to be crucial to understanding addiction and recovery. The authors found a complex tangle of self-identity issues and parent-child problems to be common in addictive behaviours. Participants were explicitly concerned with issues of identity, and various childhood experiences were identified as the beginning of their addictions, including isolation, repression, loss, rejection, assuming unrealistic responsibility, frightening unpredictability (often an addicted parent) and abuse. The participants complained of the lack of a 'solid' or independent identity and referred to early experiences as contributing to their addiction problems.

There is a significant lack of research looking at identity, meaning and the problems underlying addictions, even when these have been identified as important.

2.8- The Body and Temporality

In terms of identity, the body has been identified as an important factor in addiction. According to Kemp (2009) those who suffer with drug addiction have a disturbed relationship with their bodies and are not only in states of intoxication. When the body intrudes for the addict, it intrudes as pain. While this theory assumes a mind/body split, Kemp describes how in addiction, the body has a life of its own (Kemp, 2009 p.122-123.) There are different ways of experiencing the body which can be; as a *thing-body*, a scrutinized body and appreciated body amongst others (Kemp, 2009.)

The author suggests for addicts, the body no longer functions in a healthy way and is limited by cravings and withdrawals. The pain of withdrawals draws the body to the here and now in which the immediate goal is to alleviate suffering. There is a loss of the self in pleasure with the 'hit' (self-abandonment), and a loss of self in pain. The objectification of the body in addiction extends throughout the addict's world: possessions are devalued and relationships are neglected (Kemp, 2009.)

According to this premise, we can see that addiction is an attempt to deny or hide the self from the reality of existence. When drugs are introduced the body no longer functions normally. The addict lives an existence of withdrawal from the body, from a meaningful world and from authentic relations with others.

Avoidance of pain dominates in addiction: the body is no longer a 'me' but an alien thing seeking its own ends (Kemp, 2009.) The individual lives a limited temporal existence in which stopping pain and avoiding suffering are the foci. While at the beginning, pleasure was the attraction, when the body is no longer functioning healthily we must explore how freedom is limited. Not only in states of intoxication but also beforehand there is a dissociation of the body as a thing-body. This is an attempt to split the mind and the body.

This argument opens up a new way of looking at how the body is limited in the addict's experience. The avoidance of pain and suffering becomes the goal for the addict. However, the self has embarked upon a life shaped by 'pleasure and pain' due to a number of influences in precedence to this self-abandonment. This unpleasantness or pain is what drives the addict to end the experience through drugs. As seen in Kemp (2009), their temporality is one of impulsivity, involving a future that is lived through the immediate embodiment of their preferred state. Life in addiction then becomes more about 'impulse control' rather than temporal existence. The addicted subject seeks to eliminate the now at all costs where drugs have no future beyond their immediate use. This is therefore an attempt to manipulate how the now is experienced.

In terms of temporality, most addicted subjects live an alienated state of being where the body demands instant relief from the 'now'. This state of being carries a lot of consequences such as impulsiveness, sleep disturbances, pain, social alienation and guilt. Objects are only kept in order to lead to the addictive process. Moreover, some addicts deliberately push towards death as an existential edge. Kemp questions whether addiction is an attempt to acquire meaning or to annihilate an existence without meaning. The author further illustrates how death gives the addict meaning when death is the ultimate limit for Dasein (Heidegger, 1962.) Any orientation to the future implies limits or finitude. The *'fix'* of the addicted subject's state of being becomes a *fix-ed* state of being; an empty now where death can offer meaning.

2.9- From Use to Abuse

There are many reasons given why people use drugs, such as: addicts seems to be a particular 'kind' of person (Biernacki, 1986); they like it and can't find reasons not to (Davies, 2006); as a way to control emotional responses (Rush & Shaw, 1981); and that using drugs is a way to solve problems by deadening oneself - a result of fear of death and an avoidance of existential givens such as freedom and responsibility (Schaler, 2000.) Nevertheless, the current dominant view of addiction as a chronic condition provides people with an identity and predictability (Jarvinen & Andersen, 2009.)

Thomas Szasz (2003) states that 'drug abuse' is only a matter of social convention and laws of persecution (Szasz, 2003 p.9.) He believes heroin use should be removed from the context of punishment.

Szasz (2003) observes that people have always used drugs for a variety of reasons, and in 1914 it was America's prohibition and 'war on drugs' that created the current problem. The problem referred to is our use of language to define drug 'addicts' and 'dope fiends', and society's persecution and punishment of people who use 'illegal' drugs. The 'disease' label and lack of control attributed to drug use helps perpetuate this myth. Szasz elaborates on the current laws for crime and persecution of drug users and states that one reason why people don't scrutinize the meaning of the terms 'addict' and 'addiction' is because it is much easier *'to examine the chemical effects of a drug a person uses than the social effects of a ceremony he performs'*(Szasz, 2003 p.17.)

Szasz (2003) believes labels are given in order to punish and control those labelled, and that the way drug addicts are viewed in society is the result of a hidden socio-political and economic agenda. Dissociation and self-abandonment are encouraged in a society where addicts are not supposed to take responsibility for their actions and yet get punished for them.

Szasz's view shows how the medical model fits into society's view of taking the addict's responsibility away from their actions. This is the only way in which addiction and crime can be perceived and punished together. This argument is seen to limit choices in a society whose primary goal is to punish rather than to understand. It also serves to limit the addict's own understanding of the concept of addiction and attribute their lack of control to circumstances beyond their capacity for change. Sasz (2003) shows how society creates addiction as a phenomena which separates the individual from his from his or her choices.

2.9.1-- Trauma and the Psychodynamic Approach

When looking at the phenomena of addiction holistically, it is important to acknowledge the correlation between trauma and substance misuse. Previous literature has shown how addiction can be used as a means of coping with a traumatic event.

Resick(2001) suggests two different ways of coping with trauma, problem-focused and emotion-focused coping. Whilst problem-focused coping is the effort to recognize, modify and eliminate the impact of a stressor, emotion-focused coping is the effort to regulate the affect from the traumatic exposure (Resick, 2001 p.121.) According to this theory, the traumatized person may edit his/her autobiographical memory in order to reconcile conflicts between events and their belief systems. The author describes chronic processing as the result of an avoidant coping style resulting in negative secondary emotions such as guilt and shame. He suggests substance misuse, anxiety and depression are often by products of chronic processing.

As seen in Etherington, human beings are social beings and drug use is often a social activity where the drug user is looking for affiliation and identification with a group. She discusses

Winnicott's (1960) theory on how the lack of a secure home-base means the child equates dependency with pain, disappointment and betrayal and tends to become overly self-reliant (Etherington, 2008 p.43.) On the other hand, for social support this may lead to the inclusion in gangs and the drug subculture isolating the drug user from 'normal life' (2008, p.185.) Moreover, people seek drugs as a means of coping with adverse life circumstances such as traumatic events. The trauma creates a sense of discontinuity which in turn originates a chaotic sense of self and disconnection (Etherington, 2008.) Other studies looking at recovery in female heroin users (Watson & Parke, 2011) showed an experience of 'lost childhood' reported by the interviewees and a tendency to resort to truancy as a means of coping with feeling ostracized and regaining control over one's environment. Watson & Parke (2011) state that drugs gave the interviewees meaning where realities of change, separation, ambiguity and loss of a parent were found to be influencing factors in the decision to use drugs. Therefore 'normality' becomes an abstract concept where drugs are a powerful antidote to feelings of guilt and depression found to be symptomatic in female drug users (Watson & Parke, 2011.)

In terms of the psychodynamic view on the subject, Freud's (1896) theory on the intra-psychic conflict as described in *'The Aetiology of Hysteria'* suggests that emotions are repressed as a result of the traumatic memory's threat to the ego. Freud looked particularly at sexual abuse and how traumatic memories can be dissociated from consciousness because they cannot be integrated into existing mental schemes. However, because the person cannot integrate the traumatic experience into their conscious awareness, they become attached to the trauma and cannot assimilate new experiences either.

From a psychodynamic perspective, addiction is characterised according to the drive theory as an inability to deal with frustration and a demand for immediate satisfaction (Loose, 2002.) It states that the effect of drugs is immediate and central. Addiction provides a kind of

satisfaction that by-passes the erotogenic zones. Drugs also give people a sense of magical oneness with the world which is temporary once the sense of guilt and depression returns. Therefore the addict will search again for the pharmacogenic pleasure effect in order to get back to the state of elation.

From this perspective, drugs and alcohol become a form of management by substitution or self-medication. In order to explore a different stance, the next section elaborates on the medical model's stance towards recovery.

2.9.2- Once an Addict, Always an Addict?

When addiction is seen as a 'chronic relapsing disorder' (Sellman, 2010), this fails to address the fact that people can in some cases recover spontaneously without treatment (Scherbaum & Specka, 2008.)

One of the reasons attributed for lack of control in the medical model is that the 'decision making' process is initiated and acted upon by primitive regions of the brain (Sellman, 2010) leaving the addict with no control before he makes the decision to use. This is based primarily on findings from animal and brain imaging studies.

Studies have showed that some heroin users overcome their addiction and recover on their own. Biernacki (1986) conducted a sociological study of self-recovering heroin users and concluded that attribution to natural recovery comes from rearranging one's identity so that the 'addict identity' becomes de-emphasized. He observed that if the addict is believed to be 'sick' then some form of treatment (voluntary or involuntary) is prescribed. The belief 'once an addict, always an addict' does not account for those who have successfully recovered from their addictions, but portrays people who went to treatment involuntarily and relapsed. In his

observation, the principal factor in maintaining addiction is immersion in a drugs-world which jeopardizes other identities (Biernacki, 1986.) According to his analysis, people stop using drugs when the consequences of their drug use become too undesirable in terms of their view of themselves and their future goals. The view that all addicts need help is contradicted by studies showing that addicts in detox treatment and therapeutic communities had more psychological and social problems than methadone treated and untreated subjects (Scherbaum & Specka, 2008.) There could be many reasons why addicts who were not seeking or had not received treatment reported fewer psychological, social and drug use problems than those in treatment. Sometimes people enter treatment for reasons including pressure from others, rather than self-volition (Scherbaum & Specka, 2008.)

From interviews of ex-addicts who recovered without treatment, Biernacki (1986) describes two main phenomena behind the decision to stop: hitting rock bottom and experiencing an existential crisis. Whilst Biernacki elaborates on these two at length, briefly he states that rock bottom is a subjective experience in which one may report feelings of humiliation and where the addict's life becomes intolerable. Secondly, an existential crisis is a more profound emotional and psychological state of self-questioning (Biernacki, 1986 p.53.) He alludes to 'burnout' and getting sick of the addict's lifestyle as another reason for quitting.

In his book, he explores different models of maintaining successful abstinence from heroin and concludes that the view of 'once an addict, always an addict' is maintained by those who try to abstain and fail, and those who witness this. Those who stayed abstinent did so via an 'identity transformation', which is a literal or symbolic move from the drug world. Drug users also maintain memberships in a variety of different worlds, whereas some identities are stable (i.e. parent, sibling) others (i.e. student, thief) are more flexible (Biernacki, 1986 p.22.) By moving away from the addict social world, a more stable non-addict identity can develop. In relating his participants' background and interviews, Biernacki shows that recovery from

opiate addiction can be achieved naturally. Some of his participants who had been addicted to heroin for 11 years chose to stop and stay abstinent for long periods of time, such as 12 years. Consequently his findings question the view 'once an addict, always an addict' and contradict neurobiological findings of addiction as a chronic relapsing disease.

According to Larkin (2002), whilst biological factors are not genetically 'fixed', in order to look at the addiction problem it is important to understand one's consistent, conscious and embodied place in the world. Some people are more likely to become addicted under some conditions, and given the right conditions perhaps most people could develop an addiction. Just like the concept of addiction, the concept of 'drug' is entirely socially constructed; a drug is understood as a drug only through the context of one's ingestion and use. Most substances are not addictive per se but people can still become addicted to them. If the property of substances are not intrinsically addictive and individuals are not destined to be addicted, in order to understand these issues it is worth soliciting and exploring how addicts seek to understand and interpret their experiences. There may be a continuum in levels of involvement in addiction. In order to shed light on the concept of addiction as a construct with strong negative experiential valence, it is important to explore addicts' experiences of such phenomenon (Larkin, 2002 p.75.)

2.9.3- Treatment and Choice

In *'The Making of the Chronic Addict'* Jarvinen and Andersen (2009) found that the expectation from staff was that participants would never become drug-free. The medical system defines addiction as an incurable disease which contradicts users' expectations of 'cure'. This gave the participants an institutionalized approved identity (the chronic addict

that is not blamed), practical help and methadone maintenance. The right to become drug-free was unacknowledged as opposed to the participants' will to do so.

According to *attributional theories* (Davies, 2000), addiction is a functional form of explanation in a given context. The fact that addicts present differently when interviewed by a 'straight' researcher as opposed to a known drug-user shows that they construct realities. To the straight researcher the amount used is maximized while responsibilities are minimized. On the other hand, with a former drug user the opposite occurs. Whilst the 'straight' interviewer is presented with the 'junkie stereotype', the known drug user was presented with a much less extreme picture. This indicates that both pictures are acts of construction taking into account how the participants perceived the interviewer and the type of information required (Davies, 2000 p.87-88.) While we cannot infer that people are in control of their drug use simply because they report to be, these findings show a functional bias in addiction. People see advantages in one explanation over another as they determine moral inferences and the verdict of audiences. These contextual variations also remove personal responsibility when crime and punishment are at play. The author concludes that addiction is a preferred style of explanation whose primary purpose is functional (Davies, 2000 p.164.) It is functional as it removes blame and responsibility in a society promoting moral censure, where using drugs is a crime. Yet it is also dysfunctional because it reduces the likelihood of competent use.

Concerning the 12-Step Approach, the idea promoted that people are powerless to control their behaviour means the client must invest in a higher power to assist them. Paradoxically, according to Davies (2000) they cease to be helpless because a belief in a higher power changes their internal motivation. A belief in God and a belief in the disease model both require an external locus of control (Davies, 2000 p.126.) As seen, self-efficacy, or the idea

about what people are capable of achieving will be affected by how they see themselves (West, 2006) and the degree of control they perceive they have over a given behaviour.

If addicts are seen as people driven by forces beyond their control, treatment designs are futile and this serves to alienate them from their own free-will. This is because human action can be explained in countless ways, and by choosing one explanation over another the client exercises a degree of control over the inferences others make of his/her actions (Davies, 2000.)

As previously noted, in terms of the experiential locus of the self, addictions are seen as non-volitional activities. The cost-benefit of engaging in addiction may not always consist of a rational decision. Volition and decision making, as well as the issue of agency and free will, form a complex relationship in the field of addiction studies. Addiction can be a mood modification activity with negative consequences and yet serve to disinhibit certain forms of behaviour, such as aggression and sexuality. It can also maintain emotional distances where required. Being an 'addict' may provide the person with a like-minded peer group, a purpose in life, an identity, create meaning and reduce complex decision making (Larkin, 2002.) Hence we must look at drug misuse as being interwoven with other issues embedded in a social and political context where the individual's experiences and understanding of choice is most important. The concept of addiction as being a continuum in levels of involvement and behaviour might be a more useful concept where the relation between addiction and choice is a complex one (Larkin, 2002.)

2.9.4- Argument for the Current Study

As stated in Davies (2000) and Kalant (2010), there is not one single 'truth' in addiction. An analysis of the current literature will show that the nature and consequences of drug use cannot be separated from the contexts in which it presents. Neurobiologists agree that the interactive system in addiction is a combination of the drug, user, environment and circumstances (Kalant, 2010.) Therefore, the consequences of these will vary depending on the circumstances surrounding the user. This emphasis on the interaction of meaning, environment and substance is supported by the free-will model. Neurobiology studies are slowly moving towards a more holistic view and letting go of the attempt to find one specific cause or genetic component.

As illustrated, if users' identities are tied up with the medical model (i.e. being an addict) this creates a self-fulfilling prophecy and decreases their motivation as they feel they have no choice. A cost-benefit analysis will reveal that this particular meaning, when attributed to their behaviour, will serve them better as it fits society's addiction system: the label frees them from responsibility yet limits other choices. Reminding clients they are making choices will enable them to review how their choices fit with their personal values and goals (Wurm, 2003.) However, the medical model takes away responsibility, freedom and choice (Wurm, 1997.) By contrast, the existential approach looks at clarification of meaning, and the concept of *'self-construct'*, which explores how people gather a set of beliefs and aspirations about who they are (Spinelli & Strasser, 1997; DuPlock & Fischer, 2004.)

Even if a decision seems to be self-destructive, it will make sense and have benefits for the individual undertaking it (Yalom, 1880.) Taking a drug, for instance will never be a psychologically neutral event but it will always depend on context.

The nature and consequences of drug use cannot be separated from its context (Davies, 2006; Kalant, 2010.) The idea that pharmacological substances makes people into *helpless addicts* needs to be contrasted against the idea that people use drugs because they want to (Davies, 2006.) By looking at the meaning of addiction in people's lives, we need to address the fact that the way addiction is conceptualized will affect self-efficacy (West, 2006) and choice. As seen in the literature review, the question of whether addiction is a disease or not is important because the answer reflects philosophical understandings about the nature of human beings, agency and moral responsibility (Kwee, 2007 p.225.) This brings us to the outline of this study's aims.

2.9.5- Aims

The study makes an existential-phenomenological investigation into the concept of choice in heroin addiction. As elaborated in the existing literature, addiction is seen as a 'problem in living' rather than a disease apart from other 'life difficulties'. This study has three general aims. The first is to respond to the need identified by previous papers and examine addicts' viewpoints and world-views in general. The second is to address this area, previously subjected to a scientific bias (Wurm, 2003), from an existential-phenomenological viewpoint in an effort to demystify the phenomenon of heroin addiction, clarifying its meaning from the participants' vantage point. Lastly, it contributes to the field of clinical practice and ways of working with addiction by obtaining an in-depth understanding of choice in drug addiction.

This research is a phenomenological study which will remain open to what emerges. As seen in Gadamer (1965) it seeks the experience of truth that transcends the domain of scientific method.

Chapter 3- Method and Procedure

3.1- Research Design and Rationale

> *'We find ourselves always in a world that gives meaning to our intentional acts' (Faulconer,* 2005.)

How do people experience choice in addiction and recovery? This study initially focused on how people make choice in addiction, and the process of choice in becoming dependent on heroin. However, as the research process unfolded in exploring choice, I realised there was also an important theme coming out about choice in recovery and therefore the focus of my research started to change and it became two folded.

Although the research questions were designed to focus on the experience of choice in addiction, some questions such as *'how would you describe your relationship with this drug now?'* and '*what brought you here? '*opened up the importance of choice in recovery as well as in the process of becoming drug-dependent.

The aim was to explore the themes in addiction considered to be important from previous literature by Schaler (2000), West (2006), Davies (2000) et al. which outlined the relevance of social responsibility, meaning and choice from an existential phenomenological stance.

From the first interview where the participant described how important her recovery was, I realised how choice seemed to be a very important topic in recovery if not more so. All participants addressed this topic when they described how they experienced choice in the present time and the process it took in order for them to feel they had choices. Recovery became a very prominent issue. In order to look at the broader picture questions such as *'Do you feel you have a choice in heroin addiction?' and 'do you chose it?*', *'do you chose*

it, do you enjoy it, is it a sheer physical addiction?' got participants reflecting on the past as well as the present and how addiction had changed them. This was an unintentional by-product of the research design as the questions list was the same for each participant interviewed.

The themes that came out of an exploration of choice were important themes talking about recovery. This illustrates another paradox in addiction, where choice in addiction is also choice in recovery. As I followed each participant by the means of a dialogue in semi-structured phenomenological interviews, I became aware that choice was also a theme in recovery and this became very interesting and prominent theme and therefore widened out the focus of my research. For example, the question; '*what is your view on the fact that heroin use in general is seen as a purely physical condition?'* would produce very different answers depending on whether the participant was focusing on the past or the present.

Even though I set out to investigate the phenomena of choice in heroin addiction broadly, my process changed as I learnt this topic could not be divorced from treatment and recovery. According to the participant's description choice was more important in recovery than in past instances where this was not thought of in the same manner, or given the same meaning. The meaning choice had for participants is very different than the meaning it elicited in their recovery. The interviews took place in treatment centres and perhaps recovery was at the forefront of all participants' minds. The interviews then allowed for an opportunity to tease out this multifaceted concept of choice in addiction and recovery. The importance of choice in recovery came as a shift in focus of the study's initial question.

The research question focuses on the experience of choice in heroin addiction. This research question has changed during the research process in order to include the experience of choice in recovery as participants addressed this topic during interviews. At

the same time, the participants were not specifically asked about recovery. The interview schedule was developed following the literature review and it focuses on what was going on in participants' lives when they started using drugs and what attracted each of them to heroin.

The interview questions were semi-structured and developed in accordance with my original focus. These questions used Emmy Van_Deurzen's (2005) four worlds of existence in order to offer a framework from which the participant's experience would be mapped out and understood. Thus, the prompts were designed to in order to address addiction holistically, questioning on a feelings level, on a physical and meanings level.

This semi-structured interview schedule was developed in collaboration with a previous academic supervisor investigating the phenomena around what was happening in the context of a person's decision to use a drug, how they noticed they had become drug dependent and how they have decided to stop using heroin. Whereas this was not an exhaustive list it aimed to engage the participants in a process of reflection concerning how and why they have arrived at a place where they became dependent on drugs and what meanings they attributed to their lived experience. This is due to the fact the literature review highlighted how people tend to use drugs to cope with adverse circumstances in their lives. Also, drugs become a maladaptive coping strategy only when entwined with other problems of living. (Schaler, 2000) The interview schedule was developed aiming to elicit whether drugs were sought as either as a recreational activity or for other means and whether this changed throughout the participant's lives. The intention behind the drug use was the interview focus as well as how drugs turned from a recreational activity to an activity where participants seemed to lose conscious control. The research question aims to investigate and elicit how and why drugs seemed to have taken over a person's life.

In summary, this study explores the nature of choice in heroin addiction and recovery by means of a detailed investigation of the experiences of participants who struggled with this dependency in the past. This focus on detailed experienced called for a method who explored *idiographic* experience as its primary analytic focus. This section expands on how the method of choice was felt to be the most appropriate in answering this study's research question.

Madill et al., suggest three different epistemological positions within qualitative methods research and ways in which objectivity and reliability can be demonstrated across these different positions. In addressing research from a realist, contextualised constructionist and radical constructionist epistemological position, each criteria of objectivity and reliability is appropriate in this context only to the extent that it is conducted within a naive or scientific realist framework (2000, p.17.) A brief summary of each epistemological position is mentioned before this study's epistemology is contextualised within a critical realist perspective. Traditional methods of investigation in psychology have emphasised objectivity, however this method has been questioned as an appropriate method of investigation for human sciences. Qualitative research is not a homogenous field comprising of a number of epistemological positions and many different methods of analysis. As previously mentioned, the three broad epistemological strands are: realist, contextual constructionist and radical constructionist which can be equated with the paradigms of natural science, human science and post-structuralism (Madill et al., 2000 p.2.) There are three realist epistemologies distinguished as naive, scientific and critical. Where naive realism sees a correspondence between theory of truth where the world is largely knowable; scientific realism asserts that the scientific method can be a true representation of the world and critical realism sees an inherent subjectivity in the production of knowledge (Madill et al., 2000 p.3.) Moreover, from a naive or scientific realist epistemology, differences in analytic style are seen as

introducing biases into the research where constructionist research aims to explain not predict (Madill et al., 2000 p.14.)

3.1.1. - A Qualitative Approach

The difference between quantitative and qualitative research methods lies in how these methods view and define science. Quantitative research methods assume a causal relationship in the world, grounded within the natural science paradigm. The 'natural science' or positivist paradigm states that objective knowledge can be gained through direct experience or observation of the world: if science is done properly, it is an objective and facts based process. According to the positivist paradigm, the purpose of science is to create explanations between cause and effect (Forrester, 2010.)

On the contrary, qualitative researchers do not view knowledge as resting upon objective facts; qualitative research is concerned with meaning and experience. In quantitative research, the researcher enters the process with a preliminary way of seeking, whereas in qualitative research methods, research is seen as a process where understanding something is different from knowing something. (Holroyd, 2008.)

In qualitative research methods, the researcher is always interacting with what is being observed. Here our assumption is that our understanding of the world is known and mediated through our experiences. This method does not work with variables between cause and effect. Moreover, underpinning these methodologies is the notion that human beings are situated in a historical, social and cultural context (Faulconer, 2005) as opposed to being mere observers of objective knowledge.

Furthermore, a pluralistic ethos is central to the non-realist philosophical tradition that underpins most qualitative research (Yardley, 2000 p.217.)

As seen in Langridge (2007), qualitative methods are concerned with the naturalistic description or interpretation of phenomena in terms of the meanings these have for the people experiencing them. The phenomenological attitude is understood as a process of retaining openness to the world while identifying and restraining pre-understandings. Phenomenology is described as the first method of knowledge (Moustakas, 1994.) It aims at gaining a deeper understanding of the 'life-world' (Van Manen, 1990.) This approach interrogates the objective view of sciences, valuing experiential understanding and the importance of meaning in human experiences (Moran, 2000.) The aim is to understand and represent the experiences of people as they actively engage in their lives (Elliott et al., 1999.) This philosophy is committed to descriptions of experiences and is rooted in questions that give direction and focus to meaning; where subject and object are not separate but interrelated. The data of experience is regarded as primary evidence in scientific investigation (Moustakas, 1994.)

In order to study experience and how the world appears to people, phenomenological psychology employs a set of methods to elicit rich descriptions of experience and illuminate the lived world of the participant (Langridge, 2007 p.5.)

As defined by Finlay (2008), past knowledge is used in order to allow the researcher to be more open and questioning of the research encounter. In this particular critical realist epistemological position, researchers must be prepared to challenge what they already know and understand that what they will achieve depends on the point of view of all participants involved in the interaction (Holroyd, 2008.) Phenomenology focuses on the appearance of things; it is committed to descriptions of experiences, not explanations or analyses (Moustakas, 1994.)

While the positivist approach might be relevant in some scientific disciplines, it is not relevant when the subject of study is the nature of subjective material and access to meaning (Forrester, 2010.) This is because the way human beings interpret and use personal beliefs, values, attitudes and experiences impact on this process. This makes it impossible to gain truly objective knowledge of what is being observed. Human phenomena are not objects to be construed based on pre-existing models of science; human life is fluid, relational and embedded into a context (Holroyd, 2008.) Thus, the phenomenological approach recognizes the role of the researcher in the co-construction of the topic under investigation and is built on an understanding of the way in which all experience must be understood in context (Langridge, 2007.)

Qualitative research methods are relevant to this particular research topic because it is concerned with meaning, the quality of experience and how people make sense of their world. The study's objective is to describe and explain events and experience (Willig, 2008 p.9), looking at participants' subjective meanings and lived experiences in relation to the subject of choice. This is suitable because phenomenology's aim is to describe and interpret people's perception of the world and examine how these are related (Moustakas, 1994.) As seen in Langridge (2007), the aim is to elicit a rich description of experience so we can understand it in new subtle ways and use this new knowledge to make a difference to the world for ourselves and others.

Moreover, as seen in Van Manen (1990) it is possible to make a distinction in human science research between phenomenology (as pure description of lived experience) and hermeneutics (as interpretation of experience via text). This argument will be further developed in the next section of this research methodology.

3.1.2- Epistemological Positions in Research

Edmund Husserl, the founder of phenomenology, believed that in order to understand how the world presents itself, the understanding of experience is key (Forrester, 2010.) Husserl's transcendental phenomenology aims to return to the things themselves by bracketing what we already know about them. Husserl applies phenomenological reduction in order to bracket past knowledge about a phenomena encountered and be fully present to it.

The phenomenological stance recognizes the role of consciousness in the totality of human experience. Consciousness is always intentional and relational to an object outside the self (Giorgi, 1997.) The phenomenological attitude attempts to eliminate prejudgment and presupposition by being with 'things themselves' (Moustakas, 1994 p.41.) It is a suspension of the natural attitude. This broadens the view of science and the scope of philosophy to include captured human existence (Moran, 2000.)

Martin Heidegger (1966), who was Husserl's student, developed his hermeneutic phenomenology from this model. Hermeneutic consciousness exists when openness to restructuring or reversing the pre-existing knowledge of phenomena is retained by the researcher (Holroyd, 2008.) Heidegger abandoned the terms 'consciousness' and 'intentionality' which were central to Husserl's philosophy (Moran, 2000.) The difference lies in the fact that interpretation is embraced as an integral part of phenomenological analysis. This tradition does not separate description and interpretation, instead stating that all description constitutes a form of interpretation. This research will draw on the epistemological phenomenological traditions of Heidegger in exploring how meaning is created through interpretation (Yardley, 2000.) The researcher acknowledges that *epoche* is not always possible (Langridge, 2007 p.18), and yet aims to bracket as much as possible in order to be open to the phenomenon being investigated.

As described in Langridge, the phenomenological paradigm focuses on the first person account of experience recognizing the need to account for the influence of the researcher on the data collection and analytical process. This is because perception changes according to context.

In line with the hermeneutic tradition, Gadamer's (1975) philosophy explores the role of language and the relationship between language and understanding where 'understanding is already interpretation because it creates the hermeneutic horizon within which the meaning of a text comes into force' (Gadamer, 1975 p.397.) He makes a distinction between two forms of interpretation: interpretation in its original meaning can be *pointing to* something; and it can also be *pointing out* the meaning of something (Van Manen, 1990 p.26.)

Gadamer's sense of interpretation is closely linked to Husserl's and Heidegger's notion of phenomenological description (Van Manen, 1990.) He accepts Heidegger's view that human beings are primarily engaged in meaning making activities. He explains the hermeneutic circle of how we are thrown into a projected world where all possibilities of action are projected onto interpretation (Moran, 2000.) According to Gadamer, language precedes and encompasses human experience. His philosophy of how language is our mode of being in the world, which is limited by culture and value systems. Moreover, Merleau Ponty's philosophy of embodiment is worth a brief mention in terms of post-Husserlian phenomenology. Merleau Ponty argues that we cannot separate our existence and our embodiment. We cannot separate the world from our experience of the world. He elaborates on how the body is another means of disclosing limitation and possibilities to our perception (Moran, 2000.)

The researcher's particular epistemological position is situated in Heidegger's philosophy which aims to explore how meanings are created through interpretation (Yardley, 2000.) This epistemological position fits into the particular philosophical underpinnings of IPA in

understanding research as a double-hermeneutic process. Therefore, Interpretative Phenomenological Analysis has been chosen as the method most suitable to answer the research question. The suitability of this method to answer the study's question is analysed in the following section.

3.1.3- Interpretative Phenomenological Analysis

Following from Heidegger's hermeneutic phenomenology, Interpretative Phenomenological Analysis (IPA) subscribes to the view that it is impossible to gain direct access to the participant's life-world.

