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The Experience of Addiction as Told by the Addicted: Incorporating Biological Understandings into Self-Story

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Abstract

How do the addicted view addiction against the framework of formal theories that attempt to explain the condition? In this empirical paper, we report on the lived experience of addiction based on 63 semi-structured, open-ended interviews with individuals in treatment for alcohol and nicotine abuse at five sites in Minnesota. Using qualitative analysis, we identified four themes that provide insights into understanding how people who are addicted view their addiction, with particular emphasis on the biological model. More than half of our sample articulated a biological understanding of addiction as a disease. Themes did not cluster by addictive substance used; however, biological understandings of addiction did cluster by treatment center.

Biological understandings have the potential to become dominant narratives of addiction in the current era. Though the desire for a “unified theory” of addiction seems curiously seductive to scholars, it lacks utility. Conceptual “disarray” may actually reflect a more accurate representation of the illness as told by those who live with it. For practitioners in the field of addiction, we suggest the practice of narrative medicine with its ethic of negative capability as a useful approach for interpreting and relating to diverse experiences of disease and illness.

Keywords

Addiction; substance use disorders; narrative therapy; biological etiology

Introduction

The National Institute of Drug Abuse's active endorsement of addiction as a “brain disease” has been described as an attempt to create “a unified framework for a problem-based field in conceptual disarray”(Campbell 2007). This increasingly popular biological model – addiction as a “disease of the brain” – reduces the problem to a system of spent neurotransmitter-soaked reward circuits, for which an individual may be genetically susceptible (Dingel 2011; Volkow and Fowler 2000), and seeks the development of pharmacological treatments to achieve a cure (Kalivas 2005).

Another dominant model – the adaptive/constructionist model – is popular with addiction treatment counselors and psychologists as it puts more emphasis on the effect of a person's environment, relationships, and identity when examining the etiology of addiction (Gergen 2005; Peale 1998). Proponents of the adaptive/constructionist model more readily espouse talk treatments aimed to facilitate self-realization and self-managed change (Prochaska 1992), a process in which success is gauged by a patient's ability to talk themselves back to health (Carr 2011).

Addiction as a socially-constructed illness has been pitted against addiction as a physiological disease. Some scholars, fed up with the addiction model turf war, have suggested mounting “a collective refusal against the domination of narratives around addiction as a disease that requires cure through formal [medical] treatment” (Gergen 2005; Pryce 2006). Alcoholics Anonymous (AA) and Narcotics Anonymous (NA), on the other hand, encourage something of a treatment middle ground. AA/NA provides some of the earliest studies on narrative therapy (Thune 1977), but has also moved to espouse the concept of addiction as a “disease” insofar as it is of utility to convince addicts¹ of the severity of their situation and the importance of abstinence.

Historically, addiction has been understood in various ways—a sin, a disease, a bad habit—each a reflection of a variety of social, cultural, and scientific conceptions (Kushner 2006; Levine 1978). Today there are a myriad of lingering theories addressing the problem of addiction, and yet, in spite of the diversity of theories and strategies, the problem persists. Addiction today remains as formidable a reality as it ever was, with twenty-three million Americans in substance abuse treatment and over \$180 billion a year consumed in addiction-related expenditure in the United States (Executive Office of the President 2004).

The primary aim of this paper is to explore how people who are addicted view their addiction against the framework of formal theories intended to explain their condition. In doing so, we will add to the “cultural stock of stories”(Hanninen 1999) that narrate the problem of addiction and discuss the curious desire for moving toward a more “unified theory” of addiction when the narratives from those who are addicted seem to reveal that no such “unified theory” need apply. Regardless of which addiction paradigms patients profess, clinicians must attend to individual accounts of illness—a practice which the rising field of “narrative medicine” promises to deepen.

Adding to the Cultural Stock of Stories

Hanninen and Koski-Jannes, in 1999, applied narrative analysis techniques to 51 written testimonies of recovered alcoholics, bulimics, smokers, and sex and gambling addicts in

¹We use the term “addict” as a stand in for other terms like substance user, alcoholic or smoker. Throughout our paper, we have chosen to refer to participants as they have chosen to describe themselves. Many of our participants self-identified as “addicts.” However, in our discussion of interview data should the participant self-identify as an alcoholic, we have referred to them as an alcoholic.

Finland. They ascertained five dominant narratives from the accounts: the Alcoholics Anonymous (AA) story, the personal growth story, the co-dependence story, the love story, and the mastery story.

They analyzed each narrative paradigm for “emotional, explanatory, moral, and ethical meaning,” for “connections of each narrative type with the story types, belief and value systems” prevalent in the larger culture, and for significant trends in each story type by gender or substance used (Hanninen 1999).

Elements of these addiction narratives reverberate in the findings of other qualitative researchers: certainly in Erica Prussing's fieldwork on alcoholism narratives of Native American women (Prussing 2007); also in Deborah Pryce's work in South Africa in which she found narrative solutions for what had previously been pharmacologic problems (Pryce 2006); and in Wiklund's examination of narrative hermeneutics of addiction (Wiklund 2008). What we add to their work is an account of how patients narrate themselves using the new biological accounts of addiction, an increasingly prevalent cultural story, and one widely represented in popular media.

Sample and Methods

Participant Sampling and Data Collection Sites

We interviewed 63 people from five sites in Minnesota: 14 from a methadone treatment program (22%), 29 from nicotine or alcohol inpatient and outpatient treatment programs (46%), 6 from an alcohol treatment program at a veteran's hospital (10%), and 14 from smoking cessation free clinics (22%). These sites were selected in order to obtain a socio-economically and ethno-culturally diverse sample. The five treatment sites were located in a large metropolitan area and a mid-size city. Participants ranged in age from 25 to 73, with the majority falling between the ages of 30 and 59. The sample included men (45%) and women (55%); 19% self-identified as African American, Asian, Native American or Bi-racial, with the remainder self-identifying as of European ancestry. Of the full sample, 28% were in alcohol treatment only, 35% were in nicotine treatment only, and 37 % were in polysubstance treatment.

