Drug Addiction-to-Recovery Trajectories in British Sociocultural and Political Contexts: A Synthetic Discursive Exploration

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Abstract

User of certain illegal drugs are arguably the most stigmatised group in British society. Moreover, people who are known to have a history of drug dependence are rarely given the opportunity to talk about their lives (Tutengs et al., 2015) much less be listened to by those who are willing and able to convey their narratives to professional and mainstream audiences. Their lack of voice has been produced by the idea that some groups lack the capacity to produce useful knowledge about their lives (Gubrium and Holstein, 2009). This qualitative, discursive study disrupts this normative inclination, exploring how eight former problematic-drug users construct their addiction-to-recovery trajectories in British sociocultural and political contexts. Underpinned by a constructionist epistemology, it starts from the premise that accounts of addiction and recovery cannot be understood in isolation from the contexts *with which and in which* they are produced.

The research has two connected empirical strands. The first strand - a Foucauldian-informed discourse analysis of England's 'recovery roadmap' - draws attention to discourses permeating the text, critically discussing their implications for people with a history of drug addiction. In so doing, it renders visible a salient aspect of the discursive environment. This attention to the discursive milieu feeds into the second strand of the study consisting of qualitative interviews with former drug users, some of whom frame their accounts through the lens of Christian faith and others with no religious inclination. Here a synthetic discursive analytic framework is utilised with people viewed as both produced by and producers of discourse (Billig, 1991). The focus, broadly speaking, is how culturally available discursive resources both shape and are utilised by speakers to construct versions of reality as well as the rhetorical-discursive strategies respondents deploy and for what purpose. Another analytic consideration relates to the notion that interviewees are 'always already positioned' (Taylor and Littleton, 2012, p.25). The interest here is in how these positionings frame their talk about the past, present and future.

In sum, this thesis draws attention to the narratives of former drug users from a range of backgrounds with differing day-to-day circumstances and belief systems. Despite being situated at opposing ends of the religious-secular spectrum, some notable similarities as well as distinctions emerged between and among religious and non-religious respondents. Although discursive research on addiction and recovery exists, this study makes an original contribution to knowledge through the application of a synthetic discursive framework to addiction-to-recovery *trajectories* constructed by individuals aligned to both religious and non-religious recovery pathways. Moreover, triangulating data derived from the documentary analysis and interview strands provides insight into how political 'new recovery' discourses permeate former drug user accounts. Finally, by positioning as paramount the stories of people with a history of problematic-drug use this study aims to counteract widespread ignorance, produced, reproduced and reinforced by sensationalist and morally loaded media and political discourses on addiction and related issues.

CHAPTER 1

Introduction

1.1 The Study

Although claims pertaining to drug use and drug users often feature in media and other texts, individuals with a history of addiction are rarely given the opportunity to talk about their own lives (Tutengs et al., 2015). For Gubrium and Holstein (2009), this lack of voice is the outcome of historic but still prevalent discourses that position certain populations as lacking the capacity to provide useful knowledge about their personal experiences. More likely to be constructed as objects of derision than bearers of valuable information, this contempt of the 'other' diminishes the ability of such populations (in this context (former) drug users) to influence how they are represented in public and professional domains and, ultimately, how they are treated by others (Tutengs et al., 2015).

This qualitative study disrupts this inclination, exploring how eight white male former dependent drug users with diverse personal-social histories and aligned to differing recovery pathways construct their addiction-to-recovery trajectories within British sociocultural and political contexts. Underpinned by a constructionist epistemology and offering a synthetic discursive dimension to the study of former drug user narratives, it works from the premise that how addictions and recoveries are represented by individuals cannot be separated from discursive contexts *in which and with which* these accounts are produced.

The research has two strands: analysis of an official strategy document on addiction treatment and recovery; and interviews with former drug users who described their past drug taking as problematic. The first strand, a Foucauldian-informed analysis of a key Government report on 'new recovery' in England, draws attention to discourses that permeate the text, the subject positions these discourses avail, and how occupying or resisting these positions shape how people with a history of drug use experience self and the world. A synthetic discursive analytic lens is

applied to the interview data. This approach draws on Foucauldian thinking and a synthetic critical discursive psychology (Edley, 2001a; Wetherell, 1998) as well as the narrative-discursive framework proposed by Taylor (2010) wherein narrative is defined as both a 'construction of sequence or consequence' (p.36) and a resource for talk.

The synthetic approach positions human actors as both 'products and producers of discourse' (Billig, 1991 cited in Edley, 2001a, p.190). This 'twin focus' (Willig, 2013) attends to the macro context with an emphasis on the constitutive power of discourses and canonical narratives *and* how speakers utilise available discursive resources to assemble versions of reality and construct self-identities. In addition, it explores how speakers variously deploy discursive-rhetorical strategies *to do* things such as position self and others, legitimise, blame and persuade with various audiences in mind. That individuals enter conversational encounters 'always already positioned' (Taylor and Littleton, 2012, p.25) is also acknowledged with an interest in how these positionings frame how participants construct the past, present and future.

The interview strand of the research is premised on the notion that different sociocultural and political environments will produce different accounts due to the availability or not of discursive resources. This applies to discourses and canonical narratives that prevail within sociocultural contexts and historical eras as well as interpretive resources aligned with an individual's personal-social history, self-identity and, in this study, their treatment modality and/or recovery pathway. That interview contexts and researcher positionalities also influence data production is recognised and discussed. This research, then, will contribute to our understanding of how discourses and canonical narratives that permeate a culture shape the subjectivities of people with a history of drug addiction and how prevailing systems of meaning provide a finite set of resources that speakers draw on to construct versions of reality.

Importantly though, as discursive resources for talking about 'addiction' and 'recovery' are culturally and historically relative (Hammer et al.,

2012), accounts produced by respondents in this study will not be transferable to all former drug users, even where drug of choice and addiction-to-recovery trajectory is much the same. The same research design applied in a different cultural context or historical moment or, indeed, with females or ethnic minority respondents, would yield different narratives due to availability and utilisation of alternative resources for talk. Moreover, with interviews defined here as context specific co-constructions, the *same* interview questions with the *same* respondents but conducted in a different moment or context may well produce variations in the accounts produced. In critical discursive research of this nature the intention is not to ensure replicability or generalisability. Although *some* transferability to other former drug users in the UK *may* be reasonably assumed, the accounts produced in this research are study specific.

1.2 An Introduction to Addictions and Recoveries

The concept of addiction in its modern-day manifestation was first advanced in Britain at the start of the 20th Century (Baily, 2005). Although discourses of multiple causality and the accompanying theoretical notion of drug dependence as a complex biopsychosocial phenomenon have gained traction, popular political and medical representations of addiction as personal (moral) failing and brain disease respectively still permeate the sociocultural and political discursive landscape (Baily, 2005; Reinarman, 2005). Many other explanatory models and perspectives have been variously proposed. These, broadly speaking, are situated on a continuum from micro frameworks emanating from deficit discourses with a focus on individual malfunctioning, pathology and immorality, mid-range explanatory frameworks that draw on relational discourses and focus on the interplay between individual and context, and macro perspectives where addicted subjects are said to be produced by social structures.

Although Volkow and Boyle (2018) highlight progress made within *scientific* communities thus enabling a better understanding of neurological factors that contribute to addictive behaviour, deficit

discourses that construct addiction in terms of individual malfunctioning retain high levels of popularity among mainstream and expert populations (Baily, 2005). Moreover, despite ongoing research, a universally applicable explanatory framework of addiction based on empirical research continues to evade research communities. Rather, contemporary constructions of active and former dependent drug users are framed by discourses of intolerance, fear and blame that highlight individual failing and ignore wider sociocultural and political factors (Buchanan, 2004a; Buchanan 2004b; Buchanan, 2006; Scalvini, 2017). For Bamber (2010), the contemporary 'addict-self' denotes an array of non-productive individuals who require moral, medical, or judicial intervention (p.65). Representations of this kind are devised to enable a process of subjugation, analysis, control and reform, the purpose of which is to produce individuals who conform to a neoliberal ideal of the economically productive and self-controlled citizen (Bamber, 2010). Analysis of interview data will enable consideration of how, or to what extent, this context shapes respondent subjectivities and permeates their talk.

Whereas discourses of addiction are culturally prevalent and historically embedded, the concept of recovery within British drug treatment policy discourse is a relatively recent phenomenon. The notion of recovery in itself is not new and has for many years been associated with 12-step Alcoholics or Narcotics Anonymous programmes. In recent times, however, 'new recovery' has emerged as a controversial and fiercely contested political treatment objective, displacing the prior emphasis on reducing drug related harms. Despite attempts to reach a recovery consensus (UKDPC, 2008; Neale et al., 2016), the debate over what 'full recovery' *should* mean continues. Some commentators align themselves with the pragmatic notion that 'recovery means different things to different people' (Van Wormer and Davis, 2018, p.xiv; UK Harm Reduction Alliance, 2012) while others concur with the official position that 'full recovery' *can only* mean total abstinence from all chemical dependency including (some) prescribed medications including those used in the treatment of heroin addiction (Gyngell, 2011; HM Government, 2012).

The failure to develop a generalisable explanatory framework for how and why addiction occurs or arrive at a recovery consensus is not in any way surprising. Simply put, addictions and recoveries are subjectively experienced processes - attempts to formulate universal theories and definitions are therefore futile. However, rather than deny (former) drug users their individual stories, researchers *can* listen to individuals talk about their experiences but with a focus on how these narratives are shaped and resourced by culturally available webs of meaning. To do this requires an understanding of the contexts in which active and former drug users are enmeshed, a key aspect of which in Britain today is the aforementioned political shift to 'new recovery' wherein abstinence from all chemical dependency has been positioned as the only viable treatment goal. Drug policy contexts including the emergence of 'full recovery' in Britain and its implications will be explored in Chapter 3 of this thesis.

Before moving on, it is important to clarify that this research does not set out to undermine abstinence as a worthy goal for some service users. It does, however, problematise the *political imposition* of a one-size-fits-all definition of recovery. Moreover, with abstinence-focused community treatment and 12-step programmes positioned as pathways through which 'full recovery' is best achieved, a range of alternative recovery experiences are obscured or erased from public and professional discourse including recovery via religious conversion (Sremac, 2013), recoveries assisted by medications (White, 2012) and recovery without recourse to treatment (Waldorf and Biernacki, 1981; Granfield and Cloud, 1999).

To sum up, in climate where the Conservative party claim possession of a unidimensional description of recovery […] articulated in an 'idiom of abstinence, coercion and criminality' (Bamber, 2010, p.62), steps are required to ensure that routes into addiction and recovery processes are recognised as diverse and subjective phenomena and that they are owned by those to whom they rightfully belong (Bamber, 2010). By giving voice to people aligned to differing recovery pathways and with diverse addiction-to-recovery trajectories, this research enables people with a

history of drug dependence to tell *their* story, exploring how the narratives they produce are constructed from a finite stock of cultural resources, the research context and by how each speaker is always 'already positioned' at time of interview (Taylor, 2010, p.38).

1.3 Significance of this Research

People who use or are known to have used 'problematic' illegal drugs are misunderstood and highly stigmatised (Lloyd, 2010). The potential for this study to broaden public and professional understanding of this disenfranchised population on its own constitutes a worthy research rationale. With that said, while 'giving voice' to those who are socially excluded is a laudable quest, the potential impact of power differentials between researcher and participant should also be acknowledged. Although respondents will have the opportunity to talk about their lives and experiences, the direction these narratives assume will be influenced by the research context and I will ultimately decide how each account is analysed and reported.

Secondly, although research on drugs and drug users is plentiful many studies utilise quantitative methods with a focus on measurable 'facts' and causal relationships (Neale et al., 2011). Assumed by many to be supported by 'the power of reason', these 'findings' sustain particular 'truths' about addiction - perspectives on drug use and drug users that are widely accepted as common sense and thus evade scrutiny (Taleff and Babcock, 1999). Qualitative addictions research is becoming more prevalent but remains relatively limited in quantity and scope. This research adds a synthetic discursive dimension to a growing corpus of qualitative drug use-related research.

Thirdly, existing qualitative research that emphasises 'user' perspectives tends to focus either on drug initiation *or* active addiction *or* the recovery process. This study explores the construction of addiction-to-recovery *trajectories* including how alignment with a particular recovery pathway shapes how life events and experiences are represented. Discourse analysis has been used to explore how 12-step recovery discourse

resources the construction of 12-step recovery narratives (Black, 2011) and how 'expert' discourses aligned with therapeutic contexts influence client self-representations (Anderson, 2015). In addition, a Foucauldian-influenced study by Nettleton et al. (2012) explored how neoliberal discourses of 'normality' shape the construction of recovery aspirations. However, there is no research to-date that applies a synthetic discursive lens to addiction-to-recovery trajectories constructed by people in faith-based recoveries and former drug users with no religious inclination both within *and* outside of 'mainstream' community treatment. What is more, this study draws attention to similarities and variations in how individuals aligned to differing recovery pathways frame and resource their accounts. In so doing, it will generate unique insights into how macro and micro discursive contexts are implicated in the construction of addiction-to-recovery narratives in contemporary Britain.

1.4 Discourse and Practice: A Brief Overview

It should now be apparent that the study of language and discourse is central to this research. It is however crucial to point out that language and material practices are intimately related – how drug users or 'the drugs problem' are constructed has a powerful bearing on how people who use drugs are treated in public and professional contexts and the implementation of 'solutions' (Gubrium and Holstein (2009). Moreover, a constructionist focus on discourse and narrative does not negate addiction as a tangible lived experience, characterised by intersecting material components including embodiment, relationships, place and space, and structural conditions. With that said, the study of addiction and related issues through qualitative *social* research involves analysis of talk and text, the status of which is construed differently according to the researcher's epistemological beliefs, theoretical framework and methodological approach. Whereas research aligned with a realist epistemology begins from the premise that language *corresponds* with experience, a constructionist discourse analytic approach concentrates on how language *constructs versions* of reality. In sum, a focus on language

in no way denies obdurate reality or human experience but critically questions the notion that either can be comprehensively captured through social research.

1.5 Researcher Positionality and Reflexivity

The purpose of this short section is to position self personally, academically and in relation to the chosen area of investigation. It acknowledges that 'who I am' and 'where I am from' will influence this research project.

Firstly, I concur with the views of discourse researchers more generally in rejecting the notion that social research can be carried out in a detached and value free manner (Taylor, 2001). Rather, I see the academic as embedded in their research whether consciously or otherwise, their beliefs and values influencing how the topic is approached and the research carried out. A spirit of openness with regards to this influence can be realised by embracing the interrelated concepts of positionality and personal and epistemological reflexivity. Positionality can be broadly defined as the researcher's social location and includes class, ethnicity, gender, political leaning and religious affiliation. Personal reflexivity involves critical consideration of how one's positionality and related interests, values, experiences and beliefs shape and influence the research project including researcher-participant interactions. Epistemological reflexivity incites the researcher to reflect on how their assumptions about knowledge and the world influence the research design and production of data (Willig, 2013). The following will introduce the reader to my social location and the experiences, observations and beliefs that influenced my decision to study and shaped my conceptions of people who use drugs and related concepts of addiction and recovery.

I am a White lower-middle class male raised in a supportive nuclear family. Politically situated to the left of centre, I find social injustice and the stigmatisation and silencing of already vulnerable and marginalised groups in Britain deeply troubling as I do neoliberal discourses of individualism and responsibilisation that blame individuals for structural

state-produced issues. In terms of religiosity I currently self-define as cautiously agnostic, leaning towards their being *something* 'other'. My research is qualitative, critical-discursive and interdisciplinary. Critical 'sociological social psychology' perhaps best captures my disciplinary area.

My interest in addiction and recovery stems primarily from observing and listening to people who I have known or been in contact with but also to a degree my own experience of being a substance user. I concur with those who position addiction as complex and multi-factorial and align myself with the notion that 'recovery' is a subjectively experienced process that cannot be objectively captured. I know or have been in contact with people who attribute their drug-abstinence or 'recovery' to a diverse range of factors including access to long-term methadone or buprenorphine prescriptions. Indeed, I am openly critical of the current political 'full recovery' agenda wherein recovery is defined only as abstinence from all chemical dependency including prescribed medications. Moreover, my knowing or knowing of people who were once addicted to drugs but are now drug free, no longer drug dependent or living a 'conventional' life assisted by medication influenced my critical questioning and rejection of medical discourses that construct addiction as a life-long and incurable disease.

With that said, I also know or know of individuals who continue(d) to use drugs despite negative implications for self and, in some cases, others. Expressing a strong desire to stop using is no guarantee that drug-abstinence will follow. In relation to people who continue to use drugs, the argument that they *choose* to do so is often cited. I believe choice *is* involved during drug initiation but mediated by a range of factors ranging from a desire to feel pleasure to severe and chromic traumas. Regarding choice *following* the development of addiction my response is to critically question the utility of 'choice' as an operational concept in circumstances where the individual does not experience their self as having the capacity to choose. I do not claim to understand why some people are able to stop using drugs while others seemingly cannot – indeed, I question if this *can*

be known in any generalisable way. Politically, my stance on addiction and recovery is a broadly pragmatic one. Humans have always searched for ways to alter their state of consciousness and, in my opinion, will continue to do so regardless of social change or political intervention. Accessible and well-funded harm reduction services are therefore an essential component of contemporary drug treatment service provision.

These experiences, observations and reflections all constitute my researcher positionality, shaping my view of addiction as complex and multi-factorial but not necessarily life-long or irreversible and influencing my position as a critic of the 'new recovery' movement. I reject the notion that a universal explanatory model of 'addiction' is 'out there' awaiting discovery and support the view that 'recovery' is a heterogenous concept that means different things to different people and, to some, has no meaning at all.

Although this research was motivated by a desire to allow former drug users to speak for themselves, as already alluded to I acknowledge that my positionality and status as researcher-interviewer will influence both what respondents say, the way they say it, which data extracts are selected for analysis and *how* those extracts are analysed and reported. Such issues pertaining to power and influence are broached in more depth within the methodology chapter alongside other aspects of researcher-participant relations. Moreover, my experiences, values and beliefs may or may not be shared by those who agreed to participate in this study. As a researcher, I believe it is reasonable (perhaps unavoidable) to begin a study hoping that the outcome will in some way help to further a personal-political agenda. However, that it *will* do so should not be taken for granted, tempered with an acceptance that the desired outcome may not materialise.

Having outlined my social location and explained how my experiences and beliefs influenced the choice of topic, further personal and epistemic reflexive engagement will be integrated into the methodology chapter and again within the thesis conclusion. Another element of reflexivity

described by King et al. (2018) as 'critical language awareness' (p.25) is addressed below.

1.6 A Note on Terminology

Rather than drug use and drug users per se, the focus of this research is on people who used illegal drugs, who describe their history of illegal drug use as problematic for self and/or others and who *self*-define as working towards recovery, recovering, in recovery or 'recovered'. In relation to drug use and addiction, Lloyd (2010) rightly asserts that 'language matters' (p.9). The widely publicised 'War on Drugs' champions a variety of stigmatising and derogatory terms (The National Alliance for Advocates of Buprenorphine Treatment (NAABT), 2008). The negative implications attached to *the imposition* of terms including junkie, smackhead and crackhead are well-reported (NAABT, 2008; Loughborough Communications Research Centre, 2010). Reducing negative stereotypes associated with dependent drug use involves consideration of the terms that we, as writers, choose to employ (NAABT, 2008). The purpose of the following is to offer some clarification of the terminology used in this thesis.

In Britain, people whose drug use results in harm to self and others are typically referred to as 'problem drug users' (PDUs) (House of Commons Committee of Public Account, 2010). However, as Lloyd (2010) explains, the term 'problem drug user' denotes the person as the problem' (p.55). To avoid this denotation, I either connect the problem to the drug, using a prefix to form problem-drug user, or otherwise simply refer to drug user, former drug user or person/people with a history of drug use/addiction. Where a distinction needs to be made between 'problematic' and 'non-problematic' form of drug use, the qualifiers 'recreational' or 'controlled' (drug use) are applied. People who are looking to access treatment for drug use will be referred to a 'treatment seekers' while those currently in community treatment will be termed service users (SUs) or clients.

The decision to utilise the phrase 'former drug user' was influenced by interactions with research participants. While most referred to themselves

as ‘recovering’ or ‘in recovery’, others self-identified as ‘recovered’ and another rejected the concept of ‘recovery’ altogether. Former problem-drug user (truncated as above) or person with a history of addiction captured all participants at time of interview and were thus deemed the more appropriate options. Although the terms ‘in recovery’ and ‘recovering’ will be used in relation to some participants and to express the thoughts of different commentators, I recognise that these terms are not universally meaningful. ‘Recoveries’, ‘recovery pathways’ and ‘recovery frameworks’ will be used to connote the many routes out of addiction. Moreover, faith-based recoveries or recovery through religious conversion will be employed to distinguish the differing recoveries of participants with community service user used to denote the two respondents who, at time of interview, were accessing community treatment.

Where the discussion turns to medications used in the treatment of heroin addiction, medication-assisted treatment (MAT) and medication-assisted recovery (MAR) or will be used. As NAABT (2008) point out, ‘substitution’ and ‘replacement’ imply that the use of medications connotes ‘a lateral move from legal to illegal addiction’ (p.1) thus misrepresenting the nature of this treatment and recovery pathway.

The term ‘addiction’ will be used because it is widely understood but will be used interchangeably with dependence. Psychological and physical dependence will be applied where this distinction needs to be made. This may seem minor but is nonetheless important: an individual in MAR may no longer be addicted to heroin but is nonetheless physically dependent on methadone, much like a person who is prescribed pain relief or anti-depressant medications is not generally described as ‘addicted’ but is nonetheless physiologically and/or psychologically dependent on their medication.

The term ‘addict’ will not be used to express my personal thoughts but will be used where the term has analytic import or reflects the views of others. With that said, White (2006) has noted how terms including

‘alcoholic’ and ‘addict’, particularly within the 12-step Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) movements, have imbued treatment seekers with important resources to make sense of and own their problem. However, when used outside of therapeutic and recovery group boundaries such terms have stigmatising consequences - the label ‘addict’ connotes drug users as a homogenous group, disregarding individual differences and locating person as secondary to the disease (White, 2006).

To conclude, the above constitutes my attempt to find a balance between expressing my own thoughts and respecting how participants self-identify while retaining the readability of this thesis. When presenting the work of other commentators or participant narratives, *their* vocabulary will be brought to bear. At points throughout the thesis, exclamation marks will be applied to signify the contested nature of words or phrases. Finally, it is important to clarify that most terms associated with drug use and drug users tend to be imbued with a ‘stigmatising flavour’ simply because they denote a stigmatised population (Lloyd, 2010, p.55). Hence, I am aware that objections are likely to be raised, whatever my terms of choice and rationale for using them.

1.7 Research Aims and Objectives

The overarching aim of this research is to explore how former drug users aligned with differing recovery pathways construct life experiences, events and self-identities within British sociocultural and political contexts

This will be achieved by addressing the following questions:

- How are ‘addiction’, ‘addicts’, ‘treatment’ and ‘recovery’ constructed in political discourse, what are the implications of this for (former) drug user subjectivities, and to what extent do these constructions and related discourses shape and resource respondent narratives?

- To what extent does the wider discursive milieu shape and resource the narratives of former drug users aligned with differing recovery pathways?

- How do former drug users deploy rhetorical talk and discursive manoeuvres and position self and others within their biographical talk and for what purpose?

- To what extent are former drug user narratives framed and resourced by how they are already positioned as Christians or community service users accessing medication-assisted treatments?

1.8 Structure of the Thesis

This thesis comprises a further seven chapters, two that critically review existing research and other literature including British drug policy, a research design chapter, three empirical chapters and the conclusions. Together they form a detailed account of drug addictions and recoveries in context while supporting my argument that the discursive milieu both shapes (former) drug user subjectivities and provides cultural resources which people with a history of drug addiction in Britain utilise in constructing their addiction-to-recovery narratives. I now outline each chapter in turn.

Chapter 2 critically reviews research and other literature on addiction and recovery in the UK. To begin, the topic is contextualised with reference to statistical, legislative and definitional information. The creation of the 'problem drug user' in Britain and dominant addiction discourses are then discussed. I move on to review the literature on drug-initiation and active addiction and then turning points that instigate recovery attempts before engaging with debates surrounding 'recovery' as a concept. Proceeding this, recovery *processes* are addressed with a focus on the construction of a non-addict self-identity as well as recovery practices. Finally, I highlight barriers to recovery with an emphasis on prejudice and stigma before

drawing conclusions, bringing to bear the contributory potential of a synthetic discursive approach to addiction-recovery research.

Chapter 3 explores British historical and contemporary drug policy frameworks. I emphasise the political shift from reducing drug-related harms to 'recovery' as an overarching policy objective before critically discussing the Government's 'new recovery' agenda in terms of its implications for people seeking treatment for addiction. Importantly, in both Chapters 2 and 3 my intention is not only to review the literature but offer critical insight into the discursive contexts which I contend shapes the subjectivities and resources the biographical talk of (former) drug users as well as influencing public and professional conceptions of people with a history of drug dependence.

Chapter 4 details the research design of both the documentary analysis and interview strands of the thesis. I begin by outlining and justifying the constructionist philosophy that underpins both strands of empirical research and define self-identity and subjectivity as concepts. My focus then turns to the documentary analysis strand of the thesis with a focus on document selection, methodology and analytic framework. This is followed by a discussion of processes involved in the interview strand of the thesis. I explain and justify methodological decisions, recruitment of participants, methods, ethics and data analysis.

Chapter 5 is the first of three empirical chapters and contains a Foucauldian-informed analysis of the Government's 2012 'recovery roadmap' for England: Putting Full Recovery First. I follow an overview of the document itself with analysis and discussion of four discourses that permeate the text: 'Full Recovery as Compassionate Act'; 'Addiction and Full Recovery as Lifestyle Choice; 'Full Recovery as Abstinence'; and 'Full Recovery as Rational and Moral'. I explore the implications of each discourse for what (former) drug users can plausibly say and do and their subjective experience of self and the world while drawing attention to how these discourses influence how they are conceived by others. In the final sections of the chapter I explain how the documentary and interview

strands of the thesis intersect and prepare the ground for analyses of interview data.

Chapter 6 is entitled 'Drug Initiation and Active Addiction'. I present and analyse extracts from participant narratives under two overarching discourses. In 'Drug Initiation: Passivity versus Intentionality' I draw attention to how participants variously construct early life experiences and/or drug initiation processes. This is followed by 'The Downward Spiral' and a focus on how respondents represent their routes into and experiences of active addiction.

Chapter 7 is entitled 'Treatment and 'Recovery' and Beyond' and comprises a further two discourses: '(The) Breaking (of) the Habit' and 'The Road Ahead as Contingent or Definitive'. Under the former I explore how speakers construct their experiences of addiction treatment and 'recovery' processes and the latter draws attention to participant constructions of their future hopes and aspirations. In both interview data analysis chapters, the overarching discourses are sub-divided into two or more related discursive constructions, informed by my reading of what participants are doing with their talk. I consider how wider discourses shape participant subjectivities and explore how cultural resources are utilised and the rhetorical strategies deployed by speakers to construct particular versions of reality.

Chapter 8 begins by briefly reviewing the empirical work before introducing and presenting the conclusions under three broad headings: 'Descent/Ascent: A Widely Utilised Narrative Resource'; 'Drug Initiation, Continuation and Maintenance'; and 'Recovering' or 'Recovered' and Future Aspirations'. Both similarities and variations between and among speakers aligned to religious and non-religious recovery pathways are noted in relation to discourse and subjectivity, their utilisation of discourses and canonical narratives as resources for talk, positioning and identity work and the discursive-rhetorical strategies they deploy and for what purpose. A reflexive discussion of researcher positionality and its implications precedes a section where I outline the theoretical and

practical implications of the study. This is followed by a critical account of the study's limitations and suggestions for future research. In the final section of the Chapter, I explain how and why this thesis contributes new knowledge to the existing body of addiction and recovery research.

CHAPTER 2

Literature Review

2.1 Introduction

This chapter reviews primarily UK-based research with a core focus on the addiction-to-recovery trajectory. To begin, the topic area is contextualised with reference to statistical data and a brief overview of British drugs legislation. My focus then turns to the 'problematic' versus 'recreational' drug use divide and the invention of the 'problem drug user' as a particular type of person. Following this, I highlight dominant institutional discourses of addiction and explore their implications for subjectivity while highlighting also the human capacity for agency. The remainder of the review is chronologically structured in accordance with the notion of drug use, addiction and recovery as a staged process. My initial focus is problematic-drug initiation. This is followed by a review of the research on active addiction. The resonance of both stages with addiction theory is brought to bear. Next, key factors that instigate recovery attempts are noted and discussed. After critically reviewing the debates surrounding 'recovery' as a concept and briefly outlining various recovery pathways, I focus on recovery processes with particular attention given to narrative identity reconstruction and recovery practices. Finally, I draw attention to factors that are positioned as hindering the recovery process with an emphasis on social stigma. The conclusion summarises key points and draws attention to how this thesis will add to the existing body of knowledge on addiction and recovery.

2.2 Drug Use in Britain: Prevalence Data

Use of illegal drugs in Britain is widespread, so much so that the UK has been labelled by the media as the drug use capital of Europe (Hickley, 2019) with some commentators proposing that drug use in the UK has become normalised (Parker et al., 1988; Pennay and Measham, 2016). Recent data (based on self and, thus, potential under-reporting) published by the Home Office (2018) estimates that 1 in 11 adults (aged 16-54) and

1 in 5 younger adults (aged 16-24) in England and Wales used an illegal drug in the last year. Regarding Class A drugs (constructed in legislation as most harmful), the figure is 1 in 29 adults with Class A drug use among younger adults increasing since 2011/12 (Home Office, 2018). Given the prevalence of drug use and the persistence of 'normalisation' as a concept, it is reasonable to infer that early drug using experiences are more likely to be retrospectively constructed as part of everyday life than a counter-cultural or otherwise deviant activity.

Although drugs are widely consumed in Britain, statistics indicate that relatively few people become addicted to illegal drugs or develop problems that require intervention. With that said, as will be noted, these statistics may not tell the whole story. In England, individuals in contact with structured treatment services are recorded through the National Drug Treatment Monitoring System (NDTMS) but account only for those accessing mainstream community services, inpatient treatment and residential rehabilitation. These numbers do not, however, capture *all* who attend Narcotics Anonymous 12-step programmes (other than when NA groups are linked directly with community services). Neither do these statistics account for all those who attribute their drug-abstinence to religious conversion, or *the majority* who stop taking drugs without recourse to any formal support (Granfield and Cloud, 1999). Moreover, treatment service users who have attained stability with the assistance of prescribed methadone *are* counted. Moreover, they are captured in the European Monitoring Centre for Drugs and Drug Addiction's (EMCDDA) definition of the problem drug use as 'injecting drug use or long-term use of opioids (including methadone), cocaine or amphetamine' (EMCDD, 2017). The recording of people in contact with structured treatment does produce reliable data, but only with regards *to contact*. To gather precise prevalence data on people who use drugs problematically, including all those who do not fit the 'in contact with treatment services' criteria, is a near impossible task.

With this lack of clarity in mind, figures from the EMCDD's United Kingdom Drug Report 2018 (based on 2016 data) indicate that there are around 330,445 'high-risk opioid users' in the UK with 138,442 accessing medication-assisted treatment (MAT). For 42 per cent of treatment entrants, opiates are the primary drug of choice, 25 per cent cite cannabis, 15 per cent cocaine, 2 per cent amphetamine and 15 percent cite 'other'. Average age at first use *and* treatment entry are stated at 23 and 34.8 years for heroin, 21.2 and 30.8 years for cocaine, 22 and 35 years for amphetamine, and 14.6 and 22.6 years for cannabis. Based on NDTMS data, in England alone, 146,536 adult opiate users (52 per cent of the treatment population) were in contact with structured treatment in 2016-17 (a slight drop of 2 per cent on 2015-16) with an average age of 39 years. Between 2015-16 and 2016-17 there was a notable rise of 23 per cent in those accessing treatment for crack cocaine problems only (2,980 to 3,657) and a 12 per cent rise in individuals presenting for crack and opiate use (19,485 to 21,854), with the latter in the 45 years and over age bracket (Public Health England (PHE), 2017).

In terms of 'successful treatment exits' (again applicable only to structured treatment), only 26 per cent of 'opiate clients' successfully completed treatment compared with 54 per cent for users of non-opiate drugs. Average time spent in structured treatment for opiate users is reported as 1039.2 days but just 170.2 days for non-opiate clients. In 2017-18, 2,680 clients died while in contact with treatment services – of these, 1,741 or 65 per cent of clients were being treated for opiate dependence with a mean age of 45 years (Public Health England (PHE), 2017). These statistics are indicative of the chronic and pernicious nature of opioid addiction in particular. They also highlight the existence of an ageing cohort of long-term heroin users, many of whom have additional and complex social and health care needs (AMCD, 2016). With regards to amphetamine, although it is a drug of choice for only 2 per cent of adult treatment seekers in the UK, this group are also likely to be chronic users with co-occurring psychosocial issues.

Although much could be read into these statistics, their purpose here is to contextualise drug usage in England and the UK. In Chapter 3, however, consideration of the policy context in which treatment 'successes' are recorded raises critical questions around how 'success' is officially defined. Chapter 3 also gives greater insight into potential explanations for the unprecedented numbers of drug-related deaths in the UK which, in England and Wales, now exceed deaths from traffic accidents (Hamilton and Stevens, 2018). Most deaths involve opiate drugs and occur among older users (AMDC, 2016). Perhaps unsurprisingly, in England drug-related fatalities are far higher in the (more deprived) North East than in London. Former Liberal Democrat MP, Lord Carlile of Berriew (now chair of addiction charity 'Addaction') described these statistics as 'scandalous'. What is more, increasing use of New Psychoactive Substances (NSP) is likely to worsen an already desperate problem (Asthana, 2017).

New Psychoactive Substances (NPS) have only recently been classified as illegal drugs. Up until 2016 when they were outlawed in Britain these substances, then known as 'legal highs', could be purchased from 'head shops' and other vendors throughout the country. Perhaps the most commonly cited of these substances is the synthetic cannabinoid known as Spice. In England in 2017, 1,450 individuals presented to services with problems related to NSP use. This 29 percent reduction in treatment presentations since 2016 has been explained by the reduction in younger people presenting to treatment. In Britain today, NPS users tend to be homeless and extremely vulnerable (PHE, 2017). Although not the focus of this research, a recent snapshot of the UK drug scene by Shapiro and Daly (2017) reported that some 'Spice' users, both older and younger, were using heroin in a bid to off-set withdrawal symptoms instigated by sustained Spice use. One would hope that the significant reduction in younger NPS users noted above is not related to the replacement of Spice with heroin, but this is something only time will reveal. As has historically been the case, legislation recently introduced to outlaw NPS has not eradicated the problem but has produced an underground and completely unregulated market with NPS potentially more dangerous now than before

the introduction of legislation (Shapiro and Daly, 2017). Indeed, the efficacy of contemporary UK Drugs Legislation - namely the Misuse of Drugs Act 1971 and Psychoactive Substances Act 2016 briefly outlined below - has been extensively critiqued.

2.3 Contemporary UK Drug Laws: A Brief Overview

While the focus of Chapter 3 is drug treatment/recovery *policy*, here the legislative context in Britain is briefly outlined. The Misuse of Drugs Act 1971 classified drugs into classes A, B or C according to their perceived dangerousness and introduced harsh penalties for possession and supply (Lloyd, 2010). The utility of the 1971 Act, indeed the effectiveness of drug law and policy per se, has prompted long and heated discussion (see Jenkins, 1999 cited in Buchanan and Young, 2000; UK Drug Policy Commission (UKDPC), 2012a). A growing number of commentators now argue that 'addiction' should be addressed as a health not criminal justice issue. The Portuguese model of drug policy characterised by the decriminalisation of drug use and adoption of a health-orientated focus is an approach that Hughes and Stevens (2010) argue merits further consideration. To date, the British establishment have rejected all calls for a critical discussion of UK drug laws, much less change.

In 2016 the Psychoactive Substance Act was introduced to criminalise the sale and possession of NPS, effectively outlawing all psychoactive substances bar those that are medically prescribed and named 'mainstream' products including caffeine and tobacco. In so doing, tens of thousands of 'legal high' users, literally overnight, became 'criminals'. Moreover, evidence suggests that political intervention has done nothing to reduce either supply or demand. As alluded to above, the now absolute deregulation of this market and the production of an underground economy has rendered these substances even more damaging to individuals and society with the addition of unknown chemical compounds enhancing their psychoactive effects and addictive potential (Beckley Foundation, 2017).

So far, the reader has been introduced to drug use in Britain with a focus on prevalence and government legislation. The remainder of the review will focus firstly on the creation of a 'recreational' versus 'problem' drug user divide. It will then move on to highlight and explore dominant discourses in which 'the contemporary addict' is enmeshed and the implications for those who are subjected to them. Proceeding this, literature on the addiction-to-recovery trajectory will be discussed with connections to this thesis noted where relevant throughout.

2.4 Producing the 'Recreational' versus 'Problematic' Divide

In Britain, people who use drugs are broadly categorised into two groups: recreational drug users and problem drug users (PDUs). Although the notion of a definitive recreational/problematic divide is a questionable one, this research focuses on individuals who are generally associated with the latter grouping: former drug users who describe their past use as troublesome or problematic, who are variously labelled problem drug users, dependent drug users, substance misusers, addicts or junkies. As noted in the introductory chapter, drug user and former drug user as well as addiction and dependent drug use are the terms used in this thesis to express my own views with various pre-fixes (recreational, problem) attached where required. Otherwise, the terminology used by the author from whom the information is taken will be applied.

Recreational drug use (RDU) is a term used in the UK to capture drug use that does not result in long-term harm to individuals and communities. When commentators suggest that drug use has become normalised, they are referring to substances including cannabis and irregular or weekend-only use of 'club drugs' such as Ecstasy. The term PDU was created by the UK government's Advisory Council on the Misuse of Drugs (AMCD) in 1982, joining existing concepts including addiction and dependence, and subsequently became a prolific term in official documents (Seddon, 2010). In the AMCDs 1982 report, a problem drug user is defined as *'any person who experiences social, psychological, physical or legal problems as a*

result of intoxication and/or regular consumption and/or dependence as a result of how own use of drugs' (p.32).

Definitions of PDU subsequently became narrower and more focused – for example 'users of heroin and/or crack cocaine' (HM Government, 2008) and 'injecting drug use or long-term use of opioids (including methadone), cocaine or amphetamine' (European Monitoring Centre for Drugs and Drug Addiction (EMCDDA, 2017). The implication is that *certain* substances (ecstasy and cannabis for example) are 'recreational' and others (heroin and crack cocaine among others) are 'problematic'. In this study the term 'problematic' relates not so much to the drug itself or even the quantities consumed, but to the impact that substances have on the lives of individuals who consume them. Hence, the broader AMCD definition stated above holds the most relevance. Moreover, it acknowledges the point made by DrugWise (2015) that so-called recreational drugs can be used problematically as well as Warburton et al's (2004) conclusion that 'problem' drugs can be used in a controlled manner. Nevertheless, the creation of the PDU had and continues to have significant implications for people who use certain drugs.

Seddon (2010a) utilised Hacking's notion of 'making up people' to argue that the term PDU created a new classification of person. By narrowing the definition of PDU to heroin and crack users only, the Home Office at the time was better able to govern a new 'social problem' group who were now deemed to endanger individuals and damage wider society. For Seddon (2010a), governing PDUs includes counting numbers, quantifying the cost of PDUs to society and correlating PDU with a range of social ills including criminal behaviour, unemployment and educational under-achievement. As Garland (2001) explains, the introduction of statistical processes enabled government to 'classify and regroup the population' (p.181), producing categories of people who prior to counting and sorting processes were considered to have little significance. The consequent creation of 'essential' characteristics which 'made up' the PDU reinforced

the notion that they constitute *a distinct* category of person requiring specific forms intervention that enable the government of their conduct.

Significantly, even though people who experience drug-related problems rarely refer to their selves as a PDU, being labelled as such has an impact on their treatment by others (drug workers, criminal justice system employees, and social workers for example) and this then shapes how the 'user' experiences their self, others, and the world (Seddon, 2010a). The term PDU, at the time of its creation, was considered less stigmatising than labels such as 'addict' and 'drug misuser' due to the (apparent) focus on problems (as opposed to individuals). Although the change in terminology did nothing to lessen the stigmatisation of people who use certain drugs, it is nonetheless notable that the term PDU is now absent from UK policy documents. Recent official publications have reinstated the use of terms including 'substance misuser' and 'addict'. Moreover, as discussed below, these contemporary constructions of 'the addict' are reproduced and reinforced by the matrix of intersecting medical, legal, economic, and moral discourses in which drug users are enmeshed (Bright et al., 2007).

2.5 Contemporary Discourses of Addiction

In macro social constructionist work, discourse refers to 'a set of meanings, metaphors, representations images, statements or stories that, together, represent objects, events, people, and groups of people in particular ways' (Burr, 2015, p.74). Discourse avails subject positions (Willig, 2013) defined as locations within discourse that stipulate how the person thus positioned can or cannot speak or behave (Bright et al., 2007). Dominant discourses receive the 'stamp of truth' (Burr, 2015, p.91) and are accepted as common-sense. These constructions are intimately related to institutions and practices, serving the interests of certain groups (Bright et al., 2007) and exerting a considerable influence on how people subjectively experience self and the world (Burr, 2015). As discourses both constitute subjectivities (Baily, 2004) *and* are utilised as resources for talk (Edley, 2001a), identifying dominant discourses

pertaining to addiction and 'addicts' is pertinent to this thesis. Despite emerging differences between Britain and Australia with regards to the direction of drug treatment policy (full recovery versus harm minimisation respectively), similarities between the two nations in terms of dominant institutions and related discourses render aspects of Bright et al.'s (2008) analysis of addiction discourses in the Australian media transferable to the Britain context. The following will highlight and discuss medical, legal, moral, and economic discourses, their intersection in the formation of political discourse, and the implications for those who are subjected to them.

Within medical discourse the drug user is positioned as 'sick' or 'unwell' – as a docile and treatable object, subject to the medical gaze. (Bright et al., 2007). The drug user is denied autonomy and positioned as incapable of rational decision making by a powerful medical elite who dictate the 'correct' course of action (Lupton, 2012). Positioned firmly on the bottommost rung of the social hierarchy the 'addict' is constructed in medical discourse as powerless and, thus, vulnerable and open to exploitation by 'experts'. This status is further entrenched within doctor-patient interactions, characterised by technical medical jargon, meaningful only to those with the relevant medical expertise (Lupton, 2012).

Legal addiction discourse constructs drug use as criminal behaviour and positions the 'addict' as criminal. According to Bright et al. (2007), the intersection of medical and legal discourses paves the way for treatments that seek to cure (mis)behaviour *and* position the 'addict' as deserving of punishment through the criminal justice system (Bright et al., 2007). The drug user as deviant law-breaker fuels discourses of responsibilisation that permeate official UK government texts (see HM Government, 2012), reinforcing notions of addiction as a moral issue. Although considered to now be outdated, moral conceptions of the drug user in fact retain a 'quiet popularity' among the political classes, professionals and lay people alike (Harding, 1986; Peterson, 2005). It is unsurprising then, that moral discourses were identified in Bright et al's (2007) analysis.

Morality refers to normative and culturally and historically relative notions of right and wrong. According to Baily (2005), addiction is essentially a 'moral concept' (p.539). Moral discourse positions the drug user as deviant, irresponsible and unwilling to exhibit self-control – as capable of doing the 'right' thing yet actively choosing not to do so. For Davis (2000) medical and moral discourses intersect to produce 'user' subjectivities. Davis (2000) further asserted that medical discourses are purposefully utilised by drug users as a way of avoiding moral judgement and condemnation. That is, to position oneself as 'sick' functions to divert blame. Davis (2000), however, has argued that medical discourses that construct addiction as disease position the dependent drug user as lacking autonomy and this undermines the potential for recovery. Nevertheless, life in Western societies is infused with cultural norms and values including moral conceptions of right or wrong – to become addicted is conceived as an example of the latter. Relatedly, a strong and productive economy is thought to be a product of people who do the 'right' thing (Bright et al., 2007), a premise that may help to explain the invisibility of *illegal* drug users in economic discourse as highlighted below.

Although one must take account of relatively recent changes, certainly to how smoking and to an extent alcohol consumption in Britain is constructed, the economic discourse identified by Bright and colleagues availed subject positions only for tobacco smokers and alcohol drinkers, depicting them as consumers in a Capitalist economy. The implicit position offered to the dependent *illegal* drug users in economic discourse, then, is as an 'enemy of Capitalism' and a 'danger to economic prosperity'. These constructions resonate with official discourses in the UK that highlight the cost of addiction to society (Barber et al., 2017). In short, Neoliberal regimes construct the user of illegal drugs as the enemy within.

Taken together, these dominant institutional discourses construct the problem drug user as a sick and passive recipient of the medical gaze, a criminal in need of punishment, morally corrupt, and a threat to economic prosperity and the nation state. In the context of neoliberal values, the

problem-drug user is positioned as the antithesis of conventional 'normality' including good citizenship, freedom and autonomy (Rose, 1999).

Although the preceding discussion draws attention to how drug users are positioned in dominant institutional discourses, it is crucial to take account of smaller networks of meaning - discourses related to, for example, gender, age, ethnicity, religion and social class - and how these intersect with broader institutional discourses that permeate British society. As Burr (2003) explains, subjectivities and self-identities are constructed from a 'subtle, interweaving of many different threads' (p.106). In the context of this research, these include interpretive resources associated with differing treatment and recovery pathways, for example Christian-Biblical discourses and discourses that prevail within community treatment and other therapeutic contexts.

To give a brief example, the subjectivity and self-identity of a working class, White male who is addicted to heroin will be formed not only through dominant institutional discourses but through discourses of age, class, ethnicity, sexuality, education, nationality and (un)employment for example. Each thread offers a limited number of culturally available discourses and subject positions which, when occupied, constitute that person's sense of self (Burr, 2015). Indeed, as Benwell and Stokoe (2006, p.79) surmise, 'addict' subjectivities are shaped by multiple discourses.

The focus so far has been primarily on how discursive contexts shape how drug users subjectively experience self and the world with little attention given to human agency. The notion of discursive resources and the functional use of language adopted in this thesis rejects some strands of discourse analytic research that promote 'discourse determinism' and offer little room for the capacity of humans to alter their life course (Burr, 2003). These radical macro constructionist perspectives position humans as little more than puppets operated by and entirely at the mercy of discourse (Craig, 1994 cited in Burr, 2003). As explained in the introductory chapter and alluded to above, the synthetic discursive

approach utilised in the interview strand of this study acknowledges the power of discourse to shape human subjectivities and experience. However, it also recognises that humans have the capacity to resist, negotiate and reject the discourses in which they are positioned, or self-identities conferred, produce counter-discourses and strategically utilise culturally available repertories of meaning as *resources for* talk. Although Baily (2005) questions if a person who inhabits the position of 'junkie' is able to discard and move away from that identity category, thousands of people *do* attain their personal vision of recovery. Indeed, the process of recovery *is* an act of resistance against constructions of 'the addict' as forever enslaved (Bamber, 2010). As Bamber (2010) concludes, the movement from addiction to recovery is in itself a profound journey of self-transformation. Hence, research methodologies employed to study addictions and recoveries must acknowledge human agency and capacity for change.

Having identified dominant institutional discourses and related constructions of 'the addict' in many Westernised nations including Britain, it will be interesting to explore how, if, or to what extent these discourses shape and resource the narratives of participants in this research. Furthermore, as most interview respondents are older and were using drugs at a time when the term PDU was more widely utilised, if the meanings associated with this term have any bearing on how respondents construct their self-identities, life events and experiences will be another potential area for consideration.

With the topic area now broadly contextualised, the literature reviewed from this point onwards will be relate specifically to stages of the addiction-to-recovery trajectory, drawing on a combination of older yet classic studies and contemporary research.

2.6 Reviewing the Empirical Research: Introduction and Rationale

The following presents findings from empirical research whilst also noting the extent to which they resonate with various explanatory frameworks of addiction. First to note is that aside from some classic British examples

(see Pearson, 1987; Parker et al., 1988; Parker et al., 1998), empirical findings on problem-drug *initiation* processes are based largely on ethnographic research conducted in deprived American urban neighbourhoods (Carnwath and Smith, 2002, p.76). Although drug addiction in Britain is by no means *the preserve* of impoverished communities there is a well-established albeit complex link between addiction, poverty, socioeconomic deprivation and social exclusion (Buchanan, 2006; Wakeman, 2016). Moreover, although the use of New Psychoactive Substances (NPS) has recently emerged as a new and pressing social issue (Shapiro, 2016; Shapiro and Daly, 2017), existing UK-based research on problematic-drug initiation processes and drug using lifestyles refer primarily to heroin users. The proceeding discussion of problem-drug initiation and continuation is framed by two classic studies carried out in the mid-1980s, both situated within what were at the time some of Britain's most deprived and recession-ravaged communities (Pearson, 1987; Parker et al., 1988). Both studies focused primarily on the addiction trajectory as represented by active heroin users. Although now dated, the findings continue to hold contemporary relevance.

Indeed, a later study by Parker et al. (1998), despite *some* notable variation in terms of social class, nevertheless *re*affirmed the link between drug use and socioeconomic deprivation. For Parker et al. (1998), the predominant profile of the late 1990s heroin user resonated with experiences of the past including links with poverty, unemployment and educational under-achievement. Aside from the inclusion of participants from wealthier backgrounds whose initiation to heroin was linked to 'dance' culture, a relationship between heroin and social deprivation was (as in the mid-1980s) the rule rather than exception (Parker, 1998). A 2007 report by Shaw and colleagues also found 'strong links' between problematic drug use, poverty and widening inequalities and the British Medical Association Board of Science (2013) cite deprivation as a significant contributor to PDU. So, problem-drug use remains located largely within poor communities and Britain continues to be a hugely

economically unequal country (McKnight et al., 2017) containing pockets of severe deprivation (Department for Communities and Local Government, 2015) with widespread relative poverty (McKnight et al., 2017) produced, in part, by the financial crash of 2008 and ensuing austerity politics (Wakeman and Seddon, 2013). Moreover, the inclusion of 'dated' research is further justified by the fact that most participants in this research experienced active addiction in the 1980s and 1990s and their primary drug of choice was heroin.

Parker et al's (1988) empirical investigation of heroin addiction is set in the context of an English community when thousands of younger residents abruptly and without warning became regular heroin users. The research team observed these 'new heroin users' and explored the impact their developing lifestyle had on them as individuals, their families and the wider community. Pearson's (1987) research was based within several locations within the North of England - again, the focus was on addiction trajectories and the purpose to give heroin users a voice and report their subjective life experiences (Preface). Parker at al's (1998) research explored a period known as the 'second heroin epidemic' characterised by the spread of new heroin outbreaks within Britain's urban locations, many of which had no previous history of heroin. Parker et al. (1988) highlighted the difficulties involved in attempting to constructing a lucid theoretical and conceptual model based on the British sociological, criminological and medical literature of the time, theories which bore little resemblance to the subjects of their study. Tellingly, two decades later the inability of theory to remain apace with empirical developments within substance misuse research continued to be highlighted (Hser et al. 2007). As alluded to in the introductory chapter, the fruitless pursuit of a comprehensive theory of addiction is certainly not the intention here.

2.7 Problematic-Drug Initiation

Both mid-80s studies emphasised how heroin initiation resided predominantly within friendship groups. This, the authors highlighted, contrasts with stereotypical images of the evil drug pusher loitering at the

school gates. In Parker et al's (1988) study, from a sample of 18 females and 43 males, approximately 65 per cent of respondents first encountered heroin through a significant other (p.46). The authors thus affirmed that a person's first offer, as well as subsequent heroin use, is closely linked to use of the drug by those close to that person. Similarly, Pearson (1987) stressed that the role of friendship groups in facilitating heroin use cannot be overstated. Given the apparent significance of social environments, it will be interesting to observe if interviewees in this study invoke a relational discourse when talking about their early drug using experiences.

Pearson (1887) reported that some individuals used heroin following the initial offer whilst others were more reluctant but with reassurance from friends came to view using the drug as acceptable. Moreover, individuals within friendship networks did not in any way feel compelled to use heroin. Rather, those who had previously tried and derived pleasure from the drug wanted to share their experience with willing friends. The decision to use heroin, then, is positioned as an active choice (Pearson, 1987; Carnwath and Smith, 2002) between consenting individuals. This bears some similarities with Carnwath and Smith's (2002) point that within drug subcultures, those who initiate use are often perceived as leaders (Carnwath and Smith, 2002). These 'fashion-moulders' first locate the drug - their peers willingly follow suit.

The notion of early drug use as a relational phenomenon was also a significant feature of Parker et al's later (1998) study which differed from the first with regards to a broader 'spectrum of susceptibility' (p.vi). This wider spectrum included use of heroin by young people in work and/or education and from more affluent backgrounds. That most of the more 'affluent' users were heavily into recreational drugs associated with rave culture and used heroin as a post-party 'chill out' drug suggests that peer relations were again a key contributory factor. So, although by the late 1990s heroin had attained *a degree* of 'social mobility', it is important to emphasise that heroin use continued to be closely linked socioeconomic disadvantage.

In terms of what Parker et al. (1988) term motivation to use, 33 per cent of participants cited curiosity aroused by prior use of substances other than heroin, with a further 5 per cent experimenting with heroin as something other than their regular drug(s) of choice. Another salient finding related to use of other substances (excluding tobacco and alcohol) prior to heroin: 92 per cent of participants had used a drug, principally cannabis, before using heroin with only 5 respondents stating that their drug-initiation involved heroin. For 21 per cent of participants in Parker at al's (1988) study, the primary motivating factor was heroin use by peers. Loosely described as peer group pressure or influence, this motivation to use occurred both internally (the need to conform to what had become 'the norm') and externally (being urged by others to conform).