Phenomenological psychology seeks to study experience and how the world appears to people (Langridge, 2007 p.7.) The aim is to capture the quality and texture of this experience, even when it cannot be directly accessed by the researcher (Willig, 2008.) The goal of IPA is a detailed exploration of a participant's view of the topic under investigation, aiming to gather information about the experience of a fairly specific group (Langridge, 2007 p.110.) IPA is an *idiographic* method of analysis, which is conducted at the individual level and makes claims about the individuals studied rather than a *nomothetic* approach which looks at population levels (Forrester, 2010.)

The aim is to select participants in order to illuminate the topic under investigation. It allows the researcher to explore subjective experiences and helps us to describe and understand participants' accounts of the processes by which they make sense of their world. As seen in Langridge: 'all human life is embedded in a particular history and culture that shapes life in the most profound way' (Langridge, 2007 p.154.)

The focus of this approach is on how participants interpret their experiences in ways that make sense to them. This method acknowledges the researcher's centrality to the analysis and research, where research is a dynamic process (Brocki & Wearden, 2006.)

3.1.4- Epistemological Underpinnings of IPA

Both transcendental and hermeneutic phenomenology rely on participants' descriptions of their experience; the difference is that whilst transcendental phenomenology attempts to bracket and abstract knowledge about a phenomena in order to better understand its essence, IPA aims to capture the experience and meanings associated (Willig, 2008.) This analysis allows for new meanings to emerge from the data rather than applying pre-understandings to meaning (Finlay, 2008.) Knowledge is seen as a co-created experience whereas 'phenomenological research is concerned with how the world presents itself to people as they engage with it in a particular context and with particular intentions' (Willig, 2008 p.68.)

The focus here is not on why experiences take place or why there may be differences between them, but to describe and document the lived experiences of the participants. IPA has been chosen as the method most appropriate to answer the research question because of its focus on the meanings people attribute to their experience, which is what this study explores. Moreover, as a *critical realist* method it assumes that reality cannot be directly experienced. This method looks at how our access to reality is through a person's understanding of their experiences at a particular time in their historical, socio-cultural and political context (Forrester, 2010.) Therefore IPA does not share the positivist view that the external world determines our perception of it (Willig, 2008.) In exploring individuals' subjective reports rather than objective accounts, IPA helps to describe and understand participants' account of the processes by which they make sense of those experiences (Brocki & Wearden, 2006.) As previously mentioned, this approach acknowledges the researcher's role in this process

making it a *double hermeneutic* process; where the researcher is interpreting the participant's interpretation of their experiences (Forrester, 2010.)

3.1.4- Rationale for the choice of IPA (why not a different qualitative method?)

IPA advocates flexibility (Brocki & Wearden, 2006), it is not committed to making claims about larger populations but to the analysis of a small number of cases. It focuses on how people perceive experiences and their life-worlds in terms of what these experiences mean for them (Langridge, 2007 p.107.) Other qualitative methods considered for this study do not have this flexibility in terms of data collection analytic method. IPA deals with each individual data set exclusively before moving onto the next. This differs from other qualitative methods such as grounded theory and discourse analysis which look at the complete data set from the start, identifying categories and discourses across the sample (Forrester, 2010.)

Grounded theory was developed to offer social researchers a clear, systematic and sequential guide to qualitative fieldwork by setting out a theoretical-level account of particular phenomena (Smith & Flowers, 2009 p.201.) As seen in Smith & Flowers (2009), it is a very specific approach to sampling and the topic does not need to be psychological. In grounded theory, by using theoretical sampling, the aim is to collect data until no new themes emerge, therefore it often requires sampling on a large scale. This method does not attempt to separate data collection from the analysis and these two aspects of research are integrated in grounded theory (Langridge, 2004 p.294.) In comparison to grounded theory, IPA is more suitable for understanding personal experience as opposed to social processes. Grounded theory is more suitable for qualitative research where the focus is not primarily psychological and looks for a high-level conceptual account (Smith & Flowers, 2009 p.44.) Therefore, grounded theory is

a method closely affiliated with causation-type research as the aim is to develop a theory. On the other hand, this study is more concerned with experiences and does not aim to infer causation or concepts.

According to Smith & Flowers, this means that a grounded theory study looks at understanding a topic based on a large sample from a conceptual explanatory level, whilst IPA is concerned with microanalysis and the details of individual experiences. Furthermore, IPA allows for more creativity and freedom in its methodology by not following rigid set of guidelines (Brocki & Wearden, 2006.) Hence opportunities for interpretative analysis, contextualised in participants' reflections, make it possible to link the findings to the relevant psychological literature (Shinebourne, 2011.)

Discourse Analysis for example, focuses on how talk and text construct particular versions of reality. It focuses on what discourse is doing and analyses in detail what is said (Forrester, 2010 p.138.) Although there are various discursive approaches, their primary interest is in the power of interaction and they share a basis with social constructionism, where discourse (Foulcouldian approach) is understood as a body of knowledge. This approach explores the constructive functions of language and practices. As mentioned in Smith & Flowers (2009), this approach is more suited if the topic of analysis is aiming for a deconstructive critique, and the research is focused on language in specific contexts. On the other hand, Conversation Analysis is more appropriate to analysing structures in conversations. This is because narrative researchers are interested in the content or structures of people's stories about events (Smith & Flowers, 2009 p.44.) Grounded theory can be applied within a realist or contextualist framework, developed by Glasser & Strauss (1967) as a radical, discovery orientated alternative to quantitative methods as an alternative to the limitation of the latter to capture lived experiences (Madill et al., 2000 p.3.) Whilst grounded theory is an approach ideally placed to bridge positive and interpretative methods which sits more comfortably

within a contextualised framework, (Madill et al., 2000) IPA conveys a more interpretative analytic style.

Finally, IPA is concerned with examining convergence and divergence in smaller samples while grounded theory seeks to establish claims for the broader population. In order to meet the study's objectives to gain insight into individual participants' life-worlds, IPA was found to be the most suitable qualitative method. The goal is to look at individual cases and elicit a rich description of experience rather than to make claims about large populations. As seen in Shinebourne (2011), 'the idiographic commitment of IPA moves across similarities and differences across cases to produce detailed accounts of patterns of meaning and reflections on shared experience'. This idiographic focus is the key feature of this approach (Shinebourne, 2011.) This is the main reasons why IPA was chosen as the best method to investigate this particular research topic. Given the focus on the participant's lives and experiences, IPA is the method most suited to answering the research question as it does not seek to build theories between populations, offer causation or analyse discourse. The focus is on how the participants conceptualised their experiences of choice in heroin addiction and how they interpreted the phenomena of addiction in their lives.

3.1.5- Criticisms of Interpretative Phenomenological Analysis

This section addresses briefly the main criticisms and limitations of the methodology of choice for this research. As previously mentioned, knowledge does not exist subjectively and this method is concerned with varieties and validity of our knowledge of different world aspects (Langridge, 2004 p.250.) Yet, one of IPA's main criticisms is that it is too descriptive. However, as seen in Langridge (2007): 'all description is interpretative there is no way of arriving at something that is purely descriptive'. (p.158)

Furthermore, Giorgi (2010) criticised IPA for being inconsistent with phenomenological scientific research criteria and not being 'scientifically sound'. He stated: 'the originators of IPA have given no indication as to how their method is related to the method of philosophical phenomenology' (Giorgi, 2010 p.6.)

According to Giorgi, all methods in science need to be intersubjective. He believes that because IPA is not rigid it deviates from what it is prescribing and it becomes unscientific. Smith (2010) responds to this by reiterating that IPA is concerned with participants lived experience 'because it considers that experience is only accessible through a process of interpretation on the part of both participant and researcher' (Smith, 2010 p.186.) In terms of IPA's underlying philosophy and lack of rigour, Smith refers to this approach's phenomenological and hermeneutic underpinnings, and its qualitative research protocols. He explains: 'Doing good IPA requires the development of some complex skills - interviewing, analysis, interpretation, writing and researchers at different stages will have different degrees of fluency and adeptness at these skills'. (Smith, 2010 p.188.)

Furthermore, while IPA has been criticised for lacking a sound theoretical basis, Shinebourne (2011) has shown how this method is congruent with the existential-phenomenological paradigm, aligning with Husserl's 'phenomenological attitude' and Heidegger's philosophy. IPA sees the person as embedded in the world, looking at meanings expressed in language. This is in line with Heidegger's approach of unveiling what is.

Lastly, Giorgi's criticism in regards to the lack of replicability in IPA's studies seems at odds with how research is conducted in human sciences generally. As addressed in Smith (2010): 'Qualitative research is a complex, interactive, dynamic process and it is not clear exactly what one would be expecting to replicate' (Smith, 2010 p.189.) Therefore, in response to Giorgi's criticism, Smith explains the balance between structure and flexibility required to

conduct a good IPA study. The ways in which IPA is consistent with its philosophical underpinnings and employs several levels of interpretation has been addressed in detail by Shinebourne (2011) and Smith (2010.) Finally, the evaluation criterion for qualitative research is different to how quantitative studies are evaluated. This will be explained and addressed in the following section of this study addressing each point to this study's objectives.

3.2 - Ethical Considerations

The study was granted ethical clearance by the New School of Psychotherapy and Counselling / Middlesex University Ethics Committee (see Appendix V). The British Psychological Society Ethics Standards for Research with Human Participants (British Psychological Society, 2009) was used as a guideline where addicts are considered a vulnerable group. The participants were interviewed at the Centre where the accessed support voluntarily for addiction issues. In terms of psychological implications, all participants were informed of their right to withdraw at any point during the interview and that should they become distressed as a result of the interview process the interviews would be interrupted. The participants had access to their allocated key-worker at the Centre should they wish to discuss any emotional issue that arose during the interview process.

Each participant was made fully aware of the nature and purpose of the study and held a copy of the study's information sheet should they wish to ask any questions at any point during their participation. After clarifying any questions they may have, and informing the participants that there were no right or wrong answers, and no deception involved in the study's objectives, the participants signed an informed consent sheet. (See Appendix IV) The participants were fully aware of the study's objectives and assured that the focus was on their

experiences. Also, the participants were informed about the confidentiality agreement and had the researcher's contact details if they wanted to withdraw their participation at any point free of consequences. (See Appendix III) One participant chose not to disclose information pertaining to previous criminal activity; this is explored further on the researcher's reflections. All participants were given a pseudonym and all identifiable information was removed from their transcripts in order to ensure confidentiality.

The participants were then debriefed after the interview following the BPS's Ethics and Standards for Research with Human Participants. In debriefing, participants were asked how their experience of participating in the research had been, were allowed to ask any questions for clarification, and were once again informed of the objectives of the research and that their participation could be withdrawn at any time without consequences.

3.2.1- Recruitment

Recruitment for this research was done in a number of ways. Several organizations were approached in order to elicit their support and participation. After receiving permission to recruit from the managers of three different organisations, the participants were recruited via posters (see Appendix 2) displayed at drug treatment agencies and by word of mouth from other participants as well as professionals from the drug treatment services who agreed to take part. No participants were recruited at the first and second organisations approached. This could be for several reasons: perhaps the posters were not noticed or visible. With the second organisation, a general counselling service, the participants meeting the criteria were not identifiable as the service had stopped advertising for addiction counselling therefore no participants were recruited from this organization.

Upon the meeting at one service, a worker suggested the incentive and stated that if an incentive was offered this would help participants feel valued for their time. This was discussed with the supervisor and it was only after this incentive was offered that participants started to come forward willing to take part. After offering a token for participation, three participants were recruited at Centre A and four participants were recruited at Centre B. The researcher applied for further ethical clearance to recruit from the fourth service approached (Centre B) and this clearance was granted to approach the organization. Participants expressed an interest in taking part to a staff member and interviews were arranged by key-workers and staff members at a time when participants were at the centre for other purposes such as counselling, group work and key-working. If the recruitment was mediated by staff, the participant was made aware that participation was entirely voluntary and separate from their programme. There was no consequence to their programme whether they chose to take part or not.

The participants were each given a ten pound Marks and Spencer shopping voucher as a token of thanks for their time. The participant who suggested this incentive described; '*people want to be given something for their time, to know they are worth something*.' This reflects a two-fold process in addiction. Firstly, the treatments structure shows how the participants expect to get something in return for showing up to the service (ex; key-working, counselling, housing, needles, script). Secondly, this also reflects more broadly the nature of addiction where a person becomes used to an instant reward or gratification following the ritual of obtaining and using drugs. The impact for the research is that it possibly created an equalization of the power in the dynamic of the research process where the participants regained control and were rewarded for sharing their experiences. Most clients were encouraged by their keyworkers to attend and were forthcoming on how the incentive was the only reason they chose to share their experiences with the researcher. Only one client refused

to take the token, saying sharing his experience was the only thing he wanted out of the research process. The client who refused the token was new in the treatment service and the researcher felt he found it beneficial to be seen and heard, as perhaps he did not have as many opportunities for one to one counselling as the other participants. The incentive is seen to highlight a need in the participants to feel valued for their input and in society in general as well as to establish a more equal relationship with the researcher. The researcher believes the participants would be less inclined to participate if they weren't being rewarded for sharing their experiences. Most importantly, given the token, some participants could have possibly felt pressured to please the researcher and perhaps say what they thought they researcher wanted to hear. This was reflected on a participant's comment '*I hope I helped you'* which illustrates that a slight bias in wanting to meet the researcher's expectations was reflected on the participant's answers to the research's questions. In spite of taking careful notice in remaining objective and explaining how there were no right or wrong answers, it is possible that offering an incentive might have influenced some of the participant's perception to offer something valuable or to contribute in ways which they believed would meet the researcher's expectations.

3.2.2- Data Collection

On receipt of ethical approval, minor changes were made to the information sheet and consent form as requested by the committee. Furthermore, in order to make the study more focused I was told to specify what type of addiction I wished to investigate. For reasons outlined in the literature review of heroin being the drug medically recognized as most addictive due to its pharmacological substances, I decided to recruit between 6-10

participants who had experienced heroin addiction in the past and were accessing drug services for support.

3.2.3- Participants

The participants in this study are past substance misusers who reported having been addicted to heroin at some point in their lives. Seven participants were recruited in total (two females and five males) all between the ages of 30 and 46 years old. Three participants were white British, two were Asian British and one participant was Black British. Participants who were currently using heroin were not excluded from this study yet no participant who was actively using chose to take part.

At the time of the interviews participants were abstinent and attending an independent charity for continued support in their drug treatment. One participant worked at the drug treatment agency as a drugs worker; another worked at the service user group at the same agency. One participant had completed the programme and was attending for aftercare whilst four participants were still completing the 12 day abstinence based programme. There were differences in the periods of abstinence of the participants varying from two months to seven years. Four of the participants had been abstinent between two and half and seven years and three of the participants had been abstinent between two and nine months. Three of the participants were parents and the two female participants had their children's custody removed by the social services. Anonymity and confidentiality were assured as main components of the contract of participation. After the contract was signed and the participants agreed to take part, I utilised recording equipment for data gathering for the purposes of IPA. The use of the recording equipment was explained to each participant prior to the interview. Only one participant made an explicit reference about the recording device by asking a specific question about how much it cost and where I got the device from.

3.2.4- Interview Procedure

As advocated by IPA, semi-structured interviews consisting of open-ended questions were used. The aim of this interview schedule was to elicit a reflection on the process which someone would choose drugs as a coping strategy, opening up the phenomena of relationships and one's stance of being in the world. As outlined by the methodology, the list of questions was phenomenological in nature and was not used as an exhaustive list. Therefore, not every question on the list was asked to each participant. However, with the general areas outlined above the list was used as a general guide, and the interviews took shape of a dialogue. Through these participants were asked about their drug use and the impact of this on other areas of their lives. The last question and the context of the interview setting elicited a response on the topic of choice and recovery which was later included in the study's aims.

After participants were identified, interview appointments at convenient times were made by their key-workers or the organization. All interviews took place in rooms at the organizations concerned. Each interview lasted between 30 and 90 minutes and was tape-recorded. Although I used a basic semi-structured questionnaire, I had a lot of prompt questions which were phenomenological in nature trying to get a rich textured description of the participant's experiences. All the questions were around the same subject of choice and what was going on in the participant's lives around the time when they started using drugs.

3.3- Analytic Process

Six interviews were transcribed utilising the services of a professional transcriber recommended by a trusted academic supervisor. Whilst the pilot interview was transcribed by

the researcher, all other interviews were listened to twice, correcting the transcripts where necessary. The transcribed verbatim included non-verbal information where appropriate, e.g. laughter and pauses. The recorded verbatim was then analysed following Smith, Larkin and Flower's (2009) method for Interpretative Phenomenological Analysis. Interviews were read and re-read a minimum of four times each. There were several methods utilised for practically analysing the data including word documents, excel sheets and post-it notes.

Following the methodology proposed by Smith & Flowers (2009), after immersion in the data by reading and listening to the interviews twice, comments were made using Smith & Flower's (2009) right hand margin and left hand margin approach. At first, the left hand margin was the initial and descriptive comments and the right hand margin was coded afterwards noting any emergent themes for each transcript in order. For example from this quote '*I got thrown off a building and stuff so this is what heroin's caused*.'[8:338-339] The following emergent themes emerged: Ed is seeing link between heroin causing him pain and injury. This theme was then assimilated into the themes and emergent themes as follows: '*Escaping death'* was assimilated into the main theme '*Either give up heroin or die*.' This emergent theme was assimilated into the main theme '*costs of heroin'* which supports the superordinate theme '*lack of control leads to recovery*.'(Example: Appendix IX)

These steps were followed by making notes on the full transcripts through a case-by-case analysis, with one analysis being fully completed before I started the whole process anew with the subsequent interview. Anything significant that emerged from the data was at first summarised, then questioned and interpreted step-by-step. The notes were at first descriptive comments, focussing on content. Secondly, the data was examined by making linguistic comments paying particular attention to language. The final level of noting focused on conceptual comments, looking at meaning and provisional meaning. After a thorough analysis of the data, paying attention to content, description and semantics, it was analysed

for emergent themes. This was an attempt to make a concise statement of what was important in the comments attached to a piece of transcript (Smith, Flowers & Larkin, 2009.) The themes were clustered into initial themes and labelled as such one interview at a time. These themes were selected according to the meaning and content that emerged from the material. Material from the preliminary analysis of each participant was examined closely when searching for connections between themes, and how the themes were embedded in the transcript. From this process, the super ordinate themes and subthemes emerged from the data according to its significance and meaning with quotes illustrating each theme (see example in Appendix IX.) Finally, links were established for each participant regarding how the themes fitted together to create super-ordinate themes. Connections across the emergent themes were made by typing the themes and a keyword that related to it onto post-it notes to see how they correlated.

The researcher then looked for connections following Smith, Flowers & Larkin's (2009) techniques for each transcript following the techniques of: *abstraction, subsumption, polarization, contextualization, numeration and function*. In *abstraction,* patterns were identified and grouped together; *subsumption* occurred when an emergent theme was important enough in terms of relevance to the phenomena under investigation to become a super-ordinate theme. This decision was made in relation to the participant's experience of choice and lack of choice in heroin addiction; *polarization* focused on opposite relations between themes; *contextualization* meant looking for connections and identifying narrative elements; whereas *numeration* was the attention given to the frequency with which themes appeared: A lot of the themes were attached importance and classified as super ordinate in terms of frequency. Finally, *function* meant examining the meaning created in a particular passage through focusing on language and the meaning the participant gave to a particular experience. In order to ground the themes with examples from the transcription, a table with

master themes and subthemes across the group, with quotes for illustration, was created for each participant and then a table with themes occurring across all the data was created to summarize the findings across all interviews. For example participants, themes of lack of support, struggle, giving up and guilt were assimilated into the superordinate theme of *'rock bottom'* which is a sub-theme of '*lack of control leads to recovery.*' (See Appendix X)

Following the methodology, after each participant's experience was analysed on its own, and after having lifted several meanings the emerging themes were aligned in tabular form. This was made after printing out the analysis for each participant and laying it down across the floor in order to map out commonalities and discrepancies across all the tables for each interview. The tables of master themes and subthemes were explored in relation to each participant to combine the data into a cohesive whole and lift the several meanings across each participant's interview. After several common themes were identified, an initial table (Appendix XI) was drafted highlighting how the themes converged and diverged across the interviews.

The validation check was conducted by means of regular feedback from this study's primary academic supervisor during the different stages of analysis where the themes and transcripts were checked thoroughly in regards to the different levels of interpretation.

Given the existential/phenomenological nature of the study Van-Deurzen (2005) four worlds of existence was utilised in one of the themes; *'heroin both gives and robs one's identity'* as an attempt to offer a framework from which the participants' lived experience could be mapped out and understood. This particular theme was chosen in order to apply this framework given the broadness of the concept of identity and the multifaceted way in which it can be analysed and understood. Thus, the four worlds of existence provided the basic

framework from which to address addiction holistically and analyze participant's world-view and subjective experiences in relation to this particular theme.

3.4- A Quality Assurance

According to Madill et al., (2000) assumptions about objectivity and reliability understood within a quantitative framework can be applied to the evaluation of realist qualitative research where the analytic categories are considered to be discovered in the data (2000, p.4.) This is not applicable to this study and to qualitative research methods in general. As mentioned in Elliott et al., qualitative research aims towards an understanding of participant's experience and defining phenomena in terms of experienced meanings, observed variations and developing theory from field work (1999, p.216.) Quality assurance is important when doing qualitative research in order to ensure more appropriate and valid scientific review suiting this particular method (Elliott, 1999 p.215.) Making one's epistemological position clear as well as conducting a research consistent with that position has been identified as the task of qualitative research methods (Madill et al., 2000 p.17.) However, as seen in Elliott (1999), the criteria needs to be different when evaluating qualitative research given that what is being tested is not causal explanations which need to be evaluated in terms of reliability and validity; the emphasis is on human experience and social life.

3.4.1- Validity in Qualitative Research

Yardley (2000) and Elliott et al. (1999)'s guidelines for assessment and quality in qualitative research have been considered. 'The ability to provide meaningful and useful answers to the questions that motivated the research in the first place' (Elliott et al. 1999 p.216.) The validity and quality of this research have been assessed against the guidelines of Yardley (2000) as

means of applying the qualitative research tradition of owning one's perspective and to assess issues of quality control. These are different to quantitative methods as the latter seeks to yield objective findings and replicable outcomes whether qualitative research methods employs theoretical samples of small numbers representing the phenomena of interest. Therefore replicability and reliability often used to measure validity in quantitative studies is seen as inappropriate criteria if the purpose of qualitative research is to offer one of many possible interpretations of a phenomenon which is in the process of changing (Yardley, 2000 p.218.) As previously mentioned knowledge is not an objective concept and is shaped by the purpose and perspective of those who create it, making the use of replicability void when it comes to evaluating qualitative studies (Yardley, 2000.)

Yardley (2000) suggests a criterion for assessing the validity and quality of qualitative research composed of four flexible principles. These are: *sensitivity to context, commitment and rigour, transparency and coherence, impact and importance.*

3.4.2- Sensitivity to Context

Yardley's first principle, sensitivity to context, is adopted through all stages of the analytic process. The researcher sought to remain mindful of the participant's perspectives in regards to socio-cultural aspects or setting-specific considerations. In terms of setting-specific parameters and potential barriers, the participants were informed about the confidentiality agreement and some participants chose not to divulge material pertaining to their past crimes. Although one of the participants did not divulge material that could lead to an ethical dilemma of having to breach confidentiality the impact on the data is seen to be minimal as the effect of this experience on the participant's life was explored without the need to disclose specific dates and context.

Moreover, choosing IPA implies a commitment to idiographic principles (Shinebourne, 2011.) Therefore, the theoretical literature applicable to the research topic has been investigated and sensitivity to socio-cultural aspects, individual experiences, commitment, and care and attention to detail has been applied throughout. The study pays particular attention to the detail of verbal and non-verbal cues, meanings and functions. There are a considerable number of verbatim extracts to support the arguments and interpretations made. These can be seen in appendices v-iii.

3.4.3- Commitment and analytic rigour

Yardley's second principle: commitment and rigour, describes an in-depth engagement with the topic, methodological competency and skill and depth of analysis. This has been met by the researcher's prolonged engagement with the topic and immersion in the data of the research. The strength of IPA lies in its scope for capturing the richness and ambiguity of participant's lived experience. Therefore, throughout the analytic process the researcher endeavoured grounding all interpretations in the data by remaining focused on the participant's textual accounts and by on-going comparisons of the emerging themes with the raw data in order to check for viability and completeness. There is an audit trail of the research process which has been supervised by the primary academic supervisor. The data has also been checked by means of academic supervision where transcripts and themes were assessed thoroughly for accuracy of meaning and interpretation. A research diary has been kept for the duration of this study recording any preliminary thoughts, preconceptions and process reflections. The aim has been for 'a rounded, multi-layered understanding of the research topic' (Yardley, 2000 p.222.)

3.4.4- Transparency

This principle describes the extent to which the research process is made understandable to an independent reader. The criteria of transparency and coherence have been addressed by the strife for clarity and transparency of the entire research process, and describing it in detail in light of the choice of methodology. Therefore, every aspect of data collection, including transcripts, verbatim and tapes are available on request. This criteria is further addressed by researcher reflexivity where the whole process is analyzed from the researcher's vantage point in order to assert for good practice.

3.4.5- Impact and importance

Yardley's fourth criteria: impact and importance, has been addressed by providing a new way of understanding the topic. The aim throughout this investigation was for an accurate and objective portrayal of the participants' accounts. This research aims to contribute to practice therefore this criteria will also be addressed by disseminating these findings. This topic is important because issues of addiction and choice are central to psychology and society at large. The concepts of addiction and ways of working with addiction have dominated the socio-economic and political agenda and many different perspectives and points of view have been offered from a multifaceted approach. This research aims to offer a different way of understanding and conceptualizing addiction by giving voice to those who have been impacted and continue to be impacted by this phenomenon. By looking at what has been unhelpful and what has been helpful from a participant's viewpoint the findings can reach different audiences and explain a human dilemma that has been previously thwarted by a political agenda.

To follow this discussion on this research's methodology, in terms of its philosophical framework, assumptions and the characteristics which underpin human science research (Van Manen, 1990), the techniques and practical procedures used have been explained in this chapter.

3.5- Researcher Reflections

> '*To interpret means to bring one's preconceptions into play so that the text's meanings can really be made to speak for us'* (Gadamer, 1975 p.398.)

In this section I will explain how my role as a researcher impacted on this study during different stages of the research project. As noted in Finlay and Evans (2009): 'engaging with analysis involves researchers dwelling with their data, examining it and then progressively deepening their understandings as meanings come to light'. In this section I attempt to take account of how I believed I shaped and impacted on the research process as well as exposing other moral dilemmas that impacted on the evolving relationship between myself and the participants. According to Merleau-Ponty (1962), to turn to the phenomena of lived experience means 're-learning to look at the world by re-awakening the basic experience of the world' (Van Manen, 1990 p.31.) I feel that I underwent a very transformational journey during this research process and yet I want to acknowledge that this is only one view and my subjective interpretation which has been impacted on this process. As mentioned in Van Manen, a phenomenological description is always *one* interpretation, and no single interpretation of human experience will exhaust the possibility of another complementary, or even potentially richer and deeper description (Van Manen, 1990 p.31.)

I am a 31 year old Brazilian woman who grew up in Brazil and Holland. I moved to the Netherlands for nine and a half years when I was 14 years old, and I have lived in the United Kingdom for eight years. Whilst growing up, my interest in addiction first originated through how the topic was portrayed in the media as a glamorous way of being. Years later when I started working in the field that I realised the reality was the exact opposite of my erroneous teenage perception of addiction being only for rock stars and supermodels.

I was never an 'addict' and never have defined myself as someone with an 'addictive personality'. I never had to battle with my self-will to that extent. My personal experience with drugs during high school in the Netherlands was brief and short lived. Losing myself, and losing control by ingesting a substance that altered my emotional state never appealed to me.

My interest in the topic of this dissertation developed once I started working as an arrest referral worker for a Crime Reductions Initiative programme (CRI) in London. My job was to assess people in police stations who had a positive drug test and to try and engage them into treatment. Part of the economic and political background of the service was a reduced prison sentence if they agreed to undergo drug treatment. Later on this changed and a drug assessment became compulsory for anyone who produced a positive drug test. I remember coming across various clients at different stages in their addictions. As I started training as an Existential-phenomenological Counselling Psychologist and Psychotherapist, I became more interested in how existential philosophy applied to practice. At work, clients would state they had no 'choice' over their addictions because addiction was a disease. This is when I started wondering about choice in addiction and how the clients I worked with could regain a sense of control they felt they had lost. I feel that my view of the concept of choice in heroin addiction has changed significantly since undertaking this research. I believe that now I have

a much deeper understanding of all the ways in which choice can be limited through someone's course in addiction.

I have held several placements and jobs in addiction since working in police stations. The conception of addiction varied with each organization and how it conceptualized and treated addiction. However, since submitting the proposal for this research in 2007 a lot has happened in my personal life while engaging in this research process.

As I began interviewing for this research, I was diagnosed with a begin brain tumour in December 2010. I interviewed three participants when I was still in good health and I did two more interviews a couple of weeks before I was to undergo brain surgery in March 2011 and the last two interviews were done two months after my operation. On reflecting how my existential crisis of coming so close to death during this process might have shaped the interviews, I feel a few points are worth mentioning.

Being told that I only had six to twelve months to live unless I had brain surgery in the next three months was an extremely traumatic and anxious time for me. This was because the tumour had grown so big it was about to shut down the right ventricle in my brain, the death would have been instantaneous without any obvious physical signs. Before my diagnosis, I did not have any symptoms; I only started experiencing dizziness when I turned my head fast which lead to a misdiagnosis of labyrintits for a year before I got a MRI scan privately. After seeing the MRI scan, I experienced all stages of shock including denial and grief. This experience made me feel emotions a lot more deeply and to open up to life's struggles and limitations in a way that I become more empathic towards other people's suffering. I did not know what to expect before and after surgery and it has transformed my sense of self significantly as it impacted on every area of my life.

I feel that I learnt to embody the paradoxes of life. I understand what is like to really want to die one minute and really want to live the next and behave in actions that would support each statement. (i.e. making plans to quit everything run away and decline the operation to deciding to fully commit to treatment.) This in turn opened me up to this research process and ways of empathizing with my participants that felt more real rather than just cognitive. I feel that I can make sense now of the multifaceted aspects of life in a much deeper and more authentic level because I have lived through such a dramatic experience. Whilst analysing people's suffering I can now recognize what trauma feels like in a way that I would only conceive of before experiencing my own. I also gained a tremendous ability to be grateful and to cherish all aspects of life. Hopefully this research illustrates the paradox that is inherent in the human experience as well as the multifaceted aspects of choice, suffering, pain and trauma narrated by my participants and reflected by my own new embracing of the subject. I learnt how to trust and to surrender to uncertainty as much as I feel my participant have described in their struggles. It is in this shared humanity between researcher and addicts, client and therapist that I see no division and has taught me to delve into the humanness and equality between us. Unfortunately this is often forgotten in the medical model when the approach tends to be towards cure; or doing something to the other.