The treatment sites varied in their approach to substance use. Most offered a combination of group or individual therapy sessions and pharmacological treatments, including methadone and drugs such as acamprosate and nicotine replacement therapy. Several programs used audiovisual aids or treatment strategies that emphasized the biological components of addiction. One used a brief educational film that highlighted the disease model of addiction; a second treatment site included a large display of living zebra fish used to study the genetic basis of nicotine addiction.

Procedures and Analysis

At each site, we distributed information about the study by either affixing a flyer to waiting room bulletin boards or distributing a handout with the interviewers' phone number. Interested patients called to schedule an interview at their convenience. Upon obtaining participants' informed consent, we conducted semi-structured interviews of 30 to 45 minutes. Participants were compensated for their time. We used a semi-structured interview guide that probed respondents' knowledge of and beliefs about six main topics: 1) understanding of the patient's own addiction; 2) conception of free will; 3) knowledge of addiction genomics; 4) benefits, risks, hopes, and fears of new genetic treatments and tests; 5) willingness to participate in genomics research on addiction; and 6) effect of media and direct-to-consumer tests. The interview guide was crafted to answer the main questions of a large study funded by the National Institute on Drug Abuse. That ongoing work examines

the social impact of an emerging genetic understanding of addiction. At the beginning of the interview, we asked participants to share the “story” of their addiction. Subsequently, while answering specific questions, participants were encouraged to draw from their personal experience to explain their responses.

The interviews were audio-recorded, fully transcribed, and uploaded into N'Vivo 8 software. We used qualitative content analysis to analyze the interview transcripts. Each transcript was carefully read by at least two members of the team. We initially assigned codes to segments of text based on themes delimited in the interview guide, but over time, refined and revised codes to incorporate themes that emerged from the data. Discrepancies between members' coding choices were discussed until a common code was agreed upon or a new code written. Summaries of each code were then constructed based on analysis and discussion of each category; key quotations describing common themes were noted.

This paper is based primarily on one code: “patient experience of addiction,” and its subthemes. Participants were classified by self-reported age, gender, and occupation. These contextual variables were analyzed after themes were distilled from the transcripts themselves. All names used in the analysis that follows are pseudonyms.²

The Experience of Addiction, In Their Own Words

“People have different experiences with [addiction]” Julia said, and each person has a “completely different process.” On the contrary, Mike claimed that “people are cut out of the same cloth,” to say that he believed the struggle with addiction is more or less the same for everyone.

We examine hence both the commonalities and idiosyncratic reflections on the experience of addiction expressed by interviewees. Other narrative analyses in the literature, such as the work of Hanninen and Koski-Jannes, have described a story's purported “cure” or key to recovery. As we did not obtain full life histories from our participants, our results describe mainly participants' experience of addiction, their understanding of addiction as a disease or otherwise, and their perspectives on the biological underpinnings of addiction. Also, since our participants were recruited in treatment centers, these accounts lack the voices of those who have sought recovery on their own (Cunningham 1999), who have foregone treatment (Cunningham 2004; Sobell 2000) or who have been denied access to care.

We have organized participants' responses by the major themes that emerged from our qualitative analysis of the interviews, rather than by the demographics of respondents or the particular substance used. The four major themes are: 1) *What's Normal?*, in which addiction is perceived as something a person grows up with, something “inherited,” whether by nature or nurture; 2) *Punctuated Equilibrium*, in which addiction follows a pattern, oscillating along a static equilibrium, flaring with specific triggers; 3) *Pedal to the Metal*, in which addiction rapidly causes a person to “lose everything” often before the person is aware they have been “sabotaged”; and last, 4) *The Snowball Effect*, in which addiction slowly arises in social substance users over a prolonged period of time, quantity and frequency gradually increasing until the accrued momentum makes it too difficult to stop.

Trends in gender, age, and substance are mentioned within the discussion of each theme. We note where participants' views reflect a biological understanding of addiction, and how they hypothesized whether these conceptions were or were not useful to them in their quest for recovery.

²Interview guide available upon request.

What's Normal?

A 50-something homemaker, Jill, described her alcoholism as a longstanding problem: “I was raised in a family that at five o'clock it was cocktail hour—every day...So I didn't know it was weird to drink everyday. I thought everyone did that, and all their friends, everybody.”

Jill's story was similar to eleven others (19% of the sample) who understood addiction as something they grew up with, something “inherited” whether by nature or nurture. Ten of the twelve comprising the *What's Normal?* theme were women, most of these mothers, who were in treatment for alcohol or nicotine addiction.

The interviewer asked if she thought her alcoholism was genetically predisposed: “Mm-hmm, it was just normal.” The interviewer probed further asking, “Why do you think it was a predisposition?”

Jill said that her biological relatives, grandmother, her grandmother's sister, her mother, and her aunt were all heavy-drinkers, never treated. “Also, I have low self esteem. And not a lot of confidence or anything, so it would loosen me up.” She recalled how she started:

Everyone else did it...The first time I got drunk I was 15 and I was living at my parents' house and they were gone and I opened a bottle of gin and drank almost the whole thing and got *violently* ill. Had to be taken up to my bedroom by some friends, threw up all over my bedroom.

The interviewer surmised, “So, a lot of social influence to start drinking then?”

Mm-hmm. And that it was just normal...I really thought everyone had a cocktail at five. And when I think back, I think, well, [so and so]'s parents never did that...but all of my parents' friends did.

Another mother, Latoya, in treatment for heroin and nicotine addiction, believed that addiction was a part of human nature: “I feel like everybody got addiction, you know what I mean, ‘cause they have addiction to smoking, addiction to going to work, you know, so somebody has an addiction somewhere in them.” Connecting her experience to a trend she perceived in others, Latoya had developed a sense that her addiction, though problematic and disabling, was not unique to her, but in fact, a common experience along the spectrum of “normal” human behavior.

Seven of the twelve with the *What's Normal?* theme felt that a genetic understanding of addiction was useful to them. Jill stated that because she thinks she has a genetic predisposition to alcoholism, an “addictive personality,” she is “very careful about pills because I figure I could become addicted to anything because I have an addictive personality. When they say have a drink, *a drink*, well, I'll have more than *a drink*.” She felt that if she had been told she was genetically susceptible to addiction before she took her first drink, it may have had a preventative effect.