Interestingly, Pearson (1987) found that 'active ambition' (p.12) was a motivating factor with some participants viewing heroin as a risky and exciting, and thus attractive, alternate lifestyle. In the absence of gainful employment, involvement in heroin could generate multiple benefits including significant sums of money (through dealing) as well as a level of social status and positive self-identity otherwise unattainable. Moreover, involvement in what Seddon (2008) refers to as the informal or underground economy provides a sense of structure - of meaning and of purpose - to lives characterised by dull monotony produced by widespread poverty and unemployment (Pearson, 1987). The notion of 'active ambition' can be linked to Gibson et al's (2004) repudiation of the myth that constructs addiction as an enduring condition characterised by loss of control (Hammersley and Reid, 2002). In Neoliberal cultures, being 'addicted' is positioned the antithesis of 'good citizenship' where self-control is held in high esteem; hence, these arguments are particularly relatable to Western contexts including the UK and warrant further exploration.

As in Parker at al's (1988) research, a large majority of respondents in Pearson's (1987) study had used other illegal drugs prior to heroin, most commonly cannabis and amphetamine. In fact, some initial encounters

with heroin were directly linked to limited availability of their usual drug of choice (Pearson, 1987, p.13). This scenario was also reflected in the narratives of eight participants in Parker et al's (1988) investigation who, due to a cannabis and speed 'drought', were offered and accepted heroin. Furthermore, as alluded to above, Parker (1998) found that many 'second wave' heroin users were 'heavy' recreational drug users. This movement from 'recreational' to 'problematic' drugs appears to give credence to 'gateway theory' where 'soft' drug (particularly cannabis) use is positioned as *causing* progression to 'harder' drugs such as heroin and crack cocaine. This theory is, however, subject to contestation and debate. Indeed, conclusive evidence of a causal relationship between cannabis and heroin and/or crack cocaine use, according to Joy et al. (2006), is non-existent. As Morgan (2009) explains, most users of cannabis do not move on to hard drug use and this, for Morgan (2009), removes all credibility from gateway theory. Indeed, the illegal status of cannabis and associated likelihood that users will meet 'hard' drug dealers when procuring their supply is far more of a danger than the properties of the drug itself (Morgan, 2009). Explored through a discursive lens, ways in which respondent's position 'soft' drug use in the context of becoming addicted will be another interesting facet of the interview data analysis.

Pearson (1987) concluded that regardless of how initial motivation to use was represented, heroin was commonly remembered by respondents as a drug that infiltrated friendship groups and quickly became the 'pervasive drug of choice' within affected communities (Pearson, 1987, p.13). Theoretically, these findings suggest that problematic-drug initiation is influenced by sociocultural (Furnham and Thompson, 1996) and sociological-structural factors (McGregor, 1999) with changing beliefs, attitudes and values mediated through peer pressure and increased cultural acceptance, often in a context of socioeconomic deprivation (MacGregor, 1999). Social learning also appears to hold relevance - the decision to use drugs was influenced by observation of role models and the consequent construction of drug use as a social norm. If behaviour is seen as having a positive impact, particularly if witnessed on a regular

basis, the likelihood of that behaviour being 'modelled' by others increases (BMDBoS, 2013). The significance of 'drug availability' requires little elaboration - if heroin (or other drugs) had not been available, using it would not have been possible. The suggestion, then, that drug initiation can be understood *purely* in terms of individual level factors is undermined by the empirical studies discussed above. Nevertheless, the multi-factorial nature of problem-drug initiation lends support to Furnham and Thompson's (1996) assertion that the thoughtful combination of different theoretical perspectives can enhance understanding of why people start to use heroin and other addictive drugs.

Having considered the research on problem-drug initiation the focus now turns to 'continuation' and 'maintenance' of drug use. That is, to quote Pearson (1987, p.21), 'if a person has been offered heroin (or another drug) and accepts it, what happens next?

2.8 Problematic-Drug Continuation and Maintenance

How a person responds to the effects of heroin and other drugs is highly subjective (Pearson, 1987; Carnwith and Smith, 2002). This notion is exemplified by Carnwith and Smith's (2002) account of two doctors who, in the interests of science, attempted to become heroin-addicted over a two-week period. In the context of laboratory settings both doctors found that heroin produced highly unpleasant effects. Carnwath and Smith contrasted the doctors accounts with those of a war correspondent who, after a period of drug abstinence, resumed heroin use on his return from covering the conflict in Chechnya. The war correspondent variously described the feeling produced by heroin as 'a warm golden explosion in my stomach' and a 'blissed sensation beyond the peak of orgasm' with 'every muscle relaxed, every sense unwinding, unburdened of the crushing weight of pain I never even knew I had' (Carnwath and Smith, 2002, p.98).

To explain this contrast, the author's utilised Howard Becker's theory that people *learn* how to experience the pleasurable effects of (in Becker's research) cannabis. For Becker, a combination of persistence and the

observation of experienced users over time, shapes how cannabis is experienced. Becker concluded that the process of getting high is, in part, a sociocultural construction rather than merely a pharmacological response (Becker, 1963). Becker's (1963) account can be usefully applied to the subjects in Parker et al's (1988) and Pearson's (1987) research. How, within a context of social deprivation and high unemployment and surrounded by heroin using peers, individuals learned to experience heroin as pleasurable and offering an escape from lives characterised by boredom, unemployment and social deprivation.

Like the two doctors noted above, for some participants in both Parker et al's (1988) and Pearson's (1987) research, heroin at first made them violently sick. For others the immediate effects were immensely pleasurable, bringing relaxation and elevated feelings of personal capacity (Pearson, 1987; Parker, 1988). Even though the *initial* effects were variously experienced, a common feature of respondent narratives were allusions to the capacity of heroin to alleviate everyday worries. For many, the feeling derived from the drug, in the sense of detachment from poverty, unemployment and substandard housing, was so all-consuming that the pharmacological impact - 'the rush' - played only a minor role in their attachment to it (Pearson, 1987). Of far more importance was heroin's euthanising properties - its capacity to produce a barrier between individual and material reality. Such findings resonate with Denning et al's (2013) argument that if drug-induced effects were only negative, people would not use them.

Moving on, a common (mis)conception relevant to drug-continuation is that substances such as heroin and cocaine are instantly addictive. However, the time-period from first use to addiction and also what the drug *does* for an individual varies from person to person. During the initial stages of what Parker et al. (1988) referred to as the 'drug career' alterations in lifestyle were minimal. For 'career users' who already had other-opiate habits, obtaining and using opiates (but now in the form of street heroin) continued to be their central focus. Among the non-

dependent group, however, two distinct heroin-related outcomes were identified.

For one group, heroin use *expanded* their available social options. This group comprised those who had become isolated due to the paranoia associated with daily amphetamine use and a small group of women who had been restricted socially by domestic obligations. Another group found their social options curtailed, for example, those who were in employment spent non-working hours searching for, buying and using heroin, while for the unemployed, rather than spending time with friends and relatives their social life became centred around heroin and the company of fellow users (Parker et al. 1988). Also of note is that the transition from non-dependent use to addiction was characterised by what Pearson (1987) described as an 'imperceptible drift' (p.38). However, once daily use became established the principle objective was acquiring enough heroin to maintain a steadily increasing habit and stave off withdrawal symptoms (Parker et al. 1988).

Theoretically, it is useful here to consider Bozarth's (1990) notion of drug addiction as occurring in two stages: acquisition and maintenance. Prior to initial use of a substance the as yet experientially unknown rewarding effects are largely irrelevant in terms of influencing a person's behaviour. Like Becker, however, Bozarth does note that *expectations* develop from social interactions including media portrayals and discussions with experienced peers. More so, and in line with the empirical studies above, drug initiation is linked to 'intrapersonal and sociological variables' (Bozarth, 1990, p.114) including curiosity and peer group influence. Although following initial exposure to a substance the peer group remains significant, as the pleasurable effects are repeatedly experienced, pharmacological variables assume greater importance. Bozarth (1990) explains this in terms of a 'shift in control' as pharmacological factors begin to override the intrapersonal and sociological aspects in shaping an individual's behaviour. At this point the motivation to use becomes stronger and coincides with movement from controlled or non-problematic

use to compulsive drug-taking and on to addiction (p.115). The speed of this shift is somewhat dependent on the pharmacological properties of substance consumed. With drugs such as heroin and crack cocaine the movement *can* be relatively swift while for other substances including alcohol, the trajectory is often much slower.

In sum, Bozarth's (1990) argument suggests that individualistic explanations such as negative reinforcement assume greater prominence as an individual's addiction 'career' progresses and drugs are used in response to cravings and symptoms of withdrawal. For respondents in Pearson's (1987) and Parker at al's (1988) research, the drift into dependent use was represented in terms of broken friendships (Parker et al 1988; Pearson, 1987), movement away from hobbies and pursuits, loss of employment (Pearson, 1977) and fractured family relations (Pearson, 1987; Parker et al. 1988) as the search for and use of heroin became all consuming.

So retrospective constructions position heroin addiction as stealthy and deceptive - less a 'sudden cavalry charge, more the gradual trudge of a foot army' (Pearson, 1987, p.63). Indeed, some participants were not cognisant of heroin dependency until they first experienced withdrawal symptoms. Moreover, as more of the drug is required, administration through injection (where smaller amounts of heroin produce greater effects) becomes more attractive. When the dependence stage has been reached, staving off withdrawals (Hughes, 2007) functions as a core organising feature in the lives of heroin users. Indeed, for Hughes (2007), the significance of withdrawal cannot be overstated with respondents often referring to strategies deployed to avoid the 'dreaded conclusion': withdrawal symptoms that begin between 6 and 24 hours from when the drug was last consumed (Hughes, 2007, p.679).

One strategy was described as 'the ability to maintain' either by using heroin or prescription drugs or both. Maintenance was described in terms of trying to sustain a 'conventional' way of life (keeping house, a car, a job, raising children and such like) by retaining control over ones' drug

usage. This, Hughes (2007) reported, involves prolonged effort, preparedness, planning and proficiency. Moreover, such findings raise critical questions regarding the notion of heroin users a homogenous group who necessarily lack control. Chaotic use, in direct contrast to maintenance, constitutes complete emersion in the drug using lifestyle. Indeed, constructions of the chaotic user are more in keeping with the so-called 'addiction myth' (see Hammersley and Reid, 2002) characterised by complete and enduring loss of control. With that said and in contrast to dominant representations of addiction, even chaotic use was represented by respondents in Hugh's (2007) study as 'episodic' and 'spasmodic' (p.680), occurring only at crisis points in peoples' lives. Even less in keeping with 'the myth' is research by Warburton et al. (2005) who reported the presence of a substantial yet hidden population of controlled or non-dependent heroin users, further refuting the notion of heroin as instantaneously addictive and users as necessarily chaotic. Notably however, respondents in Warburton et al's (2005) study were all relatively affluent and structured their lives around family, social events, work and other conventional activities.

That respondents in Pearson's study who were living in socioeconomically deprived communities with high unemployment and a drug using culture dismissed the notion of controlled use as impossible, again, underscores the importance of context. For many, long-term regular use of *street* heroin *will* if not initially then eventually, restrict a person's capacity to live a 'conventional' life (if 'conventional' is indeed what they desire). The onset of physical dependence (to heroin) produces a state wherein withdrawal symptoms (restlessness, sweating, insomnia, anxiety, stomach cramps and diarrhoea, aches and pains) can only be avoided or arrested by using adequate quantities of opiate drugs at sufficiently regular intervals. Without access to heroin the user will suffer both physiological withdrawal and intense psychological cravings. At this point, their addicted status is beyond doubt – heroin is now required to feel 'normal' (Pearson, 1987). This is the stage in the addiction trajectory when the psychological

and physiological need for heroin may override a person's natural instincts, producing a disconnect from their personal-moral compass.

One participant in Pearson's (1987) study began 'thieving' to support her habit. Another, a nursery nurse, despite her initial and prolonged reluctance to try the drug, eventually started to use when her boyfriend lost his job and began to spend time with regular heroin users. For this female respondent, feeling unwell whilst visiting a friend and feeling better when reacquainted with the drug triggered the realisation that physical dependence had now set in. These two participants had contrasting personal-social histories. The first lived in a locality where unemployment had reached 35 per cent with heroin use at endemic proportions and permeating local youth culture, the other was from an area where heroin was in relatively short supply. The first was eighteen years of age and unemployed, the second in her late-twenties and in gainful employment. Nonetheless, in terms of the transition from non-dependent use to addiction their experiences were remarkably similar, resonating with the canonical notion of a 'descent' or 'downward spiral' into addiction.

In much the same way and despite differing life and drug-related experiences, for participants in Parker et al's (1988) study the transition to addiction was accompanied by dealing (13 per cent), burglary (26 per cent), shoplifting (25 per cent), theft, fraud, or a combination of the above, to finance the habit. In this sense, and to quote Pearson (1987), heroin can be 'a great leveller' (p.81). With that said, even among daily users from areas high in deprivation, the stereotypical representation of the 'addict' as utterly divorced from conventional values and morals is simply inaccurate. Many respondents expressed a deep attachment to family and regretted the heartache they had caused. These emotive assertions were particularly the case with sons in relation to their mothers.

Notions of morality – here *among and between* heroin users in a community – are also highlighted in Wakeman's (2016) autoethnographic research into the 'moral economy of heroin use in austerity Britain'.

Wakeman notes how particular 'skill-sets' (p.371) are exchanged between heroin users, often without words. One respondent (Ryan) had the contacts to ensure swift movement of stolen goods alongside consistent supplies of heroin, while another (Tony) was able to 'offer' protection to Ryan (and others) through his notoriety and status. Another respondent (Helen) often cooked for Ryan and Ryan would return the favour, bringing Helen a small amount of heroin during *her* time of need. Wakeman (2016) explains exchanges of this nature in terms of a 'bond-assertion of partners within the moral economy' (p.371), partners who meet one another's material *and* emotional needs. In this context, it is important for each actor to position self as both valuable and considerate. Another notable observation is the role of trust in these relationships. A breach of trust (not paying back a small monetary loan as agreed for example) would be noted and punished, materially, emotionally or both through the withdrawal (at least for a while) of needed services. As Wakeman (2016) explains, 'the consequences of violating the moral-economic order must be enforced to ensure its proper functioning' (p.373). This moral economy, then, provides structure and meaning to lives which would otherwise be amorphous and meaningless. Moreover, this meaningfulness and structure is acquired only through being a heroin user. The skills these individuals possess - their social capital - would have no utility in conventional contexts. Like representations of early drug use, constructions of involvement in drug using networks draw on lifestyle and relational discourses and evidence a degree of resistance to subject positions availed by moral discourses of addiction. Entrenchment in this way of life is alluded to by drug users as *their* 'normality' but is nonetheless the antithesis of *conventional* neoliberal notions of 'good citizenship'.

Where Wakeman (2016) considered 'order' among a group of heroin users within a locality, Gibson et al. (2004) refer to 'entangled identities' to capture the sense of disconnect and confusion that permeates respondent accounts as mainstream self-identities and routines are gradually replaced by the 'addict' lifestyle. Participants expressed guilt and remorse about

who they had become, alluding to their ‘dirty bodies’ and poor oral hygiene and how controlling the symptoms of withdrawal took precedence over mainstream practices including appointments with health professionals. For Nettleton at al. (2010) the ‘using body’ of active addiction ‘demands attention, repair and resolution’ (p.347) due to withdrawal symptoms that only opiates can alleviate. This, in the words of William Burroughs (1977) captures the insidious processes whereby junk claims victory by default. Both Gibson et al. (2004) and Nettleton et al. (2011) draw attention to the embodied aspects of opiate addiction with Gibson’s respondents positioning their selves in a moral discourse as inferior subjects. In this thesis, participants constructions of the ‘addict lifestyle’ will be explored and considered in terms of their resonance with the versions of reality produced by existing research.

As alluded to above, the ‘descent into addiction’ is a cultural narrative often utilised by drug users to represent the progressive nature of drug dependence alongside metaphoric constructions deployed to depict their ‘fall’ into the ‘grip’ of addiction as the drugs ‘take hold’. What appears to be a relentless downward trajectory can, however, be reversed. Gibson et al. (2004) utilise the notion of *dis*entangling to capture participant attempts to reaffirm control of their lives. Having inhabited a life centred around drug use and associated practices and with non-drug using friendship groups a distant memory, what influences a person to attempt movement away from a challenging yet familiar drug using lifestyle? What are the turning points that prompt an individual to seek treatment and attempt recovery? In exploring these questions and, later, when considering recovery processes, addiction-specific literature will be supplemented with criminological research on and theories of desistance, and with good reason. Although addiction ‘recovery’ and ‘desistance’ from crime are often discussed as distinct phenomena there is considerable overlap between the two (Best et al., 2017). Indeed, Maruna (2001) draws on Zamble and Quinsey (1997) in asserting that persistent offending and substance addiction are so entangled that the two phenomena ‘may be inseparable’ (cited in Maruna, 2001, p.62)

2.9 Turning Points

Despite early perceptions based on the stipulated wisdom that addiction is a lifelong condition, contemporary research on recovery processes has revealed a fluctuating (Gibson et al, 2004, p.598) and complex phenomenon involving numerous personal and contextual factors (Mackintosh and Knight, 2012; Neale et al., 2016). The simplistic explanation noted above was first questioned by Winick (1962) who highlighted that significant numbers of drug dependent individuals stopped using drugs between 23 and 37 years of age. Winick hypothesised that addiction was therefore a self-limiting process and argued that many drug users simply 'mature out' of addiction, an argument that mirrored earlier criminological research positing a direct link between ageing and desistance from crime (Gluek and Gleuk, 1940). The dominant precursors to recovery, for Winnick, were changes in lifestyle which render the continuation of drug use unacceptable.

Moreover, in 1973 the 'once and addict always an addict' construction became increasingly fractured when Robins discovered that most opiate-addicted soldiers on returning from Vietnam in 1971 stopped using drugs, many without treatment. Robins argued that the movement back to conventional life eliminated the need for a drug which had enabled them to cope with the traumas of war. Hence, with support from friends and family the majority of veterans 'rediscovered' their prior identities (see Robins, 1973 and 1993 for detailed discussions). The Vietnam episode highlights both the importance of context in assessing the likelihood of *recovery from* addiction but also how quickly individuals can *become* addicted when faced with adversity (Carnwath and Smith, 2002).

Just as criminological theories of 'maturational reform' have been subjected to critique (McNeill et al., 2012), a later exploratory study by Waldorf (1983) concluded that Winnick's (1962) 'maturing out' thesis was useful but insufficient. Transcripts from focused interviews with 201 ex-addicts (half treated, half untreated) revealed that personal motivation to stop using opiates arose from changes associated with 'maintaining

expensive habits' (Waldorf, 1983, p.237) including lifestyle alterations and encounters which the police. In addition to maturing out, Waldorf (1983) identified other patterns of recovery including 'retirement', switching from heroin to other drugs (most often alcohol), and religious, social or political conversion.

Parker et al. (1988) noted that when the turning point arrives, the drug itself is seldom perceived as the problem, more so the 'hassle' of financing an addiction and obtaining an adequate supply of drugs. The research team found that the impetus to seek help originated primarily from two sources, namely immediate family members and law enforcement (p.56). Moreover, they concluded that for those who felt pressured or coerced into recovery, treatment was unlikely to succeed (Parker et al., 1988). Participants in Pearson's (1987) research gave numerous and diverse reasons for wanting to stop using drugs. Some were simply fed-up with the lifestyle while others were concerned about the impact on self and family members. A change in friendship group or meeting a non-using partner were also in some cases significant considerations. Fear of being caught for shoplifting or other crimes were other often cited reasons. For some the decision was not freely made, produced instead by a sudden 'drug drought' and disruption in supply, an impending court appearance where evidence of continued drug use could influence the court's decision or probation orders where individuals were given one last opportunity to avoid a custodial sentence. Pearson (1987) also observed that almost all instances of self-motivated attempts to 'quit' were accompanied by subtle pressure from family members, friends, or professionals (p.148). These findings suggest that factors which trigger decisions to 'go straight' (Maruna, 2001) are diverse and plentiful. For some, such decisions involve the weighing-up of risk versus reward, aligning with the notion of desistance as a rational choice (Clarke and Cornish, 1985).

McIntosh and MacKeganey (2000) conclude that turning points can be both positive and negative. For one respondent, the epiphanic moment occurred when (s)he realised a leg may need to be amputated due to

long-term injecting. For another, the prospect of a lengthy prison sentence triggered the decision to stop using whilst for one the turning point was the drug-related death of a partner. The implication here is that encountering the 'feared self' - 'an image of what the person does not want to become' Paternoster and Bushway (2009, p.1107) - provided the initial motivation for change. Positive events which precipitated decisions to 'quit' included falling in love and the birth of a child alongside a desire to build or restore relations with the mother and new baby (McIntosh and MacKeganey, 2000). These latter points are supportive of the idea that social controls may limit the desire to engage in criminal behaviour (Laub and Sampson, 1993) and corresponds with Schroeder et al's (2007) assertion that the formation of conventional relations with a '*pro-social*' (p.213) intimate partner creates a context that fosters recovery from drug use. It is worth noting, however, that control theories of desistance have been criticised for neglecting human agency (Vaughn, 2007) in favour of the determining potential of external factors and downplaying the role of identity change and subjectivity – the meanings different people attach to informal social controls, such as employment and marriage, can diverge substantially between individuals (Paternoster et al., 2016). Giordano et al. (2002) propose a more agentic view of the subject with 'hooks for change' such as those noted just one, albeit key aspect, of a cognitive transformation process that leads to long-term desistance.

Respondents in Mackintosh and Knight's (2012) study described how, as their drug use escalated, previous 'aspirations, potential, capabilities and enthusiasm' transformed into 'poverty, aversion, despair and shame' (Mackintosh and Knight, 2012, p.1096). Reflecting on the person they had become triggered the desire to seek help and support. Indeed, for Mackintosh and Knight (2012), the concept of 'potential' as an initiator of change emerged as a consistent theme in the data. Participants variously highlighted the potential to be perceived by loved ones (in particular their children) as more than a no-good druggie, the potential to be viewed by others as worthy (of help and hope) and arrive at a place of self-acceptance and the rediscovering their inner potential. Other turning

points included new-found realisations about the 'true' nature of drugs (McIntosh and McKeganey, 2000), growing awareness that dependent drug use and happiness are incompatible and that the capacity to choose if and when to use drugs had long since disappeared (Mackintosh and Knight, 2012).

Although the literature reviewed above provides interesting insights, all apply a realist epistemology. This thesis adopts a alternative focus, exploring how turning points are constructed and for what purpose.

Having critically discussed experiences and events that instigate recovery attempts, the focus now turns to 'recovery' itself. Critically, however, movement towards a goal entails having an endpoint in mind, an idea of what the desired goal actually looks like. With this in mind, the following section reviews the literature on 'recovery' as a concept, drawing attention to its construction as both a vague and contested idea.

2.10 Recovery: Definitions and Debates

Despite recent attempts to produce a workable definition based on professional *and* service user input (Neale et al., 2016), addiction recovery remains an ambiguous concept (Laudet, 2007; UKDPC, 2008; Neale et al. 2012; Neale at al., 2016). For some, the term is synonymous with abstinence from all drugs including prescribed medication (Gyngell, 2009; 2011) while others offer a broader definition, related more to improvements in psycho-social functioning and the accumulation of recovery capital including gainful employment, adequate housing, a stable family life, access to peer support and improved health. These broader definitions also capture the many stable, socially productive clients who access Medication-Assisted Treatment (MAT) (UKDPC, 2008; Neale et al., 2012).

That 'recovery' continues to be ill-defined (Neale et al., 2016) is problematic in several respects. Firstly, if treatment services are to nurture recovery and researchers evaluate the effectiveness of recovery interventions, a stable definition of recovery is required (Neale et al.,

2016). Furthermore, although recovery (as subjectively experienced) has been realised by many former drug users, without a clear definition it is difficult to establish with any accuracy how many former drug users have attained it (Laudet, 2007). As Laudet (2007) explains, 'the faces of people in recovery' continue to be influenced by mass media constructions of 'dysfunctional characters' (p.244). In an attempt to progress towards an objective definition of recovery, Laudet (2007) interviewed American inner-city crack and/or heroin dependent residents three times over three years. Respondents in Laudet's study defined recovery as both abstinence from all drugs and improvements in other life areas with a focus on regaining whatever had been lost. A limitation of this research noted by Laudet (2007) herself was participants' prior exposure to 12 Step Fellowships wherein total abstinence is perceived as the only viable end state. The notion of regaining life itself was also linked to the 12-step construction 'sobriety is not enough' (AA, 1939/2001 cited by Laudet, 2007, p.252). Laudet's conclusions suggest that alignment with a specific recovery pathway (in this case 12 Step programs) shapes how recovery is articulated and implies that representations of recovery cannot be detached from the contexts in which and from whence they are formed. In this case, 12-Step discourse both shaped and resourced respondent understandings of and the meanings they attached to recovery. Such conclusions support the utility of discursive research on addiction and recovery with a focus on how narratives are shaped by how a respondent is already positioned within a recovery pathway and sociocultural context.

McKeganey at al. (2004) also concluded that the majority of treatment-seeking drug users desire 'abstinence'. Based on the views of 1007 drug users starting a new episode of treatment, the research involved structured interviews with individuals aligned with either community, residential or prison-based drugs services. Using a standard tick-box questionnaire, participants were interviewed at 8 monthly intervals with the initial interview at treatment initiation. The research team found that for a small majority (56.5%) of participants, the *sole* treatment goal was to attain abstinence. Indeed, this finding has been widely cited and

utilised by some service providers and drug treatment professionals as 'evidence' that abstinence is now the mainstay of recovery and that harm reduction-based interventions are no longer needed (Neale et al, 2011). Neale et al. (2011), however, criticised McKeganey et al's (2004) research, arguing that much of the detail relating to participant responses had been lost due to the quantitative methodological approach adopted.

Neale et al. (2011) problematise quantitative research designs aligned with the positivist paradigm where 'facts' and 'truths' are uncovered and displayed primarily in numbers and statistics. Moreover, they argue that an 'official' preference for multiple participants and the collation of numbers and percentages marginalises the use of qualitative methodologies with smaller samples. Accordingly, the notion that meanings, definitions, values and knowledges are ultimately 'socially constructed, relative and subject to opinion' (Green and Britten, 1998; Harrison, 1998 cited in Neale et al., 2011) is disregarded. These arguments lend support for additional qualitative enquiry into addictions and recoveries and hence this thesis.

In contrast to McKeganey et al. (2004), Neale et al. (2011) collected linguistic data during in-depth interviews with 30 'recovering' heroin users. The sample comprised 5 males and 5 females from each of the following groups: individuals beginning a new prescription with methadone or Subutex; those who were actively detoxifying from either illicit or prescribed opioids; and those who had recently entered residential rehabilitation (p.190). Their objective was to shed light on the subjective meanings attached to recovery and the recovery process. Interestingly, Neale et al. (2011) conclude that abstinence as a concept is poorly understood by participants. The research team argue that numbers who cited 'abstinence' as their sole objective in McKeganey et al's (2004) study cannot be accurately quantified due to variations in meanings attached to the term, variation that existed 'even among their sample let alone across time place and culture' (p.191). Neale et al. (2011) found that for some participants abstinence applied to all drugs, to others only illicit drugs or

‘problem’ drugs such as heroin and crack cocaine. Furthermore, as Neale and colleagues emphasise, participants in McKeganey et al’s (2004) study were not asked what abstinence meant *to them*.

Neale et al. (2011) argue that where researchers fail to probe participants in terms of what *specific* drugs they wish to abstain from, substances including cannabis, alcohol, tobacco even, may not be mentioned or even considered. Neale and colleagues moreover brought to bear notions of temporality - did participants wish to attain abstinence ‘immediately and forever, now but not in the future, or not now but in the future?’ (p.192). The research team also note that people may wish to be abstinent from all illegal and prescribed opioids *at some point* but nonetheless, in the interim, appreciate the benefits of such treatment. They conclude that an expressed desire for ‘abstinence’ does not necessarily mean abstinence from all drugs. Some individuals may wish to continue accessing harm reduction services for continued use of alcohol, cannabis or prescribed opioids. Even in cases where the desire for abrupt abstinence from all chemical dependency was assured, various harm reduction services may still be required to minimise multiple harms (psychological, material and social) accrued from years of drug dependence. In sum, this research indicates that more attention is required with regard to what abstinence *actually means* to individuals. It is also telling that McKeganey et al’s (2004) key finding - that the majority of treatment seekers desire abstinence - has been the focus of several other critiques (see Martin, 2005; Trace, 2005; Roberts, 2005).

Another qualitative study by Neale et al. (2012) involving interviews with 40 former heroin users found that recovery is closely linked to improvements in multiple life areas including personal relationships, mental and physical wellbeing, paid work and criminality. Participants also expressed a desire to feel socially accepted, to belong, to aspire and to lead fulfilling lives. More recently, Neale at al. (2014; 2015; 2016) engaged stakeholders including service providers, significant others, and drug service users in another attempt to produce a workable recovery

definition. After much deliberation, 27 recovery indicators were identified (see Neale et al., 2016, p.38) with abstaining from alcohol and/or *street* drugs, not experiencing cravings and taking care of mental health given highest priority. This is undoubtedly a useful piece of work which takes account of the views of a range of individuals including those in treatment and recovery. However, the study was devised with *structured community* treatment in mind with the authors admitting to 'limitations in scope and scale' (Neale at al., 2016, p.39). Moreover, Neale et al. (2016) assert that unless barriers to recovery are addressed, *any* definition of recovery will have limited utility.

Simply put, from existing research we can ascertain that there is no 'one size fits all' recovery definition and that recovery is a process not an event (UKDPC, 2008). Although the lack of a recovery consensus produces difficulties for services who are expected to deliver it, that recovery is a subjectively experienced personal journey (UKDPC, 2008) and that it differs, often substantially, between individuals is unlikely to change (White and Kurtz, 2006). This diversity is produced by variations in the seriousness of an individual's problems, the internal and external resources that people have available to them and personal priorities. Individual preference is also a significant mediating factor with multiple recovery pathways available, ranging from the secular to the spiritual to the religious as well as medication-assisted forms of recovery. In short, what suits one person will not necessarily suit another.

To sum up, recovery remains contested and ill-defined. There is, however, a broad consensus that recovery means more than simply using or not using drugs (Laudet; 2007; UKDPC, 2008; Best et al., 2011; Neale et al., 2012; Neale et al., 2016) and is better described as a *subjectively experienced process* than an end state (UKDPC, 2008; Best et al., 2011). It is, moreover, a process that means different things to different people but often includes changes in attitude, thought, behaviour (Laudet, 2007; UKDPC, 2008) and the overall quality of one's life (O'Sullivan et al., 2017).

In drawing this section to a close, the literature reviewed above supports the assertion made in the introductory chapter - that attempting to formulate a universal definition of recovery is a fruitless task. Recovery (and addiction) are subjective phenomena - how they are represented by individuals will vary according to time and place. Rather than a realist ambition to discover a transferable definition of recovery per se, applying a synthetic form of discourse analysis will enable exploration of how individuals aligned with differing recovery pathways *construct* their recoveries and the discursive resources they draw on to do so. This, I argue, *is* a viable undertaking and forms a rationale for the chosen methodological approach.

Before moving on to review the research on recovery processes, it is important to note that despite 'differences in the instrument of recovery' (change as a gift (religious) versus change as personally owned (secular) for example), all recovery pathways are thought to promote a 'revisioning of the self and of one's life context' (Morgan, 1995 cited in White and Kurtz 2006, p.24). 'Recovery' may be achieved through adherence to religious (Christian conversion, faith-based recovery), spiritual (12-Step programmes such as Narcotics Anonymous) or various secular recovery pathways (White and Kurtz, 2006). People in medication-assisted versions of treatment or recovery *could* align themselves with any of the above pathways, and significant numbers of people 'recover' without recourse to any formal treatment or recovery support (Granfield and Cloud, 1999). As space does not permit in-depth exploration of each recovery pathway, the following section will present a largely generic review of existing research on addiction recoveries while also incorporating literature specifically on recovery in the context of Christian conversion. As alluded to above, research on desistance from crime and related theoretical frameworks will also be integrated into the discussion. Narratives of recovery and identity reconstruction receive considerable attention with recovery *practices* - the relational, embodied and socioenvironmental aspects of recovery - also brought to bear.

2.11 Recovery Processes

Amidst an explosion of recovery-related literature that emerged between 1960 and the early 1990s, numerous hypotheses relating to the recovery process or movement away from addiction made their mark (Taieb et al., 2008). Concepts of self and identity, discourse, narrative, and embodiment are key themes that characterise empirical research with participants who (in the main) self-identify as being 'in recovery' from drug addiction.

Research carried out over the last two decades highlights identity reconstruction as salient to recovery (McIntosh and McKeganey, 2000; Gibson et al., 2004; Hughes, 2007; Mackintosh and Knight, 2012; Sremac, 2013; Sremac and Ganzevoort, 2013a/b) and, indeed, desistance from other forms of criminal activity (Maruna 2001; Paternoster and Bushway, 2009; Stone, 2015). The formation of a non-addict identity involves creating a significant gap between the drug using and 'conventional' self (Gibson et al. 2004, p.597), namely, the construction of a self-identity without drug user characteristics (Mackintosh and Knight, 2007, p.1094). These studies support the findings of earlier interview-based research by Biernacki and Waldorf (1971; 1981) who reported that individuals who desisted from drug use without formal treatment positioned the capacity to construct a non-addict self as central to the recovery process. For Giordano et al. (2002), however, although identity is an important aspect of the desistance process, it must be preceded by, initially, an 'openness to change' and then exposure to and acceptance of 'hooks for change' in the form of pro-social roles and/or activities. This, Giordano and colleagues argue, enables a shift in identity and initiates a process whereby the old way of life is perceived as undesirable.

Identity is also an important concept in Maruna's (2001) phenomenological exploration of narratives produced by persistent offenders and successful desisters (a majority of whom where former drug users). Where persistent offenders displayed a lack of self-efficacy and positioned themselves as 'doomed to deviance' (p.118), those who were

‘making good’ utilised a variety of alternative discursive strategies to accentuate the extent of their progress. These ‘redemption narratives’ include an expressed desire to produce something of value by helping others. This desire to give back was captured in what Maruna (2001) labels ‘generative scripts’ (p.118), narrative constructions which function to exonerate the speaker of shame and guilt and legitimise the ‘new’ and improved self. Moreover, giving back filled a void previously occupied by crime and also acted as a form of therapy, helping the helper as much as the recipient.

Maruna (2001) also draws attention to how desisting speakers emphasised the ‘true self’ – a person of good character who had always been present regardless of past actions. Drawing attention to the true self involves an array of rhetorical strategies including excuses, justifications and comparisons with (more deviant) others, disrupting the normative notion that admissions of guilt are a essential aspect of the reform process. As means of explanation, Maruna (2001) highlights how in Western cultural contexts admissions of immoral behaviour are conflated with an irredeemable self, a notion linked to the ‘once a criminal always a criminal’ mentality that prevails.

Finally, desisters displayed high levels of self-efficacy and an optimistic view of personal control over future events – a surety about one’s (positive) destiny. Maruna (2001) asserts that this ‘tragic optimism’ (p.97) involves the fulfilment duties that *have always* been intrinsic to the individual’s true self. Interviewees mined their personal-social histories for evidence that their former lives have a wider purpose – for example, the accumulation of wisdom and understanding that now enables them to give back to others through counselling and other generative activities. Moreover, whereas the deviant self is passively constructed as a product of circumstances and events, the present and future are positioned as the individual’s responsibility. To quote Maruna (2001), ‘once the going gets good the passive descriptions fade away and the ‘I’ reappears, assuming almost hypercontrol’. Within redemption narratives, any suggestion of

recidivism is emphatically dismissed – admitting to the possibility of future deviance is deemed too risky, a threat to the construction of a self in full control of a positive destiny (Maruna, 2001). Maruna et al. (2004), moreover, argues that ex-offenders do not seek to establish a 'new' identity but instead transform a shameful life into something that has current value, thereby adopting the position of 'wounded healer'. Personal histories are reinterpreted in a way that positions the criminal past as both justifiable and aligned with their favourable perception of who they are today – the 'true' self that had always existed (Paternoster et al., 2016).

Research by McIntosh and McKeganey (2000) also focuses on narrative identity reconstruction but here respondents emphasised *the distinction* between the 'old' and 'new' self. Semi-structured interviews with 70 individuals who self-defined as 'in recovery' enabled the identification of three core aspects of identify reconstruction (McIntosh and McKeganey, 2000). Firstly, respondents reinterpreted various aspects of the 'addict lifestyle' in a negative manner, for example, by emphasising how the pleasurable aspects of drug use had dissipated and how drugs were now used only to feel psychologically and physiologically 'normal'. McIntosh and McKeganey (2000) found that this reinterpretation of drug use was widely represented in terms of a realisation that drugs produce a false or distorted sense of reality. Respondents also utilised narrative to differentiate their self-identities prior to and following drug use, comparing who they had become with who they aspired to be. This is consistent with Paternoster and Bushway's (2009) argument that offenders need to envisage the 'possible self' by 'crafting a new and positive vision of what they wish to become' (p.1206). Consideration of the 'possible self' not only sets the scene for the formation of a pro-social identity but transmits a positive message to conventional society, thereby increasing the likelihood of involvement in 'mainstream' roles (Paternoster and Bushway, 2009).

The final point above relates to McIntosh and McKeganey's (2000) third key area of narrative identity reconstruction: providing an convincing explanation for recovery. As McIntosh and McKeganey (2000) explain, assertions made by drug users regarding their recovery ambitions are often challenged, disputed or disregarded, hence, being able to produce a powerful and convincing explanation to support the desire for change is a way to convey credibility and authority, thereby encouraging acceptance in others. Notably, as part of the 'redemption ritual', Maruna's (2001) sample of successful desisters appeared to be 'almost obsessed' (p.156) with proving the legitimacy of their transformation. In a similar vein, Sremac and Ganzevoort (2013a) reported how respondents who overcome addiction through Christian conversion utilise 'testimonial talks' (pg.401) to justify and make their lives accountable to others. These testimonial constructions offer renewed credibility to narratives rendered dubious by a drug-using past (Sremac and Ganzevoort, 2013b). It is only when former 'deviants' are 'formally and symbolically' positioned by others as 'success stories' that suspicion regarding their legitimacy begins to fade (Maruna, 2001, p.158).

That the discourses permeating Western cultures constrain the degree to which former offenders feel able to express culpability has already been noted (Maruna, 2001). For McIntosh and McKeganey (2000) also, self-identity reconstruction corresponds closely with wider recovery discourses and literature. Although *seemingly* a product of the individual, recovery narratives are actually produced through the utilisation of discursive resources acquired through interactions with 'significant others' including drug treatment professionals. This use of the discursive milieu by former drug users is also brought to bear in a narrative-orientated constructionist studies on recovery through religious conversion (Sremac and Ganzenvoort, 2013a; Sremac and Gansevoort, 2013b). Sremac and Ganzevoort (2013a) drew attention to how ex-users who convert to Christianity narrate their conversion testimonies by drawing on 'canonical language' described as the 'dynamic interplay' (p.401) of discourses associated with their specific religious community *and* aspects of their

personal-social histories. Through the production and reproduction of testimony, Christian converts reconstruct past events and self-identities from the 'vantage point of the present' (Sremac and Ganzevoort, 2013b, p.224). In so doing, they exhibit to significant others a credible present-day self, formerly tainted by addiction.

These empirical findings noted above lend support to Taieb et al's (2008) claim that recovering drug users may be *particularly* in need of discursive resources including history, fiction and expert literature to give meaning to their lives, to reconstruct their self-identities and enable the process of change (p.990). Taieb et al. (2008), moreover, assert that when 'users' are confronted with multiple discourses that seek to render comprehensible 'a phenomenon for which no single truth exists' (p.990), using narrative enables new understandings of the recovery process to emerge. This thesis elaborates and expands upon these studies with a focus on culturally available resources including canonical narratives and the use of rhetorical strategies including legitimisation and persuasion. Moreover, it explores how constructions of both 'addiction' and 'recovery' are shaped through the lens of Christianity and/or 'new recovery' and by dominant social discourses that permeate neoliberal culture.

Mackintosh and Knight (2012) employed a phenomenological analytic framework to develop an in-depth understanding of the recovery journey and its impact on the recovering individual's sense of self. In-depth semi-structured interviews gave respondents the opportunity to share their experiences of addiction and the recovery journey. As with McIntosh and McKeganey's (2000) research, a dominant theme to emerge was the significance of formulating 'an identity or notion of self without addiction' (p.1096). Within this overarching theme, meeting the challenge produced by a fundamental crisis of existence, accepting self-responsibility for change and recognising the undesirable were highlighted as factors that set the recovery journey in motion. Other thematic constructions identified by Mackintosh and Knight (2012) were 'searching for the non-addict self' and 'claiming the new identity' (p.1096). Here, a process of self-reflection

enabled reclamation of the new self which involved disregarding how others had defined them and positioning the self in a new and positive light. Of interest in the context of this thesis will be to explore from a discursive perspective if participant accounts resonate in any way with the themes highlighted above.

The recovery literature reviewed thus far has attended primarily to the construction of a non-addict self-identity through narrative. For Reith and Dobbie (2012), narrative is used to produce a 'coherent sense of self' (p.512), enabling speakers to interlink disparate life events and experiences and to render meaningful the totality of one's life. In short, narrative identity reconstruction is a central aspect of the recovery process. With that said, to focus *only* on language ignores the co-occurring changes in *material* practices including the relational and embodied aspects of movement away from the 'addicted self'. Moreover, as Reith and Dobbie (2012) explain, the process of biographical reconstruction is 'grounded in material circumstances' (p.511). Some of the practical-material aspects of overcoming dependency are highlighted by Mackintosh and Knight's (2000) notion of the reclamation journey, a journey that involves distancing oneself from behaviours, people and places, within and through which the addict identity had previously been defined. Participant's reported that creating distance produced elevated levels of self-esteem, self-worth and self-acceptance. Some respondents highlighted supported accommodation as a supportive space to rediscover the self without drugs. Equally, however, for individuals with high levels of vulnerability and resistance to change, this context accentuated boredom and loneliness - it contributed to relapse and the back-slide into active addiction.

Although identity reconstruction featured in Gibson et al's (2004) study, it also attends to the notion of recovery as relational and embodied. During focus groups and in-depth interviews, respondents recruited from drug detoxification programmes, post-detoxification units and residential rehabilitation facilities expressed a need to account for how they became

‘someone who they were not’ and ‘recover a sense of who they were’ (p.604). Like respondents in Mackintosh and Knight’s (2012) study, this involved creating space between their selves and active drug users. Gibson et el. (2004) conceptualise divorcing the addict-self as a process of ‘disentangling’ that involves efforts to reinstate command of self-identity, restoration of the body and addressing contextual and relational issues.

Gibson and colleagues, moreover, note a semantic change in the way participants represented their drug-using selves, indicative of creating social and psychological distance between their addict and emerging non-addict identities. Respondents also issued moral judgement upon their prior drug-using self to further justify the disentanglement process. For some, this included addressing their oral health and other bodily factors. Interestingly, withdrawal symptoms did not emerge as a primary concern but were positioned as an unpleasant yet necessary aspect of the disentanglement process. The import of embodiment to the recovery process is also highlighted by Nettleton et al. (2011) with respondents drawing attention to problems with sleeplessness, dealing with boredom, the re-emergence of painful emotions and dental pain as well as issues relating to eating and drinking, all of which had been largely irrelevant during life under the influence of heroin and other drugs.

After years of drug-taking these features of everyday life (re)surface during recovery attempts, features that have to be re-learned and coping strategies put in place. Although Nettleton et al. (2011) by no means dismiss the salience of narrative and identity reconstruction, they do argue that a greater appreciation of recovery as lived experience also requires a focus on embodiment. Moreover, as part of ‘the reconstitution of self’ (p.612), Gibson et al. (2004) point out that many former drug users must again confront the relational-material contexts in which drugs were consumed. Drug using friends and even family members may purposefully resist a friend or relative’s non-drug using self. Indeed, for Gibson et al. (2004) movement away from the drug subculture therefore requires an almost ‘superhuman effort’ (p.612) which, in statistical terms,

makes recovery highly unlikely. These findings suggest that more attention to the bodily aspects of recovery is required as well as the contexts in which recoveries are most likely to occur.

Gibson and colleagues also called for additional focus on the 'myth' of addiction that is produced, reproduced and reinforced in popular and official discourse. This 'myth' posits that addiction will inevitably lead to moral degradation and the drug user will end-up a social outcast. Moreover, internalisation of 'the myth' can restrict an individual's capacity to recover from dependence (Gibson et al. 2004). Gibson et al. (2004), like Nettleton at al. (2011), move beyond narrative identity reconstruction to consider the material aspects of recovery. As alluded to earlier, in this thesis addiction and recovery are conceptualised as tangible lived experiences with discourse and practice intimately interrelated. This study will expand on existing research by considering how positionings in discourse enable and constrain what respondents can plausibly do and also what they can plausibly *say*.

A 2012 study by Nettleton and colleagues focused on recovery narratives in the context of neoliberal discourses of normality. Empirical data from interviews with a mixed-sex sample of individuals in England at various stages of recovery from heroin addiction found that users often affirm that they 'just want to be normal' (p.1). Drawing on Foucauldian notions of 'governmentality' and 'the norm', Nettleton et al. (2012) investigated 'recovering user's accounts of normality as they are envisioned and expressed' (p1). The research team suggest that the seemingly unsurprising finding that recovering heroin users express a desire for 'normality' is in fact *produced by* neoliberal discourses and practices. Neoliberalism, Nettleton et al. (2011) argue, actively 'privileges the norm' (p.2) and politicians devise projects to inspire citizens towards the attainment of conventional normality.

Using discourse analysis, Nettleton et al. (2012) identified six discursive repertoires of 'normality talk' that transcended respondent accounts (p.1). In keeping with Foucault's approach to understanding the social world,

rather than an interest in accounts as properties of individuals they focused on the 'discursive strands' that infiltrated 'normality talk' across the whole sample (p.5). This approach produced data that highlighted the vocabulary available to people in recovery, revealing culturally available 'repertoires of normality talk' (Abstract). Among others, the repertoires 'aspiration to everyday practice', 'embodied normality', 'normal can be boring' and 'normal drug use as problematic' (p.179) were detected and each is discussed below.

In 'aspiration to everyday practice', Nettleton et al. (2012) note that although 'normality' is a state that drug users often crave, in practice it can be difficult to attain. Moreover, once attained, it can be dull and monotonous. 'Embodied normality' included having a normal sex drive, normal bowel movements (constipation often accompanies opiate use), sensory awareness, and the capacity to menstruate. In 'normal can be boring', Nettleton and colleagues noted that the return to a 'normal' life is sometimes represented as something to be feared. The research team raised a salient issue in noting that recovery discourses construct any drug use (including alcohol) as a failure. Even if recovery is achieved, conventional activities such as going out for a drink remain out of bounds for former drug users. This tied in with the 'normal drug use is problematic' repertoire or discourse. Nettleton and colleagues found that people in recovery are fearful that everything they do will be scrutinised, subjected to the public gaze. Drinking a few pints may be constructed as a relapse - social lubrication repositioned as 'drug using behaviour. Some respondents, having internalised full recovery discourse, felt a need to consistently self-scrutinise less one joint or one alcoholic drink reproduces active addiction.

Nettleton et al. (2012) also assert that by having 'embodied normality' (p.9) in conjunction with the stability produced by involvement in mainstream practices, non-dependent substance use may be feasible, contradicting the populist construction of recovery as total abstinence. Indeed, some respondents positioned the desire to again be able to have

a drink (or joint) without devastating consequences as the overarching purpose of their recovery engagement. One interviewee explicitly dismissed becoming 'squeaky clean' as a desirable goal. Indeed, these 'precariousness features of normality' (p.183) are, in Nettleton et al's view, exacerbated by 'full recovery' discourse and the reproduction and reinforcement of total abstinence as the only feasible recovery option. So, whilst respondents had a desire to leave chaotic use behind, negotiating 'normality' was replete with tensions and contradictions. Conventional life, for some, represented boredom and monotony, both of which are detrimental to sustained recovery. Activities that 'normal' people engage in (a drink to wind down after work or enjoy at the weekend for example) are *perceived* as out of bounds. Moreover, this type of purposeful abstinence actually positions these individuals as *un*conventional, *re*producing the sense of otherness that being 'in recovery' is assumed to resign to the past.

The research carried out by Nettleton and colleagues (2012) but also that conducted by McIntosh and Knight (2000) and Gibson et al. (2004) all lend support to Nugent and Schinkel's (2016) claim that although widely represented as positive event, long term desistance – the process of 'going straight' (Maruna, 2001) - can be a painful and highly challenging process. This assertion is reinforced by Wakeman's (2016) findings as previously discussed, including the idea that prolonged emersion in a drug-using culture produces a stark disconnect from conventional society; not only do 'users' become 'bond partners' who rely on one another for material and emotional support but the skill-sets so essential for survival within this (sub)cultural context, have no utility within 'conventional' society. These circumstances, it can be reasonably assumed, would abate any desire to (re)enter the mainstream.

In sum, recovery as a concept contains the presumption that former drug users are deviant and require restoration in line with 'acceptable' social, emotional and physical standards. To desire normality is, then, both a private and public issue. For many former drug users the negotiation of

normality is precarious, the boundaries of *their* normality constrained. Postmodern notions of diversity as the 'new normal' is not extended to people with a history of drug addiction (Nettleton et al. 2012). What is more, the stigmatised status often accrued during periods of active drug use can remain regardless of whether a drug-free state has been achieved and retained (Clark, 2005).

As Nettleton and colleagues allude to, former drug users in England (and thus this study's participants) are neoliberal subjects. Neoliberalism is *the* dominant (secular) discursive formation in Western societies including the UK, framing and influencing the lives of most if not all British citizens. The various social discourses and other cultural resources highlighted in this literature review reflect Neoliberal ways of knowing. This study will build upon Nettleton et al's (2012) findings by exploring where relevant the extent to which a range of neoliberal discourses shape the subjectivities and permeate the narratives of both Christian and non-religious respondents.

2.12 Societal Barriers to Recovery

The literature reviewed so far has highlighted personal and contextual difficulties that may be confronted during the recovery process and constrain the formation of a non-drug using identity. These include issues relating to self-esteem, movement away from drug using peers, family-relational problems, the embodied manifestations of chronic addiction and integration into 'normal' society. Moreover, the socioeconomic deprivation often experienced during periods of active addiction does not simply dissipate alongside the decision to pursue recovery. These issues are all significant but perhaps most dis-abling of all in relation to recovery and mainstream reintegration is the social stigmatisation of those who are drug dependent or are known to have a history of addiction. Defined as an indelible stain that makes a person unacceptable to others (UKDPC, 2010a) stigma is intrinsically connected to stereotyping, prejudice and discrimination (Lloyd, 2010a) and forms a major barrier to recovery from drug dependence. It is an obstacle invariably facilitated through language.

Terms commonly employed to denote drug users ('junkie', 'smackhead', 'crackhead' and 'speed-freak' for example) by the media and lay people alike, may undermine a person's willingness to access treatment that is constructed as the preserve of 'thieving junkie scumbags' (Radcliffe and Stevens, 2008), restrict their capacity to reintegrate socially (Travis, 2010a) and hamper employment and other opportunities.

Indeed, gainful employment has been positioned within UK drug strategies (Home Office 2010; 2017) and England's 'recovery roadmap' (HM Government, 2012) as a vital element of recovery capital and a 'best practice outcome' that service providers and users must strive to attain (Home Office, 2010; Putting Full Recovery First, 2012). Many of the obstacles the former drug user may confront with regards to employment originate in childhood, persist and escalate during school years and cumulate in social isolation and a dysfunctional lifestyle in adulthood (Klee et al., 2002). Kemp and Neale (2005) concluded that the chaotic lifestyle of many drug users, ineffective treatment services and negative views held by employers combine to produce a significant obstacle to securing paid work. What is more, evidence offered by the UKDPC (2008) suggests that most employers would refuse to hire persons known to have a history of drug dependence even if they were otherwise suited to the job.

For many former problem-drug users, before entry to gainful employment can be even considered other 'primary' issues must first be addressed (Klee et al., 2002; Kemp and Neale, 2004; Spencer, et al., 2008; Singleton and Lynam, 2009; Simonson, 2010). For example, finding and sustaining appropriate, secure and stable accommodation, addressing physical and/or mental ill health, and accessing both formal and informal support are all 'primary issues' that need to be attended to before key issues related to employment – becoming 'work-ready' for example – can be tackled (Spencer et al., 2008; Kemp and Neale, 2005). As discussed below, research on addition stigma indicates that dismantling the barriers that negate recovery attempts will be a long-term task.

Research carried out by Loughborough Communications Research Centre (2010) highlights how media discourse consumed by millions of British citizens produces, reproduces and reinforces constructions of current and recovering drug users as bad, dangerous and to blame for their predicament. A drug using self-identity intersects with social class, gender and ethnicity, producing multiple barriers to recovery. Lloyd's (2010a) review of relevant literature concluded that a 'lifetime stigma' attached to problematic drug use may prevent access to adequate housing and public and health services. Indeed, McLaughlin's (1996) extended literature review concluded that negative and stereotypical views held towards drug using clients by many health care professionals often translates into ineffective and inhumane care. Moreover, as already alluded to, derogatory labels continue to be applied to former or recovering drug users *regardless* of prolonged stability (Clarke, 2005). Indeed, for those with a history of drug-related issues, the label of 'problem drug user' can become a 'master status' and obscure other aspects of self-identity (Lloyd, 2010a). In sum, stigma facilitated by politicians and the media can have profound implications for both active and former drug users in terms of self-concept (Rees, 2010) and their capacity to engage in conventional life itself. To return to Nugent and Schinkel's (2016) study, these societal and relational barriers to recovery contribute to the widely ignored yet present and interconnected 'pains of desistance' encompassing social isolation, goal failure and hopelessness.