I have experienced what heroin must feel like when I was on a cocktail of paracetamol, codeine, morphine and steroids. I feel that heroin is a choice people might make to block what they perceive to be an enormous amount of physical and/or emotional pain. I can empathize with my participants' struggle for survival. I can also really understand how seeking relief can become 'addictive' because it means not engaging with physical or emotional pain. As opposed to delving into what you are running away from which is what is required to treat addiction, most people prefer a state of disconnection from feeling overwhelmed. To move into alignment with a disconnected body it takes a conscious

decision to experience the pain one tried so hard to avoid. However, running away can become addictive and in that sense a lot of psychology can be about 'addiction' to different feeling-states. There are many types of addiction, for example: eating disorders, gambling, sex, alcohol etc. I hope that this research can add a new insight to the concept of addiction and open up new venues for exploration which are more holistic and applicable to practice. I believe that the courage to change a difficult pattern of behaviour is reflected on the words and experiences of my participants to offer hope and possibility to those who may think it is not possible. I see a lot more possibilities these days in both my personal and my professional lives.

Having come through the other end, it is difficult to reflect on how I would have engaged with this topic differently had I not gone through such a transformational process during this research. I think that overall, my journey has been extremely beneficial and a great tool in understanding addiction and humanity further. Although this experience does not define me, my ability to cope with my own suffering allowed me to understand and gather new meanings from my participants' descriptions of their life-worlds. I feel that due to what happened to me I have a new sense of how the participants lived through their experiences.

Chapter 4 – Findings

The participant's demographics are outlined below.

Participant	***Gender***	***Age***	***Ethnicity / Social Class***	***Length of time in addiction***	***Period of time abstinent***	***Background***	***Employment***	***Education***
1-Rosie	F	46	White British/ Working Class	25 years	7 years	UK city not London	Prostitution	Left high school at 14
2- Lucy	F	30	White British/ Working Class	15 years *(8 months using heroin)*	5 years*(still uses cannabis)*	Outer London	None reported	Left high school at 15
3- Tom	M	32	White other-mixed/ Working Class	7 years	7 years	Cyprus/ English	Catering	High school
4-Joe	M	41	Black British/ Working Class	26 years	9 months	Outer London	Navy	High school
5-Anand	M	43	Asian/ Working Class	14 years	5 months	East Asia	Mechanic	Left high school
6-Ed	M	40	White British/ Working Class	23 years	2.5 years	East London	Construction	Left High school
7-Mo	M	30	Asian/ Working Class	15 years	2 months	East Asia	None reported	High school

Table5.1. Summarizing participant's demographics and length of time spent in drug use and abstinence.

As we can see from the demographics, all participants came from a disadvantaged socio-economic background and most have not attended or completed high school. Rosie came from a city in the north of England and left home aged 14, getting caught in a cycle of addiction and prostitution. Lucy also reported no previous jobs and did not complete high school. Both Anand and Mo came from Asian backgrounds, lived in East London and dropped out of high school. Anand spent some time in his home country before returning to England and worked as a mechanic whereas Joe used to be in the navy. Tom dropped out of

college and worked in the catering industry whilst Ed dropped out of school to work in construction.

A total of three main themes and thirteen sub-themes were identified from the analysis. The length of time the participants had been abstinent at the time of the interviews will have an impact on the findings regarding how their identity is conceptualised in terms of their addiction and recovery. This will be explored further in the last two themes.

A summary of the super ordinate and subordinate themes for all participants is illustrated below:

Super ordinate Theme	**Rosie**	**Lucy**	**Tom**	**Joe**	**Anand**	**Ed**	**Mo**
1.Not belonging	*[2:54]*	*[3:128-131]*	*[1:25-35]*	*[4:70-71]*	*[4:175-177]*	*[7:303-304]*	*[3:140-141]*
Sub-Theme							
1.1. Indifference	*[3:84-86]*	*[2:58-61]*	*[1:25-27]*		*[1:47-48]*	*[7:291-295]*	*[1:20-21]*
1.2. Abuse	*[2:47-49]*	*[2:88-93]*	*[6-7:285-288]*		*[3:138-142]*	*[8:367-370]*	*[2:124-137]*
1.3. Objectifying Others	*[13:398-400]*	*[3:129-131]*	*[6:265-270]*		*[12:536-541]*	*[6:274-277]*	*[9:426]*
1.4. Replicating powerlessness	*[8:219]*	*[4:163-164]*	*[2:89-91]*	*[5:229-230]*	*[6:285-299]*	*[2:72-76]*	*[11:501-523]*
Super ordinate Theme							
2. Heroin both gives and robs one's identity	*[5:102-111]*	*[3:103-111]*	*[1:38-48]*	*[4:159-161]*	*[8:359-369]*	*[2:79]*	*[4:152-157]*
Sub-Theme							
2.1. Psychological Dimension: Shame and Self-abandonment	*[9:264-265]*	*[7:315-317]*	*[4:166-170]*	*[6:249]*	*[4:461*]	*[5:240-244]*	*2:52-53]*
2.2. Social Dimension: Withdrawal and Isolation	*[11:324-327]*	*[4:187-189]*	*[5:211-227]*	*[6:256-257]*	*[11:519-520]*	*[3:134]*	*[5:231-235]*
2.3. Physical Dimension: 'Pain-Relief'	*[11:320-322]*	[8:292-293]	*[9:389-393]*	*[1:37-39]*	*[18:853-863]*	*[6:255-256]*	*5:231-235]*
2.4. Spiritual Dimension: 'Spiritually dead'				*[3:84-85]*	*[10:444]*	*[7:326-328]*	
2.5- New Possibilities	*[15-16:446-466]*	*[9:390-391]*	*[12:541-553]*	*[12:567-568]*	*[20:915-919]*	*[4:402-403]*	*[13:599-607]*
Super ordinate Theme							
3. Lack of control leads to recovery	*[12:363-368]*	*[8:357-359]*	*[13:609-613]*	*[6:247]*	*[11:495-499]*	*[5:199-208]*	*[11:489-491]*
Sub-theme							
3.1- Rock Bottom	*[15:433-437]*	*[8:384-388]*		*[8:337-338]*	*[19:861-864]*	*[8:337-342]*	*[11:489-491]*
3.2 – Not-Feeling	[3:68-73]	*[7:305-309]*	*[7:314-315]*	*[8:3640367]*	*[18:834-835]*	*[3:130]*	*[3:105-111]*
3.3- Choice as an emotional response	*[3:64-68]*	*[4:147-149]*	*[10:442-446]*	*[6:247]*	[11:495-499]	*[5:199]*	[5:233-235]
3.4- Treatment is a choice to feel again	*[12:359-363]*	*[7:318-325]*	*[8:363-378]*	*[7:289-290]*	*[20:908-914]*	*[7:311-313]*	*[10:454-455]*

Table 5.2. Summarizing main themes and sub-themes identified in the analysis. Please note this table does not contain all the quotes used in the analysis but provides an overview.

Please note the significance of the transcript notations:

(...) Pauses

() Utterances

{...} Material omitted

(xxx) Material intelligible

The significance of the findings will be expanded by each theme subsequently in the following section:

4.1.1. Not Belonging

Each participant interviewed described an experience of not belonging. This can be seen explicitly in the narratives of six participants. Descriptions of not belonging are discussed in relation to the participants not seeing themselves within their families of origin. Six of the participants state that they did not feel they fitted in, Joe describes: *'I always felt like I was missing something missing out...'* [4:70-71] Similarly, Ed also felt he did not belong in his nuclear family: *'I never really didn't know how to fit in I struggled to fit in'*. [7:303-304] Whilst for Rosie, the sense of not belonging came from being adopted: *'...I was adopted you know, kind of never felt I fitted in'*. [2:54] As illustrated by Rosie's experience, the theme of not feeling accepted and trying to get a sense of belonging by taking drugs, is prominent in all interviews.

Lucy describes an experience of being marginalised in her family because her mother was an addict: '*...so from the age of eleven my mum was taking drugs and a lot of her partners were on heroin (…) so I'd see them do it quite willingly you know openly...'* [2:58-61]

This experience of exclusion is shared by Mo and Anand who both felt they did not belong because they were part of a minority ethnic group in a predominantly white British society. Mo: '*...before I started smoking crack I used to get bullied my neighbourhood I lived in was really racist'*. [3:116-117]

Anand emigrated when he was very young: '*...my entire family up-rooted from this country'*. [1:33] This gave him a sense of not knowing where he fitted in to both societies, as well as his family. He understood this had a negative effect on him. He explains: '*the transition in the beginning was very, very hard you know going to a country where my parents come from and for us to like we basically it was hard for us to speak the language as well'*. [2:59-61]

Thus the participants became marginalised and started using drugs to compensate. Mo: '*...I knew I needed to belong to something this is happening too many times now and that's what really changed me...'* [3:140-141]

However, taking drugs further exacerbated the participants' sense of not belonging and they became further marginalised. This can be seen in Tom's quote:

Tom: '*I started using drugs at school and getting into trouble committing petty crimes and then I chose to go to college I started using heroin in college...*' [1:25-27]

As all of the participants felt they did not belong to their families or their environments, they looked to achieve a sense of belonging by taking drugs. This only took them further from what they were trying to achieve and increased their sense of not belonging. They became even further marginalised in society.

4.1.2. Indifference

The sub-theme of indifference supports the theme of not belonging as the participants started looking to 'mother' themselves due to the lack of parenting they received. In looking for meaning, there is a gap in how the participants felt they fitted into the world. This is seen in Ed's narrative: *'I was a problem child as they like to call it yeah they got that label {...} I've seen psychiatrists I don't know why I don't think I'm mental...'* [7:291-295] By receiving the label of 'problem-child' Ed struggled to make sense of his experience and felt indifferent and

at-odds with his situation. Indifference is inferred as a response to feelings of not belonging, so drugs became a route to self-empowerment. Tom on the other hand, felt that drugs were just something to do:

'...everyone was doing it wasn't about you know having a rough upbringing or anything like that it might not be great but a lot of peoples weren't but we just had access to all of them drugs and we used them and then obviously we'd get silly'. [1:40-43]

The participants spoke about a way of being which was characterised as self-reliant and indifferent. In order to empower herself, Rosie talked about how she ran away from home when she was 14 years old:

Rosie: *'I had a disagreement with mom and at home and my daddy wasn't well but so I didn't go back for twenty years and... it's kind of... It was kind of - but I don't know what happened in those twenty years'.* [3:84-86]

Therefore, drugs became a method of self-parenting and of regulating emotions. This was a response to the disempowerment and enmeshment the participants experienced. In turn, the participants looked to control their emotional states and became emotionally indifferent. This is seen in the following extract from Joe:

'I had a really good upbringing and that and I remember the first time I smoked it I was going skiing 'cause I used to go skiing a lot when I was a kid and it was three weeks till I was going on holiday I remember smoking a spliff and I thought God if I could do this every day my holiday will come quicker and when you're sort of out of your mind sort of thing you know'. [1:46-51]

In Lucy's case, her indifference came from her lack of understanding of what a 'normal' and 'not-normal' upbringing was. She was surrounded by drugs growing up and didn't know any different.

Lucy: '*It was all around me it was it was all I knew you know normality to me (...) all her friends were drug users so every time I went to their houses to see my mum it was always, always full of drug people'*. [3:128-131]

Indifference is understood as the participants trying to control their environment by regulating their internal states. It was the way the participants coped with abandonment. They saw their environments as chaotic and threatening, as seen in the next passage.

Anand: '*...was really hectic when we grew up so I suppose that has stayed with me and I've been in trouble so many times...'* [4:175-177]

For Mo, indifference was a way of coping. He describes it as an *'automatic mode'* [3:103] and he '*didn't care about the consequences'*. [3:112-113]

4.1.3. Abuse

Abuse is defined as physical violence, neglect, lack of boundaries and enmeshment. Five of the participants spoke about their experiences of abuse. For Rosie, when she was fourteen years old she ran away from home to London where she was picked up by a paedophile at Euston station.

Rosie: *'I just got off the train at Euston he offered me (...) somewhere to live and somewhere safe to go and then the very first night he gave me drugs and abused me...'* [2:47-49]

This contributed to her marginalisation and feelings of not belonging. For Lucy, abuse is illustrated in how her mother gave her drugs without her consent. She became a single parent when she was fifteen years old.

Lucy: *'...my daughter was about two months old and I was really tired I couldn't get up and she made me a cup of tea and I actually felt better and I said to her why do I feel so good and she said 'cause I put a bit of speed in your tea' so it become every morning a little bit more*

and a bit more and then we become using together we used quite a lot together me and my mum.' [2:88-93]

In contrast to the emotional abuse experienced by Lucy, Ed remembers experiencing physical abuse from his father following some damage to the neighbour's roof he caused when he was ten years old:

Ed: *'...I mean so I got put in the police station by my old man and when I got home he kicked seven bells of shit out of me I've had things thrown at me and I've been kicked up and down the stairs through, through naughty things that little boys do...'* [8:367-370]

At a later stage Ed recognized this punishment was disproportionate and yet at the time none of the participants felt their upbringing was abusive. It was all they knew. By contrast, Anand described a background of violence when he relocated to his country of origin. He had to pick up arms to *'defend himself'* [3:113] from the age of eleven. In making decisions that affected him, his parents *'didn't take his feelings into account'*. Anand was told by his father: *'if you get beaten up, have another fight'*. [3:139] He internalized this world-view and believed it was the right thing to do.

Anand: '*Yes we was taught from an early age if you get beaten up outside you know you need to sort it out outside don't come home getting beaten up and my dad that's how he was you know I remember one time coming home from school busted up and then like you know he said no food for you that night basically didn't get fed you know…'* [3:138-142]

We can see how the marginalisation and feelings of not belonging were exacerbated by the different forms of abuse experienced by six of the participants. Both Anand and Mo were victims of multiracial incidents and felt the world was a dangerous place, and that they could only rely on themselves to survive:

Mo: *'I was only about bloody nine years old and they were sixteen my dad sent me to get some milk and I came back with the milk bottle smashed on my head and I was only about*

nine and after that about a year after that when I went to school some white men in the park four or five of them put a crow bar on my leg you understand and two years after that someone stabbed me in the park same thing fucking Paki this that or whatever and I'm like thirteen years old {...} and I don't understand...' [2:124-137]

Each participant experienced a form of failed protection and this abandonment in early childhood is seen as abusive. In Tom's case the abuse can be seen as implicit, illustrated by how his mother used to let him smoke weed, give him whiskey once he left rehab, and hide drugs in the house:

Tom: *'The heroin in different places at certain time and ring me and tell me where it was there's so much collusion in it there's so much that she brought into my addiction she became very good at it and I became very good at finding and it's like a cat and mouse you know craziness'*. [6-7:285-288]

As opposed to other participant's accounts, Joe did not report experiencing abuse during his upbringing. He only reports an inability to cope with his emotions:

Joe: *'I was in the Royal Navy for a couple of years and I had a good upbringing and I had good friends but I've always thought that I had to live on the edge you know I've always like flirted with danger all my life'*. [4:159-161]

Although six of the participants explicitly reported being brought up by unfit parents, they only came to realise this at a later stage. Drugs became a way to cope with the abuse and trauma they experienced growing up. It was the only thing they could control in their environment. As seen in this sub-theme, drugs became a way to relate to the world, belong and not belong, and find meaning.

4.1.4. Objectifying Others

All of the participants mentioned how they objectified others as a response to feelings of not belonging. This conveys a sense of rejection as a response to feeling rejected during their upbringing. Objectifying and rejecting others was their primary way of relating to and fitting into the world. The participants started objectifying others because they had been objectified themselves, with their feelings having been unacknowledged while growing up. For Mo, this was a way of being characterised by a false-self he created to mediate his experiences of feeling out of control and not fitting in.

Mo: *'I'm dishonest sort of thing dishonest because of that I've grown away from extended family and family is really important and we have family events and I would never turn up for it because everybody would have that uncomfortable feeling when I'm there…'* [9:426-429]

Therefore, relationships with family became problematic as the participants didn't know how to engage with themselves and others emotionally. This is interpreted as a response to the exclusion they felt while growing up. Unable to recognize the other's subjectivity, the participants treated family members the way they had been treated: as a means to an end.

Anand: '*you have to go and ask your family to give you money and I'd have to go and like you know I'd get money off my mom and if you have to your mum every day at a regular time and you have to ask for the same amount every day you know they're gonna start asking the question like you know what do you want the money for don't worry mum I just need it, don't worry mum I just need it just give me £10 like just give me the £10…'* [12:536-541]

Because they were not allowed to develop their emotional world the participants limited themselves by becoming practical. This was also the only way the participants knew to empower themselves and survive: '*I didn't care how I got that money I didn't think about the consequences of who I was hurting. I mean often... shoplifting ok you are not hurting people*

but there were times I'd hurt people I robbed people I, any opportunity to get money, so it was all about chasing money to get the next fix'. [5:132-135]

Objectifying others became a way of relating when the participants sought to control their environment to meet their needs. It was a self-centred way of being, in that other people did not matter. This is understood in terms of what happened to the participants in their families. As Rosie mentions: *'...if you are living at home you rob off them, but you lie to them, you know at the very least you lie to them... '* [13:398-400]

Similarly, Tom reports:

Tom: '*...I'd manufacture a story in my head telling me I'd been mugged and I'd play it out in my head that many times that I'd start sweating and I'd start to trip and I'd go home and you know I wouldn't stop till I'd got a tenner you know so there's a lot of you know you'd play yourself and you play everyone else around you it's crazy'.* [6:265-270]

For Joe, Ed and Lucy the theme of objectifying others is less explicit. Joe did not talk much about his relationship with his parents as he stated: '*mum and dad are both dead now'.* [4:153] He mentioned feelings of guilt at not getting clean before his mum died: '*I've lost all that and me mum died in 2005 she knew about the drugs and I always thought I'd get clean before she dies and that didn't happen'.* [10:456-457] His experience is different as he did not speak directly of a bond with his parents during this interview, except to say he had a '*stable upbringing'.* [4:155]

On the other hand, all of Lucy's relationships growing up involved using drugs: '*all her friends were drug users so every time I went to their houses to see my mum it was always, always full of drug people'.* [3:129-131]

For Ed, his way of objectifying others is projected as perceived negative judgments: '*I think everyone judges people there's got to be times when people look at you and go you've got nice shoes how come I ain't got those shoes and in a way that's judging'.* [6:274-277]

As seen above this sub-theme explored how participants objectified others in addiction. While most participants turned their back on their parents and treated them the way they had been treated, they did not recognize the other's subjectivity and separateness.

4.1.5. Replicating Powerlessness

This theme explores how drugs were used to cope and escape a hostile environment by providing relief. This is linked to the lack of parenting and the abuse experienced by six of the participants. As a way to try to achieve a sense of belonging, the participants try to create meaning in their lives.

Ed: '*I'd say it was the ignorance and then once I smoked it, it was sort of like yeah to me that was I don't like the term but people use my choice of drug know what I mean it made me feel (...) I don't know if the word's wanted it made me feel wanted it made me fit in it made me feel comfortable within myself*'. [2:72-76]

Drugs became a way to escape reality. As seen above, Ed describes what was attractive about heroin and how it made him feel comfortable and wanted. This is shared by Mo: '*...it actually comforts you and takes away all your feelings do you know what I'm trying to say without the heroin you're thinking I'm a scumbag I ain't got nothing*'. [11:501-523]

The paradox of the participants replicating the experiences of disempowerment they were trying to avoid can be seen in the above quote. The experience of feeling wanted was one of the main things that drugs were used as a substitute for. Yet the participants only succeeded in replicating these negative feelings through using drugs. The lack of love from a parent is translated into a sense of lack. This sense of lack is then addressed by using drugs and alcohol as a coping mechanism. For example, Rosie felt she '*never had a home base*' [6:164] and

'never had the stability'. [6:164] Rosie started prostituting herself after being picked up by a paedophile when she was 14 years old. She explains: *'I would get vodka to get me to go to work because it would block out memories...'* [8:219] Similarly, Lucy also used alcohol as a way of coping with her disempowerment.

Lucy: '*...I was drinking from morning till night (...) I'd get up quite sick if I didn't have a drink (...) yeah and it just progressed really from there'*. [4:163-166]

This extract shows how the participants felt powerless to control anything in their lives, as they couldn't control what they felt, they tried to escape through drugs. Joe confirms this when he states: *'What that my head's been messed up I think I haven't really faced a lot of things used drugs to escape'*. [5:229-230]

By taking drugs, participants experienced relief and comfort which was missing in their lives without heroin. This was at first empowering, as can be seen in the extract by Anand about how he changes his mind about heroin and how it became a competition who could take the most drugs:

Anand: '*didn't know what it was till after he got monged out the boy who was giving it to us till he got a bit buzzing and that's when he got his packet out and he started put his brand of stuff in there {...} I was having a go at him and saying to him how could you do that to us like we're not into this shit we're just you know we're just smoking cannabis and drinking {...} we didn't have a clue all we know my God this is brown sugar it's like a new thing like a new hype and the boys who can take it and we was like we can take more drugs'*. [6:285-299]

The participants' feelings of disempowerment are seen in how the reality of using drugs every day starts to cost them their lives. Tom's narrative illustrates this: '*...when got a proper habit you have to fend for yourself*'. [5:202-209] The way the participants sought to manage a complex and chaotic world is further explored in the next main theme.

4.2. Heroin Both Gives and Robs one's Identity

The theme of identity is central to the participants' narratives. As seen, each participant failed to individuate themselves from their families of origin. For Lucy, this took place in the form of merged identities with her mother. In the following extract we see how she failed to individuate. Lucy: *'...we didn't have many boundaries no {...} when I was fifteen I had my daughter I realised - you know she gave me speed when I had my daughter'*. [3:103-113]

Lucy's identity then becomes enmeshed with her mother's: '*we become using together we used quite a lot together me and my mum'*. [3:121-122] Whilst Tom was offered drugs by his brother: '*he'd introduced me to five or six drugs and it hadn't been problematic when heroin was there I was like okay...'* [2:51-52]

Apart from Lucy who adopted her mother's drug-user identity, the participants started using drugs to separate themselves from their parents, as a means of individuation. Initially, drugs were a *'social-thing'* and perhaps a part of growing up they shared with others. In becoming an 'addict' the participants took it further. They developed an 'addict' identity because they never got an identity within their families. Joe: *'I've always thought that I had to live on the edge you know I've always like flirted with danger all my life'*. [4:159-161]

Similarly Ed '*didn't see himself as equal'* [7:319-322] to his family because he describes: *'I was uncomfortable as a kid anyway always fighting'*. [2:79] To separate from his family he sought an identity by taking drugs: '*....going to school truanting really being one of the lads one of the boys didn't think I needed education you know it was all about the persona {...} and heroin by the time I was fifteen'*. [1:39-47] Mo, Ed and Anand joined gangs. Mo decided he '*needed back up'* and '*would only go places where he knew people'*. [4:182]

This can be understood in terms of identity. The participants felt powerless to assert their identities as they were not comfortable in their families, or else felt enmeshed. Drugs became a way to empower themselves. For Mo, Ed, Joe and Anand violence and drugs came together.

Mo: '*…I worked out in this college it was full of Asian people and just some white boys but more (xxx) boys and that even reinforced my views even more because I'm doing alright now and the girls like me anyone's scared of me and I can intimidate people and if anybody says anything I make a phone call and the boys turn up do you understand I was comfortable with that'*. [4:152-157]

Whilst Ed and Mo both mention a few times how heroin made them feel comfortable, both Mo and Anand described this new identity in terms of empowering:

Anand: '*...we didn't realize we must have been all over the shop you know at the time but we thought to ourselves ahh we're the dons we're the daddies like you know and plus we had a reputation in the area nobody messes with us and stuff like that 'cause we used to fight all the time and we was all hyped up you know when you got when you're hyper you think anything and everything's possible…'* [8:359-369]

Joe mentioned his membership in gangs briefly in terms of his new sponsor: '*there's probably not much he can tell me about gangsters anyway'*. [6:287-288] This new identity was merged with violence for four of the participants as Joe described: '*crime has kept me in addiction'*. [9:429-430]

This identity emerged as the participants never received an unconditional bond and were instead separated from their parents. Drugs were a way to merge with something they could control and would not abandon them. Their addict identities meant that the participants could break away from all relationships and only socialise with people who also used drugs. This is described by Rosie:

Rosie: *'I would always end up in the wrong foot, abusive relationships or meeting up with the wrong type of people. I was very much attracted to negativity {...} It's a company you keep you know like and the relationships you build are usually quite negative and negativity breeds negativity you know when an using addict meets another one then you have two using*

addicts {...} I don't like using the word normal but normal people don't understand'. [5:102-111]

This identity became a way for the participants to turn their back on the world and of not caring. Having explored what influences the emergence of an 'addict' identity, this theme now goes on to examine what the identity of being a heroin-user meant for the participants on psychological, social, physical and spiritual levels. This theme will be divided using the four dimensions of existence to explore the multifaceted aspect of identity in addiction. The focus is on how heroin both gives and robs a person's sense of identity.

4.2.1. Psychological Dimension: Shame and Self-Abandonment

As we have seen, the participants used drugs to individuate and empower themselves in order to control feelings of abandonment and vulnerability. Heroin gave the participants an experience they lacked. This can be seen in the following excerpt where Ed talks about what initially attracted him to heroin: '*it also made me feel so comfortable within myself made me feel confident because you know you've got I don't mean to sound (xxx) but you got to the stage where I didn't really give a shit what anyone thought and that's in the early stages using it was like da, da, da I'm superman do you know what I mean I am invincible...'* [5:240-244]

Both Ed and Anand expressed a need for the drug. Anand said he *'never felt in love with anything more'* [12:565-566] and heroin was '*his best friend'*. [17:785-789] He explains: *'I could never see myself without heroin'*. [4:461]

We can see how at some point in their lives, this identity became all-consuming on a psychological level: '*...you wake up in the morning you wake up because you need heroin and you got to sleep because you need heroin'*. [16:722-724]

However, it became a way of abandoning themselves, as illustrated in the following excerpt by Mo: *'what difference is it gonna make from smoking crack or heroin really when I'm on crack already'*. [2:52-53] Mo reports struggling with a sense of 'false-self' while combining identities. He felt he needed to pretend to be a certain way. *'I project this image [...] really that's not me but I play along with that now'*. [5:209-219]

This can be seen as self-abandonment, as Mo explains: *'really inside I knew that's not me sort of thing I'd get into a fight yeah and everybody would beat me up but actually I've never hit anyone really other people other people are beating the guy up and I'm just do you understand I never had the guts to punch someone in the face what I'm trying to say and I knew that about myself but everybody thought I'm the hard nut and they all looked up to me and everything and I played along with that...'*[4:161-170]

This self-abandonment was different for Tom as he struggled to combine the identity of a drug user with other identities: '*...how can you fit in being a junkie and being a chef it's really difficult you know so yeah physically my health was shit you know cause working as a chef which is a hard job and I was a committed drug addict'*. [4:166-170]

The word '*committed*' illustrates the impact this identity has on participants. The meaning of 'junkie' for Tom is expanded below.

'...once I started injecting that's when you know I really started feeling like a junkie you know like I'd do desperate things to get drugs and to use I did horrible you know like messy things that you'd look at and you'd think that's disgusting you know that's not something normal people do...' [4:146-152]

On a psychological level, heroin stripped the participants of their sense of identity. Rosie states: '*when I was using I didn't care, I didn't wash, I didn't change my clothes, I didn't eat, {...} I had no self-worth or self-esteem...'* [9:264-266] The loss of self through heroin use can be further seen in the next quote.

Rosie: *'I lost my children through addiction, I lost my home I lost my relationships and most of all I lost myself and I think once you lose yourself, until you can find yourself back you can never get any of these things…'* [10:280-282]

A lack of self-care was also experienced by Lucy, she describes: *'why she's so skinny I had all black eyes like drawn eyes I wasn't taking care of my hair or my makeup but I didn't care in the end...'* [7:315-317]

Shame emerges in retrospect as a response to this new identity, Lucy states: *'I felt so ashamed'* [6:289] All the participants describe a sense of shame at this identity during their interviews. This is illustrated in the following quote by Joe: *'....to everyone else it's look at them they're all junkies you know what I mean and I was a junkie and I thought everyone else didn't know but now I'm clean I can look and think everyone must have known you know I was so ashamed of it that's what is was I was really ashamed'*. [6:249-252]

The shame experienced was a response to the lack of authenticity in their lives and the participants' withdrawal from the world. It is an existential guilt at not living the life they wanted and falling into the trap of addiction. Mo states: *'...without the heroin you're thinking I'm a scumbag I ain't got nothing I'm thirty years old my partner's left me'*. [11:507-513]

However, some participants only came to this realisation at a later stage. This was because once the identity of an addict becomes established; the way they feel is the only control they have. As we have seen, heroin leads to a total abandonment of oneself. It both gives and robs one's identity, in the sense that it was the only thing in the participants' lives. The next sub-theme looks at the social aspects of this identity.

4.2.2 Social Dimension: Withdrawal and Isolation

In terms of the social dimension, heroin can be seen to both give and rob participants of their identities in the following ways. At first, the participants withdrew from society. Ed

describes: *'I'm withdrawn from society anyway'*. [3:134] However, there is an attraction to this lifestyle, as described by Ed, Joe and Rosie. The appeal of the dangerous lifestyle is narrated by the following excerpt from Rosie: *'...what was exciting about it what was good about it, there is another part of me that can get an adrenaline from the danger that I was in, and I know it wasn't a glamorous life but it can seem appealing there can still be something about it that people find attractive'*. [11:324-327]

For Ed part of the attraction was that heroin was the only constant thing in his life, it gave him all the relationships he needed: *'...when I started at fifteen, sixteen by twenty, twenty one I had nothing else {...} she become my partner she become my house she become my kids she become my life when people say heroin's a lifestyle no it wasn't for me a lifestyle you can change every other month{...} no, no, no heroin wasn't like that for me heroin was twenty three years of hard graft of staying with me it's the only thing that never left me it never left and I never left do you know what I mean'*. [5:244-256]

Heroin was seen as all-encompassing, and Ed felt he didn't need anything else. This highlights a sense of isolation: *'...I could make money in this 'cause there's loads of people even though it a secret society, it's a secret society do you know what I mean'*. [5:211-125]

The isolation becomes apparent because the participants feel they are stigmatised. Joe adds: *'Yeah that people would think I'm worthless and that because like I'm into heroin and all that'*. [6:256-257]

Unless relationships are formed with other addicts the participants become detached from society. Anand describes this 'secret identity': *'I was working for till last February () nobody had a clue that I had a habit'*. [11:519-520]

The participants became marginalised and isolated as the heroin was seen a 'secret' and only shared with other users. However, for Tom 'sharing addiction' becomes even more problematic.