Perhaps owing to the majority of mothers comprising the theme, as well as a tendency to embrace the idea that addiction was heritable and environmentally pressured, many³ in the *What's Normal?* theme mentioned the hope to author a “new normal” for their children. Some highlighted the biological understanding they were taught as part of treatment. In this way, the biological component of their story was a useful fuel for vigilance in parenting of

³Generally, if we say that “the majority of participants expressed” or “many” we are referring to a proportion greater than two-thirds of the cohort.

children who may have a genetic vulnerability to addiction. Even if they didn't find the genetic understanding useful for themselves, they thought it might be useful information for their children. Tanya, a mother in treatment for nicotine addiction, said:

I seen my mom smoke; I was like, oh, that's cool! I should smoke. And I have been smoking since I was 15. Now I'm 37 and I kind of want to make a good influence on my daughter – so she sees how hard it is for me to stop smoking. Hopefully, she will never pick up that first cigarette and get addicted to it.

Routine and ritual, a large component of the addiction experience described by nearly all of the participants, tended to be discussed more often among those who “grew up” with addiction. Participants described their smoking habits with the warm nostalgia that many would use to talk about how their mother had chocolate chip cookies on the table every day after school. Jill admitted that she “never thought of abstaining” because drinking was such a normal, ritualized part of her day:

I was drinking after I got up in the morning. I would have a Coke, and then I'd make a drink and drank all day long...I didn't drink until the bottle was gone, I'd drink until it was half gone and then I would go upstairs and go to bed and get up the next morning, have a Coke, make a drink.

From the accounts of participants who used substances because it was “normal” at home to do so, once the context of “normal” changed (in a new environment), the stigma they felt being suddenly “abnormal” was a commonly reported motivator for starting treatment. Abby, a late-forties smoking mom, decided to quit when she started working for a firm that did cigarette litigation. “It was really frowned upon [at the firm], it was like a taboo to be a smoker.” Irene, a smoker in her fifties, blamed her thirty-year habit on Hollywood's glamorization and “the Marlboro man, he was just too sexy for life.” She also attributed her smoking to “watching my parents all my life smoke cigarettes. [I thought] that it was just a general part of life. I mean, I really thought everybody did this.” When asked what led her to seek treatment, she described a cultural shift in stigma against cigarette smokers.

People started making me feel like I was a convicted felon...Now all of a sudden it's a filthy, dirty disease that everybody is shying away from...We used to walk into a loaded elevator with a cigarette and not one person would ever say ‘[cough] Excuse me, I don't want you to smoke!’ It was socially accepted and everyone kept their mouths shut... I mean, before I quit smoking, I told my husband, I said, ‘I wanna move to Missouri where smoking is still legal because they make me feel so terrible here.’

Irene's comments bear the flavor of oppression and victimization that characterize aspects of Hanninen and Koski-Jannes' personal growth stories where the recovery comes only after the “butterfly breaks out of a cocoon.” It follows that if addiction stemmed from oppressive relations or even oppressive traditions within a rigid family structure, then the solution was to be found in the agency and authenticity gained when the storyteller breaks loose from co-dependency and listens to their own needs and desires.

The *What's Normal?* perspective also echoes elements of Hanninen and Koski-Jannes' co-dependence story in which addiction is a familial pattern or curse that extends across generations, caused by secrecy and repression of truth, and results in an external locus of self. In the co-dependence narrative, addicts were not morally guilty but victims of victims. Hanninen and Koski-Jannes observed that the cure for this group was achieved through an individual's courage to stop repressing negative feelings or secrets and embrace openness and awareness about themselves and their family. Awareness could “break the curse.”

The sense of normalcy with substance abuse inherited from and triggered by their family environment, or in mimicry of family behaviors, easily fit with the biological narrative, and the idea that one's susceptibility to addictive behaviors could be transmitted through genes. For some, an awareness of their genetic status seemed like it could offer a similar awareness of "the curse."

However, for five respondents in *What's Normal?* the biological understanding had its rub. "It scares me for my children," Elise said. She said that nobody wants this for themselves or their family, but she felt powerless and susceptible, and imagining that it was biologically linked made it worse. Irene described feeling biologically ostracized in response to the news of recent addiction genetics research and felt that scientists were "delving too deep" with DNA studies:

You know what I mean by the lesser in society?...People with the weak genes. We only want to keep the bright, intelligent, normal, non-addictive. I think we're getting into some danger zones when we start getting too deep in this stuff. I really do. ... All of a sudden I'm a leper. ... It makes me feel bad and it makes me feel like my parents were little lepers of society. And if given the choice, the powers that be would get rid of the leper.

Suffering societal stigma was mentioned by nearly all participants, across all themes. For Irene, oppression and judgment for her morally-charged behavior seemed to be just one more problem she had accepted as "normal" behavior of others.

Punctuated Equilibrium

Joe, a self-described blue-collar worker in his late forties, shared what he believed to be a strong connection among his mental health, employment, and alcoholism cycles:

It is anxiety and stress that I was dealing with. [Alcohol] just calmed me down so that I used it as a tool, like a self-medication for me...I have depression and anxiety and overwhelming problems with employment, it was very stressful...but it has nothing to do with family or anything...I would quit for a month here and there; I have quit for a couple of weeks here and there. But I always went back when the anxiety and depression set in when I'm dealing with work.

Overall, *Punctuated Equilibrium* was the most common theme among all of the interviews, representing 22/63 of respondents (35%). Titled to make a loose analogy with evolutionary genetics, this theme describes addiction as a problem that oscillates along a static equilibrium, flaring only with specific triggers. Most respondents with this theme reported being employed and many described work as one of the significant stressors, or punctuations, contributing to their addiction. The *Punctuated Equilibrium* theme was more common among middle-aged males, mainly alcoholics and smokers.

Joe placed his alcoholism in the flux of cyclic depression and anxiety. He relapsed and remitted upon the tides of his mental health and employment status. A common factor that influenced his drive to drink or empowered his abstinence was the amount of stress in his life:

I resigned one job due to the stress and then I would start another one and that is the one I'm at now and I enjoy the job, but the increase in work duties just kept piling up where the stress was built up again for me. You know, in this day and age, they try to put as much responsibility as they can on people ...I mean management does, basically to cut costs and that hurts the blue-collar people. I mean, and the stress just got worse and that is why I started again. It just kept back and forth, back and forth.