People who are attempting to overcome addiction already face an uphill struggle in dealing with the physiological, psychological, relational and societal implications of long-term addiction, the interrelation of which produce a significant barrier to sustained recovery. Unfortunately, the anti-stigma campaigns and anti-discrimination legislation that have been introduced in the US to facilitate recovery from addiction (see Faces and Voices of Recovery, 2019; Landry, 2012) have not been reproduced in Britain. Despite the *clear and well-researched* links between stigma and unsuccessful recovery attempts, the UK government has failed to address negative conceptions of current or former drug users. Indeed, medication-

assisted treatment and, by association, people in medication-assisted recoveries (MAR) are openly disparaged by some politicians and commentators (see Holehouse, 2014; Gyngell, 2011). Although as noted above, discourses including those that position the drug user as 'other' *can* be resisted or rejected and alternative identities claimed, their reproduction and reinforcement in political and media rhetoric has produced notions of the 'tainted addict' as a societal 'truth'. This, I would argue, can only undermine the capacity to 'recover' from drug addiction.

2.13 Conclusions

This chapter has covered a lot of ground and the conclusion will draw attention to points which I consider to be most salient to this thesis. So in conclusion, people with a history of addiction are positioned in a range of intersecting social and institutional discourses which shape their conceptions of self and how they are conceived by others. However, in opposition to discourse deterministic approaches, I argued for the need to also account for the human capacity to *resist and utilise* discourse, hence justifying the *synthetic* discourse analytic framework employed in this thesis. The literature on problematic-drug initiation and continuation raised interesting points. Movement into the drug using lifestyle involves other people and is usually a steady process rather than a dramatic decline often in a context of socioeconomic deprivation. I highlighted how this period of regress aligns with the canonical notion of a 'descent' or 'downward spiral' into addiction. Notions of a 'moral economy' between active drug users yielded interesting and though-provoking findings that disrupt normative assumptions. With regards to recovery as a concept the debate continues with 'experts' still unable to reach a recovery consensus. For me, 'recovery' is a subjectively experienced process and simply does not lend itself to objective definitions and measurability. Hence any consensus attempt, but particularly one that incorporates the diverse views of former drug users, is an exercise in futility. Turning points that precede recovery attempts are also diverse and plentiful but tend to coalesce around significant life events both positive and negative. The

drawbacks of quantitative research focused on ascertaining the *meaning* of recovery were noted, further justifying additional qualitative inquiry. More recent qualitative research on recovery processes tends to have a constructionist flavour with an emphasis on narrative identity reconstruction with some attending to the extra-discursive dimensions of recovery. Specifically discourse analytic research draws attention to how neoliberal discourses of 'normality' shape former drug user aspirations. Moreover, discursive research highlights how 'expert' and 12-step discourses permeate the accounts of people who access community treatment and 12-step recovery respectively with religious discourses resourcing the construction of ex-user testimonies. The tendency of existing discursive research to focus only on treatment and recovery gives credence to my decision to broaden the scope and explore the construction of addiction-to-recovery trajectories. Finally, stigma was highlighted as a significant barrier to recovery, a barrier that I argued is exacerbated by the British government's failure to act.

To finish, although existing research yields interesting insights into *what* (former) drug user's say about their lives, the application of a synthetic discursive lens will attend to how discourses and narratives shape how former drug users experience self and the world *and* how their addiction-to-recovery trajectories are discursively accomplished. It will draw attention to participants' identity work and the implications of being already positioned within a particular treatment and/or recovery system. This extended and dual focus will offer unique insights and a new dimension to existing qualitative research on addictions and recoveries in Britain.

CHAPTER 3

Drug Policy Perspectives

3.1 Introduction

Chapter 2 contextualised the topic and discussed discourses and their implications before critically reviewing the literature pertaining to different aspects of drug initiation-to-recovery trajectories. In this chapter I focus on British and specifically English political responses to problem-drug use in chronological order from the early 1900s to the present day. My decision to review policy frameworks was influenced by the assertion that official documents governing addictions and related issues are taken for granted and evade critical scrutiny (Taleff and Babcock, 1999). What is more, the discursive remnants of historic policy frameworks still pervade the contemporary landscape and in conjunction with recent policy papers form part of the discursive backcloth that I argue frames the drug user in particular ways, constitutes (former) drug user subjectivities and resources their talk. Before discussing specific UK drug strategies I first briefly outline the implications of devolution in the context of drug policy throughout the UK.

3.2 UK Drug Policy in the Context of Devolution

Although the term UK drug policy will be widely used in this chapter, as UK Drug Strategies produced in Westminster are national in scope *to an extent*, devolution has rendered their application more complex. Simply put, Britain as a whole is governed by and must abide by UK drug *law* developed in Westminster, namely The Misuse of Drug Act 1971 and the Psychoactive Substances Act 2016, as well as drug-*related* policy areas that are not yet devolved. Within post-devolution UK Drug Strategies, references to criminal justice and policing apply only to England and Wales while references to work carried out by the Department for Work and Pensions apply to England, Wales and Scotland. Wales, Scotland and Northern Ireland are however individually responsible for areas including health, housing, social care and education and have been handed the

power to decide how they will address drug-related problems in terms of the delivery of treatment and recovery interventions (Barber et al., 2018).

As each country has its own strategy regarding the devolved areas highlighted above, references to these areas in the UK Drug Strategies of 2010 and 2017 apply only to England. Moreover, as the focus of the proceeding discussion is primarily treatment and recovery policy (a devolved element), the recovery strategies introduced by each devolved nation will not be detailed. Putting Full Recovery First (PFRF) 2012 is the strategy document that currently guides approaches to treatment and recovery in England. Most devolved administrations have also 'jumped on the recovery bandwagon' so to speak with only Wales' strategy always retaining a clear focus on harm reduction. With that said, Scotland have recently introduced a new strategy with a more explicit focus on reducing drug-related harms (Scottish Government, 2018).

Having briefly clarified devolution in relation to UK drug policy, the ensuing discussion will draw attention to shifts in the focus of British drug policy over time and the impact that drug policy has had and is having on active and 'recovering' drug users. To begin, the historical context of British drug policy from the early 1900s will be briefly covered, drawing attention to salient turning points. The latter section on contemporary policy takes 2010 as its starting point when the UK Coalition government was voted into power. This constituted a moment sea change – a seismic shift in policy focus – and some time will be spend covering the Coalition's 2010 UK Drug Strategy before the current Conservative government's 2017 UK Drug Strategy is brought to bear. Although the aforementioned publication of the strategy document PFRF 2012 was also a salient political event, this document is the object critical analysis in Chapter 5 and is only briefly reviewed in this chapter.

3.3 British Drug Policy: Historical context

With origins that can be traced back to 19th century discourses of degeneration and eugenics, the term 'problem drug user' first emerged in relation to policy and research discourse over three decades ago,

cohabiting the drugs field alongside earlier concepts of ‘addiction’ and ‘dependence’. Although the Wood Committee on Mental Deficiency and the subsequent Wood Report 1929 identified the existence of ‘problem social groups’, to reiterate a point made in the previous chapter, the ‘problem drug user’ (PDU) was invented in 1982 by the Advisory Council on the Misuse of Drugs (ACMD), creating a new kind of person (Seddon, 2010a). The term and its subsequent prominent usage coincided with the development of what is now widely known as ‘the drugs problem’ - the widespread use of drugs by young people for recreational purposes and a new and unprecedented wave of heroin use in deprived urban areas that produced a sizeable population of so-called problem drug users who were positioned as harming self and society at significant cost to the British economy (Lloyd, 2010).

Although the notion of ‘recovery’ in relation to addiction is a relatively recent one adopted from the field of mental health (Watson, 2013), treatment for addiction per se has a varied political history. The Rolleston Report of 1926 first introduced the concept of replacement prescribing for heroin addiction with GPs prescribing pharmaceutical grade heroin (and cocaine) to a small number of largely middle and professional class drug users. This practice continued until the early 1960s when the increasing pervasiveness of illegal drug use among populations officially constructed as a societal menace, instigated alterations to this ‘relatively benign and homegrown approach’ (Webster, 2007, p.150) dubbed ‘The British System’.

The gradual emergence of drug use as a moral issue can be linked to a ‘creeping moralisation’ (Monaghan. 2012, p.30) that arose in social policy more generally, underpinning political interventions that seek to alter the behaviour of ‘problematic’ populations while ignoring the deeper issues underlying the behaviours they display (Monaghan, 2012). Monaghan’s (2012) observations relate to those made by criminologist David Garland with regards to the emergence of an anti-welfarist agenda. Garland (2001) highlights the movement away from modernist penal policies

centred on rehabilitation and the environments that *produce* criminality to late modern retributive state interventions that disregard the productive effects of wider social factors. These changes, Garland (2001) argues, are indicative of wider shifts in cultural attitudes towards crime since the 1960s and the subsequent introduction of populist policies and interventions shaped more by media discourse and public opinion than expert knowledge and evidence. Related discourses of individualisation and responsibilisation are central components of political texts on addiction and related issues to this day.

In 1960s Britain, the rise in 'addict' numbers and emergence of a drug-using subculture was attributed primarily to the over-prescribing of heroin by a small number of medical practitioners, some of which found its way on to the black market. The Dangerous Drugs Act of 1967 reduced significantly the availability of prescribed pharmaceutical heroin. In addition, Drug Dependency Units (DDUs) were established with only specially licensed doctors handed the power to prescribe (Seddon, 2007, p.64). Where before drug users may have been considered 'different', increasing numbers produced the notion of drug users as 'dangerous other'. Further restrictions on prescribing practices were introduced with addiction treatment positioned as a specialist activity. Moreover, the contested principle upon which contemporary drugs law is based – that the state is responsible for the prevention of harm to individuals and wider society – was later enshrined in The Misuse of Drugs Act 1971 (Shiner, 2006, p.61), legislation which, as noted in Chapter 2, remains in place to this day.

Following a period of stabilisation during the 1970s, the early 1980s has been described as a 'watershed' moment for British drug policy making (Monaghan, 2012). Prior to this point 'the drugs problem' did not, in discursive terms, exist (Seddon, 2006, p.682). An influx of heroin into Britain's poorest communities and the spread of HIV/AIDS and its link with injecting drug use as well as a surge in 'addict' numbers located primarily in areas of high deprivation and unemployment, instigated the emergence

of a ‘significant harm reduction alliance’ (Monaghan, 2012, p.30). Various actors, mainly external to government, lobbied for drug policy based on a pragmatist philosophy, arguing that drug users should have access to needle exchange services, health education, free condoms and flexible prescribing of methadone (Robertson, 2007 cited in Monaghan, 2012, p.30). This era of harm reduction is characterised by Stimson (2000) as the healthy chapter of British drug policy. However, for Hunt and Stevens (2004), the focus on health occurred, not out of concern for people who use drugs, but the perception that problem-drug users are responsible for transferring HIV/AIDS to ‘mainstream’ populations. This point is reinforced by Blank (2002) who asserts that the health and wellbeing of people who use drugs *has never* been the primary concern of UK policymakers.

As alluded to above, in policy discourse, problematic-drug use is conceived as residing predominantly in the individual with the impact of structural and contextual factors comparatively neglected (Hughes, 2007). This ‘tendency towards ontological individualism’ (Hughes, 2007, p.673) is highlighted and rejected by Buchanan and Young (2000) who posit a direct link between the endemic drug use of the time and the 1980s recession when entire communities were destabilised by deindustrilisation (also see Seddon, 2006). The consequent dearth of apprenticeships and factory work rendered a generation of school leavers surplus to requirements. These victims of the ‘New Right free-market revolution’ (Buchanan and Young 2000, p.3) turned to the euthanising properties of heroin to veil their socioeconomic realities. However, evidence of a link between socioeconomic deprivation and addiction (Seddon, 2006) were dismissed by UK Prime Minister of the time Margaret Thatcher. Rather, Thatcher and the US President pronounced the ‘addict’ as a new adversary (Buchanan and Young, 2000) with political campaigns on both sides of the Atlantic positioning the ‘problem drug user’ as a social pariah, threat to community cohesion and a risk to life (Buchanan and Young, 2000). This is consistent with Garland’s (1996) assertion that in late modernity a ‘criminology of the other’ constructs ‘problem populations’ as morally challenged and ‘threatening outsiders’ (Garland, 1996, pp.461-462).

Moreover, a 'crime complex' characterises many contemporary Western societies, triggering hostile responses towards the disruptive effects of criminal activity on conventional life. In so doing, attempts to 'understand the offender' have been undermined while condemnation of those who are deemed to transgress normative notions of good citizenship have increased (Garland, 2000, p.200).

The 1995 UK National Drugs Strategy: Tackling Drugs Together ushered in what Stimson (2000) disparagingly referred to as the crime phase of UK drug policy. Although public health concerns remained, drug-related crime took precedence (Hunt and Stevens, 2004). Central to the 1995 strategy was the premise that drugs and criminality were intrinsically linked and that by 'treating' drug users, either voluntarily or through compulsion, crime rates would fall. Despite research revealing the drugs-crime link as an unsupported assumption (Seddon, 2000), in Monaghan's (2012) view it is largely on this premise that drug policy has been formed with some commentators arguing that the 'War on Drugs' itself handed governments a plausible rationale to implement populist measures in the context of crime control per se (Garland, 2018). For Buchanan and Young (2000), British drug policy since the 1980s has been 'ill considered, reactive and counter-productive' (p.1). Rather than improving the situation, drug policy as exacerbated existing problems and has contributed towards the production of an environment in which drug use has flourished. Indeed, a seminal 2012 report noted that many members of the wider public, and indeed politicians, believe that drug policy in Britain has been largely ineffective - it has failed to curb the harm that drugs can cause (UK Drug Policy Commission (UKDPC), 2012).

In 1997 Tony Blair's New Labour government introduced a ten-year strategy: Tacking Drugs to Build a Better Britain (1998-2008). The 1998 Crime and Disorder Act (Monaghan, 2012) introduced the Drug Treatment and Testing Order (DTTO). The DTTO was targeted specifically at drug users who funded their addiction through crime. Moreover, it gave courts the power to sentence drug-using offenders to treatment, supplemented

with random drug screening (Seddon, 2010b). However, claims that the link between drug use and crime is 'undisputable and uncontroversial' (Seddon, 2010b, p.96) is a contested assertion (Seddon, 2010b). The 1998 strategy (updated in 2002) also highlighted the need to increase numbers of people entering treatment and the provision of adequate funding. Another central tenet of drug treatment at this time involved the long-term prescribing of methadone, the efficacy of which has been the subject of fierce and prolonged contestation and debate (Monaghan, 2012; Gyngell, 2009; DrugScope, 2009a; Drug Policy Alliance, 2012; Eastwood et al., 2018).

In 2008 New Labour introduced another ten-year strategy: 'Drugs: Protecting Individuals, Families and Communities'. Where from 1998 the primary emphasis of policy was crime reduction in conjunction with long term methadone treatment, the 2008 strategy made explicit the need to 'encourage' behavioural change (Monaghan, 2012, p.34). This reflected wider New Labour social policy developments of the time, with notions of support and correction progressively intertwined (Monaghan, 2012, p.35). For Wincup (2011), this shift in emphasis was influenced by concerns that an estimated 100,000 drug users were reliant on state benefits yet failing to tackle the root of their dependency. In Monhagan's (2012) view, the consequent adoption of a carrot and stick approach where non-engagement with treatment could trigger loss of state benefits, was designed to enable dependent drug users to avoid the moralistic 'sin of worklessness' (p.35). The political emphasis on behavioural change and abstinence was a 'line of continuity' between the 2008 National Drug Strategy and the approach adopted in by the Conservative-Liberal Democrat coalition government in 2010 and then the Conservative government in 2017, albeit under the guise of 'new recovery'.

3.4 The 'New Recovery' Era in British Drug Policy

Though drug policy development has historically been characterised by common-sense, compromise and a flexible approach (Duke, 2013), under the British government elected in 2010 a new discourse of 'full recovery'

emerged (Duke, 2013), establishing a direction of travel subsequently continued by the current Conservative minority government. Watson (2013) argued that the 2010 Drug Strategy, although supposedly based on evidence, threatened to harm and marginalise drug users further still. Stimson (2010) suggests that the Coalition's intention was to shape drug treatment founded on an assumption that people experiencing drug problems are 'a burden on the state' (p.2). The following considers the 'recovery' section of the 2010 UK Drug Strategy with an initial discussion of the consultation process on which it was (supposedly) founded. This will be proceeded by critical commentary of the 2017 Drug Strategy published by the Conservative government elected in 2015. The government's 2012 'recovery roadmap' for England - Putting Full Recovery First - is the object of in-depth analysis in Chapter 5 so here will be only briefly previewed. Before drawing conclusions, the aftermath of the political shift to full recovery as an addiction treatment agenda will be critically considered.

3.41 The 2010 Drug Strategy: Consultation Process

The 2010 National Drug Strategy consultation process elicited a range of views and perspectives, the majority of which alluded to the need for a diverse range of treatment interventions. DrugScope (now DrugWise), the national membership organisation for the drugs field, welcomed the emphasis on creating a recovery-orientated system yet highlighted also the crucial importance of continued investment in harm reduction services. This sentiment was echoed by other organisations (UKDPC, 2010b, Transform, 2010, Release, 2010, UK Harm Reduction Alliance (UKHRA), 2010; Royal College of Psychiatrists, 2010), some of whom called into question the minimal timeframe allowed for consultation, lack of impact assessment (UKDPC, 2010b, Transform, 2010, Release, 2010) and limited evidence underpinning the proposed changes (Release, 2010, Transform, 2010). The requirement to abide by treatments with internationally proven efficacy and recognition in National Institute of Clinical Excellence (NICE) guidance was also brought to bear (UKDPC, 2010b; Royal College of Psychiatrists, 2010, UK Recovery Federation,

2010) along with the need to embrace medication-assisted and other recovery pathways (UK Recovery Federation, 2010). The greatest return on investment, according to UKDPC (2010b), would be found by ensuring availability and quality and through offering a 'broad range of treatment and recovery options' (p.8). However, not all respondents supported all treatment options with medication-assisted treatment (MAT) using methadone singled out as particularly problematic.

The Addiction Recovery Foundation (2010) criticised the substantial increase in spending on methadone since the National Treatment Agency (NTA) was formed in 2001, stating that governments initial task should be to move people off tax-funded methadone prescriptions and into abstinence-based treatment. A similar critique was presented in the Centre for Policy Studies (CPS) report: 'The Phony War on Drugs' (Gyngell, 2009). The CPS criticised extensive use of methadone and the lack of access to residential rehabilitation. Gyngell (2009) argued that this situation (widespread methadone prescribing) had been created by the drug treatment field's extensive adherence to National Institute for Clinical Excellence (since 2013 the National Institute for Health and Care Excellence (NICE)) guidelines. This, Gyngell claimed, is because the NICE evidence-base is confined to 'clinical treatments' – hence professionals are restricted in terms of the knowledge on which they can draw (p.36).

In response to what they described as a polarised and damaging harm reduction versus abstinence argument, SMART Recovery (2010) recognised the value of a more ambitious treatment system while highlighting also the diverse ways in which clients themselves construct abstinence and recovery. SMART Recovery pointed out that for some individuals, abstinence and meaningful recovery may involve the use of anti-depressant medications whereas others see methadone as consistent with their personal vision of recovery, enabling them to find employment and social stability. Although SMART Recovery endorse abstinence as an ambition, they argued that any move to make medications a 'sine qua non of recovery' (p.2) would be both fruitless and unconstructive, a position

endorsed by others (Lloyd, 2010a). The strategy published following the consultation - 'Reducing Demand, Restricting Supply and Building Recovery: supporting people to live a drug free life' (HM Government, 2010) – appeared to take at least partial account of the differing philosophies within the drug treatment field.

3.42 The 2010 National Drug Strategy

In terms of addressing supply and demand, the coalition government's 2010 national drug strategy adopted a similar approach to previous drug strategies. One significant divergence between the 2010 strategy and previous drug strategies was the ambition to enable every service user to 'choose recovery' by putting in place appropriate support structures. Recovery, as a concept, was described as a person-centred journey based on the three principles of 'wellbeing, citizenship, and freedom from dependence' (p.18).

Another key component of the new agenda focused on the development of a new and ambitious workforce and their role in enabling individuals to draw upon their 'recovery capital', namely 'the sum of resources necessary to facilitate recovery from drug dependence' (Best and Laudet, 2010, p.2). Recovery capital in official terms comprises social capital (relationship building including two-way obligations), physical capital (for example money, employment and safe accommodation) human capital (including skills, overall wellbeing, hopes and aspirations) and cultural capital (personal values, attitudes, beliefs) (HM Government, 2010; Westminster Drug Project, 2013). The strategy also called for various 'best practice outcomes' including freedom from dependence, prevention of drug-related deaths and blood-borne viruses, a reduction in crime and re-offending, sustained employment, improved physical and mental health and the capacity to be an effective and caring parent.

The 2010 UK Drug Strategy, moreover, advocated the development and implementation of 'Recovery Champions' whose role it would be to 'spread the message that recovery is worth aspiring to' (p.21). The introduction of the 'recovery champion' is indicative of a 'responsibilisation strategy'

whereby agents of the state work to solicit non-state actors who can contribute towards the resolution of social problems in the belief that such contributions are in their own best interests (see Garland, 1997, p.188). Key structural changes included the transfer of functions from the National Treatment Agency to Public Health England (PHE) and a new system of 'payment-by-results' (PBR) where, rather than numbers accessing and being retained in treatment, payment for providers accords with pre-defined 'recovery outcomes' with an emphasis on treatment exits. Despite views expressed during consultation, the position of 'substitute' medications and other harm reduction measures received little clarification. Whilst acknowledging the existence of people in medication-assisted recovery, the strategy also insisted that '*all* (my emphasis) those on a substitute prescription must engage in recovery activities to increase numbers who leave treatment each year free from all chemical dependency (p.18). Indeed, the strident anti-methadone and anti-harm reduction rhetoric that characterises the government's recovery roadmap for England - Putting Full Recovery First 2012 - indicates that the inclusion of references to 'medically assisted recovery' within the 2010 National Strategy may have been a decision based on a requirement to *sound* 'evidence-based' as opposed to a choice motivated by genuine desire.

3.43 Responses to the Strategy

In response to the 2010 strategy, DrugScope (2010) welcomed the pledge to build upon progress so far and commitment to multi-agency working. The ambition to create a more recovery-orientated system (National Treatment Agency (NTA), 2010) and adherence to person-centred and evidence-based practice (DrugScope, 2010) were also well received. However, the potential difficulties involved with delivering services in a time of 'policy change, uncertainty and spending cuts' (DrugScope, 2010) were accentuated with the new system of PbR described as a 'social experiment on a particularly vulnerable group' (Roberts, 2011, p.30).

For Gyngell (2011), the strategy failed to put a much needed 'cap' on methadone prescribing, asserting that the cost of methadone had reached

£750 million a year. In response, DrugScope accused Gyngell of 'grossly exaggerating' the cost of methadone treatment, pointing out that the £750 million figure in fact constituted the entire drug treatment budget. Furthermore, DrugScope highlighted the right of all patients to access evidence-based treatment under the NHS Constitution and the potential for stigma accrued from representations of methadone treatment (an evidence-based medical intervention) as merely entrenching addiction (see Harm Reduction Alliance, 2011). This exchange exemplifies the previously noted harmful and polarised debate (SMART Recovery, 2010) between advocates of harm reduction interventions and medically assisted recovery and those who believe all treatment and recovery pathways should be geared solely towards abstinence.

Three years on from the 2010 strategy's introduction Watson (2013) published an extensive critique, stressing the limited pre-strategy consultation and underlining the negligible evidence-base on which the strategy was based. Watson, moreover, argued that applying a system of payment-by-results to drug treatment would produce 'cherry-picking' of those clients most likely to offer the greatest financial reward, thus marginalising the more complex cases. Duke (2013) concurred with Watson in stating that more affluent clients with high levels of or access to recovery capital are likely to be advantaged in ways that those from more deprived areas are not. Watson (2013) also emphasised the huge challenges involved in developing a successful recovery-orientated system in a context of austerity

Other critiques focused on the removal of a ring-fenced budget for drug treatment and transferal of National Treatment Agency (NTA) functions to Public Health England (PHE). Watson (2013) argued that without ring-fenced funding, financially stretched local authorities would in all likelihood direct money towards causes deemed more deserving of public money. Also highlighted were failures to address addiction-related stigma (Watson, 2013) and other social and structural factors which hinder recovery (Duke, 2013) were also highlighted. It is an example of public

sentiment and political ideology combining to produce ill-informed interventions and, in so doing, contributing to the othering of already marginalised groups (Garland, 2000). Although rhetorically the 2010 strategy *exuded* an evidence-based and inclusive aura, Watson (2013) claims that a number of stated policy objectives were undermined by the government's broader political agenda and the populist proclamations of high-ranking Tory politicians.

Another critique emerged based on findings from a qualitative study by Neale at al. (2013) who concluded that a focus on full recovery is pushing people prematurely towards abstinence with negative consequences including 'cross addiction and relapse' (p.168). Watson (2013), moreover, asserted that political and media discourse represents those in receipt of prescribed methadone as the 'epitome of the undeserving poor' (p.294). This point is particularly significant when considered alongside Wiggan's (2012) assertion that official discourses of worklessness and dependency divert public attention away from Britain's economic instability while re-asserting the validity of behavioural explanations for social problems. This interpretive framework positions drug service users who are unable to attain and sustain abstinence as responsible and 'to blame' for a predicament produced by the failures of neoliberal government. These last points were reflected by Luty (2013) who, writing in the British Medical Journal, argued that the Government's recovery agenda is really to do with 'recovery from economic recession' (p.29) and the apparent 'need' to drastically reduce public spending.

In 2017 another long-awaited English Drug Strategy was published. BBC correspondent Mark Easton reported in 2016 that one would imagine that the record high drug related deaths in Britain since 2010 would prompt government to introduce a 'robust and effective strategy' for addressing the crisis. However, as Easton confirmed, Ministers quietly abandoned the idea of a formal consultation and the 2017 Drug Strategy briefly discussed below (there is little in the way of new information) was published *within* government and *without* meaningful public discussion or debate.

3.44 The 2017 UK Drug Strategy

The 2017 Drug Strategy is notable only for how remarkably similar it is to its predecessor (Winstock et al., 2017). A new sub-section on 'Global Action' (p.39) now accompanies 'Reducing Demand', 'Restricting Supply' and 'Building Recovery'. Reducing Demand does draw attention to emergent concerns and vulnerable groups including users of New Psychoactive Substances (formerly known as legal highs), those who engage in 'chemsex', an ageing cohort of heroin users, the homeless, sex workers and war veterans but offers little in the way of workable solutions. In 'Restricting Supply' the focus remains very much on tackling criminality with additional sub-sections on the new drug driving laws and the Psychoactive Substances Act 2016 as well as a need to address drugs dealing via the internet.

The overarching messages emanating from the 'Building Recovery' section of the 2017 strategy mirrors those contained in both the 2010 strategy and the 2012 report 'Putting Full Recovery First' (see below). Rhetorical constructions including 'Our ambition is for fewer people to use drugs in the first place but for those who do [...] we want to help them stop and live a life free from dependence' (p.6) along with 'We must go further' [...] 'We will raise our ambition for recovery' and 'no-one should be left behind on the road to recovery' (p.28) prompted Winstock et al. (2017) to conclude that the 2017 strategy continues where its forerunner left off. What is more, assurances contained within the strategy regarding use of the evidence-base to support recovery are not new as Putting Full Recovery First also makes these proclamations. In fact, for Stothard (2017), the 2017 strategy overtly 'dismisses or ignores' clear evidence provided by the AMCD in relation to the unprecedented number of drug-related deaths.

Writing in the British Medical Journal, Ford (2017) expressed immense concern over the continued absence of a harm reduction focus. Moreover, a critical review released by the Harm Reduction Alliance – a coalition of organisations including the National Aids Trust, Substance Misuse

Management in General Practice and the International Drug Policy Consortium - reiterated Ford's concerns. Limb (2017) highlights cuts to substance misuse treatment - £22 million in 2017 alone, a fall of 5.5% since 2014-15 while Stothard (2017) refers to the 2017 strategy as 'an idealised ambition with little basis in reality' (Abstract). In short, positive commentary on the 2017 strategy is difficult to find. Albeit the recovery rhetoric is perhaps less strident than that in Putting Full Recovery First 2012, the overarching focus - drug free treatment exits driven by payment-by-results - remains intact.

3.45 England's 'Recovery Roadmap': A brief overview

As alluded to above, sandwiched between the 2010 and 2017 UK Drug Strategies the Government published a document focused solely on treatment and 'recovery'. As Putting Full Recovery First (PFRF) is the focus of Chapter 5 it is not discussed here in any depth with the rationale for selecting PFRF as a data source presented in Chapter 4.

Briefly here though, during the early stages of working on this thesis I noted the following …

> *'It is my opinion that practical implementation of the guidelines contained with the recovery roadmap have the capacity to inflict great damage on people who use or are attempting to stop using drugs not to mention their loved ones and wider society'*

The link between 'full recovery' ideals as expressed in PFRF and the record numbers of drug-related deaths in the nine years since 2010 suggest that my intuitive comments were accurate. Worryingly, there is no indication that the aims and objectives stated in 'the roadmap' have been withdrawn or revised despite multiple warnings against an *exclusive* focus on abstinence at the expense of harm reduction (Strang et al., 2012; ACMD, 2016; Stothard, 2017). For Fernandez' (2018), full recovery is superseding the health needs of drug service users. The guidance contained within PFRF continues to be relevant, the consequences damaging.

In sum, PFRF is a poorly written document, its content apparently driven more by ideology then evidence. Indeed, PFRF has received little if any 'expert' support of note, an example of how professional expertise is losing influence, downgraded in favour of reactionary measures driven by public sentiment (Garland, 2001). Nonetheless, it is utilised as guidance by (some) treatment providers who, incentivised by PbR, are required to focus on treatment exits regardless of the consequences to individuals, families and communities. For these reasons and for others later explained this text was initially and remains still the focus of analytic attention in Chapter 5.

3.46 Full Recovery: The Aftermath

With criticisms relating to both 2010 and 2017 National Drug Strategies were noted above, the focus here is on the full recovery agenda more broadly. Despite the publication of official impact assessments (Home Office, 2010) and reviews (Home Office, 2015) of the 2010 Drug Strategy, Drug and Alcohol Findings (2017) draw attention to 'gaps in evidence' which render partial any conclusions that have been drawn. Evidence relating to cost-effectiveness is incomplete and benefits associated with structured treatment, although officially positioned as 'robust', have been based on 'questionable assumptions' (Drug and Alcohol Findings, 2017).

As previously alluded to, what *has* come to light since 2010 are substantial increases in drug-related deaths which at 3756 in 2017 are at record levels. Although many factors are thought to have contributed to this situation including changes in the type of substances consumed (O'Connor, 2018), it is telling that the Advisory Council on the Misuse of Drugs (AMCD, 2016) found that the biggest increase relates to opioid use.

The AMDC (2016) conclude that key drivers of opioid-related deaths include an ageing population of heroin users, the higher purity of street heroin and rising levels of deprivation as well as local government funding cuts and 'changes to the commissioning and provision of treatment services' (p.23). The political implementation of full recovery and associated drive to move people out of treatment has produced risky

practices within treatment services. One such practice is the sub-optimal dosing of methadone and other medications used in MAT which increases the risk that service users will 'top-up' with illicit substances and/or drop-out of treatment altogether. Exerting pressure on clients to leave treatment before they are ready to do so is also linked to overdose and death. Moreover, the recommissioning of services and regular changes of treatment provider have been linked to 'arbitrary changes to the conditions attached to individual clients' based more on ideology than clinical need (AMCD, 2016, p.27). Rejecting research evidence and the advice of experts in favour of public sentiment and political ideology leads to punitive and ill-informed policies (Garland, 2000) - contemporary drug policy making appears to be a case in point.

The AMCD (2016) also draw on conference presentations by Dennis (2016) and Flood (2016) as evidence that some services are failing to provide treatments that reduce drug-related harms *or* enhance recovery. Feedback from service users indicate that some services are disregarding national clinical guidance by imposing time-limits on the duration of methadone and buprenorphine treatment, imposing dose reductions regardless of clinical need, withdrawing treatment for relatively minor transgressions, and encouraging service users to access mutual aid groups and psychosocial interventions when their clinical need is for opioid substitution therapy (AMCD, 2016).

Moreover, Drug and Alcohol Findings note that members of service user-led forum 'The Alliance' argue that (mis)interpretations of 'full recovery' by some service providers is instigating the rationing of treatment options, coercive approaches to dose reduction and detoxification and the use of 'unfunded self-help groups' to provide post-detoxification support. Service user coordinator, Alex Boyt, notes that clients who would normally be retained in treatment are now being set unattainable goals relating to social reintegration alongside the threat of script withdrawal if these 'goals' are not reached. Boyt concludes that the recovery agenda 'is probably killing people' with the 'curtailing treatment' side of the recovery

equation now in full flow while the 'widespread gains' relating to personal-social functioning and wider recovery goals are overlooked (Drug and Alcohol Findings, 2016).

Although claims-making by service users about the negative impact of full recovery may be described by some as anecdotal, in a paper published in the British Journal of Mental Health Nursing, Fernandez (2018) refers to 'full recovery' as a 'curse'. Fernandez moves on state that unprecedented cuts to funding and the implementation of PbR have led, both to the continuous restructuring of drug treatment provision, *and* the loss of experienced staff - he concludes that the recovery agenda is in dire need of review before effective interventions are 'lost for good' (p.120). It is reasonable to surmise that the aftermath of full recovery introduced by the 2010 National Drug Strategy, reinforced within 'Putting Full Recovery First' 2012 and continued by the 2017 National Drug Strategy has produced not a sense of hope but of fear and despair.

3.5 Conclusions

This chapter raised a number of notable points, first contextualising drug policy in relation to devolution before presenting a chronologically structured discussion of how the focus of UK drug strategies has shifted over the years. It highlighted how dependent drug users have been variously constructed as a threat to public health, a drain the British economy and a threat to conventional ways of life. This was followed by an extended focus on the sea change that occurred in 2010 when 'full recovery' was introduced as the overarching treatment goal, since continued in the 2017 UK Drug Strategy. The consequences linked to the imposition of 'full recovery' as an overarching treatment goal were also critically considered. As the object of in-depth critical analysis in Chapter 5, the controversial 'recovery roadmap' for England was only briefly previewed. Evident within the discussions above is the interrelationship between discourse and practice. The focus on public health that instigated widespread methadone prescribing and other harm reduction measures and the 'crime phase' of drug policy that ushered in a plethora of Criminal

Justice System interventions. Today under 'full recovery' the practice focus is on abstinence-based treatment with harm reduction pushed to the margins and associated implications far-reaching and severe.

Before moving on, it is relevant to point out that older participants in this research may have witnessed several phases of policy-informed practices and related variations in how addicts, addiction, treatment and recovery have been discursively constructed. Moreover, as noted, the medical and moral discourses aligned with earlier political interventions continue to circulate. Although 'full recovery' now dominates, earlier policy discourses are still available as resources for talk, forming part of the interpretive backcloth that shapes how former drug users today experience self and the world and make sense of and represent life events and experiences.

CHAPTER 4

Research Design

4.1 Introduction

This chapter applies to both the documentary analysis (Chapter 5) and interview strands (Chapters 6 and 7) of this research. I begin with an overview of philosophical assumptions that underpin the methodological approaches utilised for both strands of the thesis. This is followed by a definition and brief overview of subjectivity and self-identity as operational concepts. My focus then turns to the Foucauldian-informed analysis (FDA), beginning with a rationale for the selection of Putting Full Recovery First (PFRF) as a data source. I then move on to engage with the literature on FDA as theory and method before outlining the stages of analysis.

My attention then shifts to how the interview-based strand of this research was designed and conducted by first explaining and justifying the deployment of a synthetic (narrative)discursive methodological framework. I then discuss recruitment and sampling of participants with key characteristics of each participant presented in table form. Proceeding this, the methods section is divided into two parts. In the first I explain and justify the use of semi-structured interviews with a narrative emphasis - the second part focuses more on the *doing* of the interviews including a reflexive account of researcher positionalities. I also critically reflect on a specific researcher-participant encounter. Next, I outline the ethical approval process including informed consent and issues pertaining to data confidentiality and participant anonymity. In the final sections of the chapter I provide an overview of data transcription and explain the process of interview data analysis. The conclusion reiterates key points. Due to the personal nature of data collection, I present much of this chapter using first-person terms and adopt a reflexive stance.

4.2 Philosophical Considerations

During the earlier stages of thinking about this thesis - engaging with social constructionist texts and discourse analytic scholarship and issues

pertaining to ontology and epistemology, I found assertions that reality is socially constructed somewhat confusing, and quite troubling the assertion that nothing exists beyond the text (Derrida, 1976). Despite claims by eminent writers that 'constructionism is ontologically mute' (Gergen, 1994, p.72), the thought of imposing a linguistic universe on this study's participants felt uncomfortable. To imply that social reality is solely textual would be to suggest that, for example, an overdose death or attending a treatment program exist *only* as discursive phenomena. However, as Edley (2001b) clarified, the assertion that 'nothing exists outside of the text' is *an epistemic* not an ontological claim. Social phenomena certainly exist and are most definitely real but *become meaningful* through language … discourse (Phillips and Jorgenson, 2002).

Further critical engagement with literature on the fiercely contested and ongoing 'realism versus relativism debate' (see Cromby and Nightingale, 1999) prompted cautious alignment with a 'moderate' or 'critical realist constructionist' ontological position (see Harper, 2011). I concur with Deihl (2016) that experiences including 'Addictions (and recoveries) are profoundly material and tangible' (pp.xiv) but acknowledge that these experiences can only be known as meaningful entities through linguistic or other forms of symbolic representation. As Edley (2001b) explains, language and discourse mediate how we come to know and understand the world. With regard to the interview strand of this thesis, events and experiences in the lives of this study's participants will ultimately be discursively represented and voice recorded. Following transcription, the texts will be interpreted - analysis of both interview data and the government strategy document 'Putting Full Recovery First' will be presented as one of many potential readings. Hence, the knowledge claims produced by this research will be subjective, constructed and contestable. This, however, is the epistemological realm and pertains not to *what is* (ontology) but to what and how we can know about it.

Discursive research is a broad church encompassing many different approaches to social research. Even *within* different schools of thought

what constitutes viable knowledge or 'correct' analytic approach are contested. A thread running through all discourse analytic work, however, is a broadly constructionist epistemology or theory of knowledge underpinned by an epistemological consensus that knowledge is historically and culturally specific, closely linked to social processes and social action, fluid rather than static, and always questionable (Burr, 2003). Constructionist scholars including discourse analysts reject a correspondence theory of language and work in accordance with the view that texts – here in the form of an official document and participant narratives - do not unproblematically *reflect* life events and experiences but *construct versions of* reality. Thus, mainstream realist notions that talk or other forms of textual representation is the outpouring of a coherent, essential self or representative of a stable, inner state are rejected along with the view that social enquiry can elicit a direct and unmediated reflection of human experience (Bruner, 1991). As it is considered impossible to know with certainty if a government (or other) text or respondent account *corresponds* with reality, the focus turns to how texts function, to what people *are doing with* their talk. Discursive-constructionist research positions language as functional and action-orientated (Willig, 2013).

For some discourse scholars, the micro study of talk in naturalistic settings is the only viable means of doing discursive social research (Wiggans, 2017) while for those who adopt a macro orientation, the identification of discourses and their power implications are of utmost importance (Burr, 2015). The Foucauldian-informed analysis of Putting Full Recovery First is more aligned with the latter with a focus on the power of discourse to shape human subjectivities, while also acknowledging human agency and the capacity of individuals to resist or reject the discourses in which they are positioned. The synthetic discursive framework I apply to interview data analysis draws on elements of both micro and macro frameworks, supporting the view that a focus on micro interactions between interviewer and interviewee should not result in a disconnect from the wider sociocultural contexts in which researcher and participant reside

(Holmes and Marra, 2010). In the context of this research, a synthetic framework enabled me to attend to the wider context - how respondents are both shaped by and draw on available discourses (including those identified in the documentary analysis) and cultural narratives – but also enabled exploration of how talk functions in the micro context of specific conversational encounters – here, the research interview.

In summary then, both strands of this research are underpinned by a moderate or critical realist constructionist ontological and constructionist epistemological position. Ontologically, this position merely acknowledges that humans contribute to the creation of the *social* world and *social* phenomena. Epistemologically, it recognises that our *knowledge* of the world and worldly phenomena are mediated by discourse and that language *constructs versions* of reality thereby rejecting correspondence theories. Moreover, a constructionist epistemology advances the view that knowledge creation is relative to time and place and intimately connected to social action. Finally, it accepts that the researcher's interpretation of the data is but one reading among many potential readings.

4.3 The Person: Self-Identities and Subjectivities

Although the meaning of 'identity' and 'subjectivity' are contested and by some are used interchangeably, in this research they refer to different though connected aspects of personhood. Self-identity refers to an individual's identification (or not) with culturally and historically available constructed categories (Lawler, 2014), their verbal descriptions of self and their emotional investment in these self-descriptions (Barker, 2012). Through self-identification - for example as a man or women, Christian or Muslim, working class or middle class - humans signify both their commonalities with and differences to others (Weedon, 2004). Subjectivity refers to a person's 'sense of self' (Willig, 2013, p.124) and captures how individuals subjectively feel and 'experience being a particular someone at a particular time in a particular place' (Mansfield, 2010, p.vi). Self-identity categories are availed by history and culture through a process of social construction - subjectivities are constituted by

discourses and related social practices as well as material conditions and personal-social histories.

Although humans are constrained by the material-discursive contexts in which they abide they also have the capacity for agency. Today, even previously reified and taken for granted identity categories including 'man' and 'women' are characterised by fluidity. For example, a woman can choose not to identify as a woman and a man not a man. In addition, a person's access to particular forms of self-identity may be constrained, denied or renounced. Moreover, although discourses – for example of hegemonic masculinity and nurturant femininity - exert a strong influence on the subjectivities of men and women respectively, these discourses *can* be accepted but may also be resisted, negotiated or rejected. Salient to research on addiction and recovery is the notion that identities can (to an extent) be chosen but can also be conferred. A person who self-identifies as 'in recovery' from addiction may struggle to escape the 'junkie' identity (s)he has been ascribed. Although only briefly defined and explained here, subjectivities and self-identities are both concepts that will be brought to bear during the analysis of empirical data.

Having outlined the philosophical underpinnings of both strands of primary and defined subjectivity and self-identity, in the following I focus on the methodological approach utilised in the documentary analysis strand of this thesis.

4.4 The Documentary Analysis Strand

4.41 Putting Full Recovery First: Rationale for Selection

There a several reasons why I selected Putting Full Recovery First 2012 as a data source. Firstly, as noted in Chapter 3, the text's forceful anti-harm reduction/anti-methadone sentiment signified a historical rupture from established community drug treatment philosophies, triggering fierce criticism from an alliance of harm reduction organisations and other commentators while seemingly ignoring the evidence base. Notably, under devolution, the Welsh government retained a focus on harm reduction

with the Scottish government recently replacing their 2008 'The Road to Recovery' with 'Rights, Respect and Recovery' (Scottish Government, 2018) with an expressed aim of reducing harms in light of unprecedented levels of drug-related deaths.

Again, and to reiterate a point from the previous chapter, although a new *UK* Drug Strategy 2017 has since been published and is very much a continuation of the 2010 National Strategy, to date Putting Full Recovery First (PFRF) has not been withdrawn or amended. It retains its status as *the* 'recovery roadmap' *for England* shaping how 'full recovery' (particularly within mainstream community treatment contexts) is implemented and experienced. PFRF continues to regulate which treatment options are available and how they are delivered. Interventions which are now deemed 'effective' and 'good value' for taxpayers and, hence, 'acceptable', put at risk vulnerable service users who rely on harm reduction interventions as well as those who live 'conventional' lives assisted by prescribed methadone or buprenorphine. For these reasons, I argue that a discourse analysis of PFRF is relevant to my exploration of how former drug users in England construct addiction-to-recovery narratives in sociocultural and political contexts. With that said and as highlighted below, I also acknowledge that the content of this document will have more of a *direct* influence on the lives of some research participants than others.

As community treatment is funded by local government's public health budget allocated by central government, it is reasonable to infer that PFRF is directed primarily at mainstream community services and their service users. With this in mind and following the theoretical notion that speakers draw on constructions aligned with their personal treatment or recovery pathways, I was conscious that this document would be of most relevance to participants who (at time of interview) were community drug treatment service users on prescribed methadone. My aim was to explore the extent to which discourses that permeate PFRF shaped their sense of self,

resourced their representations of treatment and recovery and influenced their positioning of self and others including drug treatment personnel.

For participants who attributed their abstinence to Christianity and/or were prescribed methadone in the past, my intention was to consider how 'new recovery' discourse influenced how *they* represented *past* experiences as well as how they constructed methadone and medication-assisted recovery *and* people who access medication-assisted treatment (MAT) today. For the remaining participants (two non-religious stimulant users and one religious respondent who had used hallucinogens and cannabis), similarly, the objective was to explore if or to what extent contemporary political discourses of addiction and recovery shaped and resourced *their* accounts and conceptions of self and others. In sum, my aim was to explore if the discourses identified during my discourse analytic reading of PFRF shaped and resourced the narratives of *all* respondents by triangulating 'findings' from the documentary analysis and interview strands of the thesis while acknowledging that the two community service users would be the ones most directly affected by the text.

4.42 Justifying a Foucauldian-Orientated Analysis

Opinions on what forms of scholarship can be considered 'Foucauldian' are wide-ranging and often conflictual (Fadyl et al, 2013). Following Capdevila and Callaghan (2008), my use of the word Foucauldian does not signify engagement with 'any methodological orthodoxy' (p.3) that strives for specific or strict allegiance to the diverse body of work published by Michael Foucault. Rather, it connotes a macro analysis of discourses in terms of their impact on subjectivity and practice (Willig, 2013). The decision to utilise a Foucauldian-inspired analysis (as opposed to the synthetic approach used to analyse interview data discussed below) was a pragmatic one. As Willig (2013) explains, Foucauldian analyses and discursive psychological approaches are designed to answer differing types of question. Foucauldian styles of analysis (FDA from here on in) are more suitable when the primary aim is to draw attention to the discursive

worlds that people inhabit and associated implications. Hence, my aim was to identify discourses permeating PFRF, the subject positions availed by these discourses and how these positions may shape how (former) drug users subjectively experience self and the world and what they can plausibly do and say. Moreover, the discourses within PFRF when triangulated with interview data enabled me to explore the extent to which subject positions availed by these discourses were taken-up, resisted or rejected by interview respondents as well as their utilisation as resources for talk.

4.43 Foucauldian Discourse Analysis as Theory and Method

Foucault himself discouraged strict adherence to theory and method, portraying his many and diverse works as synonymous with a 'toolbox' and encouraging researchers to select different tools depending on the job at hand. In short, 'there is no 'Foucauldian theory' that can be plucked from his works and applied in a straightforward way by other (Garland, 2014). Because Foucault did not specify how to do an FDA, step-by-step accounts of Foucauldian analyses do exist but differ substantially (see Willig, 2013 and Parker, 1999) and are by no means common (Graham, 2011, p.663). This lack of a definitive method (Morgan, 2010) can, however, be used to the analyst's advantage with particular elements of Foucauldian-inspired scholarship utilised in a way most befitting the study at hand (Garland, 2014). This approach is supported by Taylor (2001) who asserted that discourse analysts may adopt their own strategies in accordance with the chosen topic.

Although the analytic stages will be covered in the proceeding subsection, briefly here, my FDA of PFRF draws primarily on elements of Willig's (2013) six stage model but also the work of Parker (1999) who outlines 20 analytical steps. Graham's (2005; 2011) writings which concentrate on the constitutive effect of statements will also be brought to bear alongside the works of Alldred and Burman (2004), Capdevilla and Callaghan (2008), Teghtsoonian (2009) and Callaghan and Lazard (2011), all of whom providing useful insights. In keeping with the spirit of Foucault, of

greater importance than *strict* adherence to pre-defined stages I would argue, is that the selected 'tools' produce something of use. For me, that something would be a reading of PFRF that enables active and former drug users, laypeople and 'experts' to better understand how PFRF operates to reproduce, reinforce and legitimise certain conceptions of addiction, 'addicts', 'full recovery' and related practices while marginalising others. A useful reading would, moreover, critically consider the discourses that permeate the text, the versions of reality they evoke and the implications in terms of what active and former drug users (and indeed drug treatment personnel) can say, do, think and feel including their capacity to plausibly self-define as 'in recovery' from dependence.

Having confirmed the lack of clarity in terms of explicit guidelines for conducting an FDA, the remainder of this sub-section provides a starting point that enables some understanding of FDA as both theory and method. As mentioned, Foucault's work is wide-ranging and diverse – the focus of his scholarship changed over time with earlier theoretical insights superseded by later ones (Cheek, 2008). As Cheek affirmed (2008), any scholar who claims to be true to Foucault would need to be explicit in terms of what historical period in Foucault's academic life and what body of work they are drawing on. Many Foucauldian concepts will not be mentioned here but one that that is pertinent to this thesis is the Foucauldian notion of discourses as 'sets of statements that construct objects and an array of subject positions' (Parker, 1994, p.245), a definition usefully extended by Burr (2003) who described discourses as referring to:

> *'a set of meanings, metaphors, representations, images, stories, statements [...] that in some way together produce a particular version of events. It refers to a particular picture that is painted of an event (or person, or class of persons), a particular way of representing it or them in a certain light'* (p.48).

Broadly speaking, this version of FDA is concerned with how language functions in the formation of social and psychological life. The focus is on

the sociocultural and political milieu and the power implications of this discursive backcloth for those who live within it (Willig, 2013). The aim is to investigate 'how objects (things) and subjects (people) are constructed in discourse' (Frost, 2011, p.70) and explore the potential effects on those who are subjected to them (Frost, 2011). Discourses make available ways of seeing and being in the world (Willig, 2013). They 'facilitate and limit, enable and constrain what can be said and done, by whom, where and when' (Willig, 2013, p.130). Moreover, discourse avails subject positions which when *or if* occupied have implications for how people think and feel about self, others and the world in which they live (Willig, 2013).

Dominant discourses reproduce and reinforce a view of reality that legitimises prevailing power relations and social structures to the extent that they become accepted as common sense (Burr, 2003). With that said, language and meaning changes - discourses that once dominated the discursive landscape may become more obscure although they can arise again. Alternate constructions are not only available but can (and do) emerge (Willig, 2008). Moreover, humans are able to critically reflect on the discourses in which they are currently positioned and either keep, resist or reject them. As an example, feminism is a counter-discourse whereby dominant constructions of women – as inferior to and dependent on men for example - have been challenged and alternative discourses and self-identities forged (Mascia Lees and Black, 2017). Foucault himself supported the formation of counter-discourses to oppose 'regimes of truth' and speak up on behalf of marginalised and disenfranchised populations (Foucault, 1980).

As alluded to in the literature review chapter, notions of resistance and the promotion of counter-discourses allow for human agency within a macro-constructionist framework. Pease (2000) highlighted the need to avoid 'discourse determinism' - a conception of discourse that leaves no prospect for resistance and change. Resistance is not, however, an easy or uncomplicated process. Burr (2003) has pointed out how dominant constructions – discourses - are bound up with institutions and social

practices. Resistance can unsteady a status quo that powerful groups wish to retain – thus to resist them may be troublesome and problematic. Indeed, Parker (1992; 1999) includes an analytic focus on the relationship between discourse and institutions. Discourses are entwined with institutional practices and implicated in the organisation, regulation and administration of social life (see Parker, 1992; 1999; Willig, 2013). In sum, although FDA concerns itself with language and language-use, it moves beyond micro contexts to questions the implications of discourse for what people can think and feel, say and do (Willig, 2008). In the context of this study, it enabled me to gain some insight into how this study's participant, particularly those in community treatment, may be enabled and constrained by the political-discursive environment and to speculate with regards to how these contexts shape their conceptions of self. Moreover, detailed analysis of the recovery roadmap also better equipped me to acknowledge resistance or reproduction of full recovery ideals within participant accounts.

4.44 Analytic Stages

With FDA (and some other types of discursive work) analytic stages are not reified but rather provide a guiding framework. Discourse analytic readings do not seek to uncover 'the truth' (Graham, 2005), neither do they speculate in terms of what the author(s) *actually* intended to convey (Parker, 1997). Rather, the aim is to highlight how particular statements function (Graham, 2005, p.6) to present versions of reality. The emphasis of this analysis, then, is not so much what statements say, but what they do (Graham, 2011, p.667).

In accordance with what Parker (2005) anticipates is a significant aspect of any Foucauldian analysis, my initial task was to clarify features of the text that I found interesting, striking, confusing or complex. Another important stage involved consideration of 'the effect of different readings of the text' (Parker, 2005, p.92). My natural inclination towards a politically attuned perusal needed to be restrained in order to assess how the text might function in an everyday or conventional sense (Parker,

2005). Another early stage involved turning image-based or pictorial aspects of the document (in this case the title page) into written form and, through a process of free association, explore the 'connotations, allusions and implications' evoked by the text (Parker, 1992, p.7).

The next step was to explore how 'addicts' 'addiction' 'treatment' and 'full recovery' are constructed within the document (Willig, 2013) and identify and label the discourses within which these constructions are situated. Discourse avails subject positions – for example, as discussed in the literature review medical and legal discourses position the drug user, respectively, as patient and criminal. Another analytic stage was to identify subject positions availed by discourses that permeate PFRF (Willig, 2008). This was followed by 'speculation about what subjects may (or may not) say from within these discourses' (Parker, 1999, p.581). Following Parker (1999), another step involved consideration about how a particular version of the world conjured-up by the text might be 'defended if attacked' (Parker, 1999, p.582).

Two further stages involved a focus on the relationships between discourse and practice and discourse and subjectivity. Practice implications involved consideration of how, 'by constructing particular versions of the world and positioning subjects within them in particular ways' (Willig, 2013, p.132), discourses influence what people can plausibly say and do. Exploration of the relationship between discourse and subjectivity involves speculation and, as an analyst, I could only theorise as to how occupying or resisting particular subject positions may shape an individual's sense of self (Willig, 2013).

4.45 Summary

So far, I have set-out the ontological and epistemological foundations of both strands of empirical research and defined subjectivity and self-identity for the purpose this thesis. I justified the decision to analyse PFRF and explained some of problematics and advantages of engaging with Foucauldian scholarship. Finally, I presented the analytic stages in this Foucauldian-orientated discourse analysis of PFRF. In the following, I

concentrate on the interview strand of this thesis in the order outlined in the chapter introduction.