Tom: *'No so you know then you really find out how shit using can be when you're involved with someone that's when it actually you know got to its worse point because when it's just you, you got to answer to yourself and if you got a cluck you do it but when there's someone else she's your girlfriend or whatever you do even more and you go to even lower depth to get gear {...} you both go out and score so that's when it really got messy you know two people using together'*. [5:211-227]

Lucy also struggled to maintain relationships. She talks about her lack of trust in relationships that can be quite destructive, which originated because she only started using heroin after meeting a heroin addict: *'he got me addicted and left me with the habit yeah and I think that was his aim'*. [4:187-189]

Relationships with other addicts are fraught with conflict as Lucy describes: '*I don't know I loved him so much it didn't matter to me I really he was a very controlling person {...} I really was in love with him ahh he was quite violent he wasn't a very nice man'*. [5:197-201]

Joe also starts using heroin after meeting another addict, Joe: '*She introduced me to heroin but it was down to me I was a bit vulnerable at the time anyway'*. [6:271-272]

The inability to connect with both addicts and non-addicts enhances the participants' sense of isolation .Mo describes being married and having a separate life from his wife: *'...five, six years seven, eight years of using it was totally different do you know what I'm trying to say I've been married five years we've been living together and she can really see me really change and not really give a fuck about anything {..} nothing else matters sort of thing this changed her and my relationship with her'*. [5:231-235]

This separation is illustrated because when being an addict becomes one's identity. The participants operate in different time-scales to other people.

Mo: '*I come home from smoking crack at seven o'clock in the morning and go to sleep she comes home seven o'clock in the evening'*. [6:243-247]

On the other hand, in the world of drugs choices around one's identity are limited. The participants' way of being became isolation or crime. Mo explains this in the following excerpt:

'when I was younger I wanted this job and that job and the studying for it and now I've turned getting that job which I can't get and I sell drugs instead and I still get the money but in a different way sort of thing'. [5:194-197]

At first this identity is exciting for the participants because it makes them feel detached and isolated from the world that rejected them. It helps them to cope with their pain. Yet heroin also robs them of their ambitions, their relationships with non-addicts, and of their true selves. Below we will look at the physical ways in which addiction took over the participants' lives.

4.2.3 Physical Dimension: 'Pain-Relief'

This sub-theme is very predominant in all interviews in terms of how the participants became dependent on heroin on a physical level. Using drugs to avoid pain was the most important thing in their lives. However, the participants then started to replicate the same experience they sought escape from. Tom describes: *'...physically you need it otherwise you're in pain, pain relief so you choose relief because the pain is that bad and it is it's not nice and as far as that goes it's medicine. For other people it might be about anaesthetizing their emotions or whatever but for me it wasn't I didn't you know just physically it worked it, it solved the problem that it had caused'*. [9:389-393]

Paradoxically, heroin is both an enabler and a disabler as Tom explains: *'…it was all about heroin you know without that you was useless without heroin you couldn't do anything but once you had that in you and you wanted a buzz you'd have to do something else you'd have to it's crazy you know you started taking the strongest pain killer to get a buzz and when that*

becomes your medicine you have to get a buzz from crack then you feel like shit…' [6:243-253] Tom describes himself as a chemist as he sought to anesthetize the pain the heroin caused by taking more heroin: '*... I'd come prepared I'd have my knife box with my knives and under it I'd have either my methadone or some needles with gear in it that I'd washed and cooked up {...} I remember once I scored and I couldn't get into my house {...} so I walked down this alley which I knew had needles in it and I picked one up and I went to the toilet in the bus station and I sat in the toilet and I drew up the water from the toilet in a used needle and injected that and that the lowest thing I think I've ever done you know I sat there with the belt around my arm and my foot on the door using the water from the toilet and a dirty needle and that was purely from physical withdrawals I'm not saying that addiction is not psychological it definitely is but the physical withdrawals'*. [4:173-188]

The quote above illustrates the extent the participants became physically dependent on drugs. It is all that matters in their lives. Anand describes this experience: '*it wasn't living was it being, being under the influence all the time it wasn't living so I can say this to you now like you know it wasn't living before it was living for me'*. [18:850-853] For Anand, he did not exist without heroin: '*It was physical or they're won't be no clucking or anything like that you know physical in the sense that without heroin I couldn't operate I wouldn't be able to operate'*. [18:833-835]

Joe further illustrates this point: *'…I was living I was waking up every day using drugs and I was live to use and use to live yeah I was using drugs to use to function you know'*. [1:37-39]

This physical dependency is a paradoxical way of living where the participants feel they have no options but to keep taking the drug. For Rosie heroin was a way of life due to its physical addictiveness: ***'...*** *especially if you are physically addicted and you know although they say crack and other drugs aren't but they are they become physically addictive it becomes a way of life...'* [11:320-322] She does not explicitly talk about pain-relief but mentions how living

in chaos is part of being an addict: '*Usually if I was coming off an addictive drug I would take another addictive drug to come off that, so it was kind of catch twenty two'*. [12:344-345]

The participants struggled with cravings, and heroin was the only thing that provided relief. This is mentioned by Mo in relation to his dependency on crack: *'Is forgotten about it if it was so simple and systematic to go through your process and do this and do that everyone would be off crack yeah it's like once it comes in your mouth everything else doesn't matter you don't care about your mum or your wife you don't care about (the Centre) f**k it let them kick me out tomorrow'*. [7:330-334]

Although all participants found heroin hard to give up, five of the participants describe struggling with a sense of desperation. According to Mo: *it is not only a physical condition but it becomes physical'*. [11:501] In terms of his own experience he describes: '*I'm desperate to think what shall I do know what I'm trying to say should I cut off my arms so I can't smoke no more it's like you're a robot know what I'm trying to say what do I do sort of thing I can't, I can't, I can't go on smoking again and it'd take me further and deeper'*. [11:479-483]

On the other hand, Lucy said she found heroin easy to give up: '*I had the knowledge of how bad it was that's why I found it a little easier to give it up'*. [8:292-293] Yet, she still struggled against her dependency to alcohol and cannabis. For Ed, it was more difficult to give up a lifetime of addiction: *'...heroin was twenty three years of hard graft of staying with me…'* [6:255-256]

This sub-theme explored how the participants' identities were driven by their efforts to avoid physical withdrawals, and how they became trapped in a cycle of addiction and dependency which robbed them of any identity outside of using drugs to survive. Pain-relief was understood as a coping mechanism, where the participants could not tolerate living in their

environments without it. This was not only because they were desperate to escape their suffering, but also because they felt it was their only way to survive. As a pain-killer heroin became a medicine which robbed them of a negative experiences, but enhancing pain on another level.

4.2.4 Spiritual Dimension: 'Spiritually Dead'

This sub-theme looks at the meanings the participants gave their experiences. Given that the participants were mainly concerned with survival, this aspect of their identity is also touched upon. They operated on a practical level where heroin robbed them of the meaning they sought to gain through it. Again there is a gap between what the participants wanted to achieve and the reality they experienced. Ed describes: *'It took over, it took over everything I lost everything it took over everything (...) yeah proper soul destroying physically destroyed me mentally destroyed me spiritually destroyed me'*. [7:326-328]

As we can see, addiction *'took over everything'* and for Ed only by being removed from his environment could he find new meaning. *'I used to sit there and think if there was a God, fuck sorry for swearing you know what is he playing at you know why is he putting me you know what I didn't even realise twenty five years had gone past'*. [7:330-332] The participants experienced time differently. To them great amounts of time seemed to pass-by very quickly while they were in addiction. In Ed and Joe's cases, they felt angry at the circumstances of their lives and there is a sense of unfairness in their tone. As seen in the excerpt by Joe below, life was lived on a plateau where no emotional highs or lows were allowed.

Joe: *'I was just I was spiritually dead like washing up a lot of coke and just smoking it'*. [3:84-85]

In terms of creating meanings in their identities, participants got to a place in which pain was experienced more acutely. At this stage they felt that they could no longer control their experiences and started looking for other meanings. Joe explains: *'I got arrested for something and I'd just had enough of getting I'd just had really I was at my wits end {...}I'm gonna end up dead and I might as well be and death would have been welcomed to be quite honest with you life was so spiritually it was so horrible I had everything {...} all the material things but you know what I mean it was just horrible…'* [9:400-407]

Feelings of void, and feeling *'sick and tired of feeling sick and tired'* [11:311] as stated by Rosie, are explicitly mentioned by six of the participants. This sense of regret is seen in this quote from Anand: *'I suppose it took my life away it has taken my life away and I feel gutted about it gutted ain't the word I'm mortified about it'*. [10:445-447]

The participants felt a void and that they were spiritually dead, and they started regretting past decisions. As illustrated in the quote by Anand, heroin took their identities and also robbed them of their humanity. *'Every reason I wasn't a man no more basically'*. [18:835]

At this stage, the participants operated at a survival level which, when it no longer works, they come to regret. However, it is only when faced with death that they get to a place in which they can feel. As mentioned, not all participants explicitly talked about the spiritual dimension and a void in meaning. Yet this can be inferred from the narratives once they get to a place of no-meaning. As Tom states: *'it was a beautiful feeling initially it was lovely and I'll never forget how nice it was in fact but if you weigh up seven years you could probably fit the niceness in maybe three months four months you know it's measurable four months you can remember that and then you look at the other time six years and eight months and you think you know what it was shit you know it was shit'*. [11:504-509] Time is meaningless in addiction once one is 'spiritually dead' and heroin takes over everything. The sense of meaninglessness will be further explored in the last theme

4.2.5 New Possibilities

Reaching the stage of new possibilities requires creating a new identity outside of addiction. Each participant talks about changing their whole lifestyle. Rosie's lifestyle change is the predominant theme in her interview and she talks at length about this new identity in recovery*: I think that people going to detox two weeks isn't enough to change your whole lifestyle you know.{...} it's about making changes and I think to do that it's a lot easier if you go away and do it somewhere else yeah and a lot of people chose to stay away but you know for some people it's ok for them to come back and make them changes but you know if you come back and you have changed and nobody else has that makes it really difficult'*. [15-16:446-466]

As we can see from this excerpt, to change her identity would have been impossible for Rosie unless she changed everything else around her. All the participants describe a similar experience. Whilst for Rosie in particular, a new identity meant adopting the twelve step treatment philosophy: *'...today I chose not to take drugs and twenty five years of not having a choice to get to where I do have a choice you know and I had to go away out of London to a treatment centre, to address some of my issues that and some of my consequences around my using and I got to have a programme in my life and today I keep it in the day'*. [14:413-420]

Treatment means a decision to learn to cope with the challenges of life differently and provides new identities for participants. Most participants, except for Mo and Tom, adopted the NA twelve-step approach. For Ed, Joe and Anand this new identity became something to strive for. Ed states: *'I look at him and think I want some of what he's got his lifestyle'*. [4:402-403]

Ed and Joe both compare themselves to addicts in recovery and are finding a new way of being which opens up new possibilities. Ed states this in terms of gaining something he lacked in addiction: *'I could have quite easily scored in jail but it was just looking at people*

that were in recovery in addiction crack cocaine drug addiction just call it that I look at him and think I want some of what he's got his lifestyle'. [9:400-403] New possibilities mean a new lifestyle, as Joe describes: '*just keeping away from the old people and stick with the winners'*. [12:567-568]

This new identity contrasts with how the participants used to be, and gently opens up new possibilities and ways of relating. This can be seen in the following excerpt by Anand: '*I never knew that you can you know come get help the way they help the way they get things out of you the sponsorship you know the twelve steps and all that I never knew these things existed so in the beginning for a person like me to come and open up and talk to somebody you know like five months ago you wouldn't have got a word out of me'*. [20:915-919]

Getting help means finding a new way to be and engaging with the world. Mo and Tom describe a new identity which is opposed to the NA model for recovery, as seen below. Mo is the only participant interviewed whose decision to quit stemmed from the threat of losing his wife. He felt angry and ambivalent during the early stages of treatment:

Mo: '*...what about the fifteen years of the service the GP the hospital appointments and everything else I've been on benefit for fifteen years housing benefit and when you add it up they're paying a thousand pounds just for me to stay in my flat every month they could have bought me a house do you know what I'm trying to say and now that I'm not in addiction no more it's like yeah you'll be alright and if I get a job now they'll stop my housing benefit {...} and then I'm homeless I've got nowhere to go you ain't got kids there's other people with more priority they can't really help you...'* [13:599-607]

Tom shares a similar outlook in terms of deviation from the predominant model. For him, new possibilities are brought about by a combination of readiness and luck:

'*...you can choose any one of them and you could go there and it could work but that's not because of the treatment you've chosen it's just because you wanna do and you're ready for*

it and you get luck and you need all of them things you need to be ready you need to go through it and you need a little bit of luck {...} I don't need to reinforce how sick I was every day in my head cause then what messages are you sending to yourself that you're always gonna be sick I'm not always gonna be sick...' [12:541-553]

The excerpt above illustrates how new possibilities are not dependent on one therapeutic model. Therefore what works for most of the participants in order to stay clean does not work for others. While Mo and Tom actively oppose the NA ethos and describe it as a *'cult'* or a *'cage'* respectively, five of the participants used this model as a way to show them new possibilities. For Lucy, this structure meant she could look outside her family for a new identity as seen in the next quote: *'I wanna break the pattern for my daughter you know my nan was a drug user and her kids were all in care like my mum and my mum was a drug user and then I was so it's gone down and I didn't want my daughter to...'* [8:383-388]

4.3. Lack of Control Leads to Recovery

This theme looks at how the participants got to a place where they could no longer control their experiences. This shows how choice is connected to their feelings; however, at first the participants did not feel they had many choices. While initially it was difficult for participants to acknowledge their lack of control, it was only when life became intolerable that the participants decided to change and seek help. Rosie states: *'I didn't feel at that time you know I had a lot of choices you know it very quickly became a way of life and I didn't know any different'* [3:64-68] The example below shows how she felt she could not make rational choices whilst trapped in addiction:

Rosie: *'it's like if someone said to me 'oh your children are there your drugs are there who would you chose?' I would like to say I'd chose my children but, if you are in addiction you*

don't make... you irrationally, I would have to have chosen the drugs first to get to my children you know so you go that sounds awful but that's the way if happens {...}well give me the drugs to get to my children'. [12:363-368]

It is only by accepting that she has no control and seeing addiction as an illness that she gets to a place in which she can manage her addiction, she states: '*... I think it's an illness that anybody could come across and it is circumstances in life. If I hadn't gotten off the train in Euston and met that particular person maybe my life may have been very different'*. [4-5:112-125] For Rosie, by accepting that she has no control over her addiction she is able to move towards recovery.

Other participants share a similar outlook by accepting their powerlessness. Anand explains: '*There was no choice in the sense like you know I, I although I've heard about that people can get help and come off of it and I've heard like you know you hear about detox units I'd just heard about the methadone I suppose at that time and I tried taking methadone but I could never tell you know overcome myself in my mind'*. [11:495-499] Given the control addiction had over the participants, it took external help to change their lives. Another example of lack of control is seen in this quote by Ed:

'*...when I got explained to me what a habit was and yeah I think I could have quite easily chose not to use but you know what I'll be honest with you the way I felt physically I had no choice mentally I could have had a choice I did have a decision to make mentally but physically I thought it's the wrong decision to stop if you decide to you know your mental choice is no I ain't gonna use {...} so mentally I had a choice verbally I had a choice obviously but physically no I don't think I did'*. [5:199-208]

It is only by accepting this lack of control and lack of choice that the participants are able to accept help outside of themselves. Joe explains: '*I've just lived in denial'*. [6:247] For Tom

while at first addiction was about managing his symptoms of cravings and withdrawals, he also got to a point of accepting he had no control as seen in the quote below:

'I started injecting and I started using crack as well diazepam and then my health deteriorated and my job was suffering so after three attempts at rehab and detoxes I moved away...' [1:28-30]

On the other hand, for Lucy there was a link between lack of control and living in a chaotic household where she took a lot of responsibility because her mother was an addict: *'…I remember always looking after my brother, looking after my sister. I was the one who was always cooking dinner'.* [4:147-149] After she enmeshed with her mother and started using drugs, it was only when she lost her daughter that she noticed her life was unmanageable.

In attempting to move to a place of recovery, Anand was still struggling with alcohol after giving up heroin. *'I was drinking nonstop like you know drinking came to me first then the drugs came and I've never stopped drinking till the 31st August last year'.* [19-876-878]

It is only through the participants noticing how they were no longer able to survive or function that they were able to give up the only thing they felt they could not survive without. This stage of reaching rock bottom will be explored in the next sub-theme.

4.3.1 Rock Bottom

By reaching rock bottom, the participants got to a place where they reassessed their situations. Here the participants moved away from using drugs to numb their feelings, which had ceased to work. Three of the participants described how their arrivals at rock bottom came about through near-death experiences. For Ed, heroin started costing more than it was worth: *'I knew 'cause I got threw off a building and stuff so this is what heroin's caused I got threw off a building.... I've got all metal work in my pelvis and metal in my knee cap two rods in my leg stabbed in the backside smashed all my teeth'.* [8:337-342]

Anand states that he '*hit rock bottom so many times it was unbelievable...*' [12:534-535] While he describes running out of money as a rock bottom for him, he also experienced almost dying, though he was unable to change at that stage. '*I come into the bath I conked out in the bath innit gone and my dad two hours later if my dad didn't like you know start banging on the door I was white I was proper white in the water innit'*. [19:861-864] Yet rethinking this experience only came after recovery. He describes his father saving his life by coincidence: '*If he didn't go in there I would have been dead and near death experiences I've had before and you know I'm lucky to be alive but then I just laughed it off...'*. [19:866-868] At the time of the near-death experiences, the participants could not feel different towards what was happening to them. For Anand this was because, in spite of reaching rock bottom, he was still using alcohol to cope.

Joe also felt nothing at the time he almost died: *'....I went out and bought a pack of needles and one of them done it for me and I died they said I went all blue {...}one of them wanted to just leave me but the other one he sat with me'*. [7:327-331] The participants, however, only thought about their experiences at a later stage. Joe: *'I didn't really think about it because I'd just get out me nut again that's how it was then but now when I think about it, it does frighten me a little to think I'd come that close to actually dying'*. [8:337-338]

As seen in the quote above, although there was little or no feeling at the time, death represented the ultimate limit situation in which Joe had no other alternative but to get clean. For Lucy, the experience of reaching rock bottom came through a realisation of what was to come if she started injecting heroin: '*I know I would have ended up injecting and that's it I think I would have been dead now'*. [9:339-341] This realisation prompted her to look at herself differently: '*I remember sitting in that bath the morning I came up here I was crying I looked so disgusting'*. [7:318-319]

Rosie's rock bottom is also only illustrated in retrospect of her experience: *'I had abscesses I had septicaemia, I had a bad heat infection, I had- I nearly lost my leg, I had hepatitis, I don't know I had various sexual transmitted diseases, {...} It's a chaotic lifestyle you live in; you don't treat things until they are at their very worst'*. [15:433-437]

Although the participants did not explicitly describe these experiences as rock bottom, we can see that the chaos of their lifestyles gets to a point that they can no longer be tolerated. According to Rosie: '*... eventually you get sick and tired of being sick and tired'*. [11:311]

Some participants suffered less physical damage and did not come up against near death. However, Mo also struggled to give up and shared a similar outlook to Rosie.

Mo: '*...the lifestyle the thought of thinking I'm going to fifty years old with some of the people I see and not having nothing because that's not me'*. [11:489-491]

Tom is only able to assess the consequences of his drug use at a later stage. We can see how rock bottom is not a stage the participants get to, but a series of consequences the participants are only able to reflect upon after recovery. Tom mentions the psychological impact of reaching his limit: *'I knew I had the problem I knew when I started getting sick but towards the end you know like I said making up stories of being mugged and all sorts of shit and it becomes so kind of schizophrenic'*. [13:609-613] For Tom it was only much later that he gained a different perspective of himself by looking at what heroin had cost him: *'...self-respect goes out the window you know the usual suspect is what you hear everyone say and for me it's mainly my teeth now I'm seven years clean and when I look at my teeth I've got bits crumbling away {...} so I'm not happy'*. [8:353-357]

The next sub-theme explores the stage of not-feeling before the participants get to a stage where they are able to change.

4.3.2 Not-Feeling

As seen in the previous sub-theme, the participants lived an existence where they blocked out their emotions. Even when reaching rock bottom, the participants could not have feelings about their situation. This was because neglect is a learned response. For four of the participants this was made explicit in their narratives. Ed, who was physically abused by his dad, described himself as a '*problem child'*. [7:291] He then used drugs not to feel. This can be seen in how he describes how heroin made him feel:

'... it's like a ready break it's warm you don't need anybody it's warm do you know what I mean till later on in the usage but yeah I woke up one morning and I was dog rough I was () what the and a friend went to me you've got a habit and I went {...} I mean soon as I had a smoke I was superman again I was like there you go it ain't that bad so using again carry on using ...' [4:177-193]

This shows how Ed used drugs not to feel, and could not feel anything about his situation. The next quote illustrates how Ed turned his back on the world: '*Sorry for swearing but fuck the world do you know what I mean'*. [3:130] This sense of anger and disappointment was what led the participants to want to block their emotional responses to a world that had rejected and abandoned them.

Joe used drugs as a way to avoid his depression. This can be seen in the next excerpt: *'...I was just using drugs when I was depressed or something I could use the drugs to self-medicate and not be depressed so maybe, so maybe I'm not interpret ting it properly but even now I fix on things'*. [8:364-367] Joe's struggle with depression can be seen in how he ran away from his emotions: '*I'd just sit there all night like really depressed really I mean severe depression that's why when I got introduced to heroin I could have crack and that or freebase coke and without having to go through all the torture of being really depressed a bit of heroin it just put me flat out you know'*. [8:348-355]

Similar to Ed, for Joe heroin was a means to avoid pain. He wanted pleasure, not pain, and he explicitly stated this several times during his interview whilst he talked about *'keeping a lid on his emotions'* and '*not having the sense to deal with things*'. [8:357-360]

Given what had happened to them, the participants felt they had no alternative but to self-medicate and numb their feelings. Drugs were a way not to feel. For Rosie, numbing her emotions meant survival in a world of drugs and prostitution. As with most participants, this was an interesting paradox of surviving and gambling with life at the same time:

'I needed to... be () I was gonna say, off my head... but I don't suppose, be...be I my own world sort of thing, I needed to.. take away pain I suppose I don't know or take away normal living you know that realisation that what I was doing wasn't what I wanted to be doing but when I did it it felt ok... so it was, I don't know it was () can't even think of the word but it was to get by... It was what I needed to do to get by...' [3:68-73]

The quote illustrates how using drugs was the only way Rosie felt she could survive her situation. Not-feeling was the only way she felt she could get by, as she explains: *'... it became a way to live and I didn't know any other way to live or survive...'* [2:54-57]

For all the participants, blocking their emotions was a way of coping with emotions they felt that they could not contain. Lucy started using heroin after she lost custody of her daughter and her partner offered her drugs to numb her sadness: '*I was so upset and I said to him no and for about two hours I kept saying no I don't want it I don't want it and then I did and I did feel better'*. [5:210-123] Not-feeling was her mode of being which she had learned from her mother. At the time, heroin provided relief: *'It was just like a big bubble and I felt so warm and just so good and I knew that I didn't look good but I felt really good... it took the pain away'*. [7:305-309]

Although heroin worked to make 'nothing else matter', the participants did not know of any other coping mechanism for life's difficulties. Mo also felt that heroin allowed him not to think of the future and stay in the present through not-feeling:

'To go and get your crack and smoke it nothing else matters it doesn't matter that you're not working anymore or what you done yesterday or anything nothing matters...' [3:105-111] He also mentions survival as a means of blocking his emotions: '*....you think just to survive you need it to get out of bed you need it yeah but once you stop it you understand it becomes a mental thing because what we don't understand when we're in the physical bit it actually comforts you and takes away all your feelings do you know what I'm trying to say without the heroin you're thinking I'm a scumbag I ain't got nothing {...} once you're on the gear reality's not there anymore you're just numb to reality and you don't really care what people think and say'*. [11:501-516]

Not knowing a different coping mechanism meant that the participants believed taking drugs was the only way to make them feel better about their lives. Tom illustrates this point in the following excerpt when he talks about being given heroin by his brother: '*I was like okay you know you hear what people say about heroin but then you hear what people say about ecstasy you know the effects and all that and nothing had ever happened to me'*. [2:49-55] For Tom, heroin was *'a buzz, kick, escape'* and later it becomes the only thing he relies to not-feel: '*…I just wanted anything to change the way I felt I was knackered'*. [7:314-315]

Heroin then becomes a way of disengaging from the world and stopping emotional responses to the environment. Neglect is a learned response as a result of rejection and abandonment. The meaning adopted is to avoid further pain. Similar to the other participants, Anand also talks about how he did not know a different way to live or survive apart from not-feeling: *'...without heroin I couldn't operate I wouldn't be able to operate'*. [18:834-835]

4.3.3 Choice as an Emotional Response

This sub-theme shows how choice is connected to the participants' feelings when they feel they can no longer control their experiences. For most participants this link between choice and emotions is only explicitly made once they are in recovery. The participants get to a stage where they want something different. This becomes a realisation of their responsibilities which brings up new emotions.

For Lucy, at first she gave her daughter to her aunt to look after, and when her daughter started questioning her, she started questioning her own experience. She explains: '*what stopped me is her getting older and you know because I was that age when I realised that my mum was doing it'*. [8:357-359] Lucy realised that apart from running from her responsibilities like her mother had, she did have different choices. However, she could only get to the point of making different choices when she felt differently towards what had happened to her. In the next quote she talks about how she felt it was unfair that she was punished for using drugs whilst her mother wasn't and how she wished she had seen a different way of life sooner:

'*I did not at the time but as I'm older I wish someone had come and taken me off my mum I wouldn't have liked it at the time I don't think but now I've got more of an understanding I wish'*. [8:377-380]

This new response to her environment was only possible once she had the space to feel differently; once she was out of that environment. Whilst she felt ambivalent about her upbringing she had very little choice because there was no space to reflect and feel about her

situation. Only when this changed did she feel differently and realise that the environment of her upbringing did not provide good enough conditions for a child.

All the participants interviewed reported an emotional shift which allowed them to contemplate different options. For both Rosie and Lucy, losing custody of their daughters and fighting to get their daughters back became the reason to get clean. For Rosie, she did not know how to change and things got worse for a while until she adopted the twelve step treatment programme. She talks more directly about how she struggled with changes prior to her recovery: *'...you need to change otherwise you lose your children but they... you'd have to change but you couldn't so I wouldn't answer the door, things got worse instead of better because... I it's like telling someone to change but you know how do you change years of living in a certain way, I didn't know'*. [13:379-383] Anand also felt he needed to change and after he found out his wife was pregnant, he stopped using heroin. Yet, because he had a bad experience in hospital he started drinking to cope:

'I had a bad experience in hospital () my baby within an hour of birth my baby in my hands the baby was dying it stopped breathing {...} I thought I lost my baby and basically the drink was the only thing around to keep me sane'. [18:819-825]

His decision to stop was also an emotional response. However, it was only when he had space in hospital that he was able to give up alcohol:

'...I had to be admitted into emergency hospital where I was gonna be dead if I didn't go into hospital that particular evening I was a gonner basically you know I was coughing up blood {...} had fourteen days detox in hospital in a lock down policy basically I couldn't be let out the hospital 'cause money or no money I'd always know how to get a drink'. [19:897-902]

As we can see from the extract above, Anand could no longer control his experiences and he did not know of any other coping mechanisms. This is how by feeling differently about his life situation he was able to change his behaviour. By being in contact with their emotions, the participants came to make different choices. They started looking for meaning in their lives outside of drugs. The experience of feeling for Joe also happened once he had the space to contemplate a new way of being: ***'****I got arrested for something and I'd just had enough of getting I'd just had really I was at my wits end of everything you know and I just had to and I just thought if I don't sort this out now then it's never gonna be sorted out and I'm gonna end up dead and I might as well be and death would have been welcomed*'. [9:397-401]

He makes a different choice because he feels guilty about his life situation, and he describes feeling ashamed of his previous way of being. '*I've lost all that and me mum died in 2005 she knew about the drugs and I always thought I'd get clean before she dies and that didn't happen and I feel guilty about that {...} I just could've done a lot more you know'*. [10:452-459] Joe talks about how he was selfish before as drugs made him not care: '*...in the world of drugs people are like {...} it's all about self you know'*. [8:344-345]

It is only when the participants get to a place in their addiction that is much more painful than where they were when they first started that they can feel compelled to change. Tom explains his experience of feeling different about his life in the following excerpt: *'...they sent me to detox and I knew I had to go 'cause it happened when everything was falling apart work wasn't doing well I looked like shit bottom line I'm working in a really good kitchen in London and I'm walking through the members are looking at me and I look like shit'.* [10:442-446]

We can see how choice is connected to their feelings once the participants get to a place where they no longer feel they have control. This is true for all the participants interviewed. In the early stages of recovery, Mo is impatient to move on with his life. While at first he

used drugs as a way of avoiding taking responsibility, Mo states that his family *'wouldn't trust him with no responsibility'*. [9:417] Drugs became a way of denying responsibility. During his interview, Mo was at a stage where he felt ambivalent about his decision to stop using drugs. He talked about his frustration and his impatience to move on. His fear of losing his wife was what motivated him to give up, and at the same time he felt that she didn't understand and that life was easier when he was on drugs: *'...it would be easier it's like, it's like when you're smoking crack you get all the support and all the love from the family because they want to fix you sort of thing and they even give you money to go out and score drugs because they feel sorry for you in a way but once you stop it's like none of that's there anymore sort of thing even being in the day time's hard for me especially I'm Asian init and they think all this stuff is crazy*'. [9:383-389]

Apart from feeling misunderstood, Mo's experience is different from the other six participants who no longer feel ambivalent about their decision to stop. Getting clean and feeling again becomes difficult when drugs are not used as a coping strategy. This can be seen in the quote by Ed who made the decision to stop in jail.

'Yes it's been emotional it's been painful but it's possible to come out the other end of it that's what I have learned do you know what I mean it is possible but it's some hard work it's a struggle but it's possible the proofs in the pudding you know it's like really I've done it not only 'cause I've been banged up 'caused I could have quite easily scored in jail {...} I feel rich when I've got my emotions and my family..' [9:396-406]

As we can see from Ed's quote, it is only once he got to a place where he had the space to be different and to be away from drugs that he was able to make a different choice. Choice is an emotional response as the participants could not make different choices when they felt no emotions.

4.3.4 Treatment is a Choice to Feel Again

Rosie was the only participant that spoke explicitly about feelings of self-acceptance: *'I think you need to learn to love yourself and that's really - I mean I like myself today, I certainly don't love myself but you know I like myself today which is a huge step from where I used to be'*. [15:455-457] This is because for most participants, feelings of acceptance were only gained through drugs. Also, Tom and Rosie had been in recovery for years while most of the participants interviewed were accessing treatment at early stages of their recovery. For Rosie, having a choice means total abstinence and a new way of being. She spoke about having a choice by illustrating the nature of her *'addictive personality'*.