Joe described some of the limiting factors that have kept him from straying too far from his equilibrium. One of the most significant influences to curb his drinking and restore balance was his wife:

My support has always been my wife. She pointed out that if I didn't quit, she would leave. ... There were divorce threats; that is basically it. I just quit, and, you know, just go for awhile and then the tension would build up, the stress would build up again and I would go back to it.

The *Punctuated Equilibrium* theme has much in common with the stress-based theory of addiction. This model assumes that people spend a significant portion of life in “equilibrium” with euthymia, solid relationships, and reliable employment. This steady state is disrupted when their threshold for stress is surpassed, an adverse event takes place, or some other anomaly occurs to punctuate that even ground with a change in slope, causing their addictive habits to return.

Many of these individuals did not describe physiological withdrawal when they remitted from their substance abuse. Nor did they commonly describe severe cravings when in equilibrium and in the absence of a trigger. But most could identify and predict the context or stressor that would trigger them into relapse.

Most often, the trigger was emotional stress or mental illness. Depression and anxiety were mentioned most frequently as cyclic patterns of instability that trended with substance abuse, as well as self-reported diagnoses of bipolar disorder and post-traumatic stress disorder (PTSD). Dave, who had a shaved bald head and carried an army camouflage backpack, remarked that his “crazy anxiety” was a significant trigger for his abuse. Rick, who suffers from PTSD, said, “I was never relaxed, which resulted in chronic muscle strain, nerve impingement, and those physiological results of fight and flight reactivity, that was constant for me. And the cigarettes really did help me relax.”

Several mentioned that they thought their treatment was more effective if it involved relieving symptoms of mental illness or resolving the emotional stress. Otherwise, the temptation to self-medicate with an addictive substance was too great. Dawn concurred with Rick and Dave: “[My addictive substance] calms down the anxiety...it takes the depression away, makes me feel like superwoman.” She described how her relapses were connected to her anxiety attacks and relationship problems:

[Treatment] helped to a point; I mean every time I went to treatment I had some good clean time behind me, but I don't know, I always went back to using again. And...where I get in trouble is with my anxiety. So, I mean if something happens, something...say, for instance, right now, my significant other has been AWOL since Tuesday, so the only time he does stuff like that is when he relapses and he is out there walkin' the streets. So, you know, somethin' like this usually, I'd be out there lookin' for him and I'd be goin' out there getting' high, too.

Many participants who described *Punctuated Equilibrium* spoke of making deals with themselves, vows to quit that crumbled when mental illness or another comorbidity flared. Paige, a housewife in her fifties, spoke about her pattern of abuse and the bargaining process:

I had a blackout, don't remember, ended up in the hospital...then I got out of the hospital after three days and swore I would never drink again. And within two weeks I was having wine again. I told myself it was just wine, it couldn't do any damage. So, yeah. And it just spiraled down and I was very, very depressed and constantly hopeless...I have emotional triggers that are problematic.

Paige also described her addiction as a disease. For her, understanding alcoholism as a disease in need of treatment, just like her depression needed treatment, stripped away the moral judgment. She used the biological understanding of addiction as a helpful construct that “takes away guilt and shame processes that we go through and [that are] hard to carry that around and get into recovery.” Thinking of addiction as a natural condition to balance around a normal value, just like diabetics learn to monitor and adjust their blood glucose within normal limits, helped reduce for her the stigma of seeking treatment for addiction.

Chip, a mid-forties janitor, said, “I kinda think that mental illness is a part of my genes, you know. I didn't just pick that up randomly, and I sometimes smoke like right now, I'm a little depressed so I smoked to kind of balance it.” He did not consider his substance use to be a genetic trait, but he did think he had a biological problem, depression, that he could treat with cigarettes.

When speaking of “emotional triggers,” the transitions in and out of addictive behaviors were sometimes subtle. Natasha Dow Schüll describes the challenge of discerning successful addiction treatment for gambling addicts because the treatment programs available so much resembled the repetitive habits they sought to treat. How different was “the zone” of playing video poker, from the zone of going several times a week to small group therapy meetings, from the zone of filling out self-assessment forms in treatment? The rituals of gambling treatment were eerily similar to the rituals of video-gaming. To illustrate her theory of a “modulating self,” Schüll uses a reflection upon addiction from one of her interviewees, Rocky, “The idea I've been fiddling with—that certain behaviors balance out other behaviors in some complicated way—is an equilibrium concept. Being a chemist and a nuclear scientist, I have a feel for different kinds of equilibria” (Schüll 2006).

Similarly, the demanding work of scrutinizing self-management processes among those who described the *Punctuated Equilibrium* theme, such as the administration of a salving substance, a drug to fight cravings, the pursuit of meetings, counseling appointments, vigilance to avoid environments where the substance is offered, or intensive treatment to control the substance use, could provoke enough anxiety itself to trigger a relapse. To what extent did treatment provoke anxiety or emotional stress that could only be relieved by substance use, and then to what extent did substance use cause anxiety and stress that could only be relieved by going to treatment? For this subset of participants, in particular smokers, this dilemma was termed “the vicious cycle.” Jack, a 50-something salesman, said

I thought after treatment I could control my drinking, but as soon as I got out and I started drinking and I just was back in the same cycle again. . . I fought with that, the first time I went to treatment because I thought I didn't believe the whole thing that with alcoholism you can't control it. I didn't really buy into that. I thought a lot of people were using that as a crutch.

Triggers that were more easily discerned were negative circumstances, specific events in time that offset equilibrium. Whereas the plot and time narrative components of emotional states are not so easily discerned or recalled, these triggers, as concrete events, could be literally placed in one's history, allowing the addict to “move on” past that place. Jerry, an aircraft mechanic, described his unprecedented abuse of alcohol within the last year as a result of an unfortunate series of events:

This whole past [year] was nothing but a joke in my life 'cause I lost my brother, two weeks after that, I worked for [company], they fired me...And then we lost the house to bankruptcy. My dad has health problems... I wanna be able to drink with my friends in a bar...use it as a recreational tool, not like it's been overpowering my life like it has been.