4.5 The Interview Strand

4.51 Methodological Approach

Whereas a Foucauldian-orientated approach informed the analysis of PFRF, for research with human participants I felt that a synthetic discursive framework with a narrative orientation was more appropriate. The chosen methodology draws on Stephanie Taylor's narrative-discursive approach (see Taylor, 2007; Taylor, 2010) and the synthetic, critical discursive frameworks advanced by Wetherell (1998) and Edley (2001). This enabled me to consider the constitutive potential of discourse and narrative and their status as resources for talk as well as discursive-rhetorical strategies deployed by speakers during the research interview. Although Taylor's approach was by no means rigidly employed (departures from this framework are later outlined) it was certainly influential.

I adopted Taylor's (2007) definition of narrative as both 'a construction, *in* talk, of sequence or consequence' (p.114) and a resource *for* talk. This definition applies to short statements containing terms such as 'then' or 'so' as well as extended stretches of talk (Taylor, 2007). The decision to include a narrative emphasis was influenced by several factors including personal and epistemological reflexive engagement. Indeed, a key consideration related to how I represent my experiences to others and others to me.

Personal critical reflection made me more aware of how, when asked to relay a personal event or a life experience, my response is often in storied form and adapted to reflect my perception of the listener, time constraints, the situational context, and how I feel at that moment in time. My response, furthermore, will be shaped and constrained by my personal-social history - the memories or the lack of I have of that event or experience and what I wish to disclose. During this research participants will be asked to tell me 'a bit about their story' of drug use

and recovery – hence, the notion that they will narrate is already assumed. It is important to reiterate, however, claiming that humans construct self-identities and represent life events and experiences in storied form does not detract from the salience of discourse, subject positions, subjectivity and resistance. That subjectivities are constituted within discursive and material environments is acknowledged and accepted. The focus of the proceeding section, however, is primarily on how people *represent* their selves and their experiences to others.

From a narrative-discursive perspective people arrive at a situated encounter (the research interview for example) 'always already positioned' (Taylor, 2010, p.38), with a sense of self constituted in discourse and unique discursive-material life experiences. Indeed, this notion of the individual, pre-shaped by the material-discursive contexts in which they live, is apparent in Taylor and Littleton's (2006) assertion that the world shapes and constrains the self that people create and present to others. A narrative-discursive approach assumes that language is functional and that self-identities are performed in interaction (Taylor, 2007; Taylor, 2010; Taylor and Littleton, 2006). To narrate is to *perform* identity and different narrations construct 'different versions of the self' (Benwell and Stokoe, 2010, p.138), life events and experiences. A synthetic, narrative-discursive approach views self-identities not as static, singular and fixed but fluid, multiple and relative to time and culture (May 2004 cited in Benwell and Stokoe, 2010). The rigidisation of identity as a 'categorical entity' (Somers, 1994, p.606) based *only* on gender, class, ethnicity and so on is thereby rejected.

Taylor also affirms that respondent accounts are derived both from past narrations and an accumulation of discursive resources drawn from the wider sociocultural contexts in which they abide. These resources include what Bruner (1991) terms 'canonical narratives': established stories that characterise a society or culture which may vary over time but remain recognisable. Taylor's (2010) UK-based research on place and identity identifies such 'common-sense resources' as the 'property ladder'

narrative (p.15) or a progression through identifiable stages of life. People use these established narratives to resource their own. In the context of research on addictions and recoveries, canonical narratives may include the 'spiral of addiction' and 'the road to recovery'. Moreover, given that some participants are public speakers and authors by trade, Taylor's assertion that speakers draw on past narrations is a pertinent one. Whether they utilise canonical narratives or other discursive resources/discourses, speakers construct accounts by drawing on socially and culturally located webs of meaning (Taylor, 2007). This discursive milieu may include professional and popular drug-related literature (see McIntosh and McKeganey, 2002) including established theoretical frameworks and ideas promoted by treatment personnel (see Taieb et al. 2008). These, in turn, are influenced by drug policy frameworks including texts such as Putting Full Recovery First.

A narrative-discursive approach sees 'identities are both in part conferred and, in part, actively claimed and contested' (Taylor and Littleton, 2006, p.25). Moreover, following Edley's (2001) critical discursive psychological framework, subject positions are also utilised as an analytical tool. For Taylor (2007), people are positioned in and constrained by, resist and are positioned by others in discourse but also *actively* 'construct, negotiate and contest' (p.3) these positions during spoken interaction. Moreover, within a speaker's account, both personal-social histories and discursive-material phenomenon including place and space (see Taylor, 2010) and embodiment may all be brought to bear. I also adopted from Taylor's work the concept of 'identity trouble'. A troubled identity is defined as one that is 'negatively valued' or discredited (Wetherell, 1998) or a self-presentation that is 'potentially hearable and challengeable by others as implausible or inconsistent with other identities claimed' (Taylor, 2010, p.98).

Moreover, a person's talk may be constrained by a lack or absence of discursive and/or material resources (Taylor, 2007). For example, an individual may have difficulty constructing a *plausible* account based on

the material and discursive dimensions of home ownership, good health and wealth for example, if they are homeless, chronically ill and are living in poverty. Following Geelan (2007), for an account to maintain credibility in the eyes of others it 'must have verisimilitude' (p.73). So although speakers draw on a wealth of culturally available discursive resources include prior narrative constructions (Taylor, 2007) this is by no means a risk-free process.

Like Taylor, I utilised Michael Billig's notion of rhetorical talk, thereby acknowledging that speech occurs in the context of wider contestations and debates whether media, political or otherwise. A person who is aware of these wider contexts may anticipate and defend against or address potential or real critiques and counter arguments. Hence, the content of conversational encounters may be influenced by invisible audiences beyond the immediate interaction. As Taylor (2010) explains, 'it is as if the speaker is addressing an interlocutor' (p.92) who may not be visible in the moment but has been encountered before, either in-person or otherwise.

To summarise the chosen methodological approach, people are seen to *enter* conversational encounters *always already* positioned by discursive-material environments and circumstances - their sense of self *always already* shaped by discourses and life experiences past and present. *Within* conversational encounters, self-identities, life events and experiences are both constrained by and constructed from sociocultural and political discursive resources including past narratives and unique material-discursive personal-social histories (adapted from Taylor and Littleton, 2006). These interactional encounters are where individuals construct versions of reality and the sites where subject positions are 'conferred, negotiated, claimed or resisted' (Benwell and Stokoe, 2010, p.139). Those who present a 'discredited' version of self or an account deemed by others as implausible or inconsistence will encounter identity trouble - a troubled self-identity requires repair. The synthetic narrative-discursive approach, moreover, takes account of how speakers may be

aware of and acknowledge wider debates and areas of contestation – conversational utterances are seen as shaped both by the immediate context *and* invisible or imagined audiences beyond the interactional encounter.

Although I am aware that opting to use an eclectic discourse analytic methodology may be deemed theoretical heresy by some, I concur with Jorgensen and Phillips (2002) that combining elements from different discourse analytic perspectives is 'not only permissible but should be positively valued' (p.4). Following Willig's (2013) overview of synthetic approaches to discourse analytic work, those who wish to understand what is occurring in a piece of social interaction ought to consider both the discursive economy (the webs of meaning that enable and constrain interaction) and 'participants local concerns and their realisation through discourse within specific contexts' (p.127). In other words, a dual focus (Willig, 2013) on both macro and micro interactional contexts in situ enabled a thorough investigation of social processes and interaction.

4.52 Departures from a Narrative-Discursive Approach

Although Stephanie Taylor's narrative-discursive approach was utilised as a guiding framework, it was not dogmatically applied. The following identifies where the methodology utilised for the interview strand of this research departs from Taylor's guidance.

In describing the discursive backcloth to human lives, Taylor variously refers to interpretive repertoires and discursive resources. In keeping with a Foucauldian tradition and to maintain some continuity between the two research strands, I refer to discourses and discursive resources interchangeably. Moreover, in comparison with Taylors, the approach utilised here places more emphasis to the constitutive power of discourse. In addition and where relevant I attend to how *particular* words and phrases function, a micro focus that the narrative-discursive approach disregards. Although Taylor (2010) draws extensively on Wetherell's synthetic (micro/macro) framework and describes it as both 'a theory of subjectivity and empirical approach' for studying 'identity work in talk'

(p.18), in her own work the term identity is employed. As previously stated, I differentiate between subjectivity and self-identity. To summarise, the framework I applied to participant narratives draws on elements of Taylor's work but with additional consideration given to both macro and micro contexts and with subtle terminological alterations.

4.6 Recruitment and Sampling

4.61 Participant Recruitment: Rationale

My aim was to recruit former drug users who attributed their 'recovery' to religion and those who did not. The rationale for this purposive approach to sampling related to the positioning of individuals aligned to these recovery pathways at opposing ends of the belief system spectrum and potential for the construction of diverse addiction-to-recovery narratives. To further explain, my feeling was that those who attributed their drug-abstinence to God may well construct recovery in terms of supernatural rescue with those with no religious affiliation positioning their recovery as product of *personal* strength and fortitude. I was also interested in exploring if arriving at the interview encounter already positioned (as a Christian) shaped how respondents interpreted past events and experiences. More broadly, as an agnostic, I was intrigued to hear how participants integrated God into their 'addiction-to-recovery' narratives. I also set out to recruit participants who were currently in or had been in contact with community treatment services and were currently or had in the past been prescribed methadone or buprenorphine. The literature suggests that these individuals would be more directly influenced by the 'full recovery' discourses and practices analysed in the documentary strand of the thesis. As explained in introductory chapter, one aspect of my positionality is a political stance against *the imposition* of 'full recovery' as the only viable treatment goal. My interest was in how and to what extent 'full recovery' discourses permeated the narratives of all respondents but particularly those in community treatment and to explore how their accounts were shaped by their positioning as community service users on prescribed medication.

In terms of inclusion criteria, all participants were adults (over 18 years of age) who described their past drug use as problematic to self and/or others and reported having refrained from using their primary drug(s) of choice for at least one year prior to the interview. Another criterion for inclusion was that participants all variously self-defined as a former drug user, working towards recovery, recovering, in recovery or recovered from addiction. The recruitment process was, however, more protracted and difficult than initially expected.

4.62 The Recruitment Process

On beginning my doctoral journey, I had expected to recruit from a personal network of individuals aligned to religious and community treatment recovery pathways and then utilise snowball sampling to recruit several more participants. The decision to adopt a convenience approach had been reached by gauging early expressions of interest. However, some potential participants relapsed back into drug use, a few were uncontactable, and others decided that they no longer wanted to participate. From the 12 individuals who had initially expressed an interest only two agreed to be interviewed, both community service users on a prescribed methadone or buprenorphine programmes.

Attending the local church and an associated small group meeting brought me into contact with an individual (Bill) who worked for a Christian book publisher. Bill had been involved in publishing two books authored by former drug users who attributed their recovery to the Christian God. He offered to email both individuals on my behalf. To cut a longer story short, within a month I had the email addresses and phone numbers of two individuals who had informed Bill that they were happy for me to contact them. A few months later, following a succession of phone calls and/or emails, the two Christian contacts snowballed into four. All were former dependent drug users who attributed their recovery to a God encounter and Christian conversion and were willing to talk about their experiences of addiction and recovery.

Additional recruitment transpired through my teaching work. Because of my research interests I am asked to teach on modules covering 'substance use and misuse' and 'social research'. During this teaching I tell students about my research and, although this was in no sense for the purpose of recruitment, it was after the same session (on substance use and misuse), each one year apart, that I was approached by individuals who informed me about their personal history and expressed an interest in participating in my research. Both fulfilled the inclusion criteria. Although I recognise that interviewing one's students may be considered problematic in terms of researcher influence and the potential for data distortion, in the 'interview preparation' section below I reflect on researcher-participant relations and bring to bear strategies used to manage and limit perceived power differentials and build trust and rapport.

The process described above enabled me to recruit a total of eight participants from a range of backgrounds, who had been dependent on various substances (heroin, cocaine, amphetamine, and hallucinogens), were aligned with a variety of treatment/recovery frameworks and described themselves as either former drug users, working towards recovery, recovering, in recovery or recovered. Four participants, as mentioned, self-identified as Christians and attributed their abstinence to God, and four explicitly stated that they had no religious or spiritual inclination. Of the latter four, two were accessing a local community service and in receipt of a prescription for methadone or buprenorphine.

The table below present basic details relating to each participant.

4.63 The Participants

Name	**Age**	**Drug(s) of Choice**	**Recovery Pathway**	**Time abstinent from drug(s) of choice**

Frank	43	Heroin & Crack	Christian Conversion	8 years
Graham	47	Heroin	Christian Conversion	15 years
Dave	39	Heroin	Christian Conversion	7 years
Eddie	24	Hallucinogens & Cannabis	Christian Conversion	18 months
Harry	32	Cocaine	No specific pathway	4 years
Andy	44	Amphetamine	No specific pathway	5 years
Ben	43	Heroin	Community Service User on prescribed Buprenorphine	1 year
Carl	41	Heroin	Community Service User on prescribed Methadone	2 years

4.7 Method

4.71 Introduction

My focus here is on explaining and justifying the data collection strategy used in this study and the practicalities of becoming and being the interviewer. This will encompass a rationale for adopting semi-structured interviews with a narrative emphasis. Areas of contestation that informed my decision-making about method will be highlighted. As both face-to-face and telephone interviews were used, each will be discussed. The intention here is to reassure the reader that using telephone interviews to collect qualitative data was effective and allowed the development of trust and rapport between researcher and participant.

4.72 Data Collection Instrument: Explanation and Rationale

The type of interview employed is best described as semi-structured with a narrative emphasis. The interview schedule (see Appendix A) was used as a guide with a semi-structured format allowing flexibility, enabling me to follow-up lines of enquiry that deviated from the schedule but were nonetheless both relevant as well as direct the conversation towards areas of interest (Qu and Dumay, 2011, p.243). My use of the term 'narrative emphasis' is best captured for now by noting the terminology I used to instigate each participant's initial response: 'I'm interested in hearing your story of drug use and recovery. Can you tell be about that?'

My intention was to allow the participant to speak largely uninterrupted about their experiences of becoming a drug user, being a dependent drug user, and the process of recovering (or being 'recovered') from 'addiction'. At the same time, my interest in certain aspects meant broaching topics that during the initial narration participants may not have alluded to. For example, my interest was in hearing how interviewees spoke about turning points in their lives, experiences of prejudice and stigma, the meaning of 'recovery' and their future hopes and aspirations. In addition, and perhaps reflecting more my interests than theirs, I wanted to hear their views of medication-assisted treatment (MAT) and medication-assisted recovery (MAR) and those aligned with it. Some participants alluded to these areas within the initial extended narrative account - here my task was re-visit or request elaboration. At other times, the questions (about MAT and MAR in particular) were not alluded to and thus became additional areas of enquiry. The semi-structured approach enabled these 'sub-areas' to be broached in a manner befitting the interview encounter.

Also of note is that the interview employed in this study is not a text-book method. Although both narrative and semi-structured interviews are highlighted in the literature, they are often positioned as two distinct techniques. Indeed, the term that acts as a pre-fix to 'interview' is itself an area of contestation and debate. As DiCicco-Bloom and Crabtree (2006) explain, interviews may be *labelled* 'unstructured' but there is no such thing as a completely unstructured interview. All that can be

reasonably claimed is that some interviews are more or less structured than others (DiCicco-Bloom and Crabtree, 2006). Although flexibility was welcome and required, I also had to bear in mind that the data generated by the chosen approach would need to be organised post-interview (Gomm et al., 2000). That is, although the narratives were chronologically sequenced and followed a similar shape, they were diverse in terms of content. There were no decisive or intentional breaks between discussion points enabling neat division of subject matter into pre-determined analytical categories.

As with the term 'interview' there is no single uncontested definition of narrative and nor, by definition, the narrative interview. However, narrative is an integral part of qualitative interview research - it cannot be disregarded or deemed irrelevant. Narrative is a 'universal competence' (Jovchelevitch and Bauer, 2000, p.1) – it is ubiquitous and infinite in its variety. All human experience can be expressed in narrative form (Jovchelevitch and Bauer, 2000). Moreover, it is through narrative that people make sense of and recall experiences, put events in order and form potential explanations for why things happen as they do (Gudmundsdottir, 2014).

Gubrium and Holstein (1997) divide scholars adopting a narrative-orientation into two broad epistemological camps: naturalist and constructionist. Although both consider human 'lives and experiences' (Elliot, 2005, p.18) the naturalist focus is on a world that words can *accurately* convey. A constructionist narrative approach on the other hand considers how the world is produced and reproduced, a world that is 'constantly in the making' (Elliot, 2005, p.18) with an emphasis on how the social world *is produced* in talk. In the context of qualitative interviewing, the constructionist narrative interviewer is interested in 'how' questions' – how the social world shapes and resources the stories that people tell, how speakers talk about and make sense of their lives, how they position self and others in interaction (Frost, 2010). Epistemologically, this study is situated in the latter camp.

It is apparent, then, that narrative is a ubiquitous yet contested concept. At this juncture it is important to establish that this is in no way a narrative study in the sense implied by imminent structural narrative analysts such William Labov (see Simpson, 2004, p.114). It is better described as discursive research that recognises qualitative interview data as narrative and employs a synthetic discursive methodology and analytic framework. Moreover, a narrative-emphasis is in keeping with the recent narrative momentum and 'increased awareness of the role of story-telling' in the construction of social phenomenon (Jovchelevitch and Bauer, 2000, p.1).

So, in accordance with Taylor's definition of narrative as previously defined, semi-structured interviews can produce narrative data while a narrative emphasis helps to capture human meaning-making in storied form as participants represent their constructed thoughts, experiences and self-identities. As already alluded to, the approach utilised here rejects a correspondence theory of truth in favour of coherence - the speaker strives to build a story that makes sense (Sandelowski, 1991). As Sandelowski (1991) elegantly states, 'Narrators strive to achieve a coherent 'interpretation of the past-in-the-present, the experienced present and the anticipated-in-the-present-future' (p.165). As interviewer my role was to facilitate and create an environment that enabled this process to unfold.

4.73 Collecting Data and Related Processes

The interviews carried out for the purpose of data collection included both face-to-face and telephone formats. The following discussion will consider the mechanics and practicalities of qualitative interviewing, including issues relating to researcher positionality, trust and rapport, interview location and self-presentation. Although the processes involved in the build-up to face-to-face and telephone interviewing are much the same (King and Horrocks, 2010), because the telephone interview as a method for qualitative data collection is considered by some to be sub-optimal (Novick, 2008) their use requires further justification.

As Sturgess and Hanrahan (2004) explain, face-to-face interviewing is widely perceived as the 'gold standard' of qualitative data collection with telephone interviews often utilised only in the context of quantitative structured research designs. The discussion will therefore proceed as follows. A critical discussion of researcher positionality will help to contextualise interviewer-interviewee relations. The qualitative interviewing process will then be explained and, unless indicated otherwise, will apply to both modes of interviewing. Next the rationale for using telephone interviews will be presented alongside their *perceived* limitations and advantages and with reference to my personal experience. My overriding argument is that both face-to-face interviews *and* telephone interviews are well-suited to qualitative research generally and to this investigation. Before concluding, a critical reflection of difficulties encountered when interviewing a friend will be offered.

4.74 Data Collection and Researcher Positionality

In order to pose informed questions and understand participant responses, a good understanding of the research topic is required (Qu and Dumay, 2011). This requirement for knowledge and understanding can be linked to researcher positionalities and arguments relating to 'Insider and Outsider Doctrines' (Merton, 1972). To briefly explain, 'outsiders' are researchers who are external to the communities they study and valued for their ability to approach the research in a detached and neutral manner. The 'Insider Doctrine' on the other hand contends that it is impossible for a researcher to understand a phenomenon unless they themselves have experienced it first-hand. Because insider researchers share characteristics and/or experiences with the study population, they are perceived by some as 'uniquely positioned' to understand the participant's life story (Kerstetter, 2012, p.100), enabling them to produce high quality research (Serrant-Green, 2002).

In response, Asselin (2003) argues, being an insider can lead to role confusion, bias and distortion of research findings. Moreover, the very notion of an insider-outsider dichotomy has been the subject of critique

(Serrant-Green, 2002; Dwyer and Buckle, 2009). This criticism is succinctly expressed by Dwyer and Buckle (2009) who highlight 'the space between' arguing that group membership does not denote complete sameness, nor being external to a group complete difference. Having alluded in the introductory chapter to my personal experience of drug use and experiences of addiction and recovery as represented by people I have known or been in contact with, I support Dwyer and Buckle's observation but also concur with Ganger and Scott (2006) who suggest that having a degree of insider knowledge generally adds a positive dimension to the research process.

To reiterate, positionality refers to the researcher's sociocultural location and life experience as well as their chosen theoretical perspective. Ethnicity, social class, gender, religiosity and political affiliation have all been as highlighted relevant to researcher-participant interactions (Sands et al. 2007). In relation to this research topic, I position myself as a partial insider who occupies 'the space between' (Dwyer and Buckle, 2009). That is, although in terms of an insider-outsider continuum I position myself as more allied with the former, broadly speaking I see the 'hyphen as my dwelling place' (Aoki, 1996 cited in Dwyer and Buckle, 2009, p.60). To reiterate and expand on points made in the introduction, I used alcohol and other drugs on a regular basis and, at times, excessively during my late teens and early to mid-twenties. The decision to stop misusing substances brought with it mainly psychological but also minor physiological withdrawal symptoms. Moreover, I live today with the vestiges of those experiences, having to employ strategies to manage and live well with anxiety.

My partial insider status is also an outcome of having close friends and associates who became chronically and severely addicted to drugs. I witnessed their gradual movement into addiction and/or listened to their accounts of being a dependent drug user as well as their attempts to stop using drugs. These gave me some insight into the 'othering' that people with a history of drug use may face, the family breakdown that often

accompanies problematic drug use, the relapsing-remitting nature of addiction, and both positive and negative experiences with community treatment services. Equally, I witnessed and/or heard about successful recoveries through various means but also the struggle to repair a 'spoiled identity' (Goffman, 1973) and reintegrate socially. My positionality is thus shaped by personal experience and the experiences of those who I have known or been in contact with. Moreover, these life experiences enabled me to bring to the research interview an understanding of 'drug-speak' (Dally, 1990). Hence, drug-related terminologies participants used before, during and after each interview required no clarification.

So, for me, positioning self as a partial insider situated in the 'space between' made sense and corresponds with a belief that I nor any other person can share nor fully comprehend the interviewees *subjective experience* of becoming and being drug-involved, active addiction or their recovery. Despite being a former church goer turned agnostic, I cannot understand what it is like to be 'saved' from addiction by God. Having immersed myself in addiction recovery literature and despite years of close proximity to active and recovering drug users I cannot know how these individuals *subjectively experienced* their lives, nor do I believe that they or any person could know how I have experienced mine. In sum, to discover how another person *experiences* their world is not feasible objective.

Although I can *choose* to believe what people tell or have told me about their lives, this is far-removed from the claim that these accounts definitively and unproblematically correspond(ed) with reality. Indeed, this type of critical reflection influenced my decision to adopt a discourse analytic theoretical framework and methodology with a focus on discourse and language use. All I can say with *a degree* of certainty is that I share the same gender and ethnic background as the participants and have some knowledge of and familiarity with some of the events and experiences they described. A partial insider status did, I feel, enable me to approach the interview encounter with a level of empathy and

understanding. Moreover, I chose to share my personal experiences of drug use with the research participants and sensed that this spirit of openness contributed in a positive way to the interview preparation process and the interview itself.

4.75 Interviewing: Preparation and Practicalities

As Qu and Dumay (2011) explain, using interviews as a data collection tool is by no means a 'trivial enterprise' (p.239). Interviewing is a skill and the researcher must plan and prepare (Qu and Dumay, 2011, p.239). To enhance the likelihood of a productive interview experience, steps were taken to develop rapport with participants in the weeks leading up to the interview and immediately before the interview proper. King et al. (2018) refer to rapport as the building of connections with others in a manner that creates a climate of trust and understanding - it involves understanding and accepting how another person feels and appreciating their point of view. The development of trust and rapport between researcher and participant is a central (DiCicco-Bloom and Crabtree, 2006), some argue the most essential (Kim, 2016), aspect of qualitative interviewing (DiCicco-Bloom and Crabtree, 2006).

Importantly, however, Reissman and Benney (1956) warned that rapport-*filled* interviews can initiate participant accounts that over-spill with the 'flow of legend and cliché' (Reissman and Benney, 1956 p.11 cited in Brinkmann and Kvale, 2015, p.111). Indeed, 'over-rapport' (Kim, 2016) may prompt participants to simply relay what they believe the researcher wants to hear. With that said, there is little doubt that *good* interviewer-interviewee relations and adequate levels of trust and rapport are advantageous. Moreover, interview research (and indeed this study) often requires positive relations to be established over a relatively short period of time (DiCicco-Bloom and Crabtree, 2006).

As previous alluded to, I feel that honesty and openness with regards to my personal-social history instigated a level of trust and the sharing of common ground (Dwyer and Buckle, 2009). It enabled a degree of rapport based on a mutual, albeit partial, understanding of one another's life

experiences that otherwise may not have been possible, creating an environment in which participants were willing and felt comfortable enough to talk about their life experiences (King et al., 2018). Furthermore, this pre-interview dialogue countered some of the *situated* power imbalances that exist between interviewer and interviewee. Although the issue of power in social research is a complex and contested area (see Kvale and Brinkman, 2015) with the researcher in control of questions asked and interpretation of data produced, redressing some of this imbalance through honesty and integrity takes on added salience during research with populations (such as problem-drug users) who may feel, or have felt, relatively powerless in the context of everyday life.

As well as engaging in open and honest dialogue about my positionality, where feasible I met participants face-to-face on several occasions prior to interviewing them. Indeed, one or more in-person meetings occurred prior to all but one *face-to-face* interview where geographic distance and mutual busyness made it impractical. These pre-interview discussions were used to explain the study and answer related questions but also to engage in everyday conversation – this enabled me to know the participant, and them me, a little better. This process, I am sure, set the scene for a more relaxed and productive interview encounter.

Four participants (three of whom I interviewed by telephone) lived a significant distance from my hometown and had busy personal and professional lives. One of the four, at time of interview, was in a different country within the United Kingdom. Arranging pre-interview in-person contact was not feasible and I relied on email and telephone communication to develop rapport. Regarding the one case where only email contact occurred, lack of verbal contact had no *notable* detrimental effect on the telephone interview for reasons I will later explain. So, either face-to-face or telephone communication, or both, preceded all but one interview. All participants appeared to be engaged with and passionate about the research topic. To further instigate trust and rapport, I made each participant aware of their status in the encounter as the 'expert by

experience' and clarified that their story was of interest both to me personally and members of the wider academic community (Farooq, 2015).

Other important considerations in interview-based research are location and self-presentation (King and Horrocks, 2018). In line with recommended practice (King and Horrocks, 2018) all face-to-face interviews occurred in a place of the participant's choosing. Among those who participated in face-to-face interviews, in all but one case, this was at participants home address, on 'their territory' (King and Horrocks, 2010, p.43). Although the presence of others including friends and family members can be problematic when conducting interviews at a participant's primary residence (King and Horrocks, 2010), this was not an issue that I encountered personally. Some participants lived alone and those who had partners and/or children living at the address suggested an interview date when they knew external disturbance would be less likely to occur. During each face-to-face interview I positioned the voice recorder as discreetly as practically feasible and adopted a relaxed yet attentive posture, actively listening as each participant related their story. Interruptions were kept to a minimum and only occurred where clarification was needed or, in some cases, elaboration. Following the initial stretch of narrative, I re-visited aspects of the narrative and/or moved on to thematic areas from the interview schedule. In terms of self-presentation, I dressed in casual, everyday clothing (as I almost always do) thereby working towards reducing power imbalances based on external appearance alone.

As noted above, the need to develop and indeed maintain trust and rapport continues from first contact, through to the period immediately prior to the interview and throughout the interview itself. King and Horrocks (2010) stress the importance of not assuming that participants fully understand what the interview process entails based on pre-interview contact alone. Although interviewees had been emailed a participant information sheet and otherwise briefed over the telephone, via email or

during in-person pre-interview conversations, this did not by any means guarantee their full comprehension of the process.

With this is mind, before the interview proper, I took time to reiterate the purpose of the interview, the nature of their involvement, how long approximately the interview would last, and encouraged each participant to voice any queries or concerns. Only after taking these steps did I ask for their consent. As discussed in the 'ethics' section below, with regards to the three telephone interviewees, participant information sheets were emailed in advance and they gave their verbal consent over the telephone. In addition, I offered to post a paper copy of the consent form to their home address in a pre-paid envelope. This offer was declined - I respected their decision. The over-riding purpose of all the actions so far described was to minimise any potential for damage to the researcher-participant relationship (King and Horrocks, 2010).

I felt that each interview went well, bar one (see 'interviewing a friend' below). Some were longer in duration than others, but all were productive and yielded useful qualitative data. This occurred despite the criticism, contestation and heated debate surrounding the use of telephone interviews in qualitative research. In response to these critiques, the following section will draw on my own experience and wider literature relating to this neglected and maligned method of collecting qualitative data.

4.76 Telephone Interviews

In a qualitative interview study into the experiences of visitors to and employees at a county jail, Sturgess and Hanrahan (2004) clarify how their decision to use telephone interviews was an outcome of participants' reluctance to engage face-to-face. For me, such decisions were due to either geographic distance, busyness or anxiety. As Farooq (2015) explains, many research participants lead full and busy lives – researchers need to accept cancellation and rescheduling as part of the data collection process. Once participant who was unable to meet as planned suggested a telephone interview – this enabled him to remain within his workplace and

me to hear and record is story. Another, despite agreeing to a face-to-face interview during email contact, on the day felt very anxious about the prospect but was happy to talk on the phone. My understanding of what it feels like to be anxious enabled me to empathise with his predicament and assume a non-judgemental stance - I thanked him for allowing me to interview him by telephone. To apply pressure on this individual in a bid to encourage him to honour our email-based agreement was not an option - to do so would have been ethically insensitive. The third participant lived too far away geographically, and a telephone interview had been agreed prior to the interview date and took place as planned.

Although unsure at the time about how the decision to utilise telephone interviews would be received by my supervisory team and the impact on data quality, I am now able to concur with Novick (2008) who argues that bias against telephone interviews in qualitative research is largely misplaced. Although the absence of 'visual cues' cannot be disputed, empirical evidence linking this with difficulties in developing rapport, response misinterpretation and compromised data quality is scarce. On the contrary, if participants feel uncomfortable about interacting face-to-face or are otherwise unable to do so, accepting the offer of a telephone interview displays ethical sensitivity. Moreover, it enables anxious participants to talk more freely than they otherwise would (Novick, 2008), particularly where sensitive information or clandestine activities are being disclosed. These comments reflect my own experience – the participant who had declined a face-to-face encounter due to anxiety offered a wealth of information *and* reported that partaking in the research had had a positive therapeutic impact.

The telephone interview was an effective alternative that enabled me to carry out three interviews that would not otherwise have not taken place. With the telephone interviewees, rapport developed through prior email and phone contact over time (as did the face-to-face interviews) and immediately before the interview proper in the form of small talk and additional discussion of the research. Certainly, the negative ramifications

of telephone interviews highlighted by some commentators in terms of data quality were not forthcoming. Each telephone interviewee spoke freely and without hesitation about a variety of activities (Novick, 2008). This free disclosure may have been a product of the 'partial anonymity' a telephone interview affords – a situation which, according to Fenig et al. (1993), may actually enhance the validity of participant responses. Listening back to the recordings and then producing the transcripts, there is no discernible difference between the quality of the face-to-face and telephone interview data. Having now experienced telephone interviewing first-hand, I fully concur with King and Horrocks (2010) who argue that the qualitative telephone interview should be seen not as a last resort but as a valuable tool for collecting qualitative data.

Although the preceding discussion is upbeat and for good reason, for neophyte researchers to negotiate an ideal first interview is possibly the exception not the rule. I did have reservations about my interpersonal abilities and the narrative-orientated approach of choice. Although my reading and postgraduate training provided me with knowledge of how to probe, prompt and work with silence, theory is not practice. It is safe to say that my introduction to the world of research interviewing, although invaluable as an experience, did not go as planned. As previously alluded to, rapport is a central aspect of qualitative interviewing but over-rapport (Kim, 2016) can be counterproductive. Goudy and Potter (1975) raised a pertinent point in stating that maximal (as opposed to optimal) rapport can veil the interview's purpose (cited in Kim, 2016). Indeed, on reflection I realised that over-rapport was a major influence on my interview with a friend as described below.

4.77 Interviewing a Friend: A Reflexive Account

Although interviewing can produce powerful stories that both 'inform and inspire' (Willis et al., 2007, p.244), I quickly discovered that obtaining 'quality' interview data can indeed be difficult and involves both practice and effort. As King and Horrocks (2010) explain, an interviewer who appears tense can create an atmosphere wherein the participant will also

feel ill at ease. Moreover, and as noted by Harris (2002) in her account of the 'friendly interview', the introduction I had pre-prepared felt inauthentic. The knowledge I already had about the details of this person's life certainly had an impact on the interview process. However, in contrast to Harris' (2002) experience, the interview, although yielding some useful data did not produce the 'in-depth extended account' I had hoped for (p.49).

Moreover, although building good relations are noted as a key ingredient for carrying out successful qualitative interviews (DiCicco-Bloom and Crabtree, 2006), when interviewing my good friend the pre-existing levels of friendship and mutual understanding of one another's lives heightened the feeling of awkwardness. My own anxiety was magnified by the anxiety the respondent was clearly experiencing, restricting my capacity to exhibit good listening skills and pay full attention. On listening to the recording, I had missed several opportunities where additional probing may have produced some interesting and relevant insights. Following the final question and answer, the release of tension was palpable – indeed, recognition of how 'weird' an experience it had been prompted mutual laughter as we returned to our far more comfortable status as friends. In sum, this was an unexpectedly difficult experience but nonetheless a useful learning curve and good preparation for future interviews. Another positive that emerged from this experience was the post-interview conversation – with the recorder turned off my friend told me about some difficult life experiences of which I had not been aware, allowing me to know him better than I had before.

4.78 Summary

My purpose in this section has been to introduce, explain and provide a rationale for the use of semi-structured narrative-orientated interviews. I critically discussed the concepts of 'structure' and 'narrative' in the context of qualitative research interviews and clarified the constructionist narrative-discursive orientation adopted in this study. Research positionality and insider-outsider doctrines were brought to bear including

an explanation for why I positioned myself as a partial insider occupying the space between. The practicalities of face-to-face and telephone interviews were presented with an emphasis on justifying and explaining my use of the latter as a means of collecting narrative data. I finished with a reflexive account of one ‘difficult’ interview and its status as a learning experience. In the next section I outline the ethical approval process and how related concepts of informed consent and confidentiality and anonymity were addressed.

4.8 Ethics

4.81 Ethical Approval

Ethical approval for this study was granted by the University of Northampton Research Ethics Committee. As part of this process I had to demonstrate my commitment to ethical research by outlining to the Committee how ethical concerns including informed consent, data confidentiality and participant anonymity had been fully accounted for and adequately addressed.

4.82 Informed consent

In the weeks prior to the interview, each participant was emailed a participant information sheet (see Appendix B). If happy to proceed, they were asked for their consent directly before the interview began. Although for the most part written consent was obtained by asking participants to sign a consent form (see Appendix C), the process was slightly more complicated when participants were interviewed over the telephone. I managed this by spending additional time reiterating the aims of the study and the nature of their participation and reading through the consent form immediately before commencing the interview proper (see King and Horrocks, 2010). This, I felt, was enough to assure me that the participant understood the research and their involvement in it, and thereby had given informed consent albeit verbally. My offer to send a consent form in a pre-paid envelope was deemed by participants as unnecessary and declined.

4.83 Confidentiality and Anonymity

All interviews, with consent, were audio-recorded. A soon as possible following the interview they were downloaded onto a password protected computer and deleted from the voice recorder. All paper-based data – print outs of transcribed interviews – were stored in a locked cabinet. Throughout the duration of the study, only myself and my supervisory team had access to the transcriptions.

To protect participant anonymity, all identifying characteristics were removed from the interview transcripts. In the thesis itself, each participant is given a pseudonym. Two participants, both authors and public speakers, suggested that I use their publications as an additional data source and were not concerned about retaining anonymity. Although this offer was not acted on, nor their books named, I was less concerned that alluding to their status as authors in combination with extracts from their account within the thesis, may provide enough information for a person thus inclined to identity them.

4.9 Data Transcription

All interviews were transcribed verbatim. In terms of detail, the transcription, following Taylor (2001), is situated between the approach often utilised in macro discourse analytic work where only a record of the words spoken by participants is deemed necessary and the conversational analytic requirement for every detail of the interaction between researcher and participant to be recorded in the interview transcripts (see Appendix D for a table of transcription symbols)

4.10 Data Analysis

Analysis of interview data was an iterative rather than strict step-by-step process. A decision was made to structure the analysis chronologically – from drug initiation through to future aspirations – reflecting the shape of all participant narratives.

Broadly speaking, the analysis started at the transcription stage and then continued with multiple re-readings of the data items and data set. No

qualitative analysis software was utilised – initial descriptive notes were made in pencil in the margins of interview transcripts or in a notebook along with their location (personal decision to use drugs, Interview B, Lines 36 and 53 (for example)).

After becoming familiar with the data set though prolonged emersion and note-taking, the analysis started with a macro search for discursive constructions – constructions were then considered in the context of wider or overarching discourses and canonical narratives. As a brief example, 'drug use as escape' and 'life on the othered side' were both constructions situated within the canonical notion of a 'downward spiral' or 'descent into addiction'. The analysis further explored how respondents utilised culturally available resources to construct particular versions of reality – where relevant, the shaping of participant subjectivities was theorised. Having analysed Putting Full Recovery First, the discourses identified by my reading of that text were also considered in terms of their constitutive potential or use as resources for talk. The next stage was a meso emphasis on how respondents positioned self and others and what this achieved and a focus on identity work including instances of 'trouble' and 'repair'. Finally, the texts were considered with a focus on rhetorical-discursive strategies deployed by speakers and what these strategies achieved. Throughout, notable similarities and differences among and between individuals aligned with the same and differing recovery pathways were observed. A common thread throughout were questions such as: What is this individual doing with their talk? What is being achieved and why? How is the discursive milieu being utilised in the production of this account? What are the implications of discourse for how this speaker experiences their self and the world?

As alluded to, the above was by no means a linear process – on reading and re-reading the transcripts with an initial focus on identifying constructions ('drug use as escape' for example) and then discourses ('The Downward Spiral' for example) significant features relating to rhetorical talk or positioning work, or an interesting aspect of self-identity

trouble and/or repair may also emerge. Moreover, the first attempt at analysis was by no means the last – recordings were listened to and transcripts revisited numerous times over many months with any new insights noted for possible inclusion in the final version of the analysis.

4.11 Conclusion

In this chapter I have discussed methodological approaches pertaining to both the documentary analysis and interview strands of the thesis. I started with a discussion of the ontology and epistemology underpinning both strands of empirical research and then defined self-identity and subjectivity. Next, I justified the selection of Putting Full Recovery First as the document for analysis and followed this with a critical account of Foucauldian-orientated discourse analysis as theory and method. I then detailed the analytic stages applied to Putting Full Recovery First. My attention then shifted to the interview strand of the thesis, first explaining and justifying the synthetic (narrative)discursive methodological framework. Departures from Taylor's narrative-discursive approach were also noted. This was followed by discussion of issues relating to recruitment and sampling with a brief introduction to each participant presented in table form. I then engaged in a prolonged and critical account pertaining to semi-structured interviews with a narrative emphasis as a data collection method. Proceeding this, the practicalities of interviewing were discussed including researcher positionality, a robust defence of telephone interview as a data collection instrument and challenges encountered when interviewing a good friend. Ethical issues and how they were addressed were then attended to including receipt of ethical approval by the relevant University of Northampton Ethics Committee. Finally, I briefly explained the transcription of interview data and outlined the analytic process.

CHAPTER 5

A Discourse Analysis of Putting Full Recovery First

5.1 Introduction

Having explained in Chapter 4 why this text was selected for analysis and having discussed Foucauldian-orientated analysis in terms of theory, method and analytic framework, in this chapter I begin with a critical discussion of Putting Full Recovery First (PFR) as a strategy document with reference to wider literature and personal observations. Following this, I describe the text and summarise its contents. The subsequent analysis is structured under four overarching discourses identified during my reading of the text. In the chapter conclusion I reiterate key points from the analysis and draw attention to their relevance to the interview strand of the research.

5.2 The Text: Wider Reactions and Personal Observations

Placed in the public domain by the 'Inter Ministerial Group on Drugs', PFRF 2012 is described as 'the government's roadmap for building a new treatment system based on recovery' (p.2). It claims to establish how a recovery-orientated system should operate. Unlike the 2010 and 2017 UK strategies, PFRF focuses not on the supply and demand aspects of drug policy but solely on treatment and recovery. Although treatment-orientated documents have in the past been published at local/regional levels, the publication of PFRF is the first time a recovery-focused strategy for England has entered the public domain.

My first thought was that PFRF was produced in reaction to right-wing critics of the 2010 national drug strategy – those who felt that the promised focus on abstinence had not been forthcoming. This initial suspicion, although not explicitly confirmed, was nonetheless handed additional credence by Daddow (2012) who asserted that the publication of PFRF prompted discontent across the addictions sphere, provoking anxiety, confusion and apprehension among academics, activists and practitioners alike. Moreover, and despite reading PFRF with care and

anticipation, Substance Misuse Management in General Practice (SMMGP, 2012) concluded that the document is both flawed and confusing.

In line with my own observations and existing literature, it is no surprise that subsequent critiques have highlighted the lack of evidence on which PFRF is based (Watson, 2013; UK Harm Reduction Alliance, 2012). The harm reduction paradigm has been adopted worldwide because of evidence in support of its effectiveness, whereas the same cannot be said for abstinence-only one-size-fits-all styles drug treatment (Best et al., 2010). Indeed Best et al. (2010) affirmed that the limited evidence-base on which the recovery concept currently rests would fail to meet National Institute of Clinical Excellence (NICE) standards. Although the 'roadmap' metaphor connotes a strong sense of direction, PFRF appears to lose its way and needed to stop and ask for direction prior to implementation (SMMGP, 2012). Reports of the internalisation of new recovery by service users and related links to premature abstinence (Neale et al., 2013) as well as record rises in drug-related deaths (AMCD, 2016) since PFRF entered the public domain suggests that the pause and rethink did not occur.

5.3 'Putting Full Recovery First': Structure and Content

Putting Full Recovery First (PFRF) is a 27-page document which 'outlines the Government's roadmap for building a new treatment system based on recovery, guided by three overarching principles – wellbeing, citizenship and freedom from dependence' (Foreword, p.2). It is divided into numerous subsections which cover 'the context for reform' (p.2) and describe the structural changes (transfer of National Treatment Agency (NTA) functions to Public Health England (PHE), changes to how drug treatment services are commissioned, a series of new partnerships, and a system of payment-by-results and focus on outcomes. In line with the coalition government's Localism Act, PFRF emphasises the role of local areas in designing services which accord with local requirements. Also stressed is the importance of 'mutual aid networks' (p.6) and the need for localities to establish 'Recovery Champions' at three levels: strategic (local

Directors of Public Health); therapeutic (among treatment providers); and community (service user mentors for those not yet in 'full recovery').

The role of the 'expert' in developing the new agenda is accentuated as is the need for evidence-based practice and interventions and a more ambitious and recovery-orientated workforce. Throughout the document, significant stress is placed on the need to move away from methadone/harm reduction orientated treatment towards abstinence-based provision. A brief discussion of alcohol (p.12) is followed by a section which covers the requirement for service users to maximise their 'recovery capital' and take responsibility for their own treatment (p.13), assisted by the development of 'patient placement criteria' (p.14). This is followed by a few short paragraphs on the need to 'provide a body of evidence to support the use of residential rehabilitation services' (p.16), investigating trends and factors in relation to drug-related deaths, and the prevention of blood-borne viruses.

These statements precede the assertion that a 'whole systems approach' is essential, characterised by the collaboration of drug treatment services with those related to health, housing, education, training and employment. On page 21 there is a short section on 'protecting children and rebuilding families'. The need for drug users to reintegrate into communities is emphasised and this is followed by relatively lengthy discussion in relation to housing needs and assisting people into employment via the Department for Work and Pensions (DWPs) Work Programme. The remainder of the document (pp.25-27) covers criminal justice interventions and rehabilitating offenders as well as the need to provide intensive support for young people.

PFRF also places significant emphasis on the promotion of 'freedom' – in this case from all chemical dependency. As Garland (1997) notes with reference to the Foucauldian concept of 'governmentality', governing through freedom is a strategy utilised by neoliberal administrations; it is designed to produce subjects who internalise and experience government objectives as desirable goals. The intention, then, is to produce self-

governing citizens who strive to fulfil *official* goals (full recovery) in the belief that such goals are 'freely chosen' and in their best interests. Alongside the overarching concept of freedom, common and re-occurring themes which permeate the text include: the move away from methadone towards abstinence-based provision; that people who use drugs should choose recovery; the responsibility that local areas and service users must exercise; the need for evidence-based and expert-led interventions; and the need to provide cost effective services which provide value for public money.

5.4 The Analysis

Notably and unlike the front page of most national drug policy documents (including the 2010 and 2017 National Strategy) which are embellished with only the Home Office symbol and strategy title, the statement - 'Putting Full Recovery First' - is surrounded by the names and symbols of eight different government departments. Published within the context of a national drug strategy which was seen by some right-wing critics as not pushing abstinence explicitly enough (see Gyngell 2009; 2011), I interpreted this as a display of unity and power – a means of symbolising that 'we, the government, are all in this together' and we (the government) are putting 'full recovery' (as defined by government) above all else. The face of Lord Henley (then Chair of the Inter-Ministerial Group on Drugs) on page 2 exudes an aura of calm authority, evoking a 'fair but firm' persona. My initial readings also revealed several omissions – the unwritten and unspoken. Silence, according to Foucault (1979), is a masking process and mechanism of power. It is a central component of the strategies that permeate and underlie discourses (cited in Brent, 2009). I observed that the term 'medication-assisted recovery' is not mentioned at any point. Rather, long term prescribing per se is positioned within PFRF as wholly unacceptable. Furthermore, talk of wider social factors associated with the problematic use of 'hard' drugs such as poverty and social deprivation, inequality or a restrictive job market (See Buchanan 2004a; 2004b; Seddon, 2006) are omitted. Despite research

reporting that widespread societal and institutional stigma has serious implications for a drug users' capacity to recover from dependence (see Lloyd, 2010a), wider societal attitudes are alluded to only once - 'the stigma in some communities' - on page 13.

The layperson, perhaps familiar only with the 'war on drugs/war on drug user's' discourse which permeates political rhetoric, is thus enrolled in a version of social reality where medication-assisted recoveries are of no significance and drug treatment interventions must be abstinence-based. Moreover, the text functions to produce a context wherein achieving 'full recovery' is the sole responsibility of individuals, with widespread poverty, inequality and social stigma of little if any significance.

After reading the text numerous times and taking notes, four intersecting discourses were identified as follows: 'full recovery as compassionate act'; 'addiction and recovery as lifestyle choice'; 'full recovery as abstinence'; and 'full recovery as rational and moral'. In the following, each discourse will be analysed and discussed in turn with relevant extracts from the text presented throughout. A conclusion highlights the significance of the analysis for this thesis.

5.41 'Full Recovery as Compassionate Act'

In 'full-recovery-as-compassionate-act' I explore how the recovery agenda is represented as being in the best interests of all – individual, family and community and, indeed, British society per se. This section of the analysis focuses on how the 'full recovery' ethos is framed as both necessary and desirable - an act of selflessness introduced by a compassionate, Conservative-led government, a government that genuinely cares about the well-being of both its 'conventional' citizens and those who deviate from 'the norm'. The quote below exemplifies how the government's position on drug use and recovery is framed …

> *'As part of the coalition government's commitment to ambitious and progressive social reform – which is driven by a commitment to social justice and a belief that everyone deserves a second chance – we are*

setting a new direction for responding to the danger of drug and alcohol misuse' (p.3)

Throughout the text, there are several statements which allude to selflessness on the part of the addressor, implying that the strategy is based around the needs and desires of others. Furthermore, establishing that the government is 'setting a *new* direction' (p.3) functions to position the old treatment system and previous government as lacking ambition and regressive - unwilling to offer people the second chance they deserve. The compassionate act discourse is further reinforced where becoming free from dependency is later represented as offering people 'the personal freedom the majority of us experience' (p.5) and 'the aim of the vast majority of people entering treatment' (p.10). This functions to represent the recovery agenda as not only progressive and ambitious but also 'fair' and 'service user led'. In relation to the discursive economy, 'full recovery as compassionate act' draws on the notion of 'compassionate conservatism' or 'Red Toryism' (see Blond, 2009), exemplified by a personal introduction by then Prime Minister David Cameron to the document: 'Modern Compassionate Conservatism' …

'We needed to be compassionate […] we believe, above all, in giving people a helping hand' (David Cameron).

The 'full-recovery-as-compassionate-act' discourse avails various subject positions and also functions as a form of defence against attack (Parker, 1999). The 'mainstream' subject is invited to support a government who believes that no one deserves be written off regardless of past mistakes. For the drug user, 'full recovery as compassionate act' avails the subject position of 'willing participant' or 'unwilling participant', of 'responsible citizen' or 'irresponsible citizen', as 'grateful' or 'ungrateful'. To reject this act of compassion, this second chance to enjoy 'personal freedom' would position the drug user as ungrateful, unwilling and irresponsible. Indeed, rejecting the government's 'generous offer' of recovery could potentially lead to the individual being deemed unworthy of 'help' in the future.

Moreover, being positioned by others as an individual who rejected a kind and selfless offer may in hindsight produce feelings of personal blame and self-loathing. That is, an person who receives yet rebuffs this 'gift' may deem self as undeserving of another opportunity. Hence, the framing of the recovery agenda as a compassionate offer may have significant implications for drug user subjectivities. Moreover, within this discourse, those who criticise the 'recovery roadmap' whether lay people, academics, service users or treatment provider's, may stand accused of lacking ambition or denying people the second chance they deserve.

This 'compassionate' opening to the roadmap, however, soon gives way to a more explicit and traditional right-wing discourse in the form of a shift towards discursive strategies that function to de-emphasise the 'problematic effects of neoliberal policy goals' whilst bringing to the fore 'individual-level variables as the source of the problem' (Teghtsoonian, 2009, p.33). Strategies of this nature are deployed in 'Addiction and Full Recovery as Lifestyle Choice' as discussed below.

5.42 'Addiction' and 'Full Recovery' as Lifestyle Choice'

In 'addiction' and 'full recovery' as lifestyle choice' my focus turns to exploring how by individualising the constructs 'addiction' and 'full recovery', the implications of wider societal factors are de-emphasised. In a context of austerity where the structural causes of inequality, poverty and unemployment are being transformed into 'individual pathologies of benefit dependency and worklessness' (abstract), constructing addiction and recovery as lifestyle choices function to divert the public gaze away from the 'failing neoliberal model of political economy' (Wiggan, 2012, p.385). Instead, individual explanations for hardship including poverty, debt and drug addiction become the focus of attention. The following quote reveals how the inclusion of some words and exclusion of others functions to position drug addiction as a personal-moral issue – a matter of personal choice.

> *'Our strategy recognizes that drug and alcohol misuse is very rarely an isolated personal problem, its reach is criminal, social and*

> *economic; its impact is felt in countless communities across the country. Crucially, we also understand that people often choose such a path in the context of wider social breakdown in their lives, such as chaotic and dysfunctional family relationships, personal debt, criminal behaviour and poor mental health'* (p.3).

Later on the construct 'full recovery' joins 'drug misuse' as a way of being that people can choose - a situation which they can opt in to or opt out of …

> *'we must go further than merely reducing the harms caused by drug misuse and offer every opportunity for people to choose recovery as a way out of dependency'* (p.6)

and …

> *'the Drug Strategy's goal is to […] become more ambitious for all those who want to address their dependency'* (p.6)

Both drug use and 'full recovery' here are constructed as decisions which reside within the individual. For example, drug misuse is described as being 'very rarely an isolated *personal* problem' and a path that people often '*choose* in the context of wider social breakdown in *their* lives' (p.3). This alludes to personal choice and individual failing as factors that precede and accompany drug dependence. Notably, wider structural factors such as widespread poverty, inequality and the economy are not brought to bear. Notions of choice are further alluded to. An example lies in the statement that people will be '*offered* every opportunity to *choose* recovery as a way out of dependency' (p.6). Another case in point is the expressed need 'to become more ambitious for all those who *want* to address their dependency' (p.6). Here the use of the words 'personal', 'choose', 'their', and 'want' are functional. The removal of these individualising and responsibilising terms presents a strikingly different picture as shown below …

'Our strategy recognizes that drug and alcohol misuse is very rarely an isolated problem […] we understand that drug use often occurs in the context of wider social breakdown'

Following Graham (2005), it is possible to see 'how language *transports* via the imagery conjured by emotive words' (p.7) that produce drug misuse and full recovery as matters of personal choice. The construction of drug use and other related issues (debt, criminality, poor mental health, dysfunctional families) as lifestyle choices positions the drug user as wholly accountable and responsible for the implications of that choice - for example, the negative effect on families (including children), communities, society as a whole and the wider economy. It is a discursive strategy that functions to apportion blame on those who (apparently) choose, despite the alternatives on offer, to continue the addict lifestyle.

Drawing on the Foucauldian notion of governmentality and following Teghtsoonian's (2009) analysis of mental health policy discourse, wider discourses of individualisation, responsibilisation and self-management focus attention on the individual drug user rather than the socio-political environment in which problem drug use is situated. Responsibility for good health and wellbeing is moved from the state to individuals, families and communities. Teghtsoonian (2009) notes how government strategies, apparently designed to address mental ill health, correspond with wider 'neoliberal policy goals and orientations' (p.33). Discursive strategies are deployed which function to de-emphasise the 'problematic effects of neoliberal policy' while bringing to the fore 'individual-level variables as the source of the problem' (Teghtsoonian, 2009, p.33).