'... there is this saying in AA 'it's the first one that does the damage' and I used to think how can it be the first one that does the damage it's the last one when you fall over, or when you end up in bed with some stranger {...} I know for me that if I have that first one that starts off the cycle of damage so you know like, and it would take away my choices. Once I pick up that first one I don't have a choice, I have a choice over the first one but after that first one... for me... I don't have a choice. I cannot stop the obsession...' [8:225:236] Yet there was still no acceptance from the people she used to know: '*you might come back really healthy, often put on weight, nobody really notices it. I came back and somebody said 'oh you got fat' and I thought I was fit and healthy'*. [16:464-466]

The decision to change by feeling again is fraught with conflict. Rosie talks about how the choice was taken away from her. In Tom's narrative he spoke about how this choice was overwhelming early on in his recovery:

'You don't know what it is you start feeling again and when you're on gear you think you're feeling you go to funerals and you cry you feel pain {...}everything seems real but when you stop using it and you come off it and you just go and sit on your bed and put your head on

your pillow and cry {...} you don't know why your crying and it's just because everything's coming alive again and everything that was sweet and now you are coming awake it's painful you know 'cause you're not used to feeling you're not used to having emotions...' [8:363-378]

Tom talks about how for him life is a lot harder being clean. This experience is also shared by Joe who struggles to manage his emotions without drugs: *'...there's lot of issues I've really got but I've just got to keep the lid on them a little bit you know'*. [7:289-290] Similar to Tom he spoke strongly about how he finds it difficult to managing negative emotions: Joe: *'...the hardest bit is dealing with all the life and the life's turns and I'm nine months clean nearly and I'm slowly starting to adjust and it's hard'*. [5:233-235]

Joe was recently in recovery at the time of the interview, whereas Tom had been clean for seven years. The participants who were at early stages of recovery reported struggling the most. Mo talked about the temptation to use to numb difficult emotions: *'At the moment I have a choice yeah but I don't think it's 50/50 it's more like the bad side of it is more than the good side of it sort of thing'*. [10:454-455]

Anand shared a similar experience when he talked about how hard it was to let heroin go: '*…heroin wasn't ready to let me go and I had to let go of heroin cut ties with it in the sense like ok you've been you've been buddy for so long and it's time for me to look forward you're only something from my past I've gotta leave you behind I've learned how to do that and it was hard...*' [20:908-914]

We can see that treatment is a choice to feel again, and that the participants in early recovery struggle the most with it. Lucy projected herself into the future when she decided to stop: '*...I knew that if I carried on it would have been so more difficult to get off*'. [7:318-325]

The emotional decision to engage in treatment and deal with underlying issues is difficult. The participants are used to not-feeling and changing to this new way of being requires persistence and support. In treatment the participants start thinking about who they are

outside of their addictions. In terms of treatment being a choice, it was only a choice possible once other choices have been taken away from the participants.

Ed illustrates this point when he talks about how the control of his life was taken away from him when he ended up in jail again, which was where he decided to change. *'God bless jail I do in some respects it's through me and jail me doing it and jail being there for me at times it's a God send really'*. [7:311-313] The decision to feel again was one that Ed made by finding spirituality, or something outside himself: *'I used to go to church years ago yeah a church outside in jail to go and score heroin but in this last sentence I used to go to church to go to church to meet other inmates not to score not to score drugs...'* [9:413-415]

Choice is therefore only possible after the participants get to an emotional place where those choices can be made. However, in order to get to a place where they could feel, other choices needed to be taken away first. Initially, using drugs was felt by the participants to be a means of survival. Whereas developing meaning in life only became possible in treatment *after* the space to develop new coping strategies had been developed.

Chapter 5- Discussion

5.1- Overview

The aim of this study was to explore the experience of choice in heroin addiction using IPA as the method of investigation. Seven participants were interviewed through a semi-structured questionnaire on their subjective experience of addiction. The analysis was carried out in order to gain an in-depth understanding in this area by paying particular attention to commonalities and differences that emerged from the themes. This section looks at the findings in relation to the existing literature on the subject. The main themes are explored in the context of the theoretical background in relation to the findings. Firstly I will summarize excerpts of my reflective journal. I wrote down my initial responses to the participants after each interview and reflected on the process as well as my impressions of them and how I felt I had impacted on the research process.

5.1.1- Sample

The excerpts below were made while reflecting on the interview process straight after each interview. All identifiable information, including names has been anonymised. I feel that I did not embody the 'typical professional' identity expected of me as a researcher. This is because I was much younger than most participants and of a similar age to three of the participants. In some ways this might have been an advantage in my favour. The participants knew that I had never experienced addiction. The participants knew that I had previous experience working in the field of addiction and that I was a practicing counsellor. I hoped to give the participants greater opportunity to share their experiences with me. Based on their interview responses, I believe that Joe, Mo, Anand, Lucy and Ed thought I was pro the 12-

step approach, whilst Rosie and Tom perceived me to be against it. By not disclosing my stance, I hoped this would give the participants an opportunity to speak more freely of their own experiences of treatment.

Furthermore, during the interviews, in the information sheet my opening statement included how there were no right or wrong answers and how I was interested in finding out about their experiences of addiction. I will attempt to describe my reflections on each participant interview below.

Interview 1: Rosie was my first interviewee who volunteered to be my pilot interview when I approached Centre A looking for participants. Rosie's interview took place in her office as she worked for the organization that helped addicts in recovery. She was very opposed to the notion of choice in addiction and believed to be an illness which can be triggered by different circumstances in life. Rosie said a few times how 'normal people' don't understand addicts have no choice. I assured her I was interested in her experience and when she shared her story I felt a lot of empathy for her. She felt that at 14 she was not a child and did not see herself as the victim of abuse. I was shocked at what she disclosed during this interview and used my therapy skills of listening, asking open-ended question and empathizing more than following any interview schedule. Yet, I was mindful of not falling into the role of therapist. I asked a lot of prompt questions and Rosie was very open which allowed me to cover all questions I had set out to ask. Rosie had been in recovery for a very long time and felt comfortable sharing her story. At the same time I felt shocked at what she had gone through.

Interview 2: Lucy seemed very keen to tell her story but did not engage with the emotional content of it. She kept saying 'I hope I helped you' and I wondered what she thought I wanted to get from the interview as I had explained earlier there were no right or wrong answers and I was interested in her experience. I wonder whether that comment also reflected

her way of being in the world wanting to please others. Yet, I had the impression she was keen to finish the interview quickly. I had a basic interview schedule in my head this time and allowed her to tell me her story asking prompt questions. I felt that Lucy was quite shy and nervous and at the end she started telling me about the abusive relationships she had in the past with men and how she felt she could not trust them.

Interview 3: Tom also volunteered to take part in this research when I approached Centre A. I had a job similar to him in the past to the job he was doing at the time of the interview. I felt at ease with Tom because of this commonality and there was a 'work colleague' relationship between us. At the end of the interview I found myself mindful of not stepping into my therapist mode by not asking questions about his brother. Again, I stopped myself from asking any therapeutic related questions as I reminded myself of my role as a researcher. My aim was to investigate the research question and focus on the participants experience towards this phenomenon. If this was a therapeutic relationship I would have been less directive. Tom had also been in recovery for a long time and was comfortable sharing his story. Given that Tom worked in the field of drug addiction he was very keen to share his knowledge from an experiential and professional level of the physical causes and consequences of drug addiction. Towards the end of the narrative he switched from telling me of his experiences to his client's experiences which was a little confusing at first. I had to remind him and myself that we were concentrating on his personal experience.

Interview 4: Joe was the fourth participant that I interviewed. His body language was slouched, and because of all the non-verbal communication I felt intimidated by him at first. Joe was quite defensive and I had the sense he did not want to delve too deeply into his emotions. He mentioned during the interview how he '*didn't want to start thinking about too many things*'. This made me feel he had to keep me at an arm's length. I also noticed Joe's impatience the way he glanced at the clock several times during the interview. Only towards

the end of the interview that Joe started to relax and be more open. Even though I felt that Joe portrays himself as a gangster, I sensed there was deep pain that he was trying to hide. When he started talking about guilt and shame, I felt I was then able to empathize with Joe. Once the interview was over and the tape recorder was switched off, Joe confided that there was a lot he didn't tell me about his crimes because '*you never know'* which I understood as his fear in me having to report him if he disclosed anything beyond our confidentiality agreement. Although he said he felt comfortable talking to me there was some of his story that he wanted to keep hidden. I wondered what he felt he could not tell me. At the time of the interview, Joe had only been sober for nine months and was still adjusting to recovery. Joe referred twice to spirituality and I regret not asking or probing deeper his understanding of spirituality and what he meant. Like a couple of other participants Joe mentioned feelings of shame and guilt about being perceived as a 'junkie' and I wonder how much of that he was projecting onto me. Perhaps his initial demeanour was a way to protect against projected judgment by researcher? I was very aware of keeping a non-judgmental, open attitude but I feel there was nonetheless a different dynamic in each of my interviews.

Interview 5: This interview was more difficult than the others for me as I had to concentrate extra hard in order to understand how Anand's culture and upbringing affected him. Also, when Anand started talking about death I was present yet mindful of my own death-anxiety because this interview took place a few weeks before my operation. Death was very present during this interview; his possible death, my possible death and the near death experience of his son. I noticed that when he spoke about his son's near death experience I was suddenly very aware of the rushing noise in my right ear which was a symptom of my brain tumour. Yet, this gave me an increased ability to engage more empathically with Anand and his struggle. It is as if time had stopped during this interview and the interview went on for much longer than I had initially planned. This is because Anand was very open and honest during

this interview which presented a stark contrast to the previous interview where Joe was more guarded. Anand talked a lot and seemed very keen to explain his experiences in relation to the research topic. He was the only participant who refused to take the token of participation and seemed genuinely happy to share his story. I believe unlike other participants who had been in recovery longer, Anand didn't have the opportunity to share his story in his recovery previously.

Interview 6: Ed was a skinhead and one of the first things he said was that he had recently come out of jail which I felt initially intimidated by. It was only later on in the interview when we were about to finish that he started disclosing personal material about an abusive background. The interview was interrupted by a member of the Centre who walked in stating that my next participant had arrived. Although the token might have been the initial incentive to participate, I felt that Ed's motivation in the end changed from giving me short answers to disclosing more personal things about himself and the spiritual aspect of his recovery. I also had to bracket my tendency towards the counselling mode when he mentioned his abusive background. I reminded myself that I was there as a researcher only and I sensed that Ed did not want to seem vulnerable or as a victim. I checked with Ed that he was ok after the interview and he was quick to dismiss his feelings towards the violence and abuse in his life. Ed was slightly defensive throughout the interview which I felt reflected his way of being in constantly feeling he needed to defend himself. I believe he felt annoyed at me initially when I could not understand his accent very well when I misunderstood the word 'jail'. I feel that Ed wanted to convey an image of a tough, skinhead gang member to mask his deeper feelings of uncertainty and pain and we only skimmed through the surface of these feelings towards the end of the interview. However, I respected his wish to go only as deep and as far as he wanted to go in his participation. I also believe that the way Ed told his story was a reflection at the stage he was at in his recovery. I noticed a pattern that participants who were in

recovery for a long time would tell traumatic stories with little emotion attached to it, and participants in early recovery would avoid talking about difficult subjects and emotions altogether. This tie in with the findings showing how the participants who have been in recovery the longest had more time to re-evaluate and reinterpret their choices and experiences.

Interview 7: Mo was the last participant I interviewed. Like Ed, he was interviewed two and a half months after my operation, so unlike Mo and Joe's interview I was a lot less anxious about death at this stage. He seemed reserved at first and he told me during the interview how he was bullied and stabbed for being Asian. He seemed quite angry and complained a lot about how his wife did not understand him and how the system was wrong and unfair. Mo talked very fast and sometimes it was difficult to understand him. I wondered whether his complaints reflects the stage of recovery Mo was at during the interview; one in which it was still hard for him to take responsibility. At first, Mo wanted to complain about everything: his identity, the system, violence, and his wife rather than to reflect on his experience. Mo described how disempowered he felt in society for being a drug addict and also for being from a minority group. He told me he had to keep pretending to take antidepressants to get benefits. Issues of identity were the most prominent topic of Mo's interview; how he felt unable to be who he was and how he didn't know who that was. At the same time, I felt I could empathize with Mo's sense of injustice and inequality. He reminded me of a lot of clients I worked with in the past who felt unseen or unheard and I wanted to provide him the opportunity to share that with me. I feel that Mo was honest about his experience of the system and how being an addict had both served and impinged on his life.

5.1.2- Context of the Study

From an existential-phenomenological perspective, the participant's lack of choice can be understood in how they chose to interpret their experiences. This is consistent with West, (2006), Davies (2000) and Spinelli (2007) showing how drugs were used to maintain a certain emotional distance (Larkin, 2002) from extremely challenging circumstances. This choice is seen as situated within a limited spectrum of possibilities the participants could have chosen from. This research was conducted at organizations which had an agenda for treatment. Thus, the 12-Step treatment model and protocols of treatment cannot be divorced from the findings. Clients were expected to abide to the treatment approach by going through their 'steps' which were at first admitting they were powerless over their addictions. This model emphasises the illness aspect of addiction which can take away responsibility and choice. In some ways, paradoxically, by admitting they were powerless they regained some control over their lives which had become unmanageable. However, this treatment model did not serve all participants the same. Although two of the participants were very vocal about opposing this treatment model, all participants had to abide by this philosophy in context of recovery and practice. While the 12-Step model's original philosophy advocates attraction rather than promotion, the participants knew that unless they subscribed to this treatment model they would be discharged from the service and their support would be withdrawn. Even though one of the participants expressed his belief that one treatment model is not superior to others, instead he believed it depended on the individual's willingness to recover, all participants were encouraged to believe that following the steps and total abstinence was the only way they could recover. The scope of this treatment programme and others are beyond the subject of this paper. However, we can see how the participants had limited choices when it came to their recovery programme. Either they conformed to a pre-set treatment agenda or the support was withdrawn. This was not a model of recovery all

participants aspired to. Some of the criticisms of this treatment programme expressed by the participants interviewed are focused on its inflexibility; the way service users are not allowed to think for themselves and how they are convinced through fear of relapse. On the other hand, some participants felt this model was the only way they could stay sober because of its directedness, inflexibility, structure and pre-set moral codes. The choice to abide by a treatment model is felt to be limited by many, but has also worked for many others. Although it was felt to be rigid in many cases, the context of treatment was felt to be beneficial to many others. Those who were excluded did not have an opportunity to voice their views for the same reason of non-conformity. We can see how choice is felt to be limited in the context of the lives of many addicts; whether in recovery or not.

5.1.3- Findings in Relation to the Existing Literature

The findings will be considered in relation to the existing literature on the subject of addiction and choice. Although not all participants abided by the predominant view which characterizes addiction as a disease, the context of the interviews was in organizations which operated from the stance of addiction conceptualised as a disease. Most participants had not thought much about the concept of addiction at this stage. The main findings suggest that apart from portraying themselves as victims, the participants were reluctant to talk about their traumas. The participants who were new to recovery tended to avoid talking about difficult experiences and the participants who were in recovery for a long time talked about trauma from an emotionally-detached perspective. On the other hand, most of the participants strongly opposed the idea of choice in the experience of heroin addiction. Choice can be seen as a complex multifaceted phenomenon where the addiction was to the experience of relief rather than the drug. Given what had happened in participant's lives, they used a myriad of

substances to escape their feelings. The addiction was not to heroin per se, but to whatever could change their emotional state (crack, alcohol, valium etc.). We can see that it is not the pharmacological components of heroin that provides the addiction but the wish to numb pain and to run away from negative emotional states that were overwhelming for the participants. The experience of powerlessness is then replicated because the numbing properties of the drugs soon wear off. Drugs then become a tool which reinforces powerlessness. As chasers of relief, the participants live only for that sensation and the chemical dependency comes only after the psychological discord. Furthermore, in guilt the participants add more to this discord reinforcing how bad they are, needing more of the substance to provide an escape. Finally, the lack of social support emerged repeatedly for the participants throughout this study. The main findings in the context of the existing literature are explored below.

5.1.3.1- Not Belonging

One of the main findings suggests how the participants used drugs to create a sense of belonging. Several participants spoke about their experiences of not belonging and feeling like they did not fit in. This is consistent with previous studies (Watson & Parke, 2011; Etherington, 2008), where the findings suggest an experience of 'lost childhood' shared by all participants. For Rosie, being adopted contributed to a sense of rejection and alienation; whereas for Lucy the sense of social exclusion emerged from the realisation her mother was taking drugs. This is consistent with the view of addiction presented in the context of participants actively creating meaning in their lives (Du Plock, 2005.) This finding is also consistent with the free-will model of addiction (Schaler, 2000; Wurm, 2003 & Davies, 2000.) where as opposed to the medical model's view of there is no choice in becoming 'addicts' (Larkin, 2002), each participant looked for stability, relatedness and belonging

(Beasley, 1998) previously missing in their upbringing. Although human beings are always in relation, for the participants interviewed drugs became a means of firstly belonging to themselves.

In regards to social victimisation as a way of not belonging (Watson & Parke, 2011) Ed, Mo and Anand's described how they felt segregated in their social environments and sought drugs as a means of belonging to something they could control. This finding contradicts the medical model where 'addicts' are seen being driven by forces beyond their control to use drugs (Davies, 2000.) As we can see with the experience of not belonging, using drugs made sense for the participant's given the choices available (Schaler, 2000.) This is linked to the experiences of not being seen, social rejection and alienation. Given their feelings of inadequacy, the participants sought belonging in a marginalised subgroup which further alienated them. The participant's choices were limited.

Previous literature on the subject shows how addiction is understood as a complex phenomena interacting with the individual's environmental circumstances (Larkin, 2002.) This is demonstrated in the findings of this study, for example, given that Mo's and Anand's racial identity was being attacked, they found other ways of building self-worth. The parallel between Mo and Anand's story illustrates how being racially bullied led to difficulties in accepting their Asian identity. For Anand, Ed and Mo, emerging themselves into a drug subculture is seen as a way of gaining respect after being disrespected. The findings are consistent with literature showing how drugs gave the participants meaning where realities of change, separation, ambiguity and loss of a parent (Etherington, 2008 and Watson & Parke, 2011) were found to be influencing factors on the decision to use drugs. Becoming identified with other drug-users was borne out of a desire to belong and reduce alienation (Etherington, 2008 p.189.) Therefore, the medical model's view of addiction as a behavioural disorder (Kalant, Nester & Malenka, 2001) can be contrasted against the findings where human beings

need to connect with others to form a sense of belonging (Etherington, 2008.) For each participant, drug use began as a social activity where the participants sought affiliation and identification with a group that led to the inclusion in gangs and the 'drug culture.' Therefore, drugs satisfied the need to belong yet further isolated the participants from nonusers and a 'normal life' (Etherington, 2008 p.185), as seen in all participants' narratives. The findings showed how all participants experienced being victimised by their families and their environments. This is consistent with Larkin's (2002) view of how some people are likely to become addicted under some conditions.

5.1.3.2- Indifference

This subtheme showed how the participants felt the need to 'mother' and protect themselves given the lack of parenting they had experienced. Ed was stigmatised in his family of origin as a 'problem child'. The literature suggests that a way of coping with and ameliorate life's challenges (West, 2006) is to become indifferent to it. This is consistent with the findings of this study where Mo, Anand, Tom, Rosie, Joe and Ed adopted an attitude of indifference towards their environment. This way-of-being served to protect them from further alienation and feelings of inadequacy.

On the other hand, Lucy felt the need to protect her mother in spite of unreasonable responsibility being put upon her. For Lucy, the interrelationship between trauma and substance misuse can be seen in how she looked after her younger siblings as a way to vicariously experience nurture. These findings are consistent with previous literature by Etherington (2008) and Watson & Parke (2011) where the mother-daughter relationship is seen as imperative to the development of the daughter's positive self-image. According to this theory, the lack of a good enough mothering can have irreparable damage to the emerging adult's self-image (Watson & Parke, 2011.) Indifference as a reaction to parental

rejection is apparent in the narratives of Lucy and Rosie, whilst Ed also felt like an 'outsider' in his own family which intensified feelings of alienation and isolation.

The literature suggests that people use drugs because it made sense for them to do so given the choices available (Davies, 2000.) Similarly, the findings show how drugs became a way to interpret and understand their experiences (Larkin, 2002.) This frame can be seen in how Lucy describes drugs as 'normal', and Mo talks about it being an 'automatic mode' where he 'didn't care about the consequences'. The definition of 'normality' seems to elude the participants where they seem to be searching for its abstract concept. This is consistent with previous literature by Watson & Parke, (2011.) Furthermore, recent studies showed how drugs are a powerful antidote to guilt and depression which is considered to be symptomatic of drug abuse in women (Watson & Parke, 2011.) This is consistent with Lucy and Rosie's narratives of indifference and drug-taking as a coping strategy.

As seen in the literature review, taking drugs can be seen as a way of making oneself passive to the world and escaping responsibility (Sartre, 2003.) The participants all reported escaping their environment mentally by regulating their emotional states to one which was felt to be numb or indifferent. The findings contradict the motivational disorder (West, 2006) view which states addiction to be a learned response to a reward seeking behaviour. For example, taking heroin gave Ed a feeling of omnipotence, making him feel that he was capable of anything. Therefore, drugs were sought for the feelings of relief and indifference towards one's circumstances they provided. This could also be seen as a reward seeking behaviour, in consistence with West (2006) motivational disorder model.

5.1.3.3- Abuse

As mentioned from a free-will model perspective, taking drugs made sense for the participants given the choices available (Schaler, 2000.) Ed, Rosie, Lucy, Anand, and Mo described how their experienced abuse. This abuse and trauma created a sense of discontinuity, which originated a chaotic sense of self, disconnection and over control for the participants interviewed which is consistent with Etherington, (2008.) As opposed to seeing addiction as a 'chronic relapsing disorder' with no decision making process, (Sellman, 2010) these findings can be understood as how drugs became a way to cope with adverse life circumstances (Szasz, 2003.)

Resick (2001) describes how substance misuse may develop as a result of having Post-Traumatic Stress Disorder (PTSD). This corresponds with Rosie's experience of being abused by a paedophile after she ran away from home at 14 years of age. Abuse and trauma may have a negative effect on self-concepts and this is consistent with the participant's experience of the development of their addictions. Ed, Lucy, Rosie, Anand and Mo all reported experiencing traumatic events and not reporting it to anyone at the time. Mo and Anand did not inform anyone of their social bullying and victimisation and when they did, they were told to 'have another fight'. This meant the participants had to develop their own coping strategies to deal with the abuse which included numbing their feelings towards it.

This is in agreement with Etherington (2008) as she mentions Winnicott's (1960) theory on how the lack of a secure home-base means the child equates dependency with pain, disappointment and betrayal and tends to become overly self-reliant. The findings agree with Wurm's (2003) theory that people actively make choices, rather than addiction being a self-fulfilling prophecy. The choice was towards an avoidant coping strategy where the self is fragmented.

Dissociation is a coping strategy to manage trauma; a means of escape from self-awareness through substance misuse by avoiding emotions. The findings were also consistent with previous studies as several participants spoke about this disconnection from self-awareness. However, the need to protect the loved one responsible for an emotional form of abuse can be noticed in the excerpts by Tom and Lucy. All the participants report an ambivalent relationship with their primary caregivers and in Lucy, Ed, Tom and Anand's case this lead to an identification with the abuser. Previous literature on identity formation shows how the basis of identity is formed through relationships with early caregivers whose influence is crucial in the development of trust. When trauma or abuse violates that sense of agency, the participants sought other ways of soothing themselves, often ignoring their wishes and overriding their basic needs as seen in previous addiction literature (Etherington, 2008 p.173-174.) All participants felt they had no one to protect them and did not entrust adults with their experiences. This finding suggests a lack of perceived control which encouraged them to avoid situations through violence and truanting (Mo, Ed, Joe, Anand) rather than confiding in people with the authority to help.

As seen in previous literature, problem-focused coping is the effort to recognize, modify and eliminate the impact of a stressor whereas emotion-focused coping is the effort to regulate the effect from the traumatic exposure (Resick, 2001 p.121.) All participants opted for the latter form of coping, where the goal is to reduce negative emotions and to restore a sense of control and safety in one's environment. Therefore, using drugs can be seen as the participant's conscious or unconscious attempt to search for meaning, ascribe cause and blame, and resolve conflicts between expectations and beliefs. The literature suggests chronic processing to be a result of repeated and severe trauma, lack of support, an avoidant coping style or negative secondary emotions including guilt and shame which results in not processing emotions. As described in the trauma literature reviewed, substance misuse,

depression and anxiety are seen as indicative of chronic processing (Resick, 2001.) This is consistent with this study's findings.

Previous literature suggests trauma often leads to repression and dissociation, impacting on a person's sense of continuous existence (Etherington, 2008 & Larkin & Griffith's 2002.) Childhood experiences of loss, rejection, abuse, repression and isolation were identified as the beginning of client's addictions. The findings agree with the literature as the participants chose to withdraw and exist in the now where frightening unpredictability and a lack of a 'solid' identity were felt to be experiences contributing to addiction problems. For the participants interviewed, undergoing a traumatic or abusive experience was only realised much later in their recovery. Therefore, it can be seen how they were acting out the result of this abuse in their addiction.

5.1.3.4. Objectifying Others

The literature review suggests an existence in addiction where possessions and relationships and devalued and neglected (Kemp, 2009.) The literature suggests that the addict lives an existence of withdrawal from authentic relations with others (Kemp, 2009.) This is noticed in all participants' accounts where the family was a means of getting money to contribute towards one's addictions (Tom, Ed, Mo, Anand, Rosie). This rejection is understood as an inability to process trauma and to develop a stable sense of self, and also as a response to a lack of love. Also, given that the participants were objectified by their primary caregiver this can be seen as a learned behaviour. All participants became self-reliant in the need to cope with their environment. Joe spoke about death and loss as his mother passed away before he got clean. This is consistent with previous findings showing how addicts struggle in creating authentic relationships with others.

The findings agree with studies suggesting that when a traumatic memory cannot be integrated into conscious awareness, the person become attached to the trauma and cannot assimilate new experiences either (Resick, 2001.) Their personality stops developing at that point as prior beliefs about self and the world cannot be integrated into the person's basic belief's systems (Resick, 2001.) The participants built a suspicious belief about the world where the trauma was continuous from birth. The belief-system adopted by all participants was one of separateness and disconnection. Therefore, the trauma was not seen as one event that defined the participant's way of being but as a stance of being of objectifying a world which is seen to have objectified them.

5.1.3.5- Replicating Powerlessness

Previous literature argues that an investment in something to obtain a sense of worth and security becomes the sole condition for existence in addiction (Kwee, 2007.) Kwee (2007) describes addiction as a state characterized by repeated attempts to replicate a false experience of escape, power and security. As mentioned previously, the participants had limited choices. This is seen in the narratives of the participants' when they talked about being nothing without the heroin: particularly Ed, Anand and Mo spoke about how heroin made them feel wanted. As shown in previous literature, the addict creates a state of organized predictability in which addiction becomes the only tolerable condition of life. This was illustrated in Lucy's quote on how she was drinking from morning until night, and Rosie's using vodka to block memories.

Burrell & Jaffe (1999) state there is a benefit in organizing one's life around one's addiction. Whilst the participants had a sense of predictability in their addiction, this seems consistent with the previous literature. According to Kwee (2007), it is not the drugs that are addictive

but perceptions of the drug which are born of existential emptiness. This feeling of existential emptiness was not chosen by the participants. They decided how to cope with the sense of powerlessness in finding relief by numbing their emotions. Mo stated that without the heroin he had nothing. Each participant seems to have adopted the stigma that society attributed to them, amplifying their feelings of self-loathing and worthlessness.

The findings suggest that drugs became a way of empowering themselves. In Tom, Anand, Ed, Joe and Mo's cases it was a way of 'fending for themselves'.

Moreover, the findings show a lack of understanding of their experiences which is linked to a lack of parenting, feelings of not belonging, and an inability to make different choices. Commonalities are seen as the participants displayed an attitude of passivity to their experiences and drugs became a way of regaining control. However, paradoxically the participants interviewed started replicating their experiences of disempowerment as they could not feel about their situation. This can be understood in light of the throwness (Spinelli, 2007) the participant's experienced and how their choices were limited by their experiences. The participants' choices became further limited once the physical side of the addiction took over. From being initially a means of escape, addiction became the predominant mode of being, taking over the participant's lives. The cultural differences is another point of interest where for both Anand and Mo taking drugs became a way of rebelling against traditional Asian upbringing making it harder for them to find their way back to fit into their original culture of origin. The rejection felt by the participants turned into an active rejection with their drug use. This in turn widened the gap between society and their addict identity.

5.2- Heroin Both Gives and Robs One's Identity

In previous literature, the role of self and identity issues were felt to be crucial to understanding addiction (Larkin & Griffiths, 2002.) The way participant's actively constructed the world in order to pursue their addictions is consistent with Schaler's (2000) free-will model. For instance, Ed, Joe, Anand and Mo started truanting and 'flirting with danger'. They spoke about 'needing backup' as they felt unprotected. However, for Tom his addict-identity was more about combining his job with being a 'full-time junkie'. The ways in which the participants remained active agents in creating meanings connected to substance use are shown in how they anticipated the future which is also seen in Schaler, (2000.) The literature suggests a complex benefit in organizing one's life around one's addiction (Burrell & Jaffe, 1999.) For the participants interviewed, the main benefit was to defend themselves from a perceived chaotic and hostile world by joining like-minded peer groups.

It is important to have a sense of self in order for self-control to operate (West, 2006) and yet the sense of self is not developed in the context of addiction. Most of the participants did not know who they were without the context of their addictions. Lucy adopted her mother's identity whereas Mo, Anand and Ed joined gangs to 'intimidate others'. Tom's addiction was at first a social event; whilst Joe did not elaborate too much on his identity as a 'gangster'. Some differences between male and female illicit drug users are worth mentioning, such as how women tend to use drugs more when they are without social support whilst drugs are used as the main social support for men. (Watson & Parke, 2011) Etherington (2008) found a link between trauma and substance misuse where women who abuse drugs are more at risk. This study shows how the women participants used drugs as a way to comply with their circumstances; '*I loved him so much.*'[5:197-204] Whilst the men used drugs to protect themselves; 'everyone is scared of me, I can intimidate.' [4:152-157]

5.2.1- Psychological Dimension: Shame and Self-Abandonment

This subsection addresses how the motivation to use drugs can underlie a motivation to cope with the challenges in one's life (West, 2006.) This is because drugs provide people with an identity and predictability (Jarvinen & Andersen, 2009.) Consistent with previous literature by West (2006) on how addiction serves a certain purpose for individuals at certain times; such as to ameliorate life's challenges, to avoid stress or because they prefer the life of the addict rather than the alternative, the participants talked about how this identity was all consuming and how heroin became 'everything' (Rosie, Tom, Ed, Anand) whilst other participants relied most on crack and alcohol (Lucy, Joe, Mo). The self-abandonment is illustrated by how the participants reported that nothing else mattered: they didn't wash, didn't care about their health or wellbeing. Mo felt there was no difference in using heroin or using crack, this can be seen as an attack on awareness. Taking drugs became a solution to life's problems. It was a way to stop caring about a world that had abandoned them. However, it was only to be achieved by the participants abandoning themselves.