Jerry believed that there was a place, a context, for healthy use of the substance, and had confidence that he would be able to return to that state. Alcoholism, he thought, was an episodic anomaly created by circumstances, like a rude and unexpected episode of unbridled speciation to a stable ecosystem. Equilibrium would reestablish itself, with time. Alcohol use was not a part of his innate character, nor would it be something he had to constantly manage in the future. Jerry did not consider himself an alcoholic but someone who had experienced a bout of alcoholism as one might experience a bout of the flu.

Like a car coasting out of its lane, these participants described an awareness of addiction similar to drifting onto the warning track. After bumps and jostles, as Joe described in the encounter with his wife, he eventually straightened out and achieved equilibrium. The drifting and realigning, as Rocky might predict, would all balance out in the end following the law of conservation. What seemed most harrowing about this narrative type was the struggle to maintain self-awareness of where one was on the continuum of illness and treatment. Self evaluation could be as difficult as driving in fog.

Julia, a student in her twenties, described herself as a “chronic relapser” for whom social stress was the trigger for alcohol use.

I always felt out of place. I always felt like I didn't fit into my skin. I was so afraid of people and of the world and I had horrible social anxiety and all I ever really wanted was to like, be a part of something, to have friends and to be comfortable with people, and I couldn't do it sober. And when I had my first drink it was like, Wow, this is what I've been looking for all of my life!

In the context of Julia's “social anxiety,” (in which the very use of a pharmaceutical industry advertisement-constructed term bespeaks the influence the media has to deliver diagnoses that individuals can choose on their own to adopt and regulate (Dumit 2006)) the use of alcohol seemed to level the playing field with her peers. She used alcohol as self-medication to regulate what seemed a more distressing disorder, social anxiety. She felt more equal terms with others when intoxicated. This might be considered, for some, nothing more than a cultural ritual, and a positive one at that, but Julia goes on to discuss why, for her, it was a problem:

I remember that there was a line that I crossed where I suddenly realized that I had to keep drinking even when everybody else was done until I blacked out or passed out. But, I remember thinking to myself, I am only happy if I have a drink in my hand.

For Julia, the warning track on the road was the line between being satisfied by the company of friends with whom she felt comfortable (a feeling enabled by the substance) and being satisfied by the comfort of the drink itself, with no regard for those in company.

The narrative of disequilibrium caused by a deficiency, whether it be comfort, interest, or love, has some overlap with Hanninen and Koski-Jannes' Love Story, where addiction was a compensation or a substitute for a sense of emptiness, unfulfilled desire, or lack of love. Dawn mentioned that she felt like she had “no self control, no self worth, you know, and then so, when the drug is there and you go use the drug, it fulfills those empty, that emptiness.” The substance, then, is compensation for what is lacking. Its use is merely an attempt to realign or reestablish what is perceived to be better “balance” or fullness. As Joy deftly noted: “If I'm bored or lonely, or hungry, or tired, I found is when I smoke a lot. Then, I don't feel so lonely, I don't feel so sad, I don't feel so bored, and I don't feel as hungry.”

Punctuated Equilibrium narrators were keenly aware of their “fullness” status, and yet, they also had insight about when they were pushing the limits of healthy. The existence of

guardrails like insight, self-awareness and concern, are strong evidence against the claim that addicts have “no control” over their substance use—that they are void of agency and powerless to addiction.

Pedal to the Metal

For some addicted, there are no guardrails. Those with the *Pedal to the Metal* theme shared the perspective that their addiction caused them to “lose everything” – their lives careened quickly toward total wreckage. Powerfully addicted from the first exposure, this was the least common of all the themes, shared by 10 of the 63 interviews (16%). This theme was typical of younger (the twenty- and thirty-somethings) polysubstance abusing men like Bill, a mid-thirties day laborer and smoker, whose story goes something like this:

I was just standing at the refrigerator and me and my friend were at this girl's house and they were in the other room doing whatever the hell you think, and well, anyway, there was a carton of cigarettes on top of the refrigerator and I decided to try it and the next thing you knew, I was stealing all of her parents' cigarettes...I heard that you can't smoke like a pack the first time you smoke a cigarette, you know. But I smoked three packs the first night! That is how much I loved it. And I never even coughed the first time I tried it.

Bill went from nonchalance and naïveté to near obsession almost instantaneously. His use remained excessive thereafter, rarely if at all limited by his setting or circumstances. After his first use, addiction, for Bill, was a full acceleration and an insatiable appetite for the cigarette. “These days I smoke three or four packs a day! And if I stay up all night I could smoke six or eight.”

Nora, a nursing assistant in her late fifties, discussed her view that she was predisposed to addiction from birth, perhaps genetically, and her pattern of indulging to excess was a personality characteristic.

I was an addict before I ever even had that first drink. And that first drink just sucked me in. I don't feel like I would have had the same unmanageability if I had never drank[sic], but I believe that I was an addict and an alcoholic waiting to happen...I always wanted more of everything. Anything if it was like a food that I liked or whatever I want *more* than one...I think it is part of my personality, but there was not a lot of progression for me. It was like once I discovered that I felt different when I drank or used drugs I wanted to feel that way all of the time. ... But I was hooked on alcohol the minute I drank. It was always there.

Users with this narrative described how, for them, quitting one substance could only be managed by starting another addictive substance. Nora, who wanted “more of everything,” described this phenomenon, “Different substances would quit working for me and then I'd switch to another substance.”

Physiologic withdrawal was a nearly universal experience for those describing this theme. Nora related the first time she had withdrawal from alcohol as being “just past the point of having a choice.” She needed alcohol, now, not just for emotional or social satisfaction, but for biologic wellbeing, and no exertion of nerve or willpower could undo her physiologic dependence. These individuals reported that abstinence policies espoused by AA/NA had much utility. They desired an external source of control while they regained trust in their own autonomy. It would be difficult to imagine people from this cohort would ever agree with Jerry, that addiction would resolve itself like a case of the flu. These folks did not trust themselves anymore, and desired to check in to an in-patient treatment facility to receive the intensive care they felt they needed.

The seemingly irreversible sabotage of the mind was a common theme in the *Pedal to the Metal* stories. Eddy said that even though he knew he was an alcoholic, and that he would have this consuming obsession his entire life, that people like him with “the disease” deny what they know, or they inconveniently forget. It is as if they are being tricked by their own biology to get one more taste.