In a similar vein, Garland (1997) has pointed to the ways in which late modern correctional strategies subjectify and responsibilise the 'deviant' and maintain that he/she must address and be held accountable for their conduct. Moreover, techniques of the self, introduced by government agencies to instil the value of responsibility and prudence in 'deviant' subjects, *assume* a correlation between individual desires and government objectives (Garland, 1997). In light of Maruna's (2001) claim that

desisting former offenders tend to *retain* their identities as 'antiauthoritarian rebels' (p.154) this, I would suggest, is at best an optimistic assumption, at worst a fundamental misinterpretation of the situation.

The institutional and non-institutional practices which constitute governmentality also give rise to the importance of adhering to 'the norm'. Examples include normal development, normal behaviour and normal functioning by which individuals are assessed throughout the life course (Nettleton et al., 2012). In their 'analysis of discourses of normality among recovering heroin users', Nettleton et al (2012) argue that …

> *'a desire to be normal is not simply a personal goal but the product of a society that encourages and privileges 'normality' - the norm' and 'being normal' form a crucial aspect of neoliberal societies whereby individuals are encouraged through projects to become normal'* (p.2).

According to Canguilhem (1978) recovery programmes seek to empower clients to 'recover' from their 'pathological' state and return to normality (cited in Nettleton et al., 2012, p.3). The 'addict' is positioned in a marginal space and judged to be a social problem in need of treatment and rehabilitation. This rhetoric of blame and individual failing offers little hope or encouragement for those who are unable to desist from using drugs. For the 'unrecovered' or active drug user, the 'lifestyle choice' discourse variously positions them as 'unwilling', 'weak', 'abnormal', 'immoral' and/or 'bad'. These subject positions not only enable and constrain action but shape subjectivities and 'the self-narratives individuals use to talk and think about themselves' (Burr, 1995, p.152). A person who is unable resist prevailing discourses and the subject positions they avail, may subjectively experience their self as a failure and incapable of making the 'correct' choice. Moreover, the links between problematic drug use and issues including socioeconomic deprivation, unemployment and mental ill health position 'the addict' in multiple intersecting discourses, each with implications.

For example, Wiggan (2012) asserted that a discourse of worklessness and dependency positions the poor and unemployed as 'benefit cheats' and 'scroungers' and those with mental ill health as weak-minded, dangerous or mad. Hence, the drug user may be subjected not only to morally loaded constructions of 'junkie' or 'addict' but also discourses associated with unemployment and mental illness. Those who are unable to resist or challenge these and the 'lifestyle choice' discourse that permeates PFRF will struggle to experience their selves in a positive light and this, in turn, is likely to constrain their capacity to 'recover' from addiction.

The above has drawn attention to how 'addiction' and 'full recovery' are positioned as a personal choice and the government's framing of its agenda as progressive, ambitious, and fair. My attention now turns to exploring how 'full recovery' is constituted within the text. Of interest here is a 'full recovery as abstinence' discourse that constructs recovery as a homogenous state.

5.43 'Full Recovery as Abstinence' (from all chemical dependency)

The focal point of this section is the polarised and increasingly divisive debate which tends to portray abstinence and maintenance approaches to treatment as an 'either/or issue' (UKDPC, 2008, P.2). Despite lines of thought that conflate the terms 'recovery' and 'abstinence', evidence strongly suggests that recovery is more than simply using or not using drugs (Neale et al., 2012). Although, for some, the term is synonymous with abstinence from all drugs including prescribed medication (Gyngell, 2009; 2011), others offer a broader definition of recovery, related more to improvements in psycho-social functioning and the accumulation of recovery capital including gainful employment, adequate housing, a stable family life, access to peer support and improved health (see UKDPC, 2008). The latter definition captures the many stable and socially productive methadone patients in treatment today (UKDPC, 2008; Neale et al. 2012). Indeed Best et al (2010) argue that a recovery-focused system *could* work with the individual, using an informed-consent, person-

centred process that offers the choice of abstinence and maintenance-based treatments.

To begin, the focus will be on how people who continue to use drugs and those who are prescribed methadone and other 'substitute' medications are constructed within the 'full recovery as abstinence' discourse, the subject positions they may occupy and the implications for subjectivity, experience and behaviour. The construct 'Recovery Champion', the subject position it avails and the implications for those who do not achieve (or desire) this status will also be brought to bear. As well as active and former drug user, the analysis also considers the subject positions made available to front line substance misuse workers and the implications for practice.

Despite prior official constructions of recovery as an 'individual, person-centred journey that will mean different things to different people' (Home Office, 2010, p.18), the quotations below reveal how PFRF positions long-term use of methadone and other medications used in medically assisted recovery (MAT) as wholly undesirable …

> *'The Coalition government has set out it's aspiration [......] to bring an urgent end to the current drift of far too many people into indefinite maintenance, which is the replacement of one dependency with another'* (p.3)

The use of the word 'drift' to represent the lives of people on maintenance prescriptions connotes a sense of aimlessness and implies a lack of agency with regards to those who access this form of treatment. Later references to 'breaking an addict's dependence for good' (p.8) and 'addicts 'parked' on methadone' (p.10) also contain negative connotations, implications and allusions. For example …

> *'Our immediate task, therefore, is to create a [....] system of recovery […] which helps people to break an addict's dependence for good' (p.8)*

'No longer, therefore, will addicts be parked on methadone […] without expectation of their lives changing. We must ensure that all those on a substitute prescription engage in recovery-driven support to maximize their chances of being free from any dependency' (p.10)

The noun 'addict' (p.8, p.10, p.11, p.19, p.23, p.24) produces an identity category which, for Parker (2005), connotes weakness of will and 'moral decay' (p.100). 'Breaking' (an addict's dependence) implies dismantling by force whilst 'parked' - putting to one side the obvious driving metaphor (this is, after all, a recovery roadmap) - alludes to an inability to progress. The use of the term 'parked' is particularly derogatory as it not only connotes a static state but implies that the individual had no choice in the matter. This terminology connotes a scenario wherein individuals are prescribed methadone only to be abandoned by those who have the power to determine their life trajectory. Although my task as analyst is to focus on how the text *functions*, I feel obliged here to point out that people *do choose* to access medications such as methadone, go on to live stable, productive lives and feel that abstinence is not necessarily in their best interests. This assertion can be clarified by visiting open access internet forums such as The Alliance.

Throughout the text 'full recovery' and abstinence from all chemicals are conflated whilst the term 'medically assisted recovery' is omitted entirely from the text. For example, it posits a shift 'away from long-term maintenance' and 'towards achieving full recovery for as many addicts as possible' (p.11). That substitute prescribing 'will not be the final outcome paid for in payment-by-results (PBR)' (p.10) implies that methadone use in any circumstance is an undesirable outcome. Moreover, it positions those who remain on a methadone prescription is the antithesis of a 'good result' even when accompanied by stability and social reintegration. As discussed earlier in the thesis, this research rejects discourse determinism and acknowledges the human capacity for agency - individuals can challenge, negotiate and resist these constructions and discourses although, to do so, is by no means an easy task (Burr, 2015).

Other instances where full recovery is constructed as abstinence include the statement …

> *'open-ended substitute prescribing will only be used only where absolutely necessary and even so with full recovery as the eventual goal'* (p.12).

and, more directly in that …

> *'people are far more likely to believe in and pursue recovery in their own lives when they see abstinence work for others'* (p.20).

That the use of prescribed medication will be used only where absolutely necessary and, then, only with 'full recovery' as the eventual goal, functions to position medication-assisted treatments as a last resort. Any positive aspects of such treatment modalities are rejected. These messages are examples of Barthe's concept of 'tautology' where 'reasoned argument is abandoned in favour of the repetition of a statement as if it were now self-evidently true' (cited in Parker, 2005, p.103). By repeatedly positioning 'full recovery' as synonymous with abstinence, the myriad ways in which clients themselves construct recovery (Borkman et al., 2016) are unheeded, likewise the arguments of those who resist 'full recovery as abstinence' and advocate for medically assisted recovery pathways (Nutt, 2015) and continued investment in harm reduction services (English Harm Reduction Group, 2017).

Another interesting point to note here is that although (recovering) drug users are variously constructed in PFRF as 'problem drug users' (p.3), 'people in treatment', 'those dependent on drugs' (p.4), 'patients' (pgs.10, 11, 12, 14), 'drug misusers', 'service users', 'treatment users' (p.13), the 'treated population' (p.15), 'people with a drug support need' (p.21) and 'drug abusers' (p.24), where the focus turns to methadone treatment the terms 'addict' and 'addiction' are deployed. Also, directly beneath the heading 'Helping people find sustained employment', it states that the …

> *'The DWP will work closely with treatment providers […] to ensure that addicts are Work Programme ready"* (p.23)

These discursive strategies function to conflate 'addiction' and 'methadone treatment' and 'addicts' and 'people who are prescribed methadone'. Furthermore, the statement above presumes that 'addicts' (and thus methadone patients) are unlikely to be even '*Work Programme' let alone* work*place* ready. In sum, the negative connotations attached to the term 'addict' are transferred to people who take prescribed methadone and other similar medications. The extracts below are other examples where the text functions to disassociate methadone from recovery …

> *'Whilst we recognize that substitute prescribing can play a part […] both in stabilizing drug use and detoxification, it will not be the final outcome paid for in Payment-by-Results. There may be people in receipt of such prescriptions who have jobs, positive family lives and are no longer taking illegal drugs or committing crime. But it is important to utilize such interventions as a bridge to full recovery, not as an end in itself or indefinite replacement of one dependency with another' (p.10)*

Also …

> *'No longer, therefore, will addicts be parked on methadone or similar opiate substitutes without an expectation of their lives changing' (p.10)*

The statement that substitute prescribing can 'place a part' in 'stabilising drug use and detoxification' but will not be considered 'a final outcome' functions, again, to remove any association between so-called 'substitute' medications and recovery. Moreover, the second quote contradicts the first - that is, to assert that some methadone patients have jobs and a positive family life and then to insinuate that 'addicts' are parked on methadone with little prospect of their lives changing displays inconsistency and adds to the incoherence of the text. Moreover, no explanation is given as to why '*people in receipt of such prescriptions who have jobs, positive family lives and are no longer taking illegal drugs or committing crime'* should not be deemed 'in recovery' nor why it should not be considered a credible outcome.

It should also be noted that these statements disregard the need to take into account service user needs and preferences (Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group (CGDMD, 2017) and the high risk of relapse associated with abstinence-based treatment per se but enforced reductions specifically (Department of Health, 2007; CGDMD, 2017). By representing methadone treatment as the replacement of one addiction with another, the text functions to construct methadone and by association (even stable and productive) methadone patients as undesirable. In sum, emphatically asserting that interventions characterised by long-term prescribing will not be considered a good enough outcome positions abstinence (whatever the cost to individuals) as more desirable than stability, if that stability is medication-assisted. With this in mind, the discussion will now turn to the subject positions made available to both service users and treatment personnel within the 'full-recovery-as-abstinence' discourse, drawing attention also to associated implications for subjectivity and practice.

To begin, it is important to first observe that the drug treatment philosophy and the dominant discourse within which drug users and treatment personnel have been embedded for the previous 3-4 decades has been one of harm reduction. Until 2010, normative perspectives on the role and purpose of treatment were shaped by a discourse where harm minimisation and treatment retention (as opposed to completion) were positioned as benchmarks of success. Harm reduction techniques, particularly for heroin addiction, include long-term methadone prescribing, an approach that the new 'recovery-as-abstinence' discourse soundly rejects. Service users who achieved stability and long-term medication-assisted recovery would, within a harm reduction discourse, be positioned as treatment success stories. Similarly, treatment personnel who successfully supported clients towards stability would occupy the subject position of 'successful professional'.

The meanings associated with 'successful' and 'effective' drug treatment have shifted dramatically. As a consequence, self-identities and

subjectivities will also be in a state of flux with language becoming 'a site of struggle, conflict and personal and social change' (Burr, 1995, p.44). Indeed, it will be interesting to explore if interview respondents, particularly those who are currently accessing medication-assisted treatment (MAT) or have in the past, challenge or take-up the subject positions availed by this shifting discursive landscape and to what extent new recovery discourses shape how respondents position self and others, including drug treatment professionals and other 'experts'.

Within the 'full recovery as abstinence' discourse, service users who continue to use drugs or wish to remain on prescribed methadone treatment are positioned as 'failures' who lack ambition. Within this discourse, someone who has achieved medication-assisted recovery following years of chaotic street drug use *can* no longer be positioned as a success story. If or not respondents on prescribed methadone draw on full recovery discourses to construct their future aspirations whilst disparaging the medication they are currently prescribed will be another interesting point of enquiry. A further area of consideration will be how *former* methadone users position their past selves and construct medication-assisted recovery pathways and those who are aligned to them.

Although research suggests that some service users will attain sustained abstinence many more ultimately will not (Zickler, 2001; Termorshuizen et al. 2005; Department of Health, 2007; Strang, 2012). Clients who challenge and resist the prevailing 'recovery-as-abstinence' discourse may do so by drawing attention to inherent contradictions in the shift to 'full recovery'. That is, they may question how an individual can be positioned as a 'success story' one day and 'failure' the next. However, as Burr (2008) affirms, 'dominant discourses are tied to social arrangements and practices which maintain the position of dominant groups' (p.151). In a context where drug service providers are subjected to government policy that pays them by pre-determined 'results', service users who challenge the prevailing recovery narrative, risk being positioned as 'a nuisance' or individuals who have rejected the 'offer' of recovery and, hence, are

'unwilling' to help themselves. Moreover, and utilising Foucault's concept of the 'docile body' wherein he highlighted the domination of the medical establishment and how patients are subjected to and unable to return the 'clinical gaze' (Lupton, 1997, p.101), the 'service user' or 'patient' is rendered powerless *relative to* professionals who produce care plans or write prescriptions. Indeed, the practical implementation of the new agenda will to an extent be reliant on the degree to which those who write prescriptions - often General Practitioners - either take-up or resist 'full recovery' discourse.

For service users who both desire *and* attain prolonged abstinence a subject position awaits – that of 'Recovery Champion' (p.4, p.6, p.20). Recovery Champions are positioned in the text as those who hold a status that all others should aspire to – the antithesis of the 'addict parked on methadone' (p.10) who 'drifts into indefinite maintenance' (p.3) thus 'replacing one dependence with another' (p.10). The noun 'Champion' connotes a winner and in so doing produces a binary opposite - the 'loser' who falls short of the 'full recovery' criteria constructed within government discourse. Notions of 'winners' and 'losers' invoked by the concept of 'Recovery Champion' may act as motivation for some who strive to reach this pinnacle. In this respect, it has the potential to enhance self-efficacy and provide a sense of direction. Moreover, to have conferred an identity as 'recovery champion' may produce a positive sense of self. With that said, the high relapse rate associated with abstinence-based treatment for heroin addiction should not be underplayed. In 2012, Harry Shapiro reported that over ten recovery champions in the North-West of England had relapsed in the last two years' and affirmed there is minimal support or guidance to prepare people for this role. Moreover, former services users who are tagged with the label 'champion' have further to fall. Indeed, in Shapiro's 2012 article a former Recovery Champion stated that …

> *'one minute you are a beacon of responsibility, you're giving talks, you're in the local paper; next minute you are walking back into treatment with your tail between your legs'* (in Shapiro, 2012 p.9)

For individuals who commit to and invest in a new self-identity as Recovery Champion, the personal implications of a sudden descent from this pinnacle could be severe. In short, if recovery opportunities are to be maximised, the prevailing oppositional thinking and construal of abstinence and harm reduction as incompatible and fundamentally opposed philosophical models of addiction treatment must be challenged (Best et al. 2010). Recovery is not a case of simply reducing or removing substances but the accumulation of positive benefits. Those seeking treatment for drug dependence should access to a menu of services and recovery pathways.

The likelihood of progress towards choice-focused model would be greatly increased through a focus on what individual clients' need and desire, thereby resisting 'one-size-fits-all' ideologies and embracing the development of a system that asks and listens but does not dictate. The UK government to-date, however, displays no signs of backtracking on the recovery agenda and related ideals. Part of this persistence could well be linked to another discourse identified during my reading of PFRF: 'full recovery as rational and moral'. Analysis of this discourse explores how the text invokes a discourse of 'worklessness and dependency' (Wiggan, 2012). This construction is enabled and reinforced by an economy wherein austerity measures continue to prevail despite the then Prime Minister Theresa May's declaration that austerity is over (Stewart, 2018). 'Full recovery as rational and moral' constructs the previous system, based on harm reduction principles, as not only unjust but of little value for the British taxpayer and a drain on the public purse.

5.44 'Full Recovery as Rational and Moral'

In 'full recovery as rational and moral' the focus turns to how the recovery agenda is constructed as a common-sense and morally sound political shift. In accordance with Parker's (1992; 1999) assertion that FDA

involves consideration of how discourses may function as a form of defence against attack, it will consider how those who resist this discourse could be positioned as undermining the best interests of the hard-working taxpayer.

The statement below exemplifies how the new agenda (towards which we all should strive) is positioned as a sensible, ambitious and necessary alternative to the 'old' treatment system and the accompanying philosophy of harm reduction …

> *'Whilst basic improvements have been made to the treatment system in recent years ...... there has been too much fatalism and waste. The coalition government has set out its ambitions to challenge the status quo and build a recovery-orientated society'. 'As a result of the rebalancing reforms we will lead, every effort will be made to confront the root causes of addiction, end chemical dependency and change people's lives'* (p.3)

The use of terms such as 'basic', fatalism', waste, 'ambition' 'challenge', 'lead', 'every effort', 'confront', 'end' and 'change' function to convey strong disapproval of the old system as well as a sense of urgency and need for change in order to repair the damage previously inflicted. Following Graham (2005), it is a demonstration of how 'performative language' is used to privilege particular visions of social reality and create the conditions from which practices can proceed and social relations can form (Foucault, 1972 cited in Graham, 2005). In recent decades, the British drug treatment system has been widely construed as successful with record numbers entering treatment (DrugScope, 2009), unprecedented treatment retention rates, improvements in health, reductions in crime (NTA, 2008; 2010) and value for money with every £1 spent on drug treatment thought to save £9.50 to society as a whole (Department of Health, 2008). However, the current economic climate and overhauling of the benefits system combined with increasingly aggressive media/government representations of methadone as 'state-sponsored

addiction' has set the scene for a new discourse to emerge - a new version of reality to receive the 'stamp of truth' (Burr, 2015, p.91).

For Foucault, knowledge (the common-sense view of social reality which prevails within a cultural context at a particular time) is closely tied-up with power. Recent political constructions of the 'old' treatment system (as wasteful and fatalistic) is an example of power being exercised through the deployment of a discourse which allows alternative practices to be represented as legitimate (Burr, 2015, p.80). In so doing, 'full-recovery-as-rational-and-moral' plays on 'the state of the nation' by invoking a neoliberal economic discourse and is thus indicative of contemporary government economic rationalities. A focus on value for taxpayer's money and fiscal responsibility has (re)shaped discourse and practice pertaining to a range of social issues (Garland, 1997). In the context of 'full recovery', the construction of 'addicts' as 'untrustworthy' and 'morally challenged' functions to produce a 'me or them' dichotomy, positioning those who resist 'full recovery' as undermining the nation's best interests.

In PFRF, the harm reduction paradigm is variously constructed as fatalistic and wasteful (p.3) and requiring a 'sea change'. Incapable of delivering recovery outcomes, it failed to offer 'genuine opportunities for recovery' (p.4) and reproduced the 'maintenance-orientated status quo of heroin addiction' (p.5) while *merely* reducing drug-related harms. This stands in stark contrast to the 'comprehensive and necessary' (p.3) full recovery agenda based on 'social justice and a belief that everyone deserves a second chance' (p.3). A bearer of 'genuine opportunities' (p.4), the new agenda will offer people *genuine* choice about their responsibilities and futures whilst enabling them to contribute to society.

Full recovery will not only allow people to enjoy personal freedom but is the 'most effective way of protecting against blood-borne viruses' (p.14). It is thus constructed as the antithesis of both medication-assisted treatment and illegal-drug addiction. Furthermore, the new agenda will assist in creating a recovery-orientated society thus contributing to

Britain's social and economic revival by ensuring 'the provision of services on a cost-effective basis' (p.17), 'value for public money' (p.14) and 'efficient and effective use of resources' (p.15) all based on 'a clear, cost-effective rational' (p.16). Through treatment which, 'evidence' suggests 'achieves full recovery and is cost effective' (p.19), a full recovery approach will 'get people off drugs, off benefits and into work' (p.17) or, at the least, will ensure that all addicts are 'Work Programme ready' (p.23).

In sum, PFRF positions the new agenda as one that will 'offer new hope for individuals and families' (p.10) and 'new hope of freedom from addiction' (p.16). It will 'change lives and transform communities' (p.5).

The statement below is indicative of how the 'full recovery as rational and moral' discourse summons the conventional British citizen …

> *'During 2011-12, the support provided to local areas will be restructured in order to adapt to the changing healthcare environment ... and make most efficient and effective use of resources'* (p.16)

This rhetoric hails the 'mainstream' subject who may be suffering personally from (non-drug induced) ill health, struggling to pay the mortgage and bills or even struggling to feed their children. Moreover, inundated by media and political rhetoric and a steady stream of 'strivers versus skivers' and other constructions of economic decline, the subject positions this discourse avails to the conventional citizen are those of being either 'for' or 'against' Britain's best interests. Perhaps already swayed by the discursive construction of methadone as 'state-sponsored addiction' – a discourse that is reproduced and reinforced by right wing politicians and media outlets - the feelings evoked by 'full recovery as rational and moral' may well function to reify mainstream opinion.

The following quote hails the substance misuse workforce, making available subject positions which, if taken-up, have implications for action and subjectivity …

'In particular we will engage with professional bodies, treatment providers and local commissioners to promote an ambitious culture of life change and a belief in a future free from any dependency for addicts and their families. Where such a belief has taken root in the workforce previously, remarkable change and recovery has been achieved' (p.19)

So for treatment personnel too, the subject positions made available by 'full recovery as rational and moral' are those of 'villain' and 'saint'. To be seen as not acting in accordance with the vision promoted above would position them as contributing not only to individuals' but the countries socio-economic demise. Alternatively, embracing full recovery provides an opportunity to occupy the positions of 'effective professional' *and* 'good citizen'. In sum, a substance misuse worker has little to gain from resisting or challenging the 'full recovery as moral and rational' discourse other than perhaps a cult hero status among illegal drug users or methadone patients. Taking-up the position of 'effective worker' and 'good citizen' by embracing full recovery ideals promises positive accolades and positive subjectivities.

Similar subject positions are made available to service providers, only with the potential for greater economic reward. Getting people off drugs (and methadone), out of the treatment system and preferably off benefits and into work ensures 'a result' - within a payment-by-results framework this triggers maximal financial reward. This does not however bode well for clients who remain chaotic, who are considered hardest to treat or those in medication-assisted recovery - those for whom abstinence is not a feasible proposition. As mentioned, within the 'recovery as abstinence' discourse these types of client are positioned as 'undesirable' and, ultimately, failed subjects. Indeed, the UK Drug Policy Commission's (2011) critical overview of payment-by-results (PBR) for drug treatment highlights the risk of cherry-picking clients who are most likely to 'succeed'.

Also evident within the 'full recovery as rational and moral' discourse is what Barthes referred to as the 'privation of history' where 'the past is forgotten so that something implausible can make an appearance' (cited in Parker, 2005, p.103). In PFRF, full recovery is also constructed as the 'best protection against blood-borne viruses (BBVs)' (p.18). Given the high risk of relapse associated with abstinence-based treatment and the subsequent increase in risk not only in terms of BBVs but overdose and death, this is both a misleading but a dangerous assertion. Positioning abstinence-based treatment as 'harm reduction at its best' discounts a wealth of evidence to the contrary (Harm Reduction Alliance, 2012). Nevertheless, producing and reinforcing the notion of 'full recovery as rational and moral' and the full recovery agenda as common-sense, creates a defence against attack from those who raise critical questions relating to this historic shift in the direction of drug treatment and any potential negative implications.

5.5 Conclusion

This analysis has revealed how the deployment of four intersecting discourses frame the 'full recovery agenda' in a manner that positions it as in the best interests of all. However, as alluded to, Putting Full Recovery First constrains the treatment options that services can now plausibly offer. I argued that the implications for drug service users are potentially severe and far reaching. The 'full recovery as a compassionate act' and 'addiction and full recovery as a lifestyle choice' discourses, at once, frame the agenda as a selfless act and 'addiction' and 'full recovery' as moral matters underpinned by personal responsibility. These discourses function to position government in a positive light, enabling them to abdicate responsibility for structural and institutional factors known to influence the instigation and maintenance of drug use and addiction and restrict the potential for recovery (see Buchanan, 2004a/b; 2006; Seddon, 2006). Moreover, the deployment of these discourses fosters subjectivities which align with government objectives (Garland, 1997) while ignoring the

potential for harm produced by a wilful disregard for the established evidence base.

Despite claiming to understand that 'recovery is an individual journey' (p.6) the 'full recovery as abstinence' discourse constructs 'full recovery' as a single state of being characterised by total abstinence, preferably accompanied by good mental and physical health, suitable accommodation, 'the capacity to be an effective and caring parent' and 'sustained employment' (p.17). I highlighted how high rates of relapse linked to abstinence-based treatment are not mentioned, rendering this silence meaningful. What is more, there is no stated plan of action should relapse occur.

I also observed how the narrow criteria by which 'full recovery' is defined, avails to drug users one of two subject positions - 'success' or 'failure' with no in-between. This is also the case for drug treatment personnel and service providers. Under PbR, either they get clients drug free, out of treatment and into employment (a result!) or the service does not receive maximum financial recompense (a failure). Although the temptation to cherry-pick 'good clients' must be strong, the consequences for those that get left behind – those who require long-term treatment - could be dire. For people in treatment and in medication-assisted recovery (who are stable, in employment, have rent/mortgage and bills to pay), the 'full recovery as abstinence' discourse could produce a predicament wherein they lose all they have gained. Finally, 'full recovery as rational and moral' draws heavily on contemporary neoliberal economic discourses of 'worklessness and dependency' and positions the new system as one that represents 'value for public money', thus functioning to harvest widespread support for the new agenda.

Between 2010 and 2019 these full recovery discourses have become ever more entrenched in England's community drug treatment services. Despite warning from advocates of harm reduction in England and the UK (Harm Reduction Alliance, 2012) as well as international commentators who fear 'new recovery' is moving in their direction (see Anex, 2012), the

British government continues to embrace the vision proposed in 2010 UK Drug Strategy, reproduced and reinforced within Putting Full Recovery First 2012 and continued in the 2017 UK Drug Strategy. Neale et al's (2013) conclusion that some service users have internalised the 'recovery agenda' may well be linked to the record high drug-related deaths (AMCD, 2016), thus bringing to bear the gravity of the situation. As we move towards the interview strand of this thesis, part of my focus will be to theorise the extent to which full recovery discourses have shaped the subjectivities of respondents who are community service users *and* those pursue alternative recovery pathways as well as their utilisation as resources for talk about addictions and recoveries in contemporary Britain.

5.6 Setting the Scene for Analysis of Interview Data

5.61 Reviewing the Synthetic Discursive Analytic Framework

To reiterate the analytic focus outlined in Chapter 4, my interest is in how respondents are positioned *by* discourse and the implications for subjectivity but particularly how *they utilise* the discursive milieu *to resource* their narratives. A further focus is how interviewees position self and others in talk and the discursive-rhetorical strategies they deploy and for what purpose. Four participants clarified prior to consenting to the research that religious faith played no role in their lives or recoveries, and four explicitly attributed their drug free status to a God encounter and adherence to the Christian way of life. In line with the notion that each participant comes to the interview always already positioned, I was curious throughout the analysis to observe if, or to what extent, Christian discourses and beliefs framed how participants in faith-based 'recoveries' constructed pre-conversion as well as post-conversion events and experiences. Likewise, for participants with no religious adherence and currently accessing community services my interest was in exploring to what extent their narratives were framed by the 'full recovery' or other treatment provider discourses. To reiterate, the interview style was semi-structured with a narrative emphasis. Rather than a concrete list of specific questions the initial request was for each participant to tell me

about their story of drug use and recovery, beginning wherever they felt most comfortable.

5.62 Analysis of Interview Data: an overview of structure

Analysis of interview data is contained within Chapters 6 and 7 and structured chronologically, reflecting the shape of respondent narratives. My focus in Chapter 6 entitled 'Drug Initiation and Active Addiction' is how participants construct life events and experiences from initial drug-involvement through to and including active addiction. The chapter is structured under two overarching discourses: 'Drug Initiation: Passivity versus Intentionality' and 'The Downward Spiral'. Chapter 7 is entitled 'Treatment and 'Recovery' and Beyond'. Here I explore constructions of treatment and 'recoveries' and then future hopes and aspirations respectively under a further two discourses: '(The) Breaking (of) the Habit' and 'The Road Ahead'. Each overarching discourse is sub-divided into two or more related discursive constructions that reflect my reading of participant accounts. Short introductory sections throughout familiarise the reader with the content.

CHAPTER 6

Drug Initiation and Active Addiction

6.1 Introduction

Chapter 6 first explores how respondents constructed early life and/or drug-related experiences. The overarching discourse – 'Drug Initiation: Passivity versus Intentionality' - is sub-divided into the two discursive constructions: 'Shaped by Circumstances' and 'Choosing to Use'. These constructions capture how some respondents positioned drug initiation as an outcome of extenuating circumstances, whereas others explicitly constructed their early drug use as a personal choice. This will be followed by a focus on how participants narrated their movement towards addiction and/or active addiction and will be introduced in due to course.

6.2 'Drug Initiation: Passivity versus Intentionality'

As the two constructions that head the analysis below imply - namely 'Shaped by Circumstances' and 'Choosing to Use' - drug initiation was represented in different ways. Some participants adopted a passive position, constructing early experiences as a product of external factors including other people and/or events and/or circumstances. Others positioned themselves as intentional actors with some emphasising that their early drug use was a very much a personal decision.

6.21 'Shaped by Circumstances'

Participants with no religious faith or inclination tended to position external factors as instigating their involvement with drugs. Andy for example, explained how he was 'chucked out the family home' by his father at aged 16. He spent two years in care before, aged 18, moving into a flat at the YMCA. He describes how the warden of the YMCA would categorise would-be residents, placing those deemed to be troublemakers in the 'first block'.

In the extract below he elaborates on this experience and the events leading up to his early involvement in drugs …

A: 'So the first block [of the YMCA] was full of, what [the warden] would call (..) druggies (.) so the first block was people that were involved with drugs or he used to think that were a problem and I was put in the first block (.) even though (..) I never used to take drugs then (.) but I was put in with all them all unruly people (.) erm at the time (..) erm what he considered unruly (..) errm in the first block in the YMCA there was a lot of drug taking (.) and I did see it around me (.) and my friends used to come up there but my friends only used to drink they weren't really into drugs, they used to smoke cannabis'

I: Right

A: 'Err used to come to my flat and smoke cannabis and drink (.) erm I used to avoid it (..) but eventually I started drinking . and then I did start to erm have a joint with em'

In this extract Andy positions himself as 'unjustly labelled' and the warden a 'judgemental arbiter' whose words and deeds were oppressive and based on false assumptions ('even though (…) I never used to take drugs then (..) but [the warden] put me in with all unruly people'). It is interesting how Andy adjusts his narrative ('I was put in with all unruly people (.) erm at the time (…) what he considered unruly') to emphasise how the wardens misconceived and subjective opinion shaped his predicament. This enables Andy to position himself as the 'innocent party' - a person who was initially averse to drinking and drug-taking ('I used to avoid it') but who was 'eventually' led astray by bad influences. Indeed, the 'toxic friend' or 'bad influence' trope is a cultural resource often utilised to justify involvement in behaviour that deviates from sociocultural norms (Esiri, 2016). Although Andy does not explicitly deny that an element of choice was involved, the implication here is that his early drug use was *more* a product of his environment – a context produced by an individual (the warden) with authority over him.

In Harry's narrative, wrongdoing by others and lack of agency are more explicitly constructed …

H: 'E-errm (..) so err (..) about 11 years old I caught my older brother smoking a joint (.) and him and his friends proceeded to get me to smoke it (..) an-n-n-d that's (2) kind of where things took off'

Harry positions his brother as a bully and himself as a casualty of intimidatory behaviour. Drawing attention to his age at the time ('so err (…) about 11 years old') functions to emphasise his lack of power relative to the group of older boys who 'got him to smoke cannabis'. Harry's version of events evokes unsettling imagery, alluding to an abuse of innocence instigated by a person he should have been able to trust. Described by Harry as the moment where 'it all took off' the implication is that his life trajectory *could have been* something other. Both Harry and Andy position themselves as the 'innocent victims' of powerful others. Rhetorically, their accounts are addressed to and function to persuade those who believe drug use is always a simple matter of choice to reflect critically on their assumptions. As Harrison (2004) states, moral responsibility for an action can only attributed to an individual, if that individual could have behaved otherwise. It is notable, then, that Harry and Andy construct versions of reality that position them as having little if any capacity to prevent what happened, thus limiting their moral accountability.

Harry moves on to describe an event that instigated movement from cannabis to ecstasy, taken with more regularity and in larger quantities …

H: 'when I was sixteen (long pause) I (4) lost-my-little-boy (.) my little boy died and (..) I was introduced kind of (long intake of breath) maybe a bit prior to this I has been introduced to ecstasy, amphetamine whatever (.) but when my little boy died that's when I went off the rails (audible intake) err got introduced to err ecstasy and everything as well and it became a bit more available within the circles I started moving within and (5 sec pause) it was only like a mood, it would help me in my mood make me happier be a bit more outgoing'

Here Harry recalls the tragic death of his son - an emotive opening statement which contextualises this extract and, to an extent, his whole narrative. He describes how before this event he 'had been introduced to ecstasy, amphetamine, whatever'. Notably, Harry positions himself as *a recipient of* substances rather than someone who actively sought out them out. Nevertheless, the throwaway 'whatever' connotes a stage of life where *the type* of drug on offer was of minimal significance. In this respect he positions himself as carefree. However, his child's death is constructed as *the* epiphanic moment in his life – the tipping point that sent him 'off the rails'.

Harry's depiction of his subsequent drug use ('it would help me in my mood, make me happier') resonates with the self-medication hypothesis: a theory that represents substance use as a reaction to physical or emotional pain (Khantzian, 1996). Although links between drug availability and drug use are also reproduced in the extract, it is the position of 'grieving father' in a discourse of 'tragic loss' that enables Harry to present his drug use as *an understandable* response to personal tragedy.

Notions of *self*-reliance that later underpin his 'recovery' narrative implicitly feature in Harry's response to my question about the extent of familial support during this time …

> *H: 'Mm no my mum, my dad he's an alcoholic erm my step-dad's an arse hole (laughs) sorry he's not an arse hole he's ok (.) erm I've got two older brothers two younger brothers errm all five us one way or another were involved in drugs or something or the other'*

By drawing attention to his alcoholic stepfather and drug-involved brothers, Harry positions himself as an individual who was exposed to substance use at an early age. Moreover, depicting his stepfather as 'an arsehole', although proceeded by laughter and retraction ('sorry he's not an arsehole he's okay'), nonetheless adds to the production of an unsupportive family context and evokes an environment where becoming a drug user could be conceived as, if not inevitable, then comprehensible. Harry's narrative and his positioning of self and others conjures up notions

of a subjectivity constituted in a material-discursive context of traumatic loss and limited family support. Detailing this context, again, enables Harry to reinforce the notion that his drug use was a product, not of lack of moral fortitude or personal irresponsibility, but by circumstances beyond his control. His narrative works rhetorically to invite the compassionate and empathetic listener into his world, inciting them to reflect on if or not the outcome *for them* would have been otherwise.

Like Andy and Harry in relation to 'recreational' drugs, Ben represents his early involvement with heroin as a product of circumstances …

> *B: 'Erm I started using heroin about 18 years ago (5 second pause) erm, it was my partner who actually started using first and then (..). then I started using obviously (...) erm (4 second pause) but yeah I've been on in 18 years'*

Ben positions himself as a casualty of his (ex)partners decision to use heroin. Representing his heroin use as an 'obvious' consequence of co-habiting with a person 'who started using first' resonates with a discourse of mutual dependency. The long pauses do, however, connote a lack surety about the social acceptability of his claim in the context of a heroin habit that had lasted almost two decades, far beyond any influence by his ex-partner. Ben has encountered a moral dilemma (Cushman and Greene, 2011) in terms of whether to accept responsibility for a stigmatised condition or attribute blame for that condition. In line with Fuller's (2007) provocative assertion that 'addicts blame others' even in the context of long-term sobriety, Ben chooses the latter and makes no attempt to repair this potential source of identity trouble (Taylor, 2010).

My decision not to probe Ben for an explanation as to why he felt that his partners drug use rendered his own inevitable was informed by my knowledge of Ben's ongoing psychological difficulties and reluctance to talk about this episode in his life. Wakeman (2014) writes about the 'biographic-emotive awareness' (p.13) that researchers may take into the field, an attentiveness that enables them to sense when following lines of enquiry are best avoided because of the potential risk of harm to

participant or researcher. Here, my personal biographic-emotive awareness influenced the decision not to ask Ben for further clarification.

6.22 'Choosing to Use'

Whereas the accounts above, in various ways, construct drug use as a product of circumstances, other respondents (to greater or lesser extents) positioned themselves as intentional agents, alluding to and in some cases *emphasising* that their initial involvement with drugs had been a personal choice. Interestingly, notions of choice at this point in the addiction-to-recovery trajectory were alluded to primarily by respondents in faith-based recoveries.

In the extract below, Graham (G) describes his movement from alcohol to 'recreational' drugs …

> *G: 'My (.) yeah (2) my drug use started when I was erm when I was a teenager (.) going back to when I kind of just left school (.) I was drinking at school like most people did'*
>
> *I: Yep*
>
> *G: Err in our class and stuff (.) but I didn't start taking drugs til just after I left I left school (.) and I always say that I started smoking cannabis taking LSD you know amphetamine taking what they call recreational drugs'*

Graham represents alcohol use at school as an everyday social activity engaged in by those around him. He positions himself as 'like the majority' and this functions to normalise and rationalise his behaviour. In this extract, the connecting word 'but' signifies a turning point and movement into a post-school, drug-using way of life. Graham's representation of cannabis as a starting point and the subsequent listing of various substances evokes the 'slippery slope' (Taleff, 2006, p.107) canonical narrative (Bruner, 1991) and the notion that progression to 'harder' drugs was an inevitable next step. Although he positions the idea that 'soft' drug use leads to the use of 'hard' drugs as a *personal* belief ('I

always say that I started using cannabis …') it is a construction that resonates with the gateway theory of addiction.

For Frank, the 'decision' to use drugs coincided with a time when he started to 'go around with a new group of people'. He explains how their talk about 'wild weekends' and use of various 'recreational' substances aroused his interest. In the extract below, Frank recalls the first time he used cannabis …

> *F: 'to me it just seemed as though [my friends] were having a bit of fun having a laugh and erm (.) it wasn't really that much of a problem and err I was curious […] so I went out (.) to a house party and erm (.) I think it was just you know had a few beers and then you know a cannabis joint started getting just getting passed round and to be honest I'd already made the decision that if, if I had the opportunity I would I would have a drag I would smoke'*
>
> *I: Oh so you made that decision before going to the party?*
>
> *F: 'I'd made a decision I had made the decision in my heart I (2) don't think I'd told anybody I would I was going to but (.) in my heart I'd made that decision (.) to do it … So I wasn't like pressure I didn't you know wasn't didn't feel I was pressured in any way'*

Here Frank normalises the drug use his friends were partaking in, constructing it as fun, a laugh, unproblematic. His assertion that the drug taking 'wasn't really wasn't that much of a problem' draws on and reproduces cultural representations of 'recreational' use as a relatively harmless activity (Manning, 2013). Moreover, it functions as a rationale for Frank's decision to follow suite. Albeit there is an interplay of pressure (the cannabis was made available) and agency (Frank decided to smoke it), Frank positions himself as a curious outsider but ultimately a free and autonomous agent, describing his initiation into cannabis use as a decision of the heart - a personal, convicted choice. Although the rational, choosing subject is a humanist construct (Rigg et al., 2007), the choosing subject is also represented in Christian discourse in the form of free will (Williams,

1993). Frank's self-identity as a Christian as well as his choice of terminology ('I had made a decision in my heart') suggest that constructions of choice and the absence of blame in this extract are influenced by Christian discourse.

Allusions to personal choice continue, with Graham stating …

> *G: 'the whole thing with addiction you (2) don't think when you make them first initial choices the affect it's gonna have on yer (…) but when I look back some of the choices that I've made y'know'*

Further on in Frank's narrative this sense of self-responsibilisation is resumed …

> *F: 'It (the addiction to heroin) was a process of wrong decisions by myself'*
>
> *I: Mm*
>
> *F: 'Umm (.) that I made in life that started when I smoked cannabis and six years later I was addicted to heroin'*

Although both Frank and Graham invoke a relational discourse in alluding to peer-involvement, the emphasis is on choice and personal responsibility. To position oneself as blaming or bestowing judgement upon others would conflict with the Biblical command to 'judge not' and could be a potential source of identity trouble (Taylor, 2005; Taylor 2010). This rhetorical talk (Billig, 1996), then, is addressed to both non-religious and Christian audiences and functions to strengthen the legitimacy of their religious belief. However, while notions of personal choice and responsibility *are* consonant with a Christian self-identity, Frank and Graham are also (perhaps unwittingly) reproducing and reinforcing damaging political constructions of addiction as personal-moral issue (Harding, 1986) and undermining already marginalised explanations that focus on the link between structural issues including socioeconomic deprivation and inequality and problematic-drug use.

Eddie (E) is a relatively new Christian and hence less versed in Christian (recovery) narratives. He is also the youngest participant with the least 'clean time'. This relative naivety was apparent in his constructions of early drug use. As the following extract reveals, Eddie responsibilises self to a lesser degree than either Frank or Graham …

> *E: 'and so I (..) ended up (.) going to college and I got in with all the pot heads there and ultimately I didn't hardly do any work n I had the opportunity to finish my college course (.) but because I was so high all the time I couldn't concentrate and (.) I had no confidence in doing my work but I'm sure I would have coped if I wasn't hooked on the cannabis every day and there were various people I was involved with there who I look back as being a really bad influence on my life then (..) but as I said I was also an encouragement to it'*

As a person whose conversion is relatively event, Eddie's emersion in the Christian way of being may not be as absolute as Graham's or Frank's, hence his desire to be viewed as 'successful' in a worldly sense more pressing. In neoliberal discourse 'success' is represented as the preserve of those who take responsibility and work hard (Verhaeghe, 2014; McGuigan, 2014). Eddie's unsuccessful bid to finish college positions him as a failed neoliberal subject (Taylor, 2017, p.35). Drawing attention to extenuating circumstances ('I'm sure I would have coped' … if not for the cannabis and 'various people') functions rhetorically to persuade real or imaginary critics that the situation was not his fault. Eddie constructs a version of events wherein a positive life trajectory was interrupted by drugs and 'bad influences', enabling him to position and experience himself as an able person who was otherwise headed for 'success'.

This version of events could, however, bring identity trouble (Taylor, 2010). Eddie's derogatory constructions of (other) cannabis users as 'pot heads' and his positioning of both drugs and other people as responsible for his misfortune is 'inconsistent' (Taylor, 2010, p.98) with both neoliberal values *and* the Christian self-identity he now claims. It is telling then, that following a brief pause, Eddie attempts to repair this damage by

implying that he was also (at least partly) responsible for not finishing college ('but as I said, I was also an encouragement to it'). His rhetoric functions to deflect accusations that he lacks personal responsibility and enables him to negotiate a more creditable self-identity in the eyes of both Christian and non-religious communities.

Respondents in faith-based recoveries did not refer *explicitly* to traumatic early life experiences. Indeed, their constructions of pre-addiction life events and experiences *undermined* 'expert' and political discourses that construct problematic drug use as the preserve of 'risk-bearing outsiders' (Taylor, 2008, Abstract), limited life options (Buchanan, 2006) or the outcome of childhood trauma (Foundations Recovery Network, 2018), further reinforcing the concept of drug-involvement as an intentional act by agentic subjects.

Frank for example stressed the positive (Christian) environment in which he was raised …

> *F: 'really up until the age of sixteen I led quite a sheltered life (.) style really I was brought up in a good um positive family environment (.) my dad was a policeman both my parents were Christians always taught good Christian values and principles I didn't come from (.) I suppose a family or background where there was any kind of involvement with drugs -*
>
> *I: Mm*
>
> *F: 'illegal substances anything like that (.) so I was protected from that really for (2) fifteen maybe sixteen years'*

Frank's representation of a good and moral Christian upbringing in a nuclear family with a male role model destabilises dominant cultural discourses that construct troubled childhoods and problematic drug use as intimately related (Hammersley and Dalgarno, 2013). His allusion to an 'idyllic upbringing', however, functions in contradictory ways. First, it reproduces both political and Christian discourses that construct the nuclear family as a protective institution for child-rearing practices (it was

only when Frank left this environment that drugs became an issue). At the same time, however, it subverts the very same discourses - despite a stable upbringing Frank became a drug user, a drug dealer and a convicted prisoner.

Although not all participants narrated their formative years with Frank's level of detail, it is nonetheless notable that meeting culturally constructed markers of success did not protect against drug use and movement into addiction and a criminal lifestyle. Graham for example explicitly positions paid employment as *the* experience that influenced his decision to begin drug dealing …

> *G:'I (3) kind of had a little job I was a car valeter'*
>
> *I: Right*
>
> *G:'And err (.) that's how I how I started to deal drugs because I thought I was the mug at work here and I knew people who were dealing drugs and making easy money'*

For Graham, having a 'little job' did nothing to off-set the allure of an illicit lifestyle. His positioning of self as 'the mug at work' implies that he felt undervalued – observing associates who were 'dealing drugs and making easy money' rendered participation in the underground economy an attractive proposition. Graham's construction of consequence reproduces the notion that glamour and riches evoked by popular representations of the underworld can be an appealing alternative to conventional life.

For Eddie, securing a place at university - an event widely constructed as a sign of personal-social progress - coincided with increasing levels of drug use …

> *E: 'but I was probably about twenty by the time this was going on now (..) ah but (.) I was taking other drugs like I used to go out clubbing a lot and I was taking ecstasy but I wasn't addicted to these drugs (.) you know it was just mainly cannabis (.) but err yeah when I got to (.) got to university in London that's when it all kicked off and I was y'know going mad for every type of drug I was taking cocaine'*

The first part of Eddie's account is resourced by cultural representations of 'club culture' and the construction of 'recreational' drugs as a 'normal' feature of young peoples' lives (Parker et al., 1998). Eddie's account, however, implies that he is mindful of how regular clubbing and ecstasy use, indeed drug use per se, may be received by some audiences. He uses a disclaimer to emphasise the non-dependent nature of his use at this time ('but I wasn't addicted to these drugs' (.) you know it was mainly cannabis') - the implication here is that his substance use at this point was under control. Eddie positions himself as an ordinary young man doing what many ordinary young people do. However, going to university is when things 'kicked off' drugs-wise - hence, a cultural symbol of human progress and middle-class aspiration (Loveday, 2014) is represented by Eddie as the catalyst for increasing levels of poly-drug use. Also notable here is Eddie's agentic positioning ('I was going mad for every type of drug') further reinforcing individualised constructions of drug use as a personal choice.

The extracts presented above prompt a questioning of taken for granted assumptions: that a stable childhood *necessarily* protects against future drug use; that people are *necessarily* always better off in work even if that work is low paid; and that higher education is *necessarily* a positive choice for young people. The narratives produced by Christian participants in this study undermine these dominant societal constructions and also theories that present social controls key predictors of sustained conventional lifestyles (see Laub and Sampson, 1993). These apparently protective or corrective institutions did not prevent movement towards 'hard' drug use and addiction. However, and in keeping with their Christian self-identities, Frank and Graham and in a less explicit sense Eddie, reconstruct the past through the lens of a Biblical narrative that urges them not to conform to the patterns of a world.

Having attended to how drug initiation was passively positioned as an outcome of circumstances or agentically as a personal choice, the focus now turns to participant constructions or drug continuation and

maintenance, constructions which resonated with the canonical notion of a 'downward spiral' into addiction.

6.3 'The Downward Spiral'

6.31 Introduction

The downward spiral or descent into addiction are discourses or canonical narratives (Bruner, 1991) often utilised to represent drug addiction as a regressive phenomenon. Here it captures how participants variously represented the contexts wherein their drug use became more problematic and, over time, the focal point of their lives. Both Christian and non-religious respondents utilised the notion of a downward trajectory but in various ways, with those in faith-based recovery tending to frame their accounts through the lens of Christian belief.

The first discursive construction is 'Escape from Life'. The focus here, firstly, is how respondents positioned drug use as an escape from negative emotions produced by their life circumstances. Attention then turns to constructions of the psychological consequences of drug use including extreme risk-taking and lack of regard for personal health and wellbeing and a desire to escape from life itself. A focus on the psychological is continued in 'Satanic Visitations' - a discursive construction produced by respondents who identified as Christians. Here, some fundamental differences between Christian and non-Christian speakers in terms of how they represent mental ill health become apparent. The final construction - 'Life on the Othered Side' – captures participant representations of prejudice and stigma. Again, significant variations between respondents emerged.

6.32 'Escape from Life'

Constructions of drug use as a form of escapism are historically and culturally prevalent (Williams, 2013) and permeated the narratives of participants in a variety of ways.

In the extract below, Frank recalls using Ecstasy …

F: 'So err so yeah I took the ecstasy and I thought it was great (.) what I found with ecstasy gave me confidence that I'd never had before (.) I found that it was easy to chat to people (.) and girls' (laughs quietly)

I: Yeah (.) mm

F: 'And er (.) you know they call it the love drug and you do you feel like you love everybody and they love you and its (2) a great feeling and that feeling of acceptance'

I: Yeah

F: 'you know I felt accepted you know with this group of people'

Frank positions himself as socially awkward by nature. As a person who had always lacked self-confidence, he locates himself a passive recipient of what Ecstasy had to offer. The drug functioned as a provider of sorts - it availed new ways of being, facilitating social interaction. In describing the effects of Ecstasy, Frank draws on metaphoric resources prevalent in 'rave culture' wherein Ecstasy is labelled the 'love drug' (Lee et al., 2011. p.529) which elicits feelings of love and acceptance of and from others. In short, Frank positions Ecstasy as a substance which, *at the time*, fulfilled his needs and produced a culturally valued self-identity and positive subjectivity.

With that said, it is notable that Frank states that he *thought* ecstasy was great - it made him '*feel* like he loved everybody' and he '*felt* accepted'. However, the terms 'thought' 'feel' and 'felt' are functional and imply that ecstasy-fuelled confidence, love and acceptance are inauthentic - an illusion. When considered through the lens of his Christian faith, Frank's construction of ecstasy implicitly draws attention to *the futility* of attempts to gain love and acceptance through drugs. The chemicals made him *feel* loved and accepted and he *thought* they were great - ultimately, however, this was not the case. Frank's rhetoric, then, can be read as a subtle warning addressed to those who have been or could be seduced by drug-taking and the (inauthentic) feelings that drugs produce.

Although Dave did not provide details relating to early recreational drug use, he described how he was first introduced to heroin while in prison. In the extract below he establishes the context wherein his heroin use escalated …

D: 'hearing of the death of my mother that's when I probably got a habit for the first time (.) so I left the jail with a habit I left the jail with a habit on heroin'

I: Ok, so you say, did you say when your mum died that's when it really took -

D: 'Yeah that's when I really started to take it quite a lot y'know'

I: 'And I suppose that was because it basically nullified those awful emotions you must have been going through?

D: 'Ah yeah absolutely (..) absolutely'

Dave positions himself as a man who while imprisoned (in an institution where heroin was 'freely available) and grief-stricken, started to use larger quantities of heroin to numb his emotions and escape, metaphorically, from his reality. Invoking discourses that construct drug use as a form of self-medication (Khantzian and Albanese, 2008), Dave's narrative functions to represent his heroin habit as a rational response to emotional pain. Rhetorically, Dave's biographical talk addresses the empathetic reader/listener, summoning them to reflect on what their own response to the same predicament would be.

Although contextually different, Frank's representation of what heroin *did for* him is similar to Dave's. Frank explained …

F: 'We moved from doing the club stuff and pub stuff (.) and we like formed a secret society that's what, that's my view it was like (.) we stayed in our house then with the curtains drawn'

Here Frank reproduces a dominant and morally loaded representation of the contemporary heroin user: as a 'deviant and unreclaimable' (Acker, 2002, p.2) character set apart from mainstream 'normality'. Frank's

repeated use of the pronoun 'We' alludes to a group of heroin-involved individuals - members of an anti-conventional subculture (Hanson et al., 2018). Reference to a 'secret society' connotes unity and trust among 'society' members supporting Shukla's (2012) finding that drug use often occurs only in the presence of those who are deemed to be intimately trustworthy. Interestingly, 'Secret Societies' are explicitly 'forbidden in scripture' (Lloyd, 2016, p.111) – that Frank describes the group *specifically* in these terms functions to draw attention to his detachment from the sacred at that time.

Frank continues …

> *F: 'and we would be smoking heroin on the tin foil that's how it started (.) and just umm yeah and I (2) suppose (..) I enjoyed the buzz (.) it took away (.) I suppose the reality (..) it suppressed my emotions, took away the reality of how much my life was in a mess'*
>
> *I: Mm*
>
> *F: 'cos y'know I wasn't enjoying my life (.) y'know I wasn't happy (.) um even though I had all the money and I was taking the drugs I had popularity I had all my friends had a house (.) but inside I was I was I wasn't happy' (voice softens)*

Frank's identity work here (re)produces a stark contrast between the sociable 'recreational' user and the asocial self-identity he assumed as heroin addiction consumed him, his life becoming veiled in secrecy and darkness. Frank affirms that he enjoyed how heroin made him feel ('I suppose (..) I enjoyed the buzz') but attributes this 'enjoyment' to the oblivion heroin produced. The drug 'suppressed his emotions' and 'took away the reality' – it enabled him to escape from life.