As seen previously, from a psychodynamic perspective, addiction is characterised according to the drive theory as an inability to deal with frustration and a demand for immediate satisfaction (Loose, 2002.) Drugs give people a sense of magical oneness with the world which is temporary once the sense of guilt and depression returns. Therefore the addict will search again for the pharmacogenic pleasure effect in order to get back to the state of elation. From this viewpoint, addiction incarnates beyond the pleasure principle. However, drugs are ambiguous in both their function and their effect, functioning either as poison or as remedies. Without the heroin, the participants reported feeling 'shame'. As suggested in previous literature by Loose (2002) drugs and alcohol become a form of management by substitution or self-medication. The way to cope with feelings of shame which enhanced their psychological discord was to increase their drug use.

As seen in the findings, unreasonable responsibility (Lucy), rejection by a parent (Ed, Rosie, Anand) and the realities of frustration and rejection lead to victimisation and a coping strategy of truancy (Ed, Joe, Mo, Anand) and avoidance (Lucy, Rosie and Tom). The participants spoke about shame and self-abandonment, where one was used to cope and to escape the other.

5.2.2- Social Dimension: Withdrawal and Isolation

The participants reported being segregated from their families and their environments enhancing their feelings of ambiguity and insecurity. Ed, Joe, Mo and Anand spoke about their feelings of alienation from society where heroin or crack was their primary partner. Ed mentioned that he is withdrawn from society anyway. Previous literature shows how the adoption of a 'drug-user' identity provides the participants with access to groups of people with whom they feel accepted and understood by and with whom they have a shared reality, which lessens their sense of alienation from 'normal society' (Etherington, 2008 p.190.) Thus, the benefits of withdrawing from 'normal society' meant a like-minded peer-group (Larkin, 2002.) This is consistent with the findings. For Lucy, drugs was all she knew and had been exposed to. Rosie ran away from home so her choices at 14 years of age were very limited. Mo and Anand felt the need to defend themselves which further isolated them, whilst Ed, Joe and Tom started using drugs to cope with their feelings of inadequacy and isolation.

On the other hand, reward seeking behaviour takes over the user's life where being a drug addict seemed like a glamorous lifestyle at first. Rosie mentioned the attraction to the unpredictability and danger a chaotic lifestyle gave her. Similarly, Joe, Ed, Tom, Anand and Mo touched upon the benefits of this identity. According to previous literature, what maintains addiction is an immersion into a drugs world jeopardizing other identities

(Biernacki, 1986.) This is noticed in the participants' withdrawal from all other relationships in their lives. Mo mentioned not caring about his relationship with his wife. Lucy, Tom, Rosie and Joe could only form relationships with other addicts which were described as very destructive.

This identity and experiences of truanting and social alienation are consistent with similar studies (Larkin, 2002.) Through both reactions the participants could engage in violence and theft (Mo, Ed, Anand, Rosie, Joe) which was punishable by exclusion and deflected attention from the real issues causing the suffering (Watson & Parke, 2011.) Ed, Joe, Anand and Mo opted for 'selling drugs instead'. Furthermore, for Mo and Anand taking drugs was a way to flee cultural-imposed responsibilities and expectations. Consistent with Szasz (2003) this punishment only serves to further alienate the drug user and in turn they became even more embedded in the drugs-world. In all these themes the participants can be seen to be caught into a paradox where their choices were limited.

5.2.3- Physical Dimension: 'Pain-Relief'

This subsection looks at the how the participant's limited choices became further limited once they experienced their addiction as all-encompassing and were willing to do 'desperate' things to obtain access to heroin (Tom, Ed, Anand, Rosie). This is consistent with the literature which states that pleasurable sensations lead to strong physical dependence on the drug (Stone & Darlington, 2000; Etherington, 2008) where participants show a real lack of concern and disregard for their physical wellbeing (Gossop, 2007.) The substances took over and physical and psychological reactions require 'constant medication' to avoid feeling ill. As mentioned in Kemp (2009), the body became an alien-thing for the participants seeking its own ends and the 'fix' became a fixed state where they lived an existence of withdrawal

hiding the self from the reality of existence. The immediate goal was to alleviate suffering (Kemp, 2009) and this is noticed in all participants' narratives.

Tom spoke about heroin solving the problem it caused and being pain-relief. Whereas Mo stated the addiction was 'living for him'. The theory of motivation suggests that different associations between pain and pleasure are possible which the individual may not consciously choose, but feels a strong impulse to do so (West, 2006.) This is consistent with the findings where the participants describe a 'catch twenty two' whereby heroin becomes a way of life. When the physical side of addiction takes over, the participants reported feeling they had no control but to continue their downward spiral by increasing their drug use. Mo illustrated this point when he spoke about 'cutting off his arm' to stop himself from smoking heroin. This shows how the lack of choices was experienced by the participants interviewed. Life became about impulse-control and yet this carried consequences such as pain, social alienation and guilt (Kemp, 2009.) At this stage, choices become limited by cravings and withdrawals. This is a temporal existence and an alienated state of being where there is a split between the mind and the body (Kemp, 2009.) Although Lucy spoke about it being a little bit easier for her to give up heroin, all other participants reported a real struggle. Heroin for Ed represented '*twenty three years of hard graft'*. [6:240]

The literature suggests that as the strength of the chemical effect diminishes over time, the person will need more and more drugs to boost and elate themselves. The effects of drugs and alcohol do not exist independently of the subject and subject structure, making it subject-specific (Loose, 2002 p.210.) This is consistent with the findings where in order to cope with their pain-body, the participants needed to take more drugs to function.

5.2.4- Spiritual Dimension: Spiritually Dead

The free-will model of addiction sees drugs as a way to solve problems by deadening oneself to them (Schaler, 2000.) The participants spoke about the meaning they gave their experiences where drugs were a means of survival that took over everything else (e.g. as with Mo, Joe, Anand, Rosie and Tom). Both Joe and Ed spoke about being 'spiritually dead' whilst Anand and Tom mentioned how they felt heroin 'took their lives away'. The literature suggests this can be seen as a limit situation where pushing towards death as an existential edge (Kemp, 2009) was the only thing that gave meaning to participant's lives. The participants were looking for meaning and found lack of meaning, feelings of void and a need for survival as opposed to wanting to end their lives.

The participants felt persecuted by 'normal people' and relied on drugs to cope with feeling 'different' (Mo, Lucy, Rosie, Anand, Joe and Ed.) Therefore, according to Joseph (1982) the description of addiction as near-death can be understood as how life is allowed to continue only as long as nothing is really alive and functioning. This is consistent with the experiences described by several of the participants where they mentioned they 'weren't living' but only existing (Anand, Joe, Ed, Tom, Rosie.) The participants were looking for meaning in their lives and yet were confronted with more meaninglessness once they felt disconnected from the world, their body and themselves. The spiritual dimension was acknowledged by the participants only by noticing the difference between 'functioning' rather than living.

From a psychodynamic stance, this gratification of the death instinct involves the total annihilation of the self as a thinking and living being. The aim is to maintain a link with the object that often has a tormenting quality. The ambivalence towards this loss is experienced

when the participants describe a nice feeling initially of comfort and escape that then costs them a lot more than they had accounted for.

5.2.5- New Possibilities

The findings indicate that the 'addict-identity' became all-consuming for the participants. The literature suggests this identity offers predictability and an institutionally approved identity (Jarvinen & Andersen, 2009.) All participants had to conform to this new identity in treatment which did not offer much choice. This subsection explores how new possibilities emerged in order to change this identity. Recovery required a total life-style change. As seen in the literature review, the 12-Step model of recovery offers a solution to the lack of apparent choice in addiction (Magura, 2007.) However, membership in the group requires a radical transformation of personal identity and interpretation of personal experiences (Schaler, 2000.) The 12-step is based on the premise of one addict helping another (Magura, 2007) and yet the religious aspect of the model is an obstacle for many as it discourages wilfulness (Laudet, 2003.) Given that telling addicts they have a disease does not enable them to stay clean, by abiding by a model of recovery such as the 12-Step programme they cease to be helpless because a belief in a higher power changes their internal motivation (Davies, 2000.) This is seen in Rosie's narrative where she describes how this model gave her a choice she felt she previously didn't have.

Some participants seem ambivalent about the 12-step treatment model. (Mo, Joe, and Tom) Mo and Tom resisted the approach's rigidity and emphasis on total abstinence which is also supported by previous literature by Beasley (1998.) As Tom explains; '*I don't need to reinforce how sick I was.*'[12:549] Others, such as Lucy, Rosie, Ed and Anand reported finding it a useful guideline.

Self-efficacy is affected by how people see themselves, and the degree of control they perceive they have over their behaviour (West, 2006.) For most participants this was about changing the patterns (Rosie, Ed, Joe, Lucy, Anand and Tom) so new possibilities could originate from new contexts (Davies, 2000; Kalant, 2010.) It is only by changing their beliefs about themselves that the participants can gather a new set about who they are (Spinelli & Strasser, 1997; DuPlock & Fischer, 2004.)

However, Mo still experiences mistrust and rejection in treatment reporting feeling misunderstood and that the support wasn't there when he needed it most. Given that Mo is in early recovery it is understood that he was still reinterpreting his experiences. This shows how new possibilities require a total transformation to a new way of relating with others. This means that for current treatment models the addict label is substituted for addict in recovery (Beasley, 1998) which did not suit all participants even those who managed to stay abstinent for long periods of time such as Tom. Furthermore, these findings suggest that identity is not fixed but constantly reconstructed. The conflict between other identities vs. the drug user identity for example the mother-identity versus the addict identity (Lucy and Rosie), father-identity (Anand) or husband-identity (Mo) is what leads to the opening up of new possibilities and identity transformation.

5.3- Lack of Control Leads to Recovery

Previous literature by Biernacki (1986) and Scherbaum & Specka (2008) mentions how it is possible to overcome one's addiction by changing one's identity. This requires a literal move from the drugs-world. This can be seen in Rosie, Lucy, Ed, Tom and Joe's decision to change their peer groups and restructure their identities. Although we can see that drugs alone do not cause addiction, previously the participants felt they didn't have a lot of choices. This

created a paradox whereby choices were taken away from them when drugs and regulating the body's internal states predominates their addiction.

In terms of self-efficacy (West, 2006) it is only when the participants change the way they see themselves and what they are capable of achieving that they feel they can make different choices. The findings suggest this is not a cognitive shift as whilst the participants were not feeling by doing drugs they could not chose a different course of action. Previously, the participant's had limited choices given their backgrounds. Throughout their lives, the scope of choices got narrower and narrower until the choice was to either give up drugs or die.

The findings are consistent with previous literature which show that it is only when addicts' lives become unmanageable that they decided to change. As Ed mentioned that physically he had no choice. Joe, Anand, Mo, Tom, Rosie and Lucy shared this perspective. Control and responsibility is a source of distress for the participants also because they never felt in control of their lives and what happened to them, as indicated by their upbringing and coping choices. Lucy described taking unreasonable responsibility at an early age: *'I was always looking after my brother and sister'*. [4:147-149] Rosie mentioned addiction being an illness and Ed, Joe and Anand shared this sense of not feeling responsible for their addiction. The 12-Step Approach does not address agency and responsibility directly (Larkin, 2002 p.337.) Therefore, accepting responsibility for change is a struggle for the participants when the model suggests they are not responsible for initiation, but entirely responsible for change (Larkin, 2002.) As seen in Wurm (2003), the language in recovery does not permit for choice making ideas. As opposed to seeing addiction as a treatable but incurable disease (Newman, 2008) it is important to look at new ways of conceptualising addiction.

The problem in exercising control means that in order to moderate their behaviour the participants required a shift from thinking of themselves as addicted to thinking of

themselves as non-addicted, which is also consistent with the findings. This shift was to happen on an emotional rather than a cognitive level. For Ed, Joe and Anand it was jail that gave them the space out of their addictions and for Lucy and Rosie it was having their kids removed; '*You are not used to having emotions*.' [8:363-378] Moreover,for Tom and Mo it was the threat of losing their jobs or his wife respectively. At first there was a difficulty in understanding addiction illustrated by Rosie, Lucy and Anand: '*I was drinking from morning until night but I didn't think I had a problem.*'[4:164-165]Whilst the other participants (Joe, Tom, Mo and Ed) basically reported living in 'denial'. This shows an existential confusion, and it is only when they lose control completely that change can begin to take place.

5.3.1 Rock Bottom

It is only by reaching rock bottom that the participants got to a place where they could start feeling again. The findings expand on the literature by showing how limited choices due to their upbringing brought the scope of choices narrower and narrower until the participants hit rock bottom. The decision to stop using drugs originates in the addict's life becoming intolerable: 'almost dying, near death experiences and hitting rock bottom' (e.g. Tom, Ed, Mo, Anand and Joe). Biernacki (1986) identified two main reasons for quitting when one experiences hitting rock-bottom or an existential crisis. The first, as seen in Rosie's case, is 'burnout' and getting sick of the addict's lifestyle. The second is rock bottom as fear being a motivation for change, which has also been mentioned in other studies, where a future with drugs can only be envisioned in a negative form (Watson & Parke, 2011.) This is seen in Lucy's example, where she anticipates the future stating she would end up injecting. At the same time, the risk is only acknowledged in retrospect: at the time the participants did not recognize the danger they were in: '*I laughed it off.*'[19:868](Joe, Anand and Ed) This is noticed in Kemp's (2009) description of near-death as a limit situation which gave the participants meaning to an existence which was a meaningless entrapment between

functioning rather than existing (Rosie, Lucy, Ed, Anand, Mo, Joe and Tom.) Schaler (2000) mentions how once the person resolves the problem underlying addiction, they abandon the addiction. However, we can see how the language pertaining in addiction which attributes failure to control behaviour to a disease limits choice-making opportunities. However, the way to solve the problem underlying addiction was not possible as long as the participants did not have the space to feel; '*Once I pick up that first one I don't have a choice, I have a choice over the first one but after that first one, for me.. I don't have a choice.*'[8:229-231]

5.3.2 Not Feeling

As mentioned in Larkin (2002), addiction can be seen as a 'flawed strategy for achieving pleasure' because maintaining high levels of pleasure or happiness over a long period of time is an unrealistic expectation. Although all participants were numbing feelings in order to continue their path of drug abuse, it was only through feeling again that they could consider other alternatives (Rosie, Lucy, Anand, Joe, Ed and Tom.) Drug addiction was initially a blissful release and the most reasonable response to a set of appalling circumstances (Etherington, 2008.) When the participants were using drugs they were not feeling, as described: '*I was superman again*'.[4:177] However, this removes the capacity to cope with failure and disappointment in a reasonable manner. Joe used drugs to escape feelings of depression, which portrays drugs as a constructive solution to problems of meaning consistent with Burrell & Jaffe (1999.) Drugs were also a way for participants to control emotional responses (Joe, Mo, Ed, Anand, Lucy and Rosie). (Rush & Shaw, 1981) This is agreement with the narratives of all participants who used heroin in order to specifically to avoid pain. As Yalom (1980) described, even if a decision seems destructive it will make sense for the individual undertaking it. The findings show how the benefits of escaping their

realities far outweighed the cost for the participants. The benefit was not feeling the pain of their situations (Rosie and Lucy), surviving (Rosie), escaping depression (Joe), blocking emotion (Ed), a buzz and escape (Tom), functioning (Anand) and numbing reality (Mo). Although most of the literature reviewed suggests a cognitive shift towards recovery (West, 2006; Larkin & Griffiths, 2002 & Jarvinen & Anderson, 2009), this study shows how the shift needs to be emotional rather than cognitive in order for the participants to consider a different behaviour.

Moreover, opening up possibilities is creating choices. Given the participant's backgrounds, their possibilities were limited and became further limited whilst they chose to disconnect from their emotions. The existence they led was one of functioning on automatic mode. Their desire to find relief and move away from discord created a chemical dependency that was only be overcome at the face of death. By facing this existential limit the participants started to acknowledge the emotions they were running away from. The only way of reclaiming control of their lives was to feel again. Whilst not feeling their existence was simply defined by either a chemical increase or decrease in arousal; *'You have to get a buzz from crack then you feel like sh*t because then you feel wired because then you have to take more gear a couple of valium and a couple of super tenants..'* [:248:250]

5.3.3 Choice as an Emotional Response

The findings show how the choice to feel again is only made when the consequences of drug use become too undesirable in terms of how the participants see themselves and their future goals (Biernacki, 1986.) Facing their responsibilities meant connecting with their emotions. Lucy mentioned how she wished someone had taken her off her mum whilst other participants spoke about having to face responsibility because they were sick of getting

arrested (Joe), because of their new responsibilities (Anand, Lucy) or pressure from others (Mo) as well as being sick of the lifestyle (Tom, Rosie.) Guilt is the main emotion the participants come up against in realising the consequences of their choices. Sartre (1945) suggests that man is condemned to be free, and therefore we have to make choices. On the other hand, the acceptance of an 'addict identity' restricts the experience of choice (Burrell & Jaffe, 1999; Beasley, 1998.) At the same time, for Tom when everything was falling apart, and for Ed feeling he was again in prison, the cost of continuing would outweigh the benefits of the drug. The participants felt they had no choices and were only able to acknowledge a different way of being once their choices became even more limited due to their circumstances.

According to Damasio (2006), feelings are a powerful influence on reason which guides decision making. The participants could not make a decision while they could not feel about a situation: 'it was all about the self'. While one participant (Mo) had to be coerced into treatment by his wife, other participants (e.g. Joe and Ed) stopped using in jail. Sartre's (1943) philosophy illustrating the role of freedom and responsibility, where man is condemned to be free and experiences this freedom as anguish, is relevant here. At the same time, it was only when the participants became aware of wanting something different via their emotions; they were then able to take responsibility for their life choices. The freedom experienced by the participants is seen to be very limited by their circumstances. This is consistent with Spinelli's (2007) concept of throwness.

Previous studies show how entering treatment for other reasons rather than one's own self volition leads to possible relapse (Scherbaum & Specka, 2008; Jarvinen & Andersen, 2009.) The choice towards treatment comes with limitations as one needs to abide by current treatment models which tend to rule out self-efficacy and self-volition. In some cases, participants felt the 12-Step approach helpful as it changed their internal motivation (Lucy,

Rosie, Anand, Joe, Ed). However, treatment services tend to alienate them from their own free-will (Davies, 2000) where the medical model takes away freedom and choice (Wurm, 1997.) Although we have seen in these findings how the nature and consequence of drug use cannot be separated from its context (Davies, 2006; Kalant, 2010) identity was identified as key. The way people conceptualise addiction has been socially defined and previous literature has shown how people are more likely to fail at recovery if they attribute failure to control behaviour to a condition such as a disease (West, 2006.) In order to recover from addiction, a radical transformation of personal identity and reinterpretation of personal experiences is required (Laudet, 2003.) This study shows the importance of emotions in decision-making especially in addiction where whilst not-feeling, the participants had no choice about their situation. The findings further demonstrate how the participants moved from a place of being chasers of relief, living only for that sensation to a place where decisions could no longer be made cognitively. Rosie suggests she was willing to prioritize drugs over her children; not because she didn't love her children but because she needed the drugs more. As we can see, once the chemical dependency took over and the participants' were running away from feelings, choices were not rational.

5.3.4 Treatment is a Choice to Feel Again

As long as the participants could not take responsibility for what had happened to them, they also could not accept responsibility for their choices.

The findings support the literature by Wurm (2003) in showing how the language of addiction does not permit choice-making ideas, because choice and responsibility are not implemented in our society. In turn, this influences the motivation of a client to change their behaviour (Wurm, 2003.) Although Rosie describes how she only accepts responsibility for

the choice she has now, Tom talked about how the most difficult part of treatment was feeling again. The literature shows that treatment works when other problems were tackled (Jarvinen & Andersen, 2009.) However, the label of addiction being given as a means to punish and control means that crime and addiction can be perceived and punished together (Szasz, 2003.) Most participants were coerced into treatment via punishment (Joe, Ed, Rosie, Mo and Lucy). This is consistent with other findings showing how treatment is sometimes entered into due to pressure from others rather than through one's own self-volition (Scherbaum & Specka, 2008.)

Biernacki (1986) talked about an 'identity transformation' as the main reason addicts stay abstinent. This requires a literal or symbolic move from the drugs-world. The role of recovery as a regression which elicits feelings of regret and uncomfortable memories is cited in other studies indicating a loss of time due to heroin use (Watson & Parke, 2011.) Lucy was unacknowledged by social services and being a young carer had a detrimental effect on her own development. Whilst Lucy lived with an addict mother she felt she belonged there as she did not know any different. Her identity was transformed once she was exposed to a different perspective. At the same time, the free-will literature suggests that addicts find moderation and abstention difficult to achieve when they are told they have an incurable and degenerate disease.(Mo, Tom, Joe, Anand, Ed) Most participants accepted this philosophy as a way to manage their emotions. In order to break the cycle, the participants had to learn to cope with pain. Tom spoke clearly about this whilst Mo was still ambivalent: *'it is more like the bad side is more.*'[10:454-455].

The literature showed how Vietnam veterans' addictions served a purpose during a high stress situation and was dropped when no longer needed (Biernacki, 1986.) Yet the findings suggest that adjusting for the participants is hard. It is giving up the only identity they know

for the unknown. For some, this transition is managed by the substitution of identities through the 12-Step Approach (e.g. Rosie, Ed, Lucy, Anand, Joe.)

According to Larkin, (2002) the argument for investigating addictive personality is flawed as there are questions about the validity of the personality trait or type as an indexical concept. Moreover, genetic tests are speculative because some people with a predisposition develop addiction problems and others don't. The participants interviewed used drugs until they got to a place where once the body took over they had limited choices. It was only by dealing with emotion and responsibility directly, and reframing their identities cognitively, that most participants could make different choices.

5.4. The Strengths and Limitations of this Study

The subject of addiction consists of a large body of literature from different approaches. I attempted to cover the subject as broadly as possible specific to my research question looking at issues of volition, responsibility and choice. As mentioned in Etherington, (2008) building conceptual links between addiction, choice, identity transformation and trauma is a difficult task as each of these concepts is informed by a separate and vast literature on their own. Due to the vastness of this subject, I recognize that I had to provide a brief overview of all relevant theories in both existential-phenomenological philosophy and theories of addiction. I have focused on the main writers from the free-will perspective including Szasz, Schaler, Wurm, Biernacki, Larkin and others. I could not review all the trauma and addiction literature and aimed to touch upon its main points. I acknowledge that all the philosophical debates about choice are beyond the scope of this study. Therefore, my aim was to provide an overview of themes of identity, addiction, trauma and the psychodynamic models whilst focusing primarily on the existential approach. The objective was not to provide a detailed overview of the psychological literature on the subject of addiction. Instead I attempted to

cover the topic as widely and as in depth as possible, while giving a brief general overview specific to the study's objectives. I am aware that I did not ask specific questions about alcohol use as my focus was on heroin, yet most participants spoke about their alcohol and drug misuse as being interrelated.

This study's purpose was to look at the relationships between the person, context, and how the participants reconstructed their experiences. The interviews were semi-structured with no leading questions which allowed the participants to reflect on their subjective experience in relation to the topic under investigation. The interviews were largely respondent-led and for the most part they reflect an interpretation of the participants' own interpretations of their early stages of recovery.

Therefore, one of the possible limitations of this study is that it did not interview those participants who felt excluded from treatment because they did not subscribe to the predominant treatment model and yet managed to stay sober nevertheless. This research is very specific to the participants interviewed, and the results of an IPA study cannot be generalised without caution.

Furthermore, this methodology examines the meanings which participants attach to their experiences (Watson & Parke, 2011.) This is both strength and a weakness given the subjective nature of knowledge. Perhaps had this research been conducted in a different setting it would have yielded different results. Most of the participants were opposed to the free-will model of addiction although this was not clearly specified in some cases. The majority of the participants were in the very early stages of recovery which influenced how they interpreted their experiences and how they made the link between perceptions of themselves and their addictions. The participants felt they had no choice and this lack of choice can be seen to be affected by their upbringing and how they sought to belong. A way

of creating and increasing choices in addiction is by opening up new possibilities and new ways of being in the world. According to this study's findings, this is seen as a felt response rather than a cognitive shift in awareness.

As a new researcher, during my interviews I had to ensure that I was researching rather than falling into the role of a therapist. New to IPA research, I felt that my inexperience initially prompted me towards a more descriptive analysis of the data. A criticism of IPA previously highlighted is the potential scope for the researcher to interpret the data according to pre-existing theoretical frameworks and personal biases (Willig, 2001.) As a response to this criticism, I have included verbatim extracts and interpretations in the Appendix in order to allow the reader to evaluate my interpretations (Watson & Parke, 2011) and to show transparency at different stages of analysis. As previously mentioned, doing good IPA requires the development of some complex skills - interviewing, analysis, interpretation and writing (Smith, 2010.) I strived to complement my of knowledge in the area by attending regular IPA meeting groups, reading a lot about this methodology, holding regular meetings with my academic supervisor, and undertaking IPA regional group meetings. The sample size of this study is relatively small, and yet can present an adequate perception given sufficient contextualisation (Watson & Parke, 2011.)

I also acknowledge that perceptions about my gender, my status, my appearance and my ethnic origin might have influenced how the participants responded to me and what they chose to disclose or not, this was reflected on throughout the research process and my analytic journal.

Chapter 6- Conclusion

6.1- Future Research

This study's findings suggest it would be valuable to look at how emotions influence choices especially in addiction where the coping strategy is not to feel. The findings show that it was only by delving into what they were running away from that the participants' were able to feel a different way towards their choices. There is a paradoxical tendency to replicate powerlessness where the participants had to reach rock bottom in order to enter treatment. The participants can be seen to be addicted to a feeling of relief rather than a drug. By having limited options from the beginning they lead an existence of withdrawal because they did not know any different. Implications for treatment can be seen in how choice is a feeling response rather than a thought. The behaviour and identity the participants grew accustomed to only changed once they faced the end of their existence, and felt the drug offered more pain rather than relief. As opposed to limiting choices in treatment, and in ways of both conceptualising addiction, ways of opening up possibilities are suggested to increase choice. Current treatment models do not provide space for moderation and include very little information on responsibility and choice.

Although the experiences of feeling unloved emerged as a commonality between participants, the nature of qualitative studies in general is to identify meanings rather than infer causes (Larkin, 2002.)

Addiction is a socially defined construct where the experience of addiction can be categorized as a problem. By investigating the relationship between the experiences and understandings of addiction within a particular context, we can see how contextual conditions were not experienced the same by all participants. Although the physical elements of addiction cannot be ignored, the benefits experienced by heroin users are that volition and

responsibility are ignored when they adopt certain levels of risk in the pursuit of pleasure. This was not a conscious choice adopted by the participants interviewed.

To move away from the moral consensus we need more research illustrating the link between identity, freedom and how individuals fail to make choices whilst feelings are being numbed through drugs.

Within the findings, numerous themes emerged enabling a valuable insight into the participants' subjective experiences in relation to choice. Feelings of rejection, lack of social support and isolation were responded to through social withdraw which replicated these feelings and masked the participants' real suffering.

The importance of feelings and the relation between feeling and reason is illustrated which can assist in prevention. However, an in depth exploration using mixed methodologies is suggested for future research to look specifically at the link between emotions, choice and identity from the experience of addicts who have been in recovery for a number of years. Another suggested focus for research in this field is a new study using IPA looking specifically at how drugs are used in order to distort and alter time. Although the participants in this study did not explicitly reflect on their experiences of time, it was noted how addiction is also used as a way of distorting the experience of time.

6.2- Summary

This study contributes to an understanding of the phenomena of choice in heroin addiction. The aim was to explore the life-world from the perspective of the participants, providing a rich and contextual description of their experiences of choice in heroin addiction. The researcher provided an in-depth literature review of the different models and current theories of addiction outlining two main approaches: the free-will model and the medical model. The literature reviewed showed the arguments outlining both approaches and concluded that due to the nature of the research question, IPA would be the best method of investigation. The idiographic nature of IPA allowed for the individual voices of each participant to be heard. This research looked at identity and meaning of drug use in the context of choice in heroin addiction.

The findings show how a lack of love led the participants to replicate feelings of powerlessness and isolation by becoming self-reliant and abusing drugs to numb their feelings. The participants became further marginalised from society and led an existence where managing their bodies by not feeling pain was important. Behaviours such as violence and truancy served to hide and ostracize them further from their own pain. The participants did not acknowledge how much they were suffering until they stopped using drugs. It was only when continuing to use heroin would have cost them their lives that they created some space to feel differently about their choices. Most of the time, the participants only got to this feeling place once all other choices had been taken away. Although ‘feeling again’ and being sober was felt to be more challenging to participants rather than their addictions, it was only by feeling again that they came to acknowledge the possibility of different choices. This illustrates a cognitive split in thinking and feeling when it comes to decision making in drug addiction. Rather than being a cognitive response, while the participants could not feel they could not make a different choice about their situation. Whilst there were mixed reports on

the efficacy of treatment within a 12-Step philosophy context, for some of the participants this proved beneficial to reconstructing their identities. Choice and responsibility is a theme that confused the participants interviewed as they lived in denial about their choices, suffering and their addictions. This shows how support for addicts in recovery is important in order to allow them the safe and confidential space to feel, explore their identities and explore different choices. Perhaps at different stages of recovery new ways of conceptualizing addiction can be integrated which might assist addicts in recovery to solidify a new way of being and a sense of self that best suits their need for independence.

This study is important as it suggests a new way of looking at the addict-identity and how choice is an emotional response rather than a cognitive one. It can be seen that rationally addicts know the dangers of their drug use. Yet, it is only once they can feel the consequences of continuing, once they reach rock bottom that the drug ceases to be an escape. This argument is not applicable only to addiction as it is well known that people only change damaging behaviours after they have processed the feelings they were trying to avoid by pursuing the escape. By delving into the ways in which the participants here interviewed assumed a particular stance towards their world we can see how their limitations only gave rise to different possibilities once they were able to feel the consequence of a different behaviour. The most important finding is the link between choice and emotions which is often unacknowledged in predominant addiction treatments.

6.3- Implications for Counselling Psychology

The significance of this study for my own therapeutic practice and that of other therapists is a new understanding which expands upon the paradox between healing traumas. The specific questions raised here highlight how a high risk environment minimises choices and in turn the participants felt taking drugs was the only way they knew of coping with life. The link between high-risk environments, socially disadvantaged backgrounds to lack of perceived choices and heroin addiction is a gap that needs to be addressed socially. If participants had felt valued or had they felt they had more opportunities in life it would minimise their self-destructive tendencies and inability to engage with emotions. The suggestion here is to see addiction as a global and social problem and to facilitate a way of engaging with life that opens up a wide range of options for recreation, employment and socialising which would in turn minimise drug taking. It is the therapist's responsibility to not only allow for a space where the clients can begin to acknowledge and navigate their emotions but to also broaden their perspectives in life. The participant's world-view is limited by the spectrum of trauma and abuse, which in turn needs to be healed and normalised before a new 'self' can emerge.