We forget...we forget even a month ago how bad alcohol had affected us, how we get sick, how we become homeless, how we lose all the money...we forget all that stuff because there are promises that if we stay sober...we gain all of these things back but the obsession is so powerful from day to day that we live with it that all the hard times go out of our mind and we think we can drink like a normal person when in fact we can't...We take one drink and that's all we want is more. It's a terrible disease, it really is.

Matt, a custodian in his twenties in treatment for alcohol abuse, was having a hard time calling himself an alcoholic. That stated, he observed that he could not seem to get himself to slow down when out at the bars with friends. Every time he drank, he drank to the point of black out, and yet he said:

I have more of a problem with it than I do an addiction...I'm probably an alcoholic, but just as much a denier. So, my head is still having a very tough time talking myself into believing I'm an alcoholic...I just don't think I was built to drink. But yet, I would. You know, I would wake up and I would be hung over and miserable and puking and I would drink again. Then there are other people out there who get a little tipsy and they are like whoops, this is my drinking experience and stop right there! ... I don't know, that is just crazy to me that somebody can do that. It is amazing! My hat is off to them.

Matt seemed to think the problem was just in his body's response to alcohol, that he was biologically less fit to tolerate the use. He acknowledged remorse after each binge, asking himself why he drank in the first place. Yet, as though detached from conscious control, struggling for insight into the pattern and its consequences, Matt would find himself hung over and miserable morning after morning.

Lily described the withdrawal aspect of addiction as “the vicious cycle,” using language she learned from people in NA:

If you have never tried [heroin] then don't because it is a very loving, encompassing drug that makes you feel that everything is okay for as long as it lasts. And then, of course, you are going to have the battle of getting more and then I had to work the job, to the get the money, to get more [drug], and then that cycle...and suddenly you are a hamster on a wheel and you want to kick yourself again because you are the retard in this, nobody else is! ... but everyone is so scared of withdrawal...we all know that the fix, the cure is the same thing that hurt us. The cause is the cure and the cure is the cause.

In Lily's case, and for others in *Pedal to the Metal*, their equilibrium was irreversibly reset, perhaps even obliterated, the moment they first tried the substance. Their new equilibrium was not so much the oscillating dance to level a plateau, but the full throttle acceleration on an exponential curve to get more and more of the drug, chasing a failing high, never wanting to come down. Those with addiction more typical of *Punctuated Equilibrium* acknowledged a difference between themselves with and without the substance, and that the transition between states was reversible. Those with the *Pedal to the Metal* kind of addiction, on the other hand, could not re-identify with the person they were before the addiction.

Grady aptly described this transition. A child selling heroin on the streets, he tried his own product out of curiosity, and everything changed:

For me, I got addicted to it because I was selling it, you know... like people would come and get their drugs everyday because they needed it... I thought they was just partying, right, I didn't know that they was just coming sick everyday – coming to get it – I didn't know that. You know...so I tried it one day, you know...I just kept usin' and usin' and usin' and then ... I tried to go without and I asked this older dude, I said, man, what is wrong with me? You know I was sick and didn't even know it. Yeah, and he said you need to do some of that stuff you are sellin' me, and you will be all right. You know and it was just like I couldn't believe how I went from [snaps fingers] just like this and feelin' all sick.”

The rapid transition into a new biologic identity, a rewired brain, a new physiology dependent upon the merciful administration of a substance, was often a huge surprise, as Grady described. Mike proclaimed himself addicted after the first use, “When I started, I was Hell on wheels...it's tripped in your head, it is on, and it is a lifetime thing.” He spoke of his upheaval as “masked insanity.” He elaborates:

...it just changes totally to where it becomes all-consuming, you don't even care about all of that now, just to get high or get going, two things that you know either I'm sick or I'm high. Everything comes down to those two things. And everything is secondary—way secondary, so...and it happens so quickly...just pfft, you are there.

For those with this tragic distillation of self, the language they used to describe their solitary obsession, their relationship with the substance and the powers it holds, shared vocabulary with magical fantasy and romance. Mike spoke of his drug use as one would talk of romantic love:

It is your up, it is your down, I mean it is your happiness, it is your comforter, it is your sidekick, you know, it is...I have always said that my three wives and other women I lived with for long periods of time and I didn't marry, but that they were really more my lovers and my using was what I was really married to.

Similarly, John had a difficult time describing his love for alcohol and cigarettes, a love for which he felt he was predisposed. During the interview it was as if words were not powerful or poignant enough to convince the sober, presumably non-addicted interviewer of the character of his obsession:

It affects me differently than people who don't have that predisposition, who just smoke socially, if you will, or drink socially. Related to drinking: The first time I took a drink it was like the black and white world became Technicolor ... The first time I smoked a cigarette, I can act it out for you, but then you can't record that. It felt like this. (Demonstrates – sighs) And I'm taking a deep breath and sinking into my chair like it was *extremely* relaxing. It relaxed my mind, my body, my breathing, everything. And that is what I was continuing to search for every time I smoked a cigarette after that.

When addicts are broadly misconstrued as individuals devoid of control or agency, it is because of testimonies such as these. Such responses were a slim minority of our participant sample, so it is unfortunate that this theme has become something of a stereotype laid over all people who struggle with addiction.

The Snowball Effect

The *Snowball Effect* theme described addiction as a problem that gradually accrues over a prolonged period of time, often twenty years or more, until eventually the behavior gains

momentum such that it is too difficult to stop. A third of our respondents conveyed this theme, a cohort notably older than the other themes (most aged mid 40s to 70), and it was slightly more common in alcoholics, but not specific to gender or employment. In a way, this theme is something of a confluence of *What's Normal?* with *Punctuated Equilibrium*, distinguished mainly by the prolonged temporality of the addiction story and the change in the self-perception of one's relationship to a substance. Isaac, a 47-year-old business owner, described the slow progression of his alcoholism.