Frank's narrative, moreover, implicitly connotes a self in need of salvation. This positioning is reinforced by the subsequent implication that he had everything ('all the money, all my friends, a house') but nothing ('but inside I wasn't happy'). This 'everything but nothing' construction reproduces and reinforces Biblical discourse and draws attention, not only

to the futility of a life on drugs, but the futility of material possessions without inner peace.

Eddie also found in drugs an escape from the mundane realities of conventional life …

> *E: 'I was a bit bored sometimes so I was really looking for something in life at the time (.) and I was trying to open my mind up to all different things that could improve my life'*
>
> *I: Yeah*
>
> *E: 'looking at […] things like (..) you know horoscopes (.) and (…) looking into all that um new age stuff at the bookshops and stuff (.) but (.) then discovered magic mushrooms' [after first using mushrooms with other people] I ended up getting them on my own […] leading to some varied experiences'*

According to Krok (2015), the notion of searching for *something* in life is a discursive resource often used to intimate a spiritual search for meaning. In the context of Eddie's Christian faith, it can be reasonably assumed that the 'something' in his opening assertion connotes God. Eddie positions himself as a 'lost soul', dissatisfied with life and on a (misinformed) quest for self-improvement. Interestingly, his list of 'things' encountered on the journey (horoscopes, New Age stuff in bookshops) are all represented in Christian discourse as antithetical to God's plan (Lloyd, 2016). Eddie's search led, eventually, to 'mind expansion' (Lloyd, 2016, p.111) through the use of magic mushrooms. Moreover, he describes how he started using the drugs alone (as opposed to in a group) – solitary use, as well as a form of escapism, is positioned in addiction literature as a sign of regression to problematic forms of drug taking (Sack, 2015). His narrative functions rhetorically as a warning to those who are feeling 'lost' and implies that any quest for meaning should be conducted with due caution.

For Andy and Harry, drug-taking *enabled* a getaway from life circumstances but also *produced* a desire to escape in a literal sense from

life itself. In the following, drugs are positioned as a means to escape from life circumstances but there are also allusions to mental and/or physical decline and minimal regard for self-preservation.

Andy describes the context wherein he started to 'dabble' with amphetamine …

A: 'I started to live with (..) my girlfriends parents and then I married her she became pregnant I lived with her on (place name) with her parents and I got my first house on (place name)'

I: Right

A: 'Shared ownership (..) I was working at [a supermarket] (..) it was then (emphasis) when I was working nights at [supermarket] (..) err with all the strain of keeping a mortgage up'

I: Okay

A: 'erm (.) having two children (...) that I started to dabble in (..) amphetamines'

I: Mm

A: 'for the first time I started to get from err (..) erm a work colleague (...) erm (..) it's then that I went, I started taking speed for the first time'

I: Okay

A: 'Err (.) starting to feel what it was like the euphoria n (..) I really did like it (..) err (...) I liked using it (..) I started using it at work (.)

Here Andy draws on a canonical narrative in the form of a normative progression through the recognisable life stages (Taylor, 2010). Living with a girlfriend, getting married, having children, finding gainful employment, an buying a propoerty are all events that constitute a conventional neoliberal life trajectory. The extract functions, however, not as a positive representation of social progression but to establish the context that produced a drug using subject. Working the night shift,

paying the mortgage and the financial cost of caring for children are represented as a source of 'strain' directly related to his use of amphetamine. Foster's (2016) comments on the production of 'neoliberal subjectivities' enable a deeper understanding of Andy's positioning as a man whose actions were shaped by the pressures of life itself.

Neoliberal discourses of individualism and responsibilsation lead to the 'reinterpretation of complex social issues as personal problems that require an individual response' (Foster, 2016 p.93). Andy implies that working the nightshift was difficult and his income did not sufficiently cover is outgoings. His 'individual response' to this 'personal problem' (Foster, 2016, p.93) was to use amphetamine. Andy represents the drug as a form of relief ('it was like the euphoria' (.) I really did like it'). Choosing euphoria over strain *could* be conceived as a rational choice by an agentic subject. It is, however, the potential impact on others – his wife but particularly his two children – rather than the amphetamine use itself that produces notions of immorality connected to this choice.

In Western contexts, 'good' parenting and drug use are normatively situated at opposite ends of the moral compass (Boyd, 1999; Du Rose, 2015). In this respect, some might confer on Andy the self-identity as a selfish man who actively chose drugs over his familial responsibilities. Such assumptions, however, emphasise the importance of attending to the wider context. Indeed, as noted by Silva (2015), in a contemporary age where security and certainty are fleeting, *feeling* unable to fulfil the 'traditional provider role' (p.11) may lead some men to forgo *all* relationships. Indeed, the extent of Andy's psycho-emotional problems and hence the factors that contributed to his behaviour, become increasingly apparent.

He described how working a night shift combined with amphetamine use produced chronic insomnia. In the extract below he relays the consequences …

> *'[…] eventually (...) err (....) I suffered a (.) had a bit of a breakdown'*

I: Right

A: 'I tried to commit suicide when I was (..) 22 years old'

I: Right

A: 'took an overdose around about the same time I was taking amphetamines (..) err (.) because of the insomnia (...) err (...) I was pensioned off (..) from [place of work] (....) I still receive a pension to this day'

I: Right

A: 'because of it, because of the illness (..) because of the insomnia (..) err they see it as an illness'

I: Mm

A: 'because I (..) by the time I left erm [place of work] I'd done six years nights' I

I: Okay

A: '[...] constantly […] because of the insomnia I had a breakdown (…) I tried to commit suicide'

This in an interesting piece of biographical talk with Andy drawing on both medical and ethical discourses to represent his experiences. Although he links the amphetamine use to the insomnia that in turn led to his breakdown and suicide attempt, Andy's focus on 'the illness' and the allusions to his employment are analytically noteworthy.

In a political context where anti-welfare discourses prevail, receiving a long-term pension at the age of 22 because of drug-related insomnia is a potential source of identity trouble. Andy risks being positioned as an 'underserving skiver' (O'Hara, 2015) and thus is in danger of being conferred an identity that is both discreditable and conflicts (Taylor, 2010) with his self-identity as a hard-working and ambitious student. To repair this trouble he legitimises this monetary offering by drawing on a medical discourse, emphasising that his receipt of a pension was 'because of it,

because of the illness (…) because of the insomnia'. Moreover, proclaiming that 'they see it as an illness' is a discursive manoeuvre that functions to abdicate himself of active involvement (it wasn't *his* decision). Andy's version of events thus responsibilises the medical 'experts' who decide what constitutes a genuine medical condition. Moreover, by utilising an extreme case formulation ('I had worked a night shift for six years (.) constantly') Andy is able to position himself as a 'casualty' of employment malpractice, further transferring blame onto his employer.

So, the breakdown and the suicide attempt which at the start of the narrative is loosely linked to amphetamine use, as the narration continues is reconstructed as the outcome of a genuine medical condition *produced* by unethical employment practices. The insomnia and the consequent receipt of a pension are constructed as avoidable *but* for the actions of others. It is a version of events that functions to vindicate Andy (of wrongdoing) and positions him as entitled (to financial recompense). Rhetorically, this 'construction of sequence and consequence' (Taylor, 2010, p.36) is an address to those who may conclude that Andy's drug-involvement invalidates is right to receive government money. Moreover, book-ending the extract with reference to his suicide attempt (aged 22) functions to affirm and then reaffirm the gravity of his situation.

In 'Shaped by Circumstances' Harry explained how at aged sixteen he lost his son. With this context in mind, his description of what cocaine did for him is perhaps unsurprising …

> *H: 'It numbs yer, it numbs yer, cocaine numbs yer when you put it in your mouth, it numbs yer body yer mind and you just forget about the (audible exhale) the what ifs the what haves (.) you suppress everything' (.) the more cocaine you sniff the shitter you feel but at the time (.) you feel good but then the next day you wake up and you feel (..) depressed even worse'*

Constructions of cocaine as a numbing agent are historically and culturally prevalent - cocaine-based solutions were for many years used as the local anaesthetic in medical practice and dentistry (Spillane, 2000). Harry

utilises this discursive backcloth to depict the embodied effects of cocaine, representing the drug as a substance that numbed his entire being and utilising an extreme case formulation ('you suppress everything') to emphasise the extent of his escapism. His representation of the highs and lows that cocaine produced are constructions derived from popular depictions of short-acting stimulant drugs – the 'rush' proceeded by the 'crash' and feelings of depression as the effects wear off (Solomon, 2001). The audible exhale of breath implies that reconstructing the past is for Harry a traumatic and exhausting task.

Harry moves on to describe additional consequences related to his drug intake, a depiction that differs contextually from Andy's but also bears some striking similarities …

> *H: 'it got to the point where eh (..) errrm (..) I gave myself a heart attack through it Chris (.) erm it was 10 years on the 30th June just gone (.) err I gave myself mild coronary spasms still didn't stop me, stopped me for about a week after coming out of hospital mm and I was back on it'*
>
> *I: What was your state of mind when you had a heart attack and then went back to cocaine was –*
>
> *H: 'It was like Russian roulette I was in a house in [place name] in [town] on a friends mantlepiece fireplace the cocaine was and they're all telling me don't touch it don't touch it I said cool I won't touch it pretended to walk out the room came back 5 mins later cocaine's still there and I sniffed it (laughingly) err it was like playing Russian roulette'*

Notable here is Harry's shift to a more agentic positioning ('I gave myself a heart attack') which contrasts with the earlier passive constructions – the being *made* to smoke cannabis and being *introduced* to a variety of substances for example. In the extracts above Harry positions himself as an individual for whom cocaine use became all-encompassing to a point where it superseded all concerns for personal health and wellbeing. His

representation of events is dramatic and laden with shock-value. One example of this sensationalist discourse is Harry's claim that he 'gave himself a heart attack'. Anticipating the potential for 'trouble' due to overstatement, he is quick to represent the medical issue as 'mild coronary spasms' which, although potentially serious and related to the heart, is not a heart attack (British Heart Foundation, 2018). Harry's use of detail to identify when this occurred ('it was 10 years on the 30th June just gone') moreover, functions rhetorically to enhance the facticity of a version of events that may be perceived by some as exaggerated.

This compulsivity and risk-taking is reaffirmed by Harry's representation of continued cocaine use post-coronary spasm as 'like playing Russian Roulette'. 'Russian Roulette' is an established and widely used metaphoric resource utilised to depict extreme risk-taking including those associated with using illegal drugs (Volkan, 1994; Linton, 2008). Here cocaine is represented as the loaded gun, Harry the trigger-happy nonconformist. He laughs as he reproduces a scene in which he 'sniffed' cocaine after his 'friends' had repeatedly warned him not to. Again, identifying a specific sequence of events and providing detail ('the cocaine was on the mantlepiece … 5 minutes later cocaine's still there and I sniffed it') functions rhetorically to legitimise a telling that may be dubiously received by others. The extract above has an almost cinematic quality with events reconstructed for maximal impact. This dramatized style of representation is not however a style that Harry sustains. At another point in the interview he states …

> *H: 'I'm sat here today Chris (serious tone) through all this I was very suicidal umm (5 second pause) I attempted to take my own life many times from 2011 to 2012 (loud inhale and exhale) (…) maybe even as far back as 2010 things (.) were really (2) really dark I: Mm H: didn't trust anyone not even my own wife not my children and I locked myself in my bedroom (..)'*

Here the tone is serious, his narrative infused with realism and his sense of isolation tangible. The pauses and deep breaths depict an individual

who is struggling to vocalise the magnitude of his experience. Harry represents his cocaine addiction as a lengthy struggle that took him to dark places. He positions himself as broken man who arrived at a place where taking his own life appeared to be the only option. Rhetorically, his narrative functions as a warning to those who may play down the potential consequences of drug addiction.

Both Andy's and Harry's narratives reveal how addiction and its consequences are discursively constructed yet permeated with references to embodiment (insomnia, coronary spasms and suicide attempts) and other aspects of material reality (workplaces, night shifts, locked bedrooms, children and wife). The references to suicidal thoughts and suicide attempts function to draw vivid attention to just how close to the edge each respondent had been. When considered in the context of who they are today (undergraduate students) these versions of events position Andy and Harry as 'overcomers' who, by drawing on *personal* resources, took back control of their lives and prevailed.

Although the psychological consequences of excessive drug consumption were also highlighted by participants in faith-based recoveries, the interpretive framework through which these representations are produced is entirely different. 'Satanic Visitations' explores how constructions of personal-psychological problems advance, albeit tentatively, the presence of 'dark forces' external to the material world.

6.33 'Satanic Visitations'

Constructions of the paranormal featured in the narratives of all Christian respondents albeit more prominently in some than others. Interestingly, such representations of the paranormal were at times partnered with a medical discourse. The function of this contradictory alliance will be elaborated below.

Frank described a period in his life when he used ecstasy and alcohol constantly for six months. This 'non-stop' use had ramifications and influenced Frank's decision to cease using Ecstasy. He stated …

F: 'The only reason I stopped [using Ecstasy is] because I got sleep paralysis'

With sleep paralysis described by the British Medical Journal (2018) as one characteristic of a diagnosable condition known as Narcolepsy, Frank at first invokes a medical discourse to represent the effects of long-term Ecstasy use. Shortly after, however, and without prompting, he further alludes to and elaborates on his experience …

F:'you just feel as though you're paralysed to the bed you can't move (.) I perhaps look at it now as perhaps there was perhaps a (2) dark force in the room maybe that's what it felt like'

I: Yeah? (2)

F: 'Being pinned to the bed' (voice softens – sounds contemplative)

Although sleep paralysis alone constitutes a rational explanation, Frank moves on to state that, on looking back, *perhaps* a 'dark force' was in the room. Frank *tentatively* draws on a paranormal discourse ('there was perhaps a dark force in the room, maybe, that's what it felt like'). Repeated use of the terms 'perhaps' and 'maybe' are hedging statements - a discursive technique that speakers use to 'manage accountability' (Wiggins, 2016, p.152) and limit potential damage emanating from retraction of a claim in the face of critique (Wiggins, 2016). Here, Frank's cautious representation – alluding to without confirming the presence of a 'dark force' – functions rhetorically to shield him from accusations of irrationality by secular or atheist audiences. Although Frank now self-identifies as a born-again Christian, constructing his experience as a spiritual attack could be received as deluded by non-Christians. Hence, it is a construction that could trouble Frank's professional identity as an adviser to people who are experiencing 'real world' problems such as poverty and debt. Concurrently however, the extract functions, albeit cautiously, to verify Frank's belief in supernatural phenomena and the 'real' possibility of Satanic attack thus indicating how Christian discourse has shaped Frank's subjectivity.

Eddie's construction of paranormal activity is more detailed than Franks. In the extract below he recounts the effects of using magic mushrooms …

'em I ended up having a bad trip (.) as I was searching for something you know this bad trip led me to believe I was seeing the devil' […] 'and I was just tripping looking into the abyss and I could see the devil staring at me which was really kinda scary'

I: Yeah?

E: 'and he had a bowler hat on (.) and all little markings on his face (.) and em (.) this wasn't good and I remember thinking ah I'm going absolutely mad here'

Eddie's account is seemingly less guarded than Frank's yet concurrently provides more closure. His 'devil-encounter', although detailed, is represented from the outset and later tentatively re-established as *related* to magic mushroom use. Eddie reiterates his search for 'something', the connotations of which have already been noted (Krok, 2015). His assertion that the 'bad trip led me to believe I was seeing the devil' marks the experience (seeing the devil) as conditional on taking hallucinogens and functions as a defence against accusations of irrationality. However, Eddie's reference to 'looking into the abyss where 'I could see the devil staring at me' is less guarded and implies that he in was in fact *confronted* with the threat of descent (Stanford, 1996). Here, the vivid detail he uses to convey 'the devil's' features and garb is a rhetorical strategy deployed to persuade the sceptical listener that this was an authentic sighting (Laroi et al., 2014). Eddie account projects a sense of uncertainty - whether to explicitly align his narrative with the notion of Satan as unquestionably real or take secular rationalities into account.

Eddie continues …

E: 'then the room I was staying in was a dingy little student accommodation type thing (.) em it was in a house but it was just a really small room'

I: Okay

E: 'and I went out and bought loads of different coloured paints and started painting like crosses and skulls and everything on my bedroom wall to everyone who saw its amazement when my landlady came she noticed that I'd painted my room like all these dark purples and reds (..) and er it was really gloomy but this was the result of the magic mushrooms'

Eddie's depiction of the environment in which this 'encounter' occurred is analytically interesting. His description of a small *dingy* room, the *dark* purple and red paints and the *gloom* in which he was enmeshed, produces a context of darkness which in Christian discourse connotes negativity and evil (Hofstede, 1990). Allusions to daubing his walls with satanic symbology – relatively normal late-teen behaviour defined and evaluated by Ellis (1991) as 'Quasi-ostension' that should not be granted 'disproportionate weight' (p.282) - is reproduced in Eddie's narrative as *particularly* occultish behaviour. Eddie's concluding hedging statement ('but this was the result of magic mushrooms'), again, is a rhetorical strategy designed to strengthen the plausibility of his account, functioning as a defence against potential ridicule or critique.

Although Eddie appropriates mainstream knowledge of LSD as a discursive resource to rationalise his paranormal experiences, there are certainly hints of possession in his account. Not only does he claim to have seen the Devil but earlier described dabbling in the occult. Moreover, his allusions to darkness and his silence in relation to *what instigated* the painting of satanic symbology, all function to conjure up a sense of the mysterious and leave pertinent questions unanswered.

When asked if he was aware of his actions at the time, the potential for paranormal activity receives further confirmation …

E: 'You know I wasn't driven by my own self and I was in kind of like (….) a different kind of mentality to what I am right now (.) you know I've been on medication ever since moments like that in (city)'

I: Yeah

E: 'but due to clean living and you know my faith I've become a lot better which I'm very thankful to God for'

Eddie's statement that he 'was not driven by his own self' implies that his behaviour was influenced by an undisclosed yet sinister force - he is insinuating demonic possession without naming it explicitly. Throughout, Eddie resources his narrative with an eclectic mix of vagueness ('I was looking for something' … 'I wasn't driven by my own self') and detail (the devil's features and garb), producing a version of events that *suggests* supernatural involvement yet plausible enough to avert critique. Eddie's closing statement, although a confirmation of his faith ('I'm very thankful to God') is buttressed by medical and 'healthy living' discourses, again functioning to enhance the facticity of his narrative. That is, Eddie became 'a lot better' due to prescribed medication, 'clean living' *and* his faith in God.

Graham, for many years a heavy user of amphetamines, was diagnosed by a psychiatrist as suffering from amphetamine psychosis. He recounts …

G: 'the amphetamine did my brain in and left me marked with these voices I was hearing (…) constant vicious hateful voices (..) calling me names I can't repeat now but cursing me […]'

I: Could you make any sense of what was going on?

G: 'Well (…) err I'd been spending a bit of (.) some time with a (.) a neighbour who was into Buddhism, New Age, Occult and stuff […] I was thinking is this happening cos of me spending time with him (.) my neighbour […] I got prescribed antipsychotics it made no difference'

Although diagnosed by a medical professional, Graham (like Frank) tentatively alludes to some 'thing' beyond the medical label. Although the explicit linking of amphetamine usage and hearing voices functions rhetorically to avert accusations of delusion and irrationality, describing the voices as 'vicious' and 'hateful' *implies* a Satanic attack (Denton Writers League, 2011). When asked to elaborate on his understanding of

the experience at that time, Graham does not commit but positions recent contact with non-Christian forms of spirituality as a *potential* explanation.

Most significant however, is his assertion that 'anti-psychotics made no difference'. Despite taking prescribed medication in line with expert advice, the voices persisted. Although Graham's version of events overtly problematises the psychiatric diagnosis, he refrains from *explicitly* positioning satanic involvement as the cause. As with Eddie and Frank, this functions rhetorically to shield him from accusations of delusion. With that said, it is widely accepted that a diagnosis and appropriate medication should improve, help to manage, or cure, a condition but in Graham's case it had no effect. In short, Graham places the onus is on the listener to draw conclusions based on the 'evidence' he presents.

Satanic Visitations has revealed how to varying degrees, Christian respondents positioned their psychological problems as a form of spiritual attack. It is quite feasible that in the local culture of the church these accounts may be or may already have been accepted as plausible evidence of satanic involvement. If relayed to a Christian audience, then, alternative (secular) explanations may well be erased from the narrative. Indeed, as Lairo et al (2014) explains, within contexts where curious sensory experiences correspond with cultural beliefs, such happenings *are often* conceived as contact with the supernatural and *not* a sign of mental illness. Moreover, speakers' use of vivid detail functions to demonstrate that their other-worldly encounters are authentic and not mechanical reiterations of an expected cultural script. Lairo et al. (2014) further explain that the discursive construction of hallucinatory experiences is shaped by the contexts of their telling (Lairo et al., 2014). Here, the research interview instigated *tentative allusions* to the supernatural that might otherwise have been proclaimed with certainty and conviction.

Another aspect of the downward spiral variously alluded to by most respondents were experiences of and responses to stigma. This is the focus of 'Life on the Othered Side'.

6.34 'Life on the 'Othered' Side'

Andy's talk about being (pre)judged by the YMCA warden and placed in the block alongside 'druggies' has already been discussed. Here, the focus is on extracts from the narratives of Carl, Ben, and Harry, Graham, Frank and Eddie.

The extract below is Carl's response to my question about how he believes others perceive him and people who use drugs more generally …

> *C: 'Oh (exacerbated) (…) 'Yeah other people (..) treat you like a dog (.) y'know' I: Yeah? C: 'Yeah (.) yep they do (.) 'errm even in (local third sector local treatment agency) y'know you're made to feel bloody sub-human you really are (.) um you're not listened to you're not taken seriously (.) they think you're just constantly lying all the time'*
>
> *I: Mm*
>
> *C: 'Y'know just to get what you want'*
>
> *I: Mm*
>
> *C: 'So they really do not take you seriously'*
>
> *I: So that view within mainstream society is reflected in drugs services as well?*
>
> *C: 'Yeah definitely because the majority of them have never had addiction problems so they don't know what erm withdrawal is, really you know'*

To offer some context, demeaning constructions of (some) drug users are reproduced and reinforced through media discourse (Taylor, 2008) and the political 'war on drugs' (Du Rose, 2015) with the former reflecting the latter and vice versa (Taylor, 2008). Widespread acceptance of these discourses as common-sense (Burr, 2003) shape the subjectivities of both service users and 'mainstream' populations (Pyysiainen et al., 2017) including drug treatment personnel. One consequence of this discursive

environment is the introduction of neoliberal practices that, to quote Rose (1996, p.59), 'respond to the sufferer as if they were the author of their own misfortune' (cited in Pyysiainen et al., 2017, p.216). As a result, individuals such as Carl are punished for their refusal choose freedom (Du Rose, 2015). This contextual overview may help to explain but by no means justifies Carl's treatment by others.

Carl's assertion that other (non-drug using) people 'treat him like a dog' because of his (past) drug use highlights his sense of alienation from conventional society. Reference to being treated like a dog (or treated like an animal) is a metaphoric resource, utilised to connote treatment that borders on if not enters the realm of the inhumane. He follows this with the assertion that *even* drug treatment personnel make him 'feel bloody sub-human'. Carl positions drug sector employees as prejudiced and lacking empathy and himself as the recipient of professional malpractice. Indeed, his account draws attention to how 'neoliberal sensibilities' deepen the division between 'the important and needed and dependent and problematic' (Wlison and Miriftab, 2015, p.35), creating an environment that legitimises unjust treatment of disenfranchised populations. This discursive context and associated practices reproduce and reinforce the sense of alienation experienced by those who are deemed to have chosen and maintained an immoral or nonconventional way of life.

Despite being a long-term methadone patient, Carl is not a 'docile body' (Parkin, 2013, p.18) who dare not question the system in which he is enmeshed (Bruno and Csiernik, 2018). His construction of professionals as oblivious to the realities of addiction ('the majority of [drug treatment] professionals have not had addictions and don't know what withdrawal is like') functions to subvert the established professional-patient hierarchy. Here Carl implicitly establishes a self-identity as 'expert by experience' (Daddow and Broome, 2010, p.23) thereby challenging the authority of those whom he positions as 'faux-experts'. Drawing on this counter-discourse enables Carl to plausibly claim that in this context *he* is the

bearer of relevant knowledge *not* the professionals. In sum, Carl's account functions to draw attention to the sense of social alienation that former drug users often experience as well as the oppressive practices metered out by (some) drug treatment personnel. It also constitutes an act of resistance against taken-for-granted and 'expert' knowledges and refutation of the notion that those who have the paperwork to qualify their expertise inevitably know best.

Although the wider material-discursive context outlined above also applies to Ben, he utilises an alternative discursive strategy to represent how other people make him feel …

> *I: 'How do you feel that other people see people who use drugs and how does that make you feel, does it bother you or (2) not'?*
>
> *B: 'It does bother me yeah because um (..) every, everybody's got demons (..) and unfortunately my demon (..) is heroin (..) err um and I do take it insulting if people like start saying they call me a smack head or (...) um (..) just abuse me really […]*
>
> *I: And how does language like druggie smackhead (.) how does that make you feel about yourself?*
>
> *B: '[...] umm [..] it just makes me feel like dirty like unclean' (..) and um mentally (...) well physically it makes me feel unwell'*
>
> *I: 'That's how the language makes you feel?*
>
> *B: 'the language yeah definitely (.) mentally and physically (..) unwell'*

Here Ben's utilises an extreme case formulation ('everybody's got demons') to negotiate a position that renders him the same, but different to others, in the sense that his 'demon happens to be heroin'. Nonetheless, his use of the term 'unfortunately' as a pre-fix to 'my demon' implies that he is aware that '(former) addict' is a particularly stigmatised self-identity.

Ben's allusion to the *embodied manifestations* of discourse is also salient. As well as the psychological impact, Ben states that the language often used to denote 'addicts' makes him feel 'physically unwell*'* as well as 'dirty' and 'unclean' as if the words physically stain him. This undermines the 'sticks and stones' trope of popular English culture and the associated notion that words are harmless. For Ben, words can and do hurt, both emotionally and physically. His account renders visible the psychological and physical implications of taken-for-granted labels directed at those who are known to have experienced heroin addiction.

Harry also referred to being judged by others. The following is his response to a question about the point when he realised is drug use had become problematic …

> *H: 'Chris, I lost my family my wife took my kids at one point (tone is quiet – remorseful - accepting) (.) my parents disowned me, well my dad's an alcoholic even he disowned me' (tone of indignation)*

Harry referred to his children often throughout the interview and it became clear that the identity of 'good father' is one that he invests in. Parental substance misuse is presented as 'overwhelmingly damaging' (Rhodes at al., 2010) and posing a significant risk to child safety (Kroll and Taylor, 2003). Although legal welfare discourse constructs contact with both parents as best for the child (Day Sclater and Kagnas, 2003), here Harry's wife is implicitly positioned as a 'good mother' who acted in the best interests of the children, removing them from potential harm. Harry's remorseful tone implies that he accepts the consequences of his actions and later in the interview he actively takes steps to repair this troubled identity (Taylor, 2010) by representing himself as now a 'good father', stating that 'I always tell [my children] I love you […] I always give them a cuddle, every time I see them'*.* His use of extreme case formulations ('I always' and 'every time') functions to reinforce this version of reality.

The notion alluded to above, that it is not only words that construct versions of reality but the tone in which they are spoken, assumes added

significance in relation to the second half of the extract. Harry's assertion that 'my dad's an alcoholic and even he disowned me' is interesting and can be read in alternative ways. One implication is that even through the eyes of another substance user his behaviour was beyond the realms of acceptability. In an alternative reading, Harry positions his father's actions as tantamount to hypocrisy and betrayal. His indignant tone indicates the latter, invoking the cultural narrative that 'one should look out for their own'. Harry's assertion, then, functions to position his dad as one individual who *should* have been there with him and for him, both as a fellow 'addict' and as a father.

In response to my question about how he felt others perceived his substance use Harry states …

> *H: 'I felt like everybody judged me no matter what I did nobody could see what I'd been through the pain of everything I'd been through, I'd done something y'know I'd lost something someone (..) that (2) that changed my life, my little boy (name) changed my life at sixteen years old having to bury your child (..) was tough and I didn't think anybody got it'*

In this extract Harry positions himself as the subject of misplaced judgement. In the context of his whole narrative, the implication is that this situation is part of what *produced* the need for something to numb the pain and, in the absence of human relational support, self-medication with drugs was one of Harry's few remaining options. This extract constitutes a refutation of the stigmatised self-identity conferred on him by others – rather, Harry negotiates and claims an identity as a grieving father who *had little choice but* to engage in drug use.

Interestingly, not all participants constructed their experience of stigma as wrong or misplaced. When asked if labels such as 'junkie' or 'smack-head' affected him, Graham responded …

> *G: 'No (firm) […] that's exactly what we were, to say we were anything else we (.) y'know we would have been kidding ourselves so*

yeah I could think up quite a few names people would refer to us as and (.) that (2) wouldn't affect me I'm not really bothered I'm off my head on heroin I'm not worried about what people are calling me' (.) y'know it (2) doesn't make any difference (.) my worlds alright cos my heads full of heroin (.) y'know what I mean'

I: Mm

G: 'Erm so but that's my that's the way I (2) saw it'

Graham positions himself not so much as unfazed but *in agreement* with the labels applied to him and his fellow heroin users. He implies that rejecting or even feeling perturbed by such comments, at that time, would have been self-delusional ('we would've been kidding ourselves'). These assertions resonate with a confessional discourse ('that's exactly what we were'). Indeed, in alignment with participants in Sremac's (2013) narrative study of conversion testimonies among former drug users, Graham's account constitutes a public confession of his past. Moreover, his self-identity as 'born again' (no longer the same person) renders the above a retrospective construction about a person who, figuratively speaking, no longer exists.

With that said, his subsequent proclamation that 'I'm not really bothered I'm off my head on heroin I'm not worried what people are calling me' implies that *the drug's effects* invalidated the stigma more so than a having particularly 'thick skin' or an *inherent* disregard for others' opinions of him. Notably, Graham finishes with the rhetorical statement ('but that's the way I saw it') thereby individualising his account and implicitly acknowledging that ignoring such comments may not be as easy for others in similar situations.

Indeed, he moves on to state …

G:'I think that now people are more sensitive (.) a few people recently have said to me that people had called them smack-heads and stuff and they take offence to that (.) they prefer 'I've got a

drugs problem' or I'm this I'm that I'm the other but (2) in my day we didn't really care (.) That's who we were and that was it y'know'

Here Graham conjures up an era where political correctness was less salient ('in my day we didn't really care (.) that's who we were and that was it'). He explicitly positions people today as 'more sensitive' while *implicitly* suggesting that those who 'take offence' to derogatory labels are unable to accept reality. For Graham, the choice to use heroin brings a stigma and this othering is something that people who use drugs should learn to deal with or accept.

As a final point, it is useful to consider that Graham arrived at the interview encounter already positioned as an experienced public speaker, an evangelist who utilises his life story to draw contrasts between his addicted self and the person he is today. Having attended an event where Graham reproduced his testimony I noted how, throughout, he used self-deprecation to narrate his story in an amusing yet captivating manner. It is not surprising, then, that these elements of Graham's lived biography (Taylor, 2010) are used to resource the narrative (re)produced for this interview. Following Shadd et al. (2006) Graham has 'interpretive control over his life' (p.175) – he has constructed and embedded a new self-identity through repeated testimonial tellings to both religious and non-religious audiences. Given his communication style, that Graham did not attempt to repair potential 'trouble' emanating from what could be construed by some as lack of political correctness was perhaps foreseeable.

Eddie also *claimed* that human opinion is of minimal concern to him but with less surety than Graham …

> *E: 'Actually I don't think about that much anymore because I feel like God has taken it out of people's minds because I've gone forward you know some people I used to hang around with might still have the cliché that I used to be a (..) pot head or something like that or call me other drug names'*

I: Right

E: 'But err self-confidence wise you know I inhibit myself by thinking oh I used to do all this and all that and I've wasted my life away (.) but (2) that's a problem that (5 second pause) reading my bible and having a relationship with God can solve' (lack of surety – no conviction)

Eddie's narrative is tentative and has a manufactured feel with his responses constructed specifically to align with a Christian ideal. That is, Eddie's biographical talk gives the impression of a man who is having to think on his feet about what 'suitable' responses to questions about human judgement *should* contain. That Eddie's response to the impact of human judgement lacks the fluency of Graham's narrative above or indeed Frank's (see below), reinforces the import of bringing to analyses consideration of how participants are 'always already positioned' (Taylor and Littleton, 2012, p.25)

Eddie's use of the term 'actually' connotes a degree of defensiveness. His assertion that 'I don't think much about [others' opinions] any more' implies that it is nonetheless something he is mindful of. What is more, his relative unfamiliarity with the intricacies of Biblical discourse is reflected by the statement that God has removed thoughts of his past from peoples' minds, thus deviating from the notion that God renews *the minds of believers* (not the minds of those who hold opinions about believers). Moreover, it contradicts somewhat his subsequent declaration that some people might still label him a 'pot-head'.

Eddie's allusion to self-confidence and how he 'inhibits' himself by dwelling on the past *sounds* more authentic and *seems* to be a construction that Eddie is more comfortable with. He concludes by stating 'but (2) that's a problem that (..) reading my Bible and God can solve'. Although here Eddie positions himself as aware of challenges still to be confronted, the long pause prior to his tentative conclusion connotes a lack of surety and conviction. In sum, this narrative accentuates Eddie's position as a 'new

Christian' who is still very much learning how to 'preform Christianity' (Kreuger, 2014, p.182).

Frank's situates his representation of experiencing stigma within a 'sinner to saint' canonical narrative. In response to a question about whether or not attitudes towards his drug use have had a negative impact on his life he responds …

> *F: 'Nah (dismissive tone) I mean for a while I (2) think that obviously initially my reputation in (home town) wasn't great because of my everybody knew I was an addict so one good thing positive thing was when I moved off the Island and gave that sort of a good few years before I really went back there but then people saw the change in me so my reputation there now after all these years and it does take some time is very good and they see me as a success story'*

Although the dismissive 'Nah' functions to position his past self as far removed from his present, Frank does move on to acknowledge that acceptance by others has been a process. He represents his ascribed identity as an 'addict' as inevitable given his past but draws attentions to its temporary status ('obviously initially my reputation wasn't great'), using an extreme case formulation to legitimise his rationale ('because everybody knew I was an addict'). Frank quickly shifts focus to the positives – the construction of his return to [hometown] after 'a good few years' conjures up notions of the Prodigal Son of Biblical discourse with community members positioned as witnesses to his transformation.

6.4 Chapter Summary

This chapter started by exploring how respondents constructed their early drug-using experiences. To begin, the narratives above starkly contradict the idea that informal social controls and conventional social bonds guard against criminality and other deviant behaviours (Laub and Sampson. 1993). One participant highlighted the strong family unit in which he was raised, another attended college and two speakers *explicitly linked* their involvement in drugs to being in paid employment and/or providing for a

family. That all became addicted to drugs, advances the argument that the focus of desistance research should shift from social controls per se, to the subjective meanings that individuals attach to such controls and ways in which agency and structure interact (Le Bel et al., 2008). Despite the similarities, significant variations between speakers emerged. Christian speakers in particular explicitly constructed their drug use as an intentional and personal choice. These agentic narrative constructions differ from those produced by successful desisters in Maruna's (2001) research, all of whom attributed their criminality to adverse socioeconomic and/or personal circumstances. In keeping with Maruna's interviewees, however, non-religious speakers alluded to wider contextual factors that contributed to or even caused them to use drugs. With that said, all participants invoked a relational discourse, constructing their early drug-involvement as a phenomenon that variously involved other people. This strategy of 'deindividuation' is a discursive manoeuvre recognised by other scholars as a technique deployed by speakers to disperse blame (Maruna, 2001, p.94). So, although Christian speakers emphasised the role of self to a far greater degree than non-religious respondents in their narratives of early drug-involvement (a strategy that I suggest reproduced the Biblical command to judge not), deindividuation was nonetheless deployed. The 'descent' into active addiction was represented by both Christian and non-Christian respondents as a form of escape. Moreover, all speakers highlighted the psychological consequences of excessive drug consumption but with Christian respondents constructing their experiences of mental ill health in terms of (potential) satanic attack. These tentative allusions to the 'Devils work' are examples of the 'I' being replaced by the 'It' (Maruna, 2001), only here to position psychological ill health (rather than drug use or crime) as externally produced. However, as argued above, within 'church culture' Devilish encounters *are often* conceived as contact with the supernatural (Lairo et al, 2014). Hence, the cautious insinuations may have been produced by the interview itself, replacing the convicted assertions that within the context of a religious meeting would be accepted as plausible. Differences between Christian and non-religious

participants were also apparent in the final discursive construction – 'Life on the Othered Side'. Whereas non-religious speakers alluded to being misunderstood and unjustly treated, Christian speakers positioned stigma as inevitable given their way of life at the time, with Frank invoking a 'sinner to saint' narrative by emphasising the dramatic change in others' opinions of him that subsequently occurred. Having focused on the period from drug initiation through to active addiction, Chapter 7 concentrates on treatment and 'recoveries' as well as how speakers' constructed their aspirations for the future.

CHAPTER 7

Treatment and 'Recovery' and Beyond

7.1 Introduction

Having focused on early life and drug related experiences and the process of becoming and being drug dependent in the previous chapter, in Chapter 7 I first explore how respondents represent movement away from addiction including their constructions of treatment and 'recovery'. The overarching discourse – '(The) Breaking (of) the Habit' - is divided into four discursive constructions based on my reading of the participant account. 'Treatment for Addiction: The Good, The Bad and The Negligible' is followed by 'Conceptualising 'Recovery': Surety, Confusion and Contempt' and both capture the lack of consensus surrounding treatment efficacy and 'recovery' as a concept. The proceeding constructions - 'God as the only plausible explanation' and 'Trials and Tribulations?' - are based on the accounts of Christian participants only but were deemed to have enough significance to warrant analytic inclusion. The second part of Chapter 7 concentrates on how participants constructed their future hopes and aspirations. The related discourses and discursive constructions will be introduced in due course with a final chapter summary reiterating key points.

7.2 '(The) Breaking (of) the Habit'

(The) Breaking (of) the Habit is a wide-ranging discourse and captures respondent constructions of various issues relating to treatment and 'recovery' processes. The bracketing of (The) and (of) will be later become apparent but broadly relates to constructions of agency and passivity. 'Treatment for Addiction: The Good, The Bad and The Negligible' considers, first, how participants constructed their experiences of addiction treatment as largely positive, negative or somewhere in between. Although some Christian respondents had no or minimal personal experience of conventional treatment modalities, their views of community treatment (particularly methadone treatment) and/or Christian

rehabilitation, where expressed, are analysed and discussed. 'Conceptualising Recovery: Surety, Confusion and Contempt', to begin, explores how respondents with no religious allegiance constructed 'recovery'. Given their diverse personal-social histories and current circumstances, the variation in responses is not surprising. The next construction - 'God: the only plausible explanation' - considers how respondents who have a religious faith craft their narratives in a way that positions God as the only *viable* rationale for overcoming addiction. The focus of the final construction – 'Trials and Tribulations?' – is how participants in faith-based recoveries represent post-conversion struggles. My interest here is the utilisation of discursive resources that resonate with secular-therapeutic interpretive frameworks.

7.21 'Treatment for Addiction: The Good, The Bad and The Negligible'

As a client whose treatment involves prescribed methadone, Carl is obliged to attend the community drug service. The extract below is his response to a question about how he feels about this treatment regime …

> *C: 'I wanna get completely detoxed and get it (the methadone) out my system (.) yeah so I can get my life back (.) it's too much of a ball and chain'*

Carl positions himself as imprisoned by the medication he is prescribed – a medication that he implies has taken away his life. His representation of methadone *treatment* as a 'ball and chain' resonates with right wing political constructions of users 'parked on methadone' (HM Government, 2012), unable to move on. Carl's construction of Medication-Assisted Treatment (MAT), then, invokes political discourses which dominate the contemporary British treatment landscape including those identified in the reading of Putting Full Recovery First (PFRF), a discursive backcloth that constrains how methadone and MAT *can* be *plausibly* constructed.

To offer some context it is relevant to point out that, in Britain, constructions of medication-assisted recovery (MAR) as a *socially*

acceptable and valid recovery pathway are marginalised and largely unavailable as resources for talk. Discursively then, the 'good methadone patient' barely exists. The narratives of those for whom methadone or buprenorphine (another so-called substitute medication used to treat heroin addiction) have been life-*saving* or life-*enabling* treatments are not voiced for fear of recrimination (Singleton, 2011; Woods, 2012) or otherwise hidden within anonymous online service user forums (see The Alliance Forum). As Fraser and Valentine (2008a) surmise, those who are prescribed methadone occupy a 'uniquely marginal social location' (p.2). Carl is no longer the dangerous 'street junkie' but neither is he the chemical free and respectable subject of 'full recovery' (Fraser and Valentine, 2008a). Even if he should wish to do so, the discursive resources that would enable Carl to position and experience himself as a 'normal', 'productive' and 'successful' citizen are not available.

Ben describes his experience of being a long-term drug treatment service user in both positive and negative terms …

> *B: 'Yeah (..) the (2) positive side of it is basically I haven't been going to prison because I've had my prescription, so I haven't had to go out shoplifting or (...) anything to get money to buy drugs'*

Here Ben reproduces the established relationship between having access to a prescription, no longer having to commit crime and not going to prison (Monaghan, 2012). His talk is resourced with a harm reduction narrative of movement from chaotic addiction to relative stability. Access to MAR has thus enabled Ben to discard negative self-identities previously ascribed and reposition himself as successful. His rhetoric orientates towards wider debates in the addiction treatment field including the undermining of harm reduction and long-term MAT as a valuable treatment option (Ashton, 2007; Neale et al., 2011; Winstock et al., 2017; Independent Scientific Committee on Drugs, 2017).

In response to a question about whether treatment services are *currently* helping or hindering, he responds …

> *B: 'Hindering me (.) they're sort of bullying me into like reducing and coming off it (subutex) (..) and I keep saying to them look I'm gonna relapse if you carry on reducing me and they just don't listen'*

Ben positions himself as 'at risk' because of drug treatment personnel who 'just don't listen' and continue to reduce his medication despite his expressed concerns. Those charged with his care, who once *enabled* his progress, are repositioned as the 'enemy within' (Capdevila and Callaghan, 2007, p.6). Moreover, as a discursive strategy this version of events enables Ben to abdicate himself of responsibility should relapse occur and forms a rhetorical address to those who may then deem him personally responsible for any future return to heroin consumption.

The extract above is also indicative of a new 'regime of truth' (Smart and Mills, 2002, p.64) – the previously discussed political construction of a one-size-fits-all version of successful treatment as abstinence from all chemical dependency (HM Government, 2012). To reiterate points raised in Chapters 3 and 5, under the UK government's 'recovery agenda' (HM Government, 2010; HM Government, 2012; HM Government, 2017) harm reduction interventions and associated discourses have been marginalised and 'successful' treatment outcomes redefined. A system of payment-by-results (Roberts, 2012; Hill et al., 2012) now rewards drug services, not for retaining clients in treatment as before, but for discharging them free of both illegal drugs *and* opioid 'substitution' medications. Ben and others in similar circumstances who access and respond well to MAT were once positioned as treatment success stories but under 'full recovery' are constantly pressured to reduce and detoxify from their prescribed medication. This political shift has occurred despite a body of evidence indicating that unwanted reductions often lead to relapse and treatment re-presentation, even overdose and death (Advisory Council on the Misuse of Drugs, 2014). Ironically, then, by curtailing Ben's access to his 'essential medication' (World Health Organisation, 2005, p.220) treatment professionals may well be reproducing the 'addicted subject' who first entered treatment many years prior.

It is important to note that it is *former heroin users* who benefit from MAT who are most disadvantaged by the recovery agenda and abstinence-focused constructions of full recovery. Although as a cocaine user methadone was not an option for Harry, he also experienced different 'treatments' involving medication …

> *H: 'I'd been seeing a psychiatrist since 2010 (..) um (.) and all he'd been doing is chucking medication at me'*
>
> *I: Mm*
>
> *H: 'It wasn't a solution, it was a solution towards me getting a fix so I could sleep, so if I didn't want to be near society I could take my meds and go to sleep and blank everything'*

To begin, it is important to note that Harry is referring to psychotropic medications used in the 'treatment' of mental health conditions ranging from depression to drug-induced psychosis and schizophrenia. Whereas for former heroin users, methadone or buprenorphine when taken as prescribed are known to produce stability and enhance day-to-day functioning (Warren at al., 2016), psychotropic medications *can* be used as means of chemical restraint (Pilgrim, 2014).

Harry's account invokes anti-psychiatry discourses and draws on popular representations of (certain) psychotropic medications as a 'chemical cosh' (Pilgrim, 2014, p.89). He relinquishes all notions of personal agency and positions himself as an object of psychiatry – an individual who was subjected to a treatment regime, disguised as a solution, but producing a vacant subject. Harry's assertion that his psychiatrist 'chucked medication' at him functions to undermine the 'experts' professional competence. The psychiatrist is positioned as an 'irresponsible charlatan' – an individual whose idea of treatment was to sedate rather than support. This version of events enables Harry to position himself as a victim of irresponsible medical decision-taking.

Harry later reclaims a self-identity as a choosing subject who shunned 'expert' advice, stopped taking all prescribed medications and moved his

family to a different area. It was in [new area] that Harry accessed non-medicinal treatments. In the extract below he describes the support mechanisms that helped him to progress …

H: 'Jenny (not her real name) did some CBT which was really (2) good and I did the anger management then I went to do some volunteer work with homeless people, so that was a matter of used to go in there and talk to people' […] 'The (recovery support organisation) would get me out running, they'd get me up allotments digging up some grass'

I: So physical activities –

H: 'Yeah physical, mental activities that tired you out'

In contrast to his time subjected to the psychiatric gaze, Harry positions himself as a man who took back control of his present and future, seeking external support (Hyman, 2014, p.24) where necessary. He draws on a therapeutic discourse and positions himself as an autonomous agent ('I did anger management … I went to do volunteer work') who purposefully enrolled in a regime of 'self-care' (Hyman, 2014). Supported by 'engineers of the soul' (Rose, 1999) including recovery workers and a Cognitive Behavioural practitioner, Harry engaged in a 'process of normalisation' (O'Grady, 2015, p.37). His path to self-improvement specifically involved engaging in Cognitive Behavioural Therapy (to identify and rectify 'faulty' thought processes), anger-management (to enhance self-control), exercise (to activate the body and mind) and voluntary work (often constructed a preparation for economic productivity). Harry's 'choices' reflect Rimke's (2000) observation of a link between therapeutic culture and neoliberal ideals. The prevailing therapeutic milieu shapes human subjectivities, compelling citizens to strive towards forms of self-care which, in turn, produce self-regulating, active, responsible and ultimately 'normal' and governable citizens (Rimke, 2000).

Unlike Harry, Andy does not identify any *specific* treatment and support strategies that either helped or hindered his progress. When asked if or not he found drug treatment services helpful he responds …

> *A: 'Yeah (.) I did find them helpful (sounds a little unsure) But (2) erm they're not erm (...) they're not an overnight remedy'*
>
> *I: No?*
>
> *A: 'You can go you can go through these drug treatments (..) if you've not got the right frame of mind and want to change they won't help you (.) they're not it's not an overnight remedy it's a point of educating someone (.) to know what they're doing is harmful to themselves (.) it's giving them the informed choice […] and (2) once you've done that it's down to the individual whether they stop or not'*

The uncertainty in Andy's tone connotes a lack of surety about the efficacy of drug treatment provision – indeed, he explicitly downplays the value of addiction services ('they are not an overnight remedy'). Instead, he produces an individualised narrative of addiction recovery, locating the source of successful treatment not in external strategies or medical interventions, but in the psyche of individuals. Although Andy does not *explicitly* blame those who fall short of attaining abstinence, his version of reality nonetheless has moral undertones and positions a complex phenomenon (Griffiths, 2008) as somewhat simplistic.

His second-person narrative ('If you've not got the right frame of mind …' 'It's giving them an informed choice […] 'and (2) once you've done that it's up to them') is also intriguing. According to Demjen (2009), second-person narration can function, variously, to evoke empathy, create emotional distance from and assert the speaker's authority in relation to the issue being discussed. In the context of this interview, Andy's second-person narration appears more aligned with the latter. Although the protagonist, his narrative takes the form of a rhetorical address to others with Andy positioning himself as an authoritative voice on recovery. This address functions rhetorically to persuade prospective and current service

users (and perhaps himself!) that without 'the right frame of mind', accessing treatment or support will be futile. However, Andy's construction of attaining abstinence as an informed choice undermines prominent scientific conceptions of addiction as a complex neurobiological, psychological and sociocultural phenomenon that requires a multi-dimensional treatment response involving 'a range of expertise' (Donovan, 2008, p.2).

Graham spent many years on a methadone prescription prior to his 'God encounter' and Christian conversion. However, when asked about the utility of treatment services responded …

> *G: 'these recovery centres they all help course they do err but for me personally (.) err (.) I (2) erm (2) drugs are not an issue any more (.) they they've not been an issue since I become a Christian (.) so that's (3) my own experience y'know'*

Graham's account - the pauses, the 'errs' and the 'erms' - suggest that he is mindful of the identity trouble that a blanket dismissal of mainstream treatment may bring. Positioning 'recovery centres' as undoubtably helpful ('they all help course they do') and drawing attention to the subjective nature of his claims ('for me personally' […] 'so that's my own experience y'know') forms a defence against potential attack. Rhetorically his account is addressed to both Christian and non-religious and audiences in that he positions himself as 'aware and accepting' of alternative treatment modalities while clarifying that his personal experience is something other – something God-inspired.

Frank had in the past unsuccessfully attempted self-detoxification but had never accessed mainstream community treatment. He reported having experienced a God-encounter whilst in prison for drug offences. On release Frank attended a Christian rehabilitation programme and the extract below is his account of what transpired …

> *F: 'what happened was even though I had a Christian conversion in prison I (2) didn't really (.) have I'd not dealt with all the emotional*

stuff that I'd, the baggage that I'd carried around with me […] on June 1st 2004 I started that programme and stopped smoking [tobacco] on the first day and erm I've not touched drugs since then I've not even had any strong temptations to use (.) and I believe yeah I've been completely healed from (2) drug addiction (.) I believe God did that I believe having people around me who (.) positive people good influences I believe what helped was moving away from (home Island) familiar places all of them things helped […] but ultimately it (2) was I believe my relationship with God and (2) the new desires that He's given me (.) that's helped me maintain my freedom and just my you know being involved in church and having good just good peers around me, who believe in me who spoke into my life who encouraged me who prayed for me prayed with me n saw that I could be something'

Interestingly, Franks allusions to 'emotional stuff' and 'baggage' resonates with constructions of the therapeutic subject as a project to be worked on (Foster, 2016) and draws attention to the constitutive power of therapeutic discourse in neoliberal culture. Moreover, stating that 'even though I had a Christian conversion in prison […] I'd not dealt with the emotional stuff' functions as an implicit admission that conversion, alone, had not been sufficient. That is, although a 'God-encounter' had already occurred, '*the programme*' is positioned as contributing significantly to his drug-abstinence. So Frank alludes to God's involvement but interestingly his narrative connotes a reluctance to *explicitly* position supernatural forces as *the sole* contributory factor.

Frank also uses detail ('on June 1st 2004 I started the programme') to enhance the facticity of his narrative. Referencing a noteworthy event ('I stopped smoking on the first day') functions to emphasise the efficacy of the Christian regime. But although Frank reproduces the Biblical concept of healing ('I believe, yeah, I've been completely healed from drug addiction') and represents his relationship with God as the *primary* reason he no longer uses drugs ('but ultimately it (2) was I believe my

relationship with God […] that's helped me maintain my freedom'), significantly, he qualifies each claim with 'I believe'. This produces a sequence of personal beliefs (as opposed to truth statements). As a discursive strategy this functions as a form of defence against attack from secular or atheist critics. Even the most ardent atheist would struggle to *plausibly* assert that Frank is not permitted *to believe* that God enabled him to overcome addiction.

So the primary function of Frank's narrative is to emphasise his belief in God, but allusions to peer support, positive influences, geographical location and the need for an extended programme of support, are more aligned with normative constructions of recovery as a journey (Yates, 2010; Scottish Recovery Network, 2012; Ivers et al., 2018) than divine healing as depicted in Christian discourse (Robbins, 1996). Frank's narrative is a situated rhetorical construction (Taylor, 2010) produced with both believers and non-believers in mind. Although Frank self-identifies as a Christian, his 'God-claims' appear to be constrained by the interview context and invisible audiences. It is however reasonable to infer that, addressed to a Christian audience, his allusions to 'God's work' may well be positioned as fact rather than belief.

Although Frank's narrative left unanswered questions in terms of God's input versus the role of therapy and community, I felt that probing him to elaborate on the efficacy of God's healing power would not be beneficial. Challenging the authenticity of a speaker's experience can have significant implications for their 'integrity and credibility' (Georgaca, 2004, p.18). As interviewer, my task was to enable participants to convey their subjective experiences and feel safe to do so, not to pose questions that could be perceived as attempts to trip them up or falsify their accounts.

The discussion so has focused on how respondents variously constructed their experiences of drug treatment. The following draws attention to representations of 'recovery' itself.

7.22 'Conceptualising 'Recovery': Surety, Confusion and Contempt'

As alluded to at points throughout this thesis, discourses of recovery are contested among addiction recovery commentators, service users and medical professionals (Neale et al., 2013). For some, recovery is compatible with the long-term use of medications such as methadone and buprenorphine while for others full recovery and abstinence are synonymous (White and Kurtz, 2006). A political 'full recovery as abstinence' discourse permeates drug treatment services, undermining harm reduction-orientated initiatives and altering how 'good and successful treatment' is discursively constructed (Neale at al., 2013). This in turn has produced a practical context wherein treatment interventions are geared towards abstinence from all chemical dependency. Although counter-discourses and constructions of methadone-assisted recovery as a valid variety of recovery experience have emerged in the US (White, 2012), in Britain such constructions retain a hidden and marginalised status, effectively denying the MAT population of discursive resources that would enable them to construct creditable self-identities.