Moreover, socially disadvantaged areas tend to not attract the best treatment options which further limit the client's ability to succeed in their recovery. The participants in this study had to re-interpret and reconstruct their life experiences which shows how in order for therapy to succeed choice must be focused upon as an ability to get out of one's current and past circumstances.

Addiction is about surviving traumas and it becomes a maladaptive coping strategy. As we can see from this study's findings by providing a safe space where the participants can understand the inherent paradox in addiction and overcome their resistance to feeling again, this gives clients a new hope for recovery. Current treatment options need to be holistic and

address the multi-layered issues presented in addiction. As reported by this small sample, a new approach to addiction which is more flexible than the 12-Step approach and less punitive would give them a chance to establish their new identity outside of the recovery model. Treatment agencies need to be flexible and existential in the options they offer clients by assisting them to assess their needs from their subjective perceptive as opposed to imposing a pre-designed care plan. In terms of practice, it is important to always meet the client where he/she is at. It may be that the client has never experienced a 'holding' space where they did not feel judged and where they feel they mattered. As an existential-phenomenological therapist and Counselling Psychologist this research taught me to go back to the basics of practice: where the aim is not to 'fix' the client but to open up new possibilities by remaining curious and non-judgmental. The findings remind us of the importance to enter the world of the client in the here/now and bracket expectations, in order to assist clients to find themselves and their own awareness. This study has inspired me to work with therapeutic groups in my current workplace. These groups are existentially focused and designed based on the principles highlighted by Yalom (1970). The aim is to give clients a multi-layered, multiple perspective looking at the principles of meaning, freedom and choice in relation to their worldview. Given the findings of this study which suggest a lack of support from others, groups can offer clients the chance to support one another by combating isolation and offering the benefit of peer interaction. The participants did not have a chance to voice their opinions to what was normal as they were surrounded by the chaos of drug use. Furthermore, therapeutic groups in addiction have been implemented with great success and a group addressing the concerns this study highlights would be extremely beneficial in practice.

As noted, issues of lack of belonging, abuse, identity, and choice as an emotional response were found to be important while the client remains central in his/her decision-making process. Disseminating research results is an important part of applied psychology in order to

influence new ways of practice. Many psychologists, whether clinical, counselling or other helpline professionals work with addiction at various points in their careers. As previously mentioned, by adopting a pluralistic perspective as a Counselling Psychologist it is crucial that we learn to engage with the limitless client perspectives we encounter in our working lives. This entails an engagement with the differences giving rise to conflict and tension (Kasket & Gill-Rodriguez, 2011 p.23) as well as informed approaches to therapy, critical positions, and alternative evidence-based practices.

Larkin (2002) suggests that psychologists must be careful in attaching the label of addiction to people as this connotation has wide use but an inconsistency of meaning. The participants here interviewed described how they struggled to make choices and we have explored this process in depth. Also, 'shaming' young offenders rather than dealing with their profound sense of humiliation is seen as counterproductive (Etherington, 2008.) It is important that the person behind the substance misuse is acknowledged, given a voice to and seen as an 'expert' actively seeking to construct meaning in his/her life (Davies, 1997.) In terms of working with this client group, it is relevant to acknowledge how change is possible only when the client gets to a feeling space where he/she is able to reframe their experiences rather than thinking about the consequences of his/her actions.

In the field of Counselling Psychology theory and practice this is important in order to open up new avenues of both conceptualizing and understanding addiction which gives clients scope to learn how to regain control of their lives. The issue of choice and addiction are central to Counselling Psychology and Psychology in general and can be applied in various aspects of theory and practice. On a wider scope, this issue illustrates fundamental meaning-making and decision making processes that encompasses all the underlying psychology of human existence. The bias in mainstream Psychology towards thinking and awareness adopts CBT as the preferred therapy modality is questioned once choice is understood as a feeling

rather than a thinking response. It can be argued that the existential approach and the free-will model can open up new ways of being and new possibilities whilst the focus on thinking and awareness keeps a person who is struggling with addiction stuck in their way of being. As the way in which choice is an emotional shift can be further understood; thinking about changing is argued to be meaningless. As previously seen, according to this study's findings change can only occur once emotions are given the space to be reinterpreted and worked through in the context of one's life. In terms of opening up the phenomena of choice in heroin addiction, time and how they came towards the feeling of having a choice became the focus in relation to past and present influences in their lives. This meant the study's focus was not time specific to the past choices but looked at the concept of choice more broadly in reflection to how the each participant changed their lives in relation to their drug-use.

References

American Psychiatric Association (2000) Diagnostic and Statistical Manual of Mental Disorders.4th ed. Washington: American Psychiatric Association

Allen, C. (2007) Crime, Drugs and Social Theory: A Phenomenological Approach. Manchester: Ashgate.

Ashworth, P. (2003) 'An approach to phenomenological psychology: the contingencies of the lifeworld'. Journal of Phenomenological Psychology. 34(2), pp.145-156.

Beasley, R. (1998) 'Existential Analysis of the Twelve Step Approach to Chemical Dependency'. Journal of the Society for Existential Analysis. *9(1).*

Biernacki, P. (1986) Pathways from Heroin Addiction: recovery without treatment. Temples University: Philadelphia.

Bor, R. & Watts, M. (2006) The Trainee Handbook: a guide for counselling and psychotherapy trainees. London: Sage.

Breakwell, G et al. (2006) Research Methods in Psychology. London: Sage.

British Psychological Society (2009). Ethical principles for conducting research with human participants. [Online]. BPS. Available from: http://www.bps.org.uk/the-society/code-of-conduct/ethical-principles-for-conducting-research-with-human-particpants.cfm [Accessed 5th September 2009].

Brocki, J. & Wearden, A. (2006) 'A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology'. Psychology and Health. Feb, 21(1), pp.87-108. Routledge: Taylor & Francis.

Burrell, M.J & Jaffe, A. (1999) 'Personal Meaning, Drug use and addiction: An Evolutionary Constructive Perspective'. Journal of Constructivist Psychology.12, p.41-63 Taylor & Francis

Colaizzi, P., 'Psychological research as the phenomenologist views it'. In R. Valle, M.King eds (1978) Existential Phenomenological Alternatives for Psychology, p. 48-71 Oxford: Oxford University Press.

Davies, J. (1997) The myth of addiction: An application of the physiological theory of attribution to illicit drug use. London: Harwood Academic Press.

Davies, J. (2006) The myth of addiction. 2nd ed. London: Routledge.

Damasio, A.(2006) Descartes's Error. London: Vintage Books.

Deurzen-Smith, E. van (1997). Everyday Mysteries: Existential Dimensions of Psychotherapy. London: Routledge.

Deurzen, E. van (2005). Existential perspectives on human issues. E. van Deurzen and

C. Arnold-Baker (eds). London: Macmillan.

Drew, L.H.R (1990) ‘Facts we don’t want to face’. Drug and Alcohol review.9, p.207-210.

Dryden, W. (1996) Handbook of Individual Therapy. London: Sage.

Du Plock, S. (2002) ‘Some Reflections on an Existential-Phenomenological Approach to Working with Addiction’. Existential Analysis. 13.1: January.

Du Plock, S. and Fisher, J. (2005). ‘An Existential Perspective on Addiction’. in E. Van Deurzen and C. Arnold-baker (eds). Existential Perspectives on Human Issues. Basingstoke: Palgrave Macmillan, p67-77

Durrant, R. & Thakker, J.(2003) Substance Use & Abuse: Cultural and Historical Perspectives. California : Sage.

Eliott R., Fischer C. & Rennie D. (1999) ‘Evolving guidelines for publication of qualitative research studies in psychology and related’. British Journal of Clinical Psychology, 38, p.215-229.

Etherington, K.(2008) Trauma, Drug Misuse and Transforming Identities. A Life story Approach.London: Jessica Kingsley.

Farber, L.(2000) The ways of the will. Selected essays. Expanded Edition. Basic Books.

Faulconer, J. (2005) ‘Knowledge of the Other’. European Journal of Psychotherapy, Counselling and Health., 7(1-2), p. 49-63.

Feldman, M.(2000) ‘Some Views on the Manifestation of the Death Instinct in Clinical Work’. Int. J. Psych-Anal., 81, pp.53-65.

Fingarette, H. (1988) Heavy Drinking. London: University of California Press. [Online] Available at http://www.nova.edu/ssss/QR/QR3-1/heath.html [accessed]

Finlay, E. & Evans, K. (2009) Relational-centred Research for Psychotherapists. Wiley-Blackwell.

Finlay, L. (2008) ‘A dance between the reduction and reflexivity: explicating the “phenomenological psychological attitude.”’ Journal of Phenomenological Psychology, 39, p.1-32.

Foster, J & Parker, I.(1995) Carrying out Investigations in Psychology: Methods and Statistics. BPS Books: Leicester.

Forrester, M. (2010) Doing Qualitative Research in Psychology: A practical guide. London: Sage

Gadamer, H. G. (1975). Truth and method. London: Continuum. (2004)

Gibbs, G. (2007) Analyzing Qualitative Data, London: Sage.

Giorgi, A. (1997) ‘The theory, practice and evaluation of the phenomenological method as a qualitative research procedure.’ Journal of Phenomenological Psychology, 28, pp.235-160.

Giorgi, A. (2010). ‘Phenomenology and the practice of science’. Existential Analysis. 21, p3-22.

Glatthorn, A. & Joyner, R. (2005) Writing the Winning Thesis or Dissertation: A Step-by-Step Guide. 2nd ed. California: Corwin Press.

Gossop, M. (2007) Living with Drugs. 6th (ed.) England: Ashgate.

Harré, R. (1979) Social Being. Cambridge, Massachusetts: Harvard University Press.

Heidegger, M. (1962). Being and Time. J. Macquarrie & E. Robinson (trans). New York: Harper & Row. Originally published in 1927.

Hyman, S. & Malenka, R. (2001) ‘Addiction and the Brain: The Neurobiology of Compulsion and its persistence’. Nature Reviews: Neuroscience vol 2, pp.695-703.

Jarvinen, M. & Andersen, D. (2009) ‘The Making of the Chronic Addict’. Substance Use and Misuse, 44: p.865-885

Joseph, B.(1982) ‘Addiction to near-death’. Int. J. Psycho-Analysis., 63:449-456. Also in Psychic Equlibrium and Psychic Change, ed. M.Feldman and E.Bott Spillius: Routledge, 1989, p.127-138

Kalant, H. (2010) ‘What neurobiology cannot tell us about addiction’. Addiction, 105; p780-789

Kalivas, P. &Volkow (2005) 'The Neural Basis of Addiction: A Pathology of Motivation and Choice'. American Journal of Psychiatry 162: p.1403–1413.

Kasket, E. & Gill-Rodriguez, E. (2011) 'The identity crisis in trainee counselling psychology research'. Counselling Psychology Review, (26, 4). The British Psychological Society.

Kemp, R. (2009) 'The Lived-Body of Drug Addiction'. Existential Analysis, 20 (1), p.120-130.

Kemp, R. (2009) 'The Temporal Dimension of Addiction'. Journal of Phenomenological Psychology, 40; pp.1-18 Brill: Leiden.

Kernberg., O.(1992) Aggression: In Personality Disorders and Perversions. Yale University Press: New Haven and London.

Koob, G. & Nestler, E.J. (1997) 'The neurobiology of drug addiction'. J. Neuropsychiatry Clin Neuroscience. 9: p.482-497. American Neuropsychiatric Association.

Kvale, S. (1996) Interviews: An Introduction to Qualitative Research Interviewing. London: Sage,

Lalander, P. (2003) Hooked on Heroin: Drugs and Drifters in a Globalized World. New York: Berg

Langridge, D. (2004) Introduction to Research Methods and Data Analysis in Psychology. Pearsons: Prentice Hall.

Langdridge, D. (2007) Phenomenological psychology: theory, research and method. Harlow: Pearson.

Larkin, M. (2002). 'Understandings and Experiences: a post-constructionist cultural psychology of addiction and recovery in the 12-Step tradition'. Thesis. Nottingham: Nottingham Trent University.

Larkin, M. and Griffiths, M. D. (2002). 'Experiences of addiction and recovery: the case for subjective accounts'. Addiction Research and Theory. 10, (3), p281-311.

Laudet, A. (2003) 'Attitudes and Beliefs about 12-Step Groups Among Addiction Treatment Clients and Clinicians: Toward Identifying Obstacles to Participation'. Substance Use & Misuse. 38, (14). p.2017-2047.

Laurie, P. (1971) Drugs. Penguin Books: Australia.

Leshner, A (1997) Addiction is a Brain Disease, and it Matters. *Science 3* October 278 (535) p.45-47.

Loose, R.(2002) The Subject of Addiction. Psychoanalysis and the Administration of Enjoyment. Karnac: London.

Macquarrie, J. (1972) Existentialism: An introduction, guide and assessment. New York: Penguin.

Madill, A., Jordan, A., & Shirley, C. (2000) 'Objectivity and reliability in qualitative analysis: realist, contextualist and radical constructionist epistemologies'. British Journal of Psychology. 91, p.1-6.

van Manen, M. (1990) Researching Lived Experience: Human Science for an Action Sensitive Pedadogy. The State University of New York Press: Canada

Magura, S. (2007) 'The Relationship between Substance User Treatment and 12-Step Fellowship: current knowledge and research questions'. Substance Use & Misuse, 42. p.343-360.

Milton, M. (2002), Evidence Based Practice: issues for psychotherapy. University of Surrey. North East London Mental Health Trust 1: Taylor & Francis.

McLeod, J. (1994) Doing Counselling Research. London: Sage.

Moustakas, C. (1994) Phenomenological Research Methods, London: Sage.

Moran, D. (2000) Introduction to Phenomenology. London: Routledge.

Newman, R. (2008) 'Addiction: A chronic medical condition'. Drug & Alcohol Review, Jul 2008, Vol. 27 Issue 4, p.450-450.

Peele, S.(1985) 'How can Addiction occur with other than Drug Involvements?' British Journal of Addiction. Society for the Study of Addiction and other Drugs. No.80, p.23-25.

Peele, S. (2000) 'What Addiction is and is not: The Impact of Mistaken Notions of Addiction'. Addiction Research 8(6) p.599-607. Overseas publishers association.

Ray, O. (1972) 'Drugs, society and human behaviour'. Saint Louis: Mosby Company.

Read, A. (2002) 'Psychotherapy with Addicted People'. In M.Weegman & R.Cohen (Eds.) The Psychodynamics of Addiction p.85-98. London: Whurr Publishers.

Resick., P. (2001) Stress and Trauma. East Sussex: Psychology Press Ltd.

Rudestam, K.E. & Newton, R. (2000) Surviving your dissertation. London: Sage.

Rush, A.J. & Shaw, B.F. (1981) 'Psychotherapeutic Treatment of Opiate Addiction'. American Journal of Psychotherapy. (1) p.61-73.

Sellman, D. (2010) 'The 10 most important things known about addiction'. Addiction: 105, pp.6-13.

Sansoy, P. et al. (2005) Ethical eye: Drug Addiction. Council of Europe Publishing, Strasbourg.

Sartre, J. P. (1943). Being and Nothingness. H. Barner (trans). New York: Phil. Library. (1956).

Sartre, J.P. (2011) To freedom condemned. Open Road: New York. Translated by Justus Steelar

Schaler, J (2000) Addiction is a choice. Chicago and La Salle: Open Court.

Scherbaum, N. & Specka, M. (2008) 'Factors influencing the course of opiate addiction'. International Journal of Methods in Psychiatric Research 17, p.39-44.

Shakeshaft, A., Bowman, J. & Sanson-Fisher, R. (2002) 'Community-based drug and alcohol counselling: who attends and why?' Drug and Alcohol Review, 21, p.153-162.

Shinebourne, P. (2011). 'The Theoretical Underpinnings of Interpretative Phenomenological Analysis'. Existential Analysis. 22, (1), p16-31.

Smith, J. A. (2004). 'Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology'. Qualitative Research in Psychology. 1, p39-54.

Smith, J. A., Flowers, P. and Larkin, M. (2009). Interpretative phenomenological analysis: Theory, method and research. London: Sage.

Smith, J.A. (2010). 'Interpretative Phenomenological Analysis: A Reply To Amedeo Giorgi'. Existential Analysis. 21, (2), p186-192.

Spinelli, E.(2000) 'Counselling Psychology: A hesitant hybrid or a tantalising innovation?' Counselling Psychology Review ,16(3), p3-12

Spinelli, E. (2007) Practising Existential Psychotherapy: The Relational World. London: Sage.

Stone, T. & Darlington, G. (2000) Pills, potions, poisons. How drugs work. Oxford: University Press.

Stimson, G.& Oppenheimer, E. (1982) Heroin Addiction: treatment and control in Britain, Tavistock: London.

Szasz, T. (2003) Ceremonial Chemistry. USA: Syracuse University Press.

Szasz, T. (1992) Our Right to Drugs. USA: Syracuse University Press.

Van Manen, M. (1990). Researching Lived Experience: Human Science for an Action
152. Sensitive Pedagogy. Albany: State University of New York Press.

Verhaeghe, P. (1995) 'From Impossibility to Inability: Lacan's Theory on the Four Discourses. Originally Published in The Letter'. Lacanian Perspectives on Psychoanalysis, 3, p91-108.

Walters, G.(1999) The addiction concept: Working hypothesis or self-fulfilling prophecy? Needham Heights, MA: Allyn & Bacon.

Watson, L. & Parke, A. (2011) 'Experience of Recovery for Female Heroin Addicts: An Interpretative Phenomenological Analysis'. International Journal of Mental Health Addiction 9, p102-117.

Wengraf, T. (2001) Qualitative Research Interviewing. London: Sage.

Weegman, M. & Cohen, R. (2002) The Psychodynamics of Addiction. Whurr Publishers: London.

West, R. (2006) Theory of Addiction. Oxford: Blackwell.

Williams, C. & Wood, R. (2010) 'Impairment in the recognition of emotion across different media following traumatic brain injury'. Journal of Clinical and Experimental Neuropsychology 32(2), p113-122. Psychology Press: Trevor & Francis Group.

Witton, J., Keaney,F. & Strang. J. (2005) 'They do things differently over there: doctors, drugs, and the 'British System' of treating opiate addiction'. Journal of drug issues. 35, 779-797.

Woolfe, Dryden et al. (2003) Handbook of Counselling Psychology. London: Sage.

West, R. (2006) Theory of Addiction. London: Blackwell.

Yalom, I. (1980) Existential Psychotherapy. Basic Books: New York.

Yalom, I. (1970) Theory and Practice of Group Psychotherapy. Fourth Ed. Basic Books; New York

Yardley, L. (2000). 'Dilemmas in qualitative health research'. Psychology and Health.
15, p215-228.

Appendix I- Project Proposal

Project Proposal

Title: ***The experience of freedom of choice in heroin addiction (an existential-phenomenological exploration)***

Name of researcher: Fernanda A. Barros

Nature and purpose of the study

This study takes an existential-phenomenological investigation of the element of choice in heroin addiction. Addiction is seen as a 'problem in living' rather than a disease that is not entwined with other 'life difficulties'. One of the aims of the current project is to respond to the need identified by previous papers that have not addressed the addicts' viewpoint and world view in general as well as process and relational issues that arise out of using heroin. Specifically this study aims to address an area, which has been previously objected to a scientific bias (Wurm, 2003) from an existential-phenomenological viewpoint in an effort to demystify the phenomenon of heroin addiction through a clarification of its meaning from the participants' vantage point, as well as contribute to the field of clinical practice and ways of working with drug addiction in general.

Given the existential/phenomenological nature of the study Van-Deurzen (2005) four worlds of existence will be utilised in an attempt to offer a framework from which the participants' lived experience will be mapped out and understood.

In other words, the four worlds of existence will provide the basic framework from which to address addiction holistically and analyze participant's world-view and subjective experiences. In addition this study will focus on the phenomena of drug addiction and question the ideology of 'involuntary addiction' in which the ingestion of a chemical substance is considered as a disease. The aim is to explore current themes in drug addiction significant from previous literature by West (2006), Schaler (2000), Davies (2000) et al. such as social responsibility, meaning and choice from an existential phenomenological stance specifically from the four-worlds of existence.

According to DuPlock and Fisher;

> *"There is a pressing need for existential phenomenological research on the nature of addiction and ways of working with people presenting with issues related to addiction to provide a counterbalance to the majority of research carried out to date in which outcomes(and particularly abstinence) play such an important role. Solution-focused therapy*

provides the context for addiction and the emphasis remains on pathologizing addiction or correcting maladaptive patterns of behaviour. This imbalance may be partly addressed by the publication of detailed client studies which present 'addiction' in the context of the client's struggle to make meaning in their lives."(Cited in Van-Deurzen & Baker, 2005 p.76)

Research will involve participants who attend an independent non-NHS funded charity providing support for people with substance misuse problems. (Centre A and Centre B) These are people who are currently in the process of detoxing from heroin.

Methodology

Epistemological Position

This study is located within a critical realist position which assumes that we can separate the world from our knowledge of it, but we need to accept that psychological 'facts' are socially constructed. 'Critical realism can help clarify the concept of reality by differentiating from the 'real' (the content of subjectively felt realities) and the 'actual' (necessary conditions)

This study is also sympathetic to social constructivist views (Burger &Luckmann, 1966) that individuals both create and are created by society as language creates and sustains social knowledge by providing an explanation about psychological phenomena and the very experience of that phenomenon. Individuals make sense of their experience in discourse and discourse can be mobilized in flexible and contradictory ways. Also, we use different sense-making resources in different social contexts; thus 'the same phenomena or event can be described and made sense of in different ways, given rise to different ways of perceiving and understanding it.' (Willig, 2001) In this study the researcher also aims to address the nature of language as action; as we learn ways of describing emotions where language has already decided and organized in discourse.

Proposed Methodology

Experimental Design and Methods to be Used

In order to conduct this study, a form of qualitative analysis; interpretative phenomenological analysis will be used. This is a phenomenological approach concerned with individual's personal view or account of an event instead of an objective statement and it has its origins in those fields of inquiry, such as phenomenology and interactionism which believes that human beings are not passive perceivers of an objective reality, but come to interpret and understand their world by formulating their own autobiographical stories.'(Brocki & Wearden, 2004) The focus is on the meanings those experiences hold for the participants; unlike discourse analysis, IPA is not about

making a theoretical reading of the text, but focuses on understanding experience. We aim to consider an individual's personal account of a physical process and IPA allows the researcher to explore the subjective respondent's account of making sense of their experiences. This is a double-hermeneutic process in which the researcher will try to interpret participants interpreting their world. Unlike narrative analysis, in which the focus is on narratives, stories and the feelings evoked; IPA provides us with a methodology for accessing participant's points of view, and assumes these are relatively stable over time. In terms of limitations of this method of choice, I will keep in mind that in some cases, participant's abilities to reflect on their experience may be difficult in cases where, for example, shame was experienced, impacting on their ability to verbalize and reflect openly on the meaning of a particular experience. (Dallos & Vetere, 2005)

IPA is capable of answering in-depth questions regarding the nature of individual's experience (Smith, 2004) *"[T]he approach is phenomenological in that it is concerned with an individual's personal perception or account of an object or event as opposed to an attempt to produce an objective statement of the object or event itself.[...] Access[to the participants personal world] depends on, and is complicated by, the researcher's own conceptions and indeed these are required in order to make sense of that other personal world through a process of interpretative activity…"* (Smith, Jarman and Osborne, 1999 p.218-219) The focus of this investigation is thus on the meanings those experiences hold for the participants. This phenomenological approach recognizes the way knowledge is a co-construction, reflecting the questions and choices the researcher makes and brings as much as the experience of the participants being investigated (Langdridge, 2007 p.59)

Procedure

This will include a 50 to 60 minutes semi-structured interview in person in which the participant will be asked open-ended questions in relation to their drug-use and the impact of this in other areas in their lives. A review of interview questions is ongoing as the aim is to make the researcher and participants biases evident. The researcher will take notes during the interview which will not identify the participant and these notes will be checked with all the participants. Furthermore all participants will have access to his/her interview notes if they wish. Upon completion of this study all material will be destroyed to assure the confidentiality of participants.

The participants will be adult heroin 'addicts' (with a history of substance misuse), who will be contacted after they respond to a poster displayed at the reception area of Centre A or Centre B Key-workers in both centres have been asked to refer any clients they feel might be interested in taking part also. The poster will briefly explain the aims of the study, and ask participants to contact the researcher if they are interested in taking part. In order to guarantee interest in the study, a small incentive of a 10 pound voucher will be given to participants for their time and participation.

a. <u>Selection of participants:</u>

- Number of participants: 7-10 (minimal requirement for an IPA study)

- Accessing Centre A or Centre B

- Heroin addicts recruited from Centre A or Centre B - homogenous population

- No current medical problems reported which could interfere in the study

- No previous diagnosis of mental health problems.

Design

Furthermore, the semi-structured questionnaire (please see draft attached) followed during interview, is estimated to take 50-60 minutes per participant. The data collected will be analysed using Interpretative Phenomenological Analysis.

After collecting the data and their transcripts, the stages in analysis of qualitative data of *immersion, categorisation, phenomenological reduction, triangulation* and *interpretation* will be followed (McLeod, 2003). Smith's (2003) Interpretative Phenomenological Analysis will be the followed method; looking for themes, connecting the themes and repeating the process with every case. Each participant's experience will be analysed on its own, and after having lifted several meanings following the methodology, these emerging themes and meanings of different experience will then be aligned in tabular form. The interviewer hopes the research will succeed in answering the research question via this method of recruiting participants.

Ethics

Once participants have been identified they will be given a Information Sheet, a document outlining the principles of the study (confidentiality, data anonymity) and a consent form to sign. Extracts from the interview will be used only with the participants consent within a larger context and all will be anonymized. Given the sensitivity of the topic the interviews will be interrupted if participants disclose something sensitive and their key worker (support worker) will be on stand-by at the clinic should they wish to address sensitive material disclosed as a result of the interview.

Anonymity

All material will be kept according to the Data Protection Act 1998 and no participant will be identifiable in written, recorded or electronic form. Data will be collected, stored and handled in an anonymous form. The collected data will be coded numerically.

Deception

This research does not require withhold of information, purpose or any deception. Participants will be provided with sufficient information at the earliest stage.

Debriefing

All participants will be fully debriefed and checked on their emotional state following interview.

Information will be provided in order to complete participants understanding of the nature of the research and in order to monitor any unforeseen negative effects or misconceptions. (BPS Code of Ethics when researching human participants)

Consent

Participants will be informed of the objectives of the investigation and aspects of research that could influence wiliness to participate. Informed consent will be sought after participants read the information sheet, ask any questions, and sign the consent form after researcher explains the purpose of the study. Special attention will be taken over informed consent as the research is dealing with vulnerable populations.

Also, the payment of participants is not to induce them or risk harm beyond that which they would risk without payment.

Withdrawal from the investigation

At the onset of the interview participants will be reminded of their right to withdraw at any time, irrespective or not an inducement has been made.

After debriefing if participants decide to withdraw from the investigation, all data will be destroyed.

Confidentiality

According to the Data Protection Act (1998) consent forms and tapes will be stored in safe place, securely locked and will not be used for any other purposes. The interviewer is the only person with access to the computer where data will be restored. Data saved in the computer will bear pseudonyms and any information that might breach confidentiality will be removed beforehand. Participants will be identifiable by a numeric code only. In the instance of publication, explicit consent will be sought from all participants.

Risk

Researcher will establish participant's engagement with suitable emotional support prior to interview, whether counselling, NA meetings or keyworking and inform participants the interview will be stopped if they get distressed. Participants will be informed of their right to withdrawal from the investigation at any point with no consequences. Participants will not be exposed to risks that are greater than their normal lifestyle. Also, researcher will inform the participants and ask about any factors that may create risks for them to participate such as pre-existing medical conditions. Participants will also be informed how to contact researcher within a period following participation should they experience stress or have any concerns.

Risks to researcher

The independent location of the interview is to be conducted at Centre A, a service in (xxx) providing support for heroin users or Centre B, an abstinence based treatment day centre. All Health and Safety guidelines abided by the Centre will be observed and followed. The researcher will ascertain that she signs the book upon entrance and exit and makes sure the manager knows her interview schedule. Researcher will alert someone when she has left the Centre. A person will be nominated to raise the alarm should the researcher not report back or return at the notified time.

The researcher has worked with similar population (heroin users in criminal justice settings) and has done a lot of training in engaging; assertive engagement, basic drug awareness; which as well as experience with this participant group will enable her to conduct the interviews mindful of any potential risks. Researcher will have access to and read participants risk assessments prior to interview.

Costs and how they will be defrayed

The researcher is self-funded and there will be travelling costs for the researcher. Participants will be given a 10 pound M&S voucher each for their contribution. Also, researcher will try to accommodate appointments when participants are at the Centre for group or other purposes. The total cost for the researcher will be 70 pounds (10 pounds, 7 participants) plus travelling costs for 2-3 days of interviewing.

Benefits

For the participants, the benefits of participating in this research is to hopefully enhance their own psychological understanding around the issue of addiction as well as further clarifying the process of detoxing and recovery. The research might give participants a space to shed light on the physical and psychological state of addiction by being able to talk through their experiences

In addition, benefits aim to include broadening the understanding of addiction and thus enhancing new ways of working with people presenting with addictions as well as current policies informing practice in this area.

Potential distress

It is the researcher's responsibility to protect participants from physical or mental harm during this investigation. This research does not pose any risk greater than everyday life. Special measures will be used in order to avoid risk, such as checking participant's condition and engagement with adequate emotional support prior to investigation. The interview will be stopped if participants experience emotional distress and participants will be asked whether they want to end the interview and discuss their stress with their counsellor or keyworker. After the interview, all participants will be debriefed, making sure they are fine and have continuous access to support from the Centre.

Participants will be informed of procedures for contacting the researcher within a reasonable time period should any stress, potential harm or concern arises following taking part in this investigation.

There will be no concealment or deception when seeking information that might encroach on participant's privacy.

Indemnity

This research abides by the BPS' Professional Liability Insurance Policies (July, 2009) to safeguard participant's wellbeing.

(http://www.bps.org.uk/the-society/organisation-and-governance/professional-practice-board/ppb-activities/professionalpracticeguidance.cfm)

Dissemination of the results

Participants will be debriefed according to the Ethical Principles for Conducting Research with Human Participants, BPS Code of Conduct, Ethical Principles and Guidelines, p.8)the researcher will 'discuss with the participants their experience of the research in order to monitor any unforeseen negative effects or misconceptions.' Copies of the full thesis will be kept at the New School of Psychotherapy and Counselling. 51-55 Royal Waterloo Road, SE1 8TX London

Any other ethical issues

None at present

Appendix II- Request for Ethical Approval

New School of Psychotherapy and Counselling

Royal Waterloo House

51-55 Waterloo Road

London

SE1 8TX

Request for Ethical Approval

Applicant (specify): ☐ UG PG ☐ PhD Staff

Module: *DPsych in Existential Counselling Psychology and Psychotherapy*

No study may proceed until this form has been signed by an authorised person indicating that ethical approval has been granted.