It took me a long time to become an alcoholic. I had to work really, really hard at it... I have been around people who drink, like all of my working life, and I can drink and not drink. It was never a...there was never any kind of associative, addictive behavior. I mean I could drink on weekends and then not drink all week. I know where there would be consequences to drinking and not do it. I would never plan or necessarily look forward to it. And, I mean that was 25 years. I mean, and then all of a sudden it just run tough. At that point, you are making conscious choices to drink rather than do something else. Or, plan to drink, start planning your activity around drinking, start planning your work day around drinking, start planning...and then at that point you kind of realize that what you are doing is exhibiting addictive behavior rather than normal behavior. So, what I'm really saying is it is not like someone who takes their first crack and becomes instantly addicted. I mean there was obviously a...I mean, there obviously becomes a psychological thing because you have been drunk over a period of time. You just regard it as an acceptable thing. You go to a ballgame, you have a few beers, you go to a barbecue, whatever; you have a few there. It is not like it is taboo thing. And it was never, actually, really a problem until I started working for myself.

"It was no longer a choice?" asked the interviewer. Isaac said, "No, it was a choice, but it was a choice that was made in one direction. I mean it was like, shall I go to the liquor store now, or...the arguments took less and less time, really." Suddenly, after years in the making, Isaac's story contains aspects of the *Pedal to Metal* theme. The *Snowball Effect* theme, hence the title, often included many different narratives of addiction experience. Multiple constructs of self, various histories of use in different contexts, all rolled upon one another, generated something like momentum. The weight of all these stories and experiences over the years pulled the person toward more and more substance use.

The hallmark of the *Snowball Effect* was the misassumption that after so many years of using without problems, addiction would never be an issue. The person was blind-sided with addiction. A mid-forties news manager, Mary, while working her "24/7 job," started using nighttime dosages of Xanax and alcohol to sleep. Over time, she started drinking earlier, and earlier. Then she was laid off:

I was so shocked that I ended up the way I ended up and I went downhill so quickly. That is what kind of surprised me because I was the person in college who was pulling my friends out of bars or the designated driver. . . I mean, yes, we had a wine cellar, but was I drinking every day? By no means! No! Was I binge drinking? No! ... I guess my assumption was that since it was never a problem before it wouldn't become one. And then once I started drinking with regularity it became a problem pretty quickly. I mean very quickly within a two-year span. And the last six months being really bad, meaning, I fell into an oven and those kinds of things."

Those in the *Snowball Effect* theme tended to be highly cerebral and evaluative regarding their addiction. Their conversation yielded abundant debate on what addiction really is, with much questioning. When does one know if they are addicted? For example, Janet was inquisitive regarding the addiction status of her peers. She admitted that she drank alone,

almost every day, and that was a problem. But when she was out with friends, she eyed others' drinking habits with resentment and concern asking:

You know, I look at these people who have been drinking for 30-40 years and I go, okay, now what are they? I mean, they cannot be *not* an alcoholic, I wouldn't think. But I don't know. It is different for everybody....I never really got totally drunk where I staggered and did all of this and blacked out. But I would be drinking all day—the slow drinking. You know, and not getting anything done. So I am an alcoholic.

The *Snowball Effect* theme of addiction was laden with rationalization of why a substance was needed. If it could be explained and justified, or if it had never been “an issue” before, it must not be a compulsion, it must not be “addiction.” Kay, a self-described alcoholic in her late thirties and a custodian, shared some of her excuses:

You know, if you are at work and you are having a bad day, you can't wait to get home and have a beer...you proceed to drink and if you have someone come over you have more drinks...It starts out so simple and innocent and it gets into a great big mess!

Narrative and Negative Capability

Of what use are accounts of illness such as these to those who care for the addicted? Narrative therapy explores how people give sense and meaning to their experiences by forming narratives (Bruner 1990; Polkinghorne 1988). In this process of self-storytelling, “individuals are constantly engaged in the process of creating themselves” (Crossley 2000). The goal of narrative therapy is to imagine, create, and promote the most positive, empowering conception of self (Charon and Montello 2002; Ritchie, et al. 2007).

Alternative to the objective knowledge of addiction as a neurobiological disease (Jellinek 2010; Volkow and Fowler 2000) or a rational product of the self-determining will (Elster 1999), narrative theories of illness offer a more subjective knowing. As described by Jamesian nurse-philosopher Mary Tod Gray, “Subjective knowing expresses the view from within: how the experience of the drug addiction feels to the individual...the addict's interior experience” (Gray 2004). Through this practice, therapists observe how addicts construct narrative identities (McIntosh and McKeganey 2000; Taieb, et al. 2008) that draw upon discursive repertoires of established cultural stories and metaphors, often overlaying their own experiences upon an existing template. A myriad of factors influence this template, also known as a dominant narrative (Payne 2006; White and Epston 1990)

Treatment centers employ their own dominant narratives in explaining addiction, and clients' frameworks for understanding addiction are shaped by the language and ideology of their treatment milieu. Our participants who spoke of addiction with a genetic/biological understanding were primarily, but not exclusively, under treatment in two treatment centers that explicitly teach a biological model of addiction as part of treatment. This finding supports other researchers' claims that addicts' views of themselves are in part shaped by the language of their treatment centers. Summerson Carr's work, *Scripting Addiction*, explains this phenomenon in detail.

Patients may or may not find useful the particular dominant model of their treatment center. For example, when reliant upon the biological story of addiction, a treatment center may focus on a drug prescription for treatment, and underestimate the environmental and social circumstances involved. Or to the contrary, if focused inordinately on the psychosocial narrative, a treatment center may overwork to re-author a personal narrative or improve the quality of family dynamics as the solution for addictive behaviors, and possibly

underestimate the extent to which the substance use has re-authored the physiology of the patient.

Notably, some participants made use of biological understandings of self in their personal narratives, such as the easy assimilation of a genetic understanding of addiction in the *What's Normal?* theme, the unanimous surprise at the perceived physiological hijacking and sudden switch of self in *Pedal to the Metal*, and, in less than half of respondents, how understanding addiction as a disease removed guilt and shame. These biological understandings—delivered from treatment centers, from media representations and pharmaceutical advertisements, from family histories—have the potential to become “dominant narratives” of addiction for the current era.