In the following two extracts Carl draws on various cultural resources and his account is characterised by ambiguity and contradiction. In response to my question about what recovery means to him and if or not he considers himself to be in recovery despite being on a methadone prescription, Carl replies …

> *C: '(..) Em (..) err (..) once I'm on the subutex (.) yeah to me that's a step in the right direction (.) because it is (.) a (2) weaker it's a weaker drug but it makes you feel better and holds you' (meaning it prevents onset of withdrawal symptoms for the period between doses)*
>
> *I: Yeah*
>
> *C: 'and it's easier to reduce on it (.) so the idea is that (.) I'll be reducing and then the goal is to be completely abstinent (.) y'know'*

To briefly contextualise, subutex (buprenorphine) is a medication used in the treatment of heroin addiction. Like methadone, it prevents the onset of withdrawal symptoms and can be prescribed on a long-term (maintenance) basis or as part of a detoxification plan. In short, some clients respond better to subutex than they do methadone and vice versa (Clinical Guidelines on Drug Misuse and Dependence Update 2017 Independent Expert Working Group, (IEWG), 2017). However, the notion that subutex offers an easier route to long-term abstinence has assumed an almost mythical status, circulating within drug sub-cultures and promogulated by some 'experts' (Addiction Survivors Discussion Board Post, 2008). Indeed, qualitative interview-based research by Neale et al. (2013) found that participants actively chose a subutex prescription based on the belief that it was easier than methadone to reduce from. However, at the follow-up interview only two of eight participants were still prescribed subutex and one of the two continued to use Class A drugs.

Carl utilises the 'subutex myth' as a discursive resource to reproduce popular (mis)conceptions of buprenorphine as a recovery-orientated alternative to methadone. Drawing on a medical-therapeutic discourse ('it's a weaker drug … easier to reduce on') functions to enhance the credibility of his assertions. As a methadone patient situated in a context of a 'full recovery' discourses 'infused with anti-methadone sentiment' (Bamber, 2010, p.62) Carl is positioned as a 'state sponsored addict'. In this respect a negative self-identity has been ascribed and his ambition to change course is therefore understandable. However, as Neale et al. (2013) surmise, the urge among drug service users to attain abstinence is *produced by* full recovery discourse. Patient subjectivities are shaped by constructions of successful treatment as abstinence and contemporary critiques of medication-assisted treatment. This 'internalisation of the recovery agenda' (Neale et al., 2013, p.168) prevents people such as Carl from experiencing themselves as 'successful', 'ambitious', 'productive', 'normal' citizens.

Representing his methadone using status as a barrier to abstinence and emphasising his desire to convert to subutex *and* detoxify, enables Carl to negotiate an alternative subject position as 'ambitious patient' from which he can plausibly claim that he has a desire to do the 'right' thing. Occupying this position enables Carl to experience himself as motivated to 'succeed'. In so doing however, he is, albeit implicitly, reproducing and reinforcing representations of those *who choose* methadone-assisted recovery as *lacking* personal ambition. It could be plausibly argued that Carl has indeed 'internalised the recovery agenda' (Neale et al., 2013, p.168) replete with political (and media) constructions of methadone as a substance that any rational and ambitious individual should avoid. Moreover, as noted by Fraser and Gordon (1994, p.324), 'there is no longer any self-evidently good adult dependency in post-industrial society' (cited in Lawler, 2014, p.80). Rhetorically, Carl's narrative is addressed to those who might question his desire for self-improvement.

However, shortly after, when questioned about the compatibility of prescribed medications with recovery Carl offers a quite different response …

> *I: Do you feel that someone can be in recovery and stable on a prescription?*
>
> *C: 'Yeah (.) definitely (.) yeah absolutely […] err I mean I'd (.) probably be quite happy to stay on the (.) the subutex script because I know for a fact that (.) I'll have I'll have energy my mood will be better and -*
>
> *I: Mm*
>
> *C: 'this (2) is a big thing when you're talking about work you know […] But yeah I mean I would (.) I would happily be on it on a on a maintenance (.) on a maintenance script yeah'*

This extract appears to directly contradict the previous one, but how to explain this variation? It could be construed as an act of self-preservation triggered by the realisation that his goal of abstinence may not

materialise. Over the years, Carl had unsuccessfully attempted long-term abstinence on numerous occasions. This shift in narrative focus aligns with Neale et al's (2013) finding that heroin users with a personal history of relapse following detoxification tend to be more cautious about their recovery prospects.

Also of interest is Carl's description of subutex as a medication that will enhance his mood and provide the energy he needs *for work*. When considered within a cultural context where drug 'addicts' are positioned as idle slackers (Svanberg, 2018), his response appears to be directed at those who may question his desire to secure employment. Lawler (2014) has argued that work is the medium through which success and failure are judged. In the event of an unsuccessful detoxification attempt, presenting subutex maintenance treatment as an option that will produce the psychological and physical attributes needed to function *at work* enables Carl to position himself as an aspiring 'neoliberal subject' (Scharff, 2016, p.217).

Indeed, constructions of the aspirational citizen are reproduced and reinforced later in the interview where Carl states …

> C: *'If they (drug treatment personnel) did that (allowed me to stay on Subutex) I would probably even (.) try and reduce myself a bit and be, be on kind of as low a dose as possible that allows me still to have energy and get up (.) get even and get work and (.) plan to be at this Open University course'*

This extract *does* several things. Firstly, by implying that he may reduce his medication in breach of prescriber recommendations constitutes an act of resistance against expert authority (Neale et al., 2013). Secondly, Carl draws on a discourse of self-responsibilisation to position himself as an autonomous agent with the ability to self-regulate his behaviour. In contemporary Western cultures, discourses of responsibilisation are pervasive (Trnka and Trundle, 2017) and autonomy is constructed as a highly desirable way of being (Lawler, 2014). The 'norm of autonomy' (Rose, 1999, p.91) binds neoliberal subjects to continuous self-scrutiny,

producing citizens who relentlessly observe their selves for undesirable traits (Lawler, 2014). For Carl, being *contented* in long-term MAT is one such trait but so is an inability to achieve personal goals.

Carl has already presented abstinence as an ideal state and subutex as a rational alternative to methadone on the basis that it would allow him to work. The extract above forms a middle ground. If prescribed subutex, Carl would willingly self-monitor his medicinal requirements and reduce his daily dose, only stopping at a point where lack of energy prevented him from 'getting up' and 'getting to work' or accessing education. Carl's description of his preferred future can be linked to Michel Foucault's concept of governmentality. Defined as the 'conduct of conduct' (Foucault cited by Gordon, 1991, p.3) governmentality is an indirect form of state control that operates through discourses of self-responsibilisation and 'appeals to freedom' (Pyysiainen et al., 2017, Abstract). This discursive context produces subjectivities whereby citizens (such as Carl) act under an illusion of freedom to fulfil the requirements of government by becoming self-regulating and autonomous subjects through an 'enterprise of self-improvement' (Rose, 1999, p.91). Carl negotiates a position as an individual with aspirations that align with normative notions of the 'good neoliberal citizenship' including freedom from dependence, gainful employment and education. To summarise, in a context where constructions of methadone as the antithesis of recovery dominate the drug treatment landscape, Carl's production of a distinction between his current situation and preferred future enables him to self-ascribe a creditable self-identity.

Although Carl's account lacks consistency, it does produce recovery as something tangible. Harry's response to my question on the meaning of recovery constitutes a blunt rejection of this premise …

> *H: 'recovery (.) is bullshit it's not recovery does, okay, if somebody breaks their neck do they recover fully from it 'no!' mental health is as damaging as physical health it's just not visible it's not (5 sec pause) physical is you, and your spirit is your mental health I'm not*

religious here either but I use a spirit as the example (…) um (..) it's damaged that's somebody's health that is them you just can't see it'

Harry exemplifies the confusion and ambiguity that surrounds the recovery concept. His initial statement – 'recovery (.) is bullshit it's not recovery' – functions to explicitly reject recovery as a state of being. Harry's attempt to construct an explanatory framework to support this assertion is, however, far from lucid. To begin, he invokes a medical discourse to (seemingly) conflate recovery from 'addiction' and recovery from a broken neck. This statement functions to produce 'addiction' as something that cannot simply be fixed. Following this, Harry engages in rhetorical talk directed as those who might question the validity of this conflation, redirecting his focus to arguments based on the import of physical health versus mental health.

Harry's next discursive manoeuvre is to conflate the mental and the spiritual. Notably, he checks his reference to religion ('I'm not religious I use the spirit as an example'), an instance of identity repair produced by recognising that alluding to the spiritual-religious may appear inconsistent (Taylor, 2010) with the non-religious identity previously claimed. The 'addict' is thus represented in Harry's account as psychologically broken to a point beyond repair. His statement that 'it's damaged that somebody's health that is them' positions the consequences of addiction as fundamental to an individual's being – such consequences are constructed as embodied and an integral feature of that person which cannot simply be reversed or removed. It is on the strength of this rationale that Harry represents 'recovery' as a redundant concept. This construction is reproduced and reinforced later in the interview where Harry states …

H: *[…] 'you know, will an alcoholic ever stop being an alcoholic, no, will druggie ever stop being a druggie, no, will a cunt ever stop being a cunt, no'*

Thus Harry's multi-faceted rejection of 'recovery' reaches a blunt climax. His proclamation is resourced by moral and medical discourses and constructions of addiction as a lifelong condition. He draws on this

discursive backcloth, utilising moral depictions of the addict as a 'forever enslaved' (Boone, 2014) and the medical-mainstream 'once and addict always an addict' (Heyman, 2009, p.65) discourse prominent within 12-step treatment programmes. Although Harry's statement has a 12-step orientation, it departs vehemently from this discourse in the sense that he rejects 'recovery' as a feasible objective.

Like Harry, Andy's initial response to the question – What does recovery mean to you? - is firm, direct and to the point. However, his follow-up explanatory framework lacks precision, contains contradiction and highlights the ambiguity that surrounds recovery as a definitive and describable state of being …

> A: *'Right (..) recovery to me (...) recovery (.) means to me (.) erm in a first instance to be chemical free'*
>
> *I: Free from all chemicals?*
>
> *A: 'Free from all chemicals (..) but (..) I understand (.) right (.) that (..) depending on what you've used'*
>
> *I: Yeah*
>
> *A: 'Recovery (..) can mean (..) being stable I: Yeah A: Not being completely chemical free it means being stable'*
>
> *I: Yeah*
>
> *A: 'And being in employment and being (.) functioning within a family unit […] A: But I think, I think the objective is (.) to be chemical free (..) but recovery (.) recovery is more than that (...) it's the social wellbeing of a person functioning with functioning properly within society […] A: Recovery is (2) a journey'*
>
> *I: Mm*
>
> *A: 'to becoming chemical free' I: Yeah A: 'Being chemical free is not recovery in itself (loud) the (2) recovery is a journey […] recovery's a journey towards being chemical free'*

I: Ok

A: 'But (..) stability comes first in (3) the process of recovery (.) and it's a gradual journey towards becoming chemical free, whether that takes months (.) or years (..) but the goal should be (.) chemical free'

It is important here to draw attention to the fact that Andy and I had conversed about the meaning of recovery prior to the interview. He was aware of my positionality as a pragmatist and critic of one-size-fits-all approaches to treatment and recovery and supporter of individual choice. Furthermore, Andy had concurred with my argument that recovery means different things to different people. The analytic importance of this observation later becomes apparent.

Andy's initial statement that 'recovery (.) means to me (.) erm in the first instance to be chemical free' is both individualised and resourced by the political 'recovery as abstinence' discourse identified in the analysis of Putting Full Recovery First. His opening statement thus positions him as an 'ideal political subject' whose chooses freedom. The pauses do, however, connote a degree of uncertainty and, indeed, may reflect a genuine lack of surety on his behalf. However, with Andy aware of my personal viewpoint, it may also function as a rhetorical strategy to deflect critique. Moreover, he proceeds to engage to an extent in identity repair, backtracking on his opening assertion. This suggests that Andy realises that presenting 'recovery' as a 'chemical free' state could be negatively valued by others and inconsistent with claims made during our off-tape discussion (see above). He negotiates a new position, stating that he 'understands' that 'depending on what drugs you've used recovery (..) can mean (..) being stable'. This assertion functions to reposition Andy as empathetic. This, and his repeated conflation of recovery and functioning – at work, within the family unit, health-wise, and socially – appears to be resourced by marginalised constructions of recovery as living life well with or without medications (White, 2012).

Andy continues this repositioning process, resourcing the remainder of his account with a canonical narrative - the metaphoric representation of recovery as a journey that may last 'months or years'. His assertion that 'being chemical free is not recovery in itself' and 'stability comes first' draw on a moderate and pragmatic treatment and recovery discourse, contradicting his initial assertion. This rhetorical talk addresses current debates on recovery as a contested and subjective concept (White, 2007; Neale et al., 2014), functioning to persuade wider audiences (including the interviewer) that his actual conception of recovery is less hard-line and more flexible than initially implied.

Although Andy constructs differing versions of recovery, within the extract he repeatedly asserts that regardless of drug of choice, the nature and length of the recovery journey or events that occur on route, the end goal should always be freedom from chemical dependency - abstinence. In discursive psychological terms, then, Andy's account is interspersed with disclaimers which function to position him as an individual who is aware that recovery is a complex and multi-faceted process *but*, ultimately, as a person who believes abstinence should be the final outcome. Moreover, his conflation of recovery and social productivity draws on neoliberal discourses of self-sufficient citizenship (Changfoot, 2006) and resonates with the 'full recovery as rational and moral' discourse identified in Chapter 5. In this respect, he reproduces an idealised version of recovery characterised by the creation of chemical free and productive political subjects. Andy's account thus functions to preserve his self-identity as a supporter of abstinence-based recovery but also enables him to negotiate a self-identity as an individual who aware and empathetic, who understands that recovery is a process, a journey that differs depending on the individual and drug(s) of choice.

As a final point, it is important to highlight that Andy's drug of choice was amphetamine. His conception of 'personal recovery' may well have been forged in a context where the use of medications to support recovery had never been broached. Thus, Andy's unfamiliarity with constructions of

MAR may be implicated in the formation of his personal narrative and insistence on a chemical free end state.

Although the treatment and recovery narratives presented above are diverse in nature, ambiguous and contradictory in part, they do produce some overarching messages. Firstly, authority figures cannot be relied upon to act in a client's best interests. Successful treatment, therefore, requires self-reliance, self-resolve and personal input. Secondly, recovery (for whom the concept has meaning) is partly about attaining abstinence but also restoring 'normal' functioning in accordance with neoliberal ideals of good citizenship.

As already alluded to, most Christian respondents had had little or no contact with 'mainstream' addiction services. The extract below is Graham's response to my question about the compatibility of methadone with recovery …

> *G: 'I (2) mean the thing is if you're on a methadone script and you're on a reduction course […] that's a form of recovery because you're aiming to get better aren't you you're aiming to solve the problem'*
>
> *I: Yeah your –*
>
> *G: 'but being on a script where you're just maintained at a certain level (.) I mean if you've been going out and (3) using y'know thousands of pounds of heroin every (3) week (.) and you end up on (2) a methadone script and you don't have to worry about money any more then it's kind of sort of recovery but it's not cos you're still addicted ain't yer (.) It's just addicted to methadone rather than the heroin but its (2) the same thing it's just a just a cleaner substance isn't it'*

Here Graham invokes the abstinence versus harm reduction debate, siding with the 'new abstentionists' (Ashton, 2007) and reinforces the political distinction between abstinence-focused treatment as progressive ('that's a form of recovery because you're aiming to get better') and methadone

maintenance treatment as regressive ('it's just addicted to the methadone rather the heroin but it's the same thing'). In so doing he implicitly positions people in medication-assisted treatment as lacking ambition (not wanting to get better) and directly substituting one substance with another (HM Government, 2012).

Although Graham's representation of methadone is perhaps unsurprising in the context his self-identity as an individual who has been 'saved by God', his narrative nonetheless resonates with the dominant political 'full recovery' discourse. The cultural resources he utilises to construct methadone treatment ('it's not solving the problem') as synonymous with heroin addiction ('it's the same thing') draws attention to how dominant (in this case political) discourses become accepted as common-sense (Burr, 2005). Both Graham's and Andy's accounts draw on 'full recovery as abstinence' and 'full recovery as rational' discourses. The implication here is that 'full recovery' has been internalised even by those who are not affected by it on a personal level. Indeed, it would appear that 'full recovery' has become a dominant cultural narrative to the detriment of community treatment users like Carl and Ben who are stigmatised and impelled to question the authenticity of their predicament.

As noted above, Harry rejected 'recovery' as a meaningful concept, representing it as 'bullshit' – an unattainable state. Graham also spurned the notion of recovery but in a very different sense. When asked about his recovery status Graham replied …

G: 'I'm not in recovery now'

I: No?

G: 'I'm not in recovery I'm recovered I was recovered when I became a Christian'

I: Right

G: 'I personally (.) I have never (.) been in recovery (.) I had an encounter with God that changed my life (.) and (2) I was recovered'

Here Graham produces a distinction between being 'in recovery' and the new (recovered) self that has been produced by a life-changing 'encounter with God'. Although he draws attention to the personal standing of his claim ('I personally'), Graham's assertion is convicted and apparently unencumbered by concerns about allegations of irrationality. As an evangelist who conveys his story to diverse audiences, Graham's testimony has 'become the paradigm through which he interprets his life' (Rambo 1993 in Seremac and Ganzevoort, 2013, p.77).

Although Frank's construction of what and who he is, is similar to Grahams, it is presented with less surety and conviction as revealed in the following question and answer sequence …

> *I: So you define yourself as being most definitely in recovery (.) can you define what being in recovery is?*
>
> *F: '(..) I well I (2) believe (..) yeah I believe I'm completely recovered'*
>
> *I: Mm*
>
> *F: 'Completely (.) some people would say I'm still an addict […] So (.) I don't certainly don't yeah some people say you know it's an illness once you're an addict THAT'S IT for the rest of your life (.) like I said you've gotta make wise choices but (2) I would say I'm certainly recovered'*

Firstly, the pauses and hesitations imply that Frank is mindful of how the version of reality he is about to (re)produce could be received by non-Christian audiences. Like Graham, Frank emphasises the personal nature of his 'recovered' status, positioning it as belief rather than fact. As the narrative progresses however, Frank begins to speak with more conviction. Acknowledging the existence of competing interpretations ('some would say I'm still an addict […] it's an illness') functions rhetorically as a form of concession but, more so, as a *critical address* ('I don't certainly don't') to 12-step advocates and other disease/illness theorists. Indeed, the point of emphasis within the phrase *'some say once*

you're an addict THAT'S IT for the rest of your life' connotes constructions of 'once an addict always an addict' as fatalistic. Frank implicitly ascribes a defeatist self-identity on those who position addiction as a lifelong illness while his reference to making '*wise* choices' (as opposed to good or sensible ones) conjures up notions of Biblical wisdom. In sum, Frank positions himself as 'recovered' from addiction but also as responsible for continued commitment to the Godly path.

Dave uses the term 'recovery' (as opposed to recovered) but his account functions in much the same way as those constructed by other Christian speakers. To recap, Dave is not an evangelist or public speaker and less familiar with public 'discursive practices of self-performance' (Seremac and Ganzevoort, 2013, p.77). To contextualise the following extract, I put to Dave that some people equate recovery with long-term methadone prescribing and follow this by asking for his views on medication-assisted recovery as well as what recovery means to him personally. He responded …

> *D: 'Total abstinence'*
>
> *I: Yeah?*
>
> *D: 'Absolutely 100% total abstinence that's recovery' (.) 'erm I don't see another way (.) yer just stabilised on medication then ain't yer (.) if you're on methadone (.) yer not really free'*
>
> *I: Mm*
>
> *D: 'You've (2) still got another addiction it's Physeptone addiction'*
>
> *I: Mm*
>
> *D: 'Total abstinence'*
>
> *I: Okay*
>
> *D: 'a lot of my friends back in Scotland say to me 'I'm off of heroin' but I say to them 'are you still on your methadone' and their like 'aye'*
>
> *I: Mm*

D: 'So they're not really free but in their head they think they're free cos they're not using heroin […] they're stabilised on methadone but they're (.) they're still on welfare and things like that definitely they've not progressed onto living a normal life going for a job things like that y'know'

Dave's construction of recovery and strong anti-methadone stance draws on pollical 'full recovery as abstinence' and 'full recovery as rational and moral' discourses, interspersed with religious connotations. His repeated assertion that recovery is 'total abstinence', 'absolutely', '100 percent' and he 'don't see another way' functions to dispel any doubts as to his position. The rhetorical question - 'yer just stabilised on medication ain't yer' – reproduces and reinforces the existing 'anti-methadone sentiment' (Bamber, 2010) and his construction of methadone as 'another addiction' resonates with the notion that such treatments are tantamount to legalised drug dealing (Gyngell, 2011).

By way of explanation Dave contextualises his assertions, drawing attention to his 'friends in Scotland' who are still prescribed methadone. Positioning the referents of his assertion as 'friends' functions rhetorically to persuade the listener that he has no stake in demeaning them. However, Dave's assertion that they are 'not really free but in their head they think they're free cos they're not using heroin' positions his 'friends' as irrational. Moreover, by conflating methadone dependency and benefit dependency and inhibited social progression he confers on to his 'friends' self-identities as failed neoliberal subjects.

Although Dave's account certainly has political connotations, incitements to 'freedom' feature in both neoliberal and Christian texts, the former in relation to freedom to accrue material wealth (Brown, 2018), the latter with reference to freedom from fleshly desires (Longeneker, 2011). Given how Dave is already positioned, it is reasonable to infer that his allusions to freedom are resourced primarily by the religious notion of freedom in Christ. In so doing, Dave reinforces a contrast between God-inspired

recovery with *real* freedom and the 'faux' freedom of people on methadone.

The following construction – 'God as the only plausible explanation' – captures how Christian respondents variously craft their narratives to position God as the only conceivable explanation for their drug free status.

7.23 'God as the Only Plausible Explanation'

Graham's account of God's role in his movement away from drugs leaves little room for alternative explanations. To contextualise, Graham at this point had moved away from the town centre to a quieter area. His life became less chaotic - he still used illegal drugs (but to a much lesser degree) and prescription drugs including methadone and benzodiazepines.

In response to the question - What was the turning point for you in terms of wanting to get better? - Graham responded …

> *G: 'I didn't want to get better'*
>
> *I: You didn't –*
>
> *G: 'because I didn't, I wasn't ill in my own eyes I was a drug user and enjoyed taking drugs'*
>
> *I: Right*
>
> *G: 'wasn't looking for a solution I was quite content I mean (.) bear in mind I'd been using drugs for fifteen years before my life turned around'*

Here Graham presents as a deviant case, resisting political and popular constructions of long-term drug addiction as an undesirable and unwanted state (O'Donoghue and Rabin, 1999). Rather, he positions himself as an individual who had embraced the 'addict' identity and was 'quite happy' and 'quite content' with drug use as a way of life. Positioning himself as a contented drug user (see Fraser and Valentine, 2008b) enables Graham to plausibly claim that he 'wasn't looking for a solution'. In so doing, he invites the listener to consider why a person who enjoyed the life *of their*

choosing would want to change. It is a discursive strategy that functions to render the possibility of *self-directed* change all the less likely, enabling Graham to position himself a passive recipient of God's work while contextualising the Godly intervention.

Graham continues …

> *G: 'I couldn't have done this for me I mean […] that's the impact God had on me (.) I couldn't have stayed changed on my own I didn't wanna change I was quite happy with the little bit of drugs it got to the stage in my life when I was quite happy I was quite happy just doing the drugs I was doing'*

Graham's representation of powerless ('I couldn't have done this for me' […] 'I couldn't have stayed changed on my own') breaks from normative representations of 'addicts' as desperate for but unable to change (Boone, 2014). It is also interesting how Graham's account evokes political constructions of long-term benefit claimants enjoying their dependency ('I didn't want to change') and contentment with the status quo ('I was quite happy'), their lives salvageable only through political intervention. Graham utilises a similar interpretive framework to represent his own powerlessness, only with God (rather than government) positioned in the role of saviour and to whom homage is duly paid. However, an alternative reading is available – one that does not necessarily conflict with Graham's narrative (he is not strictly anti-methadone per se) but stands apart from the core message.

Although not construed by Graham as such, he could at that time be defined as in medication-assisted recovery. He felt relatively stable, was on a maintenance prescription of methadone, and used illegal drugs occasionally and in moderation. By positioning himself as 'quite happy on drugs', Graham reproduces the notion that total abstinence is not a prerequisite for stability or contentment (Du Pont, 1997, p.247; Katsafanas, 2013 p.112). That is, Graham's narrative implies that people *can* use drugs in moderation and/or be in long-term methadone treatment *and* feel satisfied with life.

Graham may reject this claim with an assertion that becoming a Christian enabled him to see that his 'contentment' was merely an illusion. Perhaps he could reiterate the stark contrast between being 'in recovery' and 'recovered' through faith in God ('I'm not in recovery I'm recovered, I was recovered when I became a Christian'). Such claims, however, would be profound only to fellow Christians. That is, Graham would be utilising a local resource (Taylor, 2010) from his faith community which, for the secular majority, would lack coherence and validity. So although the *function* of the extract above is to represent Graham's 'recovered' status as produced by God and God alone, from another perspective it actually reproduces and strengthens the principles which underpin harm reduction.

Unlike Graham, Dave does not position himself as a contented drug user. However, albeit the discursive strategies deployed by Dave differed substantially to Graham's, how they function (to present God as the only plausible explanation for his recovery) is the same. When asked about the turning point in his life Dave responded …

> *D: 'Err well er my experience is (2) based on Christianity and I had an encounter with Jesus and I can say I'm definitely different because (5 second pause) the addiction all through my life and the side effect for me of addiction was feeling guilty and feeling shame and feeling condemnation'*
>
> *I: Yeah*
>
> *D: 'I'd tried everything to try and get myself off it (.) not taking drugs, trying to get a job just trying to live a normal life (Dave earlier mentions a hospital detoxification and follow up programmes in the psychiatric hospital) but my mind had never changed the guilt the shame and condemnation was still there'*

To begin, it is interesting to again note the contrasting strategies deployed by Graham and Dave. Whereas Graham's account could be described as contextually leftfield, Dave sticks to the script in presenting a stereotypical 'saved by God' narrative, drawing explicitly on Biblical discourse. He

occupies the position of 'captive' within a 'trapped in addiction' canonical narrative. Dave's assertion that he 'tried everything but my mind never changed' is curiously lacking agency, the implication being that something other was required that would change his mind for him. Moreover, he identifies the 'side effects' of drug use as 'guilt, shame and condemnation' - the very states that God is said to produce freedom from. This use of terminology, I would suggest, is no coincidence. In sum, Dave positions himself as a man whose secular options had been exhausted. Periods of abstinence and attempts at secular 'normality' failed to take way the thoughts and feelings that drugs both fuelled and quelled.

Dave continues …

> *'It wasn't until (name) asked me to ask God into my life and I had no idea about God, no concept about God or anything like that at all […] he asked me to ask Jesus into my life and something inside me wanted to do it and I started to say a prayer of repentance (.) and felt the most amazing sense of forgiveness love and joy (.) and that sense of guilt shame and condemnation lifted off me straight away … INSTANTLY'*

Here the passivity and hopelessness that permeated the previous extract is replaced by a sense of agency as Dave asked for and received God's grace then chose to say a prayer of repentance. He positions prayer as the medium that instantly set free a man who for years had been plagued by guilt, shame and condemnation. This construction of sequence and consequence (Taylor, 2010) is resourced by the 'ask and ye shall receive' Biblical narrative and reproduces the notion of God as healer. Moreover, Dave's assertion that he had 'no idea and no concept about God' is a discursive manoeuvre that functions to enhance the miraculous quality of what he describes. He reproduces a dominant 'captivity to freedom' Christian construction resourced with established Biblical discourse. So Dave's 'miserable captive' to 'joyous Christian' narrative performs the same function as Graham's reported shift from 'contented drug user' to 'drug free Christian' with both working to position God as the only

plausible explanation for their freedom from drug addiction. This notion is further reinforced by Graham in the extract below.

Graham, as previously mentioned, was diagnosed with amphetamine psychosis and lived with hearing voices for many years. In the extract below he describes returning home following a prayer meeting …

> *G: 'I got back to my flat after the meeting (.) closed the door (.) got ready to talk back to the voices I was expecting to come cos I learned over the years to talk back to them (.) there was silence (.) nothing (.) the voices were gone I had lived with them for nine years been prayed for now they were gone'*

Here Graham presents a sequenced account of events, utilising detail to emphasise the authenticity of his narrative. The extract functions to emphasise a dramatic 'pre-prayer-versus-post-prayer' transformation – a condition he had lived with for years and gotten used to simply vanished. Graham imbues 'the voices' with an almost human-like quality, implying that he has formed a relationship with them over a nine-year period. His statement that 'there was silence (.) nothing (.) […] I had lived with the voices for nine years been prayed for and now they were gone' functions with dramatic effect. Graham's account reproduces and reinforces the notion that prayer is powerful and leaves little else but Godly intervention to explain the extraordinary event he describes. The miraculous nature of this event is further reinforced when one recalls how Graham had earlier explained how prescribed anti-psychotics failed to relieve the amphetamine psychosis, yet prayer provided instant cure. In short, his version of events is one that cannot be easily rationalised in secular terms.

A commonality among all Christian narratives presented above are constructions of extraordinary transformations from addiction to freedom. The section below focuses on how participants constructed explanatory frameworks for post-conversion 'trouble'. Here the discourse moves away from the supernatural somewhat, taking on a more therapeutic-secular orientation.

7.24 Trials and Tribulations?

The focus of this section is the trouble encountered by two Christian respondents *following* religious conversion. It is important to clarify that neither the Christian Bible nor any respondent implied that once 'saved' all troubles would cease. What I found interesting, however, is that the *Biblical* notion of 'trials and tribulations' *was not* utilised to resource explanations of post-conversion relapse. As neither Graham or Eddie spoke of relapse or other post-conversion challenges, the following draws on the narratives of Frank and Dave.

To briefly re-cap, in the preceding section I presented Dave's narration of his many unsuccessful attempts to break the addictive cycle through secular means and how, following a prayer of repentance, the 'guilt, shame and condemnation' that he positioned as both a consequence of addiction and reason for his inability to break away from a drug-involved lifestyle disappeared in an instant.

The extract below is Dave's response to my follow-up question: And you haven't used drugs since?

> *'Yeah I've had a few relapses though because coming from that kinda way of life no (.) and that you take a lot of kinda stuff in to'*
>
> *I: Yeah*
>
> *D: 'you take a lot of stuff into it and you start having to deal with a lot of the issues (.) why, what caused you to go down that path in the first place'*
>
> *I: Yeah*
>
> *D: 'Y'know and the cause with me was probably (.) feeling a lot of rejection and that in my life'*
>
> *I: So were those –*
>
> *D: 'these were the driving factors of my drug addiction (.) rejection (.) low self-esteem (.) confidence all things like that'*

I: Were they the issues that triggered the relapse do you think?

D: 'Yeah absolutely' (235-251) […] 'It's about choices'

I: So those periods of time when you relapsed, were the triggers y'know the fact that you were still –

D: 'Dealing with myself -

I: Yeah

D: 'dealing with myself you know'

It is interesting how Dave uses religious terminology to describe his God encounter yet draws on a therapeutic discourse to construct an explanation for post-conversion relapses. Personal-social histories ('coming from that way of life you know'), low self-esteem and lack of confidence are social-psychological constructs that resonate with therapeutic-secular discourse (Madson, 2015). Dave invokes a secular as opposed to a religious discursive framework to justify and make sense of his lapses. Although he positions God's intervention as an extraordinary experience and epiphanic moment, the implication here is that his subjectivity continues to be shaped by Western therapeutic constructions. For Dave, to *remain* drug free requires work on the self. Representing his lapse as an outcome of his personal-social history and psychological issues is, however, a functional discursive manoeuvre as discussed below.

Reproducing a commonly deployed (secular) rationale functions to absolve God of responsibility and places the onus on Dave to rectify these issues. This absolution of God from being in any way to blame is captured in Dave's assertion that 'It's about choices'. Here the religiously attuned listener may be drawn to notions of free will while the politically attuned critic might link Dave's assertion to the internalisation of 'neoliberal subjectivity' (Schwiter, 2013, p.154) and the production of a choosing self (Rose, 1996, p.17) who feels responsible for the consequences attached to his choices.

The overarching implication in Dave's representation of why he relapsed is that God can only do so much – guilt, shame and condemnation are constructed in religious discourse as objects from which God can instantly free us through prayer. Low self-esteem, low self-confidence and traumatic personal-social histories are psychosocial constructs - humans are positioned in neoliberal discourse as responsible both for their presence and their resolution. The implication is that the 'joy' Dave experienced following his prayer of repentance was no antidote to deep-seated psychological traumas. Dave positions himself in therapeutic discourse as damaged by life and a 'project to be worked on' (Lawler, 2014, p.20), a person who must commit to a programme of self-care and exercise choice in a responsible manner. It is his duty to resolve that for which he holds himself responsible and thus maintain and build upon the gift bestowed by God following his prayer of repentance. Comparing Dave's representation of the God-encounter with his rationalisation of subsequent relapses reveals a degree of contradiction and potential source of identity trouble (Taylor, 2010), an inconsistency that Dave does not attempt to repair.

As mentioned earlier, Frank's conversion experience occurred in prison. He described the overwhelming sense of love and peace that followed his prayer of repentance alongside new desires and a feeling of assurance that from that point forth his life would be different. However, like Dave, the conversion experience alone was not enough to consign heroin use to the past. In the extract below, Frank responds to my question regarding how it felt to use heroin after the religious encounter …

> *F: 'Yeah well obviously I felt, I felt (.) guilty after using the drug you know after but I (2) suppose […] yeah I'd fooled myself really thinking that was ok but, I think the last time I'd used heroin I'd only um I'd got out of prison (.) it was May 30th and um I had an overwhelming (.) just desire to use heroin again and umm I didn't think that (2) would've been the case, I'd managed to get some heroin (.) erm (.) I smoked a bit on the foil but I felt guilty straight*

away and I knew that I was perhaps (..) I just felt convicted by God that it was wrong and I didn't enjoy the buzz so I flushed it down the toilet'

The experiences narrated by Frank and Dave bear clear similarities. Both present the God-encounter as an epiphanic moment but draw on an alternative set of discursive resources to justify a subsequent relapse. Frank uses detail ('It was May 30th and I had an overwhelming desire to use heroin again') to enhance the facticity of his account. He represents post-relapse feelings of guilt as self-evident ('well obviously I felt guilty after using the drug'), the implication being that sin following a God-encounter will 'obviously' produce remorse.

It is interesting how Frank's contextualises his relapse. Although stressing that he 'didn't think that [the craving] would've been the case' draws attention to the power of the God-encounter, having overwhelming urges to use and 'fooling oneself' resonates with secular relapse discourse (Tiffany, 2001). Moreover, feelings of guilt and the disposal of the any remaining drugs following a lapse is by no means restricted to those who have experienced a religious encounter. Frank, however, represents the disposal of heroin as a direct consequence of feeling 'convicted by God'. In this sense, then, Frank is *reconstructing as God-inspired* a series of events that many former or recovering drug users experience regardless of religious belief. It is a narrative that functions as a rhetorical address to both Christian and non-Christian former drug users as a warning against complacency.

Having analysed and discussed how respondents constructed the processes involved in becoming drug free, the final discourse draws attention to their constructions of what lies ahead.

7.3 The Road Ahead as Contingent or Definitive

7.31 Introduction

Analysis of this discourse explores how participants constructed the future. 'Contingent-Precarious Futures' captures how respondents with no

religious inclination represented the road ahead as holding varying degrees of uncertainty and risk, produced by their reliance on favourable personal-social conditions. 'Definitive Futures' is a construction produced in the narratives of Christian participants and relates to how respondents constructed their futures as fated and/or undoubtedly positive.

7.32 Contingent-Precarious Futures

Narratives produced by non-Christian speakers contained both implicit and explicit allusions to futures that were less than secure. The following extract is Carl's response to my question concerning his feelings about the future …

> *I: So, to sort of sum it up you (.) generally feel quite optimistic about the future but a lot of it depends on how the treatment services, you know, how much say you have in your treatment?*
>
> *C: '*IF *they push me too quick to get off it [MAT] I will relapse (.) and then I'll be back to square one if they push me (.)* IF *they do it at a rate that I that I can cope with then (.) yeah, I've got hope that I can reduce very slowly and then become completely abstinent'*
>
> *I: Mm*
>
> *C: 'but if they push me too quick I'm gonna fall flat on my face'*

The analysis has already revealed inconsistencies and ambiguities in how Carl constructed what recovery means to him. Here, his narrative reproduces and reinforces the insights of Neale et al. (2013) who concluded that recovery-orientated treatment may prompt service users towards detoxification and abstinence before they feel ready.

Carl positions himself as an individual who ultimately hopes to attain abstinence but who's future success is dependent on professional decision-takers. He positions abstinence as possible only if his medication reduction programme is 'very slow' and one that he can cope with. His consistent use of the phrase 'IF they push me' connotes an environment wherein Carl foresees enforced reduction if his preferred future does not

align with full recovery ideals. Moreover, his account positions drug treatment personnel as having control over what lies ahead and himself at the mercy of 'expert' decision-making practices. In this sense, he invokes a medical discourse and reproduces the established doctor-patient hierarchy (Price, 2007).

However, as before, Carl subverts the established order of things by utilising the concept of 'experiential authority' (Noorani, 2013, p.49), positioning himself as an authoritative voice when it comes to his personal recovery journey. This construction of a dual identity – as both 'patient' and 'expert' – enables Carl to plausibly assert that he knows and is capable of conveying what constitutes a reduction schedule that will ultimately produce a 'self-chosen' and desirable result (Sugarman, 2015, p.105). Treatment aligned with Carl's expressed wishes and cognisant of his experiential authority is likely to produce a positive outcome for all concerned while a course of action that disregards his expertise *will* reproduce an 'addicted subject' with Carl falling 'flat on his face'. The latter would be disastrous for Carl but would also undermine the capacity of addiction professionals to create productive neoliberal citizens.

Carl's narrative functions to responsibilise the 'experts' while limiting the extent to which he can, or should, be held personally accountable for failure. Positioning himself as both 'patient' and 'experiential expert' enables Carl to plausibly claim that the blame for any future relapse will lie with drug treatment personnel, thereby negating feelings of *personal* failure. Alternatively, a reduction program aligned with his expressed wishes and producing 'full recovery' would allow Carl to experience himself as the conduit of success. His narrative, then, is a rhetorical address to those charged with his care. Given the 'full recovery' context, Carl's personal vision of 'success' constitutes an act of resistance against powerful discourses and related interests and practices, thus rendering his future a precarious one.

Where Carl positions his future success as dependent on empathic understanding from decision-takers, Harry locates risk within his own

personal desire, his capacity to resist temptation and his ability to progress in life. He states …

> *H: 'You know Chris nothing would give me greater pleasure now than to go out (.) just have a few beers at the students union and then jump back to (town) get a few more beers, couple of lines (.) chatter with the lads cos you talk shit when you're on coke (.) good catch up and get on it for a couple of days that would be heaven (.) it actually wouldn't it'd be hell, no, my heaven is hell' (Harry appears to disengage with the interview context and retreat into his own world)*

This narrative construction can be read in different ways. The initial extreme case formulation ('nothing would give me greater pleasure …') could be conceived in terms of Harry's inner strength. Although to consume beer and cocaine would provide Harry with immense pleasure, he is nonetheless able to resist the urge. This reading positions Harry as man who is able to remain steadfast in the face of temptation. An alternative reading of the whole extract, however, emphasises Harry's continued vulnerability. His utilisation of street discourse to construct a hypothetical sequence of events ('have a few beers, jump back to town, couple of lines, chatter with the lads, get on it for a couple of days') functions to normalise the routine he describes. Maintaining abstinence, then, requires Harry to consistently suppress his desires.

He moves on to the state that a drink and drug session 'would be heaven' but quickly attempts to repair this 'trouble', claiming 'actually it wouldn't it would be hell'. Harry next assertion – 'no, my heaven is hell' - connotes confusion and a fragmented self-identity. My field notes indicate that Harry, at this point, appeared to disengage from the immediate interview context, as if attempting to work out what it is that he actually desires. He appears to be engaging in a critical dialogue with a former self, narrating a 'good old days' construction that is dramatically punctuated with a present-time remembrance of the consequences attached his personal-social history ('my heaven is hell').

Harry's narrative connotes struggle and conflict between past and present self-identities. He has forged new self-identities - as 'good father', 'good husband' and 'good student' - and earlier positioned himself as an individual who reclaimed his life from the verge of self-destruction. However, his conflation of drug use and 'great pleasure' implies that memories attached to his 'old self' continue to influence his subjectivity. His narrative alludes to a predicament wherein Harry is not yet able (or willing) to fully relinquish identity as a drug user. Despite his explicit rejection of religion prior to the interview, Harry's narrative has latent religious connotations, evoking an ongoing battle between current and former self-identities, conjuring up metaphorical imagery of an individual with the devil on one shoulder, an angle on the other.

The following extract only reinforces the precariousness status Harry's future …

> *H: 'I could relapse, basically anything I do that's not moving forwards Chris I could relapse'*

In this statement Harry positions himself within a 'progress as paramount' discourse as at significant risk. He states that *any* life event or happening that *he* construes as a backward step could trigger a relapse. Hence, for Harry, it is not conventional relapse prevention constructs such as contact with drugs or drug paraphernalia (Sanders, 2011) that may trigger a return to drug use but the eb and flow of everyday life.

At a later stage in the interview he conflates receiving an A grade with the cocaine high and explains this assertion in terms of self-fulfilment and self-worth …

> *H: 'I get the same from a line of cocaine as what I do an A+'* […] *'Its (3) self-fulfilment isn't it Chris its self-worth nobody else got my grades'*

Harry's conflation of 'good grades' and 'self-worth' is indicative of how neoliberal concepts and ideals produce and reproduce certain types of subject. In their discussion of perfectionism as a hidden curse among

students in an age of neoliberal principles, Curran and Hill (2018) highlight the many ways that students can be ranked and thus positioned as 'more' or 'less deserving'. Those who are positioned as 'less deserving' are done so based on the assumption that they are in some way inherently 'weak' or 'flawed'. Curran and Hill argue that the pressure exerted on students by neoliberal discourse to rise above their peers is reshaping learner subjectivities with consequences ranging from low self-worth, anxiety and depression to suicide.

Harry, in the terms expressed by Curran and Hill, fulfils the perfectionist criteria. If his academic grades do not meet his own high standard, he is likely to experience inner turmoil. Moreover, there is a distinct possibility that Harry will not consistently attain A+ grades. This, alongside the ups and downs of everyday life as well as the positive imagery he still conjures up regarding alcohol and cocaine use, taken together, produce a precarious future.

When asked about his hopes for the future, Andy also referred to his education and getting 'good' grades but offers a different rationale for this aspiration …

I: So just finally to finish off how do you see your future now in terms of your goals your aspirations your recovery?

A: 'Well (.) erm (..) my aspirations are obviously to (.) finish my university course (..) to get a good grade'

I: Yeah

A: 'And (.) to (.) either carry my education on or (.) get err (..) be able to find good employment'

I: Right

A: 'And erm (..) you know that's everything that (..) y'know (.) people that have judged me in the past would never have expected'

I: Yeah (.) yeah

A: 'That's not, that's not that's not a drug that's not a drug addict or an alcoholic (.) that goes to university gets a degree and maybe (2) carry on and do a Masters or gets (.) gets good employment'

Completing university, attaining 'good' grades and finding 'good employment' are reproduced in Andy's narrative as 'obvious' and common-sense aspirations. Such aspirations, reflecting those of other participants, is legitimated in neoliberal discourse and linked to the production of neoliberal subjects including the 'deserving student' (Curran and Hill, 2018) and 'productive citizen' (Petrovic and Kuntz, 2014, p.241). Andy's construction of personal ambition is resourced by a canonical narrative: the normative personal-social progression through recognisable stages noted by Taylor (2010), in this case from undergraduate education to postgraduate study or on to gainful employment.

However, the primary function of the extract above is to produce a stark contrast between what Andy aspires to be and others' expectations of him. It is a rhetorical construction addressed to the naysayers - those who would or may already have told him that as an 'addict', he will never achieve. Andy positions himself as an odds-beater, regardless of personal-social history and the expectations of others. This, at first reading, appears to align with Silva's (2015) assertion that despite the loss of 'conventional scripts' (p.15) as a resource for constructing adult identities, traditional 'progress-orientated narratives' (Silva, 2015, p.16) where success is achieved through personal application and surmounting obstacles are still in operation.

Andy, however, at time of interview was 45 years of age, supporting Silva's (2015) observation that 'traditional markers of adulthood have become delayed' (p.1). Moreover, a 'new therapeutic model of selfhood' (Silva, 2015) has produced subjects who look inward for signs of pathology. Andy's story reflects what Silva (2015) refers to as a 'therapeutic narrative' (p.6), a narrative that compels subjects to locate the source of their problems within painful pasts, to vocalise a narrative of suffering and, lastly, to emerge triumphant by reconstructing a self that

has overcome adversity and realised freedom. When considered in the context of Andy's overarching narrative then, the extract above represents a hybrid construction, produced by drawing both on a traditional narrative of normative social progression and 'a therapeutic model of psychic suffering and self-transformation' (Silva, 2015, p.7).

Although the precariousness of Andy's future is perhaps not as obvious as that of other participants, it is nonetheless uncertain. His assertion that 'addicts' and 'alcoholics' do not go to university or get good jobs is resourced with a moral discourse and related constructions of 'addicts' as 'failed subjects'. Although Andy vocalises 'mainstream' aspirations, this ambition should be considered in the context of 'addiction' as a condition where cycles of relapse and remission are commonplace (Gutman, 2006). Moreover self-identity is produced in difference - a person recognises themselves in terms of what they are not (Dhamoon, 2009). If getting 'good' grades and a 'good job' are constructed as the preserve of 'normal' (non-addicted) people, then a lapse and/or falling short of achieving these aspirations would position Andy as abnormal. This, then, risks introspection and the (re)production of an 'addict subjectivity' and self-identification as a category of person who cannot accomplish 'mainstream' goals.

What is more, Andy's construction of personal achievement as a way of proving others wrong, while presented implicitly as a source of motivation, also leaves him vulnerable to judgment and feelings of inferiority should his preferred future not materialise. In sum, a positive self-identity and subjectivity are presented by Andy as dependent on attaining neoliberal constructions of success and, in so doing, silencing the doubters. It is the possibility that he will fall short of these self-imposed criteria for 'success' and related consequences that render his future contingent and precarious.

7.33 Definitive Futures

Christian respondents constructed future aspirations in various ways but with a surety that did not feature in the narratives presented above.

Unlike non-religious respondents, 'success' was not overtly positioned as reliant on external conditions and circumstances. Again, this brings into focus the importance of context and how people arrive at the interview 'always already positioned' (Taylor and Littleton, 2012, p.25). As believers, to represent the future as in some way dependent on the things of this world would be to reject the Biblical command for total reliance on God. In this way then, the biographical talk of Christian respondents is both enabled and constrained by their positioning in Biblical discourse.

Graham, for example, emphasised that he knows what he is, what he does and what he will continue to do …

> *G: 'Yeah just I mean I'm an evangelist that that's what I do I'm a public speaker and my (2) goal (..) my goal is principally to reach more people with (2) God's story (.) creatively using my story to do that whichever shape or form that is'*

Graham starts by affirming his self-identity as evangelist ('that's what I do I'm a public speaker'). Unpacking his subsequent assertion is less straightforward. The proclamation that his aim is 'to reach more people with God's story by creatively using my story' has a tautological quality. Graham implies that who he is today constitutes the fulfilment of God's design for his life – thus, by proclaiming his conversion narrative, Graham is fulfilling part of God's master plan: that 'the earth be filled with knowledge of the glory of the Lord' (Habakkuk 2:14, NKJV). Graham positions himself as God's ambassador (Collela, 1998) – a mouthpiece for the Lord - and the reproduction of his testimony (through evangelism) is, effectively, God's way of communicating to others. Indeed, as Collella (1998) surmises in her interpretation of Paul's message to the people of Corinth, 'God saves us and through us He reaches out to others' (p.50).

It is interesting how Graham refers to *creatively* using his story in different 'shapes and forms'. This supports the discursive notion that narrative and the act of narrating is a context specific construction (Taylor, 2010, p.37). Graham implies that his 'story' is subtly modified in a manner befitting the audience, an implication aligned with Taylor's

(2010) argument that personal narratives are ‘shaped to do work in the particular circumstances of the telling’ (p.69). Thus, for Graham, narrating to a group of school children would be a modified version of that represented to a church congregation, a group of agnostics, a research interviewer and so on. That is, to prevent ‘trouble’ arising from inconsistency and the consequent need for repair, each ‘creative’ telling would constitute a ‘new *version’* as opposed to a ‘new *creation’* (Taylor, 2010, p.69). Modified, yes, but not to an extent where more recent tellings become inconsistent with those previously told.

Graham’s moves on the articulate another aspiration …

> *G: ‘also to get emerging people who are coming through like (name) and just try (2) and help them on their journey as well so it’s kind of (.) err it’s kind of leaving a legacy isn’t it’*

His desire to ‘help others on their journey’ is another sacrificial construction that invokes the Biblical command ‘do good and share with others’ (Hebrews, 13:16 NIV) and ‘help God’s people’ (Hebrews 6:10 NIV), both of which are constructed in Biblical discourse as pleasing to the Lord. Moreover, these are further enactments that enable Graham to experience himself as an ambassador for God. Although secular and Biblical constructions of legacy are in some ways similar (leaving wealth for one’s children’s children (Proverbs 13:22) for example), Graham’s notion of legacy corresponds with a life that glorifies the Lord and is reproduced though others for years to come. Both extracts position Graham as a man who believes that his past is being and will continue to be used for good.

Frank’s future aspirations are similar in many ways to Grahams …

> *F: ‘Yes (.) um well I’ve got a book coming out in (month) and I’d really like to get that book (.) I mean it’s a book based on my story based on the events of the past based on what I’m doing now and (2) the reason um why I’m in a changed place in my life because of that decision I made to ask God into my life back in 2002’*

I: Mm

F: 'So really um and it's a book that I believe brings hope to any person that finds themselves in a helpless situation (.) in an addictive cycle I just believe that it brings hope I would say you know to people who may feel helpless or my (2) old mentor used to say this 'you may feel helpless at this time but you're not hopeless' cos (2) nobody's hopeless so it's a book that brings hope to people who are in despair (.) my heart is to get into prisons as many copies as I can (.) so yeah you know for (2) free obviously so that will be sort of part of my project to raise funds to do that um but yeah just to encourage people and to (.) yeah to inspire people to change'

Frank's also aspires to bring hope to the hopeless by using his testimony. Although his intentions are admirable, they could be critically conceived as a 'what worked for me should do so for you' view of addiction recovery. With that said, Frank qualifies the assertion that his testimony is one that 'brings hope to any person in a helpless situation' with 'I believe' thus producing a subjective opinion (as opposed to an objective fact). Moreover, it is interesting how Frank vocalises his desire to get copies of his book into prisons, but quickly checks himself by affirming that they would be 'you know for (2) free obviously'. In presenting the dispatch of his text into prisons as something he will 'obviously' do for free, Frank averts the potential for 'trouble' based on a (mis)interpretation of his desire as a financially lucrative one. The primary function of this narrative is to position Frank's past transgressions and the (God-ordained) future emanating from those indiscretions as a force for good.

Both Graham and Frank represent their future aspirations as definitive. Their testimonies constitute the performance of religious identity (Harding, 1987 cited in Sremac, 2013). Both participants allude to a definitive future that involves reaching out to others - relaying their conversion narratives to multiple and diverse audiences who they hope will subsequently embrace the versions of reality they present (Sremac, 2013).

Perhaps reflecting is relative a lack of experience in performing Christianity Eddie's representation of future goals and aspirations, in comparison to Graham and Frank's, are more aligned with 'mainstream-secular' constructions ….

I: In terms of your goals and aspirations and your recovery can you just tell me a bit about what your hopes for the future are?

E: 'Right (.) well I've always had a thing in my heart that I'll get, because drugs were number one in my life for such a long while, I never thought about relationships about getting married or anything like that (.) I never got around to thinking about doing driving although I did get to a few tests (.) and I failed those cos I couldn't concentrate due to being on drugs and stuff

I: Yeah

E: I've not really had my own flat for a while (.) so I'm really looking forward to that and (.) yeah meeting the right Christian friends in my life and just going forward with the church (.) finding what roles I can play with the church in the future'

Eddie's narrative supports Tanner's (1997) observation that for Christians to incorporate a mix of Christian and 'secular' practices is not unusual. This religious-secular blend, for Tanner (1997), constitutes a significant aspect of Christian-mainstream relations. With that said, although Eddie's aspirations are 'mainstream' to a degree, his biographical talk is interspersed with allusions to Christianity, imbuing the narrative with a Godly flavour. Also of note is the Eddie's reproduction of the established notion that 'addicts' prioritise their drug(s) of choice above all else (Abadinsky, 2011) – this functions to rationalise his lack of conventional acquisitions.

However, his reference to 'always' having a 'thing in my heart' connotes an internal ever-presence – the implication is that God was within Eddie throughout his times of trouble. Talk of the heart, moreover, evokes Biblical constructions of God communicating via the heart and functions to

position his aspirations as God-inspired. Eddie also alludes to his desire for a relationship leading to 'marriage' – this is a rhetorical address to fellow believers and positions Eddie's longing for coupledom in the form of 'marriage' as a Godly-yearning. He concludes his narrative by affirming is religious self-identity, drawing attention to his desire to meet the right *Christian* friends and to be closely involved with *the church*. Although Eddie's representation of future goals and aspirations is not indicative of a well-practiced and polished conversion narrative, it nonetheless constructs his future as stable and secure.