For collaborative research with another institution, ethical approval must be obtained from all institutions involved.

This form should be accompanied by any other relevant materials (e.g. questionnaire to be employed, letters to participants/institutions, advertisements or recruiting materials, information sheet for participants[1], consent form[2], or other, including approval by collaborating institutions). A fuller description of the study may be requested.

Is this the first submission of the proposed study? ☐ Yes *x*☐ No

Is this an amended proposal (resubmission)? x☐ Yes ☐ No

Is this an urgent application? x☐ Yes ☐ No

(To be answered by staff/supervisor only)

Supervisor to initial here:

Name of investigator(s):

Fernanda Barros (researcher)

Name of supervisor(s):

Dr. Rosemary Lodge

Dr.Andreas Vossler

Title of Study
The experience of freedom of choice in heroin addiction (an existential-phenomenological exploration)

1. Please attach a brief description of the nature and purpose of the study, including details of the procedure to be employed. Identify the ethical issues involved, particularly in relation to the treatment/experiences of participants, session length, procedures, stimuli, responses, data collection, and the storage and reporting of data.

See attached project proposal

2. Could any of these procedures result in any adverse reactions? x☐ Yes ☐ No

If "yes", what precautionary steps are to be taken?
During the investigation participants (in sharing how they experienced addiction) may be reminded of sensitive issues. For this reason, participants will be those attending Centre A or Centre B for emotional support, so that should such issues arise, they will be in therapy or receiving adequate emotional support in key working (this will be established prior to interview) and therefore able to address these issues appropriately. *Given that I am a trainee counselling psychologist, and based on my current experience as (a trainee) practitioner, I will be very alert during the interviews in case any potential distress arises. In the event of distress I will gently reflect upon my participant's experience and ask them whether they feel like terminating the interview. I will then debrief them and make sure that they get the chance to discuss their distress (without offering therapy and therefore blurring my role as a researcher with that of a practitioner) and refer them to a key worker (who will be on site) should they need further support.)* *After the interview, all participants will be debriefed, making sure they are fine and have continuous access to support from the Centre's A and B.*

3. Will any form of deception be involved that raises ethical issues? ☐ Yes X☐ No

(Most studies in psychology involve mild deception insofar as participants are unaware of the experimental hypotheses being tested. Deception becomes unethical if participants are likely to feel angry or humiliated when the deception is revealed to them).

Note: If this work uses existing records/archives and does not require participation per se, tick here and go to question 10. ☐

(Ensure that your data handling complies with the Data Protection Act)

4. If participants other than NSPC or Middlesex University students are to be involved, where do you intend to recruit them?

(A full risk assessment must be conducted for any work undertaken off university premises)[6,7]

Participants will be those attending emotional support and treatment for addiction issues at Centre Aa service user group providing after care treatment in Bxxx and participants enrolled on an abstinence based treatment day centre based on the 12 step model of recovery at Centre B, both centers offer support for people with substance misuse problems. *Number of participants: 7-10* *- Attending key-working sessions, counselling and support for heroine detox at Centre Aor Centre B* *-Previous Heroine User* *- No current medical problems reported which could interfere in the study* *-No previous history or diagnosis of mental health problems* *- Referred by their key worker, or word of mouth, self-referrals*

5. When did you receive programme planning approval for this study:

(If you were asked for revisions to your original proposal, this date should be when you received approval of the revisions)

01/11/2007

Please attach a copy of the programme planning approval

6. Does the study involve:

• Clinical populations	x☐ Yes	☐ No
• Children (under 16 years)	☐ Yes	x☐ No
• Vulnerable adults such as individuals with mental health problems, learning disabilities, prisoners, elderly, young offenders?	☐ Yes	x☐ No

7. How, and from whom (e.g. from parents, from participants via signature) will informed consent be obtained?

(*See consent guidelines*[2]*; note special considerations for some questionnaire research)*

When the participant accepts and co-signs the consent form and returns it to the investigator after reading and clarifying the Information Sheet. *-Participants retain the right to withdraw at any moment without giving reasons or penalty.*

8. Will you inform participants of their right to withdraw from the research at any time, without penalty? x☐ Yes ☐ No

(*See consent guidelines*[2])

9. Will you provide a full debriefing at the end of the data collection phase? x☐ Yes ☐ No

(*See debriefing guidelines*[3])

10. Will you be available to discuss the study with participants, if necessary, to monitor any negative effects or misconceptions? x☐ Yes ☐ No

If "no", how do you propose to deal with any potential problems?

NB: You are not at liberty to publish material taken from your work with individuals without the prior agreement of those individuals.

11. Under the Data Protection Act, participant information is confidential unless otherwise agreed in advance. Will confidentiality be guaranteed? x☐ Yes ☐ No

(See *confidentiality guidelines*[5])

If "yes" how will this be assured? (See [5])
Each participant will have a unique numeric or alphanumeric key and data will be identifiable by this key only. A separate record will be kept identifying participants which will correspond to that key. This record will be kept separately and securely in a locked computer accessible only by the researcher. *Consent will be explicitly sought in order to publish the data without identifying participants.* *Participants can request to see the data collected on them at any time.* *Records will be kept for 3-10 years in case of publication as indicated by the Data Protection Act 1998.*

If "no", how will participants be warned? (See [5])

12. Are there any ethical issues which concern you about this particular piece of research, not covered elsewhere on this form? ☐ Yes X☐ No

If "yes", please specify:

NB: If "yes" has been responded to any of questions 2,3,5,11 or "no" to any of questions 7-10, a full explanation of the reason should be provided if necessary, on a separate sheet submitted with this form.

13. Some or all of this research is to be conducted away from Middlesex University — x☐ Yes ☐ No

If "yes", tick here to confirm that a Risk Assessment form is to be submitted: x☐

14. I am aware that any modifications to the design or method of this proposal will require me to submit a new application for ethical approval. — x☐ Yes ☐ No

15. I am aware that I need to keep all materials/documents relating to this study (e.g. participant consent forms, filled questionnaires, etc) until the completion of my degree. — x☐ Yes ☐ No

16. I have read the British Psychological Society's *Ethical Principles for Conducting Research with Human Participants* (DPsych) or the relevant Universities Counselling and Psychotherapy Association guidelines (DProf) and believe this proposal to conform with them. — x☐ Yes ☐ No

Researcher:	Fernanda Barros	Date:	27.09.2009 revised on 9/9/2011

Signatures of Approval

Supervisor:		Date:	
Ethics Panel:		Date:	

(Signed, pending completion of a Risk Assessment form if applicable)

[1,2,3,4,5,6,7] Guidelines are available from the Ethics page of Oas!sPlus

Appendix III- Risk Assessment

INDEPENDENT FIELD/LOCATION WORK RISK ASSESSMENT FRA1

This proforma is applicable to, and must be completed in advance for, the following fieldwork situations:

1. *All fieldwork undertaken independently by individual students, either in the UK or overseas, including in connection with proposition module or dissertations. Supervisor to complete with student(s).*
2. *All fieldwork undertaken by postgraduate students. Supervisors to complete with student(s).*
3. *Fieldwork undertaken by research students. Student to complete with supervisor.*
4. *Fieldwork/visits by research staff. Researcher to complete with Research Centre Head.*

FIELDWORK DETAILS

Name Fernanda Barros …….. **Student No**

Research Centre (staff only) *M00194840*……

Supervisor Dr. Rosemary Lodge **Degree course** ……DPsych in Existential Counselling Psychology and Psychotherapy ……..

Telephone numbers and name of next of kin who may be contacted in the event of an accident

NEXT OF KIN

Name

Osanan Barros……..

Phone

…+61437122900……..

Physical or psychological limitations to carrying out the proposed

fieldwork	None
	……
	……
Any health problems (full details)	None……
Which may be relevant to proposed fieldwork activity in case of emergencies.	……
	……
	……
Locality (Country and Region)	Centre A Centre B
	……
Travel Arrangements	Public transport; bus and underground …….
	……
	……
NB: Comprehensive travel and health insurance must always be obtained for independent overseas fieldwork.	……

Dates of Travel and Fieldwork January 2010, February 2011 and may 2011……

……

PLEASE READ THE INFORMATION OVERLEAF VERY CAREFULLY

Hazard Identification and Risk Assessment **PLEASE READ VERY CAREFULLY**

List the localities to be visited or specify routes to be followed **(Col. 1).** Give the approximate date (month / year) of your last visit, or enter 'NOT VISITED' **(Col 2).** For each locality, enter the potential hazards that may be identified beyond those accepted in everyday life. Add details giving cause for concern **(Col. 3).**

Examples of Potential Hazards :

Adverse weather: exposure (heat, sunburn, lightening, wind, hypothermia)

Terrain: rugged, unstable, fall, slip, trip, debris, and remoteness. Traffic: pollution.

Demolition/building sites, assault, getting lost, animals, disease.

Working on/near water: drowning, swept away, disease (weils disease, hepatitis, malaria, etc), parasites', flooding, tides and range.

Lone working: difficult to summon help, alone or in isolation, lone interviews.

Dealing with the public: personal attack, causing offence/intrusion, misinterpreted, political, ethnic, cultural, socio-economic differences/problems. Known or suspected criminal offenders.

Safety Standards (other work organisations, transport, hotels, etc), working at night, areas of high crime.

Ill health: personal considerations or vulnerabilities, pre-determined medical conditions (asthma, allergies, fitting) general fitness, disabilities, persons suited to task.

Articles and equipment: inappropriate type and/or use, failure of equipment, insufficient training for use and repair, injury.

Substances (chemicals, plants, bio- hazards, waste): ill health - poisoning, infection, irritation, burns, cuts, eye-

damage.

Manual handling: lifting, carrying, moving large or heavy items, physical unsuitability for task

If no hazard can be identified beyond those of everyday life, enter 'NONE'.

Give brief details of fieldwork activity: ……

Interviews will be conducted at the centre in which clients attend regularly in order to get a variety of interventions for addictions; including; needle exchange, counselling, acupuncture. Script for methadone or subutex, meditation, key-working, group work etc.

……..

…….

…….

…….

1. LOCALITY/ROUTE	2. LAST VISIT	3. POTENTIAL HAZARDS
Centre A **Centre B**	**24/08/09** **May 2011**	**Safety standards- conduct interviews whilst managers on duty** **Substances- check medical condition and drug usage of participants prior to interviews. (i.e.; as part of risk assessment, so that I can consider if I need to take any precautions or whether the participant is in a fit state to be interviewed)** **Sign in and out of property making sure someone in charge knows when I am interviewing** **Participants attending centre as part of drug-related court order (potential past criminal behaviour). (i.e. Check participant's history in risk assessment as part of safety measures for researcher) All participants were voluntary attendants**

The University Fieldwork code of Practice booklet provides practical advice that should be followed in planning and conducting fieldwork.

Risk Minimisation/Control Measures **PLEASE READ VERY CAREFULLY**

For each hazard identified **(Col 3),** list the precautions/control measures in place or that will be taken **(Col 4)** to **"reduce the risk to acceptable levels",** and the safety equipment **(Col 6)** that will be employed.

Assuming the safety precautions/control methods that will be adopted **(Col. 4),** categorise the fieldwork risk for each location/route as negligible, low, moderate or high **(Col. 5).**

Risk increases with both the increasing likelihood of an accident and the increasing severity of the consequences of an

accident.

An acceptable level of risk is: a risk which can be safely controlled by person taking part in the activity using the precautions and control measures noted including the necessary instructions, information and training relevant to that risk. The resultant risk should not be significantly higher than that encountered in everyday life.

Examples of control measures/precautions:

Providing adequate training, information & instructions on fieldwork tasks and the safe and correct use of any equipment, substances and personal protective equipment. Inspection and safety check of any equipment prior to use. Assessing individuals fitness and suitability to environment and tasks involved. Appropriate clothing, environmental information consulted and advice followed (weather conditions, tide times etc.). Seek advice on harmful plants, animals & substances that may be encountered, including information and instruction on safe procedures for handling hazardous substances. First aid provisions, inoculations, individual medical requirements, logging of location, route and expected return times of lone workers. Establish emergency procedures (means of raising an alarm, back up arrangements). Working with colleagues (pairs). **Lone working is not permitted where the risk of physical or verbal violence is a realistic possibility.** Training in interview techniques and avoiding /defusing conflict, following advice from local organisations, wearing of clothing unlikely to cause offence or unwanted attention. Interviews in neutral locations. Checks on Health and Safety standards & welfare facilities of travel, accommodation and outside organisations. Seek information on social/cultural/political status of fieldwork area.

Examples of Safety Equipment: Hardhats, goggles, gloves, harness, waders, whistles, boots, mobile phone, ear protectors, bright fluorescent clothing (for roadside work), dust mask, etc.

If a proposed locality has not been visited previously, give your authority for the risk assessment stated or indicate that your visit will be preceded by a thorough risk assessment.

4. PRECAUTIONS/CONTROL MEASURES	5. RISK ASSESSMENT	6. EQUIPMENT
Managers will be on site. interviews will be conducted at the participant's support centre Participants will be in the process of detox and attending support groups in the place where interviews will be conducted. **emergency procedure will be established with manager prior to research interviews** **will check health and safety standards of centre** Make sure someone is on duty and aware of interview taking place, observe incident guidelines and make sure researcher is safe; near the door etc. There will be a risk assessment for each participant and this will be checked prior to interview	moderate	Training, information and pilot interviews t be conducted as test-trials

PLEASE READ INFORMATION OVERLEAF AND SIGN AS APPROPRIATE

DECLARATION: The undersigned have assessed the activity and the associated risks and declare that there is no significant risk or that the risk will be controlled by the method(s) listed above/over. Those participating in the work have read the assessment and will put in place precautions/control measures identified.

NB: Risk should be constantly reassessed during the fieldwork period and additional precautions taken or fieldwork discontinued if the risk is seen to be unacceptable.

Signature of Fieldworker (Student/Staff)	…Fernanda Barros …….…….……	**Date**	……27/10/2009…. eviewed on 9/9/2011….
Signature of Student Supervisor	…….…….……	**Date**	…….…….….

APPROVAL: (ONE ONLY)

Signature of Curriculum Leader (undergraduate students only)	…….…….……	**Date**	…….…….….
Signature of Research Degree Co-ordinator or Masters Course Leader or	…….…….……	**Date**	…….…….….

Taught Masters Curriculum Leader

Signature of Research Centre Head (for staff fieldworkers**)** …… **Date** ……

FIELDWORK CHECK LIST

1. Ensure that **all members** of the field party possess the following attributes (where relevant) at a level appropriate to the proposed activity and likely field conditions:

N/A Safety knowledge and training?

N/A Awareness of cultural, social and political differences?

√ Physical and psychological fitness and disease immunity, protection and awareness?

N/A Personal clothing and safety equipment?

N/A Suitability of fieldworkers to proposed tasks?

2. Have all the necessary arrangements been made and information/instruction gained, and have the relevant authorities been consulted or informed with regard to:

N/A Visa, permits?

√ Legal access to sites and/or persons?

N/A Political or military sensitivity of the proposed topic, its method or location?

N/A Weather conditions, tide times and ranges?

N/A Vaccinations and other health precautions?

N/A Civil unrest and terrorism?

√ Arrival times after journeys?

N/A Safety equipment and protective clothing?

√ Financial and insurance implications?

√ Crime risk?

√ Health insurance arrangements?

√ Emergency procedures?

√ Transport use?

√ Travel and accommodation arrangements?

Important information for retaining evidence of completed risk assessments: Once the risk assessment is completed and approval gained the **supervisor** should retain this form and issue a copy of it to the fieldworker participating on the field course/work. In addition the **approver** must keep a copy of this risk assessment in an appropriate Health and Safety file.

Appendix-IV- Semi Structured Interview Questions

SEMI-STRUCTURED INTERVIEW QUESTIONNAIRE

The experience of freedom of choice in heroin addiction (an existential-phenomenological exploration)

Introduction

Thank you for your participation in this research. I am really interested in how you see things, and want to understand your experience on this subject as it may inform so called professionals. I am interested in exploring your experience rather than medical viewpoint.

Often drug use in general is seen as a purely physical condition; however this research aims to look at heroin use in a more holistic way; I am therefore interested in your subjective experience of using heroin and how it is reflected in different areas of your life.

Background

- **Tell me a bit about yourself (Prompt: context, keywords, issue)**
- **When did you start taking drugs, what was happening in your life at the time?**
- **Was it always heroin (or x drug), if not then what was so special/ or attracted you about heroin? (prompts: body level, emotional level, social level)**
- **Do you feel you have a choice in heroin addiction?**
- **How did you start using heroin – please describe a typical situation of using heroin**

- **What was going on in your life at that time (<u>prompts</u>: on a feeling level, on a relational level, on a meaning level).**

- **How would you describe the consequences of your drug use? (<u>prompts</u>: what did it to for you? positive? Negative? On a feeling level, on a relational level?)**
- **How would you describe your relationship with this drug now?**
- ***What about your relationship with other people?***
- ***How does heroin affect your life?***
- **Do you choose it? Do you enjoy it? Is it a sheer physical addiction? Do you want to free yourself from it?**
- **What brought you here?**
- ***Feeling level prompt: what does heroin do for you now, physical prompts: it seems like.. Meaning level: negative choices, not choosing***

- ***What is your view on the fact that heroin use and drug use in general is seen as a purely physical condition?***

Appendix – V – Recruitment Poster

Share your views ! and get a £10 pound voucher

If you have used heroin in the past and you are currently attending a drug treatment agency for support,

Would you be willing to talk to me about:

Your experience of heroin use,

your feelings, thoughts and understanding of drug addiction,

and

whether you felt there is an element of choice in it?

If **yes** please email me at:

drugresearch@hotmail.co.uk

A bit about Me:

My name is Fernanda Barros, I was a placement counsellor at The Crossing and the Awareness centre. I am a trainee-counselling psychologist at the New School of Psychotherapy and Counselling (NSPC) For my last year research, I am interested in exploring the subjective experience of heroin addiction with particular focus on the presence or absence of choice in heroin use . Participants get a 10 pound M&S or Sainsbury voucher for their time. Please txt **07539617194** and I will call you back to arrange a 50-60 minute interview at the Centre. Or sign up at Reception by leaving your name and number and I will contact you.I look forward in hearing from you!

Fernanda- drugresearch@hotmail.co.uk/ 07539617194

Appendix – VI

Information Sheet

Researcher: Fernanda Barros

Institution: New School of Psychotherapy and Counselling/ Department of Psychology, Middlesex University, The Burroughs, London NW4 4BT

1. Study title

The experience of freedom of choice in heroin addiction. (an existential-phenomenological exploration)

2. Invitation paragraph

You are being invited to take part in a research study. Before you decide to participate, it is important for you to understand why the research is being done and what it will involve. Please take your time to read the following information carefully, and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take your time to decide whether or not you wish to take part.

3. What is the purpose of the research?

The research is part of a Doctoral Programme in Existential Counselling Psychology and Psychotherapy. The research aims to examine the experience of freedom of choice in heroin addiction.

4. What will happen to me if I take part?

You have been asked to participate in the research in order to reflect on your experience of heroin use, and explore the meaning of addiction and choice from a first person's account. If you decide to take part you will be asked to attend an interview at The Centre with the researcher which will last for about 50-60 minutes. This interview will be recorded and the recording will only be accessible by the researcher and yourself should you wish so. Questions will attend to your experience of drug use and will follow a semi-structured layout. You will also be given the opportunity to discuss any other issues that might not be covered but are relevant to your personal experience. The taped interview may be listened to by whoever is transcribing the tapes, and by her research supervisor. All recording of the interview will be erased at the end of the study.

5. What are the possible disadvantages and risks of taking part?

In talking about your experience of heroin use, the interview may bring back feelings relating to past distressing events or raise new questions for you. It is therefore important that you consider carefully whether you feel able to talk about your experiences before you decide to take part in the research. Should you become upset during the interview, the researcher will check whether you wish to continue the interview or not.

6. Consent

You will be given a copy of the information sheet and asked to sign a consent form prior to taking part in the research. Your participation in this research is entirely voluntary. You do not have to take part if you do not want to. If you decide to take part you may withdraw at any time without giving a reason. All personal information will be made anonymous in the write-up on the thesis. All data collected will be stored, analysed and reported in compliance with the Data Protection Act 1998.

7. Who is organising and funding the research?

The research is organised by the researcher. There is no funding from an external body.

8. Who has reviewed the study?

An Ethics Committee reviews all proposals for research using human participants before they can proceed. The NSPC Ethics committee has recently reviewed this application on behalf of the University of Middlesex, Department of Psychology research ethics committee.

Thank you for taking time to read this information sheet.

Appendix- VII- Consent Form

New School of Psychotherapy and Psychology Department, Middlesex University School of Health and Social Sciences

Project title: **The experience of freedom of choice in heroin addiction**

I have understood the details of the research as explained to me by the researcher, and confirm that I have consented to act as a participant.

I understand that my participation is entirely voluntary, the data collected during the research will not be identifiable, and I have the right to withdraw from the project at any time without any obligation to explain my reasons for doing so.

I further understand that the data I provide may be used for analysis and subsequent publication in an anonymous form, and provide my consent that this might occur.

I understand that a recording is being made of this interview and will be securely stored until a verbatim transcript has been made. The data collected from the record and the tapes may be stored for up to 3-10 years if the research is published. (this is according to Data Protection Act 1998 guidelines.)

Print name of participant Participant's signature

Print name of researcher Researcher's signature

FERNANDA BARROS F.Barros

Date

Appendix- VIII- Letter of Ethical Approval

Fernanda Barros
Flat 3
27 Beaufort Gardens
London
SW3 1PR

18th May 2010

Title of Study: *The experience of freedom of choice in heroin addiction (An Existential Phenomenological exploration)*

Dear Fernanda

Re: Ethics Approval

We held an Ethics Board on 14 April 2010 and I can now confirm that your project has been approved.

Congratulations!

Yours sincerely

Prof Digby Tantam
Chair - Ethics Committee
NSPC

Appendix – IX Developing Themes

Participant: Ed (40,M)

Emergent themes	***Original Transcript***	***Descriptive comments***	***Interpretation***	***Semantic comments***
Costs of heroin	P: Not all of it 'cause there's certain parts of it missing not missing but yeah but most of the memories I remember in jail when I've cleaned up at certain stages which ain't been very long in jail was the only times I got a four this time and ended up doing 2 years yeah but I knew 'cause I got threw off a building and stuff so this is what heroin's caused I got threw off a building R: You got thrown off a building P: I've got all metal work in my pelvis and metal in my knee cap two rods in my leg stabbed in the backside smashed all my teeth R: So how do you mean that's what heroin has caused you P: Through heroin trying to rob me through	memories are missing. Only memories in jail after he cleaned up. Did a 2 year sentence out of 4.got thrown off a building because of heroin	memories only when cleaned up, almost lost his life	
		metal in pelvis, leg and knee and also smashed all his teeth and was stabbed in the back		disbelief thrown off a building and loss of memory
			physical destruction?	
Escaping death		heroin responsible for his accidents		
			heroin's fault?	
				can't believe what happened?
Heroin responsible for misfortunes				not taking responsibilit y
				disbelief
		madness	doesn't make sense?	took over
		Cost his life for a while		

Disbelief ***Costs*** ***Misunderstood*** ***People dont understand*** ***Methadone is worse***	heroin R: Try to rob you through heroin P: Yeah it's all madness R: So it could have cost you your life P: Yeah it did for a while R: So what is your view when people say heroin is just a physical addiction what do you think of that P: I know that's bullshit R: That's bullshit P: I don't know did they read that out of a book or something text books have they ever been on heroin R: It's the medical model, the doctors think it's just physical they give you methadone and you'll be okay P: Methadone is just a plaster it's just a substitute I've done methadone, methadone is worse than heroin I think it was invented by the Germans during the world war R: You mentioned I'm just going to go back really quickly you mentioned having violence from your	Bullshit that it's only a physical addiction thinks people read it in books and have no understanding of heroin methadone is worse than heroin, invented by the germans during the war was hit by dad for being a naughty boy but never saw it as excessive until pointed out by sister.problem child by the age of ten, took all the lead off the roof to sell for money. Put in police station. Dad beat him up. Kicked up and down stairs for things little boys do.	took over his life not physical anger at misunderstanding methadone only substitutes	misunderstood text books are wrong methadone is even worse accepted label of problem child, got

Abuse	father P: Yeah for being an naughty boy do you know what I never really seen it as excessive until my sister pointed it out when I was in jail on a visit she was visiting me in jail I don't know how the conversation started but I was a problem child at the age of ten I done ten, fifteen grand worth of damage to something I took all the lead off the roof to earn money and what makes you think like that at ten know what I mean so I got put in the police station by my old man and when I got home he kicked seven bells of sh*t out of me I've had things thrown at me and I've been kicked up and down the stairs	did some damage and they tried to bill his dad for the damage got punched and kicked realised that if he did naughty things in gangs he wouldn't get punished. It was accepted. Only realising this now after being in jail	disproportionate violence from that after he did something little boys do. punished a lot for causing damage as a child	severely beaten got severely punished for the damage he caused

Appendix- X Table of Super ordinate themes

e.g.- interview 6- Ed (40, M)

Theme 1- Abuse, misunderstood and not fitting in lead to anger

Emergent Theme	keywords	Page/ Line
Practical needs met but not emotional	violence towards me	6:284-289
Label and not fitting in	problem child, struggled to fit in	7:291-304
Physical Abuse	for being a naughty boy, problem child	8:362-371
	Punching, kicking, he used to give it to me	8:373-378
Lack of understanding	it aint just people from council estates	5:232-234
Feeling judged	don't understand, unknown, pushed away	5:224-230
Using not to be judged	feared being judged, coping mechanism	6:261-269
Judged no matter what	everyone judges people	6:271-277
Misunderstood	it's b****t	8:351
People don't understand	read out of a book	8:353-354
Anger for 23 years	anger issues, different life	4:157-158

Theme 2-Heroin masks feelings of inferiority and offers escape

Emergent Theme	keywords	Page/ Line
Feelings of inferiority	family did but I didn't see myself as equal	7:319-322
Heroin makes one invincible, careless	warm don't need nobody, superman legs shaking	4:177-193
Heroin masks inferiority feelings	wasn't comfortable in my own skin, it offered leadership	6:279-281
Escapism	reality escaping	6:244
	It was a buzz, kick escape	5:237-238
Heroin is everything	invincible she become my partner 23 years hard graft	6:240-256
Anger and rejection	f** the world	3:130
Heroin was cool	was uncomfortable as a kid, the thing to do	2:78-81
Heroin attractive made him feel wanted	made me feel wanted, comfortable with myself	2:70-76
Using to stop pain	I chose not to stop taking it.. lump made me better	3:121-128
Gave him everything he wanted	he's got a bird, he's got money	2:83-88

Theme 3- Physically no choice

Emergent Theme	Keywords	Page/Line
Not knowing leads to progression	thought it was cannabis oil	2:94-99
Withdrawal made him use	heroin was intense not a feeling like it	4:169-175
Not caring what it is	didn't need to be conned	3:101-104
Physically no choice	the way I felt physically I had no choice	5:197-208
Physical craving	got more physical, physical drove me	4:162-167

Theme 4- Joining gangs to belong

Emergent Theme	Keywords	Page/Line
Bad role models	he's doing it it seems to be allright	2:66-68
Identity through social deviancy	truanting, drinking, fighting heroin by 15	1:39-47
Socio-stigma	horrible stigma robbing old grannies	5:217-220
Heroin as a career	selling drugs it's a secret society	5:211-215
Socio-withdrawal	I'm withdrawn from society anyway	3:132-135
Outskirts of society	they're not normal part of society	3:137-139
Lack of understanding	ignorance	5:222

Belonging in gangs	part of my gang	3:142
	everyone was using...drink	4:145-148
	I try not to smile	4:155
	that's what attracts kinds nowadays	2:90-91
	if you did naughty things no one punished you	9:384-388

Theme 5- Social Reintegration through Prison and taking Responsibility

Emergent Theme	Keywords	Line
Structure	after jail sentence	1:12-14
	need some sort of safety net	1:16-20
Breaking old patterns	I'm gonna use and turns into addiction	1:22-27
Support	needed all the support	1:29-33
Leaving the pain behind	been emotional, painful, it's a struggle	9:396-406
Anger at life circumstances	what's God playing at	7:330-332
Finding meaning in something other than drugs	go to church to go pray	9:410-418
Clean in prison	in prison	7:315-316
Jail offered safety	through jail it's a god send	7:309-313

Theme 6- Either give up heroin or die

Emergent Theme	Keywords	Page/ Line
Methadone is worse	methadone is a plaster, worse than heroin	8:357-358
Heroin responsible for misfortunes	through heroin try to rob me	8:344
Habit leads to withdraw	being sick, beat up all the time	3:106-118
Didn't know it was addictive	Grange hill.. i didn't know	2:58-63
Lack of knowledge about heroin	didn't see it as I'll keep away	2:49-56
Escaping death	metal in my pelvis.. knee cap	8:341-342
Costs of heroin	memories in jail, 2 years thrown off building	7-8:334-339
Heroin lead to nothing	took everything, I lost everything soul-destroying	7:326-328
Disbelief	all madness	8:346
Costs	it did for a while (cost his life)	8:348

Appendix- XI Developing Table of Master Themes Draft

Common themes	***Participants examples***
Drugs to cope and escape	*Fighting, defending, intimidating, bullied, stabbed(Anand)* *nothing else mattered,(Mo)* *'naughty boy' anger,(Ed)* *isolated, structure escaping from reality (Joe),* *all you need is your mobile phone(Tom),* *took the pain away, bad parent (Lucy)* *, takes away normal living (Rosie)*
Drugs as a choice to belong	*Uproot, peer pressure (Anand)* *Not fitting in, Asian(Mo)* *He's got a bird, he has got money (Ed)* *Always felt like I was missing something (Joe)* *Mum, loved him so much using together (Lucy)* *Left for the bright lights of London (Rosie)*
Heroin Both gives and robs one's identity	*Wasn't a man anymore (Mo)* *Ashamed, smoking crack (Anand)* *23 years of hard graft (Ed)* *Madness, chaos, gangster, spiritually dead (Joe)* *Solved that but takes away everything else (Tom)* *All I knew, embarrassed going to the dealers (Lucy)* *Miss the excitement, never had the stability (Rosie)*
Rock bottom (responsibility and choice)	*Lack of support (Anand)* *It's a struggle (Ed)* *Ashamed, better today, impatient (Joe)* *Life is harder being clean (Tom)* *Shame, guilt, trying to give up for daughter (Lucy)* *You give up everything you care about (Rosie)*
Addiction as an illness?	*Today I have a choice (Rosie)* *I chose to continue to take it (Ed)* *Yes I did because X didn't want me to take it (Anand)* *What difference is it gonna make (Mo)* *Medicine (Tom)* *Merged boundaries (Lucy)* *Looking for structure (Joe)*