One might expect to find themes clustering by the substance used or by the legal status of the drug. We expected the interview accounts to reflect those differences. That cigarette smokers would relate one experience, narcotic addicts another story, alcoholics yet a different narrative. What was surprising was how the themes were not necessarily determined by substance. Some of our cigarette smokers had *Pedal to the Metal* themes to their addiction, and some heroin addicts had a *Snowball Effect* reaction to their drug. Because the participants’ experiences did not seem to cluster neatly by substance, this finding seems to highlight the complexity of the experience of addiction. The experience of addiction is layered with individual biology/genomic landscapes, cultural contexts for the behavior, and psychological determinants, all of which shape the experience. Julia said it best; everyone has “their own process.”

Furthermore, there was little evidence of or use for a “unified theory” of addiction among patients themselves. A unified theory of addiction may be just as dubious as a “unified theory” of people. We are more unique than our DNA, more imprinted than the intaglio of our family crest, and more fickle than the times. The dynamism and fluidity of each person's self-narrative is not unlike the complexity of each person's genome. An earlier era's view of the genome as fixed, unchanging, and immutable (Keller 2002) is giving way to a more liquid understanding incorporating epigenetic phenomena. Our biology, psychology, society, environment, and circumstances are in a state of constant correction, in which, almost imperceptibly, addiction is simultaneously a cause and a result.

People bear templates of DNA and experiences alike whereupon the epiphenomena of their unique biochemistries, cultures, and willful souls are entangled. Just as geneticists and molecular biologists labor to witness the patterns and anomalies written in the libraries of genomic testimony to being, so clinicians and therapists witness the motif and novelty in their patients’ accounts of illness – accounts told, imaged and assayed. What might be of use for those working directly with addiction patients, in light of the mysterious and often unpredictable nature of nature, is adopting a perspective of negative capability as offered by the practice of narrative medicine.

Negative capability is a state of mind in which an individual transcends the constraints of a closed intellectual system, such as a theory. Narrative medicine is an emerging practice in the United States that uses literature and illness narratives as a touchstone upon which to build a moral imagination. Physicians and health care practitioners meet together to perform close readings of texts, to write, and through these exercises, hone their skills of “attention, representation, and affiliation.” The intent is that this sensibility will carry over into professional work with patients. Through bearing witness to the stories of patients, told in their own words, physicians are realizing that the power of “recognition allows [them as] protagonists, despite moral ambiguity and interpretive tension, to act” (Charon 1996, p. 244; of Nussbaum 1990, p. 3-53).

Narrative medicine is a means to foster empathy as remedy for the counterproductive stigma that can burden the patient-provider relationship when together they face the challenges and frustrations of disease and illness. Acknowledging the universal aspects of experiences like shame, anger, and grief narrows the gaps between self and other, patient and physician, patient and counselor, patient and family member in a relationship where both are able to empower one another in the process of recovery.

Looking to our interviews for an example, grief was a common sentiment that emerged from the transcripts. In the practice of narrative medicine, attuning to patient language is critical. For example, after listening to Nora's account of grief with quitting alcohol: "I felt like I should hang a black wreath on the door...oh, I was depressed and angry and it was like giving up my constant companion," the practice of narrative medicine would explore the weight of Nora's analogy. Her image of the "black wreath on the door" is a powerful symbol of the attachment she feels toward alcohol and it should call the listener to reflect upon his or her own black wreaths, literal and figurative. If the listener is able to imagine and ascribe personal significance to the idea of a "black wreath," in the shadow of this totem, Nora and her listener can experience the healing power of an intersubjective bond. The black wreath, a representation and externalization of the addiction suffered by the patient, can be examined as a subject that both patient and clinician recognize at the same time, as equals, as co-experiencers of grief. A scene such as this—in which two people puzzle together over one of life's more mysterious experiences—seems preferable to the imbalanced relationship where a broken victim seeks the help of a "provider," offering only a prescription, who is assumed to be whole and healthy by contrast. Nora's image of the black wreath also evokes the loss of a friend, which should cause the listener to wonder (in a state of negative capability) about whom or what else Nora has loved and lost, and how other sources of grief may be entangled with Nora's emotional response to quitting alcohol.

Michael Stein, an internist, recently authored a literary account of his clinical work with addicted patients, in which he weaves together representations of himself and his patients, melding his voice and theirs into one story with one common goal: empowering recovery (Stein 2010). In *The Addict*, Stein reflects on the unique stories of each of his patients, interspersing poignant self-reflection about his own biases and how, with humility, his struggle to attune to the needs of his patients continually challenges his understanding of the nature of addiction, as well as his understanding of his own role in offering care. In Stein's account, and through our research groups' conversations with people in treatment for addiction, we recognize in the stories aspects of ourselves. They teach us to suspend disbelief, to hold off the irritable reaching after fact; they discipline the listener, the reader, the witness, to honor the state of negative capability. In this place of uncertainty and possibility, the distance between us and addicted "others" disappears.

Experiences are the human conduit for affiliation, and though in this paper the experiences as told by the addicted may seem disorderly or in disagreement with one another, perhaps this is an important aspect of addiction that should not be glossed over in favor of a unified framework. Addiction is protean, such that if we try to reduce its character to one name-able form, with one "unified theory," we will have failed to address it in its entirety. Keeping close the wisdom of William James, we suggest that "the sanest and the best of us are one clay with the lunatics and prison-inmates" (James 1911). Addiction is not just the disease of one particular organ, not just the result of an unfortunate upbringing, or an unfortunate choice; addiction is not the affliction of, or, what is "the matter" with the ill other, addiction is *a matter* with us.

When deliberating about policy, we recommend that patients' voices not be disenfranchised from the research done for their supposed benefit, that the experience of the addict not be

reduced or considered universal, “unified,” or “typical.” The data we have presented in this paper shows how narratives of people addicted are a combined product of individual agency and socialization from treatment program ideologies. The diversity, then, of addiction narratives is now and always will be myriad and infinite, and the effort to understand them a noble foray into an ever deepening pool with the bottom always beyond reach—a problem that we believe is more awe-inspiringly Kantian than hopelessly Sisphyean.

While continuing to probe the intersubjective depths, attention to narratives can reduce stigma and promote affiliation between the provider and the patient while not delimiting the illness to a reductive explanation informed by a single scientific theory. Without patient voices directly represented in research (Meisel and Karlawish 2011), we may miss a relationship between the biological and social narratives of addiction that would better unite the efforts of all those who seek to care for those suffering the consequences of substance abuse.

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