Dave had earlier alluded to feelings of shame produced by is self-identity as an addicted drug user. Towards the end of interview I asked him how he felt about interactions with mainstream society today and his self-identity as a Christian moving forward. Dave responded …

> *'I'm very comfortable in it (.) very comfortable and I tell everybody (..) every opportunity I'll share with somebody (.) cos I know that's the only thing that can help'*

Here Dave speaks with conviction, emphasising how secure he feels in his self. He utilises extreme case formulations ('I tell everybody' […] every opportunity I'll share') to draw attention to his evangelistic zeal. He positions himself as a 'faithful witness' who takes 'every opportunity' to share his story and faith with others.

Dave moves on talk about the future, his goals and aspirations …

> *D: 'Err I think that I have a very bright future (.) there's no two ways about that I've had many I gained many skills and qualifications now err to counteract what's happened in the past I'm 16 years way from it all now, I've probably spent about 12 years out (.) so I've came away quite a lot from so and I've built up skills and qualifications and it's just moving forward now (.) just continuing to move forward and that (.) continuing to gain the skills necessary for the job that I'm in'*

Like Eddie, Dave's construction of the future does not have an overtly religious orientation. His utilisation of the 'no two ways about it' idiom

functions to position his future as undoubtedly positive. Interestingly, he highlights the accumulation of 'skills and qualifications' as activities which have off-set his past addiction and associated issues. Despite identifying as Christian, this implies that Dave's vision of personal-social progression is shaped by secular-neoliberal constructions of the 'good citizen'. He positions himself as a 'striver' ('moving forwards […] continuing to gain skills necessary for the job I'm in'). Moreover, drawing attention to drug free time ('I'm 16 years away from it now') is a discursive manoeuvre that functions to stress how far removed he is from the transgressions of the past. Although Dave positions himself as a firm believer in God, when representing his personal aspirations he draws attention to the conventional normality that now characterises his everyday life.

As a final point, listening to all four Christian respondents narrate their future aspirations there is a notable difference in emphasis between Graham and Frank (public speakers and authors who make their living through self-stories alluding to how they are 'recovered through Christianity') and Eddie and Dave. This suggests that the environment in which a person's everyday life is lived provides the interpretive resources out of which future aspirations are formed and conveyed. For Eddie and Dave, their future as Christians will be played out predominantly in the secular-mainstream world, whereas for Graham and Frank everyday life revolves around church and ministry. This contextual variation produced different narrative emphases in response to the questions posed. However, a sense of certainty and conviction in their talk about the future was a commonality among all four Christian speakers.

7.4 Chapter Summary

This lengthy chapter has explored how participants constructed treatment and/or recovery from dependent drug use and their hopes and aspirations for the future. The first discourse, purposefully labelled '(The) Breaking (of) the Habit', reflected a key distinction between Christian and non-Christian respondents. That is, whereas Christian speakers emphasised *the breaking* of the addiction by God or adherence to the Christian faith,

non-religious speakers tended to draw attention to personal effort – how *they* broke their habit.

Although the efficacy of drug treatment itself was variously represented, 'experts' were positioned in a largely negative light with respondents highlighting failure to listen, enforced reductions or over-use of psychotropic medications to sedate. I suggested that responsibilising the 'expert' functioned to limit personal accountability for negative treatment outcomes. Community treatment specifically was variously represented by non-religious speakers as a form of imprisonment (Carl), a successful harm reduction tool (Ben) and an institution that can educate but cannot replace the role of individual motivation and responsibility (Andy). Christian respondents tended to cautiously downplay the efficacy of mainstream treatment programmes. This, I argued, was a discursive manoeuvre that functioned to implicitly position alignment with the Christian faith as the only way 'true' freedom can be achieved.

Another discursive construction focused on representations of 'recovery' as a concept. Here respondent accounts, to an extent, reflected the contestation and debate that surround recovery discussions in public and professional domains. Only one participant (Harry) rejected the possibility of attaining recovery/recovered altogether. Carl first rejected and then accepted medication-assisted treatment as consistent with recovery, a contradiction and change of direction that functioned to shield him against accusations of failure should long-term abstinence not materialise. Other non-religious and Christian speakers, to a greater or lesser degree, alluded to 'recovery' as a state of abstinence in conjunction with 'good neoliberal citizenship' characterised by conventional normality. Variations between respondents lay in the degree of tentativeness with which this 'abstinence assertion' was made, with some speakers alluding to stability and 'work' as key elements of the recovery journey and others bluntly asserting that recovery *is* 'total abstinence'. I argued that these narratives resonated with the 'internalisation of full recovery' thesis proposed by Neale et al. (2012).

Drawing on Giordano et al's (2002) staged theory of cognitive transformation and with reference to the two community service users (Ben and Carl), both expressed openness to change - Carl in particular was able to *envisage* a life outside of treatment. In the context of contemporary drug treatment and whilst on MAT, however, the capacity to *embrace* hooks for change are restricted as are opportunities to form a new self-identity. As stable patients, given the opportunity, Ben and Carl have the capacity to adopt roles as 'wounded healers' (Maruna, 2001) and utilise their experiences for the good of self and others. Until constructions of people in medication-assisted recovery change, however, the self-identity as 'heroin addict by another name' will continue to be conferred and internalised by clients, constraining their capacity to engage in conventional society. Moreover, as Nettleton et al. (2012) explain, discursive resources for constructing positive versions of medication-assisted recovery are simply not available and the potential for identity trouble emanating from alignment with a culturally discredited recovery pathway ever-present.

Two Christian speakers rejected 'in recovery' as a self-identity category and instead positioned themselves as 'recovered' due to their God encounter and Christian way of life. Moreover, Christian speakers utilised various discursive strategies to position God as the only *plausible* explanation for their drug-abstinence with a focus on extraordinary occurrences that are difficult to otherwise explain. Among Christian participants, the taking-up of a passive position wherein being 'saved' is the only available option was perhaps inevitable as it functioned to position God's intervention as paramount. Nevertheless, as Maruna (2001) notes, the subsequent decision to follow God and engage in the Christian life is indicative of personal agency. Indeed, I noted how most Christian respondents also invoked a therapeutic discourse, emphasising the need to participate with a (Christian) recovery programme, to self-monitor and engage in work on the self - this raised critical questions relating to the efficacy of supernatural healing versus therapeutic engagement and self-care. Christian narratives corresponded broadly with Giordano et al's

(2002) model of cognitive transformation: most speakers expressed an openness to change with Christian encounters constituting the hook for change, a hook that was subsequently grasped. This led to the envisaging a more appealing (God-involved) self and finally the formation of a new identity in God whereby old 'sinful' behaviours became unappealing. As Giordano et al. (2008) explain, religion is a form of social control with religious discourse directing the believer in how to live a pro-social life. Only Graham presented as a deviant case who prior to his God encounter, claimed to have had no desire for change. Although seen here as a discursive manoeuvre that functioned to emphasise the power of God, it nonetheless contradicts the first stage of Giordano et al's (2002) theory and the recovery literature more widely, wherein openness to change is positioned as a pre-requisite for successful desistance.

The final discourse – 'The Road Ahead as Contingent or Definitive' – captured key differences in how non-Christian and Christian speakers narrated their future aspirations. Non-Christian speakers constructed a future, the attainment of which was both aligned with and dependent on their meeting normative Westernised notions of success. For both Harry and Andy, education was the hook for change with a good future bound-up with continued successful engagement with informal controls (Laub and Sampson, 1993). Though informal social controls *can* play an important role in preventing future deviance, their efficacy depends on how they are subjectively experienced (Weaver and McNeill, 2007). Harry alluded to the permanence of the addict self and also expressed some ambiguity concerning his desire to desist from cocaine - this suggested that his old way of life continues to hold some appeal (Giordano et al., 2002). Harry, moreover, emphasised that relapse is only one (subjectively experienced) backward step away. For Andy, his expressed desire to prove others wrong implied a need for external validation (Maruna, 2001) which at the time had not been forthcoming. Such assertions and allusions are not demonstrative of the self-esteem and self-efficacy that Maruna (2001) argues is a requirement for long-term desistance.

Christian respondents on the other hand, constructed the future as undoubtedly positive. Here I noted how Frank and Graham (evangelists and authors) constructed the road ahead in terms of working for God for the benefit of others. Their narratives, to an extent, were compatible with the redemption script and the concept of 'wounded healers' as highlighted by Maruna (2001). With that said, Maruna (2001) argues that successful desisters do not so much break from their past selves but distort past events to correspond with their current positive conceptions of self. Frank and Graham have both authored books that offer in-depth and (seemingly) unimpeded interpretations of their deviant pasts. Moreover, the narratives they produced during this study displayed no obvious mining of the past for pro-social selves. Rather than identifying as 'antiauthoritarian rebels' (Maruna, 2001, p.154) who had not changed at all, they disrupted Maruna's redemption script by emphasising their *fundamental* identity change, namely, a new identity in God. Eddie and Dave also positioned the Christian identity and continued commitment to the Christian way of life as central. However, their future aspirations were more explicitly aligned with (although not reliant upon) conventional controls such as work, healthy relationships and other facets of 'mainstream' life. Despite variations, all four Christian speakers constructed the future as secure, in some cases ordained, with God and the Christian lifestyle positioned as conduits for their future prosperity.

Having analysed the interview data through Chapters 6 and 7 with a chronological focus on the construction of addiction-to-recovery trajectories, the primary purpose of Chapter 8 is to draw conclusions.

CHAPTER 8

Review and Conclusions

8.1 The Empirical Research: A Review

Drawing on the premise that conceptions of self and constructions of self-identity and experience cannot be divorced from the sociocultural and political contexts *in which and with which* they are produced, this research applied a discourse analytic lens to a government strategy document and the addiction and recovery talk of eight male former drug users living in England. As well as contributing a constructionist dimension to the corpus of realist research on addiction, by comparing and contrasting how individuals aligned with *differing* recovery pathways construct addictions *and* recoveries this study builds on existing discursive research which concentrates primarily on the treatment/recovery element of the trajectory.

The empirical research was two-stranded. The first strand was a Foucauldian-informed discourse analysis England's official 'recovery roadmap': Putting Full Recovery First. Addiction and recovery-related discourses that permeated the document were identified and discussed in terms of their implications for the subjectivities and experiences of both active drug users and those who are in or working towards recovery from addiction in England. Moving forward, the objective was to explore to what extent both these discourses and other political and sociocultural discursive resources shaped and permeated the narratives of research participants.

Having drawn attention to the discursive milieu, the second strand of empirical research involved qualitative interviews with eight former drug users. Four interviewees attributed their abstinence from various drugs to a God-encounter and Christian way of life. The other participants explicitly denied any religious adherence - two were former heroin users accessing medication-assisted treatment from mainstream community providers and two were former stimulant users not explicitly wedded to any particular

treatment or recovery pathway. Each participant was asked initially to narrate their story of addiction and recovery. Data was analysed using a synthetic discursive framework that enabled what Willig (2013) described as a 'twin focus' on both macro and micro-level discursive contexts.

Before drawing conclusions, it is important to (re)emphasise that in terms of recovery pathway or treatment modality the eight interview participants could be loosely categorised into three groups: four individuals who identified as Christians and attributed their drug-abstinence to the Christian faith; two (non-religious) community service users on prescribed methadone; and the two (non-religious) former stimulant users who did not align themselves with a specific recovery framework.

8.2 The Empirical Chapters: Drawing Conclusions

8.21 Introduction

With the broad aim of this thesis, data sources and analytic approaches reviewed above, the conclusions will be presented as follows. To begin, I draw conclusions pertaining to the shape and framing of participant narratives across the data set. Following this I concentrate on how speakers constructed their initial drug-involvement and the process of becoming addicted and the proceeding section considers constructions of 'recovery' and future aspirations. My emphasis throughout is on how and where narratives converged and diverged in terms of shape and detail both across the sample and among and between participants aligned with differing recovery pathways. I then move on to present a reflexive discussion of how 'who I am' influenced the data analysis. Within the following three sub-sections I comment on the theoretical and practical implications of the thesis, address the study's limitations and suggest directions for future research respectively. A final section draws attention to how this research offers an original contribution to knowledge.

8.22 Descent-Ascent: A Widely Utilised Narrative Resource

Although unique personal-social histories and differing recovery pathways produced distinct stories of addiction and recovery, there were notable

convergences in how speakers *framed* various stages of their recovery-to-addiction trajectories. Most notable were similarities in how respondents framed movement *in to and out from* addiction. This convergence, I suggest, was an outcome of the availability of canonical narratives – common-sense resources for making sense of addiction and recovery processes. This observation is supported by Weegman (2018) who notes that although the details of addiction and recovery narratives display tremendous diversity most assume a distinct shape - a descent into addiction and ascent towards recovery, a process of 'decline and renewal' (p.153). Indeed, notions of 'descent' and 'ascent' have also been highlighted as resources that frame constructions of addiction and recovery by Keane (2002, p.161) as well as illness and recovery narratives more generally (Hutchinson, 2017). These studies emphasise the how these interpretive frameworks are culturally entrenched in the Western world. It is perhaps unsurprising, then, that they were utilised by respondents in this study.

Before moving on it is necessary to re-emphasise that my assertion that particular cultural narratives or discourses *framed* respondent representations of the addiction-to-recovery trajectory *in no way* implies that constructions situated within these interpretive frameworks were the same or even similar. That is, although particular interpretive frameworks were utilised as framing devices across the sample, the detail of accounts (how specific events and experiences were represented, how speakers positioned self and others, and the discursive-rhetorical strategies deployed) often varied significantly, at times starkly, particularly between Christian and non-Christian speakers but also at times among participants aligned to the same recovery pathway and/or religious or non-religious world view. Even where life events and experiences converged (experiences of psychological distress or 'othering' for example), it was notable how the discursive resources a person has at their disposal for making sense of these experiences and the differential subject positions availed by the *local*-cultural milieu,, at times produced stark representational divergences.

8.23 Drug Initiation, Continuation and Maintenance

Not all participants chose to begin their story with reference to early drug-related experiences but, among those who did, this was broadly represented as a relational phenomenon – something that in one way or another involved other people. However, despite this similarity, the detail of accounts relating to early drug-involvement differed substantially. For some, drug use was explicitly constructed as a personal choice invoking the 'addiction as lifestyle choice' discourse identified in the reading of PFRF. Others constructed their drug-involvement as a product of the environment. Notably, the former construction – drug use a personal decision – was more prevalent among Christian speakers while the latter construction tended to be utilised by non-religious respondents. From a realist perspective these differences could or would be attributed to differing life experiences. However, from a discursive position it is plausible to tentatively infer that this variation was produced by respondents' access to discursive resources. By this I mean that Christian speakers are influenced by and have access to Biblical resources that emphasise free will and construct their old way of life as one that was governed by distasteful human (as opposed to Godly) desires. Moreover, they are positioned in Christian discourse a born-again, as new persons. Thus, to present their drug-involvement as a personal choice functions to draw attention to the shift from the 'old' to the 'new' and 'saved' self.

Although, like Maruna's (2001) sample of successful desisters, two Christian speakers implicitly position their selves as 'wounded healers', I suggested that Christian narratives corresponded broadly with Giordano et al's (2002) staged process of desistance involving openness to change (albeit with Graham presenting as a deviant case), hooks for change, the envisaging of a new self and, finally, the stage when old 'sinful' behaviours have no appeal. This notion of a fundamental change in personhood is unavailable as a resource for non-religious speakers who therefore have more stake in providing a convincing rationale to justify past behaviours that may be deemed as at best misguided, at worst

immoral. In this sense, their narratives were consistent with participants in Maruna's (2001) study who used a variety of linguistic techniques to validate past criminal behaviours.

Across the sample, a 'descent into addiction' or 'downward spiral' canonical narrative framed accounts of drug continuation and maintenance, the process of becoming a person who used drugs problematically and prolongation of that way of life. To reiterate Weegman's (2018) assertion that notions of 'descent' or 'decline' are cultural resources widely utilised to frame accounts of addiction, it is unsurprising that this was the dominant interpretive framework utilised by this study's participants. Another common construction situated within the 'downward spiral' narrative and alluded to by six of the eight speakers were constructions of drug use as an escape from everyday life. This indicates that drug use as a form of escapism is another prominent cultural resource utilised by former (and active) drug users to rationalise the continuation and maintenance of addictive behaviours.

When narrating their experiences of active drug use, a majority of respondents highlighted their experiences of psychological distress, reproducing and reinforcing the relationship between addiction and mental ill health. Despite this broad convergence, the resources utilised to make sense of these experiences of psychological ill health differed starkly between Christian and non-religious respondents. All Christian speakers drew on a paranormal discourse to make sense of their mental health issues, constructing their experiences as the outcome of Devilish encounters or Satanic attack. In this respect, how each participant entered the conversational encounter already positioned as believers in Biblical 'truths' both shaped and resourced their retrospective constructions of what instigated their psychological distress. This supports existing (though scarce) research on how former drug users who 'recover' through Christian conversion draw on both their personal-social histories and linguistic resources provided by their faith communities during testimonial talk (Sremac, 2013; Sremac and Ganzevoort, 2013a; Sremac

and Ganzevoort, 2013b). Moreover, responsibilising the Devil, albeit tentatively, is an example of the 'It' replacing the 'I' – this, following Maruna (2001), can be seen as a linguistic strategy that enabled speakers to position mental illness as externally produced but here in a manner that reproduces and reinforces Biblical discourse. With that said, Christian respondents also deployed discursive strategies and rhetorical techniques to limit personal accountability, utilising hedging and *tentatively* weaving in secular-medical discourses alongside allusions to paranormal activity, thus forming a defence against those who may attack the validity of their claims. Here, my researcher positionality (openly agnostic) may well have contributed to the production of more guarded accounts than would have been the case if representing a similar version of events to an audience of fellow Christians. This presumption reinforces the notion of qualitative interviews as situated co-constructions and highlights the productive effects of researcher influence. In contrast, Andy and Harry (ex-stimulant users not in contact with services) utilised what might be termed conventional resources to construct psychological distress, explicitly linking their experiences of mental ill health to drug usage and life circumstances. Andy in particular positioned himself as overwhelmed by long working hours, a strain that I argued was produced by a perceived need to live-up to normative neoliberal ideals including 'good fatherhood' and home ownership.

Another commonality across the sample were allusions to past stigma and judgement by others. Again, distinct variations emerged between religious and non-religious speakers with regards to how the personal impact of being 'othered' was represented. Christian speakers tended to construct stigma either as inevitable given their way of life at the time, of little personal consequence, or both. Respondents with no religious faith on the other hand constructed stigma as unjust and personally damaging. In drawing conclusions, my interest is in why human judgement was represented in different ways by religious and non-religious respondents with a focus on the productive effects of the discursive milieu. Again, a plausible explanation relates to Christian informants' access to and

personal acceptance of the Biblical narrative. Firstly, Christian texts implore the believer to fear only judgement from God with human judgement positioned as nonconsequential. Secondly, as alluded to above, the Biblical narrative avails to the Christian convert the subject position of a 'new person' who has been 'born again' – this constitutes a fundamental change in subjectivity and self-identity. For believers, the old self who once was subjected to human judgement no longer exists in either a material or symbolic sense.

It is reasonable to suggest, then, that divergent responses to questions about stigma, like the rationalisation of mental ill health, are products of the *local* resources (Taylor, 2010) Christian speakers have at their disposal for making sense of past judgment and who they are today. To position one's self as literally a 'new person' and having that God-given self-identity conferred and reinforced through Christian texts and religious speakers, enables the Christian convert to position their self as untroubled by past labels *that can* no longer apply. This conception of self (as literally as 'new' person) is unavailable to non-Christians - the wounds inflicted in the past were against the person who re-tells their story today.

In summary, I have drawn attention to how initial drug involvement was positioned by respondents as a relational phenomenon with Christian speakers more inclined to construct drug use as a personal choice and non-religious respondents bringing to bear extenuating circumstances. I also highlighted how participants across the sample utilised the downward spiral canonical narrative as a framework for representing drug continuation and maintenance. However, life events and experiences including psychological distress and human judgement that occurred during the active addiction phase were differentially constructed. I have argued that these differences were produced by the availability or not of local resources, with Christian speakers drawing on a paranormal discourse aligned with their faith community to rationalise mental health issues while utilising various rhetorical strategies to enhance the facticity of these Devilish encounters. Finally, I suggested that being positioned as

a 'new person in Christ' enabled Christian speakers to construct past othering as inevitable or of little personal consequence, a subject position that is unavailable to non-believers.

8.24 'Recovering' or 'Recovered' and Future Aspirations

To reiterate, I have concluded that 'downward spiral' or 'descent into addiction' canonical narratives framed constructions of movement into active addiction and continuation of that way of life. I also noted that the framing of addiction-to-recovery talk in terms of a 'descent' and 'ascent' has been observed by other commentators on addiction and recovery (Keane, 2002; Weegman, 2018). Although, again, there were significant variations in narrative content, in line with existing research the respondents in this study *framed* constructions of movement away from addiction and/or attempted movement away from treatment services with 'breaking of the cycle' and 'ascent towards recovery' canonical narratives. This included the two participants who were accessing community services and in receipt of medication-assisted treatment, both of whom expressed *a cautious* desire to 'break away' from services and 'be free' of medication. Indeed, the canonical notion of 'breaking the cycle' was utilised as an interpretive framework for constructions of the 'recovery' process across the sample.

Another commonality was the framing of 'recovery' or 'recovered' with the 'full recovery as abstinence' discourse identified in the Foucauldian analysis of Putting Full Recovery First. Only one respondent (Harry) rejected the concept of 'recovery' or 'recovered altogether' positioning recovery as 'bullshit'. Although some participants were less emphatic than others, respondents ultimately constructed recovery as involving abstinence from both illegal drugs and prescribed opioid medications. As alluded to above, this included the two speakers (Carl and Ben) who were accessing medication-assisted treatment at time of interview. Although Carl and Ben, and indeed Andy (former amphetamine user), offered some resistance to 'full recovery' ideals – for example, by drawing attention to the futility of *enforced* reductions (Ben and Carl), alluding to positive

outcomes associated with being in treatment (Ben) and highlighting the need for stability before becoming 'chemical free' (Andy) - the power of prevailing full recovery discourses to shape and resource former drug user narratives was evident, even among those outside of mainstream services.

With that said, both respondents who were accessing MAT at time of interview alluded to feeling conflicted between the positive versus the negative aspects of prescribed medications. Carl certainly positioned himself as fed-up with being tied to treatment, constructing his prescription metaphorically as a 'ball and chain'. Moreover, both Ben and Carl alluded to their disillusionment with treatment personnel who disregard their requests for a manageable reduction schedules, putting them at risk of relapse. Although Ben and Carl both expressed a desire for change and were able to envisage a life beyond treatment, I argued that the absence of positive representations of medication-assisted treatment/recovery and the anti-methadone discourses that prevail within British cultural contexts are constraining their capacity for identity change. Despite having *the potential* to adopt the role of wounded healer (Maruna, 2001), to position the self as a 'contented methadone user' is a source of 'trouble' and would produce an identity that is negatively valued (Taylor, 2010). Following Edley (2001a), speakers have access to a finite selection of cultural resources that both enable and inhibit what they can plausibly say. While reflexively acknowledging my position as a critic of the full recovery agenda and recognising the potential for data distortion (see 'reflexive engagement' below), it would nonetheless be interesting to explore if positive constructions of medication-assisted treatments or recoveries prevail to a greater extent within contexts where such recoveries are not positioned as inferior.

Discourses identified in the FDA of PFRF were also utilised by speakers who positioned their selves as 'saved by God'. Frank, Graham and Dave (all Christian respondents with a history of heroin dependence) variously positioned 'recovery' or 'recovered' as synonymous with abstinence

invoking the 'full recovery as abstinence' discourse. 'Full recovery as rational and moral' was also utilised, for example to conflate methadone usage and state benefit dependency (Dave) and position medication-assisted treatment as 'heroin addiction by another name' (Dave and Graham). In sum, full recovery discourses were variously reproduced and reinforced by six of the eight respondents. This not only supports Nettleton's assertion that the full recovery agenda has been internalised by community treatment users on methadone but draws attention to how full recovery discourses are invoked by speakers *outside of* mainstream community service including individuals with no personal history of heroin use (Andy) or medication-assisted treatment (Dave and Frank).

A further notable observation was the rejection of 'in recovery' or 'recovering' as a self-identity category by two Christian speakers with Graham and Frank both positioning their selves as 'recovered'. This, again, can be related to Taylor's (2010) assertion that speakers draw on local discursive resources that permeate smaller-scale contexts, in these cases religious communities, personal-social histories and past narrations. For Graham and Frank, both authors and evangelists to position self as anything other than 'saved' and 'healed' and hence 'recovered' may bring 'identity trouble' in the form of an identity that is inconsistent with identities previously claimed, for example, in a written biography or during a public speaking engagement. That the two other Christian respondents (who did not identify as public speakers or authors) were *not* resistant to 'in recovery' or 'recovering' as means of self-identification lends support to this line of reasoning. So constructions relating to mental ill health and stigma as well as 'recovering' versus 'recovered' reinforced the notion that local resources aligned with personal recovery pathways contributed significantly to the production of variation in narrative content between religious and non-religious speakers.

This argument also relates to the rhetorical strategies utilised by Christian respondents to position their recovery/recovered status as 'miraculous' and 'God-ordained'. Importantly however, this was proceeded in all but

one case by allusions to recovery as a process involving other humans and support systems. Despite the *implication* of a God-inspired healing, all Christian speakers (other than Graham) constructed the post-God encounter period as synonymous with a 'journey' involving therapeutic notions of peer-support, self-care and self-improvement. This indicates that *positively experienced* informal controls are a core element of sustained desistance, regardless of the initial God-encounter. In this sense, the narratives of religious speakers resembled the accounts of participants with no religious faith. In sum, it would appear that neoliberal therapeutic discourses and the established narrative of recovery as process or journey are influential constructions, utilised even by those who position their selves as 'saved by God' (perhaps to enhance the plausibility of a recovery narrative directed at an agnostic researcher and potentially hearable by secular audiences). So recovery as a process or journey can be considered a dominant cultural narrative in a similar vein to 'the downward spiral' and 'breaking the cycle' interpretive frameworks previously discussed.

Continuing the focus on 'recovery', a significant variation between respondents aligned with Christian and non-religious recovery pathways were constructions of movement away from addiction and the drug-using way of life. Whereas religious participants positioned their selves as 'saved' or 'rescued' by God, Andy and Harry (former stimulant users with no religious inclination) constructed their drug-abstinence as a personal endeavour requiring personal effort. When looking at each narrative as a whole, these differing representations take on added significance. As previously noted, Christian speakers tended to construct early drug use and addiction as a *personal and purposeful choice* thereby invoking Christian discourses of 'free will' and the 'choosing self' of neoliberalism. (Rose, 1998, p.168). In contrast, non-religious respondents constructed initial drug-involvement as a product of their environment, corresponding with existing research on desistance narratives (Maruna, 2001). So within non-religious narratives there was a shift from passivity to agency but in

Christian accounts the shift was from agency (choosing to use) to passivity (recue by God).

Attention to the performative function of language offer further insights into these directional shifts. Simply put, for Christian respondents the rescue narrative functioned to position God as a real and powerful presence. While choosing to use drugs conjures up notions of free will and the sinful 'unsaved' man, to later position one's self as helplessly addicted enables the production of a testimony that forefronts the power of God. For non-Christian participants, however, constructing their drug use as a product of the environment functioned to deflect personal blame while representing drug-abstinence as a *personal* achievement functioned to endow them with characteristics associated with the 'good neoliberal citizen'. Indeed, in Carl's (former heroin user in community treatment on prescribed methadone) account the constitutive power of neoliberal discourse and its status a cultural resource was readily apparent. Despite being constrained by full recovery discourses and practices, he was still able to negotiate a self-identity 'aspirational citizen' and envisage a life characterised by education or gainful employment.

In sum, with regards to constructions of becoming drug free the Christian narratives functioned to give glory to God and highlight *God's* strength. Most Christian participants reproduced the notion of God as all powerful Saviour by drawing attention to their own weakness and powerlessness in the face of addiction. Graham utilised an alternative strategy through which he sought to demonstrate the power of God by positioning himself as a contented drug user who had no intention of changing but was changed nonetheless following a God-encounter. In contrast, non-religious respondents – Harry and Andy in particular - variously accentuated their own strength and perseverance. This functioned to position them as individuals of strong character who were able to overcome adversity and prevail against the odds. However, despite this positioning and as noted below, there were aspects of Harry's narrative that rendered uncertain his prospects of sustained abstinence.

Turning finally to constructions of future hopes and aspirations, all respondents framed their preferred future with a narrative of personal-social progression. There were, however, variations between religious and non-religious respondents in terms of how this was achieved and also the degree of certainty with which the future was represented. Christian respondents constructed the future as very much definitive or God-ordained, although divergences among Christian speakers also emerged as noted below.

For Frank and Graham (both authors and evangelists) and following Taylor (2010), their constructions were resourced with narratives previously told (in publications and to listening audiences) and concentrated on reaching and inspiring others with God's story. With Dave and Eddie, albeit they both reproduced the Biblical notion that a God-inspired future is a good future, their aspirations had a more secular flavour – to progress in work, to pass a driving test, to meet a wife or form a relationship, to furnish a new flat. The divergences that emerged among respondents aligned with Christian recovery pathways can be linked to how speakers enter a conversational encounter always already positioned. For Frank or Graham to deviate from a script that is known by those who have witnessed their spoken testimony's or perused their written biographies could bring identity trouble in the form of an identity that is inconsistent with identities previously claimed (Taylor, 2010). Dave and Eddie, although both alluded to continued commitment to the Christian way of life, were afforded a more a flexible portrayal. This flexibility, I would argue, was produced by their relative anonymity.

The two speakers in community methadone treatment constructed a preferred future very much dependent on interactions with the treatment system but nonetheless aligned very much with normative neoliberal goals including family life, work and education. Carl's narrative in particular functioned to position drug treatment personnel as responsible for his future success. The analysis highlighted how constructions of the future by all four non-religious respondents lacked the conviction of their Christian

counterparts with allusions to high-risk of relapse and dependence on others and/or otherwise reliant on achieving normative dimensions of 'success'. Indeed, I suggested that for Harry and Andy, their preferred futures were bound-up with continued *successful* engagement with informal controls (Laub and Sampson, 1993), particularly education. Harry, however, implied that relapse is only ever one (subjectively experienced) backward step away while Andy alluded to a desire prove others wrong connoting a need for external validation. I argued that these precarious positionings are not demonstrative of the self-efficacy required for long-term desistance (Maruna, 2001). What is more, Harry's reproduction of the 'once and addict always and addict' construction and elusiveness regarding the pleasure versus the pain of cocaine usage made it difficult to conclude that fundamental identity change had occurred.

In sum, my reading of the data relating to 'recovery' or 'recovered' and future aspirations' suggests that respondents who self-identified as born-again Christians and professed allegiance to a life lived in accordance with God's (Biblical) instruction exuded more surety about the future than non-religious participants. Whether or not this conviction manifests in the longer term is beyond the parameters of this study, although existing research does posit a link between religious commitment and sustained desistance (Giordano et al., 2008; Holligan and McClean, 2018). Moreover, it gives some indication of how religious discourse avails subject positions that enable (and constrain) particular modes of being and thinking in and about the world. Although recovery through religious conversion is by no means an appealing path for every person, based on the narratives of respondents in this study I would tentatively suggest that being *committed* to a belief system wherein drug use is discouraged, that also enables access to the support of a community of like-minded others, may produce a sense of certainty in terms of continued drug-abstinence than might otherwise be the case.

8.25 Summary

In the conclusion I have highlighted how dominant addiction-recovery discourses and narratives framed the narratives of this study's respondents. Bringing back to mind the literature reviewed in Chapter 2 and the diversity of *this* sample (in terms of their personal-social histories, recovery pathways and present-day circumstances) it can be reasonably argued that in Britain at this time, particular discourses and canonical narratives are both available and widely utilised for talk about becoming drug dependent and (attempting to become) drug free, *regardless* of individual circumstance or recovery pathway. This supports the critical discursive notion that speakers (in this case former drug users in Britain) are members of a linguistic community who are both shaped by and have at their disposal a finite selection of common-sense resources (Edley, 2001a). Key variations in narrative content and how individual participants positioned self and others in talk often emerged through the deployment of linguistic resources that prevail within smaller-scale contexts; these 'local resources' (Taylor, 2010 p.67) relate to the individual's personal-social history and (in this research) their treatment modality or recovery pathway.

Finally, although the recovery narratives presented here corresponded with *elements* of criminological theories of desistance, no one theory unproblematically reflected participant accounts. This lends support to the emerging consensus and reinforces my own view that *there is* no one-size-fits-all explanatory framework for addiction recovery.

8.3 Reflexive Engagement

In the introduction to this thesis I explained my researcher positionality and related concepts of personal and epistemological reflexivity. This involved consideration of my agnostic stance with respect to religiosity and how my personal experiences of drug use and experiences as represented by people I know or have been in contact with shaped my perspectives on addiction and recovery. Moreover, with regard to the full recovery agenda I positioned myself as a critic of one-size-fits-all abstinence-only approaches to treatment and recovery and the prevailing

anti-harm reduction and anti-methadone sentiment. In keeping with a 'spirit of openness' (King et al., 2018), the following will draw attention to a section of the analysis whereby positionality was in danger of *distorting* participant narratives to align with my personal-political position, necessitating a re-think.

At one point in his narrative, Carl (community service user on prescribed methadone) constructed treatment as a 'ball and chain' and expressed a strong desire to break free from this context. Rather than reading the data in accordance with a constructionist theoretical framework, this at first initiated a realist critique involving assumptions about what had *really* prompted Carl's desire to leave treatment and methadone behind. Although Carl made no reference at all to his dose of methadone, I suggested that his quest to leave treatment and detoxify from methadone must be linked to the chronic under-dosing that characterises treatment of heroin addiction in England. In other words, I moved far away from the narrative extract and *the relevant* discursive milieu, opting instead to launch a personal attack on an aspect of the drug treatment system that, yes, in my opinion is problematic but was not relevant to the data extract or cognisant with a constructionist epistemology. Here, the advice of my supervisory team was key – their feedback on drafts during the course of writing this thesis enabled me to return to the highlighted data but also to acknowledge and rectify other similar analytical errors.

With this said, my personal-social history and related values permeate this thesis. Both the analysis of discourses in Putting Full Recovery First and participant narratives is *my* reading of the data underpinned by a constructionist epistemology and discursive theoretical framework. I am conscious that other discourse analysts would in all likelihood produce alternative readings of the data in accordance with their positionalities and conceptual frameworks. Moreover, researchers applying realist or phenomenological frameworks would perceive the data in a different light, again producing a very different interpretation. In sum and to reiterate a point previously raised, my reading is one of many potential readings and

I certainly do not present my findings as 'the truth'. This does not, however, render this thesis bereft of theoretical and practical utility.

8.4 Theoretical and Practice Implications of the Study

Theoretically, this thesis contributes to our understanding of how former drug users in England are both shaped by and utilise the discursive contexts in which they abide to construct their addiction-to-recovery narratives. Although the 'downward spiral' into addiction and 'ascent' towards 'recovery' have been noted as canonical narratives that framed the accounts of all participants, much of the *variation* between narratives can be attributed, certainly to the individuals personal-social history, but particularly to the discursive resources aligned with their 'recovery' pathway or treatment programme. This was most notable among speakers who attributed their recovery or 'recovered' status to God and community service users on prescribed methadone.

Religious speakers framed not only their recovery journey and future aspirations through a Christian lens but also life experiences and events that occurred *prior* to their Christian faith. This indicates how commitment to a belief system and familiarity with related narratives and discourses form an interpretive framework that enables individuals to make sense of past experiences that otherwise may remain swathed in confusion.

With regards to the community service users, 'new recovery' discourses permeated their accounts in that they positioned abstinence as the preferred outcome and personal goal. There were, however, areas of contradiction as respondents also highlighted the benefits of being in treatment, thus reflecting the shifting and contradictory discursive landscape. Notably, both community service users had accessed treatment during the harm reduction *and* full recovery phases of UK drug policy. Theoretically, their references to positive aspects of medication-assisted treatment (MAT) can be seen as the discursive remnants of a time when stability and treatment retention were the central focus of policy and professional discourse and practice.

Most respondents, however, including those with no personal experience of MAT and/or community treatment, constructed methadone use as incompatible with 'true' recovery. In this sense, narratives across the sample reproduced and reinforced the anti-methadone discourse that prevails in British political, media and many professional contexts. To adopt an explicitly pro-methadone or anti-abstinence position in a context where 'new recovery' has emerged as the dominant discourse would instigate identity trouble and the need for repair.

Neoliberal-therapeutic discourses that incite Western subjects to engage in a project of the self (Lawler, 2014; Foster, 2016) also shaped the subjectivities and resourced the accounts of most speakers. Respondents expressed a desire for conventional life goals, particularly work and education. Indeed, with regard to the construction of future aspirations, only the two experienced Christian speakers largely evaded neoliberal ideals, alluding instead to a future centred on serving God through serving others. But even among these two respondents, one emphasised the importance of continued self-observation and peer support. In sum, this thesis has highlighted how what former drug users say and their sense of who they are cannot be divorced from the sociocultural and political contexts with which and in which their narratives are produced.

These theoretical observations have practice implications. For one, drug treatment professionals would be well-advised to become more aware of how the ideologically constituted full recovery paradigm, reproduced and reinforced during therapeutic encounters, shapes the subjectivities and self-stories of the clients with whom they work. Being cognisant of how the agenda individualises personal issues while obscuring socio-economic contexts that produce addiction and constrain recovery would equip workers with additional insight, enabling more targeted and appropriate responses. As noted in Chapter 5, prior to the introduction of full recovery as a political goal in 2010, long-term stable methadone patients were positioned as success stories. The shift in political discourse has repositioned those same individuals as 'undesirable'. An understanding of

how these contradictory positionings and the negative self-identities explicitly or implicitly ascribed those who cannot attain abstinence shape treatment user subjectivities would generate greater levels of empathic understanding. If on the one hand a service user is being informed that recovery involves psychological good health and social engagement but on the other is being positioned as a failure due to their continued use of a prescribed medication that supports their psychosocial wellbeing, this is a contradiction that requires critical reflection and resolution. This research indicates that professionals need to think through the implications of discursive (as well as material) contexts for the service users with whom they work.

Another important practical consideration that emerged from this research is the need to accept that recovery continues to be a contested concept and to some former drug users the term is meaningless. The uncritical labelling of 'in recovery' to people with history of addiction is a generalisation that may decrease rapport between worker and client. Indeed, this mistaken assumption is one that prior to undertaking this research I was guilty of. It was only on meeting and talking to participants that I was made aware that the terminology employed to denote former drug user status is something that individuals may have strong feelings about. In practice or research contexts, to ask an individual how they would prefer or expect to be identified demonstrates an awareness of and respect for that person's individuality.

A further practical implication pertains to the observation that former drug users for whom involvement with a particular faith community supports their drug-abstinence may reconstruct past experiences and future aspirations in ways that do not reflect the worker's (or researcher's) world view. It is important not to dismiss these accounts or try to reshape them but rather to listen and accept them. For some, attending church may be far more beneficial than attending the internal recovery groups that are now often used as a pre-condition for continued access to treatment. Hearing and respecting why participants reject and propose particular

courses of action and *enabling* them to follow their preferred path is far more supportive of recovery than dogmatic insistence on a particular intervention with little consideration of how effective this will be. For treatment professionals the question should not be: Is this individual ticking the organisational full recovery boxes? Rather, it ought to be: Is this person feeling as though they are moving towards a better life, whatever that life may look like, why is this and what can we do to support and encourage it?

In sum, this research has highlighted the need to accept and work with a plurality of recovery pathways and recovery definitions. Moreover, it is essential to look beyond the individual and explore the wider contexts (including worker-client relations) that are influencing a particular individual's conception of self and shaping how they construct their self-identities and life experiences and events past, present and future.

8.5 Study Limitations

One potential limitation of this study is the relatively small number of human respondents. Although the empirical research is two-stranded with the interview-based element forming only one strand, additional participants would have been preferable alongside some gender and ethnic diversity (see 'Directions for Future Research'). Although the representativeness of the 'findings' could be called into question, a focus on *participant* narratives rather than 'empirical generalisation' (Titscher et al, 2000, p.40) is the overarching goal of critical discursive research. Each interview is a situated co-construction with my reading of the data positioned as one of many potential readings. With this said, when respondent accounts are considered alongside existing research, a degree of transferability to other White male former heroin users in England aligned to Christian recovery pathways or accessing community treatment services in receipt of prescribed medications should not be dismissed.

8.6 Areas for Future Research

In terms of future research, it would be interesting to carry out discursive research with former drug users from ethnic minority groups, women, and young people in Britain with the intention of exploring to what extent discourses associated with each group (discourses of femininity and race and ethnicity for example) produce alternative subjectivities and accounts. Moreover, to explore if the narratives generated by the discursive resources each has available to them differ substantially to those constructed by respondents in this study. Although discursive research on 12-step recovery narratives is already relatively prevalent, research with individuals who align themselves with other recovery pathways (SMART Recovery; Residential Rehabilitation; Recovery Communities; etc) would also be well-worth pursuing. I would also like to carry out research with the largely hidden population of contented methadone/subutex users, a group I reached out to via an online forum without success.

Cross-cultural research would also be a fascinating and worthwhile undertaking, exploring how addiction-to-recovery narratives are constructed by former drug users from Westernised nations who adopt different approaches to drug use, addiction and/or treatment and recovery (Portugal, Amsterdam and Australia for example) as well as research with former drug users from non-Western nations. This may further strengthen the claim that subjectivities and accounts are shaped and resourced by culturally available webs of meaning.

Although there have been attempts to link 'recovery' research and 'desistance' theories, this remains an underdeveloped area. As mentioned during this thesis, addiction recovery and desistance from offending are interrelated - practically inseparable (Maruna, 2001). Albeit I continue to see recovery as very much a subjectively experienced process that differs between individuals and a process that cannot be captured by any one theory, future research involving collaboration between criminologists and recovery scholars can only be beneficial in terms of enhancing knowledge and understanding.

I would also suggest that adding a discursive dimension to addiction and recovery research that, to-date, has been explored only through a realist or non-discursive lens would generate new and interesting insights into these complex phenomena. That is, research that concentrates on how language *constructs versions* of reality where before conclusions have been drawn only on the basis that language *corresponds with* reality would offer an alternative angle and produce new insights.

8.7 Final Words

Existing research on addiction is prevalent with research into recovery more limited but by no means unavailable. Moreover, although the use of quantitative addictions research with a focus on measurable 'facts' and causal relationships (Neale et al, 2011) retain a high degree of popularity, qualitative explorations into both addiction and recovery have in recent times become more prevalent. This research contributes to this growing corpus of qualitative research. However, and as alluded to at points throughout this thesis, discursive research into these social phenomena are far outnumbered by qualitative research underpinned by realist epistemologies aligned with a correspondence theory of language. What is more, existing discursive research tends to focus only on the recovery element of the addiction-to-recovery trajectory. With this context in mind the present study – this thesis - contributes to knowledge in a number of ways.

Firstly, the nature of discourse analytic research and explicit acknowledgement that 'findings' or claims-made constitute a particular and context-specific reading of the data – that is, the rejection of replicability as a quality criteria - by definition, positions my reading of the empirical data as one possible reading among many and hence an original contribution to knowledge.

Secondly, although Putting Full Recovery First has been the subject of a small number of (primarily critical) commentaries, the Foucauldian-informed analysis of this text in Chapter 5 of the thesis is the first of its kind. That the discourses identified during the documentary analysis were

subsequently triangulated with the interview data adds another layer of originality.

Thirdly and as already alluded to, existing *discursive* research concentrates only on 'recovery' – for example, how 12-step discourses are utilised by individuals in 12-step recovery programmes (Black, 2011), how neoliberal discourses of normality shape how former drug users talk about future hopes and aspirations (Nettleton et al., 2012) and how treatment provider discourses variously resource the self-stories of community service users (Anderson, 2015). The interview strand of this thesis extended this focus while integrating insights generated during the analysis of Putting Full Recovery First.

As previously explained, the deployment of a synthetic discursive methodology and analytic framework enabled a 'twin focus' (Willig, 2013) that (as far as I am aware) is yet to be applied to research on addiction-to-recovery *trajectories*. An added focus on positioning and self-identity work including instances of identity 'trouble' and 'repair' as well as consideration of how research participants enter conversational encounters always already positioned is also (to my knowledge) a unique contribution to addiction-to-recovery research. Although an interpretive phenomenological analytic framework has been deployed by Flaherty et al. (2014) to examine how people *experience* secular, spiritual and religious recoveries, the utilisation of synthetic discursive approach to exploring how addictions *and* recoveries are *constructed* by former drug users aligned to differing recovery pathways has generated both interesting and novel insights. In sum, this research has produced new knowledge that contributes to the existing corpus of addiction and recovery scholarship.

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APPENDIX A

Interview Schedule

- I am interested in hearing your story of drug use and recovery/how you became drug free? Could you tell me a bit about that, starting from wherever you feel comfortable?
- **Prompts/Sub-topics**
- Can you tell me how you became involved with drugs?
- How did your use of drugs change over time?
- Can you recall times when you decided to reduce your drug usage or 'come off' drugs completely? How did you feel about your drug usage at this point?
- Looking back, how do you feel about your drug usage now?

- Can tell me how you felt others perceived you/your drug use and how this made you feel?
- **Prompts/Sub-topics**
- Are/Were you affected at all by the language that is often used to describe people with drug addictions? junkie; crackhead; druggie; smackhead; etc
- Can you explain how this made you feel about yourself and your life?

- What does the term 'recovery' mean to you, if anything?
- Can you tell me about your recovery journey?
- **Prompts/sub-topics**
- Can you tell me what/who has most helped you, why and how?
- Do you feel a person can be on a (methadone/buprenorphine) script and be in recovery? Why?
- Can you tell me how it feels to no longer be addicted to [name drug]?
- How could your current situation be improved? Would anything in particular make a positive difference'?

- Have you had/what have been your experiences of drug treatment services now and in the past? Can you tell me a bit about this?
- Does your past effect your life today in any way? Can you expand on that?

- Can you tell me a bit about how you see your future? What are your goals and aspirations?

- Is there any else you would like to add before we finish?

Thank participant and ask how they feel and if there is anything they would like to say off-record about the interview process

APPENDIX B

Information Sheet

I would like to invite you to take part in this research study which is looking at the life experiences of people who have had problems or issues with drugs. I would like to hear about your experiences with drugs and also your experiences of drug rehabilitation or recovery. Before you decide whether or not to take part, I would like to make sure that you understand why I am doing this research and what taking part would involve for you. Please take your time and read the following information carefully. If anything is unclear or if you feel you need more information, please feel free to ask me.

What is the purpose of this study?

I have chosen to look at the experiences of people who have had drug-related issues and have experienced the process of rehabilitation/recovery from these issues. In Britain, people who are known to have used drugs are often talked about in a negative manner. I would like to discover how people who have had drug-related problems or issues feel about this and what affect it has had on their lives. The British government has said that drug users will now be expected to become free of drugs and enter mainstream society. This includes finding employment, being able to access health/social care services, finding decent accommodation and becoming involved in community life. The government call this a new 'recovery agenda'. However, people who know how it is to have drug problems or issues often don't get an opportunity to discuss their experiences or express their opinion. How they actually feel is often overlooked. I believe that people with personal experience of drug use, who have tried to stop or have stopped using drugs altogether are the ones best placed to know what will and will not help them. I hope that this research will help others to have a better understanding of what people with drug problems experience in their day to day lives.

Why have I been invited to take part?

You have been invited to participate in this study because you are a former drug use issues who is now in recovery. I am therefore interested in hearing about your thoughts, feelings and life experiences.

Do I have to take part?

No. It is your choice. If you decide that you do want to be involved we will meet up at a place that is convenient for you and go through this information sheet. I will give you a copy to keep. I will then ask if you will agree to take part. With your permission, this agreement will be recorded on a digital voice recorder. Once you have agreed to take part you can change your mind before the first interview takes place and withdraw from the study completely. You do not have to give a reason why you have decided not to take part.

What will I be asked to do if I agree to take part?

If you agree to take part, I will ask you to read a consent form or will read the consent form to you. This is to confirm that you understand what your rights are and what the research will involve. You will not have to sign your name; your agreement to take part in the study will be recorded on a digital voice recorder. I will ask to interview you once every 6 to 8 months over a period of 2 to 3 years. Each interview will last for between 1 and 2 hours. I am interested in hearing your personal story – your life experience. I will ask you some questions about how you became involved with drugs and what being a drug user in British society has been like for you. I will also ask about your experiences of trying to stop using drugs - what you have found helpful or unhelpful. I would like to know of any people or places that have had a positive or negative effect on your life and why they have had this effect. I understand that the word 'recovery' may mean different things to different people. I would like to know what recovery means to you. You can ask to see a list of questions that you may be asked before the interview begins. The questions are not in any particular order. The type of questions I ask will depend on your personal story. You have the right not to answer questions or ask for the interview to be stopped at any point. With your permission I would like to voice-

record each session so I am able to keep an accurate record of what you have said.

I am responsible for making sure that this research does not have a negative impact on your wellbeing. If you feel any of the questions are too personal or upsetting, please let me know and we can move on to another question, have a break, or stop the session altogether.

When I write-up the results of the research you will have the opportunity to correct any information that you feel is wrong or ask for particular information to be removed. It is important that I interpret what you have said correctly and that there is no misunderstanding.

Will anyone else get to hear the recording?

Other than me (the researcher) only the research team involved in this project will have access to the recorded interview. The names and contact details of the research team are provided at the end of this information sheet. You are welcome to contact them with any questions or concerns that I am unable to help you with.

Will my taking part in the study be kept confidential?

All recorded and written information will be stored in a locked cabinet. I will personally type out exactly what you have said. Your real name will not be used at any point in the research. You can choose to use a name that is not your own, or to be known as Participant A, B, C, etc. If after the interview you decide that certain information should not be used, this information will not be included when I write it up. The information that you give me will only be used for this study. The research team are the only people who will have access to it. After the study is completed, all recorded information will be destroyed.

When I write up my report, I will use direct quotes from the interviews. All these quotes will be anonymised (your real name will not be mentioned), as will any other names or place names.

If you tell me something that makes me believe that either you or someone else is at risk then I would have to break confidentiality. However, I would always discuss this with you first.

Are there any disadvantages or risks in taking part?

Although the information you give will be kept in a secure place and your actual name will not be mentioned, I cannot give a 100% guarantee that information will not be lost or stolen. If this happens, you will be told as soon as possible. I would like to take this opportunity to remind you that any information that you do not wish to be included in the written report will be removed.

Are there any benefits in taking part?

Although I cannot guarantee there will be benefits to you personally, having the opportunity to express your thoughts and opinions may have a positive effect on how you feel. I am hoping that the study will help wider society to understand what people with drug problems actually experience which may be beneficial to you in the long run. At the moment, peoples' thoughts and opinions about drugs often come from the media reports or from government. This type of information can be misleading and portrays people with drug problems in a negative light. I want to understand and report your side of the story.

What will happen if I don't want to continue taking part in the study?

You are free to withdraw from the research up to 4 weeks after the first interview takes place. No explanation is required. If you do not want to be interviewed again, just let me know.

What will happen to the results of the study?

I will write a report about the findings of the study. The report may be published in a public arena. I am also likely to share my findings with others through academic conferences and publications. You will not be identifiable in any report or publication.

Who is organizing and funding the research

I am a PhD student at the University of Northampton. I am funding this research myself.

Questions or concerns

If you are concerned about any aspect of this study, I will do my best to answer your questions. If you feel that you need more information, please feel free to contact a member of the research team. You can do this my contacting my research supervisors: Dr. Jane Callaghan or Dr. Rachel Maunder at the University of Northampton.

How will the information be stored?

The information that you give me will be stored electronically for up to 5 years after the study ends. This information will be protected by a password. The answers that you give me will not be stored with any personal details that you have given me.

Complaints

If you wish to make a complaint about this study you can speak to me personally or contact one of my research supervisors.

My contact details

Chris Jackson

Mobile: 07794 764735

Email: chris.jackson@northampton.ac.uk

APPENDIX C

Participant Information Sheet

I have agreed to participate in this research - I understand/agree that:

1	The purpose of the research has been fully explained to me	
2	What I am required to do during the research process has been fully explained to me	
3	I have a right to withdraw from the research up to 4 weeks after the first interview without giving a reason. I do not have to agree be interviewed again.	
4	I have a right not to answer questions during the interview process.	
5	The interviews will be voice-recorded with my permission.	
6	The researcher and research team will be the only people who have access to the information that I give; everything I say during the interview will be securely stored and destroyed when the research ends.	
7	The recorded interviews will be typed word-for-word by the researcher; all details that could identify me (names, places, events, etc) will be removed from the report.	
8	With my permission, the information I give during the interview will be used when the report is written up. The work may also be published but my personal details will be made anonymous so I cannot be identified.	
9	I have a right to see the report and change information that I have given if I feel it is wrong or ask for certain information to be removed.	
10	I have the right to contact the researcher and/or research team at any point during the research process; any questions will be answered as accurately as possible.	

APPENDIX D

Transcription Symbols

Discursive Event	Transcription Symbols
Interviewer	I:
Participants	Andy – A: Ben – B: Carl – C: Dave – D: Eddie – E: Frank – F: Graham – G: Harry – H:
Pauses of 1, 2, and 3 seconds	(.) (..) (…)
Pauses (over 3 seconds)	(4 sec pause) (5 sec pause) etc
Emphasised words or phrases	CAPITAL LETTERS
Missing text (to shorten extract)	[…]
Stutter	I d-d-don't know
Repetition of a word	I (2) don't really know; I (3) don't really know
Respondent interrupts interviewer (dash)	I: So how did you feel about - H: Pissed off
Extended words or expressions	Okaaay; Errrm
Unclear content	(I was diagnosed??)
Inaudible content	(inaudible)
Respondent verbal/facial expressions, actions or external events	(sounds exacerbated); (sharp intake of breath); (appears to disengage); (D appears angry); (somebody enters the room); (B's mobile rings); etc